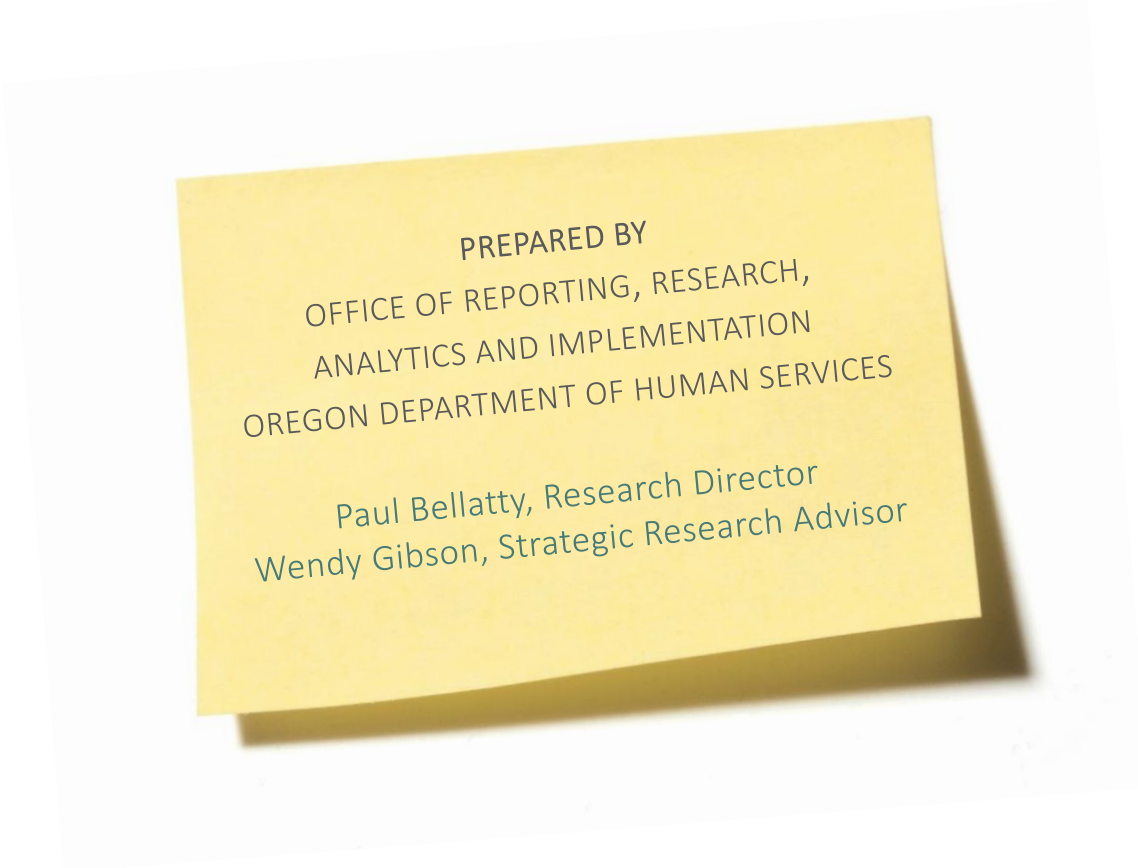
Identifying Capacity Needs for Children within the Oregon Child Welfare System

SUMMARY DOCUMENT MAY 2019

UTILIZING RESEARCH TO ESTIMATE THE NUMBER OF PLACEMENT BEDS (E.G. FOSTER CARE, PROCTOR CARE, RESIDENTIAL TREATMENT, ETC.) NECESSARY TO OPTIMALLY SERVE YOUTH INVOLVED WITH THE CHILD WELFARE SYSTEM. DETERMINING THE RIGHT-SIZE OF THE CONTINUUM OF CARE WILL ENSURE THE MOST APPROPRIATE PLACEMENT AND LEVEL OF CARE FOR CHILDREN AND YOUTH.



PREPARED BY

OFFICE OF REPORTING, RESEARCH, ANALYTICS AND IMPLEMENTATION
OREGON DEPARTMENT OF HUMAN SERVICES

Paul Bellatty, Research Director
Wendy Gibson, Strategic Research Advisor

DHS

Executive Summary

Purpose

The purpose of this research is to identify the current placement capacity required, based on identified needs and characteristics of youth and families within the Oregon Child Welfare system, to meet the safety and health needs of children, youth, and families.

Acknowledgements and Assumptions

Recognizing the scope of this project is imperative. Acknowledging what this research can accomplish is as important as what it cannot accomplish. The research assumes no systemic changes to how youth come into the Child Welfare system or changes impacting youth transitions out of the system. These data and capacity recommendations suggest which placement beds are required within the system today. This research acknowledges child and youth need and begins to right-size the capacity of the child welfare placement continuum. The research assumes and acknowledges placement is defined by the location where the child is receiving needed services and interventions based upon need.

Limitations

The research results do not take into consideration the full spectrum of children and youth served by various systems or funding streams; rather it focuses specifically on Child Welfare involved children and includes all levels of placements children and youth involved with Child Welfare require. The research does not address the funding mechanisms or state level authority for the administration of each level of care.

In Development

The Office of Reporting, Research, Analytics and Implementation (ORRAI) is currently developing a suite of empirically derived tools to support decision-making along the life of a case. These tools include a safety screening tool, safety at reunification and safety within Child Protective Services (CPS). These tools, in time, are expected to have an impact on the size of the substitute care system; therefore, capacity needs are expected to change over time. The second phase of this capacity project includes developing placement matching capabilities. Placement matching will identify the ideal placement for youth entering the Child Welfare system to achieve optimal outcomes. This research will also have an impact on the size and capacity of the system over time

Strategy Overview

The implementation of research tools support efforts to make Oregon's Child Welfare system data-informed. Although data alone will not prevent maltreatment, data-informed decisions improve the likelihood of children remaining safe, the likelihood children are placed in the right service for the right amount of time and the likelihood of successful adoption. A data-informed system provides the best information to those making important decisions at key points throughout the life of a case.

Abstract

Currently in the State of Oregon there are approximately 7,500 children/youth placed in the Child Welfare substitute care system on any given day. Children/youth placements in Oregon have been dictated by placement availability with less focus on child needs and provider capability. This research will estimate the number of placement beds (e.g. foster care, proctor care, residential treatment, etc.) necessary to optimally serve the substitute care population. System experts will recommend a placement type for a random sample of children/youth entering substitute care. Researchers will then use statistical techniques to identify the best placement for each of these same youth; the best placement recognizes the placement type with the optimal child outcome. The differences in these two results will refine estimates of placement capacity to create the optimal continuum of care. The data captured throughout this project will shed valuable light on the root of the problems in families. This information is necessary for sustaining system changes.

Methodology

STEP 1: Random Sample – A random sample of 1,000 target removals was pulled from Oregon's IT system, OR-Kids. These target removals focused on a single child removed from home and placed in the substitute care system during a three-year period (Dec. 2014 - 2017). The sample was randomized to accurately reflect the characteristics of the overall system (i.e. geography, age, etc.).

STEP 2: Case Reviews – A review tool was developed to document the child and family characteristics. The topics on the tool included the removal reasons, parental factors, child issues, services offered and placement issues. Experts from across the connected child-caring systems reviewed the tool and definitions to ensure the information being collected was accurate and comprehensive *(see appendix A)*. Using the tools, case reviewers looked at the individual removals and cataloged all the child and family characteristics that were documented within a six-month window post-removal. The reviews included all electronic documentation and hard-file case documentation such as investigation reports/assessments; medical records, mental health assessments, Citizen Review Board documentation, court orders, and case notes. The final information was keyed into an electronic version of the tool and cataloged for analysis.

STEP 3: Panel Reviews – Cases were split into two groups based on whether issues were present for the children that may have impacted placement. For example, a child who was placed in substitute care due to parental issues only and presented no behavioral or mental health issues, was categorized as family foster care and did not require a full panel review. The remaining cases were reviewed by a group of experts from across Oregon's child-serving state agencies *(see appendix B)*. As a group, the experts first organized all the substitute care placement options into a singular flow based on level of intensity *(see appendix C).* Secondly, the group collectively reviewed the case information and determined the most appropriate placement for the child/youth based on their expertise. The panel did not receive any

information which might present biases into the decision including race, ethnicity, location and actual placement.

STEP 4: System Inventory – The current system inventory was captured through contracting records. The family foster care system has some data challenges making it difficult to use the data for accurate bed counts. To estimate the inventory of the family foster care system, some assumptions were made:

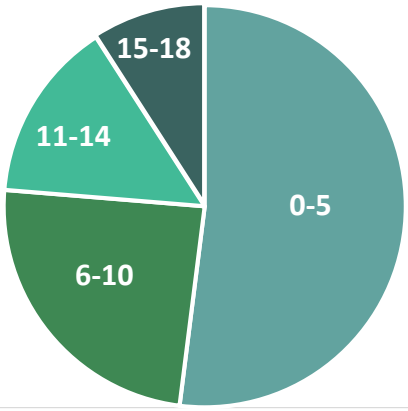
- The average percentage of child-specific foster care placements would remain steady into the future. This percentage will be applied to the final estimate. For example, if 65% of current placements in family foster care are child specific placements, then 65% will be in the future as well.
- Determination of how many "placements" are available in a single certified home is based on historical date. The maximum number of children ever placed in a certified home at one time is assumed to be the number of placements available in that home.
- If a foster care provider successfully had a child in their home with a CANS rating of 2 or higher, then the home was assumed to be able to serve high needs behavior child/youth placements.
- If a foster care provider successfully had a child in their home with medical or personal care dollars attached to the case, then the home was assumed to be able to serve high needs medical child/youth placements.

