# OREGON DIFFERENTIAL RESPONSE:

## YEAR 1 SITE VISIT REPORT

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# Executive Summary

In November 2014, the Oregon Department of Human Services (DHS) contracted with the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign to conduct a comprehensive evaluation of the implementation of Differential Response (DR) in Oregon. DR is a nationally recognized approach that creates a multi-track system enabling child protective services to respond differently to reports of child abuse and neglect depending on the severity of a report. As part of the evaluation, Pacific Research and Evaluation[1] conducted a series of interviews and focus groups to describe Oregon DR implementation in terms of how the model was developed at the state level and implemented in the first two districts in the state. This Executive Summary provides a synopsis of the key findings of the Oregon Differential Response: Year 1 Site Visit Report.[2]

This Executive Summary incorporates an implementation science framework that the National Implementation Research Network (NIRN) developed. Oregon used NIRN's framework to guide the implementation process and ensure successful implementation of the DR model. Based on extensive research and existing literature on best practices for how a new initiative should be put into practice, the NIRN framework is divided into three main stages: exploration, installation, and implementation. This report is organized according to the NIRN stages of implementation.

## Methodology

The information in this report was collected through a series of focus groups conducted during site visits in the summer of 2015 in the first two districts that implemented DR in Oregon: District 5 (Lane County) and District 11 (Klamath and Lake Counties). Additional focus groups and interviews were conducted with staff members from DHS's central office and other key stakeholders around the state. In total, 79 individuals representing a variety of roles and perspectives participated in these focus groups and interviews. Focus groups and interviews were recorded and transcribed for qualitative analysis.

## Oregon DR Program Description

Before discussing the findings from the focus groups and interviews, it is helpful to briefly describe some of the basic components of the two-track DR system with the key terms that will be used throughout this report and to delineate the differences between the two tracks. Broadly defined, DR is an approach that allows child protective services (CPS) to respond differently to accepted reports of child abuse and neglect. In Oregon, DR consists of a two-track system: Traditional Response (TR) and Alternative Response (AR). Both require a comprehensive CPS assessment. TR devotes substantial attention to evaluating allegations of maltreatment and determining whether these allegations are substantiated. AR focuses on assessment of family needs through enhanced engagement strategies. Both responses offer optional services to families identified as having safe children and moderate to high needs. AR deemphasizes forensic interviewing and sets aside fault finding, the substantiation of maltreatment allegations, and entries into the child welfare central registry. Factors that are considered in making decisions about initial response track assignment (TR or AR) include the type and severity of the allegations.

[1] Pacific Research and Evaluation is a subcontractor of CFRC.

[2] Recommendations that are included at the end of the full report are incorporated in appropriate sections throughout the Executive Summary.

In reading this report, it is also important to be familiar with several other statewide child welfare initiatives that were being implemented around the same time that DR was being designed and implemented. In 2009, Oregon DHS partnered with the Oregon Commission on Children and Families and Casey Family Programs to lead an initiative to identify strategies to safely and equitably reduce the number of children in foster care in Oregon. Under this initiative, three concurrent strategies were identified to form what DHS leadership describes as the "three-legged stool": the Oregon Safety Model (OSM), Strengthening, Preserving, and Reunifying Families (SPRF; Senate Bill 964), and Differential Response.

## Exploration

The next section describes how Oregon decided to adopt this nationally recognized approach to serving families in the child welfare system. As early as 2010, DHS began to research how DR might be integrated into traditional child welfare practice.

### Identification of Need

Several influencing factors culminated in the decision to integrate DR into Oregon child welfare practice. Driven by a focus on reducing foster care placements (i.e., the Safe and Equitable Foster Care Reduction initiative), DHS sought to address the needs of families being referred to the child welfare system because of neglect. At the same time, the OSM Refresh was initiated to revive child welfare worker utilization of the safety assessment model,[3] and the OSM dovetailed with DR's focus on family engagement. Finally, there was support from the legislature to move in this direction: the DHS leadership's advocacy and changes in fiscal forecasts resulted in the legislative allocation of resources for OSM, additional resources for child welfare staffing, and funds to provide in-home support services for child welfare families (i.e., SPRF services). This shift in child welfare practices, backed by legislative support and resources, moved Oregon in the direction of DR implementation.

### Acquisition of Information

DHS gathered information from other states to understand how DR was structured in those jurisdictions and how the model might be best adapted for Oregon. DHS worked with Casey Family Programs and the National Resource Center for Child Protective Services (NRCCPS) to provide support in this exploration process. Casey Family Programs helped DHS compile information from other states, connecting Oregon with jurisdictions whose DR models had components that might work well in Oregon. NRCCPS conducted a series of focus groups with various internal and external stakeholders across the state to gauge the amount of support for and concern about the adoption of a DR system in Oregon.

### Dissemination of Information

After information about DR was gathered, DHS communicated its intentions to child welfare staff and community partner organizations. DHS conducted a series of focus groups with community partners and presentations about DR in the district offices to introduce the idea of DR around the state. Although there were initial concerns raised in the exploration stage, these concerns were addressed through increased communication and conversation among interested parties, including dissenters.

Overall, a significant amount of time and effort was put into the exploration stage of Oregon DR implementation. DHS was thorough in gathering information about how DR might be structured in

[3] The OSM was introduced in 2006. However, DHS developed the OSM Refresh to retrain staff on the core components of the model.

Oregon, learning from the successes and challenges of other states, and sharing information with stakeholders who helped develop the basic structures of DR in the formative stages of the process.

## Installation

After the decision was made to adopt a DR model in Oregon, during the installation stage, DHS central office led the effort to determine what needed to occur prior to the rollout of DR in district child welfare offices and communities around the state.

### DR Implementation Team

Building on the work completed in the exploration stage, a DR team structure of committees and subcommittees was established in 2013 to guide the decision-making process, moving DR from a conceptual framework to how it would function in practice.

A small number of DHS staff was designated to guide and support the DR installation process. Leading the effort was the current DR program manager who was hired in December 2012; this is when DR implementation gained momentum, with strong leadership for the statewide effort. A few DR consultants worked closely with the DR program manager to support the initial efforts related to DR implementation. This central office DR team was described as a passionate and effective group whose members were energetic about the implementation of DR.

The design of the Oregon DR model was developed through a committee process: the DR steering committee was responsible for overseeing the planning process during the exploration phase and overseeing the implementation team during the installation phase. The steering committee met monthly and consisted of high-ranking DHS administrators and partners who were the final decision-making body for the work. The DR implementation team and ten subcommittees were responsible for making recommendations about the configuration of the Oregon DR to the steering committee and managing the details of what needed to be done at the state level before DR could be implemented in local DHS offices. The committee members, for the most part, did not serve on other DR committees in order to incorporate varied perspectives and create buy-in for DR implementation. Committee members included representatives from state and district offices, from frontline staff to high-level administrators, national consultants, service providers, individuals representing communities of color, and individuals representing parents. Interviewees indicated that the committee structure worked well and encouraged discussions that incorporated the extensive knowledge of the various committee members. At the same time, there were frustrations among some committee members who believed that the implementation was happening too quickly.

### Legislative Changes

In some states, legislative changes are necessary to enable the implementation of DR practice. In Oregon, DHS decided to refrain from making a statutory change, first because it wasn't necessary and second to allow for flexibility in the evolving DR practice. Now that the DR model is more established, DHS leadership is considering the option of formally integrating the DR model into Oregon statute.

### Data Development

In reconfiguring the existing child welfare system to accommodate the DR model, Oregon's state automated child welfare information system (SACWIS) needed to be modified. These changes were made gradually for several reasons. First, with the understanding that the Oregon DR model was still evolving, the DHS central office recognized the need to modify the system slowly and thoughtfully. Second, smaller changes were deemed appropriate because of the staged rollout of DR across the state; some district offices needed to enter information about AR cases, whereas other districts continued to use

SACWIS as they had traditionally. Overall, DHS leadership indicated that modifications to the state data system were made relatively easily.

### Staged Rollout

During the installation stage, a decision had to be made about the manner in which DR would be rolled out across the state. DHS wanted to begin the rollout process in districts where the environment was supportive of adopting the DR model, allowing lessons to be learned and the experience shared with other districts. Having taken lessons learned from other jurisdictions, DHS elected to conduct a staged rollout of DR implementation, beginning in May 2014. DHS utilized the DR implementation team and subcommittee structures to help brainstorm the factors that should be considered in selecting the first districts to implement DR.

### Evolutionary Process

In reflecting on the installation stage, many of the interviewees described the evolutionary nature of the development of the DR model in Oregon. As discussions progressed and decisions were made about the DR model, more information was gathered and experience was gained. These insights sometimes required modifications to decisions that had already been made. DHS wanted to create a flexible DR model because they anticipated that aspects of the practice would need to be adapted over time. There was a general understanding that this evolutionary adaptation was ultimately good for the development of DR practice. Although there were frustrations along the way, interviewees recognized that these adaptions would be subtle as DR continued to be implemented in other districts across the state.

*Recommendation*: Because questions and issues will continue to arise over the next few years of DR implementation, it is important to ensure that there is clear communication about adaptations that are made, especially as more of the state begins to function with a two-track system. The central office DR team appears to be the hub of current expertise about DR practice in Oregon. It is important to create a system in which decisions are communicated to this team, and this team should be responsible for systematically communicating information about resulting changes to the community and handling questions raised in the field. Interviewees indicated that they appreciated the regular communication from the DHS child welfare director; this communication process should be continued and potentially enhanced as additional counties begin to plan for and implement DR across the state.

### Disproportionality

Disproportionality, in the context of this report, refers to the overrepresentation of ethnic minority groups in the child welfare system and the tendency for these groups to have unequal access to needed services. DHS believes that the DR model will have a positive effect on the disproportionate representation of minorities in the child welfare system. In reconfiguring the child welfare system to incorporate the DR model, central office paid particular attention to the issue of disproportionality. DHS invited individuals to serve on DR planning committees who could bring an equity lens to the conversations about how DR would look in Oregon. DHS also made a targeted effort to include the tribal perspective, inviting representatives from the tribal community to participate in DR committee work, presenting at Oregon's Indian Child Welfare Act (ICWA) advisory board meetings, and conducting a series of focus groups with Oregon tribes to gather feedback to contribute to the DR planning process. DHS described other ways that they have tried to address issues of disproportionality at the state level, including a focus on the root causes of poverty, workforce representation, contracting, and culturally appropriate messaging.

### Initiative Fatigue

Although administrators and managers at the state and district levels clearly articulated how simultaneous implementation of the three-legged stool promotes better child welfare practices, some interviewees

suggested that the extent of change was at times confusing and overwhelming for staff and community partners. The volume of coinciding initiatives to change child welfare practice and a history of initiatives that stalled before full implementation caused line staff and community partners to be skeptical that DR would actually happen.

*Recommendation*: As subsequent districts begin to plan for the implementation of DR, careful consideration should be made regarding the timing of implementing SPRF services and participating in the OSM Refresh. It may be most effective to ensure that staff members are comfortable with OSM and SPRF services before a district office begins implementing DR. This is especially true in terms of staff members being trained in one initiative before delving into a new practice.

## Initial Implementation

During the initial implementation stage, the DR model was developed from a conceptual framework to a practice model with more clearly articulated terminology, policies, tools, materials, and goals. In this stage, a range of activities were completed to put the practice model into action. According to the NIRN framework, it is essential to address three types of drivers during this initial implementation stage to create successful changes.

### Organizational Drivers

Organizational drivers are factors within an organization that support the smooth implementation of an intervention. There were a few organizational factors that supported the implementation and sustainability of the DR model. First, DHS recognized the importance of generating support for the DR model through clear communication with district staff and community partners. A communication plan was created to share information about the implementation of DR across the state. As part of the communication plan, the DHS child welfare director regularly sent emails to district offices, providing information about DR and the progress being made toward implementation and addressing frequently asked questions. Several interviewees indicated that these communications were extremely helpful. District administrators often forwarded these communications to internal staff and community partners so that both groups were aware of the changes that were about to occur, creating buy-in for the DR implementation process. This concerted effort to communicate to staff and community partners helped ensure that there were few concerns to the implementation of DR.

The combination of communication and the DR model's flexibility (described above under evolutionary process) appeared to be a strength during the early stages of DR implementation. Because there were still many details to be worked out when DR practice was rolled out in the first two districts, the lack of clarity for administrators and workers was an inevitable challenge. However, the established modes of communication and pathways to iterative change enabled relatively quick adaptation as district-specific challenges became apparent.

*Recommendation*: These communication efforts should continue as DR is implemented in new districts. These efforts should target child welfare staff members and partners in the local communities.

There were several other system-level factors that supported the successful implementation of DR. The OSM Refresh and SPRF funding complemented the implementation of DR by providing a broad context for a larger system change. The funding specifically designated for DR was limited: there were only five funded DR positions in central office; additional general funds were allocated to increase the number of DHS workers at the district level, but these positions were not specifically designated for DR. According to DHS leadership, this gave the department greater flexibility and stability for DR, as any reduction in DR funding would only affect a small number of DR positions in central office.

Finally, the availability of data to drive decision making is vital to the continuous quality improvement process. At the state level, administrators have access to a variety of metrics related to workload and staff performance, which can be used to monitor and improve DR practice. At the district level, administrators can gather data on multiple measures, although some line staff and supervisors raised concerns in interviews about the degree to which these data sources accurately reflect the context and fluctuations of day-to-day child welfare practice.

### Leadership Drivers

Leadership drivers are the methods used by the individuals responsible for implementation to promote and drive the change process. Interviewees described leaders as the individuals directly responsible for leading the implementation efforts and addressing issues as they arose. Seen through another lens, leaders were seen as champions of the cause, the individuals who would advocate for the model despite the inevitable challenges.

At the state level, interviewees indicated that a variety of individuals and organizations took on a leadership or champion role. All members of the DHS leadership team were recognized for their advocacy and work toward the success of a smooth DR transition during the exploration and implementation stages. In particular, the DR program manager was explicitly identified as a leader for the advancement of DR because of her ability to engage in the effort on multiple levels. Other individuals mentioned as real advocates in the implementation of DR included the DHS child welfare director and the DR consultants. Casey Family Programs reportedly played a vital role in the implementation of DR by providing valuable consulting services and other resources.

At the district level, interviewees suggested the need to identify champions who are able to foster support for the DR model from internal and external audiences. Champions at the community level possess referent power within the community, meaning that their local roots enable them to influence policy. Staff members described this influence as especially important in the initial stages of implementation, when concerns raised by people skeptical of the DR model were addressed, which in turn often created champions out of former skeptics.

Interviews with district staff revealed a wide range of champions involved in the implementation of DR. Workers in almost every focus group identified their coworkers as champions, including consultants, screeners, caseworkers, and supervisors, pointing out that successful implementation requires the effort of everyone involved.

### Competency Drivers

Competency drivers ensure that practitioners can effectively perform the new work that needs to be done following implementation. The structure and success of competency drivers have an immediate practical impact on the success of DR practice.

Staffing: When DR was introduced, staffing configurations at the state and district levels changed for a host of reasons. Experienced supervisors were reassigned from district offices to become DR consultants with central office. Although interviewees viewed it as beneficial to have the expertise of these seasoned workers in the field as DR consultants, replacing them at the district level was challenging because it meant moving less-experienced staff members into supervisory roles during the transition.

