SB 942: Putting First Things First in Child Safety

Quality Screening, Comprehensive Assessment, Adequate and Well Trained Workforce

Child Welfare in Oregon is Struggling

- Oregon failed every measure of quality in recent federal child welfare assessment
- DHS has recently paid out tens of millions in tort claims for injured and deceased children
- Oregon has higher rate of abuse of kids in care than national average, and does not meet national benchmark for preventing reabuse of children in any setting
- Oregon has too many child fatalities related to abuse and neglect
- Workforce is demoralized and inexperienced with high turnover and inadequate access to training and support

Screening and Assessment are Key

- Time and again, CIRTs following Oregon child fatalities point to inappropriate screening decisions and lack of comprehensive assessment (See DHS CIRTs, posted online)
- Screeners report that they only feel confident they have made the right decision 50% of the time (University of Illinois Report)
- Recent review by DHS with a 90-95% confidence interval shows that in 47 out of 76 cases, workers deemed children "safe" who were actually "unsafe" (This review was done in response to GJ CIRT)

New initiatives are detracting from core responsibilities

"They have experienced an increased workload associated with the implementation of Differential Response coupled with some unforeseen staff turnover. This situation has put them in the unfortunate position of having to prioritize the mandatory work over all else. As a result, the Josephine County Office has had to shift staff to cover the workload in the area of Child Protective Service Assessments resulting in a reduced staffing level in the adoption and foster care home study arena."

-Jason Walling, Child Welfare Deputy Director to Rep. Stark's Office
Summer 2016

Senator Sara Gelser, March 2017

New initiatives are detracting from core responsibilities

"We know that with the implementation of DR it was necessary that we refocus on our ability to practice our Safety Model to fidelity. As a result of this, the comprehensiveness of the assessment has been increasing, thus the workload associated with completing an assessment. We also know that DR has increased the workload simply by way of increasing the amount of collaboration that is required in engaging a family. Unfortunately we do not have additional staff resources to shift to DR counties as they implement and sustain the new practice."

-Jason Walling, Child Welfare Deputy Director to Rep. Stark's Office
Summer 2016

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Workforce not adequate for DR Implementation

"Caseworkers and screeners both felt their workloads increased after DR implementation. Caseworkers reported they were spending more time with families because of the DR practice model, which they viewed as beneficial, but expressed concern about the adequacy of staffing resources. Screeners reported they were spending more time with each report, and that pre-DR staffing levels were not adequate based on their post-DR responsibilities." – University of Illinois, Oregon Differential Response Evaluation

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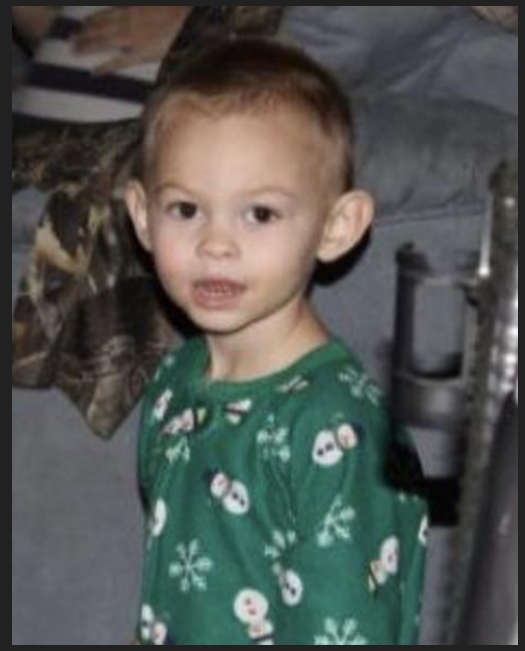
Inadequate staffing/resources ripple through system

"Since the agency's highest priority is child safety (report screening and assessments), districts end up having to pull resources away from adoption home studies and foster family support. In addition, the work is difficult and employees are constantly turning over. (I recently did a little field work and 2 of the 3 people I worked with were planning to leave the agency in the near future - and I think this was in an office that generally has a good manager and track record.)"

