Disability Rights Oregon

TO: Chair Sanchez, Vice-Chair Moore-Green, Vice-Chair Nosse, & Members of the House Committee on Behavioral Health
FROM: Disability Rights Oregon (DRO)
DATE: February 23, 2021
RE: DRO 's Testimony in Support of House Bill 2417

Dear Chair, Vice-Chairs, and Members of the Committee:

Disability Rights Oregon (DRO) submits this testimony in support of House Bill 2417 requiring the Department of Human Services to help administer mobile crisis services with counties.

Mobile crisis response services are a nationally-recognized prevention program providing behavioral health services to support youth, adults, and their caregivers before situations turn into an emergency.

Evidence from other states shows that mobile crisis services and supports dramatically increase the stability of youth residing in foster homes as well as successfully decreases police involvement and emergency department stays by providing treatment to both youth and adults in their home and community. *See* National Conference of State Legislatures (NCSL) "*The Legislative Primer Series for Front End Justice: Mental Health*." As noted on page 4 of NCSL's primer, mobile crisis services "strengthens community partnerships and provides first responders with a variety of options to address behavioral health crises in a way that meets the needs of an individual in a clinically appropriate setting."

HB 2417 also addresses a recommendation made by the Oregon's Secretary of State's Audit in September 2020 in their report, "*Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and Their Families in Crisis*." On page 68, the auditors made this recommendation:

> Coordination of services and network is critical, particularly during the pandemic. Oregon must prepare to meet this need to support children, young people and families and provide resources and support at the right time. Adequate response to COVID-19 issues requires the creation and utilization of early intervention strategies and trauma-informed mobile response and stabilization services, and an increase in the coordination of the service network.

Finally, HB 2417 represents a significant reinvestment away from institutions – including hospitals, foster care, or the criminal justice system – and back to communities.

Disability Rights Oregon (DRO)

For more than 40 years, DRO has served as Oregon's federally authorized and funded Protection & Advocacy System. DRO is committed to ensuring the civil rights of all people are protected and enforced, including youth in correctional settings. In recent years, DRO has filed a class action lawsuit regarding the Department of Human Services failure to provide appropriate services to foster youth with disabilities.

NCSL

The Legislative Primer Series for Front End Justice:

Mental Health

National Conference of State Legislatures | AUGUST 2018

This report is the first in a series that will explore policies that impact the front end of the criminal justice system. Each brief will look at who is entering the "front door" of the criminal justice system and give examples of legislation, national initiatives, best practices, promising programs and key research on timely issues. The series will give legislatures the tools they need to consider cost effective policies that protect public safety.

The National Conference of State Legislatures is the bipartisan organization dedicated to serving the lawmakers and staffs of the nation's 50 states, its commonwealths and territories.

NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues, and is an effective and respected advocate for the interests of the states in the American federal system. Its objectives are:

- Improve the quality and effectiveness of state legislatures
- Promote policy innovation and communication among state legislatures
- Ensure state legislatures a strong, cohesive voice in the federal system

The conference operates from offices in Denver, Colorado and Washington, D.C.

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The Legislative Primer Series for Front End Justice: Mental Health

BY AMBER WIDGERY

For people in the midst of a mental health crisis, the criminal justice system and jail are all too often the first or only available response—but not necessarily the best. Legislators play a critical role in changing the way we think about and use jails in America. State law can dictate both the policy and the resources necessary to effect change, and legislators are community leaders who can convene necessary stakeholders to advance new approaches for handling individuals with mental illness on both the state and local levels.

Statewide support for system-level changes can alter how we respond to mental illness in our communities, reduce the number of people who come into contact with the criminal justice system, and maintain public safety. For those with mental illness who are appropriate for entry into the justice system, access to appropriate treatment can be provided or increased.

This report examines ways in which states can support diverting appropriate individuals with mental illness away from the criminal justice system entirely. Most experts and policymakers agree that the justice system is generally not the best intervention for those accused of low-level offenses, and that community-based services may be better suited to breaking the cycle of justice system involvement. This report also identifies correctional interventions for those for whom community-based services are not appropriate. These interventions can hold offenders accountable while also connecting them to treatment and services that are designed to reduce recidivism.

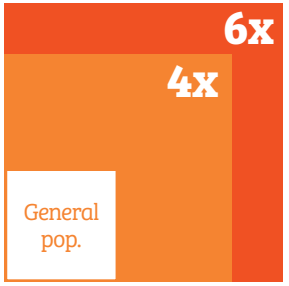
Jails: De Facto Mental Health Institutions and Burgeoning Populations

A movement in the 1950s to "deinstitutionalize" mental illness drastically decreased the availability of state hospital beds for people with mental illness.[1] The intent was to treat individuals instead in a community-based setting, a policy change that was appealing for both fiscal and civil rights purposes.[2] Unfortunately, community-based treatment capacity was not developed as planned, and now local jails largely serve as de facto mental health institutions.

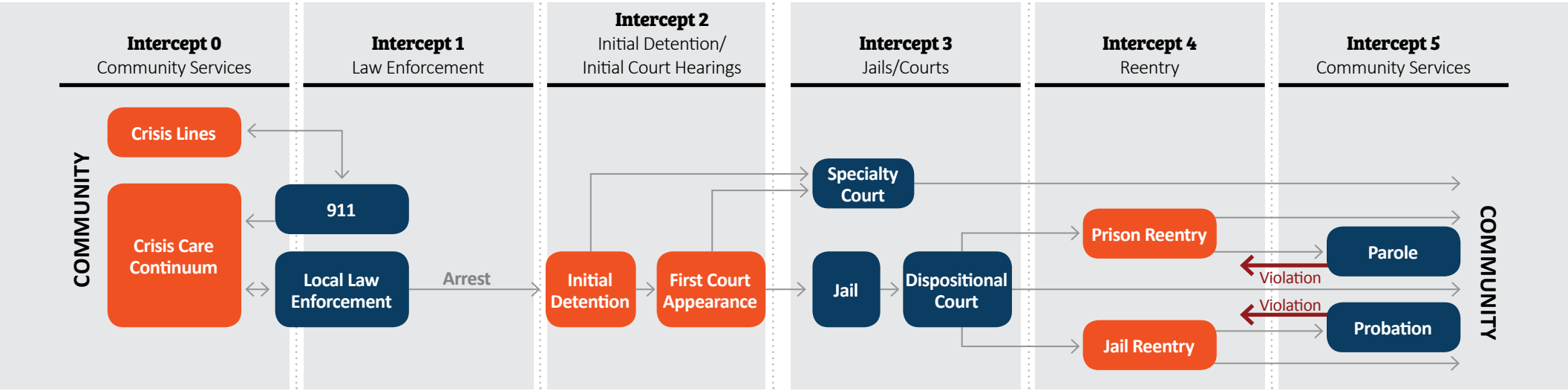
Today, a person who is experiencing a mental health crisis is more likely to encounter law enforcement than receive the medical assistance they need.[3] Jail populations currently reflect this reality. Rates of serious men-

Serious Mental Illness in Jails

Rates are four to six times higher than in the general population.



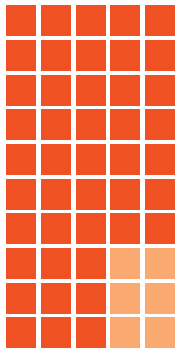
The Sequential Intercept Model



Policy Research Associates Inc.

tal illness in jails are four to six times higher than in the general population.[4] The most recent studies estimate that about 2 million people with serious mental illness are admitted to local jails annually.[5] A recent survey showed that in 44 of the 50 states, a prison or jail holds more individuals with mental illness than the largest remaining state psychiatric hospital.[6]

The use of the justice system to address the mentally ill has contributed to significant growth in overall jail populations. At least 700,000 people were held in local jails each day in 2015.[7] By contrast, that number in 1970 was just 157,000.[8] Our jails have grown significantly over the past several decades and according to the Vera Institute of Justice, nearly 11 million people are admitted to the country's more than 3,000 jails each year.[9]



Mentally Ill Stretch Jails

In 44 of the 50 states, a prison or jail holds more individuals with mental illness than the largest remaining state psychiatric hospital.

Opportunities to Reduce Mental Illness in Jails Using the Sequential Intercept Model

The Sequential Intercept Model (SIM)[10] is a framework communities can use to evaluate various systems and existing resources to organize targeted strategies that assist justice-involved individuals with behavioral health disorders. The tool helps to methodically evaluate a system and determine how those with mental and substance use disorders flow from the community into the criminal justice system and eventually return to the community. The SIM tool identifies opportunities–or intercept points (0 through 5)–where justice-involved individuals can be linked to services, rerouted from the justice system, or prevented from entering the justice system altogether. The model can help policymakers determine available resources, identify gaps in services, and develop policy and service changes.

Intercept 0: Community Services

While community and crisis services have traditionally been part of the SIM mapping process, Intercept 0 was formally integrated into the model in 2017. Intercept 0 includes both crisis response and law enforcement strategies that can reroute individuals prior to entry into the justice system. There are many types of crisis care services[11] that can assist individuals who have mental health needs; however, it is critical that communities are aware of these resources. This includes law enforcement officers, who are often the first point of contact for people experiencing a mental health crisis even when no criminal act has occurred.

Legislation and state funding have supported community mental health services to various extents over the years. Most recently, states are starting to look at how those community-based services can be better used by improving coordination with the criminal justice system and ensuring that individuals avoid the criminal justice system, if appropriate.

In 2017, the Colorado legislature acted to ensure that people in mental health crisis avoid the justice system if appropriate. Senate Bill 207[12] removed language from statute that allowed, at any time for any reason, an individual confined on an emergency 72-hour mental health hold to be detained in a jail, lockup or other facility used to confine persons charged with or convicted of a crime.

The goal of the legislation is to end the use of jails and correctional facilities as a placement option for people under emergency mental health holds who are not charged with a crime. To ensure these changes would take place, the bill appropriated funds to enhance Colorado's existing coordinated behavioral health crisis response system. The enhanced statewide framework strengthens community partnerships and provides first responders with a variety of options to address behavioral health crises in a way that meets the needs of an individual in a clinically appropriate setting.

INTERCEPT 0 IN PRACTICE: AN EXAMPLE OF COLLABORATION

In Charleston County, South Carolina, the Tri-County Crisis Stabilization Center opened its doors in 2017, providing the community and law enforcement with an alternative to arrest and jail for individuals who need mental health services. The facility is part of the South Carolina Department of Mental Health and receives funding from local hospitals, which expect to recoup some of their support from costs savings due to reduced visits to their emergency rooms.

Charleston County Sheriff's deputies provide security for the facility and in exchange, now have quick access to services for people they encounter during routine patrols and when responding to a call where someone may not have committed a criminal act or may not otherwise be appropriate for arrest. Officers now have options, including a "crisis triage service" phone number for a master's-level social worker at the center who can provide expertise, information, back-up from a mobile crisis team, and even a short-term psychiatric treatment bed or detox and sobering services.

Intercept 1: Law Enforcement

There is significant overlap between Intercept 0 and Intercept 1, because diversions and services under Intercept 0 can be initiated by the community or through the assistance of law enforcement over the course of their interactions with the community. Intercept 1, however, focuses more fully on law enforcement, and opportunities for officers to connect individuals with appropriate community-based services and reroute them away from the justice system altogether prior to arrest.

States have acted to assist law enforcement personnel in recognizing people with behavioral health issues, and in some instances, have also provided the framework for non-traditional law enforcement response procedures.

At least 27 states and the District of Columbia have laws requiring officers to be trained to respond to mental health, substance use and behavioral disorder issues. These laws specify which officers are to be trained, which entity is responsible for conducting the training, whether funding is provided, and whether the training is mandatory. This kind of training can increase officers' understanding of mental health issues generally, but can also be used to increase awareness of available community-based services.

Additionally, at least 12 states have enacted legislation creating requirements and/or guidelines for establishing Crisis Intervention Team (CIT) training.[13] Generally, these teams are formal partnerships among police departments and mental health providers that train responding personnel to identify and assess crisis situations, de-escalate crisis situations if necessary, link individuals to services, and divert them from the criminal justice system when appropriate.

INTERCEPT 1 IN PRACTICE: LOCAL INNOVATION

Starting in 1999, the police department in Houston, Texas developed Crisis Intervention Response Teams (CIRT).[14] These teams include an officer with special Crisis Intervention Team (CIT) training and a licensed professional clinician. The program started out as a small pilot, but today the department has 2,654 officers trained in crisis intervention.[15] The units only respond to calls involving individuals in mental health crisis, and in 2016 alone, there were 35,457 calls for service.[16]

Houston has also worked to address mental health concerns even earlier in the process by identifying and rerouting 911/emergency calls for service where a mental health crisis is apparent. Callers are connected directly to a helpline counselor in the dispatch center through a partnership with the Harris Center for Mental Health.[17] This direct connection can help avoid police dispatch altogether for calls involving mental health crisis where there is no accompanying criminal act.

Intercept 2: Initial Detention and Court Hearing

Intercept 2 includes policies that connect people to services or divert them away from the traditional criminal justice process after arrest, from the point of arrest and booking through initial court appearances.

In 2017, Arkansas enacted Senate Bill 136,[18] which authorized and established the framework for operating crisis stabilization units (CSUs) across the state. The units are clinical facilities that provide short-term stays for people in need of assessment and treatment services for behavioral health conditions. Individuals can be referred to a CSU by a law enforcement officer who arrested the individual for a nonviolent offense. The facilities are also available to receive people referred by community mental health centers, an Intercept 0 intervention.

The intent in creating the units was to improve outcomes for those with behavioral health issues who would otherwise end up in jails or emergency rooms, which are ill-equipped to provide this kind of assistance.[19] The first CSU opened in Sebastian County in March of 2018.[20] As the three other CSU's open, they are expected to help alleviate jail overcrowding, assist first responders and improve the odds that those who need help can find it.[21]

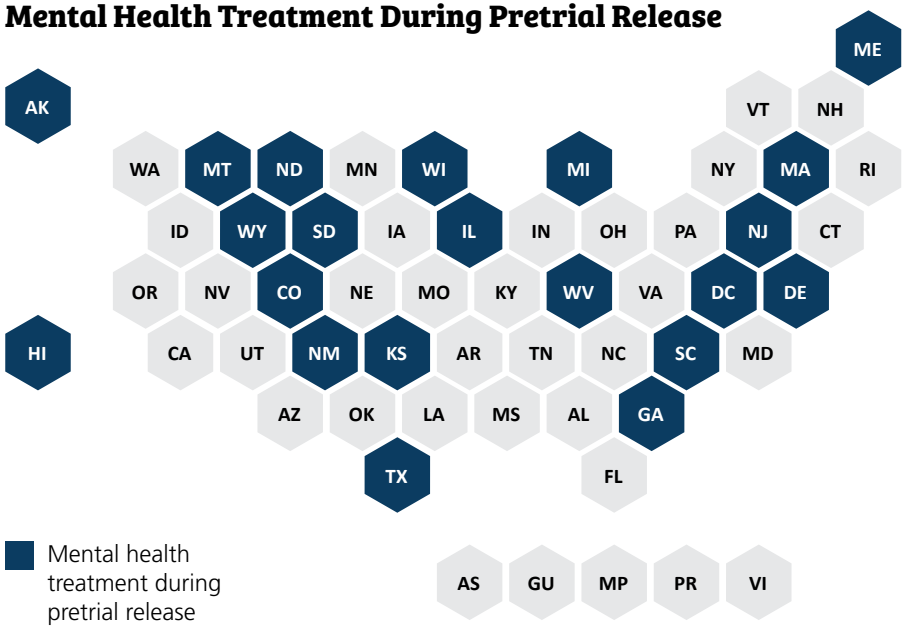
State and local action supporting immediate law enforcement led diversion options, like the legislation in Arkansas, is expected to continue expanding, but screening for mental illness, at or after booking, can also be a critical step to connect an individual to services. Those connections are often made by court-ordered conditions of pretrial release or pretrial services programs charged with supervising defendants prior to trial.

States have passed legislation to encourage these connections to services. Nearly half the states permit courts to authorize or order mental health treatment or counseling as a condition of release.[22] The majority of states also authorize courts to impose any reasonable conditions of release the court determines to be necessary, which can include a referral to services or a mental health screening or evaluation.[23]

The time frame from booking to initial appearance also provides an opportunity to identify defendants who may be suited for pretrial diversion programs in lieu of traditional criminal justice processing. Six states–California, Connecticut, Indiana, Mississippi, Nevada and Washington–have statutorily created pretrial diversion programs for individuals identified as having a mental illness.

An additional 37 states have statutory pretrial diversion programs that are not population specific, but can be used for people with mental health needs.[24] For example, many of these laws provide broad authorization for prosecutorial diversion agreements, where charges are held in abeyance or not sought in exchange for a defendant's agreement to voluntarily seek treatment.

States that Authorize or Require Mental Health Treatment During Pretrial Release



Source: NCSL, 2017

INTERCEPT 2 IN PRACTICE: STATEWIDE ACTION

The Vermont General Assembly enacted Senate Bill 295 in 2014[25] authorizing the use of pretrial needs screening on a statewide basis for specified defendants. The objective of the screening is to obtain a preliminary indication of whether a person has a substantial substance abuse or mental health issue that would warrant a subsequent court order for a more detailed clinical assessment.

Today, needs screening is available to most defendants in Vermont who are arrested, detained and unable to post bail within 24 hours if deemed appropriate by a pretrial services coordinator. The screening is voluntary, and information obtained during the screening can only be used for limited purposes.

Under this law, courts are authorized to order defendants to participate in a clinical assessment with a mental health treatment provider and follow the recommendations of the provider. Additionally, they can order a defendant to participate in pretrial services. Pretrial services may include connecting the defendant with community-based treatment programs, rehabilitative services, recovery supports and restorative justice programs. Failure to comply with either of these court orders does not result in a violation of conditions of release.[26]

Intercept 3: Courts and Jails

Intercept 3 includes policies that can connect people to services via the court system or while they are housed in jail. Courts can link a defendant to appropriate services by moving them to a specialized docket or treatment court designed to address their specific needs, often mental health or substance use.