Using these assumptions, administrative certification data was pulled directly from the system to create a proxy count of family foster care beds currently open in the system, by type.

STEP 5: Matching – Researchers identified "identical twins" in the data through matching techniques. This allowed researchers to create a control group that is statistically identical, less the placement, for purposes of an impact analysis. The final calculations determine the estimate of stability for children/youth residing in the different placements and identify the most stable and successful placement for the child/youth. The final count of placements required to serve the 1,000-sample population is scaled to system size to create the final estimated number of placement beds and inform the required buffer size *(see page 21 for buffer discussion)*. The difference between the estimated number of placement beds (with buffer) and the current inventory determines the system capacity gap.

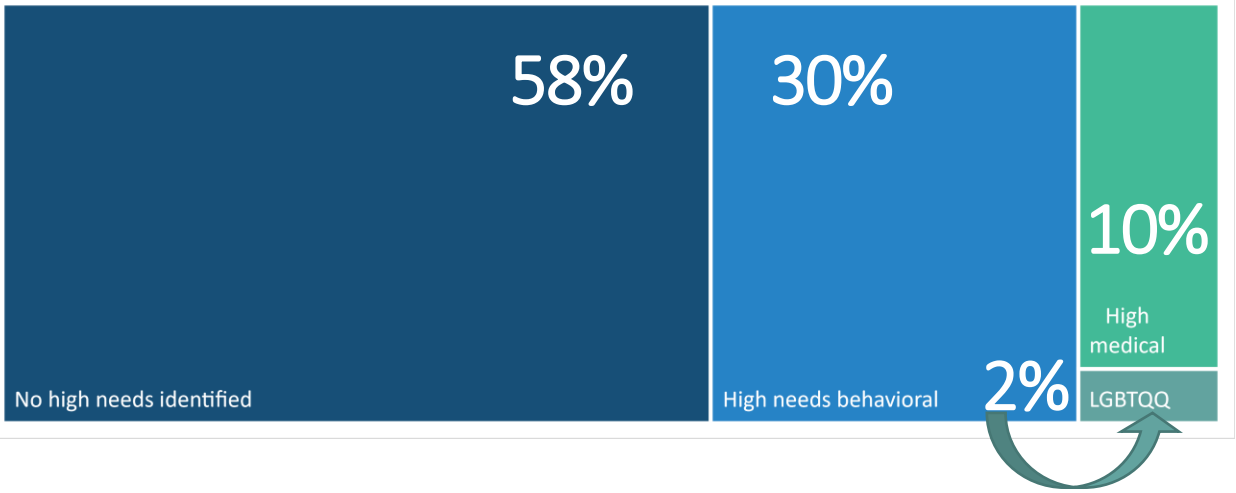
A look at the *overall sample*

(n=1000)



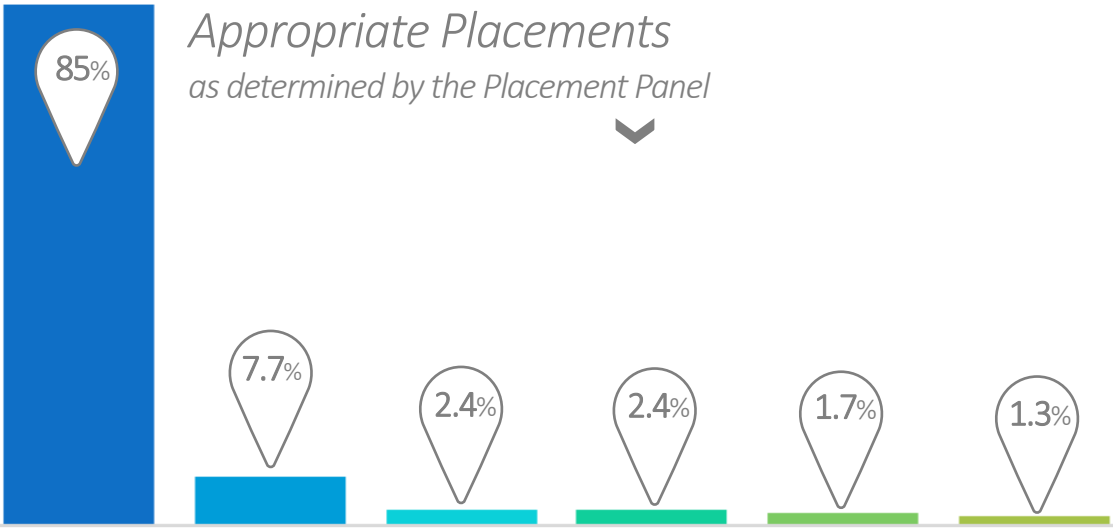
Age Groups

Specific Needs



Appropriate Placements

as determined by the Placement Panel



Foster Care
- Family Foster Care including relative, kith/kin and non-relative

Residential or Behavioral
- Basic Residential
- Intensive Residential
- Therapeutic Foster
- Group Homes

In-Home Plan
- DV Family Placement
- Dual Diagnosis or A/D Family Treatment
- In-Home w/Safety Plan

Tribal
- Place with tribe and/or jurisdiction turned over to tribe

OHA LOC
- Psychiatric Residential
- Sub-Acute
- Acute

I/DD
- DD Foster Care
- DD Group Home
- DD Enhanced Foster

Documented Issues

Identified Child - Mental Health Issues	COUNT	% of Sample
Adjustment disorder	244	24.9%
Developmental disorders/learning disorder/delay	152	15.5%
Speech disorders/communication disorders	146	14.9%
Anxiety disorders (other besides PTSD)	138	14.1%
Mood disorder/depressive disorders	134	13.7%
Posttraumatic stress disorder (PTSD)	134	13.7%
Attention-deficit/hyperactivity disorder (ADHD)/Attention deficit disorder (ADD)	109	11.1%
Victim of multiple incidents of physical abuse	97	9.9%
Sleep disorders	75	7.6%
Victim of sexual abuse	74	7.5%
Oppositional defiant disorder	52	5.3%
Intellectual/Developmental Disability	44	4.5%
Drug related disorders/drug abuse	37	3.8%
Autism	34	3.5%
Conduct disorder	29	3.0%
Other trauma/stressor related disorders	23	2.3%
Alcohol related disorders/alcohol abuse	18	1.8%
Reactive Attachment Disorder	18	1.8%
Eating disorders/issues	12	1.2%
Anti-social behavior	12	1.2%
Pyromania disorder/fire setter	11	1.1%
Bipolar Disorder	6	0.6%
Schizophrenia/psychotic disorders	4	0.4%
Personality disorder (all types)	2	0.2%

Identified Child - Physical Issues	COUNT	% of Sample
Drug exposed infant	118	12.0%
Drug affected infant	90	9.2%
Asthma	69	7.0%
Gastrointestinal problems (feeding tubes, reflux, constipation, etc.)	61	6.2%
Respiratory Issues (infections, pneumonia, bronchitis, tuberculosis, etc.)	60	6.1%

Low birth weight/premature birth	56	5.7%
Encopresis/enuresis	47	4.8%
Allergies	43	4.4%
Heart disease/heart problems	28	2.9%
Epilepsy/seizure disorder	22	2.2%
Sensory impaired hearing	22	2.2%
Nutritional deficiencies	19	1.9%
Broken bones / physical abuse injuries	19	1.9%
Failure to thrive	18	1.8%
Fetal alcohol syndrome/affect	16	1.6%
Brain abnormalities	14	1.4%
Apnea	12	1.2%
Neurological problems	12	1.2%
Congenital abnormality	10	1.0%
Kidney issues	8	0.8%
Physical disabilities	7	0.7%
Traumatic brain injury (TBI)	5	0.5%
Cerebral palsy	4	0.4%
Diabetes	4	0.4%
Anal or genital warts/herpes	4	0.4%
Skeletal issues (scoliosis, etc.)	4	0.4%
Hyper/hypo-thyroid issues	4	0.4%
Chromosomal abnormalities (Downs, Turners, etc.)	3	0.3%
Anemia issues	3	0.3%
Chronic migraines	3	0.3%
Hepatitis	2	0.2%
Shaken baby syndrome	2	0.2%
Terminal medical conditions	1	0.1%
Cystic fibrosis	1	0.1%

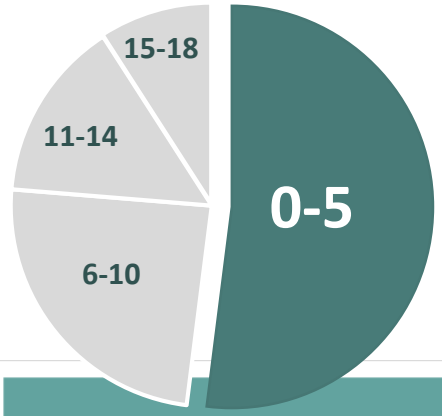
Identified Child Behaviors	COUNT	% of Sample
Exposed to domestic violence	307	31.3%
Angry/aggressive behavior	170	17.3%
Academic problem/delay	135	13.8%
Out of control/acting out	94	9.6%
Parentified child	62	6.3%
Self-mutilation	56	5.7%
Suicidal ideation	56	5.7%
Sexually acting out	54	5.5%
Criminally involved misdemeanor	35	3.6%
Sexually active	28	2.9%
Serious delinquency (felony level)	21	2.1%
Destructive	20	2.0%
Animal cruelty	13	1.3%
Sexual offender	12	1.2%
Sexually aggressive	9	0.9%
Gang affected/involved	5	0.5%
Severely emotionally disturbed (SED)	5	0.5%
Teen parent/pregnancy	4	0.4%
Prostitution	1	0.1%

Documented issues are not mutually exclusive and multiple types of issues can be recognized for a single child.