Laurie Byerly, LFO, to Rep. Stark's office, July 2016

Safety

- Kids are as safe in DR Counties as Non-DR Counties– What does this mean if children are not safe anywhere?
  - Lack of comprehensive assessment is a systemic problem
  - High rate of abuse in care
  - Increasing trauma to kids coming into system
  - Inappropriate screening decisions are a systemic problem
  - Qualitative and quantitative data point to severe problems



DHS Not Meeting Key Quantitative Metrics

- Mandatory Face to Face Visits only completed 67.6% of time (Source: Director Saiki WM Presentation)
- Only 65% of all child abuse calls assigned for assessment have first contact within policy timelines (Source: Director Saiki WM Presentation)
- Only 34.2% of abuse assessments are completed within policy timeline (Source: Director Saiki WM Presentation)
- Only 3-10% of cases result in services, depending on district (University of Illinois Study, 2016)
- Only 174 Alternative Response Families accepted services in 2016 statewide out of 2,638 families who had an assessment open on the Alternative Track (University of Illinois Study, 2016)
- On average, assessments take at least twice as long to close as permitted by policy (University of Illinois Study, 2016)

Oregon fails key safety measures from 2016 CSFR

Statewide Data Indicator	National Performance	Direction of Desired Performance	RSP*	95% Confidence Interval**	Data Period(s) Used for State Performance***
Recurrence of maltreatment	9.1%	Lower	10.9%	10.2%–11.6%	FY13–14
Maltreatment in foster care (victimizations per 100,000 days in care)	8.50	Lower	14.34	12.76–16.12	14A–14B, FY14
Permanency in 12 months for children entering foster care	40.5%	Higher	36.5%	35%–38%	12B–15A
Permanency in 12 months for children in foster care 12-23 months	43.6%	Higher	40.1%	38%–42.2%	14B–15A
Permanency in 12 months for children in foster care 24 months or more	30.3%	Higher	28.1%	26.7%–29.5%	14B–15A
Re-entry to foster care in 12 months	8.3%	Lower	6.8%	5.5%–8.3%	12B–15A
Placement stability (moves per 1,000 days in care)	4.12	Lower	4.28	4.11–4.45	14B–15A

Assessments are not completed on time

From CSFR, March 25, 2016

Item 1: Timeliness of initial investigations of reports of child maltreatment

The table below provided by the Office of Business Intelligence as a summary of ROM data shows the number of allegations of abuse or neglect assigned to screening and assigned either a 24-hour or 5-day response time for calendar years 2014 and 2015.

	24 Hour Response			5-Day Response			Total Investigations		
Year	Timely 24-hour response	Total 24-hour response times	Percent	Timely 5-day response	Total 5-day response times	Percent	Total Completed Timely	Total	Total Percent
2014	13553	21289	63.7 %	1139	7019	16.2 %	14692	28308	51.9 %
2015	13808	22050	62.6 %	1165	7509	15.5 %	14973	29559	50.7 %
Grand Total	**27361**	**43339**	**63.1 %**	**2304**	**14528**	**15.9 %**	**29665**	**57867**	**51.3 %**

CSFR Identifies Problem Assessments and Safety Planning

"The CFSR case review results revealed challenges similar to those identified in the statewide assessment and external review. The results showed practice concerns with making face-to-face contact with alleged victims of child abuse and neglect during investigations, and with conducting comprehensive assessments of risk and safety, both initially and at critical case junctures, such as when case circumstances change and prior to case closure. These practice concerns affect the state's ability to engage in appropriate safety planning, especially for children remaining in their family homes."