Treatment courts, which serve individuals with mental illness, provide an opportunity to divert people away from the traditional criminal justice system. These courts emerged in the late 1990s, and have since rapidly expanded across the states.[27]

Today, 20 states have statutorily authorized mental health treatment courts.[28] Additionally, 19 state legislatures have authorized veterans treatment courts to address the needs, including those related to mental illness, of veterans and active members of the military.[29] Many more of these specialized courts exist at the local level,[30] and a vast number of resources exist, addressing everything from how to set up a court to how to evaluate outcomes.[31]

For those who are not appropriate for diversion from criminal processing, access to or continuation of services and treatment, including medication, can be critical. Screening for mental illness at booking or intake (Intercept 2), can help to facilitate initiation or prevent disruption of services while the defendant is incarcerated. Various tools are available to help jurisdictions identify individuals who need further evaluation or treatment.[32]

Treatment availability in jails is often limited because of inadequate resources. About two-thirds of the nation's just over 3,000 jails are located in rural counties, where tax bases are smaller and resources for even basic services can be sparse.[33]

Beyond resources, treatment can also be difficult because of the constant fluctuation in the jail population. About seven of every 10 individuals held in jail are being held pretrial and are not convicted of an offense.[34] Length of stay for defendants eligible for release can be unpredictable and vary greatly. The remainder of the population is generally serving a sentence of less than one year or sometimes being held for another agency.[35]

State legislatures can be key to ensuring that both rural and larger urban jails have the resources needed to provide services to help reduce recidivism and demands on the criminal justice system. This can be accomplished through legislation to create treatment programs or by distributing funding to local jails. Additionally, legislators can help increase capacity for treatment in local jails by leading regional or state-local collaboration efforts.

INTERCEPT 3 IN PRACTICE: JUDICIAL INTERVENTION

The Ramsey County Mental Health Court in Minnesota was established in 2005 and serves about 40 participants each year.[36] The court accepts individuals both pre- and post-adjudication who are diagnosed with a serious mental illness and charged with a nonviolent misdemeanor or felony offense. The program generally lasts one to three years, starts with screening for mental health and substance use needs, and involves four phases: engagement, active treatment, stabilization and program completion/graduation.

The court team consists of local judges, a program coordinator, case managers, a probation officer, prosecutors, a public defender, pro bono defense attorneys, graduate clinical interns and a law student who is certified to practice as a student attorney.[37] Some members of the team volunteer their time, but the program has also been sustained by funding from state, local and federal sources.[38]

Outcome data from the program show that Ramsey County Mental Health Court graduates are less likely to be charged with or convicted of a new offense and less likely to spend time in jail than those from a comparison group of similarly situated individuals.[39] A growing body of research evaluating mental health court outcomes has also found that mental health courts generally result in reduced recidivism rates for participants.[40]

INTERCEPT 3 IN PRACTICE: STATE AND LOCAL COOPERATION

The Utah Department of Corrections has implemented the Inmate Placement Program in coordination with 26 counties that operate jails across the state. By contract agreement, state inmates are housed in local jail facilities to the mutual benefit of both the state and the localities.[41]

One of the benefits to county jails under this arrangement has been the infusion of state funding for programming in the county jails. Traditionally, access to treatment is more robust in prisons than in jails. The average length of stay in prisons is longer and start-up and operating costs for programming can be prohibitive for locally run jails. In Utah, the statutory reimbursement rate is higher for jail beds in counties that operate treatment programs for state inmates.[42] In FY 2016, the Utah Legislature designated $508,000 for programming in local jails where state inmates were being held.[43] This state funding stream has helped establish programs that might not otherwise exist in county facilities.

Intercept 4: Reentry

Intercept 4 focuses on policies directed at assisting people who are leaving jail. According to the National Institute of Corrections, jails in the United States process approximately 12 million releases per year.[44] Helping these individuals successfully transition from an incarceration setting to the community can have a significant positive effect on public safety and poses an opportunity to reduce recidivism.

The relatively short length of stay for individuals in local jails and the lack of resources can make implementing robust reentry programming difficult. The vast majority of jail inmates remain incarcerated for less than a month,[45] so the time frame for treatment during incarceration is very brief. This can make the transition and connections to community resources vital, specifically if services, treatment or medication were interrupted by the jail stay.

Because the opportunity for intervention can be so brief, it is important to coordinate available community- and jail-based resources and consider interventions along the jail-to-community continuum. This starts with interventions and screening at intake developed under Intercept 3. Tying jail-based programming to reentry interventions under Intercept 4 will ensure continuity of treatment and services.

Continuity of care can be improved if a jail uses an approach known as "community in-reach," a practice allowing community-based organizations to work within the jail.[46] Community in-reach can facilitate a smoother transition, and help to bolster services that might not otherwise be available to jailed inmates. In-reach services can assist with a number of key reentry challenges, including housing, employment, behavioral or mental health treatment, physical health care and government benefits.

Community in-reach can also help prepare an individual for those critical first hours and days after release, a time when inmates are at a particularly high risk for drug relapse, homelessness, missing doses of medication or other problems that can lead to recidivism.[47] Most people leaving jail are not subject to continued supervision, like inmates leaving prison might be, so strong case-management services and setting up initial contacts and appointments can be crucial to making a more successful transition.

A study of The Jail Inreach Project in Harris County, Texas, found that "directly linking," or physically escorting inmates to initial appointments the morning after they are eligible for release was more successful than allowing inmates to "self-release." That is the standard procedure, where inmates are released in the middle of the night without any additional assistance in contacting service providers.[48] Inmates who elected to self-release were six times less likely to be successfully connected to services.[49] Ensuring connection to services is crucial. Initial data from the program indicates that successful linkage to treatment has so far appeared to reduce the likelihood of rearrest.

INTERCEPT 3 AND 4 OVERLAP: USING STATE FUNDING

The Colorado legislature sought to assist county sheriffs with providing screening, assessment and treatment for individuals with substance use and mental health disorders when they created and funded the Jail Based Behavioral Health Services Program in 2010.[50] In addition to funding jail-based interventions, the program also has a significant reentry component that creates partnerships for continuity of care in the community for individuals who need services upon their release. Most counties in Colorado now operate a program that has, at a minimum, a clinician to offer screenings, assessment and treatment in jail, and a case manager dedicated to transitional care and seamless continuation of treatment services in the community.[51]

The Colorado legislature continued its jail reentry work in 2017, when it enacted Senate Bill 21. The law establishes a program to provide housing vouchers and supportive services to persons with behavioral or mental health disorders who are being released from jails or other correctional settings.

INTERCEPT 4 IN PRACTICE: USING PUBLIC BENEFITS

A recent report from the National Association of Counties highlighted work being done in Cook County, Illinois.[52] The county established a Medicaid enrollment process through a partnership with local entities and hospitals. Under the partnership, staff are available seven days a week at the jail intake area, where they screen people for Medicaid eligibility as they wait for results from health and mental health assessments. Staff enroll these individuals into Medicaid if they are eligible.

Additionally, the county is now providing prerelease services in its "discharge lounge" for those with serious mental illness. These services include providing individuals with resources for housing, doctors' appointments, continuation of medication and more.

Intercept 5: Community Corrections

Intercept 5 focuses on intervention policies for those on community supervision, which primarily involves individuals on probation.[53] The most recent numbers from the Bureau of Justice Statistics estimate that nearly 3.66 million people were on probation at the end of 2016.[54]

Similar to people in jail, those on probation also disproportionately suffer from mental illness.[55] Well-tailored community supervision provides an opportunity to link offenders to appropriate services, but it can also be difficult for those with mental health issues to comply with rules under a system that is not designed to meet their mental health needs.[56]

Probationers with mental illness face a unique set of challenges with supervision that are directly related to their conditions; however, they also struggle more than others with meeting basic needs. They are more likely to face socioeconomic challenges—such as homelessness, unemployment and reliance on public assistance—that make supervision compliance difficult.[57] Thirty percent of local jail detainees with mental illness are homeless in the year prior to their arrest, compared with only 17 percent of individuals without mental illness.[58] Additionally, 44 percent of probationers with mental illness are unemployed compared with 24 percent of those without mental illness.[59] Because of these and other challenges, offenders with a mental illness are twice as likely to have their probation revoked.[60]

State support for programs that help individuals overcome these challenges can be key to preventing rearrest and further contact with the criminal justice system.

INTERCEPT 4 AND 5 OVERLAP: HOUSING FIRST

Housing First is a program that connects individuals to stable housing. Housing First is differentiated from other housing programs because it does not require sobriety and people are not eliminated based on a criminal record or poor credit history—common barriers for justice-involved individuals. Housing First prioritizes establishing a stable environment and then focuses on placing participants with voluntary treatment and other service programs.

In 2013, the Hawaii legislature enacted Senate Bill 515, appropriating funds to the human services department for Housing First programs.[61] Implementation in Honolulu has been studied by the University of Hawaii. Two years in, the study found that individuals in the program are 55 percent less likely to be arrested after one year and 61 percent less likely to be arrested after two years.[62] Researchers also found a 21 percent improvement in general health and participants were 64 percent less likely to be admitted to the hospital.[63]

INTERCEPT 5 IN PRACTICE: HOLISTICALLY TREATING CO-OCCURRING DISORDERS

The number of people with co-occurring mental and substance use disorders involved in the justice system is significant. People with mental disorders are more likely than those without a mental disorder to also have an alcohol or substance use disorder.[64] One way states are trying to address the needs of this population is by expanding the use of medication-assisted treatment (MAT) for those with opioid disorders.[65] MAT has been defined by legislatures as the use of medications and drug screening, in combination with evidence-based counseling and behavioral therapy, to provide a holistic approach to treating substance use disorders.[66] MAT has been shown to have positive outcomes, including improved patient survival rates, increased retention in treatment, decreased illicit opioid use and other criminal activity, increased ability to gain and maintain employment, and improved birth outcomes for pregnant women with substance use disorders.[67]

In 2015, the Indiana legislature moved to incorporate MAT as an option throughout the state's justice system, including for individuals being supervised in the community. Senate Bill 464 authorized community corrections programs to coordinate or operate drug and alcohol abuse counseling programs, including programs that use MAT. The new law also required the corrections commissioner to prioritize community corrections and court-supervised recidivism reduction grants for programs that provide alternative sentencing options for persons with mental illness, addictive disorders, and intellectual and developmental disabilities. Programs for addictive disorders were authorized to include MAT. Courts with probation jurisdiction that seek state financial assistance are now required to consult with the corrections department and the division of mental health and addiction to more effectively address the need for substance abuse treatment, including MAT. Medication-assisted treatment was also authorized to be ordered as a condition of probation.[68]

To further ensure implementation of MAT, the legislature enacted House Bill 1304, which required training for judges, prosecutors and public defenders on the availability of probation programs for offenders with addictive disorders, including information on MAT.[69]

Conclusion

State lawmakers have an opportunity to make informed policy and budget choices that can help improve outcomes for people with behavioral health needs while maintaining public safety. Recent actions in state legislatures reflect growing bipartisan cooperation to divert and treat individuals with mental illness who are under correctional control or are at risk of coming into contact with the justice system. Moving forward there is an opportunity for lawmakers to reduce use of jails to house the mentally ill, while also creating a more fair and just criminal justice system.

Notes

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8. *Id.*
9. *Id.*
10. "The Sequential Intercept Model (SIM) was developed over several years in the early 2000s by Mark Munetz, MD and Patricia A. Griffin, PhD, along with Henry J. Steadman, PhD, of Policy Research Associates, Inc. The SIM was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system." Policy Research Associates, *The Sequential Intercept Model* (2017), http://www.usf.edu/cbcs/mhlp/tac/documents/mapping/sim-handout-new.pdf. *See also*: Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 Psychiatric Services 4, 544-549 (2006), https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.4.544; Dan Abreu et al., *Revising the Paradigm for Jail Diversion for People with Mental and Substance Use Disorders: Intercept 0*, Behav. Sci. Law, 1-16 (2017).
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14. Houston Police Dep't Mental Health Division, *Crisis Intervention Training (CIT) Program* (2014), http://www.houstoncit.org/boarding-homes.
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Secretary of State
Oregon Audits Division

Department of Human Services

Oregon Can More Effectively Use Family Services to Limit Foster Care and Keep Children Safely at Home

July 2020

Report 2020-26

Secretary of State Bev Clarno
Audits Division Director Kip Memmott

Secretary of State
Oregon Audits Division

Executive Summary

Department of Human Services

Oregon Can More Effectively Use Family Services to Limit Foster Care and Keep Children Safely at Home

Why This Audit is Important

» Keeping children out of foster care can prevent life-long harm, provided effective services can stabilize their families.

» Oregon's child welfare system removes children at a higher rate and returns them to foster care more often than the national average, adding to already high caseworker workloads. Children also receive fewer post-investigation services than the national average.

» Congress's new "Family First" act directs states to deliver evidence-backed family services that support parents and children, helping to keep children out of foster care or return them home quickly.

» More efficient and effective services are critical to maximize child safety, family well-being, and the limited dollars available for services.

What We Found

1. Effective preventive services can keep children at home, increase family well-being, and reduce costs, racial disparities, and child deaths. (pg. 12)
2. Case workers within the Department of Human Services (DHS) Child Welfare division are faced with high workloads and tight deadlines, and struggle to help parents access and engage in in effective services to prevent removals. (pg. 17)
3. Oregon's disparate system of child and family services, with services offered by multiple programs and agencies, makes it more difficult for Child Welfare to reduce child abuse and preserve families. (pg. 17)
4. The availability and quality of crucial services vary substantially by geographic area. These services include in-home safety services, mental health care, substance use disorder treatment, and affordable housing, all addressing key reasons children enter foster care. (pg. 26)
5. Child Welfare can more effectively manage provider performance and match families with appropriate services. (pg. 32)

What We Recommend

We made 10 recommendations to DHS to work with its partners to improve coordination and focus on child abuse prevention, help caseworkers stabilize and reunify families, and improve service access in rural areas. The agency also needs to better use data to identify effective providers, address service gaps, improve provider performance, and provide clear reports to policymakers on service availability and effectiveness.

State funding is uncertain given the economic effects of COVID-19. We included recommendations that do not require substantial resources but can help shift Child Welfare's focus to keeping more children safely at home.

DHS agreed with nine of our recommendations and partially agreed with one. Their response can be found at the end of the report.

The Oregon Secretary of State Audits Division is an independent, nonpartisan organization that conducts audits based on objective, reliable information to help state government operate more efficiently and effectively. The summary above should be considered in connection with a careful review of the full report.

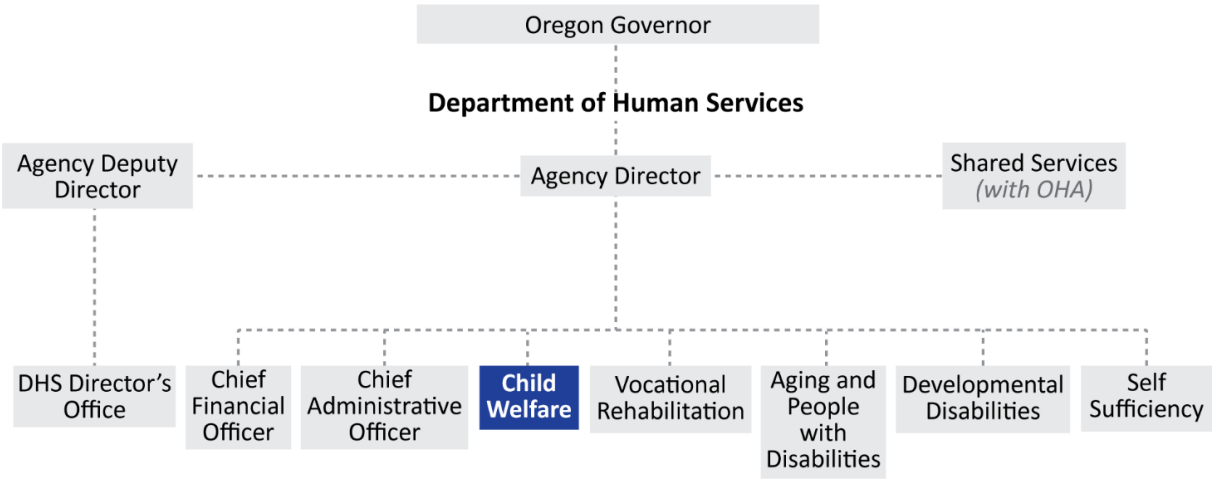
Introduction

This audit focuses on how Child Welfare and its partners within and outside the Department of Human Services (DHS) can more effectively and economically use family services to safely limit foster care and keep more families intact. Service improvement can help bolster struggling parents and children. By reducing children removed to foster care, improving services can also help reduce the shortfall of foster homes and high Child Welfare caseloads documented in our 2018 foster care audit.

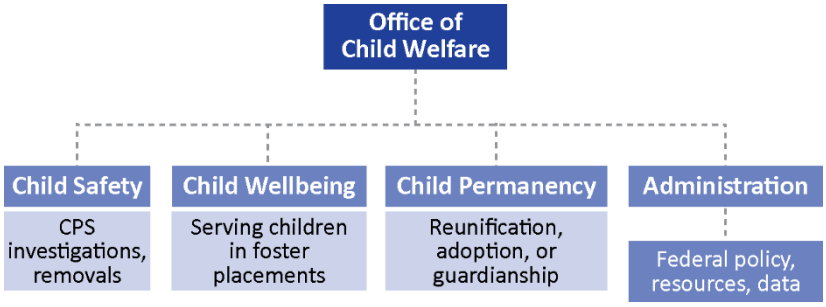
Oregon Child Welfare at a glance

- 10,887 children spent at least one day in foster care
- 89,451 abuse reports received
- 9,048 cases founded for abuse
- 2,820 of 13,674 victims removed from their homes

- Numbers as of 2019



Child Welfare is part of DHS, which has a budget of $12.6 billion per biennium, more than 9,000 employees, and five operating divisions, of which Child Welfare is one. Its director is appointed by the Governor, who has a human services policy advisor in her office. DHS serves some of Oregon's most vulnerable residents, including neglected and abused children, families in poverty, and elderly people living alone. Sixteen districts across the state do most of the hands-on work with clients, backed by management and central office staff. The shared services office includes contracting, financial services, and internal audits, which supports both DHS and the Oregon Health Authority (OHA). DHS and OHA were a single agency until 2009.



The Office of Child Welfare has a budget of $1.35 billion per biennium and approximately 3,200 employees. It runs a child abuse and neglect hotline, investigates reports of neglect and abuse, and provides services to families and children when a child's safety is threatened. Caseworkers from the office's Child Protective Services (CPS) unit remove children from a home if they believe it is not safe for them to remain, sending them to foster care in group settings or in individual homes with relatives or strangers.

Judges approve or reject these removal decisions and monitor steps Child Welfare has taken to prevent removal. After the state is granted custody, the goal of permanency caseworkers is to reunify children with their families or to have stable families adopt them or act as guardians. Child Welfare services for children, youth, adults, and families aim to promote child well-being and family stability, whether in the child's family home, or in foster care.