A look at age groups

age 0-5

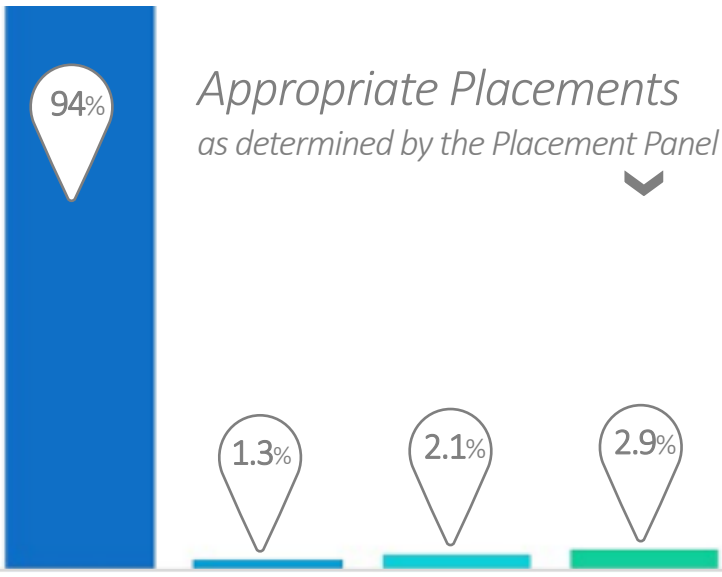
(52% of sample; n=520)



Age Groups Specific Needs

Appropriate Placements

as determined by the Placement Panel



Foster Care
- Family Foster Care including relative, kith/kin and non-relative

Residential or Behavioral
- Basic Residential
- Intensive Residential
- Therapeutic Foster
- Group Homes

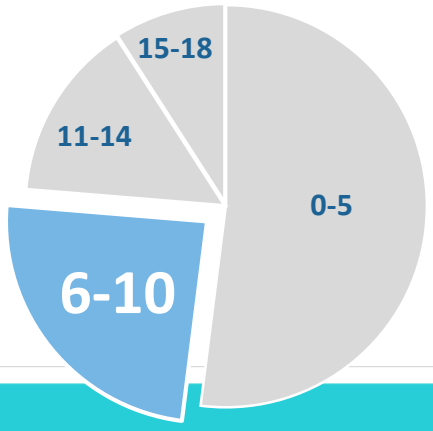
In-Home Plan
- DV Family Placement
- Dual Diagnosis or A/D Family Treatment
- In-Home w/Safety Plan

Tribal
- Place with tribe and/or jurisdiction turned over to tribe

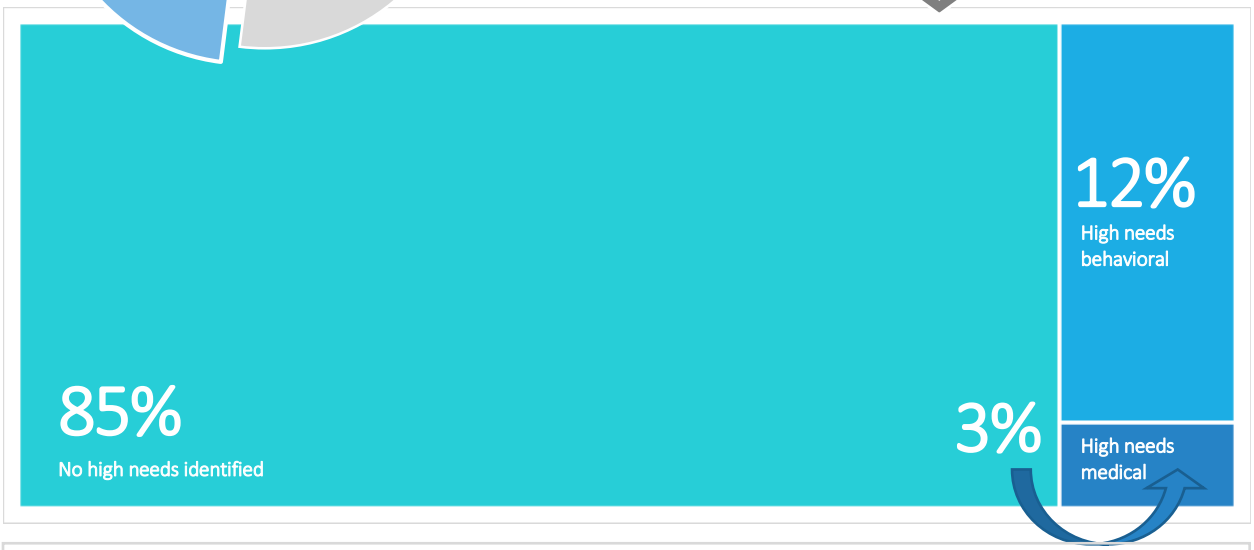
A look at age groups

age 6-10

(24% of sample; n=243)

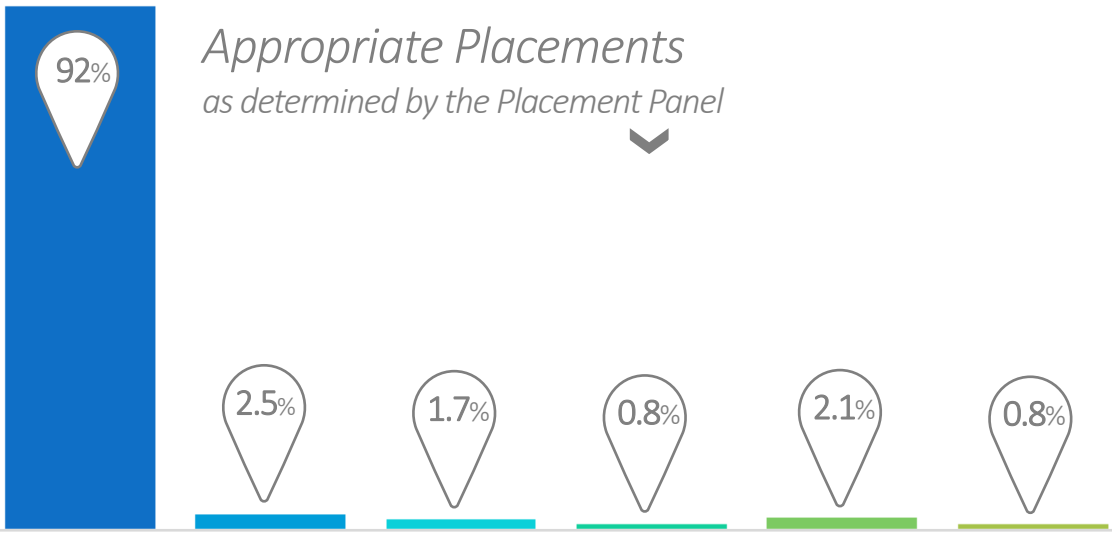


Age Groups Specific Needs



Appropriate Placements

as determined by the Placement Panel



Foster Care
- Family Foster Care including relative, kith/kin and non-relative

Residential or Behavioral
- Basic Residential
- Intensive Residential
- Therapeutic Foster
- Group Homes

In-Home Plan
- DV Family Placement
- Dual Diagnosis or A/D Family Treatment
- In-Home w/Safety Plan

Tribal
- Place with tribe and/or jurisdiction turned over to tribe

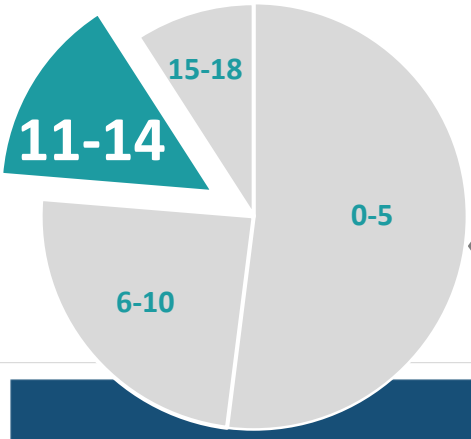
OHA LOC
- Psychiatric Residential
- Sub-Acute
- Acute