-CSFR, Final Report, December 2016

DR Contributes to delayed assessment

From CSFR, March 25 2016

- Oregon as a whole is challenged to respond within the timeframes established in administrative rule (OAR 413-015-0210). Oregon is trending in wrong direction. . . Additionally, upon further analysis, Oregon has identified the area of greatest concern in timeliness of response in cases with a 5-day response time, which was met only 15.5% of the time in 2015. These cases represented approximately 25% of the assignments in 2015 however, this designation is rapidly increasing due to the implementation of Differential Response (DR), which has increased the number of reports with a 5-day response timeline.
- The impact of this change has been demonstrated in an analysis of screening decisions in January 2016, where DR counties averaged 43% of assigned referrals receiving a designation of 5-day response compared to Non-DR counties who average only 16% of cases assigned as 5-day response.
- The overall measure of timeliness for 2015 is 50.7%. Additionally, Oregon recognizes that performance at a 62.6% timely response for assessments with a 24-hour designation leaves substantial room for improvement that must also be addressed.

Qualitative Measures: Staff identify inadequate training

Finally, some staff (n=30) responded to the question with critiques of current training. One noted dissatisfaction with messaging around certain initiatives, like this CPS worker: "There needs to be consistency in the message given about OSM. We continue to be told different things by different supervisors and consultants." Some felt the current trainings were too rushed: "I feel that CORE had good ideas but due to having to learn a large amount of information in 4 weeks and not being able to relate this to work, the training I have received has now been lost." Others felt the trainings took too long: "I think the trainings could be more effective by being quicker and more direct."

Source: University of Illinois Study

Less than 1% of staff report training leaves them "extremely" prepared to do work

"Oregon asserts that initial training is available to all staff, however, the training does not meet the readiness need of the new employee. "

Table and quote from CSFR March 25, 2016

Post-Training preparation:

How prepared were you (your workers) to carry cases after completing CORE?		
	Supervisors	Workers
Not at all prepared	0.0%	11.0%
Slightly prepared	42.5%	43.2%
Somewhat prepared	45.0%	31.4%
Moderately prepared	12.5%	13.6%
Extremely prepared	0.0%	0.9%

Senator Sara Gelser, March 2017

GJ Safety Assessment

Following the CIRT conducted after the death of GJ, DHS performed a safety assessment of DR counties to check the safety of children on AR track assessments. In conjunction with the Office of Business Intelligence 101 cases were randomly pulled from DR counties across the state. This provides a 90-95% confidence interval for relative safety of children in AR track.

A similar study has not yet been done for kids on TR track. Regardless, the results demonstrate significant gaps in safety for children and youth receiving assessments in the Oregon CPS system.

Qualitative Measures: Highlights from GJ Safety Assessment

- Rats biting children that are gaining access to the home
- Animal feces, garbage and other debris
- Urine soaked clothing thrown on the floor and does not launder them
- One child may have medical issues that may not be receiving medical care
- No pictures of the house are in the electronic file
- No information from collaterals
- No one addresses the child's enuresis, or contacts the any of the children's physicians who have information about reported medical issues
- Case is open for four months

Qualitative Measures: Highlights from GJ Safety Assessment

"Worker wrote biased statement : 'As this case worker arrived at the home it was immediately apparent that this was not a typical client home. The home very nice, gated, and situated on a well maintained property'. "

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Qualitative Measures: Highlights from GJ Safety Assessment

"The progressive history in this case is rather concerning. It is apparent that the identified father on the case has a confirmed, long history of being violent against his children (multiple children) and his partners. The child's fear and the father's history does not reconcile well in the safety analysis that the child is manipulating to be able to play sports despite his bad grades. No safety threats were considered at all and no analysis was done as the case worker clearly felt the child was lying. The worker did not explore other collaterals outside the realm of the father's power and control over the mother of the alleged victim as well as his current partner, with whom he has past DV, and her children. "

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Qualitative Measures: Highlights from GJ Safety Assessment

"There are a lot of problems with this assessment. It appears that whomever actually assessed it left the Agency and another worker typed up the prior workers notes. The concern was neglect due to mom overdosing. Mom denies this and said she had a medical issues, appears that worker obtained a release for medical records but no confirmation about what those records said. Also no interview with maternal grandparents who cared for the child while mother was in the hospital. One line in many of the sections that is where information about family functioning is intended to be captured. The safety threat identification section is blank. In the basis for the safety decision the worker selected the incorrect safety threat. The explanation for how it didn't meet threshold was also inaccurate."