Child Welfare provides direct services to clients, but also relies on other agencies and providers

Within Child Welfare, families and children can receive services before a child is removed from the home, for "family stabilization," or after a child enters foster care, for family reunification. Most of the current family services are delivered for reunification, after children are removed and placed into foster care. Once children are in DHS custody, in either foster care or in-home supervision, courts can order parents to participate in services. Before children enter DHS custody, services are voluntary.

From 2014 to 2019, our analysis indicates Child Welfare nearly doubled its direct spending on family services — services designed to facilitate family stabilization or reunification — from roughly $24 million in 2014 to $44 million in 2019. Providers contracted by Child Welfare and DHS typically provide these services.

Much of this 2019 spending came from two programs: In-Home Safety and Reunification Services (ISRS) and Strengthening, Preserving, and Reunifying Families services (SPRF), a program the Legislature created in 2011. Both programs are reflected in Figure 1; however, SPRF is not a single line item in the chart. Instead, SPRF services span multiple categories such as housing, parent training, meeting facilitation, and front end intervention, among others. In 2019, total SPRF expenditures were $13.6 million. Continued SPRF funding after 2020 is uncertain.

Figure 1: Most spending in 2019 came from the ISRS program

Child Welfare Reunification & Retention Services	2019 Spending (in millions)
In-Home Safety and Reunification (ISRS)	$9.9
Parent Mentoring and Counseling	$7.2
Housing	$7.2
Parent Training and Support	$5.5
Alcohol and Drug Treatment	$4.1
Domestic Violence	$3.9
Child Care & Respite Care	$2.4
Meeting Facilitation for Child Visits/Disputes	$2.0
Front End Intervention at CPS Stage	$1.7

Source: Auditor analysis of actual 2019 expenditures in the state's accounting system.

Clients also receive services from outside Child Welfare

In addition to services Child Welfare provides, parents and children also heavily rely on services from other agencies and programs. Child Welfare does not pay for these services so their costs are not included in Child Welfare's expenditure data. However, caseworkers and Child Welfare officials often cited three services as important in our interviews:

Physical, mental, and addiction recovery care: Coordinated Care Organizations (CCOs), regulated by OHA, pay for physical and behavioral health services under Medicaid. The majority of children and youth in foster care are eligible for Medicaid. This includes counseling, mental health treatment, and addiction treatment, services typically provided by counties or providers contracted by counties.

Self-Sufficiency support within DHS: Among other services, Self-Sufficiency Programs provides Temporary Assistance for Needy Families, a cash payment coupled with job search assistance to low- or no-income families; Supplemental Nutrition Assistance Program food assistance; and Family Support and Connections services aimed at preventing child abuse, such as parenting classes, help building social supports, and housing and transportation assistance.

Developmental Disabilities support within DHS: The Office of Developmental Disabilities Services provides assistance for adults and children diagnosed with neurological conditions such as autism, cerebral palsy, epilepsy, and low IQ. Services include help with communication, grooming, and safety and social skills. The office's services, primarily funded by Medicaid, do not include specific training in parenting skills, but they can help clients live independently and be more successful parents.

Many more agencies and community providers deliver broader preventive services

Child Welfare gets most involved in providing services during and after investigations into child abuse and neglect. A larger range of services provided by federal, state, and local entities can help families before they come to Child Welfare's attention and before abuse and neglect occur.

The services from OHA, CCOs, DHS Self-Sufficiency, and DHS Developmental Disabilities divisions are instrumental in the broader prevention of child abuse and help families that may be at greater risk of being involved with Child Welfare.

County governments provide on-the-ground mental health care, federally funded Women-Infant-Children assistance and other family support programs. The Oregon Youth Authority provides services for youth.

The federal government, local housing agencies, and Oregon Housing and Community Services provide affordable housing programs. Services though schools, Education Service Districts, and the Oregon Department of Education benefit both children and parents, including Early Head Start, parent engagement, and home visiting programs for parents of infants.

Oregon's community service providers, from local agencies to non-profits, are a backbone for prevention of child abuse. Some are governmental, including teachers and school counselors, public school nurses, home nurses, and county-funded health clinics. Others may be funded by both government contracts and donors, including faith-based groups, food pantries, domestic violence women's shelters, relief nurseries, and advocacy centers. Doctors, psychiatrists, and counselors, both private and working for community organizations, also have a central role.

Child Welfare's General Fund support has grown substantially, though COVID-19 reductions could significantly reduce spending

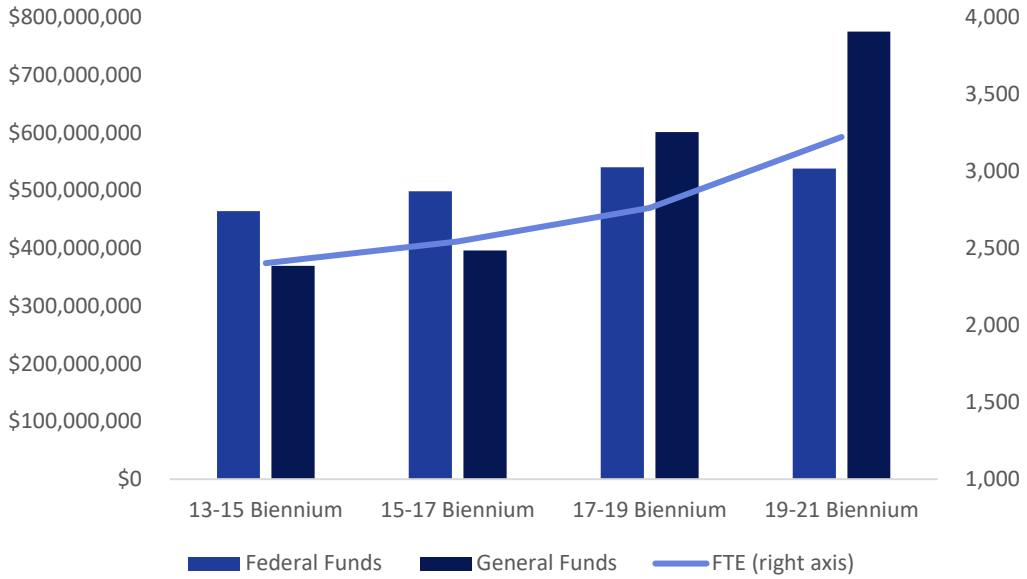
State taxpayers have made large investments in Child Welfare in recent years, reinforcing the need to make sure the office's funding is spent efficiently and effectively. Reductions related to COVID-19 could also substantially reduce spending for the 2019-21 biennium.

Child Welfare's budget has increased 58% in the past four biennia, more than the 40% increase in total state expenditures in that time. Most of that $500 million increase — 82% — came from

the state's General Fund, not federal funding. General Fund dollars for Child Welfare have risen 110% since July 2013, nearly triple the rate of increase in Oregon's total General Fund.

The division's staffing, expressed as full-time equivalents (FTE), rose by a third during that time to 3,222 in the latest budget, including a planned increase of roughly 460 FTE for the current biennium. These staffing increases were, in part, to help address caseworker overload. However, the staff increase was smaller —142 FTE — compared to current service levels at the beginning of the biennium.[1] Also, as we noted in our follow-up to the 2018 audit, even the increases in the 2019-21 biennium, were they all to take place as planned, are not enough to meet national Child Welfare workload standards.

Figure 2: General Fund spending has driven the growth in Child Welfare's budget and staff



Source: Legislative Fiscal Office budget documents. Numbers for the 13-15 and 15-17 bienniums are actual dollars, while numbers for the 17-19 and and 19-21 bienniums are budgeted dollars because actuals are not yet available.

For Child Welfare, budgeted spending has been about 5% less than actual dollars spent, meaning actual spending in the current 2019-21 biennium would likely be lower than budgeted in normal conditions. More significantly, cuts related to COVID-19 could substantially reduce funds for the 2021 fiscal year, the last year of the current biennium. In May 2020, at the Governor's request, DHS and other agencies proposed cuts for the 2021 fiscal year absent COVID-19 assistance from the federal government and use of state reserve funds. DHS outlined $65.9 million in cuts to Child Welfare, more than a third of the total budget increase for the current biennium. Many of these cuts could reduce services to families.

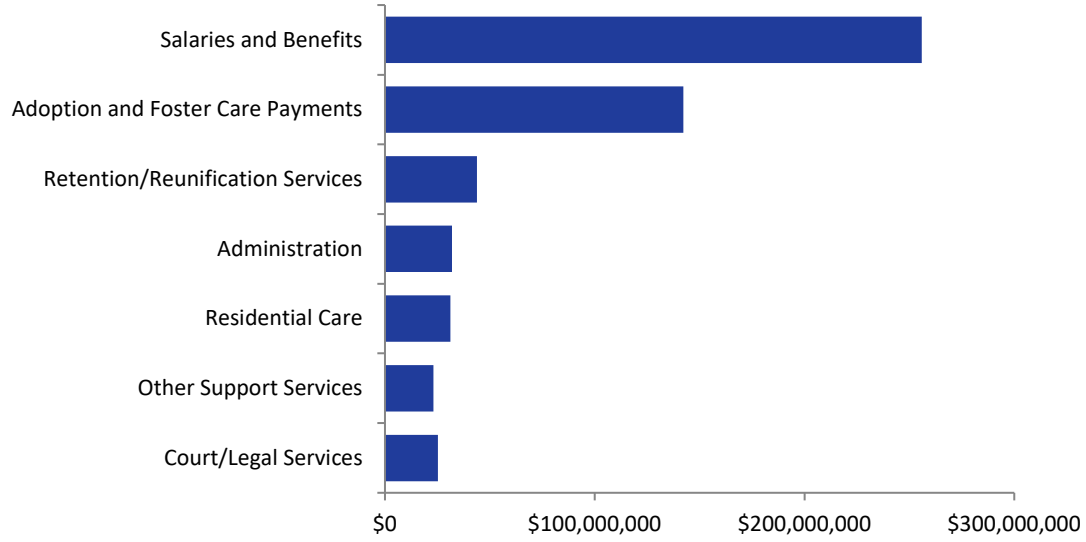
Actual spending details drawn from the state's financial accounting system show both spending categories that have grown and the categories that take up the bulk of Child Welfare's budget.

From 2014 to 2019, Child Welfare expenditures rose by about $150 million. About half of that increase was for staff. Adoption and foster care payments, retention and reunification services, and administration all accounted for about 13% to 15% each of the total increase.

[1] In the budget process, the current service level for staff in an upcoming biennium is an estimate of the number of staff it would take to do the same work approved in the previous biennium. When staff are added in the middle of the previous biennium, as they were for Child Welfare in the 2017-19 biennium, the estimated current service level estimate for the next biennium increases.

In 2019, about half of Child Welfare's actual expenditures went to salaries and benefits. Another quarter paid for monthly payments to foster or adoptive parents, helping them cover expenses for children in their care.

Figure 3: Most of Child Welfare's 2019 spending was for staff and payments to foster and adoptive parents



Source: Auditor analysis of 2019 expenditures in the state's accounting system.

Outside Child Welfare, the new Student Success Act approved by the 2019 Legislature includes some additional funding for preventive services. The Act provides a projected $2 billion per biennium for K-12 education and early learning through a new commercial activities tax. Preventive programs scheduled to receive funding include Early Head Start ($22.3 million in the 2019-21 biennium), relief nurseries ($2.8 million), parenting education ($1 million), and Healthy Families Oregon ($2 million), a home visiting program for new mothers. However, as with Child Welfare's budget, reductions in economic activity related to COVID-19 may mean less money is raised and available to spend.

The federal Family First Act emphasizes using evidence-based services to keep families together and children out of foster care

The Family First Prevention Services Act, signed into law in February 2018, aims to use federal dollars to help states shift their Child Welfare systems to prevention, reduce foster care placements, and improve children's prospects by placing them in family foster care settings and limiting congregate care placements.[2] Chapin Hall, a consulting group focused on child and family well-being, calls the Family First Act the "most significant child welfare law to pass in 20 years."

Among other provisions, the Act:

- Helps pay for eligible evidence-based preventive services. It gives states the option to use federal Title IV-E funding — the major federal source of money for Child Welfare — to pay for half the cost of services provided to children at risk of entering foster care, their parents and relative caregivers. In the past, absent waivers from the federal government, the funding was focused on services after children were removed from their homes. States can also use another pot of federal money, Title IV-B, to help pay for

[2] Congregate Care: A placement setting of group home or institution. These settings may include child care institutions, residential treatment facilities, or maternity homes.

family services while children and youth are in foster care, and for up to 15 months after they are reunified with their families.

- Targets problems that are key factors in removals. The federal government will reimburse states for mental health treatment, substance use disorder treatment and prevention, and in-home, skill-based parenting programs, all services designed to address major reasons why children are removed from their homes.

- Seeks to improve foster care. It provides grants to states to recruit and retain high-quality foster parents.

- Strengthens requirements for residential care. It restricts federal reimbursement for children with high needs placed in group care to facilities that meet Qualified Residential Treatment Program standards — as does a new Oregon law.[3] As of June 2020, four of Oregon's 14 providers had completed accreditation. According to Child Welfare officials, nine of the remaining 10 providers were expected to be accredited by a July 1, 2020, deadline, but COVID-19 delayed accreditation team visits. Under a short-term provisional accreditation that takes effect July 1, 2020, DHS estimates that Oregon will have enough qualified residential treatment program beds for the 200 to 210 children needing them by the deadline.

The federal government expects states to partner with providers of mental health, substance use disorder treatment, and early childhood programs, along with courts, to increase prevention services and reduce the number of children in foster care.

Oregon has until September 2021 to submit a five-year plan on how it will implement and execute Family First requirements. Child Welfare expects to make limited changes initially, in part to gain experience with supporting services ranked as evidence-based by federal researchers, then make incremental changes going forward. An estimated $6.2 million in transition money from the federal government will help maintain services levels as the state implements Family First.

Oregon should be able to expand its efforts later, particularly if its services are found to be evidence-based and if cooperation between Oregon agencies providing and paying for services improves. The biggest initial contribution of the Act beyond higher group care standards may be its push for a more preventive system, one that addresses the root causes of child abuse and neglect.

Safely reducing removals can benefit children, even if families have substantial problems

Deciding whether to remove children from their home or leave them there presents risk, no matter what caseworkers choose. Leaving children in an abusive home can result in harm or even death — from 2018 to mid-2020, DHS issued 63 reports on children in Oregon who died within 12 months of child welfare involvement and had remained in their homes. For the past six years, at least one in five incidents investigated by Child Welfare was founded for child abuse or neglect, amounting to more than 10,000 children a year. Nearly half those children were younger than 6 years old. The trauma from child maltreatment has been linked to risky health behaviors, chronic health conditions, and early death. In many removal cases, caseworkers told us, removal into foster care is the clear safe choice.

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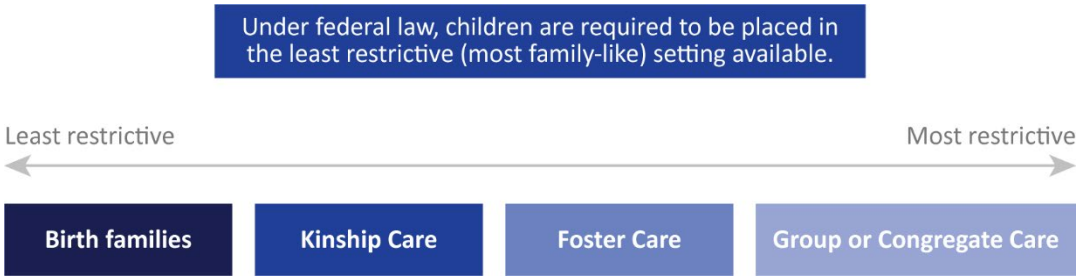
[3] ORS 419B.356 – Qualified residential Treatment program becomes operative on July 1, 2020, and applies to placements of children or wards occurring on or after July 1, 2020.

However, the effects of removing children from their homes and families is also substantial, a fact recognized by federal and state protections of family rights. Under federal law, children are to be placed in the most family-like setting, even if families have substantial problems or maltreatment has occurred.

Figure 4: Federal laws emphasize a preference for keeping families intact



Source: National Conference of State Legislatures.

Some research, albeit dated, suggests children in comparable circumstances have less favorable outcomes if they are removed. A 2007 study found children assigned to CPS investigators with relatively high removal rates were more likely to be placed in foster care, and had higher delinquency rates, teen birth rates, and lower earnings than similar children assigned to investigators with low removal rates. A 2010 study found that children placed in out-of-home care had higher rates of post-traumatic stress disorder than children who received in-home services. Research on younger children indicates children placed in foster care often exhibit more problem behaviors than children not removed, particularly if children are unfamiliar with their foster caregivers.[4]

> "We have some amazing foster parents, but the fact is they are not the parents of these children. Kids can get really close to them and they can help, **but kids want their parents**."
> *- CPS caseworker*

According to experts in childhood trauma, a break in parent-child attachment is highly traumatic for children, even those maltreated by their parents. Foster care placements can also remove children from their school and community, a social safety net that includes teachers, neighbors, extended family, friends, faith groups, sports teams, and others who provide critical support. Foster care can split sibling groups into separate homes, and send children and youth through multiple placements — 41% of Oregon's 6,771 children in foster care as of May 2020 already had three or more placements. Former foster children interviewed for the audit cited frequent moves as one of the most traumatic aspects of foster care.

> "At every (foster) home, **I would wait a little longer to unpack my bags**."
> *- Former foster child with multiple placements*

Our interviews also emphasized that many foster children succeed. However, long-term outcomes for foster children are relatively poor and extend well into adulthood, particularly for those who age out of the system without a permanent home. Studies have identified higher rates of imprisonment, mental health disorders, unemployment, and homelessness, among other measures.[5]

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[4] Kimberly Howard et al.: Early Mother-Child Separation, Parenting, and Child Well-Being in Early Head Start Families.
[5] Joseph J. Doyle Jr: Child Protection and Adult Crime: Using Investigators Assignment to estimate Causal Effects of Foster Care
Peter J. Pecora et al.: Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study

Child Welfare management faces substantial challenges, including lawsuits, intense scrutiny, and high turnover in leadership positions

In recent years, Child Welfare has faced scrutiny from legislators, attorneys, the Governor's Office, the media, and auditors, all highlighting problems the agency needs to address. Societal issues, from COVID-19 to rising housing prices, also complicate Child Welfare's mission to empower children and families to live independent, safe, and healthy lives.

