

Sensitive Review Committee Report
Conclusions and Recommendations
March 9, 2012

Membership

Senator Jeff Kruse
Senator Laurie Monnes Anderson
Representative Wayne Krieger
Representative Mike Schaufler
Representative Carolyn Tomei
Freda Bax, Psy.D.
Iris Bell
Vikki Bishop
Katherine Bradley, Ph.D, R.N.
Erinn Kelley-Siel
Carrie Rasmussen
Duke Shepard
Janet Dougherty-Smith
David Willis, M.D.

DHS Staff;

Cheryl Baldomarolucas
Caroline Burnell
Jerry Buzzard
Lois Day
Mickey Serice
Jerry Waybrant

The Committee scheduled four meetings on the following dates:

October 25, 2011
November 8, 2011
December 14, 2011
January 23, 2012 (Conference Call)

Introduction

In September 2011, Erinn Kelley-Siel, Department of Human Services Director, convened a Sensitive Review Committee comprised of legislators and child advocacy experts to review a complex child welfare case. The Sensitive Review Committee process is focused on cases that are closed and is intended to be a process by which lessons learned in one case can improve the dependency process going forward.

The case reviewed by this Committee was particularly complex because, in addition to a referral to child welfare, the family had been engaged in multiple child- and family-serving systems, including child welfare in Washington state, the early childhood system, additional social support services, the public health and medical systems and the addictions treatment and recovery system.

This case offered lessons not only for DHS child welfare, but also for the conversation that is on-going about the future of Oregon's early childhood and health care systems.

During this review, the SRC members struggled to balance its recommendations against several, broader policy questions too broad in nature to resolve here. Those questions are:

- How to reconcile a child's basic human rights, including the right to thrive, with parental rights such as the right to privacy?
- What is the responsibility of systems – and the people in the systems – when families move or detach from connectivity to community resources?
- How can Oregon help families to see DHS Child Welfare as a resource to families, rather than just as an enforcement agency?

The Committee strongly urges that the recommendations offered in this report should – depending on funding and other policy considerations — be considered during the 2013 Legislative Session. In addition, those recommendations that do not require legislative action or additional resources should be acted on as soon as is practicable by the Department.

Conclusions and Recommendations

1. Conclusion – Communication Between Jurisdictions:

Communication between Oregon and Washington and between medical and social agencies/resources across Oregon counties presented challenges.

Recommendations:

1a. DHS should review the Interstate Compact for the Placement of Children (ICPC) and determine if enhancements can be achieved within the existing Compact to improve communication for children entering and leaving the Oregon child welfare system. DHS will explore a legislative concept to adopt the new ICPC currently under national discussion. DHS should also engage with an interim legislative committee to review the new ICPC agreement under consideration nationally and consider recommendations to offer to the national organization regarding the new ICPC.

1b. The legislature should consider an approach that involves written agreements related to the continuation of services when reviewing the Early Learning Council and Health Care Transformation initiatives in Oregon. The legislature should explore written provider agreements and/or protocols for children: 1) who are involved in community services or child welfare; 2) who have significant risk factors; and 3) who move from one Oregon county to another and from one state to another.

2. Conclusion - Coordination:

The family in this case was receiving many community resources for an extended period of time. These resources were early intervention in nature for the most part. Notably, the agencies and providers involved with this family experienced challenges collaborating with each other. There was no identified, single entity to communicate and connect all services into a single effort to support this family.

Recommendations:

2. Ask the Early Learning Council and the Oregon Health Authority (through its person-centered, primary care home model) to explore the following:
 - a. Ways to identify early in contact with a family, the level of vulnerability for children and to design ways to intervene early and stay connected with the child and family, even when the child and family moves from one Oregon county to another or from Oregon to another state. This effort should leverage existing efforts, such as the evidence-based Healthy Start screenings in development.
 - b. Ways to standardize the home-visitation system toward early intervention in families with children at risk (e.g., develop risk indicators for a referral to public health and/or person-centered primary care homes). The transformed health and early learning systems should monitor outcomes focusing on better systems coordination and better connections with families in need.
 - c. Consider when a treatment provider (medical, behavioral or social services providers) works with a child, the provider should treat the child within the context of the child's family. This may include the provider meeting with the immediate and relevant extended family members, identifying family stressors and assisting families to connect with community resources.
 - d. Coordination of services when a family is using multiple systems. A family using multiple systems should have the benefits of all systems working and coordinating their work together for the good of the family. Within the context of appropriate confidentiality and privacy laws, social, health and education systems should work together to improve coordination across systems at the local level.