I/DD
- DD Foster Care
- DD Group Home
- DD Enhanced Foster

A look at age groups

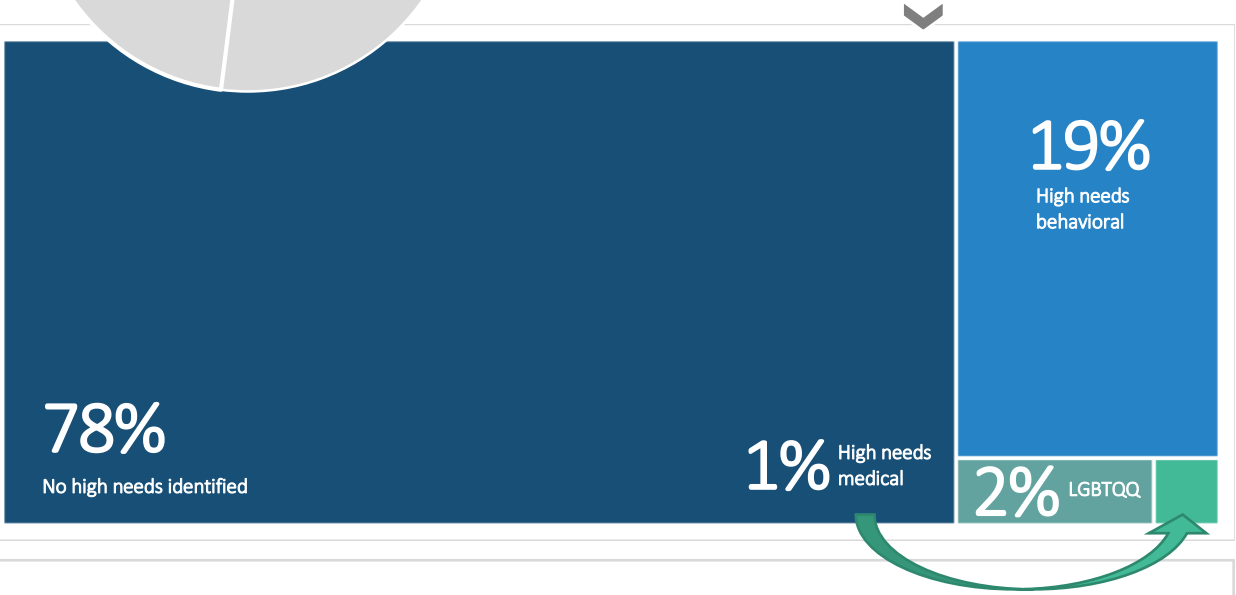
age 11-14

(15% of sample; n=146)



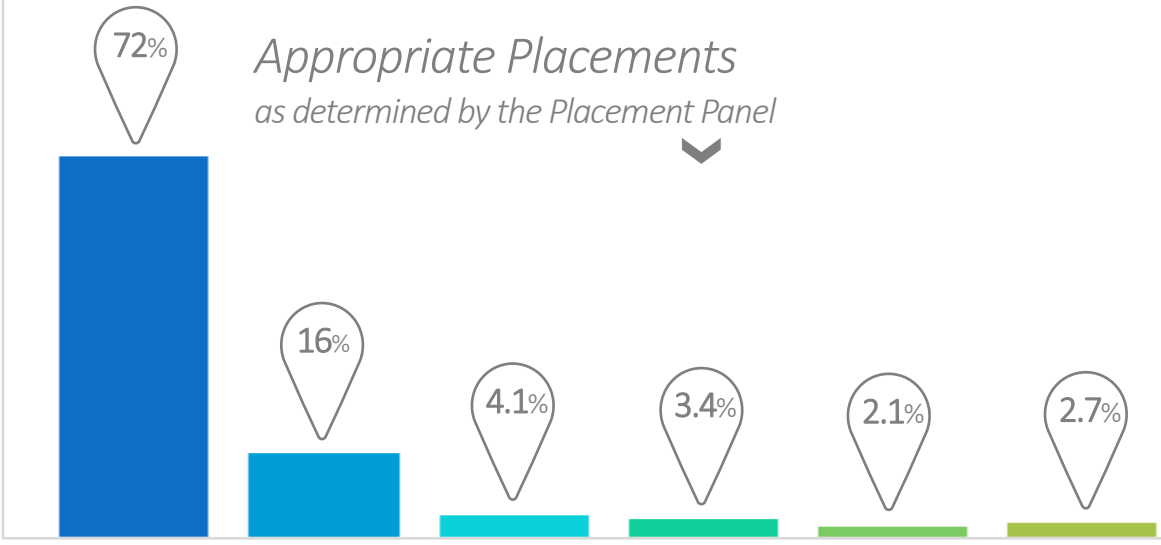
Age Groups

Specific Needs



Appropriate Placements

as determined by the Placement Panel



Foster Care
- Family Foster Care including relative, kith/kin and non-relative

Residential or Behavioral
- Basic Residential
- Intensive Residential
- Therapeutic Foster
- Group Homes

In-Home Plan
- DV Family Placement
- Dual Diagnosis or A/D Family Treatment
- In-Home w/Safety Plan

Tribal
- Place with tribe and/or jurisdiction turned over to tribe

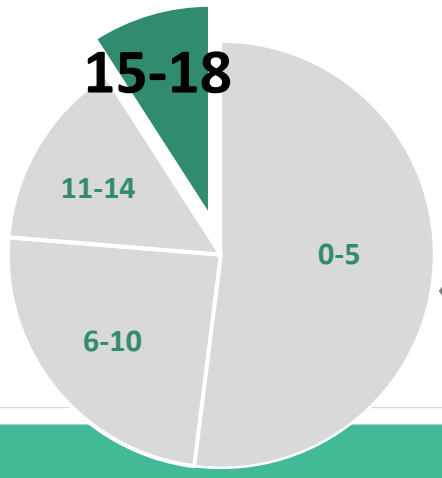
OHA LOC
- Psychiatric Residential
- Sub-Acute
- Acute

I/DD
- DD Foster Care
- DD Group Home
- DD Enhanced Foster

A look at age groups

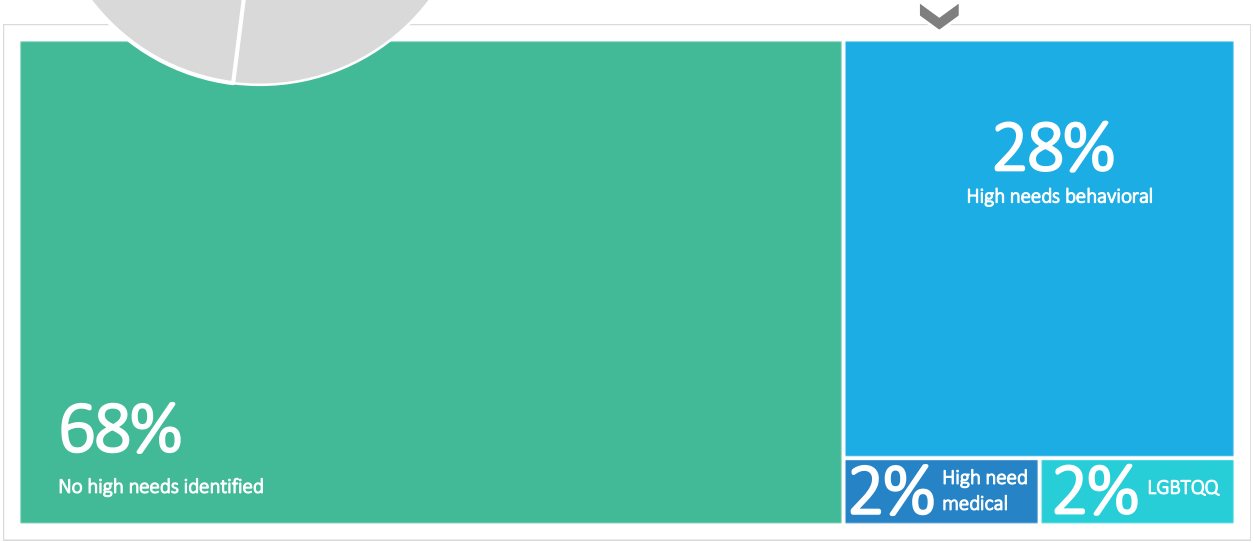
age 15-18

(9% of sample; n=91)