Another staffing challenge at the district level was knowing how many caseworkers to assign as AR workers and how many caseworkers to assign as TR workers. District 5 and District 11 initially divided their staff into two teams consisting of exclusively AR or TR workers. However, citing difficulty with

finding the right balance of AR and TR caseworkers and internal conflict arising from the notion that AR cases were "fluff" compared to TR cases, district administrators eventually moved toward blended teams with caseworkers trained to take cases from both tracks. Caseworkers who had been on staff for longer were observed as having more difficulty with the transition to a two-track system than younger caseworkers. Many district staff discussed DR's effect on caseworker caseload. Interviewees indicated that caseworkers began to feel more stretched around the time DR was being implemented, although the extent to which DR figured into this change is unclear.

*Recommendation*: Staffing configuration is an important consideration for new districts as they implement DR. The first two districts found that mixed caseloads eased some of the staffing tensions experienced immediately after DR implementation in their sites. New districts should take this into consideration in determining their own DR staffing structure.

Training*:* One of the subcommittees of the DR implementation team was devoted to developing a training and coaching plan. DHS contracted with a curriculum writer who had assisted with DR curriculum development in other states. DR consultants and other content experts at central office worked with the writer to develop the curriculum for Oregon. DR consultants administered the training modules in District 5 and District 11.

One of the strengths of the training process was that it seemed to evolve as the DR model evolved. District staff provided feedback regarding their experiences in trainings and the modules were revised between iterations. Yet, district staff suggested that the trainings were repetitive and that sessions could have been shorter because they were not always a productive use of the staff's limited time. DR consultants and screeners wanted some of the trainings to be more complex to prepare them for the difficult "gray areas" often encountered in the field. The timing of the trainings was also reported to be a difficulty. In District 5, DR training occurred around the same time as the OSM Refresh and the establishment of SPRF services; in District 11, DR training occurred about a year after the OSM Refresh training. There seemed to be a "saturation" of trainings, especially in terms of the meetings and discussions that occurred before DR rollout began during the readiness phase.

*Recommendation*: Now that the DR training has been conducted in a few districts, it would be helpful to reflect on how the training can be improved for future rounds, reducing duplication and redundancies. This could be done in consultation with the original DR training subcommittee. Because the model continues to evolve, it would also be useful to regularly provide a "DR Refresh" in districts where DR has been implemented; this would allow central office to share the progress of the state rollout, reiterate important components of the DR model, and address questions that staff members may have.

Coaching/DR Consultants: Eight DR consultants filled a coaching role and helped facilitate the transition from training to application, ensuring that skills were being appropriately used in daily activities. District staff often praised DR consultants for their availability, arriving onsite prior to implementation, and often remaining onsite for several months after implementation to ensure that staff members could easily ask for assistance when challenging situations arose. The consultants' hands-on approach eased doubts and gave encouragement to workers; this approach was described as invaluable. DR consultants were generally seen as highly engaged at multiple levels, often available to go out in the field with caseworkers or sit in on meetings with other staff members.

Although the caseworkers offered predominantly positive feedback regarding the coaching they received, some indicated that there seemed to be a lack of consensus on how consultants should transition out of the district offices after DR was successfully implemented. Some interviewees reported that there were inconsistencies in the advice that different DR consultants gave them. Interviewees also raised concerns

about the sustainability of the coaching model, indicating that attention needs to be paid to avoiding DR consultant burnout.

*Recommendation*: As DR continues to be implemented across the state, the need for consultation resources is likely to be significant. It is important to have a clear plan for how these positions can best support the increasing number of districts that may need assistance. In particular, one concern is that the staff in these positions will be stretched too thin in terms of travel and knowledge of the district offices they are supporting. It is important to anticipate how much time DR consultants will be able to allocate for each district and to be aware of the effects on consultants (e.g., amount of travel, burnout). One district manager recommended the development of a timeline and exit strategy so that everyone is clear on the availability of DR consultation for each district. Given that DR consultants may be less available in districts that implement DR later, it is important to develop a peer-support network in which district staff in neighboring or similar communities can offer support and assistance to districts that have recently implemented DR.

Supervision: In the context of DR, supervision is the process by which staff receive feedback on the work they perform. District supervisors were generally described as readily available to caseworkers. Caseworkers frequently depicted scenarios in which they could simply walk over to a supervisor and immediately receive assistance with questions regarding their cases. In general, supervisors appeared to proactively make themselves available, sometimes during lunch or while at an appointment if another supervisor wasn't available. District caseworkers seemed to be appreciative of this hands-on, practical form of support. Yet, some supervisors indicated that they struggled in providing expertise on a model that they were less familiar with and felt the pressure of learning a new system alongside their caseworkers.

*Recommendation*: As new districts implement DR, it is important to ensure that supervisors have a solid understanding of the DR model. Adequate supervisor training is crucial to their ability to support their workers in adopting this new practice model. This may be an area in which additional training and mentoring opportunities could be developed to support future rounds of implementation.

Performance Assessment: Interviews with district staff members yielded mixed feedback regarding performance assessment. Caseworkers from both districts indicated that most of their overall performance assessment came from informal meetings with supervisory staff. This appeared to be a welcome practice, as caseworkers appreciated knowing which areas they could improve in as they worked, rather than only learning this information in their annual reviews. Formalized evaluations, however, were reported to occur infrequently and to varying degrees. Caseworkers almost exclusively referred to Employee Development Plans (EDPs) negatively, citing their minimal utility and too-frequent updating. Some supervisors agreed with this stance.

## DR Practice

After several years of exploration and planning, the Oregon two-track DR model was formally launched in May 2014 in District 5 and District 11. During site visits, staff members described how the implementation of DR has changed the way that child welfare workers screen, assess, interact with, and support families. Staff members also explained how the two-track system has changed workers' roles and responsibilities.

### Screening and Track Assignment

Interviewees described how the child welfare screening process changed after the implementation of DR. If a child abuse report is screened that constitutes an allegation of abuse or neglect, screeners must now determine whether the case is eligible for the AR track or the TR track. To make this determination,

screeners use Oregon's track assignment tool. The track assignment tool provides criteria for which types of cases have to be assigned to which track and examples of allegations for AR and TR cases. When DR was first launched, it was not always clear which types of allegations were better suited for the AR or TR track. Therefore, when DR was first implemented, screeners relied on the examples listed on the track assignment tool because they were not confident in their ability to make a subjective judgment about track assignment. Screeners indicated that this decision-making process is a vital component for screeners to learn in the DR trainings. Because it is not always clear which track a case should be assigned to, District 5 and District 11 utilize a group decision-making process to address the challenges of track assignment. District staff members spoke highly about these group meetings, commenting that they provide an opportunity for group learning regarding how AR eligibility determination decisions should be made.

Screeners described how their responsibilities increased after the implementation of DR. To determine whether a case is eligible for AR, screeners are now making more collateral calls, researching a family's history with child welfare, and completing the track assignment tool. In the site visit interviews, screeners expressed frustration about their workload, concerns about inadequate training for new screeners, and a desire for more support. There is a sense that DR has increased the workload for screeners and that current staffing is not adequate to cover these additional screening responsibilities.

*Recommendations*: Interviewees made several recommendations about the eligibility decision-making process. First, now that the criteria are clearer, DR training for screeners can be enhanced to ensure that screeners understand the process and make consistent screening decisions. District 5 and District 11 adopted a group decision-making process to help determine track assignments. This was especially helpful when DR was first implemented, providing an opportunity for group learning and assistance for screeners in making track assignment decisions. As new districts begin to plan for rollout, managers should give adequate attention to their screening units, in terms of ensuring adequate staffing levels, providing training for screening staff, and eliciting feedback during the implementation process to see how the screeners are doing.

### Initial Contact

After a screened report has been assigned as an AR or TR case, the caseworker is responsible for the initial contact with the family. A major difference in practice between AR and TR cases is that the family assigned to the AR track should receive a phone call from caseworkers prior to the initial in-person meeting (TR cases traditionally receive an unannounced initial visit from their caseworker). When a caseworker calls a family assigned to the AR track, the caseworker asks for their scheduling preferences for the initial meeting and whether they would like to have a support person at the initial meeting. Several caseworkers commented that this initial phone call helps establish a better relationship between families and workers, decreasing some of the hostility that the family might have toward their assigned caseworker. There was some concern about this approach to initial contact because giving families greater decision-making power can be uncomfortable for families as they are used to being told what to do. Caseworkers also indicated that it is sometimes difficult to schedule a time for the initial meeting given the client's availability.

### Family Engagement

A key aspect of the DR model is caseworkers' effort to engage the family, collaboratively working to identify and address family needs. In an effort to emphasize the importance of family engagement in DR practice, one of the DR subcommittees was assigned to focus on family engagement, developing a family engagement training module and toolkit for caseworkers. A range of interviewees reflected on how family engagement has been interwoven into AR practice; they also commented on how this focus on family engagement has filtered into broader TR practice. In an effort to engage families more, families are asked

to contribute more when designing safety plans, and caseworkers are trying to use language in the safety assessments that is less formal and easier to understand. Overall, there is a common perception among caseworkers that the emphasis on engaging families has positively changed the interactions between families and caseworkers, regardless of track assignment.

### Risk and Safety Assessment: the OSM

The OSM is Oregon's practice model that guides safety decision making through the life of a child welfare case. The OSM is used at all stages of a case, from initial assessment to case closure for the purpose of ensuring child safety. Interviewees described how OSM has changed the child welfare assessment process since it was implemented in 2006: the assessment is now more of a summary, rather than a detailed, chronological report, and safety service providers now have greater oversight of domestic violence cases.

Interviewees from many organizational levels reflected on the degree to which the OSM is being implemented with fidelity. Several individuals at both the state and district levels indicated that there has been a lot of training about OSM and as a result, staff are getting better at implementing OSM with fidelity. Some interviewees believe that there is more fidelity to OSM with founded cases because these case will get more attention and staff want to make sure they have covered everything that they are supposed to. Interviewees expressed concern about the lack of a clear definition of what constitutes child safety; the use of the OSM has not decreased the volume of child welfare cases as expected. Despite remaining concerns about OSM fidelity, several interviewees spoke positively about the potential to improve fidelity.

*Recommendation*: One component of this DR evaluation is to conduct a fidelity assessment of the OSM. This is an important activity to fully comprehend the degree to which the model is being implemented with fidelity, especially among different types of child welfare cases.

### Family Strengths and Needs Assessment

The Family Strengths and Needs Assessment (FSNA) is the instrument used to assess family strengths and need and determine which individualized services may be offered to improve family functioning. Families in either the AR or TR tracks can receive the FSNA as long as no safety threats exist and the family is identified as having moderate to high needs. Contracted service providers meet with families and have 15 days to complete the FSNA assessment. After the assessment is completed, the family, provider, and caseworker participate in a case closure meeting and discuss the next steps.

Although some service providers and supervisors made a few positive comments about the utility of the FSNA, caseworkers and supervisors discussed frustrations with the FSNA. First, they saw the FNSA as unnecessary because caseworkers have usually already identified family needs, and families are less engaged in the FSNA process because they have already been assessed by caseworkers. Second, the interviewees regarded the FSNA as inefficient because providers have reportedly spent more than 15 days on completing the assessment. Last, caseworkers and supervisors believed that service providers lacked the proper skill and training to conduct the FSNA. In general, interviewees agreed that this process of assessing families for individualized service needs was cumbersome and duplicative. This process has created frustration among workers and managers.

*Recommendation*: Overall, this assessment process should be revisited and refined to reexamine the function and purpose of the tool.

### Strengthening, Preserving and Reunifying Families

The introduction of SPRF funding has improved service availability in District 5 and District 11 by providing access to more services and encouraging partnerships that did not exist prior to funding. In particular, SPRF funding has given families access to an array of services that were not available in the past: housing services, mental health services, family navigators, and a relationship-building program. However, many obstacles still remain for the provision and availability of services in local communities, including long waitlists for services such as housing and mental health treatment; lack of sustained services for families; lack of services such as child care or transportation; and the challenge of providing services to families in rural areas.

### Culturally Responsive Services

District staff members reflected on the availability of culturally responsive services in their communities. District 11 interviewees indicated that they have improved services for the Native American population by hiring an in-home navigation provider who can provide culturally appropriate support for tribal families. DHS has also strengthened its relationship with a local tribal health organization. Native American families have a DHS child welfare worker and an Indian Child Welfare Act caseworker, enhancing their ability to support families. Staff members in District 11 did indicate a lack of culturally responsive services for the Hispanic population. Interviewees in District 5 indicated that many local organizations have been focused on addressing cultural competency, specifically for the Hispanic population. DHS has reached out to work with local organizations to develop culturally appropriate services. DHS has also identified bilingual service providers in almost every service category. Although improvements have been made in these areas, interviewees indicated that more culturally responsive services are needed for the rapidly growing Spanish-speaking population.

### Relationships with Community Service Providers

The introduction of SPRF funding and DR has positively affected relationships between community partner organizations and DHS: communication has improved, existing relationships have been strengthened, and new relationships have been formed. Families have benefited from better communication and collaboration among community providers regarding how to support the family and their needs. In implementing DR, Districts 5 and 11 did not experience significant pushback from the community. When there was pushback, it stemmed from confusion about the change in practice (e.g., changes in the severity bar, when law enforcement should accompany caseworkers for visits), rather than concerns about the two-track system.

### Reassignment

Over the course of an AR case, safety threats may arise, and caseworkers must reassign an AR case to the TR track. There was a consensus among interviewees that families were being appropriately reassigned from AR to TR when a safety threat arose.

### Case Closure

The guidelines for the length of time that cases should be open have changed with the implementation of DR, providing an extra 15 days for all CPS assessments in order for caseworkers to complete the FSNA. Some interviewees stated that the service providers have difficulty completing the FSNA in 15 days because they have to coordinate with families, conduct the assessment, and then hold the case closure meeting. Interviewees described the resulting concerns about overdue CPS assessments. For both districts, this issue of the case closure process is a source of stress for service providers and child welfare.

# 1. Introduction and Purpose of Report

In November 2014, the Oregon Department of Human Services (DHS) contracted with the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign to conduct a comprehensive evaluation of Differential Response (DR) in Oregon. DR is a nationally recognized approach that creates a multi-track system enabling child protective services to respond differently to reports of child abuse and neglect depending on a multitude of factors and depending on the jurisdiction. In Oregon, track assignment is based on the type and severity of a report. The intent of this comprehensive evaluation is to understand how DR was developed and implemented in Oregon (the process evaluation), and to explore the effects of DR on children and families in the child welfare system, in terms of outcomes for children (the outcome evaluation) and the amount of resources necessary to implement and maintain DR in Oregon (the cost analysis). The University of Illinois, in partnership with Pacific Research and Evaluation, will work closely with the Oregon DHS staff over the next three years to gather information and data through a wide variety of methods to successfully complete these three components of the Oregon DR evaluation. Further details about evaluation activities can be found in the Oregon DR Program Evaluation Plan, available on the Oregon DHS website.