Figure 5: Child Welfare has faced numerous challenges in recent years

COVID-19 Impacts	DHS had reduced in-person visits between children in foster care and their parents and providers and caseworkers were often working with clients by phone. Domestic violence calls to crisis lines spiked amid stay-at-home orders and job losses. At the same time, calls to the Oregon's Child Abuse Hotline dropped dramatically amid school closures, raising concerns that abuse could go unreported. In Oregon, school personnel make about 20% of calls to the hotline. State economists say funding for Child Welfare and other government programs will fall because of the slow economy and reduced state tax collections. The CARES Act, the federal bill to address COVID-19 impacts, provides forgivable loans for nonprofit service providers and a $45 million, 15% bump in Title IV-B funds for abuse prevention, family preservation, placement permanency, and worker training. As of the writing of this report, Congress had not passed specific aid to help state governments weather revenue shortfalls.
Legislative Oversight	Among other steps, the Legislature has changed Child Welfare's system of providing services to at-risk families, successfully pressed DHS to move forward on a centralized abuse hotline, and raised substantial issues about Child Welfare's practice of sending some high-needs children to out-of-state residential treatment facilities.
Lawsuits Focused on Operations	In 2016, a lawsuit challenged Child Welfare's practice of temporarily housing some youth in hotels instead of foster or group homes. A 2018 settlement agreement has reduced hotel use, though 37 children were housed in hotels in the first three months of 2020. The broader problem of limited placements for high-needs youth also remains. In April 2019, 10 foster children backed by advocates sued the state alleging poor treatment of foster children and foster parents. The suit, still ongoing, seeks reduced caseloads and thorough, swift plans for services when children enter foster care. Similar, successful suits in other states have increased Child Welfare staffing.
Governor's Intervention	After the latest lawsuit was filed, the Governor created a Child Welfare oversight board and hired consultants to focus on issues such as out-of-state placements and agency hiring. The consultants finished their $3.5 million job in December 2019. By late June 2020, Child Welfare reported four youth in out-of-state placements, down from 86 in April 2019, and expected to have no out-of-state placements by the end of the month.
Leadership turnover	The Office of Child Welfare has had four directors since 2015. The latest director, a former foster child herself, arrived from Maryland in November 2019.

Secretary of State Performance Audit	In January 2018, the Audits Division issued a critical audit of Child Welfare, report 2018-05, "Foster Care in Oregon: Chronic management failures and high caseloads jeopardize the safety of some of the state's most vulnerable children." It found an inadequate number of suitable foster care homes, low staffing, high caseloads and worker turnover, and repeated DHS failures to adequately implement new programs.[6] The Audits Division issued a follow-up to that audit in June 2019, report 2019-24, "DHS has made important improvements, but extensive work remains to ensure child safety." It concluded that DHS made progress on all 24 of the audit's recommendations. However, it also found that staff remained overburdened and the state still lacks enough foster homes and residential beds for high-needs children.[7]

6 Report 2018-05: "Foster Care in Oregon: Chronic management failures and high caseloads jeopardize the safety of some of the state's most vulnerable children."
7 Report 2019-24: "DHS Has Made Important Improvements, but Extensive Work Remains to Ensure Child Safety."

Audit Results

The Child Welfare division of DHS has many responsibilities, foremost among them ensuring that children are safe, attending to children in state custody, and helping the foster parents who support them. Services provided to families — parents of origin and their children — can help improve safety, reduce removals, and reduce demand on a strained foster care system.

Family services are not a panacea, but we found effective services can make a substantial difference in addressing chronic neglect and reducing racial disparities in foster care. Services can help the state save money by reducing removals of children from their homes. Family services can also help ensure child safety when children return to their homes from foster care or in cases where caseworkers identify concerning behavior, but it does not meet the standard for removing a child.

Oregon's Child Welfare system ranks low on some key family measures, results that better use of services could help address. Yet caseworkers face substantial obstacles to helping families access services, including high workloads, limited authority, and the need to cross numerous jurisdictional boundaries to get families the help they need. Key services to prevent removals, including treatment for mental health and substance use disorders, are limited and vary by geographic area. Child Welfare can also more effectively manage services to gauge which services are performing best, improve provider performance, and match families with the services that are most likely to help them.

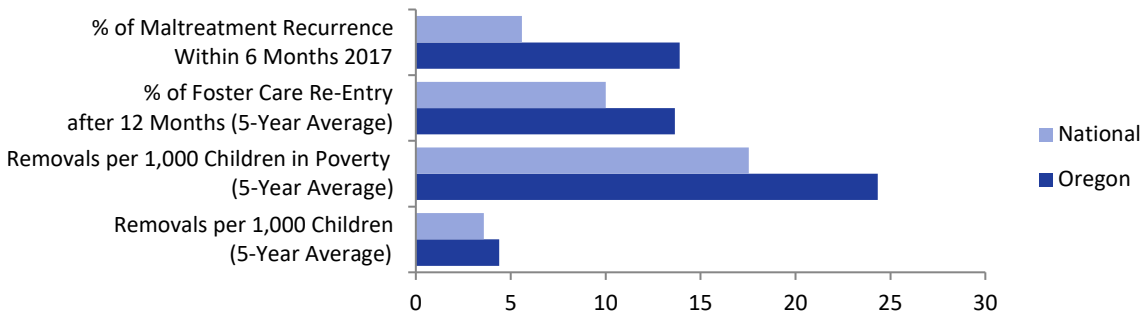
Oregon's Child Welfare system ranks low on some key family measures

Oregon falls behind other states and national averages on some important family outcomes. Oregon places more children into foster care, children re-enter foster care at a higher rate, and wait times for services are longer than the national average. Oregon's maltreatment recurrence rate, which focuses on children who had a second report of maltreatment six months after an original substantiated report, was more than double the national average in 2017.

Effective and timely family services could help improve Oregon's performance, helping families retain their children and providing help that reduces foster care re-entry and repeat maltreatment.

Removal rates measure the number of children removed and entering foster care as a proportion of all children or of children in poverty. Oregon's average removal rates for children in poverty over the last five years are particularly high relative to the national average, as depicted in Figure 6. Nationwide, accounting for poverty can provide a fairer basis of comparison for Child Welfare. Researchers estimate that rates of child abuse and neglect are five times higher for children in families who are living in poverty.

Figure 6: Oregon falls behind national averages on key measures

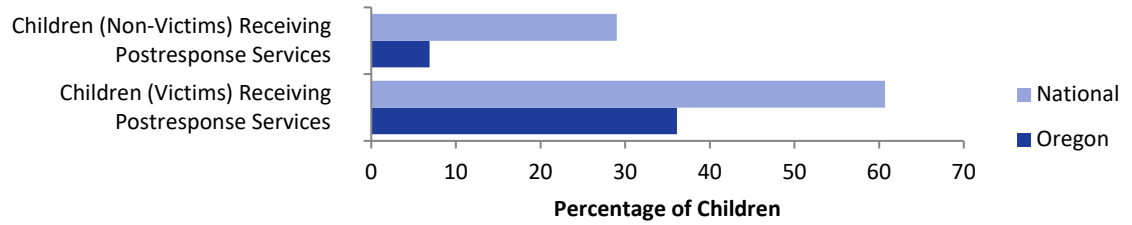


Source: OR-Kids, Children's Bureau, AFCARS, Annie E. Casey Foundation Kids Count.

In 2018, children and their families in Oregon had to wait longer to start receiving Child Welfare services — on average, 55 days. The national average is 32 days, with a handful of states having a wait time of about two weeks or less. Wait times for services is a constant issue that caseworkers report across the state.

Oregon children, both victims of child abuse and children found not to be victims, also received fewer post-investigation services after Child Welfare responded than the national average in 2018. To be included in this metric, the services had to be delivered within 90 days of the disposition of the child abuse or neglect report. Services included family preservation, family support, and foster care.

Figure 7: Fewer Oregon children received post-investigation services



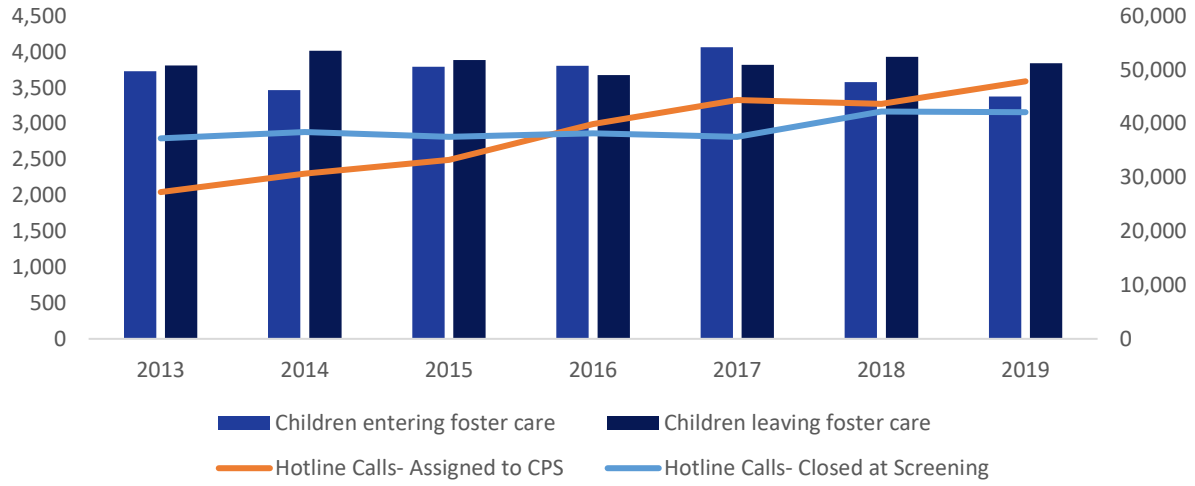
Source: Children's Bureau.

It is important to note that Oregon does well on some key family outcomes. As of 2017, the state's rate of foster children in group and institutional care (4.7%) was considerably lower than the national average, and its rate of children in relative foster care (35%), as opposed to living in regular foster care, was slightly better than the national average. Oregon's rates remained about the same in 2019, according to DHS.

Some overall state trends are also encouraging, assuming child safety is maintained. In 2018 and 2019, the number of children leaving foster care was greater than children entering care, and removal rates per thousand children declined in both those years.

The overall number of children entering foster care also declined in the past few years, despite an increase in calls to the child abuse hotline and referrals for investigation. The number of child abuse or neglect victims able to remain in their family homes rose. This is a positive outcome when safety threats to children can be managed with in-home safety plans and support services help parents build better relationships with their children.

Figure 8: Despite increased hotline calls, more children exited foster care than entered in 2018 and 2019



Source: Child Welfare Data books and OR-Kids.

A federal government review in 2016 addressed Oregon's performance

The federal Children's Bureau periodically reviews the performance of state child welfare systems. For Oregon's most recent review, in 2016, the bureau determined that all seven outcome areas evaluated were not "in substantial conformity" and needed improvement, a common result for many states. In the latest round of evaluations, Oregon ranked relatively well — from 10th to 25th — on seven key family measures among states, though researchers caution that limited case reviews used for the evaluations make state comparisons less reliable.

Oregon ranked lower — 36th — on children receiving adequate physical and mental health services, and 42nd in protecting children from abuse and neglect. In addition, Oregon's results for the two outcome measures most related to family stability indicated room for improvement:

1. Children are safely maintained in their homes whenever possible and appropriate. Oregon reviewers judged this outcome substantially achieved in 60% of the 96 foster care and in-home cases reviewed, including 14 of the 30 in-home cases reviewed.

2. Families have enhanced capacity to provide for their children's needs**.** This outcome was substantially achieved in just 42% of the 96 cases, again including 14 of the 30 in-home cases.

Effective preventive services can help reduce costs, address chronic neglect, lessen risks of child death, and reduce racial disparities in foster care

We found evidence that effective services can help reduce costs, in the long term and potentially the short term. Our review of cases involving child deaths found examples where preventive services could have helped reduce the risk of the worst outcome. Research also suggests that services can help reduce the high number, relative to their population in Oregon, of African-American and American Indian children in Oregon's foster care system.

The evidence did not suggest that services are a panacea for families in the Child Welfare system. Parents can struggle with long-running mental health issues and substance use disorders. Abusive and neglectful behavior can pass from generation to generation. Families can reject offers of help, or fail to complete service programs.

However, services provided to families can help improve safety, reduce removals, and reduce demand on a strained foster care system.

Our conversations with caseworkers and our limited case reviews highlighted both effective and ineffective intervention. For example:

- In early 2018, a mother abusing drugs received a full slate of preventive services, including drug rehabilitation, parent mentoring, and mental health services, at a cost to Child Welfare of just under $280,000. She did not complete any of the programs, however, and her two children remaining in the home, ages 11 and 3, were removed and placed in separate foster homes.
- Between 2018 and the end of 2019, a single mother with two children on the autism spectrum was reported for neglect after leaving her children home alone while she went to work. In addition, the home was in an "unlivable" state and the children were not attending school. After a short removal, Child Welfare spent about $2,500 on an in-home plan that included a safety service provider who knew the children and checked in on them regularly. The provider and a case worker helped the mother navigate not only child welfare but self-sufficiency, online education, Medicaid, and Social Security insurance services. The family was re-united and Child Welfare case was dismissed.

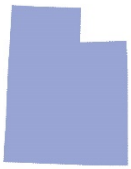
- In mid-2019, a mother of a young child was homeless and addicted to drugs at the time of the CPS assessment. She received front-end services, child care assistance, and a placement in a residential treatment facility that allows her to keep her child with her. She is participating in all services to date, with a Child Welfare preventive service cost so far of about $7,000.

Effective services can help reduce costs

Some services have been shown at the national level to be not only effective overall in helping children stay safe and families stay together, but cost-effective for society and for taxpayers. A cost-effective designation means these services have the potential to both save money and improve lives.

At the national level, the Casey Institute and the Washington State Institute for Public Policy have both analyzed the cost-effectiveness of programs that can help prevent child abuse, with the Washington institute periodically analyzing programs nationally at the behest of the state Legislature.[8]

Cost-effective services include nurse family partnerships, parent-child interaction therapy, and trauma-focused cognitive behavioral therapy, all available in Oregon at limited levels, and Homebuilders Intensive Family Preservation Services, which is not. For parent-child interaction therapy, specifically for families in child welfare, the Washington institute found costs savings of about $25,000 per case over decades, including $10,000 in taxpayer benefits, compared to program costs of less than $2,000. The largest savings were long-term, mostly avoiding reduced earnings tied to child abuse and neglect.



Other analyses suggest potential for short-term cost savings within Child Welfare as well, if services are effective in safely preventing removals to foster care or returning children to their homes. For example, Utah's Division of Child and Family Services estimated in 2014 that for the annual costs of placing a single child in foster care, 11 families could receive in-home services.

Short-term cost savings is not the only variable in selecting a service, but it is important in the Child Welfare budget framework. As the federal Children's Bureau notes: "(J)urisdictions struggling with funding are sometimes reluctant to direct money toward prevention efforts when programs for children already in the system, such as foster care, have many funding needs."

At this point, Oregon does not have clear data tying service spending to child welfare outcomes. However, the costs of foster care in comparison to service costs indicate that prevention services have the potential to save money in the short term as well as the long term.

For example, a research study found that Oregon's relief nurseries are effective at helping families likely to be involved with child welfare reduce risks of abuse and improve family functioning.[9] A separate 2009 Casey Family Programs analysis concluded that respite care for children to help parents in crisis, a common relief nursery offering, helped reduce time in foster care. In our contract review, a relief nursery contract we examined charged roughly $550 per family each month for service navigation, employment assistance, communications with

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[8] Casey Institute, Cost Effective Foster Care Reduction; Washington State Institute for Public Policy, Benefit-Cost Results.

[9] Relief Nurseries provide services to families with very young children at high risk of involvement with the child welfare system. Services include early childhood education, home visits, parent education classes and support groups, respite care, case management, and assistance accessing basic resources and other community services. Some Relief Nurseries provide mental health treatment for adults and children, play therapy, and other intensive programming designed to meet the needs of children and families.

caseworkers, home visits, and other services. That compares to foster care payments ranging from $693 to $1,755 a month. The base rate is already considered a low reimbursement compared to the actual costs of taking care of a child.[10]

Similarly, a contract for a residential drug treatment center that houses both children and parents cost Child Welfare about $30,000 a year per family; a local Child Welfare office review found it to be effective. At the range of foster care reimbursements — $8,300 a year to $21,000 a year — keeping the child out of foster care would save money in 16 months to four years.

These costs are likely incomplete, both on the prevention side and the foster care side. Many families and children need multiple services, whether the child is in foster care or at home.

Effective services could help reduce risks of child deaths and address chronic neglect cases

Child Welfare's Critical Incident Response Team (CIRT) evaluates child deaths and issues public reports when the victim, their siblings, or another child in the household have been involved with Child Welfare within 12 months of the fatality. We reviewed 71 of the public reports issued between 2014 and the spring of 2020. We then analyzed 12 cases from 2018 to early 2020 in-depth. At our request, the CIRT staff provided confidential internal review documents associated with the cases. We separately gathered and analyzed Child Welfare service spending on these cases.

Our review found significant issues, including cases with extensive Child Welfare history and clear service gaps. We cannot conclude that the deaths would have been averted had a full suite of services been available and received. The families had multiple challenges and CIRT reviewers raised other concerns outside service provision, including caseworker overload, improper screening decisions at the Child Abuse Hotline, and caseworker difficulties completing comprehensive assessments of families. However, the review did indicate that DHS either did not have service available or did not use the service tools at its disposal in these cases to help reduce the risk of child deaths and injury.

For example:

- A child died in a fire of the motorhome in which the family's children were sleeping. The motorhome had no electricity; candles were used for light and a wood stove for heat. The mother also died trying to rescue the child. From 2005 to 2017, the family was reported to Child Welfare 17 times, the latest in 2017, and at least three of the reports cited concerns about the children's living conditions. The last investigation came in 2014. Case file and spending records show no money was spent on services for the family until after the child's death. Services that may have helped include navigation services around housing, parenting classes, parent mentors, and foster care prevention services.

- An infant living in an isolated rural area died of malnutrition and dehydration. The infant was on an inappropriate diet that the parent had been warned about, but the family preferred alternative treatments. Child Welfare received 12 reports on the family from 2010 to 2018, three referenced inadequate or inappropriate medical care. Again, records show no services provided to the family until after the child's death. Services that may have helped prevent the incident include parenting classes focused on proper nutrition

[10] The USDA estimates it costs $1,082 a month to raise a middle class child, considerably more than the $693 monthly base rate for foster care. Child Welfare pays higher rates as the needs of foster children rise.

and meal planning for infants and children, mental health assessments and treatment, and parent mentoring.