Senator Sara Gelser, March 2017

Qualitative Measures: Highlights from GJ Safety Assessment

"The case was originally called in as a result of a different family investigation on the same property. During their investigation they saw two small children who were left unsupervised for an extended period of time. Those children were being cared for by a man who was not their legal or biological father. The mother continued to prostitute and use drugs. The man remained responsible for these children despite having no legal or biological relationship to them. Throughout the course of this assessment, he leaves the children on three occasions with unsafe care providers (people using drugs) and there is information one of the adult employees of his business may have sexually abused the daughter. A different worker assesses mom and new boyfriend by interviewing the child and deem the environment to be safe but don't consider mom's substance abuse. Services are implemented to help the man get an appropriate daycare plan in place. DHS is notified by LEA that the man frequently has meth users around his property as he sells cars to them and repossesses them. Safety threat #1 should have been considered as the only legal parent to these children essentially abandoned them with a man who did not provide adequate supervision. They were subsequently removed about a year later after the man was pulled over with a prostitute in his car. She is holding one of the children and has methamphetamines on her. When the police/dhs do a welfare check to the man's house, the children's mother and several other methamphetamine users are found in his home along with methamphetamine."

Senator Sara Gelser, March 2017

Qualitative Measures: Highlights from GJ Safety Assessment

"The worker failed to consider the entire family condition and how it impacts child safety. CAS from a week or so before this referral was indicating step dad was in anger management and MH, but has to constantly be re-directed for being inappropriate and making violent comments about stabbing people and finding dead bodies. AR case from 03/29/16 was regarding the 3 yo being aggressive with her younger cousin, attempting to kill family pets, and trying to stab her father. Unable to determine from 05/05/2016 when the 3 YR old ingested a Tramadol and ended up in the hospital. Family put a lock outside 3 YR olds door to keep her out of the knives at night. They were told to remove the locks. Other history includes concerns for substance abuse, bruises on the child that were CAS instead of being assigned, parents yelling and cussing at the child, not properly dressing her, etc. Family has repeatedly been found to have Moderate to High Needs, but keeps declining services."

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Qualitative Measures: Highlights from GJ Safety Assessment

"Assigned AR 5day on 2/10/16. Documented first contact 4/6/16, then on 7/25 assigned to another worker. Report was mental health issues with mother. Mother hallucinating and buying a gun. We took it at face value that children said they felt safe with their mother. "

Qualitative Measures: Highlights from GJ Safety Assessment

"3 adolescent siblings engaged in highly concerning deviant sexualized behavior. One of the boys has also engaged in highly sexualized behavior with other same age boys. Lack of supervision by the father. He locks them in the basement together for days only allowing them to leave to use the restroom. The worker narrates that the children are safe because the parents are willing to get the kids into counseling and both are "protective" however the documentation is not clear on how this decision was reached."

Qualitative Measures: Highlights from GJ Safety Assessment

"Throughout the assessment the mother was in crisis and fleeing a domestic violence situation, the assessment was closed without insuring what the mother's safety plan was and whether it was sufficient to manage the safety of the children. The worker did not see the relatives home, where the mother was staying or engage the relative in setting up a sufficient safety plan for the children. "

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Qualitative Measures: Highlights from GJ Safety Assessment

"The family admits to telling their 7yr old that they were going to drop him off at DHS if his behaviors didn't change. This family has extensive history with the agency and the child was returned to their care in July 2014 and their case with The application of the threshold was completely missed for example, "severity is not met because the allegations are not severe," and under vulnerability, "child is not vulnerable because he is able to express himself clearly." The child is 7. The other concerning thing about this referral is that the worker discusses a FSNA referral with the family during his first face to face contact with them. In addition, the parents are threatening their young child with foster care especially since he has already been in foster care."