The process evaluation includes three areas of inquiry: 1) a DR implementation evaluation that describes the implementation process at the state and local levels and DR practice, 2) a fidelity assessment of the DR model, and 3) a fidelity assessment of the Oregon Safety Model (OSM). This Year 1 Site Visit Report describes the implementation process using information gathered through site visits conducted in two Oregon DHS district offices, in addition to focus groups and interviews with key individuals at the state level, which were conducted in the summer of 2015.[4] Collecting information on program implementation and practice enables program managers and administrators to make midcourse modifications if early feedback suggests that aspects of DR are not working as anticipated. Over the course of this evaluation, two rounds of site visits will be conducted in each of the four districts that implemented DR prior to June 2015, providing DHS with updated information regarding the successes, challenges, and lessons learned as DR is implemented across the state.

This report provides an overview of DR implementation in Oregon in terms of how the model was developed at the state level and first implemented in two districts. Starting with the early stages of exploration, the report first describes the process of defining the DR model at the state level. This section describes how state-level DHS staff led this process and incorporated the perspectives of other state-level stakeholders who participated in the early development stages. Next, the report describes how the state worked with the two districts as they prepared to implement the two-track model in their local child welfare systems. This discussion focuses on the organizational modifications that were made to ensure successful implementation at the local level. The report then describes how child welfare case practice has changed as a result of the adoption of a two-track system. This section also discusses how service delivery and relationships with community partners have changed since DR was implemented. The report concludes with a summary of successes and challenges discussed during the site visits and recommendations based on the information collected through the site visit process.

[4] For simplicity's sake, throughout this report we will refer to "site visits." This includes the focus groups conducted during the site visits and the focus groups and interviews with state-level staff members.

Throughout this report, discussions are framed in terms of the National Implementation Research Network's (NIRN) implementation science framework, which Oregon adopted to ensure successful implementation of the DR model. This framework draws upon extensive research and literature on best practices regarding how a new initiative should be put into practice. According to the NIRN framework, the implementation of a new initiative progresses through four distinct stages: exploration, installation, initial implementation, and full implementation. The exploration stage includes the assessment and creation of readiness for the intervention, a critical component of an effort's early stages. The installation stage consists of preparing for the reconfiguration of the existing system and planning for the implementation stage. In this stage, guiding resources, policies, and procedures are developed and modified in preparation for the change in practice. The initial implementation stage encompasses efforts to establish and sustain changes such that the intervention becomes integrated into a new way of working. The initial implementation stage is used to develop staff competencies, help administrators adjust organizational roles, and ensure the sustainability of effective practices. The final stage is full implementation, when the new initiative is fully operational and has become business as usual; at this point, the new practice is delivered with fidelity and achieves the intended outcomes.

For successful implementation of a new initiative, NIRN defines three important drivers: competency, organizational, and leadership, each of which encompasses specific factors that influence the success of implementation. First, to ensure the competency of staff members, NIRN suggests the importance of considering how staff members are selected, trained, and coached to deliver the new initiative. Second, implementation is more often successful when there are designated administrators to facilitate the implementation and organizational support (e.g., policies, funding) and data systems to support a new initiative. Third, it is important that there is clear leadership for the new initiative as it evolves and encounters obstacles to change along the way. These three NIRN implementation drivers provide a framework to guide administrators in enhancing the likelihood of successful implementation of a new initiative.

The implementation science framework provides guidance to administrators for how to successfully integrate a new intervention into existing practice. This framework was used to guide the process of establishing the DR model in Oregon. As such, this report will use the implementation stages and drivers framework to describe what happened in each implementation stage as DR was rolled out across the state.

# 2. Methodology

As a subcontractor for the University of Illinois, Pacific Research and Evaluation is responsible for conducting the site visits for the Oregon DR evaluation. This section will describe how the site visits were planned and conducted and how the information gathered during the site visits was compiled and analyzed for this report.

## 2.1. Instrument Development

The focus group and interview protocols were developed in collaboration with the DHS DR staff. A set of questions was developed to assess the early implementation activities and the core implementation drivers as described in the NIRN implementation framework. A second set of questions assessed topics within

DR case practice. Although each interview guide was tailored to the intended audience, the guides included a common set of questions. These questions were categorized into several areas of inquiry:

- Exploration: impetus for DR, other child welfare reforms, input from others
- Installation: DR model, data development, community buy-in
- Implementation drivers: organizational and contextual factors, system intervention, leadership, facilitative administration, decision-support data systems, staff selection, training, coaching, supervision, performance assessment
- DR practice: general, screening, CPS assessment, reassignment, strengths and needs assessment, services, case closure, community partners

The interview guide for district administrators is included in Appendix A. Other interview guides are available from Pacific Research and Evaluation upon request.

## 2.2. Participant Recruitment

In the summer of 2015, site visits were conducted in the first two districts that implemented DR in Oregon: District 5 (Lane County) and District 11 (Klamath and Lake Counties). Additional focus groups and interviews were conducted with staff from DHS's central office and other key stakeholders in the state. Pacific Research and Evaluation staff were responsible for setting up site visits and recruiting the appropriate individuals to participate.

In the spring of 2015, the DR program manager gave Pacific Research and Evaluation the contact information for the district managers in District 5 and District 11. Pacific Research and Evaluation worked with the district managers to explain the site visit process, develop a site visit schedule, and identify individuals to invite to the focus groups. In each district, separate focus groups were held with managers and administrators, supervisors, CPS workers, screeners, community partners, and service providers. District staff notified all potential participants of the schedule, and Pacific Research and Evaluation followed up with an invitation that included the following information: the focus group schedule, an informed consent form, and information about how to contact Pacific Research and Evaluation staff if potential participants had questions. A site visit was conducted in District 5 in May 2015 and in District 11 in June 2015.

Pacific Research and Evaluation also conducted a series of focus groups and interviews with staff members involved in the development and implementation of the DR model at the state level. Pacific Research and Evaluation staff members worked with the DR program manager to identify individuals to include in these meetings. The DR program manager helped to schedule two focus groups in Salem, one with the DHS leadership team and one with the group of DR consultants. The DR program manager also provided Pacific Research and Evaluation with a list of state partners who were involved in initial model development. Pacific Research and Evaluation contacted these individuals directly to schedule a time to conduct a telephone interview. State partners who were interviewed included individuals representing the Confederated Tribes of Grand Ronde, the Portland State University Child Welfare Partnership Training Program, two contracted service providers in Multnomah County (including one that serves the African American community), the Oregon Judicial Department Juvenile Court Project, the National Resource Center for Child Protective Services, and Casey Family Programs. These state-level interviews and focus groups were conducted between June and August of 2015.

In total, 79 individuals participated in 14 focus groups or interviews for this round of site visits. Table 1 lists the individuals who participated in these data collection efforts.

**Table 1: Participants in District- and State-Level Focus Groups and Interviews**

| Role | District 5 | District 11 | State | Total |
|---|---|---|---|---|
| Leadership | 7 | 2 | 7 | 16 |
| Supervisors | 6 | 6 | n/a | 12 |
| CPS workers | 7 | 8 | n/a | 15 |
| Screeners | 4 | 3 | n/a | 7 |
| State/District partners | 7 | 4 | 8 | 21 |
| Service providers | 2 | | n/a | |
| DR consultants | n/a | n/a | 8 | 8 |
| **Total** | **33** | **23** | **23** | **79** |

Throughout the report, there are references and quotations attributed to people of various roles. For consistency, Table 2 lists the position titles used in the report:

**Table 2: Position Titles Used in the Report**

| Role | State Level | District Level |
|---|---|---|
| Leadership | DHS leadership | District administrator |
| Supervisors | n/a | District supervisor |
| CPS workers | n/a | District worker |
| Screeners | n/a | District screener |
| State/District partners | State partner | District partner |
| Service providers | State partner | District partner |
| DR consultants | DR consultants | n/a |

Focus groups and interviews lasted one to two hours, depending on the number of questions asked. At the beginning of each focus group or interview, a Pacific Research and Evaluation staff member explained the intent of the focus group or interview, how the information gathered would be used, and that the session would be recorded. Participants were then asked to review, sign, and return the informed consent form to Pacific Research and Evaluation. At this point, the audio recorders were turned on and the focus group or interview began. At the end of the focus group or interview, a Pacific Research and Evaluation staff member asked participants if they had any additional questions and thanked them for their participation.

## 2.3. Data Analysis

When the site visits and interviews were completed, audio recordings were transcribed by an independent transcription service. Pacific Research and Evaluation then used a qualitative software package, Dedoose, to conduct the analysis of the information gathered during the site visits. Dedoose is a web-based mixed-methods software application that allows users to identify numerous topical areas of interest and then code all interview data into these areas of interest. Dedoose allows large amounts of qualitative data to be consolidated into more manageable groupings of information.

For this project, a coding tree was developed that reflected the topics included in the site-visit interview guides. The transcripts were then imported into Dedoose. After discussing the coding tree as a group, three members of the evaluation team at Pacific Research and Evaluation independently coded a single focus group transcript. In reviewing this coding as a group, these staff members discussed the coding process and developed more clarity and consistency for subsequent coding. Team members then coded all transcripts into major topics of interest (nodes). For the next round of coding, each team member took the lead on a section of the report (i.e., exploration, installation, implementation, or DR practice), reviewed

all information coded in these sections, and applied sub-nodes as appropriate. By completing this process, team members were able to review entire sections of interview data, identify themes, and check for coding consistency. A holding node was created to bookmark any inconsistencies or disagreements in coding practices; this node was reviewed by team members, and recoding was completed as needed. At this point, each staff member was responsible for using Dedoose to compile interview data, with attention to identifying themes or variations in responses and selecting illustrative quotations to include in the report. Based on the topics of interest and the coding tree, a detailed outline for the report was developed. During the writing process, team members met frequently to share findings and discuss how findings should be compiled into this report.

It is important to note that quotes are integrated throughout this report and are usually word-for-word quotations, although some have been modified to enhance readability and grammar.

# 3. DR Program Description

This section provides a basic description of the DR model, introduces DR language, and describes other child welfare initiatives that will be discussed in subsequent sections of this report. The information provided in this section was compiled through a review of materials provided to Pacific Research and Evaluation and available on the DHS website; these descriptions reflect DHS documents, not information collected during the site visits.

## 3.1. Oregon Differential Response

At the heart of the DR model is the description by the leadership at Oregon DHS of how DR fits into the broader child welfare system in Oregon. Child Welfare Director Lois Day describes DR as a system change that "redesigns the front door to child welfare." According to the DHS website, "DR moves away from a one-size-fits-all approach to child protection by adding an alternate response track. Differential Response promotes partnering with parents, family, communities and neighborhoods to keep children safe."[5] As DHS Director Erinn Kelley-Siel stated, "Differential Response is central to our efforts to preserve families, keep children safe, and avoid foster care entry wherever possible."

More specifically, the Oregon DR brochure[6] describes how the model has the potential to change the experience of families involved in the child welfare system:

> Differential Response is a family-centered approach for families struggling with issues of child abuse or neglect. Differential Response includes two tracks, an Alternative Response and a Traditional Response. Oregon calls this approach "Safe Children—Strong, Supported Families" because children can stay with their family when they are able to:
>
> - Act immediately and decisively to deal with threats to their child's safety;
> - Assist in adequate safety planning to manage threats to a child's safety; and

[5] http://www.oregon.gov/dhs/children/differential-response/Pages/default.aspx
[6] https://apps.state.or.us/cf1/DHSforms/Forms/Served/de1562.pdf

- Be supported by family, other supports, or community partners who can help them when they can't do it alone.

The intended outcomes of DR are articulated by DHS in the DR Vision Statement:[7]

> Oregon's vision for DR is that as a result of its implementation, the state will see the following outcomes:
>
> - Children will be kept safely at home and in their communities using the OSM and its core concepts and tools to guide decision making;
> - The community and Oregon DHS will work in partnership with a shared responsibility for keeping children safely at home and in their communities;
> - Families will partner with Oregon DHS to realize their full potential and develop solutions for their challenges;
> - Fewer children will re-enter the child welfare system through improved preventive and reunification services for families;
> - Disproportionality will be reduced among children of color[8]; and
> - Private agencies and community organizations will experience stronger partnerships with Oregon DHS on behalf of children and families.

In addition to the above overview of the vision for DR, it is helpful to briefly describe some of the basic components of the two-track system with the key terms that will be used throughout this report and to clearly delineate the differences between the two tracks. Broadly defined, DR is an approach that allows child protective services (CPS) to respond differently to accepted reports of child abuse and neglect. In Oregon, DR consists of a two-track system: Traditional Response (TR) and Alternative Response (AR). (Flow charts for the AR and TR tracks are included in Appendix B.) Both require a comprehensive CPS assessment using the OSM to guide safety decision making. TR devotes substantial attention to evaluating allegations of maltreatment and determining whether these allegations are substantiated. AR focuses on the assessment of family needs through enhanced engagement strategies. Both response types offer optional services to families identified with safe children and moderate to high needs. AR deemphasizes forensic interviewing and sets aside fault finding and the substantiation of maltreatment allegations and entries into the child welfare central registry. Factors that are considered in making decisions about the initial response track (TR or AR) assignment include the type and severity of the allegations. Table 3 highlights the differences between the TR and AR tracks.

[7] http://www.oregon.gov/dhs/children/differential-response/Documents/DR-vision-statement.pdf

[8] Disproportionality in the child welfare system is defined as the overrepresentation of children from racial and ethnic minority groups who are involved the child welfare system. Nationwide, minority populations have higher rates of investigations and foster care placements and lower rates of service provision, relative to the white child welfare population.

**Table 3. Differences between Traditional Response and Alternative Response Tracks**

| Traditional Response (TR) | Alternative Response (AR) |
|---|---|
| Comprehensive Safety Assessment on allegations of physical abuse, sexual abuse, and severe harm | Comprehensive Safety Assessment on allegations of neglect and no severe harm |
| Typically 24-hour response | Typically 5-day response |
| No scheduled joint first contact with community partner offered | Scheduled joint first contact with community partner offered |
| Agency driven | Family driven |
| Individual interviews | Family interviews |
| Disposition/finding required | No disposition/finding required |
| Central Registry entry as indicated | No entry in Central Registry |

The two-track system provides a differentiated response to a report of child abuse and neglect, but DHS clearly emphasizes the common principles of traditional CPS (TR) and the AR track:[9]

- Both focus on the safety and well-being of the child;
- Both promote permanency within the family;
- Both recognize the authority of CPS to make decisions about removal, out of home placement, and court involvement, when necessary; and
- Both acknowledge that other community services may be more appropriate than CPS intervention in some cases.

Subsequent sections of this report will provide significantly more detail for many of the components described above. This section is intended to provide a brief overview of DR prior to delving into the feedback gathered through the Year 1 site visits.