In reviewing recent public reports and confidential review documents, auditors noted missing details of services in these reviews. Missing information included how long services were provided, whether the client participated, and how effective the services were, which could help CIRT identify systemic service issues that contribute to a fatality.

These cases and the CIRT review also illustrate the struggle that Oregon's Child Welfare system and others nationwide have in dealing with chronic neglect — when caregivers repeatedly do not meet a child's basic physical, developmental, or emotional needs over time. In Oregon, neglect in general is the largest category of founded abuse, at 43% in 2018. Founded neglect cases also rose 33% from 2013 to 2018, state data shows, and neglect accounts for roughly three-quarters of maltreatment fatalities in Oregon and nationwide.

These cases stop short of physical and sexual abuse, when removal decisions can be more straightforward. Oregon's CIRT team has identified chronic neglect response as a substantial issue. In our review, it stood out as a problem that services could help address.

That conclusion is consistent with advice from the federal Children's Bureau. The agency emphasizes early intervention services that focus on basic family needs along with improving substance use disorder and mental health treatment programs, housing services, and early childhood centers as important steps to reduce chronic neglect. Chronic neglect cases also require in-depth family assessments, rather than focusing on a particular instance and report as Child Welfare systems typically do.

Oregon's CIRT team is working with the University of Kentucky and the National Partnership for Child Safety to develop strategies for improving child safety and preventing fatalities. That work is important. Other steps that could help increase the focus on preventive services include focusing more on services in CIRT reviews — both services provided and services that might have helped — and expanding summary discussions of effective services in public reports on CIRT cases to include both services paid for by Child Welfare and services provided outside the agency.

Effective family services are one key to reducing persistent racial disparities in foster care

Nationwide and in Oregon, American Indian and African-American children are placed in foster care in higher numbers relative to their populations. That disproportionality is long-running and the causes and potential remedies are complex, extending well beyond Child Welfare. Experts say that family supports and services, timely and culturally appropriate, are one of many steps that can help reduce the gaps.

In Oregon, hotline calls come in at a considerably higher rate for American Indian and African-American children, a disparity that runs through the system all the way to the number of children entering foster care.

Child Welfare experts say potential explanations for this disparity include higher poverty levels — poverty and related instability in housing and employment are risk factors for abuse. Other potential causes include racial bias in hotline reporting and child welfare practices, and lack of resources for families of color. In addition, hotline reporting may be higher in part because higher poverty means more contact with government agencies that provide benefits, raising the family's visibility to potential reporters.

Figure 9: More American Indian and African-American children are in Oregon's Child Welfare system relative to population

Child Welfare Data* 2019 Calendar Year	American Indian / Alaska Native	Black or African American	White	Hispanic	Asian / Pacific Islander
Child population	13,843	32,354	586,049	192,664	48,709
% of total population	2%	4%	67%	22%	6%
Child hotline reports last 12 mos.	3,672	6,110	71,294	12,509	2,186
% reports filed	4%	6%	74%	13%	2%
Founded abuse cases last 12 mos.	409	561	7,305	1,709	209
% founded cases	4%	6%	72%	17%	2%
Entered foster care last 12 mos.	146	141	2,085	658	63
% foster care entries	5%	5%	67%	21%	2%

** Data is for children, reports, and cases with an identified race.*
Source: Auditor analysis of Oregon's Results Oriented Management (ROM) data.

Overrepresented groups may also receive fewer services or have more trouble accessing them, according to the Children's Bureau. Removals can also increase if parents are unable to access services to prevent removal that are outlined in their case plans. A lack of culturally appropriate services — a gap Oregon Child Welfare has identified — can also reduce engagement and participation.

OR-Kids data indicates spending on parent-based services, such as stabilization, mentoring, and parent training, was approximately equal for American Indian, African-American, and white children, at about $1,700 per case on average from 2014 to 2019. Parent-focused spending was lower, at $1,300 a case, for separate cases of children covered under the federal Indian Child Welfare Act, which requires that caseworkers make more active efforts to connect families with services. However, this may be because the case-specific data did not include tribal government spending.

These spending results, absent data on accessibility and effectiveness of the services, are not definitive. Yet, even equal spending on services may not be equitable, given the significantly higher rate of American Indian and African-American children in foster care in Oregon.

Confederated Tribes of Grand Ronde found service approach helped reduce foster care placements

To address these disparities, the Children's Bureau, the National Council of Juvenile and Family Court Judges, and other experts recommend providing more preventive services, including more culturally appropriate services, for families involved with or at risk of entering Child Welfare.

In Oregon, the Confederated Tribes of Grande Ronde took this approach starting in 2009, expanding preventive services for families. By 2017, tribal officials reported that admissions to foster care dropped by 50%.

However, the tribal government's social services manager told the Legislature it took four to six years to see substantial outcomes and to have families who need help voluntarily contact the program. According to the manager, it takes time to train staff to enhance skills to engage

families, build capacity to support the needs of families, and get parents to trust in the intentions of child welfare.

Child Welfare practices and Oregon's dispersed network of child and family services across agencies create obstacles to helping families

Child Welfare's primary focus is child safety, not family preservation. However, its mission also includes empowering families, and caseworkers are required to make reasonable efforts[11] to avoid removals, including providing services. The office's brochure for parents promises that they can apply to any service they qualify for and plan services with a caseworker's help, though it does not guarantee eligibility for the services.

Those standards, however, can be difficult to meet. CPS caseworkers — juggling high caseloads, short timelines, and challenging investigations — struggle to focus on services for families. Engaging families is difficult, particularly so for CPS workers. Parents often see them in a negative light because of their investigative role and the potential for them to remove children. Support from service providers for engagement and family observation is limited.

CPS also has a limited scope for providing services for families already involved with Child Welfare. As a result, some families need services from other programs within DHS, including Self-Sufficiency and Developmental Disabilities. Some families also need services from other agencies, such as OHA and state and local housing agencies. These services can reduce risk for families that have had Child Welfare involvement and, more broadly, in families at risk of Child Welfare involvement in the future. Yet given Oregon's dispersed network of services across agencies, those connections are often difficult to navigate.

CPS caseworkers are not well-positioned to engage families in services that would prevent removal

CPS workers investigate cases referred from the Child Abuse Hotline. Those investigations include interviewing alleged victims and family members, as well as "collateral contacts," such as teachers, doctors, and others who can add perspective. Caseworkers are expected to assess family functioning in-depth in order to determine whether children are safe and what services might help families function better.

Beyond the expected depth of investigations, CPS caseworkers at the front-end of Child Welfare cases face other substantial challenges to connecting families with services, as noted in Figure 10. Those obstacles range from high workloads that limit time spent with clients to limited crisis assistance.

[11] Reasonable efforts are not specifically defined by law. Reasonable efforts include providing appropriate services to assist the parents in adjusting their circumstances or conditions to allow the child to either remain in the home or to be returned to the home. What is reasonable depends on the circumstances of each individual case.

Figure 10: CPS caseworkers face substantial obstacles to connecting families with services

Obstacle	Details
High caseworker workloads and turnover	Our 2018 audit found that high caseloads in Child Welfare put huge pressure on caseworkers, many of whom are new and inexperienced. DHS has hired more caseworkers and, in our field visits, some field staff said their office's workloads dropped because of new hiring. However, Child Welfare's staffing increases in the last budget did not bring the agency up to national standards, and high workloads and limitations on time spent with clients were primary concerns raised in our field visits. DHS does not have accurate caseload data, another issue identified in our 2018 audit. Its monthly reports to the Governor show that turnover has significantly eroded new hiring gains approved in the last budget. According to Child Welfare's March 2020 report to the Governor, new caseworker hires totaled 327 for the 12 months ended February 2020. In that span, 137 caseworkers departed as of February and another 62 were promoted, reducing the net increase to 128, or about 40% of the original total. Child Welfare's new 24/7 central hotline, implemented during 2019, has also resulted in more referrals to field offices and more investigations, further increasing workloads.
Extensive data entry and casework procedures	Paperwork and data entry take significant caseworker time, reducing the time caseworkers can spend with families. As documented in our recent IT audit, the OR-Kids case management system, used to retrieve and enter case information, is cumbersome to work with and hindered by usability issues.[12] This has resulted in worker dissatisfaction and distrust of the primary tool required for case management work, the audit found. Investigation procedures are extensive and time-consuming — the caseworker procedure manual is more than 1,900 pages long. The manual includes lengthy procedures for documenting assessments, assessing child safety and family functioning, and evaluating domestic violence. The 33-page domestic violence section spells out 91 sample questions for the victim alone. Caseworkers have also been focused on reducing overdue assessments, often on lower priority cases, further increasing workload. *cont. next page*

[12] Report 2020-01: "Oregon's Child Welfare Information System is Adequate for Case Management, but Enhancements are needed to Improve Usability."

Tight front-end deadlines	CPS caseworkers have 60 days to complete what is expected to be an in-depth assessment of a family. The 60-day time frame also applies to building case plans for an unsafe child and establishing family services that could help keep children in their family home. When it comes to receiving services that would help a family stay together, that time frame can be unrealistic, field staff told us. Addiction treatment has limited availability, and waitlists for services such as mental health treatment and stable housing can extend well beyond two months. As noted earlier, the average wait to initially receive services in Oregon was 55 days, compared to the national average of 32. If children are in immediate danger and a CPS caseworker must initiate a protective action that requires a parent, caregiver or child to leave the home, caseworkers have just 10 days to help families create an in-home safety plan that allows the family to reunify. Otherwise caseworkers must file a juvenile court petition within 10 days for temporary custody. The tight deadline, caseworker workload, and a lack of intensive safety service providers make it more difficult to prepare an in-home plan. The deadline can be extended by 30 days with supervisor and program manager approval if the alleged perpetrator agrees.
Lack of safety support services for families	Caseworkers and their supervisors consistently told us that having more safety support at the beginning of cases — contractors or other qualified people who can check in frequently or stay with families — would help greatly in reducing removals. Busy caseworkers do not have time for frequent check ins with families, raising risks if children are left in a potentially unsafe home. Reliable relatives and friends can fill that role, but staff told us many families involved with Child Welfare do not have those connections. ISRS, the In-Home Safety and Reunification Services program, includes contract safety providers to work with families and keep an eye out for child safety. However, their availability varies across the state. Field staff also said the contractor visits, which occur several times a week and typically only during the day, can be too infrequent to assure caseworkers that children are safe. Providers that do provide more intensive services are quickly overbooked. In Multnomah County, demand for a safety service provider that caseworkers realized could help prevent removals surged and took up much of the district's budget for services. Other services that could help with family engagement at the front end, including parent mentors and service navigators, are focused primarily at the permanency stage of the case, after children have already been removed. Workers also cite a lack of services and supports for families with English as a second language.
Limited crisis assistance and quick coordination across agencies and programs	CPS responds quickly. Other programs, agencies and service contractors frequently do not. Addiction support is inconsistent in availability across the state. Quick coordination to help clients in crisis access services is also difficult, with long wait times for mental health and housing services, and a time-consuming process to qualify parents and children for developmental disabilities services. A common sentiment in our field visits was that Child Welfare is the provider of last resort in a system that has failed families long before Child Welfare's involvement. Our upcoming audit of children's mental health will focus on shortfalls in mental health services for children, another substantial concern for Child Welfare field staff.
Limited quality of services and varied service availability around the state	Please see report section below titled, "Service availability, access, and quality are limited and vary substantially by geographic area" for additional discussion of service challenges in Oregon.

All told, these challenges increase the chances of child removal, and make it less likely that CPS workers will be able to move families into in-home cases. The in-home cases, with or without DHS taking custody of the child, still require significant effort and are difficult to set up and monitor given workload demands, field staff told us.

> "What it takes to move families forward is **really intense engagement with families**. That's what people come here to do, that's why people work here. With their workload, that's the hardest thing for them to do."
> *- Child Welfare manager*

High workload and limited support also limit caseworkers' ability to understand and help families, which can increase caseworker turnover. Child Welfare's Leveraging Intensive Family Engagement (LIFE) program, which focuses on reunifying families after a child is removed, has seen strong staff retention, the program's manager said.

We identified potential solutions from research, service effectiveness ratings, and interviews inside and outside DHS, including interviews with other agencies and other states. The changes range from low intensity — lower cost, fewer staff required, fewer organizational obstacles, or less time to implement — to high intensity, with more significant effort, more costs, or more staff required.

Aside from increased caseworker staffing, a harder task given COVID-19 budget reductions, remedies for front-end challenges detailed in Figure 11 range from expanding training to significantly increasing caseworker support.

Figure 11: We identified both low- and high-intensity potential solutions to front-end challenges

Lower-Intensity Solutions

- Assign assessment write-ups to case aides or other support personnel when caseworkers conclude that cases do not involve safety threats to children.
- Provide more training on parent engagement and motivational interviewing for contractors or providers and caseworkers. Motivational interviewing is rated as evidence-based under Family First and is part of Washington, D.C.'s prevention strategy.
- Have existing providers, such as parent trainers, mental health contractors and addiction specialists, accompany caseworkers on initial family assessments in neglect cases or visit the family shortly thereafter.

Higher-Intensity Solutions

- Develop protocols with Self-Sufficiency, Developmental Disabilities, mental health providers, and CCOs to spell out responsibilities, timelines for action, and procedures in Child Welfare cases. Include this level of detail in contracts with service providers as well.
- Increase front-end positions to increase family engagement, either through contractors or Child Welfare personnel, such as parent mentors and family engagement specialists.
- Station direct support personnel in Child Welfare offices for areas that require high levels of expertise, such as mental health, domestic violence, and developmental disabilities. A CCO representative, for example, can help coordinate care.
- Provide more intensive safety support services when a safety threat is identified. The Family First Clearinghouse has certified one intensive support contractor, Homebuilders, as evidence-based. In other states:
    - Oklahoma's program includes clinicians that actively help families engage in services after a safety threat is identified, going beyond just referring families to services.
    - Maryland's interagency family preservation services unit includes staff available for 24/7 family support.

Child Welfare is statutorily limited in the scope of family services it can provide

> "We would like to get (in-home) services in right away to teenage parents or parents just feeling overwhelmed by parenting, parents just at their wits end — maybe they've got a 9-year-old in charge of three younger kids. **But parenting support is not available unless there's a safety threat**."
> *- CPS caseworker*

Child Welfare faces significant limitations on services it can offer. Once a case is referred from the hotline, CPS caseworkers can offer service referrals and bring in addiction and domestic violence specialists to help. However, they generally must determine a child is in present danger or a safety threat to a child exists before offering in-home family services that the division will pay for. Also, services stop or extend for just a short time after the safety threat is gone.

By law, Child Welfare also cannot serve a pregnant mother who is taking drugs until her baby is born, a factor in several of the CIRT death cases we reviewed. Under Oregon law, health care providers are required to encourage and facilitate voluntary counseling, drug therapy, and other assistance to a patient in order to avoid having the child, when born, become subject to protective services. Other states have taken stricter approaches and provided more supports. Twenty-three states and the District of Columbia consider substance abuse during pregnancy to be child abuse under child welfare statutes, according to a May 2020 report by the Guttmacher Institute. Nineteen states have created or funded drug treatment programs specifically targeted to pregnant women; Oregon is not among them, the Guttmacher Institute found.

As noted later in this section, the state is expanding Project Nurture, a promising program for pregnant women with substance use disorders. Oregon's new contracts with CCOs to cover Medicaid members also include pregnant women as a priority population, along with individuals with substance use disorders in need of withdrawal management or in medication assisted treatment. These are potentially significant improvements.

Until 2017, some Child Welfare districts had a "differential response" track that broadened their ability to provide services. Under that model, which is common across the nation, referrals from the Child Abuse Hotline were slotted into one of two categories: "traditional" cases needing an investigation and cases where risks were high in a family, but a full investigation that required a conclusion on whether abuse occurred was not required. That second group was slotted into alternative response, receiving services if they wanted them, help connecting to the services, and continued monitoring of their status. However, the Legislature effectively eliminated differential response in 2017, requiring a full investigation of all cases, because of concerns that the model was endangering children and increasing caseworker workloads. Child Welfare officials said the model required caseworkers to complete more thorough family assessments and increase collaboration to engage families.

The hotline and caseworkers can still refer families to services. Caseworkers are required to do so when an investigation is closed and they believe the family has "moderate to high needs" and still needs assistance. However, services are voluntary, and caseworkers do not continue to check in on the families.

That unserved but still risky group is likely substantial. Alternative Response was not operating statewide when it ended, but it was used for nearly 7,200 cases a year at its peak, and caseworkers defined nearly 5,000 cases as "moderate to high needs" in 2015. Caseworker tabulation of the moderate-to-high-needs designation has dropped to near zero, case records indicate, but in 2019 investigations concluded as "unable to determine" totaled more than 5,000 cases. In these inconclusive cases, by definition caseworkers have found "some indication the abuse occurred," but not enough to justify a founded conclusion of abuse.

Oregon's disparate system of services makes it more difficult to focus on reducing child abuse and preserving families

Child Welfare is responsible for addressing child abuse, yet its limited ability to serve families means it cannot be held solely responsible for child abuse prevention. In Oregon, the services needed to prevent and address child abuse are scattered among state, local, and nonprofit agencies and programs. To succeed, the state needs a coordinated community approach to reducing child abuse.

However, Oregon's disparate system makes it more difficult to coordinate services, though coordination is a must for child and family safety and for helping families address their needs, according to guidance from the federal Children's Bureau.

In 2017 guidance, the bureau wrote: "The incidence of child maltreatment is deeply influenced by poverty, violence, and substance use. While separate programs to alleviate these issues are helpful in preventing maltreatment, system-wide collaboration and data sharing across multiple service sectors — child welfare, juvenile justice, early childhood, education, public health, and the behavioral and mental health fields — are essential to improving child and family safety and well-being on a broad scale."

Oregon's recent efforts to upgrade coordination of services for children with distinctive mental or behavioral health needs is a significant step. The "System of Care" approach includes centralized statewide policy development and planning. If executed well, the effort could help address some of the most severe cases in Child Welfare or, preferably, stop them from arriving there in the first place. Early Learning Hubs under the Oregon Department of Education's Early Learning Division include services for families as well as children, and provide a potential community base for broader sets of services. Family First calls for coordination among agencies, and DHS's preparation of a five-year Family First plan that focuses on keeping families together may help clarify roles and responsibilities both within the agency and with other agencies. Oregon officials have already concluded that the lack of a coordinated approach is costly and inefficient.