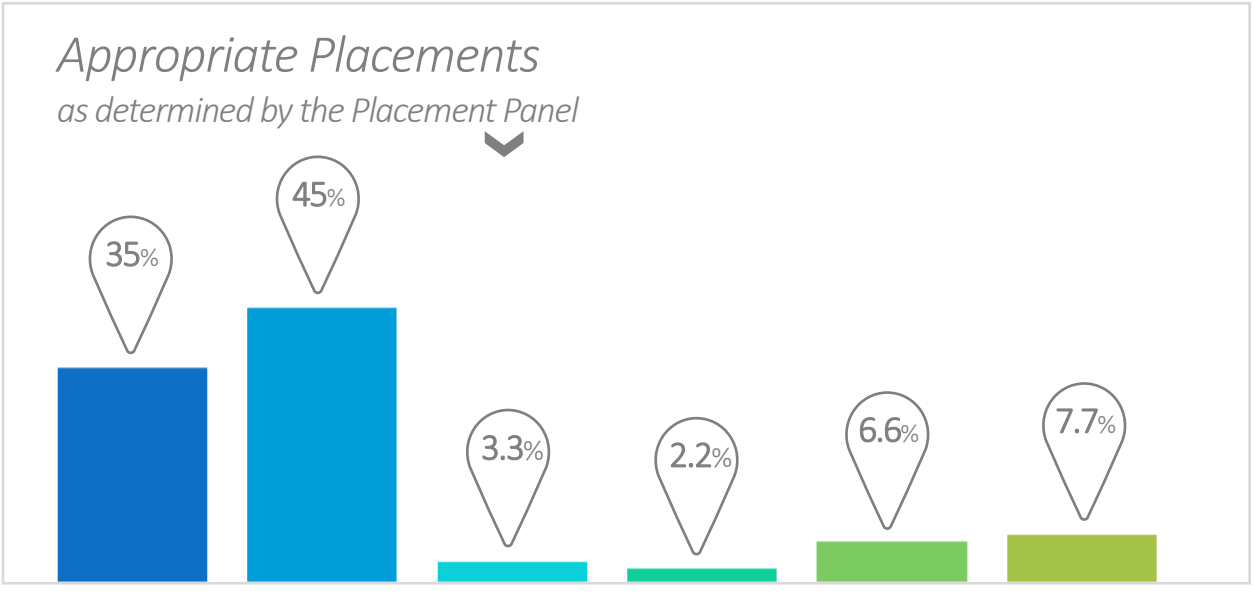
Age Groups

Specific Needs



Appropriate Placements

as determined by the Placement Panel



Foster Care
- Family Foster Care including relative, kith/kin and non-relative

Residential or Behavioral
- Basic Residential
- Intensive Residential
- Therapeutic Foster
- Group Homes

In-Home Plan
- DV Family Placement
- Dual Diagnosis or A/D Family Treatment
- In-Home w/Safety Plan

Tribal
- Place with tribe and/or jurisdiction turned over to tribe

OHA LOC
- Psychiatric Residential
- Sub-Acute
- Acute

I/DD
- DD Foster Care
- DD Group Home
- DD Enhanced Foster

Initial Findings: Reasons for Removal

The removal reasons categories are not mutually exclusive and multiple types of abuse and perpetrators can be recognized in a single case. The analysts recognized both the female and male in the situation as well as other. The other category could be a family friend, neighbor, grandparent or anybody outside of the primary female and male caregiver in the household.

Abuse Issues

TYPES OF ABUSE	Female	Male	Other
Abuse of a sibling	4.5%	4.1%	0.9%
Alcohol exposed infant	0.4%	0.0%	0.0%
Alcohol affected infant	0.2%	0.0%	0.0%
Alcohol affected child	0.4%	0.1%	0.0%
Alcohol exposed child	0.3%	0.1%	0.0%
Child fatality	0.0%	0.1%	0.1%
Current sexual abuse - familial	0.9%	2.9%	0.6%
Domestic violence	10.9%	16.5%	0.9%
Drug affected infant	5.0%	1.7%	0.0%
Drug affected child	1.8%	1.4%	0.2%
Drug exposed infant	4.6%	1.2%	0.0%
Drug exposed child	6.6%	3.8%	0.7%
Mental/emotional abuse - familial	2.8%	2.4%	0.1%
Physical abuse	6.6%	7.1%	0.6%
Physical abuse resulting from domestic violence	0.4%	1.1%	0.1%
Sex offender has access	1.3%	3.7%	1.3%
Third party sexual abuse (non-familial)	0.0%	0.3%	0.3%

Neglect Issues

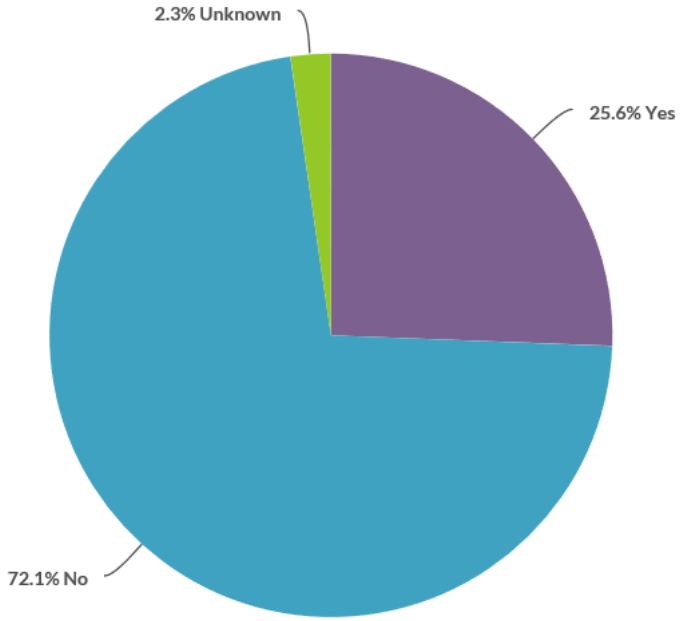
TYPES OF NEGLECT	Female	Male	Other
Child not supervised	11.1%	6.1%	0.8%
Child deserted/abandoned	8.1%	3.3%	0.3%
Failure to thrive	0.5%	0.5%	0.0%
Household safety/living conditions unsuitable	5.6%	3.6%	0.9%
Medical neglect	6.4%	3.6%	0.2%
Moderate neglect	23.5%	15.0%	1.4%
Nutritional/dietary	0.9%	0.9%	0.0%
Personal hygiene/sanitary conditions	1.5%	1.1%	0.2%
Severe neglect	11.5%	8.4%	0.8%

Parent Location Issues

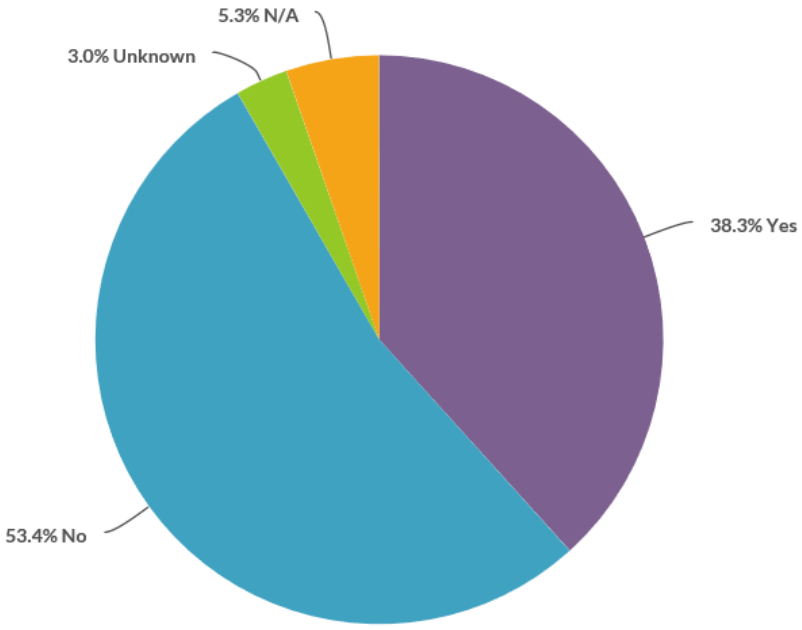
TYPES OF LOCATION ISSUES	Female	Male	Other
Parent deceased/child orphaned	1.2%	2.8%	0.4%
Parent to detox or A/D treatment	1.2%	0.3%	0.0%
Parent(s) incarcerated	9.0%	15.6%	1.2%
Parent(s) location unknown or out of vicinity	4.8%	18.7%	2.7%

Prior Placement

Was there ever a prior placement of the INDIVUDUAL CHILD?



Was there a prior CPS placement of any sibling from the home?



Slowing the System through Prevention

The frequency of specific family characteristics point to the need for additional prevention supports. The enhancement of these support systems could slow the inflow of children/teens into the Child Welfare system by providing in-time supports to the family before the need for removal of children.

1) Alcohol and drug treatment
2) Domestic violence
3) Housing issues
4) Teen parents

Approximately a quarter of the removal cases had a teen parent and/or a new baby. This information points to a natural point in time to provide prevention supports and parenting skills training.

System Inventory

For purposes of this research, the substitute care system within Child Welfare was broken up into three distinct "umbrella" areas: family foster care, residential/treatment care, and highest need care. Each of these areas represents a grouping of different placement and level of care options. The full list is detailed below with their represented level of intensity. The first two levels of intensity are reserved for in-home or no substitute care placement.