## 3.2. Contemporaneous Child Welfare Reform Efforts

To understand DR in Oregon, it is important to be familiar with several other statewide child welfare initiatives that were being implemented at the same time that DR was being developed and implemented. Several of these efforts are briefly described below, providing context for subsequent discussions in this report. These descriptions were taken from a November 2013 presentation at a legislative session to help state legislators understand the broader context of child welfare efforts across the state.[10]

Safe and Equitable Reduction of the Number of Children Experiencing Foster Care in Oregon: In 2009, Oregon DHS partnered with the Oregon Commission on Children and Families and Casey Family Programs to lead an initiative to identify strategies to safely and equitably reduce the number of children in foster care in Oregon. In particular, this initiative sought ways to:

- Increase the number of children who can safely remain in the home;
- Increase the number of children safely and successfully returning home;

[9] From a PowerPoint presentation on the DHS website: http://www.oregon.gov/dhs/children/differential-response/Documents/about-or-dr.pdf
[10] Legislative presentation November 2013: Lois Day and Stacy Lake: http://www.oregon.gov/dhs/children/differential-response/Documents/DR-legislative-presentation.pdf

- For those children who cannot return home, increase the number who can exit the system to a achieve greater permanency;
- Tend to the health, education, and well-being of children while they are in care; and
- Address the disproportionate representation of children of color in the system.

To accomplish these goals, three primary strategies were identified for implementation:

- OSM Fidelity Work:[11] Ensures that the right children and families are served at the appropriate level of intervention;
- Statewide Implementation of SB964/Strengthening, Preserving, and Reunifying Families (SPRF) services: Enhances the foundational service array for DR and the provision of ongoing child welfare services; and
- Oregon's Model of DR: Implements within the child welfare program an additional track designed to give families more of a voice in their services and less consequences from being involved with child welfare services.

Below is a brief overview of the OSM and the SPRF legislation, again taken directly from the November 2013 legislative presentation:

The OSM is a structured decision-making assessment process that focuses on improving safety assessments by:

- Instituting an overarching process that requires safety assessment and management at all stages of case management from screening through case closure;
- Emphasizing child safety by focusing on overall family functioning as opposed to whether an incident of abuse occurred or not;
- Including a comprehensive approach to the assessment of parents' ability to keep their children safe by clearly identifying conditions for safety within the family and conditions for return and the provision of any needed services;
- Focusing on safety threats using safety threshold criteria, not risk;
- Enhancing the OSM through DR, not deviating from that model;
- Refreshing and enhancing supervisors' understanding of the elements and applications of the model through training and intensive field consultation; and
- Building additional field consultation into ongoing support for the practice.

Although the OSM was first implemented in 2006, the model was not implemented with fidelity across the state. For this reason, DHS developed the OSM Refresh to retrain staff on the core components of the model. The OSM Refresh roughly coincided with the implementation of DR in the first two districts.

[11] Referred to in this report as the Oregon Safety Model (OSM).

SB 964 – Strengthening, Preserving, and Reunifying Families (SPRF): According to the DHS SPRF brochure,[12] in June 2011, Governor John Kitzhaber signed into law Senate Bill 964, which requires the DHS, child welfare division to provide extensive services to each family throughout the case.

The focus of the directive is to reduce the amount of trauma to children and families by offering additional family-focused services starting at the assessment phase of the case and extending into aftercare services when children are returned to their families. The legislative assembly had several findings regarding best practices including:

- Severe trauma may occur when children are removed from their families, resulting in negative future outcomes;
- Improvements in permanency outcomes for children are most likely achieved when services are offered that allow children to remain in their homes when appropriate and safe;
- Keeping families intact while services are provided preserves child-parent bonds and improves outcomes for children and families;
- The duration of stay and level of trauma for children placed in foster care is lessened when family-focused services and routine visits are offered early and often. Continuing services should be offered to children and families when children return to their parents or caregivers; and
- Housing is essential to the safe reduction of the number of children in foster care.

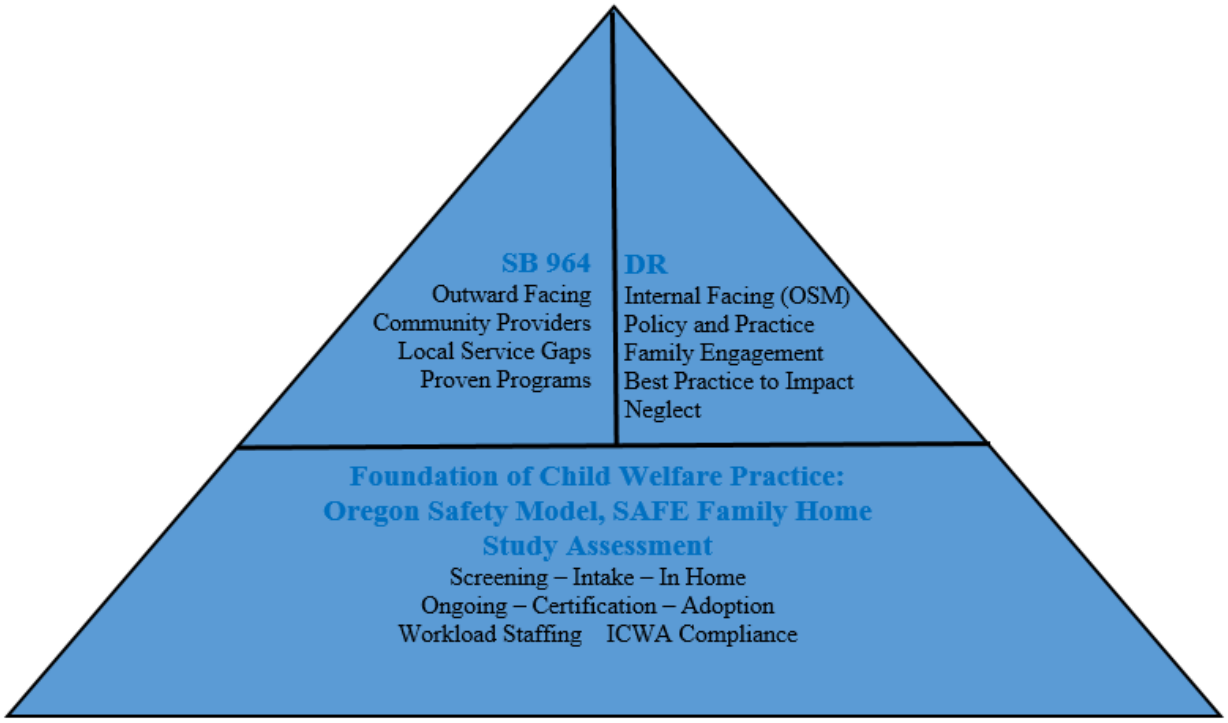
The specific programs implemented as a result of SB964 will include an array of services, which may include the following, depending on resources and availability:

- Mental health and drug treatment providers will accompany DHS staff during the initial visit when responding to an allegation of child abuse or neglect;
- DHS staff and community providers will work with the family in addressing safety concerns, developing safety plans, and facilitating services and visitation;
- DHS and its partners will provide culturally competent services that are evidence-based or evidence-informed;
- DHS and its partners will provide immediate access to supervised drug-free emergency and short-term housing; and
- DHS will provide family-finding services to identify extended family to help with support, resources, or alternatives.

These three initiatives were intended to be implemented concurrently, as depicted by DHS in Figure 1.[13] Often in the course of site visit conversations, the three initiatives are described together to form what DHS leadership describes as the "three-legged stool."

[12] http://www.oregon.gov/dhs/children/differential-response/Documents/SPRF%20Brochure.pdf
[13] Legislative presentation November 2013: Lois Day and Stacy Lake: http://www.oregon.gov/dhs/children/differential-response/Documents/DR-legislative-presentation.pdf

Figure 1: The Three-Legged Stool: SB964, DR, and OSM




As described in the presentation to the legislature in November 2013, the anticipated timeline for Oregon child welfare reform efforts was:

- Complete OSM Refresh trainings by May 2014;
- Conclude statewide implementation of SB 964/SPRF by May 2014; and
- Begin staged implementation of DR in May 2014 in Districts 5 and 11. Implementation continues with groups of two to four districts implementing every six to nine months, with full statewide implementation expected by the end of 2017.

## 4. Exploration Stage

This section of the report reflects on how Oregon decided to adopt this nationally recognized approach to serving families in the child welfare system. According to NIRN, implementation science defines the key activities that should occur in the exploration stage of a new initiative: identify the need that should be addressed, acquire information about the proposed intervention, and disseminate information to gain support. Each of these activities is important in the process of deciding to adopt a new intervention.

As early as 2010, DHS began to research how DR could be integrated into Oregon child welfare practice. This section of the report describes the early context and initial activities that occurred during the exploration stage of DR implementation. The information in this section of the report was primarily gathered through interviews with DHS leadership, DR consultants, and state partners.

## 4.1. Identification of Need

Several influencing factors culminated in the decision to integrate DR into Oregon child welfare practice. In general, DHS was trying to address the needs of families being referred into the child welfare system because of neglect. According to the child welfare director:

> *We were looking for a way to make our program have better impact on families that were coming to us. We had specific concerns around the populations that were founded for neglect because it didn't seem that our traditional intervention really fit the challenges those families brought, and we were not being as successful with those families in keeping their kids out of care. And when they came into care, we weren't being as successful getting them back. So it seemed like we needed to look at our model and see if there was a different way we could go about approaching those families.*

This emphasis on the front end of the child welfare system was driven by several factors. Because of relatively high placement rates, DHS had begun to focus on equity issues in foster care, an effort that was articulated in the state's Safe and Equitable Foster Care Reduction initiative described in Section 3.2. Having spent several years focusing on decreasing placement rates, the Oregon child welfare system had plateaued in its reduction in the use of foster care. Data indicated that removals stemming from founded referrals for neglect continued to be a prominent aspect of the child welfare system. For this reason, DHS began to explore strategies that could positively affect the population involved in foster care. The focus on front-end diversion dovetailed with permanency efforts that DHS had adopted to address the needs of children who had been in placements for long periods of time.

The emphasis on reducing the use of foster care was supported by state partners who were involved in the discussion of equitable reduction of the use of foster care, especially for Native American and African American populations. In 2009, the Child Welfare Equity Task Force was created to identify strategies to address disproportionality in child welfare; this group had begun conversations about why foster care is not always the best answer for children and families who are at risk. From these discussions, the task force recommended a shift from traditional intervention to a more prevention-focused model of child welfare. As one member of the DHS leadership team stated, "They didn't call it DR, but they were asking for it." (Section 5.7 provides further discussion about Oregon's statewide focus on disproportionality in child welfare.)

Another factor that was an impetus for DR was the OSM Refresh, which was initiated to revive child welfare worker use of the OSM adopted in 2006. As one DHS leadership team member stated, "DR really complemented the OSM model in terms of the engagement. DR removed some of the punitive aspects of our investigations that didn't seem as necessary with certain populations as it might be with others, like founded dispositions in the child abuse registry." In addition, there was support from the legislature to move in this direction. Effective advocacy by DHS leadership and changes in fiscal forecasts had resulted in the allocation of resources for OSM, additional resources for child welfare staffing, and funds to provide in-home support services to child welfare families (i.e., SPRF services). This shift in child welfare practices, backed by legislative support and resources, moved DR implementation forward. As the DHS director stated:

> *We had implemented in-home services and were starting to serve more kids at home, and in that process we had learned that there were families for which a founded [report] really probably*

> *didn't make a lot of sense. But we were also unsatisfied because the in-home services we could self-fund and implement had to be of really short duration and we could see that their efficacy in that short timeframe was harder to achieve. We had had these conversations with the legislature going on about additional capacity for supports at the community level. The recession had started to turn a corner, the credibility of the agency and the child welfare system had been turning a corner. The communities in general were saying, "We're okay with this idea." So we had safety model resources; we had a commitment from the legislature to do the staffing piece, which was going to be huge. And then we got buy-in for, "All right, now we'd like to kind of change the way our front door works."*

## 4.2. Acquiring Information

According to the Child Welfare Information Gateway, over the past two decades more than two-thirds of all states in the country have implemented or initiated plans for DR. In the exploration stage of implementation, DHS gathered information from other states to understand how DR was structured in other jurisdictions and how the model might be best adapted for Oregon. For support in this exploration process, DHS worked directly with two organizations that it had relationships with through prior efforts related to OSM and safe and equitable reduction of foster care: Casey Family Programs and The National Resource Center for Child Protective Services (NRCCPS).

Casey Family Programs worked closely with DHS to help gather information on existing DR models, provide a framework for implementation, and build an infrastructure to support DR implementation. In particular, Casey Family Program staff helped DHS compile information from other states, connecting Oregon with jurisdictions that had components of the models that could work well in Oregon (e.g., Minnesota's interactions with tribes about DR). Casey Family Programs provided resources that allowed DHS staff and partners to visit Ohio to understand the details of the DR model in Ohio. As one member of the DHS leadership mentioned, "We need to emphasize how important Casey was because at the time, with budget issues, DHS was not sending anyone to anything. But Casey, that funding really supported our ability to gather more information about DR."

The National Resource Center for Child Protective Services (NRCCPS) worked with Oregon staff in the exploration stage to help conceptualize and implement the model in Oregon. Having worked closely with DHS in the implementation of the OSM, NRCCPS staff understood Oregon child welfare and how OSM complemented the DR model. To assist DHS, NRCCPS conducted a series of focus groups with various internal and external stakeholders across the state. The intent of these focus groups was to gauge how much people understood about what the department was doing and how DR would work, given that there seemed to be significant variability in the level of understanding about DR around the state.

> *We conducted focus groups with all the different stakeholders in the system. Then all of that information was gathered and we presented to breakout groups throughout the state. In those breakout groups, we presented an overview of DR and got feedback from stakeholders and asked them what they liked about the model, what questions they had about it, what collaborations they felt they had in place already that we could build on, what would be indicators of success of expectations, those types of things. And then we took all that information that we got from those breakout groups and folded that into the design team process.* (State partner)

More information about the role of Casey Family Programs and NRCCPS is included in Section 5.2.

The child welfare director said that the culmination of the information-gathering process was "a 50-page report of 'Here's what is out there. Here are the similarities and differences.' It was honing down to 'Who do we want to emulate?' 'Who do we want to look like if we do this?' and 'How are we going to make it maybe a little bit different than other states?'" The child welfare director then asked staff from the DHS Office to provide more information about jurisdictions that had been successful with DR in terms of evaluation findings.

> *This honed it down because there wasn't a lot of evaluation at that point. In Oregon, we're pretty focused on, "You need to show us what success looks like and why." You need to be able to validate you're moving in the right direction*. (DHS leadership)

DHS staff gathered a significant amount of information about how DR had been implemented in other jurisdictions, which informed the development of the DR model in Oregon. This information was used to determine which components of DR from other jurisdictions were most appropriate to adopt or adapt to create a two-track child welfare system in Oregon.

## 4.3. Dissemination of Information

After information about DR was gathered, DHS began to communicate its intentions to staff within child welfare offices and to the broader community of partner organizations. Prior to the exploration activities described in this section, initial conversations about adopting a DR model for Oregon began as early as 2010. In mid-2011, DHS began initial efforts to launch DR. NRCCPS conducted a series of focus groups with community partners and DR presentations in the districts to introduce the idea of DR around the state. However, this initial effort to launch DR was described as unsuccessful for several reasons; there was turnover in DR staff (including the DR program manager) and the focus on establishing SPRF contracts seemed to have taken precedence and temporarily slowed the work of DR. Ultimately, these early efforts did not gain momentum: "There was a lot of confusion about what it was going to look like, and there wasn't a lot of clear understanding of how we were going to do it" (DR consultants).