> "When every other system has narrowed or closed their doors, **we're the one left with the child at the end of the day**."
> *- District family services manager*

However, Oregon does not have an in-depth strategic or long-term plan for reducing child abuse that encompasses the many players involved, including DHS, OHA, early education and parenting programs, juvenile justice programs, judges, attorneys, parents, foster parents, and other stakeholders. Child Welfare's Family First plan may make some strides in this direction, though it is not clear whether the plan will include involvement and commitments from other agencies or other programs within DHS. At the ground level, the state lacks cross-agency liaisons who could help coordinate and link clients to services between its complex systems, when busy caseworkers cannot.

Coordination and shared accountability is particularly crucial because many of the evidence-backed and cost-effective services that can help reduce child abuse lie outside Child Welfare. That list includes: nurse family partnerships and mental health services through OHA; functional family therapy through juvenile justice; and Healthy Families Oregon early home visiting services through the Oregon Department of Education's Early Learning Division.

In addition, many families that have contact with Child Welfare receive public assistance from other programs outside Child Welfare, such as Medicaid medical coverage, SNAP food assistance, and TANF cash benefits for families in poverty. In 2018, 83% of the children who had contact with Child Welfare received Medicaid or SNAP benefits. The federal Women, Infants, and Children program also has the ability to reach a large proportion of children at greater risk of

maltreatment. A strategic plan can help ensure the Child Abuse prevention efforts are going to the most effective and efficient services. During the audit, we also saw several encouraging state and community level prevention practices that can link well with Child Welfare, and could be considered when developing an effective strategy.

- Family Support and Connections Services in DHS's Self Sufficiency Office provides parent skill training for any family receiving TANF cash assistance. Child Welfare and TANF populations overlap — about a third of the Child Welfare caseload is on TANF, and the Family Support program is specifically designed to reduce child abuse. In general, Child Welfare works closely with Self Sufficiency; the two programs share district offices. However, the Family Support program is relatively small, funded at about $4.5 million in the latest biennium. It serves about half the estimated need, DHS says.

- Oregon is expanding the Project Nurture program, which serves pregnant women with substance use disorders, into five counties. The project, a coalition of Oregon maternity care providers, substance use treatment providers, and CCOs, provides clinical care, peer mentoring, and links to social services that continue through the first year post-partum. An April 2020 study found implementation of Project Nurture in Multnomah County was associated with an increase in prenatal visits among pregnant women with opioid use disorder and decreased foster care placements for the year after children were born. The study also found potential savings of $300,000 a year in the county from reduced foster care costs. In 2019, with the Governor's support, the Legislature expanded the program into four more counties at a cost of $2.5 million.

- Several states, including California, have used "Care Portal" to better connect Child Welfare to the community. The faith-based service fills internet-based requests from caseworkers to help families, with beds and other goods as well as services such as pest extermination and financial planning. Its focus includes helping biological families and preventing children from entering foster care. Oklahoma officials said the service had saved the state $3 million in its fourth year, with little spending on the state's side for support.

- Child Welfare is working with and assessing the performance of Safe Families for Children, a nonprofit that tries to prevent removal of children by providing host families for children of families in need, giving parents time to address crises or their own issues. The group also includes volunteers who provide transportation and other support. Safe Families can help a range of families involved with Child Welfare, from families under investigation to families referred from the Child Abuse Hotline who have not been investigated.

At the county level, Yamhill County is trying to coordinate services using federal, state, and local money to keep families together. The effort includes the county's human services department, its CCO, Child Welfare, nonprofit service providers, the county's early learning hub, schools, physicians and others.

The service array is extensive. CCO staff collect and help coordinate referrals to county health clinics, connecting patients with public health nurses, Healthy Families early home visiting, a Head Start Relief Nursery, and Women-Infant-Children programs. Service integration teams, paid for by the county and the CCO and staffed by the CCO, provide financial support for families' basic needs. Pregnant women can get psychosocial as well as physical assessments, and a community health worker hub supports families with complex medical needs. Safe Families for Children is operating in the county. The county also has three relief nursery sites focused on pregnant mothers and mothers with children up to age 5. It has five drug treatment and

recovery homes and a family stabilization house, with recovery mentors available and around-the-clock peers in the home. Child Welfare can refer willing families to services after screening and during or after investigations. Child Welfare data is also helping community providers decide where to do outreach for preventive services, such as handing out free diapers to start building a relationship with community families in need. For several years, the county has shown relatively strong performance on Child Welfare metrics.

Nationwide, some states have made major structural efforts to coordinate services and eliminate obstacles. Washington State, for example, created a new Department of Children, Youth and Families, pairing Child Welfare with early learning and juvenile justice to focus on services and better use of data to measure outcomes and prioritize children most at risk. The move came after a 2016 Blue Ribbon Commission report that pointed out problems with scattered services.

Texas has a prevention and early intervention agency. Over time, New Jersey has developed procedures to pay for needed behavioral treatment services first, then figure out who will pay.

At the county level, Allegheny County, in Pennsylvania, established 28 Family Support Centers in economically disadvantaged areas to support parents and young children and studies have found some evidence of fewer maltreatment investigations in areas served by the centers. Washington, D.C., is taking a similar approach.

These are among a number of potential changes that could help Oregon coordinate services, preserve families, and reduce child abuse. Other potential solutions include:

- Establishing cross-agency system service navigators who help caseworkers and clients access services across programs and agencies, and community or cross-agency liaisons who build relationships between different agencies and providers.
- Developing best practices within Child Welfare for increasing community involvement in Child Abuse prevention and work with district managers to implement them.
- Expanding Family Support and Connections Services and community relief nursery services, coordinating with Child Welfare's family services.
- Working to maximize cooperative in-home cases in Child Welfare, providing an in-home staffing structure.
- Establishing a family preservation and prevention unit within DHS or across agencies that can respond to Child Welfare cases and expand to helping willing families access and engage in services.

Parent Mentors who "know what it's like to lose your child"


Christa Scaggs, parent mentor

Christa Scaggs Child Welfare involvement included having her daughter taken from her custody, Child Welfare cases in two counties, and an eight-year struggle to overcome her drug addiction.

Today, more than two years clean and living with her daughter again, Scaggs is a parent mentor with Morrison Child and Family Services. As a mentor, she helps other parents with addictions navigate Child Welfare, helping them do what it takes to get their children back.

"We've been there," Scaggs said. "We know what it's like to lose your child."

We spoke with Scaggs and three other Morrison Services mentors who serve under a contract with Child Welfare. All have had their children removed in the past due to their addictions, one of the top reasons for child removals in Oregon. All are at least two years sober.

The idea is that the mentors will have an easier time connecting with parents, boost parent engagement in services, and help them navigate the confusing Child Welfare system. Having been engaged with Child Welfare themselves and now as service providers, they also see problems in the system from a unique perspective. Among them:

Scarce Support: In order to keep their children at home, parents involved with Child Welfare often have to find someone outside the family who can support them and check in to make sure the children are safe. Mentors can help fill that need, using a strength-based approach to encourage parents. "Most of our clients don't have anybody positive in their life," said mentor Nicole York, whose own case moved more quickly because she had a parent mentor.

Communication Gaps: Communication between parents and caseworkers can be limited, so mentors act as a bridge. Mentor Josh Russell experienced that as a client, when he and his wife struggled with opioid addictions, their baby was removed, and they desperately wanted information. Now, he said, he plays damage control for busy caseworkers. "I try to tell my clients, if you're not hearing from them, you're probably doing great."

Service Engagement: Getting addicted parents engaged in services can be hard. Once in the door, parents face a high turnover rate among treatment providers. "Even if someone is ready (for treatment), it takes a long time to get engaged," said Amber Barker, a mentor who had two children in foster care. "You just get comfortable with someone, then they leave."

Insufficient Services: Parents need more services, the mentors said, including parenting classes, domestic violence support, psychiatric evaluations, and help for homeless families.

Currently, the mentors are used only to help families reunify after children are removed. The mentors and parent advocates say it would help to make connections earlier in the process, when addicted parents are first involved with Child Welfare and trying to keep their children.

Addiction recovery is difficult, and success is not assured. Portland State University studies of parent mentors have been inconclusive, not showing improvements in Child Welfare outcomes, but identifying more parent engagement in recovery activities and connections to support networks. Scaggs and the other mentors say it's a team effort.

"I'm an eight-year project, with multiple relapses," Scaggs said. "But a caseworker at the end wouldn't give up on me. A lost cause can make it."

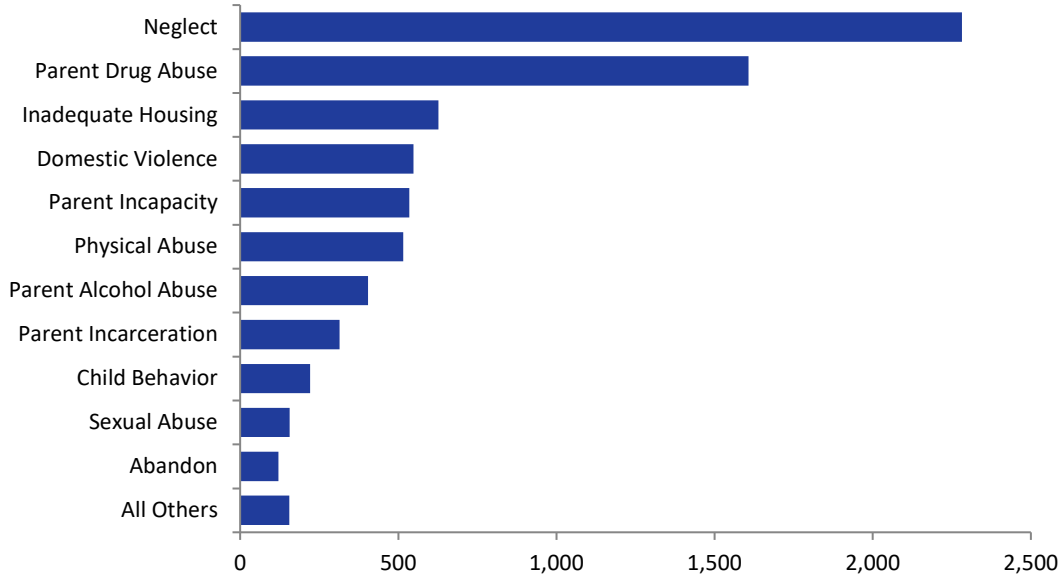
Service availability, access, and quality are limited and vary substantially by geographic area

When working with families, caseworkers face gaps in the availability of crucial services, access delays that contribute to removals and longer wait times for family reunification, and service quality problems that limit service effectiveness. These problems arise across the state, but are often greater in rural areas. They affect both services paid for by Child Welfare and services covered by other agencies, such as Medicaid services under OHA.

We found that Child Welfare faces shortfalls with the very services that caseworkers say are most important for keeping families together and returning children quickly to their homes: substance use disorder treatment, mental health treatment, and affordable housing. Services to assist parents, such as In-home Safety and Reunification Services, parent mentors, and navigators, also vary substantially by county.

Figure 12 shows top reasons caseworkers give for removals (multiple reasons can be given for one case). Mental health problems are not called out specifically, but field staff told us mental health issues are often a contributing factor to removals.

Figure 12: Top reasons for child removal include neglect, parent drug abuse, and inadequate housing



Source: Fiscal Year 2019 data from Oregon Child Welfare's Results Oriented Management (ROM) website at the University of Kansas.

Front-end services and other assistance services for parents paid for by Child Welfare vary substantially by county

In-home Safety and Reunification Services (ISRS) are Oregon's primary source of assistance to parents involved in Child Welfare at risk of having their children placed in foster care. The agency also pays directly, under its Strengthening and Preserving Families Program, for services that help parents, such as parent mentors, system navigators, and parent training, typically after their children are removed.

The odds of families with a Child Welfare case receiving these services varies around the state. As shown in Figure 13, we analyzed spending and service provision by case and by county for navigators, mentors, and ISRS services in a selection of urban, rural, mixed, and remote rural counties from 2014 to 2019. Average spending per case did not show a clear pattern, but this limited analysis showed the percentage of cases receiving services was greater in Multnomah

County. Navigator services were absent or minimal in three of the nine counties we analyzed. Statewide, parent mentors are concentrated in a small number of counties, none rural or remote.

Figure 13: Spending by case and by county on key parent services paid for by Child Welfare, 2014 to 2019

County	Type	Average amt spent per case on navigators	Average amt spent per case on mentoring	Average amt spent per case on ISRS	% of total cases with navigator services	% of total cases with mentoring services	% of total cases with ISRS services
Columbia	Mix	3,318	1,605	3,697	4.3%	1.5%	5.0%
Yamhill	Mix	2,617	1,079	6,246	0.1%	12.3%	5.5%
Coos	Rural	3,345	771	1,616	4.8%	4.8%	7.5%
Douglas	Rural	2,318	840	1,889	3.3%	0.1%	8.6%
Jefferson	Remote	-	-	2,166	0.0%	0.0%	4.5%
Malheur	Remote	3,423	633	2,788	15.4%	1.6%	6.5%
Wallowa	Remote	-	3,063	2,778	0.0%	1.3%	5.1%
Washington	Urban	1,186	3,101	2,316	3.1%	14.2%	7.8%
Multnomah	Urban	2,357	1,407	2,108	8.7%	21.7%	22.0%

Source: Spending data from OR-Kids case management system; auditor calculations.

DHS gives its 16 districts leeway in deciding how to spend money, which may account for some of these differences. The available number of providers relative to demand may also be higher in some areas, including Multnomah County — a 2016 federal review found parent engagement and in-home services among the services inconsistently available across the state. DHS has allocated a 5% differential increase in 16 rural counties to help support services in smaller communities.

Child Welfare faces problems with mental health service availability, access, and quality

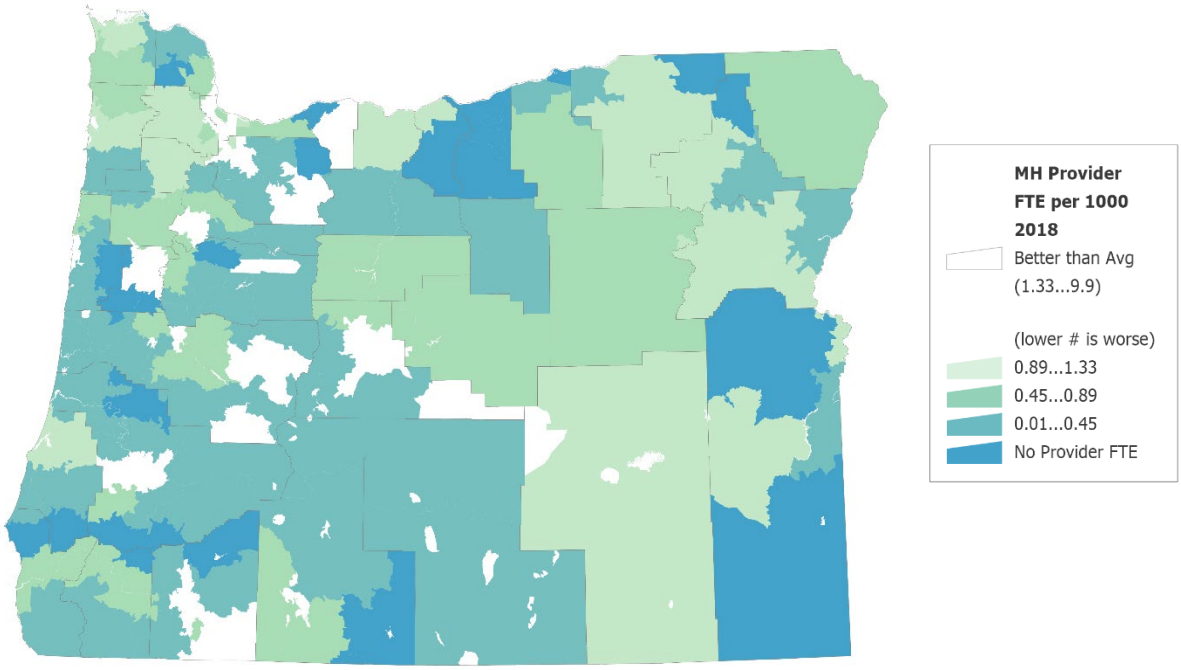
Mental health spending for families on the Oregon Health Plan (Medicaid) is largely covered by CCOs across the state and outside Child Welfare's control. OHA oversees the CCOs, which receive state and federal money for physical, mental, and substance use disorder health care through the Oregon Health Plan.

At DHS, data from OHA tracking mental and behavioral health services provided to families involved with Child Welfare is extremely limited. DHS and OHA officials disagree on the reasons for this, but it is clear the data or communication problems underlying this lack of information for helping to identify specific Child Welfare service gaps and trends have not been resolved.

At a broader level, the Oregon Office of Rural Health at Oregon Health and Science University does identify potential gaps in service by analyzing the prevalence of mental health providers across the state. Its latest analysis, released in August 2019, counted psychologists, clinical social workers, family therapists, nurse practitioners, psychiatrists, and other mental health providers per 1,000 people in 130 primary care service areas.

The analysis found that 22 of the areas, all classified as rural or remote, had no mental health providers at all. Another 49 service areas, all but one of them considered rural or remote, had 0.5 providers per 1,000 people or fewer. In urban areas, the average was 1.71 providers per 1,000 people, nearly triple the overall rate in rural and remote areas. Figure 14 maps out these gaps. On the map, white areas have the most providers; blue areas have none.

Figure 14: Mental health providers are scarce in many areas of the state



Source: Oregon Office of Rural Health. For more detailed map, please see https://www.ohsu.edu/media/106461

During our visits to Child Welfare offices, we heard substantial concerns about the availability of mental health care from rural and urban offices. Field staff in some offices pointed to months-long wait lists for psychiatric evaluations and for mental health services following those evaluations, including a lottery system in one rural area. A 2019 internal survey by Child Welfare also documented concerns about long waitlists, even for crisis-related services, and an OHA official told us timelines for services do not meet Child Welfare's needs. OHA said it has hired a complex care coordinator and an analyst who work with Child Welfare coordinators to improve access to complex care for youths involved with Child Welfare.

In rural areas, these problems are compounded by long travel times and limited hours — a particular issue when parents are working. Rural areas can also face the problem of having a single provider of mental health care and addiction services. If clients have already tried them once, they are often reluctant to try again, caseworkers said.