3. Conclusion - Consistency:

Several professionals who interacted with this child and family seemed to view the same events as posing different levels of risk for the child. For example, medical issues such as failure to thrive and a feeding tube were not necessarily viewed as a concern – even given the child's age - because the

family reported involvement with a medical professional. Professionals in the educational, social and medical communities appear to have different understandings of what it means for a child to be at different levels of risk.

Recommendations:

3a. DHS child welfare, and the private/public child health system should create and implement a training process (e.g., OPS START) between child welfare and child health providers regarding:

- 1) Recognition and identification of family risk and child neglect;
- 2) Coordination and communication between person-centered primary care homes and DHS;
- 3) Consistency and continuity of person-centered primary care homes and medical “passports”; and
- 4) Child protection and the “differential response” model.

3b. DHS should refine mandatory reporter training to better articulate to mandatory reporters the best way to make a report of child neglect to law enforcement or to DHS. This should include more clarity about what information about a child’s circumstances is most helpful to DHS during an investigation of neglect, and how to provide balanced and objective data based on the reporter’s experience.

3c. DHS should provide training to DHS child welfare staff and to community partners on an added approach to protecting children, which emphasizes early engagement of family and relatives, early and ongoing collaboration with local resources, and prevention services for families.

4. Conclusion - Prevention:

DHS is often viewed as a “protective” agency (rather than a preventative agency) due to the primary mandate to protect children and remove them from harmful situations. This may prevent or cause hesitation in some families seeking help from DHS. This may also prevent concerned extended family members (e.g., grandparents) from contacting DHS when significant

risk factors are present for a child and family for fear of losing contact with their relative-child.

Recommendations:

4a. DHS child welfare, in consultation with the Oregon Health Authority and in partnership with communities, should develop a response system that identifies neglect issues in the context of the continuum of neglect. The system should support families to obtain resources and services from agencies other than child welfare and without child welfare having to be the custodian of the child. The Committee understands that the 2011 Legislature asked DHS to explore implementation of a “differential response” model in child welfare and believes this model could make a difference for families struggling with challenges associated most often with neglect.

4b. DHS and the OHA should write rules or guidelines describing when and how to engage and consult with the DHS and OHA Medical Directors regarding child and family services. The agencies should develop a plan to use the DHS Medical Director as a resource to consult on cases of potentially medically needy children and to support coordination with appropriate local community agencies, particularly when the concerns about a child don't rise to the level of child welfare intervention with a family.

4c. DHS should consider in its child protective services written communication to families, something that explains why DHS intervened and why people make calls to DHS requesting DHS to intervene. This written communication should be designed to help families understand that DHS' entry is to help protect the child and support the family's efforts to protect the child and that the report to DHS is often mandatory by law.

4d. Ask the Interbranch Government Group to review the role of grandparents in a dependency case and consider ways to keep appropriate and willing grandparents engaged with grandchildren in the custody of DHS.

5. Conclusion – Release of Information:

The SRC members identified that when a family does not sign a release of information, there are statutory and regulatory barriers for community providers to sharing information and coordinating critical services.

Recommendation:

5. Ask the legislature to explore ways to facilitate the exchange of child and family information between medical, social and educational providers for children and families identified as at risk and needing community support.

6. Conclusion – Treatment for a child or parent must include a family assessment in relation to that child.

The SRC members were concerned about addiction and mental health treatment providers not taking into consideration the presence of a child(ren) within the home.

Recommendations:

6. Addiction and mental health treatment providers serving children and adults should take into consideration the child's immediate and, possibly, extended family as part of any assessment of the conditions and circumstance of a child and/or a parent. Addiction and mental health providers need to engage the entire family, not just the immediate family, in interviews, assessments and monitoring whenever possible. Because of developmental needs as well as the likelihood that parent stress levels may be higher, particular attention should be paid when infants, toddlers and preschool-aged children are in the home of a parent(s) in recovery.