The dissemination efforts that occurred more recently had greater success than the initial unsuccessful effort in 2011, which can be attributed to several factors. First, as described above, DHS had ongoing conversations with stakeholders around the state about a shift in child welfare practice. DHS leadership described the effort in the following way:

> *I think there were several stars that aligned at once. We had really earned credibility around our foster care reduction effort and we had started conversations in communities with what were called at the time "Casey teams." We had several communities around the state that were talking about why foster care was not always the best answer for a child and family that were at risk. So we knew we needed buy-in and we had actually started some of the process, but certainly had not taken it as far as we've taken it now with DR, from even being able to change the conversation in Oregon away from sort of a child rescue-based conversation to a family support stability-based conversation.*

Throughout the exploration process, there were some concerns about the implementation of DR in Oregon. This dissention took several forms, ranging from doubt that DR could be successfully launched to confusion about how DR would differ from current child welfare practice and how DR fit with the other initiatives that were being implemented, as the following comments indicate.

> *I think there were dissenting voices from pretty much every side. You had some legislative folks who weren't sold. We had stakeholders who weren't sold. We had some courts who weren't sold. They always raised the states who had stopped doing DR. So we did do a little research into that as well: why did these states stop doing it, so that we had a response for them, and how we were going to avoid that, in essence. It took a concerted, dedicated, consistent, longer-term messaging to get people on board.* (DR consultants)

> *For the most part, the [Native American stakeholders] thought differential response was a no-brainer. It seemed like good practice, a good way to individualize your response, but they were really skeptical, just like pretty much everybody else, that we would be able to implement DR and then continue to maintain it and do it in a way we really wanted to do it, or the way that we were talking about doing it.* (DHS leadership)

> *It's been a struggle to keep the buy-in a little bit because the way that [the DR program manager] is teaching us how to do this is slow by comparison to what I think the legislature's typical tolerance for transformation is.* (DHS leadership)

As implied by the above statements, the concerns about DR appears to have been addressed through increased communication and conversation among those involved in implementation, including the dissenters. Overall, a significant amount of time and effort was put into the exploration stage of Oregon DR implementation to gather information about how DR might be structured in Oregon, learning from the successes and challenges of other states, and sharing information with stakeholders in the formative stages of the process. Several interviewees commented on the value of this stage of the process. As one state partner commented, "From my perspective, the exploration part really helped us to look at things thoughtfully." Another state partner concurred:

> *I think that that part of the process was really, really important. I'm glad that we spent as long as we did on it. It was kind of a fickle process because we didn't have strong leadership in the beginning phase and it kind of faltered. But once we had a dedicated staff person that was able to bring all of the stuff together, I think the wealth of information that we got not only from other states, but from the concerns from our own disciplines and peer technical assistance from Ohio were really, really helpful.*

As subsequent sections of this report will describe, the activities conducted during the exploration stage of DR implementation provided a solid foundation for the next steps in implementation.

# 5. Installation Stage

After the decision was made to adopt a DR model in Oregon, the DHS central office led the effort to determine what needed to happen prior to rollout in district child welfare offices around the state.[14] During the installation stage of an intervention, decisions must be made about how an existing system needs to be reconfigured to support the implementation of the new practice; these decisions focus on what resources will be needed to do the work ahead and how to prepare staff for upcoming changes. Building on the work that was done in the exploration stage, in the summer of 2013, a team structure of committees and subcommittees was established to guide this decision-making process. At the state level, a concerted

[14] Oregon has a state-administered child welfare system.

effort was made to be inclusive during the installation stage by incorporating suggestions and concerns from a range of stakeholders around the state.

This section of the report describes how decisions were made as the DR model evolved into a clear practice model. This section also describes several key decisions that were made in the course of planning for DR implementation, including whether statutory changes were necessary, how data systems needed to be modified, how DR would be rolled out across the state, and how the DR model would evolve over time. This section also describes other influential factors that affected the design of DR in Oregon, including DHS's focus on addressing disproportionality and concerns about initiative fatigue.

## 5.1. DR Implementation Team

After the decision was made to move forward with DR implementation, an organizational structure was created to assist the process of developing the DR model, moving it from a conceptual framework into how it would function in practice.

### 5.1.1 Central Office DR Team

A small number of DHS staff were designated to guide and support the DR installation process. Leading the effort was the DR program manager. The position was previously held by another individual, but in December 2012, Stacy Lake was hired to oversee the development and implementation of DR in Oregon. The revived leadership to lead the statewide effort was a turning point when DR implementation gained momentum. Some of the state partners who participated in the early design work of DR in Oregon commented on how important Lake's contribution was to the successful implementation process:

> *[The DR program manager] has been the leader and she's been amazing I think…She's very capable in her leadership and she's very collaborative and she's very open to questions. She's very open to challenges. If you tell her "I don't like that because here's why I think it might not work" or whatever, she listens to that, considers it, may not always implement it, but she's just been a very good role model in the process I think because she kept everything moving forward.*
>
> *One of the things that definitely helped, we've mentioned this a couple times, [DR program manager]'s leadership throughout. I mean she just has a really nice style of including people and also moving the work forward. And so, I think that was a huge thing working for [DHS].*
>
> *Bringing [the DR program manager] on, she was just a great addition to really move that work forward. And really, from my perspective, she works from an engagement kind of principle mind. And so her ability to be really thoughtful and engaging and keep things moving forward and provide information and make sure people are knowledgeable and have input really models a lot of what we want to do with DR but really helped move the work forward.*

A few DR consultants were also involved in the installation stage of DR implementation to support the DR program manager. The roles and number of DR consultants expanded as the statewide rollout progressed, but in the early stages of implementation, the first few DR consultants were involved in the exploration and installation stages. These DR consultants worked closely with the DR program manager to support the efforts of the DR team structure. One state partner commented on the success and strength of the central office DR team:

> *[The DR program manager] has really spearheaded it. What I liked about her was that she put a team of young, energetic, connected people around her. I mean they're all people that are just passionate about the work. You know I really appreciate the team that she has. In fact, one of the people that I recommended and she was hired, but I think that was—you know because [the DR program manager] was new to Oregon and you know there was skepticism about the DR implementation anyway.*
>
> *And bringing in somebody who doesn't know Oregon—But I think instead of taking the usual suspects who've implemented this in various places or who've been around for a long time, she did surround herself by a very effective, young, and energetic team of people—child welfare workers—who were passionate and excited about doing something different.*

### 5.1.2 DR Committee and Subcommittees

The design of the Oregon DR model was developed by a committee. During the early exploration stage, a design team was created that included DHS staff and partners from across the state who represented various perspectives such as service providers, parents, tribes, and the courts. This team also included DHS staff members at various levels, who provided the frontline and management perspectives.

After Oregon moved into the installation stage, the DR implementation team structure shifted. Some of the individuals who were on the initial design team continued their involvement, and additional members were invited. A new team structure was developed that was slightly smaller and more nimble. Figure 2 shows the configuration of the DR implementation team.

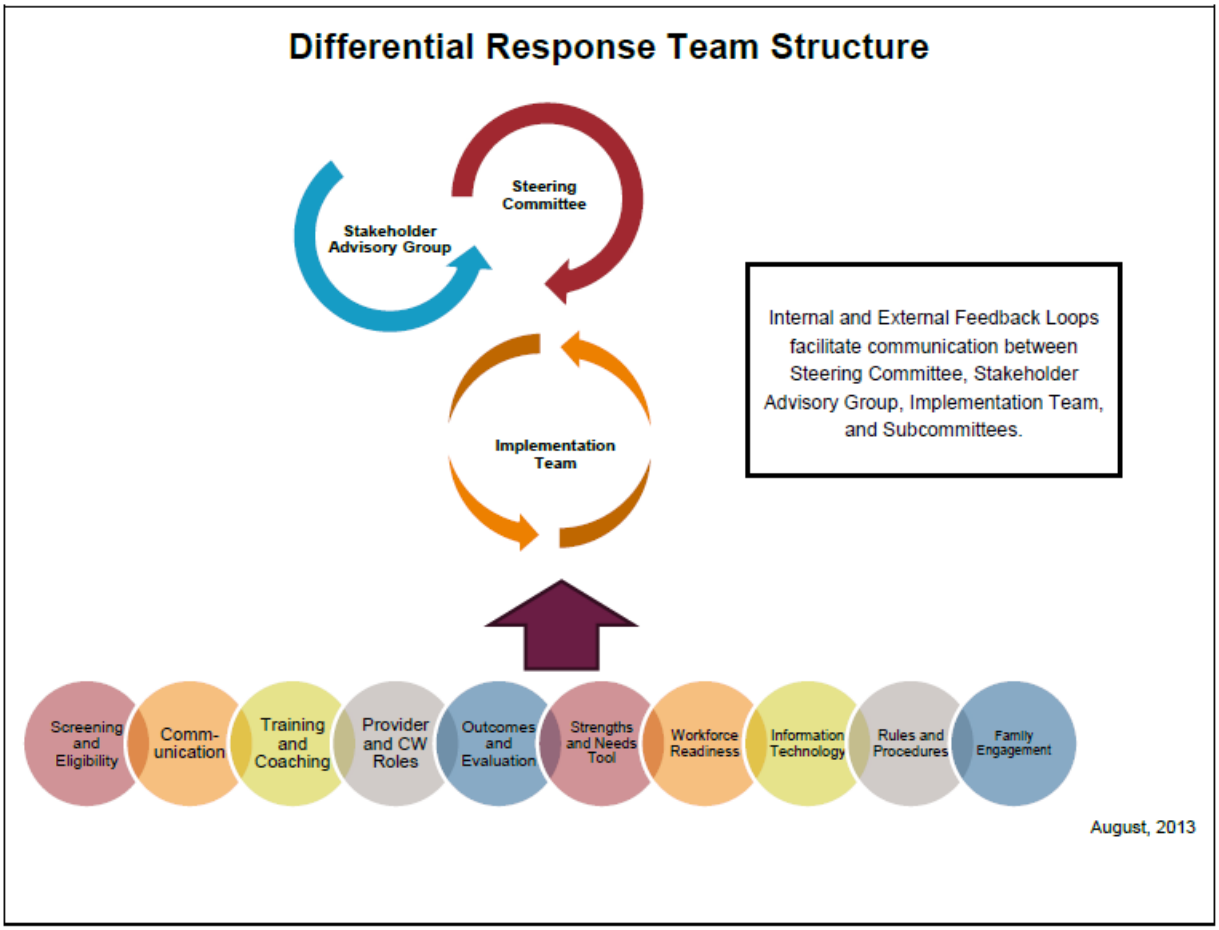
The steering committee was responsible for overseeing the planning process. The steering committee met monthly and consisted of high-ranking DHS administrators who were the primary decision-making body for the work. The steering committee also included several district staff members, Casey Family Programs, NRCCPS, tribal representation, and the cross-systems equity coordinator.

The implementation team met monthly and consisted of some of the members of the steering committee (Casey Family Programs, NRCCPS, Equity Team Members, and tribal representation), along with community providers, training staff, judicial representation, frontline staff, and parent representation. This implementation team was supported by the central office DR team.

The subcommittees (the smaller circles at the bottom of Figure 2) were each assigned a different area of focus and were responsible for "getting into the weeds of the various work streams that were created to get the work done" (DHS leadership). The subcommittees met every two weeks (or as needed) and included a wide range of representatives, from central office, urban and rural district offices, frontline staff, consultants, tribal representatives, community providers, trainers, and parents. A DR consultant supported the work of each subcommittee.

Although some key individuals were involved in multiple committees, there was little crossover from the steering committee to the subcommittees. This was intentional; the groups were for the most part kept distinct in order to incorporate varied perspectives into the DR design process. See Appendix C for a list of the individuals included on all the DR committees and subcommittees.

Figure 2: DR Team Structure[15]




In selecting individuals to participate in these various teams, DHS made a strong commitment to engage a diverse group of individuals to participate in various aspects of the planning process. According to interviewees, the intentional selection of implementation team members was successful in creating buy-in for DR implementation:

> *We engaged the communities in a different way than we had. We wanted to have meetings with partners that we didn't have in the past. We brought people to the table who were key stakeholders and asked them. Not only did we ask for their thoughts about how to do something, we actually carried through, we followed through with it and did it. So those were pretty critical things that built trust, in my opinion.* (DHS leadership)

> *One of the strongest things that we noticed was that the individuals that were in those subcommittees were really critical. There was field representation, there was central office representation. It was a really intentional process to bring in the field perspective to the work. And so many of those people that were involved in the subcommittees are then kind of champions out in implementation.* (DR consultants)

[15] http://www.oregon.gov/dhs/children/differential-response/Documents/Committee%20organizational%20chart.pdf

> *I think it was really good for collaboration because in bringing in and actually engaging all of the various stakeholders that we did, people felt that their voices had been heard and there was more buy-in and less nervousness about this huge change.* (State partner)

With its commitment to include a diverse group of individuals to design the DR model in Oregon, DHS had a strong interest in ensuring that people from communities of color and parents who had prior experience with the child welfare system had a voice in the design process. Several individuals representing communities of color participated on DR planning committees, including the chairman of the Child Welfare Equity Task Force. There was not a specific committee designated to determine how DR might address issues of disproportionality. Instead, these individuals ensured that an equity lens was used throughout the implementation planning process and within various subcommittees. As one of these state partners indicated, "I tried to make sure that in the implementation of DR, the people that had been in some ways affected by child welfare in unfortunate ways would see an equitable and fair implementation of this program across the state." In addition to representation from the African American community, there were also individuals included in the design committees who represented tribal interests. One such individual held a variety of roles, including co-chair of the Indian Child Welfare Advisory Board and DR steering committee member.

> *We meet monthly and get updates from the counties that are implementing or those that are getting ready to implement and look at some of the data from those counties. And then, if there are places where we need to make decisions about process or procedure or implementation, we talk through those things as well….I frequently say in our advisory committee that using DHS's model on how to plan, how to implement, to practice change around DR has been so successful that I think we need to mirror that in terms of looking at the Indian Child Welfare Act.* (State partner)

Two individuals representing the parental perspective were included in the DR planning process. One was a parent with personal experience navigating the child welfare system. The other individual worked for an organization that provides support services to families involved in the child welfare system. This individual was also a member of DHS's Child Welfare Advisory Council, where her role was to make sure that parents were represented. Although not a client, she was focused on providing the parent perspective, sharing experiences of the child welfare clients she had worked with, making sure that the family voice was represented, and that the family members involved in the process were being heard. As this individual stated, "It's really important that we bring former child welfare clients into this process and that they would share their experiences—positive and negative."

When asked if the perspectives of these individuals were heard in implementation discussions, there was consensus that their perspectives were valuable and usually heard clearly. As one state partner said, "The former child welfare clients really had meaning and value in this process," and another partner commented that "parent representation in monthly implementation team meetings…was really positive and impressive."