> "It takes **weeks, months to get services in place for children, and the adult system is even longer.** There's no way to keep a family intact because services are months and months out."
> *- Child Welfare supervisor*

The quality of mental health services is also a substantial issue, according to our visits, Child Welfare's survey, and our discussions with providers. Therapists are often inexperienced, short of expertise on trauma-informed care, low-paid, and, as in Child Welfare itself, turnover is high, forcing clients to start over multiple times. Provider cancelations can be frequent. Services paid for under Medicaid are limited to those approved through the Health Evidence Review Commission.

OHA requires CCOs to track and report how long it takes them to provide an assessment of children after they enter foster care. However, CCOs do not report data on how rapidly children actually receive mental health care after the assessment. They report no data on services provided to adults in the system, and none for children who are not removed.

Providers told us that CCO pay rates are too low to support a more stable workforce. Child Welfare can make improvements, too, they said. Caseworkers are often difficult to reach or

hesitant to share information. Child Welfare contracts are not flexible enough to allow for enhanced services when needed. The timelines for services are short, only two months under In-home Safety and Reunification Services family stabilization contracts, making it difficult to make lasting progress.

As noted earlier, OHA has developed new five-year contracts with CCOs that now include priority populations for timely care, among them individuals with substance use disorders, foster children or children in the custody of DHS, children with early signs of behavioral problems, and pregnant women and parents with dependent children. These changes could help improve service availability within Child Welfare.

Addiction treatment services have diminished and access varies significantly based on a client's location

Unlike mental health care, addiction treatment efforts in Child Welfare include teams of staff and contractors who help connect parents and youth with services. Child Welfare established Addiction Recovery Teams in 1991, with contracted service providers in Child Welfare offices who can accompany caseworkers on calls and act as immediate advocates.

However, those teams have dwindled. As of this report, Child Welfare has no contracted services for the teams in 15 of 36 counties, all of them rural. The remaining counties have had service reductions in the past five to eight years, or have reduced the amount they can pay providers, affecting quality of service. Larger branches still have skilled contract providers who can work alongside staff. For example, the Multnomah County district has contracts for seven alcohol and drug outreach workers, and Multnomah and Washington counties have a combined contract for six counselors. District 9, with a main office in The Dalles, covers five counties with one Addiction Recovery Team contract provider.

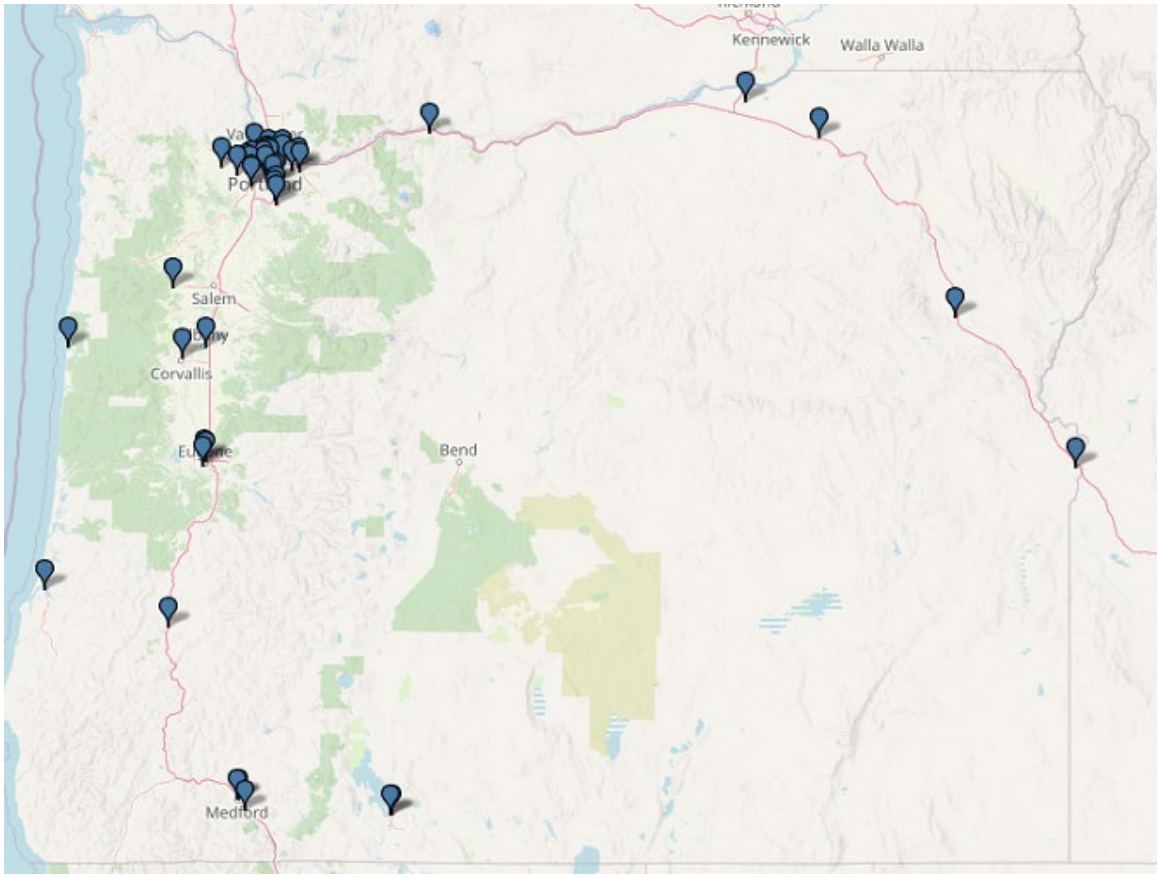
In 2019, the Legislative Policy Research Office mapped contracted substance use disorder treatment providers across Oregon; see Figure 15. The analysis showed a tight cluster in and around Portland and the I-5 corridor, with relatively few in other parts of the state.

Additional treatment centers for opioid addiction, funded by the federal government, have helped, and demand is less in rural areas. In our interviews, however, Child Welfare staff in Ontario, Coos Bay, Roseburg, Klamath Falls, The Dalles, and Albany all pointed to shortfalls in addiction treatment that have affected their cases. Child Welfare's 2019 survey also found that access to substance use disorder services was among the top three caseworker concerns in seven of 16 districts, all rural or partially rural.

One area where the disparity in service access shows up starkly is in residential substance use disorder treatment programs for parents that allow young children to remain with them, known informally as "Mommy and Me" programs. The programs also include parent skills training and transition mentors. In our fieldwork, several offices said they had seen strong results from the programs and that they are useful in avoiding foster care placements and returning children home. The centers are not spread throughout the state, but people who need the services can go to centers outside their CCO coverage area.

However, our analysis of OHA data suggests that parent placements in the treatment centers vary significantly, depending on the client's CCO. In 2018, among 13 CCOs with complete data, placements in the programs ranged from a low of 0.1 placement per 1,000 members in a central Oregon CCO to a high of 3.1 placements per 1,000 members in a southern Oregon CCO. The highest overall placement rate came for parents enrolled in Fee-for-Service Medicaid, and not covered by a CCO, at more than three times the statewide average.

Figure 15: Substance use disorder treatment providers are concentrated in the Portland area



Source: Analysis by Jamie Hinsz of the Legislative Policy Research Office.

High housing costs also increase the risk of removals and longer stays in foster care

Inadequate housing can increase removals or increase stays in foster care in three ways:

- Inadequate housing is a top reason for removals, though it is almost always combined with other factors, such as neglect and drug abuse;[13]
- Supervised in-home cases, less intrusive than a removal, are only allowed if the parents and children live in "a home-like setting"; and
- Inadequate housing delays children returning home from foster care, even if parents have addressed other problems that led to removal.

Housing related hardships have been linked with CPS involvement and child maltreatment in a number of studies. A recent study found that, regardless of other financial hardships, housing instability is a unique family stressor that can lead to harsh and neglectful parenting.[14]

Child Welfare is trying to address the problem. In some districts, housing navigators and contractors help families work through affordable housing challenges, helping them pay rent, utility deposits, and application fees, and address poor rental histories and criminal records that

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[13] Inadequate housing definition per federal Children's Bureau: Housing facilities were substandard, overcrowded, unsafe or otherwise inadequate resulting in their not being appropriate for the parents and child to reside together. Also includes homelessness.

14 Slack, K. S., Font, S., Maguire-Jack, K., & Berger, L. M. (2017). Predicting child protective services (CPS) involvement among low-income U.S. families with young children receiving nutritional assistance. International journal of environmental research and public health, 14(10), [1197].

"Housing is a large and uncontrollable factor in placement and family decisions. It is very difficult to get families into housing; **there just isn't enough**."
- Child Welfare permanency caseworker

make renting difficult. Other districts have contracted for specific slots in affordable housing programs for Child Welfare clients.

The housing problem is tough to resolve, however. In Oregon, it is a statewide issue, not limited to just rapidly growing urban areas, according to the Oregon Office of Economic Analysis. Rural Oregon incomes are on par with rural American incomes, but home prices are 30% higher in rural Oregon and rents are 16% higher. Causes included faster growth in Oregon, limited construction, and growth in vacation homes and rentals in some areas.

We heard housing concerns in every district we visited, including concerns about long wait lists and lottery programs. Child Welfare's survey found much the same, with caseworkers in 11 of 16 districts listing housing as the top service gap, and all but one listing it in the top three.

The problems are large, but smaller solutions specific to Child Welfare can help

Solving issues such as housing, mental health, and addiction treatment availability is well outside Child Welfare's control. However, some potential solutions particular to Child Welfare can help. For example, discussions with parents and Child Welfare's own survey indicated better caseworker communication around service availability and more information on case and safety plans would help. Parents also noted delays in referrals to services from Child Welfare, a particular concern under tight deadlines faced by front-end investigators.

Other solutions, drawn from research, stakeholder suggestions, Child Welfare officials, and officials in other states, include:

- Add additional publicly reported performance metrics for CCOs around the Child Welfare population that tie into Family First goals; station CCO assessors in DHS branches; or shift responsibility for coverage of Child Welfare families to just one CCO to enhance accountability.
- Work with the Oregon Office of Rural Health and other stakeholders to quantify needs for providing Child Welfare mental health and addiction treatment services in underserved areas.
- Shift more toward telemedicine in rural areas, tapping Child Welfare's and OHA's increased experience with online communications as part of its COVID-19 response.
- Increase efforts to provide transportation in rural areas. District 10, based in Redmond, runs a volunteer-based driving service to help clients make appointments.
- Where expert providers are scarce, including in rural areas, consider contracting directly with therapists and other experts or bringing experts onto staff in DHS district offices. Oklahoma, for example, has embedded mental health experts for consultation in each of their five child welfare regions, with the costs paid half by its mental health office and half by child welfare.

- Use dedicated housing vouchers for Child Welfare clients.
- Provide clear reports to state leadership and policymakers on service access, availability, and effectiveness throughout the state, working with OHA and programs within DHS to identify services outside Child Welfare as well.
- Increase central management leadership in working with providers to address issues, such as communications with field staff, contract flexibility, and access to services. These procedures vary by district.

Child Welfare can more effectively manage provider performance and match families with appropriate services

Child Welfare has some strong practices to build on in managing service contractor performance and efficiently delivering services to clients who are most likely to benefit from them.

Some service contracts, particularly for front-end In-home Safety and Reunification Services, include performance measures that tie directly to important Child Welfare outcomes, including keeping children at home and returning them home quickly. Individual contract managers in districts have developed tailored methods for monitoring contractors. The DHS Office of Reporting, Research, Analytics and Implementation (ORRAI) provides performance information, and DHS contract consultants are helping with specific issues. ORRAI, with significant statistical knowledge, has begun to analyze services to determine if they make a difference in key child welfare outcomes, such as keeping children at home.

However, we also found important shortfalls in Child Welfare's performance management, including the division's ability to determine which services are working best and with which families. Needed improvements include higher and more consistent standards for managing service contracts, contracts that more clearly spell out expectations of providers, better tracking of service performance, and better use of data to evaluate and allocate services. These shortfalls may extend to DHS as a whole, though we did not evaluate contracts or contract management in other programs.

The State of Oregon's procurement manual sets the baseline for contract performance management. It emphasizes a performance-based contractor statement of work on the front end, and a plan that includes how the agency will document, monitor and control contract performance. The contract manager's primary role, according to state guidelines, is to monitor performance throughout the life of the contract, including contractor progress reports, appropriate on-site reviews, and written surveys of clients.

Child Welfare can more effectively manage provider performance

We reviewed large Child Welfare contracts and interviewed 10 central and district contract administrators, in addition to contract administrators interviewed during field visits. We found three key issues that Child Welfare can address to better meet the state's standards and manage contracts to improve family services.

1. Limited central oversight leads to wide variations in contract oversight

The contract management system, like Child Welfare, is largely decentralized, with the 16 districts in the state taking unique approaches. In larger districts, entire teams may oversee contracts. In smaller districts, they may be assigned to one worker with multiple duties. Some districts have regular meetings with contractors to give and receive feedback. Contract administrators in other districts have little contact with service providers.

Some administrators expressed confidence that they were on top of contract performance. Others administering large contracts emphatically said they were not. A 2018 DHS internal audit concluded that contract administrators were not complying with training policies in some cases and did not have sufficient knowledge of the job.

> **"We have a huge gap of knowledge and experience and skill.** Some administrators are doing amazing contract management, and then it's all the way down to people who are brand new with 100 other things on their plate."
> *- District contract administrator*

Central oversight of district contract management is limited, with little guidance on performance management for contract administrators and limited involvement in quality control and improvement for service providers.

2. Provider contracts do not enable strong performance oversight and improvement

In 13 of 17 cases in our review of large contracts, the contracts included clearly defined performance metrics. However, these large contracts did not include other requirements that could help improve results over time:

- With one exception, contracts only required contractors to report issues involving single clients, not monthly or periodic summaries of overall contractor performance, success at engaging clients, and the contractor's efforts to improve results and client engagement.

- Also with one exception, the contracts did not require that contractors meet or correspond regularly with Child Welfare to discuss overall performance issues or obstacles to improving performance.

- The contracts do not require that Child Welfare and the contractors agree on goals tied to the metrics in the contracts, only that contactors report results of individual cases.

- Only one of the contracts we reviewed included a requirement to survey clients served and report results to Child Welfare.

Finally, several large contracts did not spell out expectations for how many hours contractors will spend with clients, beyond a minimum of spending at least one hour to be reimbursed. For contractors not paid by the hour, this lack of specify can allow contractors to work less than Child Welfare expects and receive the same amount of money.

3. Child Welfare needs to improve its outcome measurement and analysis

Key outcomes in Child Welfare include keeping children safe, keeping families together if possible, and returning children to their families as quickly as possible. With the exception of In-Home Safety and Reunification Services contracts, the performance metrics in contracts we reviewed did not focus on these outcomes. Instead, they focused on whether clients met particular service goals or accessed services.

The contract administrators we spoke with said they would like more detail on outcome results for families served by their contractors to help them determine which contractors are most effective. ORRAI has the skills to provide this analysis. However, ORRAI's staff serve all of DHS and may not have the personnel to gather data, analyze service performance, and help implement changes in the field over time given budget challenges.

As noted earlier, in the case of mental health and addiction treatment services paid for by CCOs, data or communication problems have limited data from OHA to help DHS track services provided and outcomes.

Contract administrators also said they want to know more about how successfully contractors engage clients, a critical and difficult task in Child Welfare. As it stands now, contractors may report not achieving a particular goal, but it is not clear why, or which contractors are doing well at engaging clients and which are not.

ORRAI sends analyses to district contract managers on the monthly results of Child Welfare contracts in their districts and all other districts over time, a strong practice. However, some contract administrators were not aware of it. The analysis also does not identify which providers

and districts are getting the best results statewide, or providers with results improving over time, information that could be shared and discussed statewide.

We analyzed this data and found substantial differences in performance between counties and between providers offering the same service. Child Welfare could use this information to identify high and low performers and initiate improvement discussions.

For example, the success rate by county for In-Home Safety and Reunification Services to stabilize families ranged from 60% to 92% for counties with at least 100 instances of the service in the latest three-year time period. Provider success rates on those services, again for providers with at least 100 instances of service provision, ranged from 52% to 97%.

The performance of mentoring contractors with at least 50 instances of providing services ranged from 27% to 73%, and the performance of service navigation contractors with at least 100 instances of providing services ranged from 44% to 75%.

Some of these differences may be due to inconsistent reporting between providers. However, differences in county performance could also contribute to substantial differences we found in overall outcome results between counties, including differences in overall removal rates. In our analysis, removal rates and other outcome measures varied substantially across Oregon counties, with five-year average removal rates ranging from 2% to 19%. Analyzing and following up on these overall outcome results would also improve Child Welfare's performance management.

Healthy Families Oregon, a home visiting program offered through the Oregon Department of Education's Early Learning Division, provides a strong example of outcome measurement and transparent reporting for a program devoted to preventing child abuse. The program's public reports include details of program evaluations and details on service delivery indicators, parent surveys, success rates based on participant demographics, and family outcomes, all by county. Outcome examples include participants reporting reduced parenting stress, participants reading to their children three times a week or more, and participants establishing their children with primary care providers.

Enhancing existing data initiatives could help improve contractor performance and better match families with appropriate services

Some promising data initiatives are in process in Child Welfare, including three that stood out for their potential to improve service performance and delivery.

Performance-based pay. ORRAI and Child Welfare are trying a performance-based payment system for the contract with Safe Families, the provider who takes care of children temporarily for parents in need. ORRAI will compare outcomes with Safe Families clients to outcomes with a statistically derived set of comparable clients in the system to see whether Safe Families made a difference, with Safe Families in line for bonus payments if they have. This approach incentivizes performance, backed by in-depth analysis. However, it adds risk and uncertainty for providers.

Overall performance analysis. Earlier in 2020, ORRAI analyzed Strengthening, Preserving, and Reunifying Families (SPRF) service performance for the Legislature. For the first time since the program was established in 2011, the analysis went beyond whether providers met service goals. Instead, ORRAI assessed whether clients receiving different types of SPRF services were better able to keep children at home after they returned from foster care compared to 300 runs against matched clients who did not receive the services. The conclusions had limitations — for example, a service might not be effective overall, but be very effective with important subsets of clients. Yet the analysis was a first step toward identifying services that help families the most.

Facilitation of family meetings, parenting skills instruction, and specialists to help navigate social service agencies and transportation were services contractors performed most strongly.

Service matching. ORRAI is delving deeply into "predictive analytics," a statistical approach that uses deep analysis of data from past cases and results to predict future outcomes and help with making decisions in the present. For Child Welfare, ORRAI is working on analytic models to help inform:

- Child Abuse hotline screeners about the relative risk of children face of being placed in foster care;
- CPS caseworkers about the probability of child safety risks and future allegations if a child remains in their home after a founded allegation; and
- Caseworkers about the risks children face of returning to foster care if they are reunified with their families.