Level 1: In-home safety plan
Level 2: Shelter location; parent with child

FAMILY FOSTER CARE		RESIDENTIAL / TREATMENT CARE		HIGHEST NEED CARE	
LEVEL	*DESCRIPTIONS*	*LEVEL*	*DESCRIPTIONS*	*LEVEL*	*DESCRIPTIONS*
3	Relative Foster Care	8	Enhanced DD Foster Care	18	Stabilization and Crisis Unit
3	Non-Relative Foster Care	9	DD Group Home	18	Psychiatric Residential
3	Tribal Foster Care	10	BRS Assessment	19	Sub-Acute
3	Family Shelter Care*	10	Shelter Evaluation	20	Acute (hospitals)
3	Kith/Kin Foster Care	11	Independent Living	21	Secure Children's Inpatient Program (SCIP)
3	ICPC Foster/Shelter Care*	12	*system gap***	21	Secure Adolescents Inpatient Program (SAIP)
4	Enhanced Shelter Care*	13	Proctor and Enhanced Proctor Care		
5	*system gap***	14	Enhanced Supervision w/Day Treatment		
6	Family Group Home	15	BRS Basic Residential		
7	DD Foster Care	16	BRS Intensive Behavioral Services		
7	Medical Care	17	BRS Short-term Stabilization Program		

** The term "shelter" in this title refers to a short-term duration.*
***Identified system gaps discussed on page 23.*

Count of Family Foster Care Homes *(as of October 2018)*			
SETTING TYPE	**# Certified Family Foster Care Homes**	**# Homes with Placements**	**Percent of Certified Homes with Placements**
Child Specific	1848	1241	67.2%
General	1523	1002	65.8%
Temporary or Extended Temp.	914	760	83.2%
TOTAL HOUSEHOLDS W/PLACEMENTS	**4285**	**3003**	**70.1%**

Number of Children Placed in Family Foster Care Homes								
SETTING TYPE	**# OF CHILDREN**							**TOTAL HOUSEHOLDS**
	1	**2**	**3**	**4**	**5**	**6**	**7+**	
Child Specific	794	317	94	27	7	2	--	1241
General	461	293	147	55	25	13	8	1002
Temporary or Extended Temp.	502	187	51	19	1	--	--	760
TOTAL HOUSEHOLDS W/PLACEMENTS	**1757**	**797**	**292**	**101**	**33**	**15**	**8**	**3003**

Capacity Needs

Availability of placement beds is essential to ensure children are placed in the most appropriate placement. The current system is strained and limited in placement options. This prevents both appropriate initial placements and the ability to move the child to a lower level of care once treatment has been maximized and the child has been stabilized in their current level. To enhance the current system and allow for both upward and downward movement across the continuum of care, buffers are calculated into the final capacity need. A buffer is extra capacity in the system. The addition of buffers will ensure beds are available at all levels in the moment of need. The amount of buffer added to each category of placement is impacted by the length of stay. The longer the average length of stay, the higher the buffer is needed to ensure availability. Buffers are a research recommendation for creating a responsive Child Welfare system and to allow for service matching based on youth need.

The following length of stay calculations and capacity numbers are based upon the current population served by the Child Welfare system and do not consider funding or state agency authority. For research purposes, the calculations do not differentiate between settings described as placements and those best described as medically necessary treatment service settings.

LEVEL OF INTENSITY	PLACEMENT TYPE	CURRENT CAPACITY COUNT	AVERAGE LENGTH OF STAY *(in days)*[2]	ADDITIONAL CAPACITY NEEDED *w/buffer*
3 - 6	**ALL Family Foster Care** *(relative, general, tribal)*	7,215	441	1,514
7	**Medical Foster Care**	24	441	8
7 - 8	**DD Foster Care** *(includes enhanced)*	388*	506	122
9	**DD Residential/Group Home**	30*	506	46
11 - 17	**BRS Residential/Behavioral** *(all types)*	460	424	99
18	**Stabilization and Crisis Unit** (SACU)	15*	--	*community shared*
18	**Psychiatric Residential (PRTS)** – *ages 6-11*	45*	217	21
18	**Psychiatric Residential (PRTS)** – *ages 12-18*	56*	217	51
19	**Sub-Acute** – *ages 6-11*	12*	44	(3)
19	**Sub-Acute** – *ages 12-18*	28*	44	(6)
20	**Acute** – *ages 6-11*	6*	--	
20	**Acute** – *ages 12-18*	33*[1]	--	*community shared options*
21	**SCIP**	17*	--	
21	**SAIP**	28*	--	
			TOTAL CAPACITY GAP >>	**1,852**

Full calculations shown in Appendix D.

** These community shared options are open to CW placements as well as other community placements (e.g. county-level placement). The beds available in these levels of care are not reserved specifically by contract.*

[1] The actual capacity number is fluid. These treatment beds can be adjusted at the hospital's discretion.

[2] Length of stay calculations include in state and out of state PRTS and Subacute placements. Calculations are based on current and true length of stay regardless of funding.

The calculations estimate 1,645 placement beds needed in levels 3-8 of intensity (foster care). This is the beginning of the conversation as foster children are believed to be most successful in their placement when matched with their local community where they can maintain their community connections. This requires a higher volume of foster parents certified and available for placements within the system to conduct ideal placement matching.

Children with intellectual and developmental disabilities (I/DD) do not always require I/DD specific placements. With the assistance of the I/DD Children's Residential team, determinations were made as to which of the 1,000 sample removals were best matched with an I/DD foster home versus a Child Welfare foster home. The results of the placement panel determined the need for an additional 122 foster placements be available in the I/DD system for children involved in Child Welfare. The I/DD forecast shows an estimated 180 placements available in I/DD Children's Residential. The placements are available to all qualified children in the I/DD system and not reserved strictly for Child Welfare placements. Historical data shows an average of 30 Child Welfare children placed in this level of care at any given time. The remainder of the placements are occupied by children diagnosed with I/DD and are not currently in Child Welfare custody. This creates a need for an additional 46 beds in this placement level specifically for children in Child Welfare custody.

The Behavior Rehabilitation Services (BRS) is severely strained in resource capacity. These programs have has been working diligently over the past year to develop additional capacity in these levels of care. Since October 2018, an additional 85 placement beds have been created for Child Welfare use which raised the current placements to 460. Although this capacity building was critical, it is not enough. The calculations show an additional 99 placements needed at this level of care. The table to the left displays the ideal distribution of placements across the BRS placement levels. Capacity growth alone will not solve the placement issues for the BRS system. There are several complicating factors involved in treatment of these youth which need to be built into the system. Specifically, Oregon lacks placements for youth with dual diagnosis (mental health and addictions) and youth with sexually harming behaviors.

Distribution of placements needed in BRS	
BRS Assessment and Evaluation	2.1%
Independ. Living (16+)	1.7%
Transition Age Youth Home	7.0%
Proctor Care (includes enhanced)	29.7%
Basic Residential	7.0%
Intensive Rehab. Services	52.5%

The highest level of care is represented in intensity levels 18-21. These levels recognize placement options created by the Oregon Health Authority to support psychiatric and mental health services. The Psychiatric Residential Treatment Services (PRTS) placements represent a critical gap in the system. When placements are not available in Oregon children are placed out of state to receive the psychiatric care needed to support their needs. The calculations show Oregon needs an additional 72 placement beds available for children and youth within the Child Welfare system. In contrast, the research shows

the sub-acute system to have additional current capacity beyond the future need. This does not represent the current system but rather the ideal state once capacity gains have been made across the system.

System Gap

The matching research demonstrates the ability to move children/youth lower on the intensity scale of placement when services are available. When looking at "identical data twins" in the system, up to an additional 6% of children could be successfully served in a foster care setting. The ability to move these children/teens lower on the intensity scale must be supported by four critical things:

1) Rapid access to mental health services;
2) 24/7 crisis support;
3) Difficult behaviors training for foster parents; and
4) Access to psychiatric services as a service element available at any level of placement.

Approximately 30% of the identified children in the sample displayed high needs behavior issues. Foster parents need specific training in this area of need to better support the children/teens in their home and reduce stress on the household. The system requires a higher capacity of facility-based placement beds to provide adequate services without these critical service supports available.

APPENDIX A
Case Review Tool and Definitions

Removal Reasons

ABUSE ISSUES

- **Abuse of a Sibling** - This category denotes children who were removed due to the abuse of a sibling (step, half or full) and have not endured abuse themselves. When choosing this category for the identified child you must also indicate the type of abuse experienced by the sibling and the abuser. Example: The oldest daughter of three children discloses that she was sexually abused by her mother's live-in boyfriend. If the mother is not protective then the abused child and her siblings would be removed, even though the siblings had not been abused. When profiling one of the siblings who were not abused, you would indicate under the in-home male both Abuse of a sibling and Current sexual abuse familial. Under the in-home female you would indicate Parent chooses perpetrator over child. If the identified child experienced abuse that was severe enough to warrant removal or opening of services, do not indicate abuse of a Sibling, even if it was a factor.

- **Alcohol Affected Infant/Child** – Should be indicated for infants/children who have ingested alcohol with a need for immediate medical treatment as a result of lack of supervision by the parent and the parent leaving alcohol containers open and within reach of children. This should also be indicated for infants/children who have been given alcohol or forced to ingest alcohol by parent or caregiver. (When selecting this reason, also select "Failure to Protect Child from Dangerous situations" in the "Parental Issues" section.)

- **Alcohol Exposed Infant/Child** – Should be indicated for infants/children in which a parent or caregiver has left alcohol containers open and within reach of children that could result in a potentially dangerous situation, or infants who have been exposed to alcohol due to maternal activities (example: breastfeeding) but the child has not been diagnosed with FAS or FAE. Child will show little or no physical/developmental problems due to alcohol exposure, or problems which are known to be temporary. (When selecting this reason, also select "Failure to Protect Child from Dangerous situations" in the "Parental Issues" section.)