Staff members from Portland State University's Child Welfare Partnership training program also participated in the DR implementation teams. The director of the training center stated:

> *Because we are on the training unit for the Department of Human Services, we are brought in generally from the very beginning when there is any kind of new initiative, changes in policy, or*

> *rule or legislation that's going to impact what caseworkers or supervisors do in the course of their work. Because we have to be able to implement those changes into the training curriculum, we have to be involved in order to make sure that the changes in practice become part of the standardized curriculum that new child welfare professionals in the state get. We were brought in in the beginning, and I deployed a number of trainers to a number of different work groups for the DR initiative based on their content expertise in that particular area. I spread my instructional staff through those work groups so that they would both be able to contribute to the thinking based on their information and knowledge, but also so that they could hear the discussions and the implications and the nuances in order to be prepared to train those down the road.*

The subcommittees were intentionally designed to divide the work that needed to be completed into more manageable pieces. As mentioned above, the ten subcommittees (see Figure 2) each included eight to ten people who were responsible for suggesting what would have to change (e.g., policy and procedures, training materials, eligibility decisions, communication methods, etc.). There was a relatively short window of time, roughly eight to nine months, in which an extensive amount of work needed to be done to launch by May of 2014. DR consultants were each assigned to two or three of the subcommittees to help facilitate conversations and ensure that deliverables were produced in a timely manner.

The committee and subcommittee structure was considered very effective. Interviewees indicated that the structure worked well and facilitated discussions that incorporated the extensive knowledge of subcommittee members. Extensive conversations occurred within and between subcommittees. The steering committee was consulted to provide guidance for and final approval of all tools and materials.

> *There were all of the various subcommittees. They gave their work to the implementation team and the implementation team would send it back down or would send it on to the steering committee where the ultimate decisions were made. And the steering committee might send it back down to the implementation team or back down to the individual committees. And so the structure created really strong feedback loops that were really helpful in moving the work forward.* (State partner)

> *We all interacted through attending some of the implementation meetings and having group conversations about the work. I think a lot of the work that we were doing as subcommittees was then brought to the steering committee to make decisions about, "Here's what we've come up with. What do we want to do—or what do we want to accept? What do we want to adapt? What direction can we give subcommittees on their work?"* (State partner)

> *Once we started working together, we were open in our communications. We worked together really well and we tried to do the very, very best job we could of working to support various jobs because we realized how important it was. I just say that that doesn't take place in your head. It also takes place in your heart.* (State partner)

Interviewees appreciated the work completed in the various committees, although some of them described how the process led to some frustration about how quickly the work needed to be done.

> *You've got 10 groups, plus the implementation team, plus the steering committee. They're all meeting at the same time in a very short timeframe. That work essentially happened from like August through before May actually. You had a lot of groups that were talking about the same*

> *things with the same times, a lot of counter-dependencies. For example, you'd have this screening committee that was trying to create a screening tool that would determine which families went down which track, while at the same time the implementation and steering committees were still having philosophical discussions about which family should go down which track. So there was a lot of back and forth and a lot of cross-dependencies.* (State partner)

> *Before they were through getting the safety model done, they wanted to get to DR. I said, "I don't think it's going to hurt if you wait a bit." "No, we're going to go." So they went….I felt it was a mistake to move as quickly as they did with DR when they had not yet been able to accomplish and demonstrate accomplishment of full implementation of OSM in the state.* (State partner)

Some members of the DHS leadership concurred that the implementation was happening too quickly.

> *I honestly think we were deficit in some skillsets we needed to do it the way we've ended up doing it…And I think that we had an unrealistic view of how quickly we could make this kind of shift…And I know [DR program manager] says we're not moving as quickly as we thought and we're moving slowly, and I know [DR program manager] said routinely last year, "We've got to slow down." So there's this tension of how do you meet people's expectations, or help them have realistic expectations, but really keep it moving.* (DHS leadership)

The steering committee continues to meet regularly while DR is being implemented throughout the state, but many of the committees have ceased to meet. This was viewed as a strength of the installation stage: implementation team members appreciated the limited duration of their commitment to the implementation effort.

> *[The commitment] was time limited, so you know everyone was able to maintain their energy and commitments because we knew there was an end goal in sight…It's not that you are planning for two years down the road, whereas this process was, this is how we're going to do it and this is what is going to happen. So that was very valuable."* (State partner)

## 5.2. External Consultants

During the exploration stage of DR implementation, Casey Family Programs and NRCCPS supported DHS in gathering information about DR practice models in other states and perceptions within Oregon (as described in Section 4.2). In the installation stage, DHS continued to work with these organizations to varying degrees, using their knowledge and expertise to enhance the design work of the DR implementation teams. This section highlights the role that these organizations played in the installation stage of the project.

Casey Family Programs: Casey Family Programs, as the designated strategic consultant, offered a wide range of support services to DHS in the installation stage of DR implementation, building on the ongoing relationship between the two agencies. Casey staff provided consultation on developing a strategic plan and conducting a comprehensive gap analysis to inform the design of the Oregon DR model. After DHS decided to move forward with implementing DR, Casey staff worked with DHS to create the committee structure for DR implementation, and then the two agencies jointly planned and facilitated the DR committee meetings. They also worked with DHS staff to provide guidance on a DR communication plan and the development of feedback loops. As the model was further refined, Casey staff supported DHS in troubleshooting and addressing implementation challenges through root-cause analysis and identification

of data to use for day-to-day monitoring and assessment of goal achievement. Casey staff played a role in tracking implementation activities to record progress and document the DR legacy, and they offered consultation on the use of implementation science, helping DHS consider implementation stages and drivers. This aspect of support from Casey staff was viewed as critical to successful implementation.

> *I think one of the most important things or components that [Casey] brought to the table was the implementation science piece. So some of that was an easy transition for DHS to adopt and accept a lot of the methodology that we were bringing to them. That framework helped them with the gaps analysis to really understand where they were at and how to recalibrate and move the work forward. And providing some solid facilitation for them to keep them on track and some of the work on track, I think was really an assist that [Casey] was able to provide.* (State partner)

National Resource Center for Child Protective Services (NRCCPS): As described above, in the early exploration stage of DR implementation, NRCCPS conducted a series of orientations and focus groups around the state to share information about DR and gather information about stakeholders' perceptions of DR to inform DHS in the implementation process. During the installation stage of implementation, NRCCPS staff participated in the Steering Committee and several subcommittees, ensuring that the linkages between OSM and DR were developed and providing the perspective of how the safety model and DR should work together.

Project Management: To assist the DR program manager in coordinating all the activities that occurred in this installation stage, DHS focused a child welfare project manager on DR almost exclusively for a short time to assist in coordinating all the logistical components of this complex implementation process. As a DR leader stated, "Initially, as we were getting going, we had 15 to 20 things going on at one time. It was like wow, this is going to be difficult to keep track of all these pieces. It was big."

Throughout the planning and installation stages, the project manager was able to break down the process and flow of activities, develop timelines to ensure that activities were completed on time, and develop contingency plans if deadlines were not met.

> *I think as a department we've recognized the need for people with that skillset to help all the rest of us keep things moving in and make sure that we're not running into each other at each intersection. So we've had more and more project managers.* (DHS leadership)

DHS's work with these three entities ended after the initial DR implementation began, although Casey's strategic consultant continues to provide ongoing support in Oregon.

## 5.3. Legislative Changes

In some states, legislative changes are necessary to enable the implementation of DR practice. In Oregon, DHS decided to refrain from making a statutory change, allowing for flexibility in the evolving DR practice. The DHS director clearly articulated the reasoning behind this decision:

> *I think the other thing about statutes legislating programs is that you lose your agility. I think when you're first implementing a new program, even if you have something in law, you want it to be a very high-level framework. I think with the tone and tenor around the trust of government, we have experienced that when we go into program conversations with our legislature, they want to be very prescriptive. And when you're doing something like this, I think that that's not helpful. So when we learned that we had enough legislative authority to defend how we were acting, and*

> *we had legislative buy-in, and we didn't have to go into all the minutiae of how we were going to get there and try and write it all down, it actually preserved some of the agility that lets us change tools or do whatever. We really have two-year increments of time to make changes. And if you don't have program agility, you'll be stuck for two years with a bunch of stuff that maybe you would like to do differently.* (DHS leadership)

Now that the DR model is more established, DHS leadership is considering the option of formally integrating the DR model into Oregon statute.

> *We ascertained early on we could do this without a statutory change. We could do it just with a rule change. We've been having some real preliminary conversations about, do we need to go back and get a statutory endorsement so that if we had a change in our administration that some other states have had that it would be in the statute, and it wouldn't be go back and change the rules again? But that's sort of a conversation I want us to have over the next year before we move into our next session.* (DHS leadership)

## 5.4. Data Development

In reconfiguring the existing child welfare system to accommodate the DR model, Oregon's state automated child welfare information system (SACWIS) needed to be modified. These changes have been made gradually for several reasons. First, central office understood that the Oregon DR model would continue to evolve and recognized the need to slowly and thoughtfully modify the system. Second, smaller changes were deemed appropriate because of the staged rollout of DR across the state. Two districts implemented DR in May 2014, whereas the other 14 districts continued to use SACWIS in the traditional manner. The 14 districts could see the changes made to accommodate AR cases, so DHS had to create a system that continued to work in the districts that had not implemented DR, as described below:

> *We kept it simple…you want to keep the changes simple because since we're improving as we go, we don't want to have to keep going in and making changes. So we kept [the changes] really high level to begin with. One of the changes was you can pick alternative response or traditional response or non-DR county to start. But we didn't say why because we didn't want to put the [screening tool] in the system yet because we wanted some time to practice with the tool to see what those reasons might be that we haven't even thought of yet.* (DHS leadership)

As DR staff become more certain of the process and instrumentation used in DR, additional modifications will be made to the SACWIS system. This incremental approach to modifying the existing SACWIS data system has worked well. After a change has been prioritized, the process allows for a constant state of improvement "so they were able to prioritize these in a way that we could get them in when we needed them in. It was actually pretty painless, I think, compared to other efforts we've made" (DHS leadership).

## 5.5. Staged Rollout to Districts

During the installation stage, a decision had to be made about how DR would be implemented across the state. DHS wanted to begin the rollout process in districts that were supportive of adopting the DR model, allowing lessons to be learned and the experience to be shared with other districts. Having taken lessons learned from other jurisdictions around the country, DHS elected to conduct a staged rollout of DR beginning in May 2014, as described below:

> *We learned a lot from the struggles that the other states had and didn't want to have those same struggles. Like hearing from Illinois about how they flipped one switch; they only wanted to have one fight and just get it over with. But they knew the challenges that would be associated with that. And then talking to some of the other states that went much, much slower than we're even going: they did an 18-month pilot, then took the time to evaluate it, then decided if they were even going to continue. So we seem to have found I think a happy medium.* (DHS leadership)

DHS utilized the committees and subcommittees to help brainstorm the factors to consider in selecting the first districts to implement DR. Several factors were considered, some of which were county size, child welfare indicator data (e.g., placement rates), status of OSM practice and SPRF contracts, urban/rural demographics, tribal presence, community support and existing partnerships, status on being up to date on assessments, and staffing levels and stability. DHS leadership described a large color-coded map that hung in an office, displaying many of the factors that were considered in selecting the order of district rollouts. DHS leadership and DR consultants described some of the factors that played into the decision about which districts should implement DR first:

> *I remember there being some advice during the implementation team [meetings], wanting to look at counties that had the highest impact but also look for some easy wins as well. So I don't remember if that was part of the final decision making, but I know that we didn't want to go to the most complex system either because you don't want it to fall before it even has a chance to get legs under it.*
>
> *I think we had five counties at the end, really, that we were looking at, and so the district managers made a decision, and we picked them.*

As the last quote indicates, there was no formal process by which a district could request to be placed on the rollout schedule. Both District 5 and District 11 volunteered to be the first to implement, and they were among the five counties identified as being a good fit. For implementation in District 5 and District 11, central office developed a district planning guide that laid out the critical components of successful DR implementation. This guide instructed districts to complete a district self-assessment, establish a local implementation team (modeled after the state's implementation team model), schedule an orientation as a "kickoff" for DR, and conduct staff training sessions and community partner outreach. The guide also recommended the use of individualized readiness consultation from central office. Central office consultants and the DR Manager provided regular assistance during the six months of readiness work leading up to DR implementation in their districts.

While managers from District 5 and District 11 described the implementation process as successful, they also describe some challenges that arose from being the first districts to implement DR when many facets of preparing for DR had not yet been clearly defined and articulated. The two districts sometimes found themselves developing processes before the state had a chance to, simply because these processes were needed in order to begin serving families once DR began. Some examples of how district staff contributed to the implementation process include: setting up subcommittees to help with getting ready for DR that included staff; sustainability planning once DR was in place including structures for determining eligibility. Interviewees from these two districts also discussed a challenge of the gradual rollout of DR. Because the last districts will not roll out DR until 2017, some district offices will be operating a two-track system, while other district offices will only have the traditional response. There was concern that this might cause confusion as families move between districts (although at the time of

the site visit, there had been few instances in which this had happened). DHS tried to address this issue by creating two sets of practice guidelines, as described below:

> *When we updated the procedures what we did basically is we have a regular child welfare handbook and then a DR child welfare handbook. They are identical except for the DR updates. What we did was we starred those chapters that had DR updates and we highlighted the changes in blue. So, if you're a DR county you can see what's different for you, so that made it easier. They didn't have to dig through to figure out what's different.* (DHS leadership)

## 5.6. Evolutionary Process

When reflecting on the installation stage as a whole, several interviewees described the evolutionary nature of the development of the DR model in Oregon. As the DR team continued to develop the DR model, they gathered more information and gained more experience, which led to modifications of some decisions that had already been made. DHS wanted to create a flexible DR model because they anticipated that aspects of the practice would need to be adapted over time.

> *I think the DR team has been really good about just going out and getting input and they have—each time we've done an implementation, they have raised things we didn't think of. So they take that, look at it, evaluate it, and adjust. It's designed so you can adjust as you go along and not abandon the model, but improve the model just by the practice.* (DHS leadership)

> *It's a "lessons learned" process. As you go from this group to this group to this group, things are going to change. Things happened that have a totally unintended consequences by doing it that way. And you may have to change it. So building it in such a way that there's some flexibility to do that, to not be completely locked in.* (DHS leadership)

Although interviewees recognized that this evolutionary process was natural and perhaps unavoidable, some of them expressed their frustration with the evolving model of DR in Oregon. The initial design team had begun to develop key aspects of the DR model, but subsequent discussions among the implementation team led to alterations in the model.

> *I think that there was some frustration moving from the design team to the implementation team because there was a big gap between the work of the design team and then the implementation team. It just didn't go from one to the other between the two phases. I also think that one of the difficulties was that some of the things that the design team had decided upon or focused upon changed once we got to the implementation team. The design team very much wanted a community partner to always go out on the CPS assessment along with DHS. Then once the implementation team started looking at that issue, they decided that that wouldn't always work for a community partner to always go out because community partners weren't always available 24/7, because for community partners that worked in some counties there weren't as many community partners. So I think that there was a bit of tension because those people had served for a long time on the design team and didn't see their work being implemented in the way that they had thought it was going to be implemented. And things kind of changed once the implementation team began.* (State partner)

Overall, there was a general understanding that this evolutionary adaptation was ultimately good for the development of DR practice. Although there were frustrations along the way, interviewees recognized that these adaptions will be more subtle as DR continues to be implemented in other districts in the state.