In a service context, this data analysis could help match services to families most likely to succeed with those services given their history and circumstances. With limited services available, accurate analytics would help allocate service more efficiently. However, we heard substantial concerns, within and outside Child Welfare, about racial and ethnic bias contaminating predictive analytic conclusions and biasing current decisions. ORRAI leaders say they have taken extensive steps to correct for bias to avoid perpetuating it through predictions, but neither the full predictive analytics program nor the bias calculations have received an independent review.

Improving management of service providers is one part of shifting to a preventive approach that can keep more children safe and more families together. As detailed in our 2018 foster care audit, Child Welfare and DHS management have struggled to sustain initiatives over time. Our recommendations, beginning on the next page, are designed to help ensure that Child Welfare makes some relatively rapid improvements that the division and its families receive support from other agencies and programs, and that Oregon sustains a preventive focus long-term.

Recommendations

This audit has focused on services for families with children involved in Child Welfare. The recommendations below focus on lower-cost efforts that should improve family prospects and reduce the load on the foster care system. The recommendations are directed at DHS management and Child Welfare management. However, to succeed, Child Welfare needs persistent support from Oregon's leaders and the division's most important partners, within DHS, in other state agencies, and in communities statewide.

1. Establish collaboration protocols with partner divisions and agencies that set common goals, procedures, and timelines for action on Child Welfare referrals and at the front end of open cases.

2. Use data analysis and input from staff, parents, and other stakeholders to identify the types of services and providers that are most successful and cost-efficient, including alternatives for improving front-end family engagement, service coordination, and safety services.
    a. Provide ORRAI with enough capacity to credibly evaluate service outcomes and staffing needs, identify the most effective services, and conduct outreach to help districts improve performance management.

3. Identify and implement alternatives to reduce caseworker workload. Potential alternatives include reducing time spent on data entry and other administrative activities and making case procedures more accessible and user friendly.

4. Develop contract measures at the district and central office level that set goals for provider timeliness, access, quality, and reporting of overall performance. Set clear performance management guidelines for contract administrators.

5. Work with contracted providers to develop diverse delivery options that address service gaps in rural areas and other underserved areas, such as delivering services online or virtually when appropriate.

6. Work with OHA, CCOs, and other stakeholders to quantify needs for mental health and addiction treatment services in underserved areas, ensure adequate coverage, and establish data sharing for CCO-provided services in Child Welfare cases. Also work with OHA to develop publicly reported CCO performance metrics that tie to Family First goals.

7. Ensure that ORRAI's efforts to account for racial bias receive an independent review, either through peer-reviewed studies or commissioned experts.

8. Incorporate detailed information on services for CIRT team evaluation of CIRT cases, including whether key services within or outside Child Welfare were effective or available.

9. Provide biennial reports to state leadership and policymakers on service access, availability, and effectiveness throughout the state, drawing on improved performance information.

10. Incorporate the previous recommendations into development of the new five-year Family First prevention plan for ongoing inclusion in periodic Child and Family Services plans.

Objective, Scope, and Methodology

Objective

The objective of this audit was to examine how Oregon can more effectively and economically use family services to safely prevent the placement of children into the foster care system.

Scope

The audit focused on Child Welfare's performance nationally and internally; how Child Welfare is preparing to meet federal Family First Act requirements; how the state can best increase service availability; how DHS can best increase the effectiveness of its service delivery; and how DHS can best determine families to serve and services to provide.

Methodology

To address our objectives, our methodology included, but was not limited to: conducting interviews and research; visiting DHS field offices; analyzing Child Welfare spending, staffing, and performance in districts, statewide, and nationally; reviewing laws, regulations, and Child Welfare procedures; reviewing Child Welfare budgets; reviewing contract documents; benchmarking against other states; and analyzing Child Welfare data, within Oregon and nationally.

Interviews and Visits

We conducted interviews with legislative officials, officials in the Governor's Office, Child Welfare leadership and staff, DHS Developmental Disabilities leadership, DHS Self Sufficiency leadership, OHA officials, the district managers of 14 DHS district offices, and leadership and staff of ORRAI. We visited 10 of the 16 districts from around the state, where we interviewed caseworkers, supervisors, contract administrators, and other staff as well as service providers, and accompanied caseworkers as they performed their work.

We also conducted interviews with Child Welfare stakeholders, among them:

- Parents currently or formerly involved with child welfare;
- Former foster children;
- Attorneys involved with the system;
- Casey Family Programs;
- Service Employees International Union, Local 503;
- Oregon Court Appointed Special Advocates (CASA);
- National Coalition for Child Protection Reform;
- Oregon Alliance;
- Oregon Foster Youth Connections;
- County officials;
- Children First for Oregon; and
- The Oregon Judicial Department's Citizen Review Board.

Analysis of Oregon Child Welfare Performance

We obtained and analyzed Adoption and Foster Care Analysis and Reporting System and National Child Abuse and Neglect Data System data from the National Data Archive on Child Abuse and Neglect at Cornell University. Readers should exercise caution in evaluating state-to-state comparisons, as each state has its own Child Welfare statutes and policies.

We also examined the federal Child and Family Service Review of Oregon Child Welfare in 2016 and compared results to those in other states. As noted earlier in this report, the accuracy of the comparisons is hampered by small sample sizes of cases used to gauge performance.

Spending Reviews

We evaluated spending from three sources: Child Welfare budgets; actual spending from financial data in the state's financial accounting system; and spending data from OR-Kids, the case management system for DHS. We examined trends in spending, differences in spending by county, and relative amounts of spending for different expense categories. We also evaluated staffing over time from budget documents. All three types of Child Welfare spending data do not include costs associated with treatment or services not paid for by Child Welfare. Some costs, for example, are covered under Medicaid or private insurance, and are not direct Child Welfare expenditures.

Case Reviews

We judgmentally selected and reviewed confidential records for 12 cases from 2018 to 2020 evaluated by Child Welfare's CIRT, which evaluates child deaths when the victim, their siblings or another child living in the household have interacted with Child Welfare within 12 months of the fatality. We also examined cases recommended by caseworkers and other field staff that illustrated both potential issues with services and the potential for services to benefit families. In addition, we examined cases with both high and low amounts of service expenditures listed in OR-Kids. The conclusions from these judgmental, non-statistical samples cannot be extended to represent the entire Child Welfare population. However, combined with interviews, research, and data analysis, the work did allow us to draw reasonable conclusions about service impacts in CIRT cases, and both the potential and limitations of family services.

Benchmarking Other States

We determined other states to research and speak with by evaluating the national performance data detailed above and by researching individual promising practices across the nation. We spoke with Child Welfare officials in Washington, D.C., and in nine states: Arizona, Delaware, Kansas, Oklahoma, Tennessee, Texas, Vermont, Virginia, and Washington state.

Contract Reviews

We judgmentally selected 17 of Child Welfare's largest service provider contracts for review, focusing on a diversity of geography and type of services provided. We then interviewed 10 contract administrators overseeing a subset of those contracts. As a judgmental, non-statistical sample, the conclusions from this work alone cannot be extended to represent the entire population of Child Welfare contracts. However, combined with field visits, additional research, and additional interviews, our methodology did enable us to draw reasonable conclusions about common issues and challenges in Child Welfare's contract management.

Internal Control Review

We determined that the following internal controls were relevant to our audit objective.[15]

- Control Environment
    - We considered management's responsibility for overseeing provision of effective and efficient family services.

[15] Auditors relied on standards for internal controls from the U.S. Government Accountability Office, report GAO-14-704G.

    - We considered management's responsibility to assign clear duties to particular staff to ensure effective and efficient services.
- Risk Assessment
    - We considered whether management has defined clear objectives around service provision to enable identification of risks and response to risks.
- Control Activities
    - We considered whether management had defined objectives around service provision and set control activities through policy to achieve those objectives.
- Information and Communication
    - We considered whether management uses quality information to achieve its service provision objectives.
    - We considered whether management has internally and externally communicated the quality information needed to achieve service provision objectives.
- Monitoring Activities
    - We considered whether management is monitoring the system of controls around service provision and the results of service provision.
    - We considered whether management has remediated internal control deficiencies on a timely basis.

Deficiencies with these internal controls were documented in the results section of this report.

Data Reliability

We obtained OR-Kids data from DHS and performed limited data reliability procedures. The OR-Kids data is stored in the Child Welfare data warehouse and also includes Child Welfare case expenditures. We relied on the conclusions drawn from our office's recent audit of the OR-Kids system, report 2020-01.[16] That audit assessed the reliability of the agency's Child Welfare data and found that while the system is able to capture information needed to support program goals, it is not user friendly.

We obtained and analyzed Adoption and Foster Care Analysis and Reporting System and National Child Abuse and Neglect Data System data from the National Data Archive on Child Abuse and Neglect via Cornell University. The data was used in accordance with its Terms of Use Agreement license. The Administration on Children, Youth and Families, the Children's Bureau, the original dataset collection personnel or funding source, the National Data Archive on Child Abuse and Neglect, Cornell University and their agents or employees bear no responsibility for the analyses or interpretations presented. For OR-Kids and national data sets, we determined that the data were sufficiently reliable for the purposes of this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of DHS and its Child Welfare division during the course of this audit.

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[16] Report 2020-01: "Oregon's Child Welfare Information System is Adequate for Case Management, but Enhancements are needed to Improve Usability."

Oregon
Kate Brown, Governor

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Office of Child Welfare Program
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June 25, 2020

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310

Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled "Oregon Can More Effectively Use Family Services to Limit Foster Care and Keep Children Safely at Home."

We appreciate the investment the Secretary of State's office has made to ensure a thorough review of Oregon's child welfare system as a whole and its ability to keep children safely at home and reduce the need for foster care.

DHS Child Welfare has drafted a Child Welfare Vision for Transformation with contributions from staff, partners, families and youth our goal is to achieve true transformation built on core values and a belief that children do best growing up in a family. The Family First Prevention Services Act of 2018, which is referenced throughout this report, presents a new opportunity for child welfare systems to build and utilize tools, collaborations, and processes that will align with the vision to make transformative changes that support families so more children are able to remain safely with their parents, families and communities.

Success will require everybody, including young people, birth and foster parents, child welfare professionals, community partners and providers, policy makers and courts. Everyone has a role to play with the child welfare agency in finding solutions and strategies, making progress and improving outcomes and experiences within the broader child welfare system.

Below is our detailed response to each recommendation in the audit.

RECOMMENDATION 1 **Establish collaboration protocols with partner divisions and agencies that set common goals, procedures, and timelines for action on Child Welfare referrals and at the front end of open cases.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	06/30/21	Lacey Andresen, Lacey.L.Andresen@dhsoha.state.or.us

Narrative for Recommendation 1

DHS Child Welfare has already begun this work with the Office of Developmental Disabilities Services, working with the young people in foster care who experience temporary lodging.

DHS Child Welfare will continue the work of identifying additional opportunities to develop collaboration protocols to set common goals, procedures and timelines for action on Child Welfare referrals.

RECOMMENDATION 2 **Use data analysis and input from staff, parents, and other stakeholders to identify the types of services and providers that are most successful and cost-efficient, including alternatives for improving front-end family engagement, service coordination, and safety services.** **a. Provide ORRAI with enough capacity to credibly evaluate service outcomes and staffing needs, identify the most effective services, and conduct outreach to help districts improve performance management.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	December 2023	Paul Bellatty paul.t.bellatty@dhsoha.state.or.us and/or Kirsten Kolb kirsten.c.kolb@dhsoha.state.or.us

Narrative for Recommendation 2

The Office of Reporting, Research, Analytics and Implementation (ORRAI) will first need to determine if there is enough data for an evaluation, then complete program evaluation/service

effectiveness for each program/service. The second step will be to automate the evaluation and determine the population best served by the program. The final step is running the models by individual/family, to determine the most appropriate program/service for optimal outcome. Partners will be included to provide information about program, data, focused services, etc.

This is a multi-phased effort that begins with service effectiveness through program evaluation and service matching and will require automation to be effective. The entire process would take 2-3 years if started immediately.

It is also important to note that this recommendation is dependent on fiscal and staffing resources that are currently not available. Budget restrictions in the wake of Covid-19 may require the target date for this recommendation to be adjusted.

RECOMMENDATION 3 **Identify and implement alternatives to reduce caseworker workload. Potential alternatives include reducing time spent on data entry and other administrative activities and making case procedures more accessible and user friendly.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	6/30/21	Lacey Andresen Lacey.L.Andresen@dhsoha.state.or.us

Narrative for Recommendation 3

In collaboration with partners, youth and parent mentors, Child Welfare has developed a new Family Report that significantly reduces workload to caseworkers. The new Family Report combines the case plan and reports to the juvenile court and legal parties, two very lengthy documents.

The Child Welfare Policy Unit is currently analyzing the structure, accessibility and usefulness of the Child Welfare Procedure Manual. Since March 2020, Child Welfare has convened several workgroups that include field staff and central office policy staff, to document the business process flow for a journey through child welfare involvement. This information is being used to identify and inform procedural updates that create more efficiency in practice to then be reflected in the Procedure Manual. Revisions to the Child Welfare Procedure Manual are on track for implementation within the next year.

Additionally, DHS Child Welfare will analyze work assignments to caseworkers to determine whether there is opportunity for using case aides in a consistent manner.

RECOMMENDATION 4 **Develop contract measures at the district and central office level that set goals for provider timeliness, access, quality, and reporting of overall performance. Set clear performance management guidelines for contract administrators.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	12/31/2020	Belit Burke Belit.Burke@dhsoha.state.or.us

Narrative for Recommendation 4

The Child Welfare Contracts Team, in collaboration with district level contract administrators, will develop a charter or work agreement that establishes goals for consistent quality, performance management and overall performance.

RECOMMENDATION 5 **Work with contracted providers to develop diverse delivery options that address service gaps in rural areas and other underserved areas, such as delivering services online or virtually when appropriate.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	9/30/2020	Belit Burke Belit.Burke@dhsoha.state.or.us

Narrative for Recommendation 5

DHS Child Welfare recognizes the benefits in delivering some services online and virtually especially in the wake of the COVID-19 global pandemic. Ongoing, the Child Welfare Contracts Team will request contracted providers to consider enhancing service delivery options that include implementing online or virtual options to address service gaps.

It should also be noted that not all services are effective through online or virtual settings. Contracted providers and the clients they serve have varying degrees of access, skill, and infrastructure to support consistent and effective service provision and participation through online or virtual services.

RECOMMENDATION 6 **Work with OHA, CCOs, and other stakeholders to quantify needs for mental health and addiction treatment services in underserved areas, ensure adequate coverage, and establish data sharing for CCO-provided services in Child Welfare cases. Also work with OHA to develop publicly reported CCO performance metrics that tie to Family First goals.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	1/1/2021	Katie Beck, Katie.Beck@dhsoha.state.or.us

Narrative for Recommendation 6

The Oregon Health Authority policy advisor to the Child Welfare Executive Leadership is convening a Medicaid/Child Welfare work group. That work group will be taking on implementing each component of this recommendation.

RECOMMENDATION 7 **Ensure that ORRAI's efforts to account for racial bias receive an independent review, either through peer-reviewed studies or commissioned experts.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	12/31/2023	Paul Bellatty paul.t.bellatty@dhsoha.state.or.us and/or Kirsten Kolb kirsten.c.kolb@dhsoha.state.or.us

Narrative for Recommendation 7

An abstract for the 2020 Annual Meeting of the Society of Risk Analysis has been submitted. Assuming abstract acceptance, a peer-reviewed manuscript would then be published in the Conference Proceedings. Additionally, the manuscript will be posted on the open source journal repository, facilitating broad review and criticism of the developed procedures. Given the potentially slow pace of the peer-review process, it is anticipated to take up to 2 years to complete this process.

RECOMMENDATION 8 **Incorporate detailed information on services for CIRT team evaluation of CIRT cases, including whether key services within or outside Child Welfare were effective or available.**

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	12/31/2023	Tami Kane-Suleiman, Tami.J.Kane-Suleiman @dhsoha.state.or.us

Narrative for Recommendation 8

The Child Fatality Prevention and Review Program will take immediate steps to incorporate changes to the case file summary template to prompt the gathering of detailed information about services provided by or outside the agency, and whether they were available and effective. In addition, service discussion will be added to the CIRT meeting agenda to ensure detailed information on services will be provided and discussed during the CIRT meeting. These changes can be implemented within the next few months.

While availability of service is fairly simple to determine, determining effectiveness of services is nearly impossible to do without a robust program evaluation criterion. In Recommendation 2, ORRAI is identifying nearly 3 years needed to develop and implement a process that determines effective and cost-efficient services.

RECOMMENDATION 9 **Provide biennial reports to state leadership and policymakers on service access, availability, and effectiveness throughout the state, drawing on improved performance information.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	06/30/2021, annually thereafter	Lacey Andresen Lacey.L.Andresen@dhsoha.state.or.us

Narrative for Recommendation 9

Child Welfare submits an Annual Progress and Services Report (APSR) to the Children's Bureau. The APSR is a narrative report on progress made towards meeting each goal and objective approved in the 5-Year Plan/Child and Family Services Plan (CFSP). It documents changes in goals and objectives and narrates a description of the services to be provided in the coming year, as well as other program information required by the federal Program Instruction. These reports are submitted to the Governor's office for approval prior to submission to Children's Bureau. Upon approval from the Children's Bureau, the report will be shared with key legislators on House and Senate Human services committees and posted to the DHS website.

RECOMMENDATION 10 **Incorporate the previous recommendations into development of the new five-year Family First prevention plan for ongoing inclusion in periodic Child and Family Services plans.**		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Partially Agree	12/31/2020	Belit Burke Belit.Burke@dhsoha.state.or.us

Narrative for Recommendation 10

While many of the recommendations will naturally contribute to the Family First prevention plan, numbers 7, 8, and 9 are outside of the scope of the Federal Program Instructions for the Family First State Plan. The charter guiding the Family First Prevention Plan work addresses the remaining recommendations as part of implementation.

Please contact Kathy Steiner at 503-385-7135 or Kathy.steiner@dhsoha.state.or.us with any questions.

Sincerely,

Rebecca Jones Gaston
Child Welfare Director

cc: Fariborz Pakseresht, Director, DHS
Eric Moore, Chief Financial Officer, DHS
Pat Allen, Director, Oregon Health Authority
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About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

This report is intended to promote the best possible management of public resources.
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