- **Child Fatality** - This will go with abuse of a sibling and indicates that a sibling of the identified child has died causing the identified child to be removed or opening services for the family. Homicides, accidental deaths, deaths by abuse and neglect and natural deaths are all captured here.

- **Current Sexual Abuse Familial** - Child victimized by a related perpetrator or a parents' partner who has continued access to the child and who resides in the same home as the child or visits frequently. This category is appropriate to capture sexual abuse by siblings who are not caretakers, and they should appear in the "Other" column. Abuse is ongoing and had occurred with 60 days of the disclosure.

- **Domestic Violence** - Situations where children are exposed to violence or threats of violence between parental caretakers, even if one of them is out of the home. Caretakers must have a current or former partner/ marriage relationship. Violence between relatives should not be noted here.

- **Drug Affected Infant (0-1yr)** – Should be indicated for infants born with confirmed drug use by the mother during pregnancy and/or breastfeeding and the child is diagnosed with withdrawal symptoms. Medical treatment is required but long-term impacts are unknown due to age, but likely.

- **Drug Affected Child (1yr+)** - Should be indicated for children who have ingested drugs with a need for immediate medical treatment as a result of lack of supervision by the parent and the parent leaving drugs out and within reach of children. This should also be indicated for children who have been given drugs or forced to ingest drugs by parent or caregiver. (When selecting this reason, also consider "Failure to Protect Child from Dangerous situations" in the "Parental Issues" section.)

- **Drug Exposed Infant (0-1yr)** – Suspected or confirmed drug use by the mother during pregnancy/breastfeeding and the Infant may show little or no physical problems due to drug exposure, or problems which are known to be temporary. A dirty urinalysis or confessed drug use during pregnancy is enough evidence for this category.

- **Drug Exposed Child (1yr**+) - Should be indicated for children in which a parent or caregiver has left drugs and/or drug paraphernalia within reach of children that could result in a potentially dangerous situation, or children 1 year or older who have been exposed to drugs due to maternal activities after (example: breastfeeding) but the child has not been diagnosed with medical conditions due to exposure. Child will show little or no physical/developmental problems due to exposure, or problems which are known to be temporary. (When selecting this reason, also select "Failure to Protect Child from Dangerous situations" in the "Parental Issues" section.)

- **Mental/Emotional Abuse -** Cruel or unconscionable acts (social isolation, extreme fear of parent, verbal abuse, parent using threats or intimidation as discipline) or statements/threats by the caretaker which could have a negative effect on the child's psychological, cognitive, emotional or social well-being or functioning.

- **Non-Current Sexual Abuse Familial** - Disclosure of past sexual abuse by a related perpetrator and the perpetrator may or may not have continued access to the child. Abuse has not occurred within the 60 days prior to disclosure.

- **Physical Abuse** - Non-accidental injury to a child which, regardless of motive, is inflicted by a caretaker. Physical abuse includes but is not limited to any injury that could not reasonably be the result of the explanation given by the caretaker, or any injury that is the result of discipline or punishment.

- **Physical Abuse Resulting from Domestic Violence -** Children injured by a caretaker during a domestic violence altercation either purposefully or on accident.

- **Sex Offender has Access** - Known or probable sex offender has access to the child but abuse has not/is not currently occurring. Caretaker is not protective. Used for sex offenders who are not partners of the parent. The sex offender is recognized as the abuser for this category.

- **Third Party Sexual Abuse** - Sex abuse perpetrated by a non-relative who may or may not reside in the home, (e.g. babysitter, family friend). Should also be indicated for sex abuse by strangers. Includes current or past abuse. The sex offender is recognized as the abuser.

NEGLECT ISSUES

- **Child Not Supervised -** Child is left by a parent with no or inadequate supervision, (e.g. parent is asleep in the home and child is playing outside alone). Parent is nearby and whereabouts of the parent are known or soon discovered.

- **Child Deserted/ Abandoned** - Children who are left with caretakers beyond the agreed upon time or children who are left with caretakers who did not agree to care for the child while parents leave for an extended period of time. Also parents who abandon their children, leaving them with or without a plan of care with no intention of returning for them.

- **Failure to Thrive** - Infants not receiving sufficient nourishment to sustain life. Medical intervention is necessary to prevent developmental delay or death. Must be diagnosed by a medical professional (or an extremely obvious case) and child must be under one year of age.

- **Household Safety/Living Conditions** - Should be related to the conditions of the dwelling itself, which are dangerous to the inhabitants and extend beyond neglect (e.g. exposed wiring, broken windows exposing the family to cold weather or the danger of broken glass, malfunctioning plumbing resulting in exposure to raw sewage etc.). Condition of the home warrants more than cleaning or payment of bills to be corrected.

- **Medical Neglect -** Deprivation or misuse of medical attention/intervention which could result in disability, disfigurement or death. Failure to treat head lice should not be noted here. Chronic ear infections which could result in hearing loss, missing important doctor appointments, severe chronic diaper rash resulting in permanent skin damage and failure to use nebulizers and heart monitors etc. should be noted here.

- **Moderate Neglect** - Parents with a history of cluttered homes, improperly dressed children (considering weather conditions), periods with insufficient food, and homes parents who fail to adequately supervise their child are considered moderately neglectful. None of the neglectful situations should be life threatening.

- **Nutritional/ Dietary -** Situations dealing with nutritional needs. Alarmingly underweight children who are not failure to thrive either due to age or lack of severity. Children who are extremely overweight not due to medical reasons; also children suffering from diseases and disorders directly due to nutrition, either intentional or unintentional.

- **Personal Hygiene/Sanitary Conditions** - Families' whose main issue is hygiene and sanitation. Children with encopresis and enuresis who are not properly cleaned and/or their clothing is not washed. Children who are seldom bathed, causing problems in school and/or having diseases or parasites directly related to personal hygiene (i.e. Recurring/chronic scabies or lice). Parents who do not enforce personal hygiene for children who are old enough to take care of it themselves.

- **Severe Neglect** - Patterns of parents' failure to provide adequate medical care, shelter, food, clothing and/or supervision. Neglect is ongoing, demonstrated either by multiple 307's or severity of neglect being such that it is not possibly a recent situation or one-time incident. Situations may include deplorable homes -- feces in the house, decaying food available to children, poor sanitation, serious accumulations of filth -- and an extensive history of poor child supervision which threatens the child's life or safety are considered severe. This neglect may be life threatening.

PARENT LOCATION

- **Parent Deceased, Child Orphaned** - Child left with no caretakers due to the death of one or both caretakers.

- **Parent to Detox/Drug and Alcohol Treatment** - Should be noted for children who are removed or services open because a caretaker is going to inpatient DA treatment or detox and no other caretakers are available. Should not be used for placements occurring after parent is in treatment or needs to go to treatment but does not.

- **Parent Incarcerated** - Should be noted when a parent is arrested and lodged and there is no one to care for the child. This category is not for parents who are incarcerated prior to the target date and are therefore not a resource.

- **Parents Location Unknown/Out of the Vicinity -** Children who are discovered to have been left alone or with inadequate supervision and parent's whereabouts are unknown. Parent is not gone for more than one day.

CHILD ISSUES

- **Child Fearful, Fears Abuse Will Occur -** Should be recognized when a child's fear of the caretaker is a deciding factor in removal or opening services. Children who refuse to return home due to fear that abuse will occur may also be noted here.

- **Child has Mental/Emotional Disability** - Children who are beyond parental control or are disruptive to the household due to a mental or emotional problem. Children who need placement for treatment for these types of issues and children with diagnosed mental/emotional problems should be noted here.

- **Child is Suicidal** - Children who have attempted suicide, made suicidal gestures or are at serious risk to commit suicide. The risk should be the driving force for the removal/opening of services.

- **Child is Sexual Perpetrator** - Children who have sexually perpetrated on other children and are a risk to children in the home, or are removed to obtain treatment. Single incidents by young children appearing to be sex play or curious exploration should not be noted. Children with mental disabilities who have perpetrated on other children but are determined to not be acting for sexual gratification should also not be noted.

- **Child has Physical/Medical Condition** - Children with physical or medical problems that require intensive care or physical suppo1t from others and/or special equipment which may be expensive and/or difficult to operate. Can also be indicated for children who are removed to obtain medical treatment.

- **Child Transitions form Previous Placement -** Family support is needed as child leaves one placement and transitions to another, or goes home.

- **Child/Parent Conflict beyond Parental Control** - Parents and child dynamics are such that they create household instability. The mildest forms of physical (hair pulling, face slapping) and/or mental/emotional abuse (name calling, screaming and yelling) may be present or escalating. The child is antagonistic and may be abusive and is responsible for aggravating the situation.

- **Child's Behavior** - Children with serious escalating behavior problems. There may or may not be an antagonistic relationship with the parent, but it is not the main problem. Truancy, temper tantrums, angry/aggressive behavior, animal abuse and destructive behavior are included. Child's use of drugs and alcohol that necessitate treatment and runaways should be recognized here.

- **Child's Behavior Reflects Past Abuse -** A child whose present behavior is problematic and has a direct link to past abuse.