Senator Sara Gelser, March 2017

The issues are real…

Qualitative and quantitative information from within DHS suggests the problems are real. If child safety is truly at the center of all DHS work, something must change and the problems must be addressed with urgency.

SB 942 puts first things first

SB 942 requires that every child abuse assessment conclude with a disposition of founded, unfounded or unable to determine until key safety milestones are met.

Dispositions give us clear data about child safety, abuse and reabuse and keep more eyes on vulnerable kids.

Safety Milestones to Meet

- Adequate staffing– 95% of workload model
- Timely initial contact after report of abuse
- Timely completion of comprehensive assessment
- Reabuse rate below national average
- Statewide centralized child abuse hotline

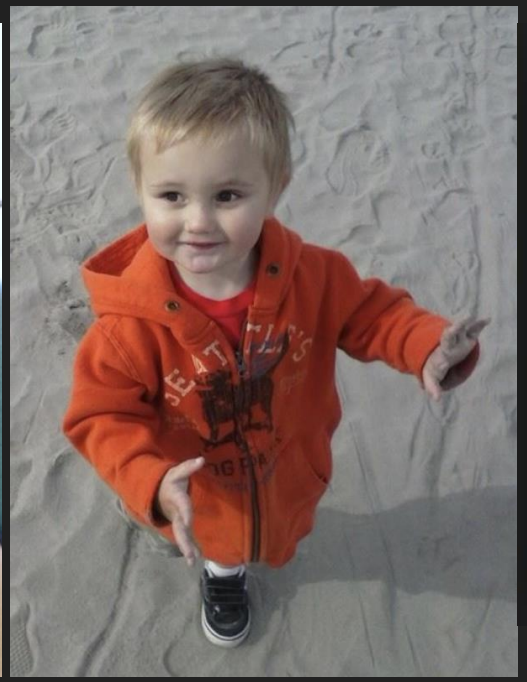
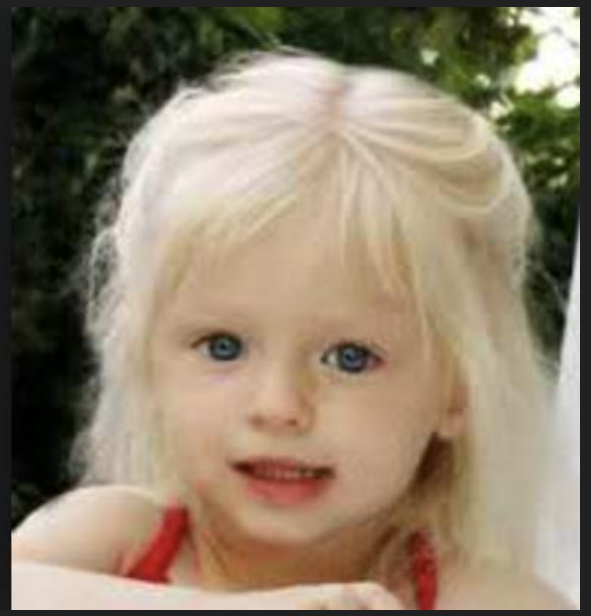
What SB 942 does not do

- SB 942 will not increase number of kids in foster care
- SB 942 does not remove the option of support services from families
- SB 942 does not undermine the idea of prevention
- SB 942 does not eliminate culturally responsive practices

We have an obligation to the kids we've lost AND the kids we can still help

Kids are paying the price for our inadequate screening and assessment system. Sometimes with their lives.



Senator Sara Gelser, March 2017

First things first…

SB 942-1 will help us develop the strong foundation needed for a quality child welfare system and will pave the way for safe and successful statewide implementation of Differential Response when the time is right

- Adequate, well trained and supported workforce
- Strong, centralized and uniform child abuse screening system
- Timely initial contact after screening assignment
- Timely and appropriate completion of comprehensive assessment
- Meet national targets for preventing reabuse