## 5.7. Disproportionality

Disproportionality in the context of this report refers to the overrepresentation of ethnic minority groups in child welfare systems and the tendency for these groups to have unequal access to needed services. Driven by the focus on safe and equitable reduction of foster care, DHS believed that the DR model would have a positive effect on disproportionate representation of minority children in the child welfare system. In reconfiguring the child welfare system to incorporate the DR model, central office paid particular attention to the issue of disproportionality in a variety of areas, as described throughout the interviews and summarized below.

Integration of an equity lens into DR design: DHS included several individuals on the steering committee and implementation teams who could bring an equity lens to the conversations about how DR would operate in Oregon. This included the chairman of the Child Welfare Equity Task Force and key leaders from provider organizations serving communities of color. DHS believed that it was important to include these individuals in the early conversations about DR to ensure that equity was a core component of the DR model. "We had a variety of people on the team; their specific purpose was to bring that racial ethnicity equity lens to the table, the cultural humility and really getting us to stop and think when we're moving too quickly." (DHS leadership)

Focus on the tribal population: DHS made a concerted effort to include the tribal perspective in the implementation of DR by including tribal representation on the steering committee and implementation team. Early on in the process, the DR program manager attended Oregon's Indian Child Welfare Act (ICWA) advisory board meetings to share information about DR. The DR program manager continues to attend these meetings periodically. NRCCPS also conducted focus groups with Oregon's nine federally recognized tribes to gather feedback, eliciting tribal involvement in the planning process and encouraging the involvement of the tribes in local discussions regarding district implementation. Several state partners who were interviewed indicated that DHS did a good job of including the tribes in the implementation process. One state partner stated that DHS "really spent the time of walking through and learning from the nine tribes." (State partner)

Use of data to assess progress: DHS leadership discussed the importance of using data to assess their progress in addressing issues of disproportionality in the child welfare system.

> *We've continued to talk about how you begin to dig deeper into the data. How do we begin to pull specific data by race and ethnicities? We're going to have to begin to build a picture that we can then take back out to the communities. I think we've messaged, "Here's what it is. Here's what our hope is." But we have to then be able to come back with data to be able to tell the story of, "this is effectively working," or it is not.* (DHS leadership)

Focus on poverty: DHS also recognized the need to focus on some of the root causes of inequities.

> *We are trying to get self-sufficiency teams and the child welfare teams talking more about how they work together, and then which families are really not qualifying for DR, but they need family stabilization support services from the self-sufficiency side in order to avoid even the next phone call to the hotline. I think that that's another piece that if we're really going to be successful in the long-term—and that's also something with communities of color, really tackling the equity issues around the income inequality and some of the bigger issues that are not even ours to own, but the*

> *things that are playing out in those communities that are difficult that ultimately over time create erosion in the family structure.* (DHS leadership)

Workforce representation: DHS leadership also described how they are "looking at our own makeup in terms of its racial and ethnic makeup, so we have established target goals. So as we got those new staff, part of what we're trying to measure is our success at reflecting our communities in terms of who we bring on board."

Contracting: DHS leadership also indicated that "in the SPRF contracts, we have specific culturally responsive contracts we do in there to try to meet those community needs." For example, one SPRF contract provides culturally relevant services to tribal families, and another focuses on African American fathers.

Culturally appropriate messaging: According to one state partner, DHS "really made sure that they had that type of community perspective as it related to their branding of DR, even with pictures that they use of families on the literature that they send out into the community. What is the messaging around this and what should these images look like so that we don't offend our clientele?"

The broad range of DHS efforts for focus on disproportionality were summarized by one state partner.

> *I think there's been a lot of talk about and trying to identify culturally relevant services for families. I think there has been a lot of effort to try to engage communities of color to be able to see what best meets a family's needs and how do we do that. I think there's a lot of training or specific training in the family engagement model that speaks to culture and how do we work with families to identify what that means to them—and have that be included in the types of services or in the types of support that we do that. I think DHS has also been simultaneously looking at things like Knowing Who You Are and Undoing Racism [training] and trying to also, as an entire workforce, address some of those diversity issues to make sure that staff are more skilled when working with families in addressing cultural needs or cultural differences.*

## 5.8. Initiative Fatigue

As described in the exploration section of this report, there was a consistent effort under the umbrella of Safe and Equitable Foster Care Reduction to focus on the front end of the child welfare system. As DHS leadership stated, "There were several stars that aligned once we had really earned credibility around our foster care reduction effort." The stars included the initiatives that were referred to several times by interviewees as the three-legged stool: DR, OSM, and SPRF. These initiatives were intricately linked and influenced the implementation of the DR model in Oregon.

Administrators and managers at the state and district levels clearly articulated how implementation of the three-legged stool promoted better child welfare practices, although some interviewees suggested that this amount of change was at times confusing and overwhelming to staff members and community partners.

> *I think there is a connection between all of it, and I think that there are people in central office that I have heard be able to really articulately discuss the links and the way they all work together. For example, the umbrella of the Safe and Equitable Reduction of Foster Care and then things like DR, family meetings, and permanency roundtables. Those become your strategies or your interventions. Then there's links between those as well. So I feel like I have a pretty good understanding of what the connections are. I'm not as sure how well the child welfare field*

> *understands the connections between them. Something I hear a lot about in my particular role is just sort of what we call "new initiative fatigue."* (State partner)

In addition to these three initiatives, other initiatives were being implemented in some counties across the state in a similar timeframe: a Title IV-E Waiver, the Safe and Together model (a domestic violence intervention), and Family Connections Oregon (focused on family group conferences, permanency roundtables, extensive family finding, parent mentoring, and parent leadership council). The volume of coinciding efforts to change child welfare practice, as well as a history of initiatives in which efforts stalled before full implementation, caused skepticism among line staff and community partners that DR would actually happen.

> *I still think that unless you're really involved in it that it's still kind of unknown and confusing. I sat on the family engagement subcommittee and sat on the strengths and needs committee. So I have had the opportunity to just be really enmeshed in DR. I have a good grasp of it. But I still get the sense, either internally from our staff or when we're meeting at the Child Welfare Advisory Council, that it's still unknown. Some of that is just needing to be in it enough to practice it and to understand it.* (State partner)

> *I think there was also initial initiative fatigue. Child welfare workers and some sufficiency workers are saying, "Oh great. We're going to have this other new model and change all the way we're doing business like we do every three years or something. And nothing is really going to change."* (State partner)

> *I know it's a concern shared by the people that were charged with the implementation of the safety model because they felt like resources were being sucked away. All of a sudden what had been the primary focus was no longer the primary focus. Even though people gave lip service to understanding the importance of getting OSM Refresh right, in practicality, it wasn't really happening…I realize that you have to do more than one thing at a time. But I don't think you have to do major initiatives all at the same time.* (State partner)

# 6. Initial Implementation Stage

During the initial installation stage, the DR model was developed from a conceptual framework to a practice model with more clearly articulated terminology, policies, tools, materials, and goals. In this stage, a range of activities were completed to put the practice model into action. According to the NIRN framework, there are three types of drivers that are essential to address during the initial implementation stage in order to achieve successful change. Organizational drivers are the administrative resources that create an environment that supports the adoption of a new practice. Leadership drivers are aspects of the system that promote and drive the change process. Competency drivers ensure that practitioners can effectively do the new work that needs to be done. Using the NIRN implementation drivers, this section of the report describes the structures and capacities of central office and the district offices that drove initial implementation in the first two districts to implement DR, covering the activities beginning in December 2013.

## 6.1. Organizational Drivers

Organizational drivers are the supports that should be present in an organization as it undergoes innovation. According to NIRN's implementation framework, an organization's support structure is composed of three important components: the system interventions that create an environment conducive to intervention success, the facilitative administrators who make changes to organizational practice, and the decision support data systems used to inform all of these efforts. Organizational drivers are, overall, the factors within an organization that support the smooth implementation of an intervention.

### 6.1.1 System Intervention

Successful implementation of a new intervention such as DR requires an environment that allows for adaptation and is supportive of system change. According to NIRN, system intervention represents the framework of strategies that exist to ensure the progress and sustainability of a model, in addition to fidelity to it. These strategies include the coordination of efforts and resources while aligning agencies at various levels.

Communication and Buy-in: DHS recognized the importance of generating support for the DR model through clear communication with district staff members and community partners. In the early stages of implementation, Casey staff worked with DHS to develop a communication plan to share information about the implementation of DR statewide, designating this task to one of the DR implementation team subcommittees. The focus on providing a clear message and consistent information was important because of the earlier, less successful, effort to launch DR (described in Section 4.3) that had resulted in considerable confusion about DR. The second round of communication activities developed by the DR implementation team had greater success because they had spent more time thinking through how the model would function and how to articulate this to agency staff members and stakeholders.

As part of the communication plan, in November 2013 the DHS child welfare director began to send out frequent emails to district offices, providing information about DR and the progress being made toward implementation and addressing frequently asked questions. Several interviewees indicated that these communications were extremely helpful. District administrators often forwarded these emails to staff

members and community partners so that internal staff members and external partners were aware of the changes that were about to occur, creating buy-in for the DR implementation process.

This concerted effort to communicate to staff members and community partners helped ensure that there were few concerns about the implementation of DR. Feedback obtained from interviewees indicated that the materials developed by the state were effective, and that staff and stakeholders understood the concepts of DR and it made sense to them. District administrators described their successful efforts to communicate about upcoming changes with their staff members and community partners.

> *We would send out the memos from the director to community partners, so they could share it with their staff, and we got a lot of positive responses by sharing this information. They appreciated getting the updates about where we're headed. And then we went to their meetings, and Differential Response would get put on their agenda for an update.*
>
> *Central office put together training videos so we trained some internal staff on how to do the training and then we identified populations in the community that needed to be trained. Then we went out and did presentations for the schools, community partners, and law enforcement.*
>
> *At the same time, we had SPRF coming into the picture so we had some new service providers that we were contracting with. So those people, as well as providers that we were already contracting with, were big partners and invited to our DR trainings that we would have with caseworkers.*
>
> *We have a lot of communication with anyone that does contracted work and we have a very high number of contractors in this community, so we have that ongoing communication with them. Once these identified community partners were getting this DR training, we had a ton of people just coming to us saying we would like to know more about DR, and then we would go out and do it for another organization.*

The caseworkers in District 5 and District 11 reported that their supervisors had informed them that their districts would be among the first to implement DR. The interviewees were not surprised because there had been ongoing communication that DR implementation would occur prior to this announcement. The only skepticism that arose from the communication about DR related to the "initiative fatigue" described in Section 5.8: DR made sense to people, but there was concern that the practice would not get off the ground. This was in part due to the early discussions about DR (as describe in Section 4.3) that occurred prior to the DR implementation activities described in this report.

Organizational and contextual factors: An array of factors at the state-level were pivotal in supporting the establishment and implementation of DR. First and foremost, many interviewees discussed how the OSM Refresh and SPRF funding supported the implementation of DR by providing a broad context for a larger system change, as described above in Section 3.2. Central office staff identified factors related to sustainability and capacity-building as key factors influencing a successful rollout. The priority of establishing a "long-haul mindset" was highlighted by the need for practices that help to sustain employees, from executive management to district workers. These interviewees expressed concern that high caseloads, travel requirements, and change fatigue could threaten staff stability.

Fiscal resources: Another factor supporting the implementation of DR was the way in which it was funded. DHS leadership described how the legislature allocated funding for the first five DR positions in

central office. Additional general funds were allocated to increase the number of DHS workers at the district level, but these were not designated specifically for DR. This, according to DHS leadership, gave the department greater flexibility and stability concerning capacity because any reduction in DR funding would only affect a small number of DR positions in central office.

Funding provided by the legislature to build the capacity needed to implement DR proved crucial, although it accounted for only a small portion of the overall resources utilized for DR implementation. Casey Family Programs provided free consultation to aid in the implementation process, as described in Section 5.2. SPRF services supported DR efforts by enhancing the foundational child welfare service array aimed at preventing children from coming into the foster care system or returning children more quickly when they were removed from their homes. Overall, the legislature's financial commitment to DR was relatively small, increasing the chance that DR will continue if budget shortfalls arise at the state level.

### 6.1.2 Facilitative Administration

Facilitative administration is management's efforts to support successful change by creating an environment within which implementation can thrive. Administrators can create such an environment by paying proactive, enthusiastic attention to practitioners' efforts and by systematically attending to feedback.

At the state level, DHS leadership reported myriad efforts aimed at gathering up-to-date information on progress and challenges as DR was implemented in District 5 and District 11. After May 2014, meetings among core leadership, the steering committee, and the child welfare advisory committee aimed to keep abreast of issues arising during implementation. Staff members from central office discussed how imperative consistent input during the meetings is:

> *We meet monthly and get updates from the counties that are implementing or those that are getting ready to implement and look at some of the data from those committees or those counties. If there's places where we need to make decisions about process or procedure or implementation, we talk through those things as well.* (State Partner)

When asked about the process of determining which information for the field will be shared with statewide leadership, the DR program manager described the following communication pathways:

> *Changes happen; it depends on how major they are if I feel like I need to bring them to leadership or not. They basically come from the bottom up. I set up a communication loop so that I'm talking with the consultants regularly, they're talking with each other regularly, we're hearing about what are the issues and trying to get resolution right away.*

At the district level, there also appeared to be consistent communication between supervisory staff and workers, although the scope of information available concerning DR was minimal, especially in the beginning.

Interviews with state- and district-level employees explained how feedback loops created the opportunity to enhance the ongoing evolutionary development of the DR model, as described in more detail in Section 5.6. Administrative support also played an active role in the evolution of DR training sessions over time. DR consultants provided feedback concerning DR trainings to the DR program manager, either based on their own observations or on trainee feedback, and the consultants incorporated changes between training

sessions. This iterative process is reflective of the developing nature of DR itself. As the trainings were evolving, so were the tools workers used to implement DR at the district level, such as the screening tool, which interviewees reported had been changed on numerous occasions. Policy-related concerns, such as the DR model's alignment with Karly's Law, also led to refinements in DR practice. The utilization of this feedback helps to maintain the focus on short- and long-term goals for implementation. One state partner discussed the paramount role of communication in the iterative process of feedback and change:

> *It requires very close communication, lots of back and forth. On the training side, it requires a lot of flexibility because we have to be able to say, "Okay, we've done that, but now we're going to have to change it and do this." It's obviously not the most efficient use of time on our end, but I would much rather have that problem than to have them at the very end.*

The combination of communication and flexibility was a strength of the administrative support offered during the early stages of DR implementation. While the model was developed with rules, procedures and tools, there was still a need to gain experience in areas such as track assignment and the CPS assessment components related to DR. DR staff from central office were very clear that they would be learning alongside district staff and helping to adjust tools and the model as they went. The established modes of communication and pathways to iterative change helped to ensure relatively quick adaptation as district-specific challenges became apparent.

### 6.1.3 Decision Support Data Systems

System intervention and facilitative administration depend heavily upon data to help inform decisions as implementation occurs. It is these decisions that drive change and shape the ultimate success of the implementation. A systematic evaluation of an intervention uses multiple measures to analyze the effectiveness and potential areas for improvement of the intervention, helping to maintain alignment with expected outcomes. Organizations use these measures to understand overall intervention performance and to gather data to support decision making.