- **Juvenile Delinquency** - Children who have committed felonies or misdemeanors relating to persons or property whether the courts are involved or not.

- **Teen Parent/Teen Pregnancy** - Teenage pregnancy leading to lack of parental support, or a pregnancy which has made an already at risk situation unsafe for the teen and the young or unborn child. Overwhelmed teen parents should not be noted here if the parent's age is not really contributing to the problem.

- **Threat to Self or Others -** Children who pose a physical threat to themselves apart from suicide (self-mutilation etc.) or to others (severe physical altercations, fire setting). Either the child or someone else is truly in danger, this is more severe that just a mental/emotional condition.

APPENDIX B
Placement Panel Membership

PAULA BAUER
Oregon Youth Authority
Area of representation: Behavior/Corrections

ALEX PALM
Oregon Health Authority
Area of representation: Child and Family Behavioral Health

LYNN MATTHEWS
Oregon Department of Human Services
Area of representation: Intellectual and Developmental Disabilities

NANCY ALLEN
Oregon Department of Human Services
Area of representation: Child Welfare Treatment Services

JANNA OWENS
Oregon Department of Human Services
Area of representation: Child Welfare Foster Care

ALICIA O'QUINN
Oregon Department of Human Services
Area of representation: Child Welfare Foster Care

CHRISTINE KEMPS
Oregon Department of Human Services
Area of representation: Indian Child Welfare Act / Tribal Relations

HOLLY CATALINA
Oregon Department of Human Services
Area of representation: Child Welfare Permanency

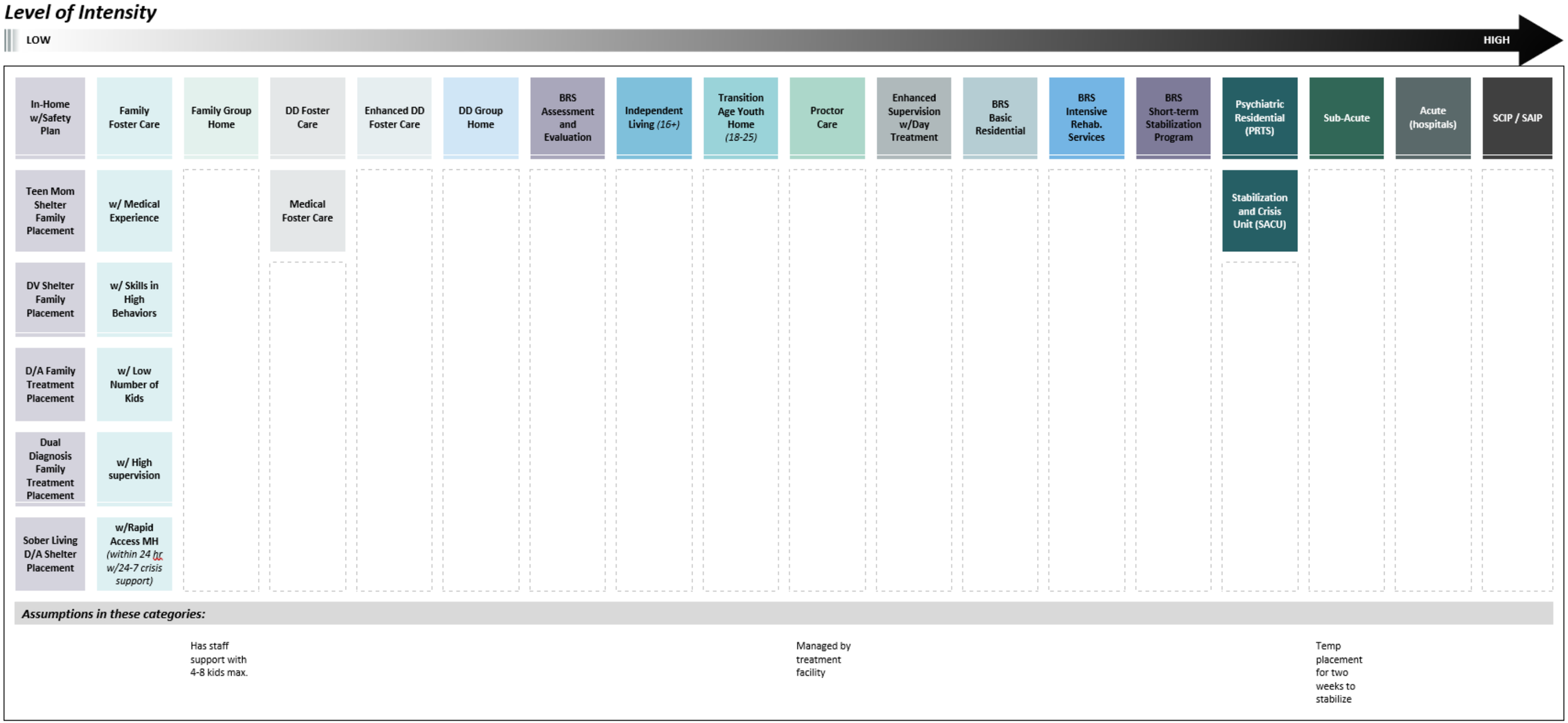
DAVID MATZ
Oregon Department of Human Services
Area of representation: Child Welfare Permanency

SARA FOX
Oregon Department of Human Services
Area of representation: Child Welfare Treatment Services

APPENDIX C

Placements and Levels of Care Map

(in order of intensity as defined by Placement Panel)



APPENDIX D

Capacity Calculations

		A	B	C	D	E	F	G	H	I	J	K
LEVEL OF INTENSITY	PLACEMENT TYPE	CURRENT CAPACITY COUNT	ESTIMATED LENGTH OF STAY (in days)	% per 1000 EPISODES	% SHIFTS	WEIGHTED NEED BY LOS	% OF EPISODES TO ALLOCATE	% OF CURRENT CAPACITY	RATE OF GROWTH *(old to new)*	# OF BEDS NEEDED	BUFFER # OF BEDS	DIFFERENCE *(needed to current)*
3 - 6	**ALL Family Foster Care**	7,215	441	85.3%	(4.10)	35,809	84.6	0.87	96.79	6,9884	1,746	1,514
7	**Medical Foster Care**	24	441	0.3%		132	0.3	0.00	107.51	26	6	8
7 - 8	**DD Foster Care** *(includes enhanced)*	388	506	0.6%	4.10	2,378	5.6	0.05	119.54	464	46	122
9	**DD Residential/Group Home**	30	506	0.7%		354	0.8	0.00	230.26	69	7	46
11 - 17	**BRS Residential/Behavioral** *(all types)*	460	424	7.1%	(0.50)	2,796	6.6	0.06	118.53	545	14	99
18	**Psychiatric Residential (PRTS) - 6-11**	45	217	1.3%		282	0.7	0.01	122.26	55	11	21
18	**Psychiatric Residential (PRTS) - 12-18**	56	217	1.6%	0.50	456	1.1	0.01	158.70	89	18	51
19	**Sub-Acute - 6-11**	12	44	0.9%		40	0.1	0.00	64.36	8	1	(3)
19	**Sub-Acute - 12-18**	28	44	2.2%		97	0.2	0.00	67.42	19	3	(6)
	TOTAL CAPACITY	**8,294**	**2,840**	**100%**	**-**	**42,344**	**100**	**1.00**	**-**	**8,294**	**1,852**	**1,852**

ID	Column	Description, Data Source and Calculation
A	CURRENT CAPACITY COUNT	Certification counts for Foster Care captured from OR-Kids. BRS and OHA LOC captured from contracted counts
B	ESTIMATED LENGTH OF STAY *(in days)*	Data source: OR-Kids
C	% per 1000 EPISODES	Calculated % of removals placed in this level of care by the Placement Panel
D	% SHIFTS	Adjustments to offset the under/over representation of groups within the 1,000 removal sample (e.g. I/DD)
E	WEIGHTED NEED BY LOS	% of episodes plus any shift adjustments made multiplied by the average length of stay: ((C*100)+D)*B
F	% OF EPISODES TO ALLOCATE	Weighted need by length of stay divided by total length of stay) divided by total of % per 1000: (E/(total of column E)/100)*total of column C
G	% OF CURRENT CAPACITY	Current capacity divided by total current capacity: (A/total of column A)
H	RATE OF GROWTH *(old to new)*	% of episodes to allocate divided by % of current capacity: (F/G)
I	# OF BEDS NEEDED	Current capacity multiplied by the new rate of growth, converted from percentage: (A*H)*0.01
J	BUFFER # OF BEDS	Manual adjustment based on percentage of beds needed to maintain availability. Adjustment based on length of stay.
K	DIFFERENCE *(needed to current)*	Total number of beds needed plus the buffer, less the current capacity: (I+J)-A

APPENDIX E
Contact Information

FOR MORE INFORMATION ON THIS RESEARCH PLEASE CONTACT:

OREGON DEPARTMENT OF HUMAN SERVICES
OFFICE OF REPORTING, RESEARCH, ANALYTICS AND IMPLEMENTATION
500 SUMMER STREET NE
SALEM, OR 97301

ORRAIRESEARCH@STATE.OR.US