OREGON CHILDREN, ADULTS AND FAMILIES

Expert Review of the Safety Intervention System

EXECUTIVE SUMMARY

ACTION For Child Protection

Executive Summary

Purpose, Objectives, and Methodology

This study was conducted by the federally funded National Resource Center for Child Protective Services (NRCCPS) to provide an expert review of the Oregon Department of Human Services (DHS) Children, Adults and Families (CAF) safety intervention system in comparison to the state of the art of Child Protective Services (CPS) safety intervention nationally. The state of the art consists of 1) the state of the knowledge base that defines, directs and supports the concept, standards and practice of safety intervention and 2) actual application occurring nationally in case practice. Notably the knowledge base is generally well formed and continuing to evolve while the nature and quality of application lags behind. Simply stated, what is known about safety intervention exceeds what currently is being done in practice.

NRCCPS experts provided 10 on site days and 15 off site days of technical assistance. Information was gathered from guided discussions with DHS Administration, Governor's Office, Child Welfare Advisory Committee, CAF Program Staff, Critical Incident Response Team (CIRT) Reviewers, Field Program Managers, and staff focus groups. Experts also reviewed staff self-assessment surveys and policy, procedures and training curriculum.

Findings: Challenges Unique to Oregon

- Methamphetamine-- The methamphetamine problem is the most prominent CPS problem of this decade in Oregon and perhaps nationally.

- Workload Demand-- Studies confirm that current national caseload standards may be twice what is reasonable to perform competently. With that said, Oregon's workload situation even exceeds these outdated national standards.

- Local Influence and Determination-- The Oregon practice of "localizing" policy, procedure, and intervention results in inconsistent application of a statewide safety intervention model.

- Staff Configuration-- Staff roles, responsibilities, assignments and relationships to each other are not systematic. The connection and interdependence of CPS staff to ongoing service staff is not well formed.

- Worker Authority to Remove-- Law enforcement emergency removal of children is preferred to the Oregon practice of child welfare workers having this authority.

- Group Decision Making-- Oregon is a leader nationally in encouraging group decision-making for case planning, but CPS's ultimate responsibility for making safety decisions needs to be made clear.

- Legal custody and In Home Supervision-- The Oregon practice of obtaining legal custody of a child yet allowing the child to remain in his home does occur in other states, but is uncommon. This may suggest to CPS staff that the legal status change alone is enough to protect a child.

- Threat of Harm—This concept as a category of abuse may perpetuate confusion because it is open to multiple interpretations and does not specify the severity threshold required to determine a safety threat.

- Strengths-Needs Based Interventions-- This nationally popular philosophy does not address certain critical aspects of CPS responsibility. The Guided Assessment Process (GAP) and the strengths-needs-based philosophy should be examined for how they fit and compliment each other.

Findings: Oregon Safety System Components

Seven components of a safety intervention system were reviewed and compared to national state of the art. The Oregon CAF safety intervention system is comparable to the state of the art as it is applied and more similar to what is occurring nationally than different.

- Policy-- CAF policy concerned with safety intervention is among the better examples that can be found across the states, but like other states concentrates on the beginning of safety intervention and does not differentiate adequately between risk of maltreatment and child safety. Shortcomings include non-linear construction, lack of step-by-step guidance, and problems with organization and cohesion.

- Procedure—The GAP represents a good foundation for establishing a more effective approach to safety intervention that can be improved by correcting and clarifying terminology and by providing more direction to staff about information gathering standards and procedures in conducting safety interventions.

- Staff Development—Consistent with state of the art, CAF training related to safety intervention is not sequential, modules are too short, knowledge is emphasized over rigorous skill development and nothing exists related to emphasizing the development of supervisors as experts in safety intervention.

- Supervision-- Supervision is relied on as the most significant influence in safety intervention; however, it is likely that many supervisors are not experts in safety intervention. This parallels the national state of the art.

- Information System-- The Oregon information system, similar to other state CPS information systems, does not set forth what kind of case information is necessary in order to analyze safety threats and does not promote competency-based intervention.

- Program Management-- The Program management role in safety intervention is not well defined nationally, and needs to be articulated. Accessibility and availability of program managers are of concern to staff surveyed, and these factors are likely related to workload.

- Quality Assurance—Like most states, Oregon passed this systemic factor in its federal Child and Family Service Review, but quality assurance systems generally do not evaluate the quality of case practice and decision making concerned with safety intervention.

Recommended Safety Intervention System Improvement Actions

The following are actions that NRCCPS recommends Oregon undertake to improve the safety intervention system. Many of these can be accomplished concurrently and are not listed in order of priority.

- DHS should build upon the Guided Assessment Process to develop a unified model of practice that emphasizes safety throughout a child welfare case.

- DHS should develop a procedures manual with revised policy that is clear, precise, and provides step-by-step direction.

- Statewide training based on the revised policy should be required for all child welfare staff and should replace the existing core training for new child welfare staff. Emphasis given to developing supervisors as safety intervention experts should receive priority.

- DHS should seek legal representation and paralegal support to remove non-casework tasks from the child welfare worker. Additionally, other non-casework tasks currently assigned to child welfare workers should be identified and removed.

- The existing child welfare information system should be replaced with one that is SACWIS compliant and that provides sufficient guidance and support for safety intervention.

- DHS should reconsider worker authority and responsibility to make emergency removals of children and the practice of DHS receiving legal custody of children without removal from the home.

- The state should reconsider the statutory term “threat of harm.” The term lacks precision and can be applied too broadly.

- The state should reconsider the requirement of Family Decision Meetings (FDMs). The requirement must be consistent with the primary concern for child safety.

- The state must address the critical child welfare system workload. Caseload sizes and supervisor-to-caseworker ratios exceed even outdated national standards and significantly compromise the safety response capacity.

Conclusions

The Oregon CAF safety intervention system is comparable to the state of the art as it is applied. The approach to safety intervention in Oregon is more similar to what is occurring nationally than different.

The work that has occurred in establishing safety intervention in Oregon to date represents a good foundation. The challenge is for Oregon to move more toward the national standards in critical areas of child safety intervention by enhancing what exists rather than by creating an entirely new system. The less complicated areas for improvement are policy and procedure. The more complicated areas for improvement are: establishing an effective staff development program; enabling supervisors to become experts; articulating the role of program management in safety intervention; modifying the information system to support and guide safety intervention; and refining the approach to quality assurance to address actual practice and decision making quality. However, the most profound challenge will likely be assuring that once the safety intervention system has been improved, sufficient opportunity exists for staff to implement the system the way it is designed. This refers to balancing workload demand with workload capacity.