Data from various metrics regarding workload and staff performance have been used to improve DR practice. Statewide metrics attempt to capture key data points pertaining to the effectiveness of DR practice. One member of the DHS leadership team outlined some of the measurements used in the data gathering process: "We have a whole dashboard of the statewide metrics we look at: number of kids in care, timeliness to investigation, length of stay, those sort of things to track as we're looking at how the DR counties are doing, and then anxiously awaiting the evaluation."

To complement the data gathered by the DHS leadership, district administrators used ongoing measurements on overdue assessments, timeliness to investigations, and in-person visits, among other measurements, to monitor the implementation of DR practice. District administrators gathered these data, at some points as frequently as daily, in an attempt to see where staff were experiencing difficulty and identify how these difficulties might be addressed. Identifying the right types of measurements to examine, however, appeared to be challenging. One state partner detailed the obstacles that district offices had to overcome before measurements could be used with confidence.

> *There is their day-to-day figuring out what data point did they want to track. How could their data system be organized to work effectively and get the data that they needed? What does their success look like, and how do they want to measure that? So really it was just a lot of facilitation*

> *with them about sharing common definitions, so we can all be on the same page as to what we were talking about when we talk about outcomes and measures and baselines.*

At the district level, efforts were made to engage in continuous quality improvement of DR practice. Such exercises included examining the screening reports for a given period of time and then reviewing cases to determine whether these reports were being assigned correctly; closed cases were also examined. These efforts served to monitor fidelity to the OSM and to provide a means of tracking with DR practice. Data on how many cases were assigned to each track were used to inform staffing decisions and improve upon existing training and screening practices.

Although information gathered through these varied methods has thus far proven useful in the evolution and improvement of DR implementation, concerns were raised about the reliability and utility of these data. In commenting on the lack of confidence in the data's accuracy, there seems to be specific concerns about the data regarding overdue assessments. One district supervisor described the process as "punitive," given that staff were held to numbers that seemingly nobody knew how to correctly interpret. Other district supervisors in the same focus group elaborated that there was a disconnect between enforcing the disparities revealed in the data and the real-world lack of resources that workers encountered, such as colleagues who became sick or went on vacation. This, supervisors argued, often substantially decreased the number of available workers to handle the workload, which could lead to a skewing of the data's interpretation. Supervisors in one district expressed frustration that the district administrators examined the data without a realistic understanding of the context and fluctuations that occurred in daily practice because the administrators were more focused on wanting to see "that numbers go down:"

> *Honestly, this program area runs a marathon every single day. You come into work, you have absolutely no idea what's going to hit you, and suddenly it's the end of the day. And sometimes we just don't have room to think about, "How am I going to get my numbers down today?" And then another day goes by. Then a week. Then we're getting another email saying that numbers are still really ugly.* (District supervisor)

## 6.2. Leadership

At the state level, interviewees indicated that a variety of individuals and organizations took on a leadership or champion role. All members of the DHS leadership team were recognized for their advocacy and work toward the success of a smooth DR transition. This support was observed during the exploration and implementation stages. In particular, the DR program manager, Stacy Lake, was clearly identified as a leader for the advancement of DR because of her ability to tangibly engage in the effort on multiple levels.

> *Every time she comes in the field with us, I make a point of it, because in the past, I don't think any of us saw those people on the second floor in the branches, unless it was on the ground training. She's there training, she's there implementing, she is so hands on. And I think that that feels really, really good to the field.* (State partner)

Tangible support from the DHS leadership was clearly an integral piece of the DR rollout. Other individuals mentioned as real advocates in the implementation of DR included Lois Day, the DHS child welfare director, and the DR consultants. Casey Family Programs was also reported to have played a vital

role in the implementation of DR by providing valuable consulting services and other supporting resources.

DHS leadership commented on the importance of champions at the community level, ensuring the involvement of these local leaders translated into confidence that the model would be carried forward despite setbacks.

> *Part of the takeaway from other states is that you want to have your champions at the community level so that when there's a bad outcome—because there will be one—that whole thing doesn't go in the other direction. It's one thing to champion and get the buy-in internally, but it's that external audience that's important—and it had to happen at the state level, and then it has to happen community by community at the local level…We've got to get leadership locally on board, saying this is the right thing, and then they become the champions in their community—and then of course at their staff too. But I think it's horizontal and vertical.*

At the district level, interviewees saw a need to identify champions who could foster support for the DR model from internal and external audiences. Champions at the community level possess referent power within the community, enabling them to utilize their local roots to influence policy. Staff members described this influence as especially important in the initial stages of implementation when concerns raised by skeptics of the DR model were addressed, which in turn often created champions of the former skeptics.

> *You want the people that you already know are going to be your champions. But you also want those ones that are going to be pushing back enough to have those hard conversations early on, but maybe not the ones that are going to completely derail your team.* (DHS leadership)

> *I think that as implementation has progressed, those that have implemented have become really some of the greatest communicators with the rest (of the state). There's outreach between line staff, supervisors and management, in both directions calling and saying, "We need to talk to you guys. You've already done it."* (DHS leadership)

Interviews with district-level staff revealed a wide variety of champions involved in the implementation of DR. Workers in almost every focus group identified their coworkers as champions, including consultants, screeners, caseworkers, and supervisors, pointing out that implementation required an effort on the part of everyone involved; for instance, a district screener stated, "There was a DR implementation team, but those things don't always go so well. We're small enough that it's much more of a situation where everybody just pitches in. It's not a formalized thing."

Support from staff members was exemplified by the willingness of several people to be reassigned to new positions, such as supervisors offering support and advocacy for DR in a consulting or coaching role. This underscores the finding that staff members at multiple organizational levels believed that their efforts were meaningful in the overall success of DR. Additionally, district administrators reported that community partners served as champions, citing the engagement model of DR as a good fit with partners' visions. The implementation of DR, therefore, was met with a high level of ownership among a range of individuals who helped establish buy-in and troubleshoot issues that arose.

## 6.3. Competency Drivers

New work practices can emerge through a range of activities, and these practices often depend on established organizational drivers and leadership. Staff members are selected for positions based on the characteristics that best fit the new role. Training and consulting sessions are conducted to teach practitioners who have undergone a selection process the knowledge and skills necessary to carry out new interventions. The structure and success of competency drivers have an immediate practical impact on the success of DR practice.

### 6.3.1 Staffing

The overall staffing structure of an organization can have a significant effect on the capacity to implement and sustain change. It is imperative for any organization to address specific questions regarding who is qualified for a given set of tasks and which roles they will assume during a shift. According to NIRN, staff selection can depend heavily on contextual factors such as the overall economy, organizational financing, and the demands of the workload, especially when introducing an intervention.

When DR was introduced, staffing configurations at the state and district levels changed for a host of reasons. Some of the restructuring was initiated to accommodate the needs associated with DR, such as the reassignment of experienced supervisors from district offices to DR consulting roles at central office. Although the process of replacing seasoned supervisors with less experienced staff was described by one member of the DHS leadership team as "eating your tail," the benefits of taking DR expertise out into the field were apparent.

Another staffing challenge encountered at the district level was knowing how many caseworkers to assign as AR workers and how many to assign as TR workers. Initially, District 5 and District 11 adopted the strategy of assigning each staff member to one of two tracks, either as AR caseworkers as TR caseworkers. This was the recommendation, whenever practically possible, of the Workforce Readiness subcommittee during the installation phase. However, citing difficulty with finding the right balance of AR and TR caseworkers, as well as internal conflict arising from the notion that AR cases were "fluff" compared with TR cases, district administrators moved toward blended teams with caseworkers trained to take cases from both tracks. Caseworkers in District 5 and District 11 ultimately seemed to prefer having mixed caseloads. As one caseworker commented:

> *I was pretty staunch that I wanted TR cases. I want the more in your face, intense cases because those are more interesting and I kind of like that work better. And then after a solid six months of doing it and just filing literally every week and only removing kids and dealing with nasty cases, I was like, you know what, I kind of want a dirty house and I kind of want just some low-level stuff where I can have these decent conversations with families about not really horrific stuff every day. So I like the balance better.* (District caseworker)

Although having mixed caseloads appeared favorable to most caseworkers, interviewees reported that some caseworkers had more difficulty adjusting to the new structure than others. Specifically, caseworkers who had been on staff for longer sometimes had more difficulty adjusting to the AR track than less experienced caseworkers. Community providers noticed that some TR caseworkers had not adjusted their practices, even when dealing with AR cases. Conversely, newer caseworkers who had learned about AR in DHS core training sessions sometimes had difficulty not calling ahead on TR cases, such as those involving a severe abuse allegation. For some caseworkers, DR didn't greatly affect their

practice: before the implementation of DR, some caseworkers were calling ahead and making efforts to work with families on a regular basis; for example, one district caseworker noted, "Even before, I think we did a pretty good job about calling ahead if there wasn't a reason not to. I think the only difference now is we're calling ahead on dirty homes, whereas before we weren't."

One concern that inevitably arises in a two-track system is the issue of how DR affects caseworker caseloads. The typical caseload that a district caseworker handles varies as a function of many variables. Several interviewees named the "human factor" as such a variable. As an example, caseworkers in District 5 reported that approximately 25 caseworkers were available to take cases; however, 10 of these caseworkers might have been gone at any given time because of illness or vacation, dramatically decreasing the number of available caseworkers on a particular day. This variability was compounded by the differing work styles of caseworkers, as one district supervisor explained:

> *We have people that are driven by their caseload being down, and we have other people that are driven by what they think is doing the right thing for the family. Not that one or the other is necessarily right, but I think people that feel like they're backed up more often feel like they're doing more thorough assessments and spending more time, whereas the people that are completely caught up on cases are going out and dealing with the "immediate." It looks fine and their focus is on keeping numbers down. It's that constant argument that as long as the numbers are down, it looks fine until something goes sideways. Then the practice issue comes into play around how it happened.* (District supervisor)

It is difficult to discern whether or not DR accounted for the variability in caseloads, given that so many systemic changes were made around the same time as DR implementation, making it less certain which changes brought about which results. Still, supervisors in District 11 believed that the changes in caseload were not as much a function of DR as they were the introduction of SPRF services. Interviewees indicated that caseworkers began to feel more stretched around the time DR was being implemented, although it is again difficult to say if this can be attributed entirely to DR. Caseworkers in District 11 mentioned the "insane amount" of information required for the minimum assessment. One district supervisor pointed out that regardless of what caused the caseload changes, high caseloads negatively affect DR, typically making it more difficult for caseworkers to thoroughly interact with families. This strain was evident in one caseworker's comment.

> *I'm not in the trenches like the Protective Services workers are, but I think I could see as an outsider that the workload minimally doubled, if not tripled or quadrupled, and for overall office atmosphere our turnover has been horrendous. We have more workers, so we're hiring for new positions, which is good, to try and help with the overflow. But we're losing a lot of our old blood, experienced blood, because the demands are just so high and people are getting burnt out a lot more, and then of course to plug it all is that the caseworkers are not nearly compensated for the quality and amount of work they're doing, so it's hard to retain good workers.*

Caseworkers reported feeling pushed to capacity. The only dedicated funding for DR is for five positions based out of central office, but the legislature provided funding to hire additional caseworkers after a workload study indicated that the organization was operating with 67% of the resources needed to do the work. Although these positions are not for DR specifically, many districts have begun restructuring their

positions in the anticipation of DR implementation, using new staffing resources to create positions to work in the front end: screening and protective services caseworkers.

Some district staff expected that DR would reduce workloads, but that payoff of DR may not be immediately apparent. The decreases in workload that many proponents touted as a benefit of DR may not be seen until several years after implementation, as one caseworker in District 11 noted: "For them to come in to say that it's going to make a big change, that it's going to change it now, I think that they should've been a little bit clearer that the return is out further than what you think and so it's going to take some time to come back."

In terms of the job requirements for particular positions, the Workforce Readiness subcommittee developed enhanced position descriptions for protective service staff to incorporate DR elements, including desired attributes and sample interview questions. At the district level, supervisors in District 11 indicated that at least a bachelor's degree is required for caseworkers, and this hasn't changed with DR. The supervisors interviewed emphasized that because their district is rural, there is only a small applicant pool from which to hire new caseworkers; there is one technical college in the area, which does not have a social work program, making it difficult to recruit new staff. Screeners reported that their job requirements are the same as caseworkers', although experience in a protective services role is preferred. Supervisors in District 5 listed positive attributes of caseworkers who would serve AR cases as knowledge relevant to casework, experience in trauma-informed care, and a focus on engagement.

### 6.3.2 Training

Implementing a comprehensive system change requires behavior change on all organizational levels. Behavior change in response to planned change in an organizational environment is typically precipitated by formalized training. Although the content of training sessions will differ according to the context, the core intent of training is to provide staff members with the knowledge, skills, and abilities to carry out the new intervention. The method of delivery for these trainings can vary widely, ranging from lecture formats and small group discussions to highly interactive behavioral rehearsals. An additional consideration is who will be trained because situational needs are filled differently by new hires compared to seasoned caseworkers, for example.

One of the subcommittees of the DR implementation team was responsible for developing a training curriculum, coaching plan, and materials for DR. As described in Section 5.1.2, this subcommittee included the Portland State University Child Welfare Partnership training program director.

To develop a DR curriculum, DHS contracted with a curriculum writer who had assisted with DR curriculum development in other states. DR consultants and other content experts at central office worked with the writer to develop the curriculum for Oregon. DR consultants then administered the training modules in districts in which DR was being implemented.

DR training materials have evolved over time. DR staff from central office reviewed the evaluations from the DR training participants and modified the curriculum based on this feedback. The training was also modified when there were enhancements to the model, new tools, and useful experiences to include as case examples. The central office DR team indicated that they have made modifications each round of training so far.

The content of the training sessions was developed for specific audiences' job descriptions and roles. A total of six modules were available to trainers to be used in different settings. Some components of the training were used for more tangential stakeholders, such as child welfare staff members who were not responsible for DR practice (e.g., permanency workers) and community partners, while other components provided more details for people whose daily work would change with the implementation of DR. Some trainings were half-day sessions, but other sessions (e.g., screening and assessment and the Family Strengths and Needs Assessment) lasted a full day. Protective services caseworkers attended three-days of DR training, which was described as highly repetitive and elicited criticism from district caseworkers.

> *We had to do three days of DR training. The first day was the exact same as the second day, except the second day we had some community providers there, but even half the PowerPoints were the exact same slides, and so it was just a lot of wasted time. I don't know if they had to have so many hours of training to justify the funding or what.* (District caseworker)

> *A lot of the training went over stuff that we've been doing, so it was kind of like, ugh, why are we doing this again? Like OSM training; I get doing an overview, but we've done it a million times.* (District caseworker)

A district administrator also recommended some changes that could be made to the DR training sessions.

> *They put together a pretty nice training module. I think the issue that you have on training is that we did them pretty close together, and there was some repetitiveness. I think we probably could've reduced the training by a third. Some of the vignettes probably were a waste of time, especially when you're already feeling rushed.*

District caseworkers suggested that the training sessions would have functioned more efficiently as a half-day meet-and-greet with the service providers in their communities. Supervisors in District 5 suggested that the iterative process of refining the DR trainings would benefit others later down the road, as many of the scenarios used in the DR trainings would be more fully developed in subsequent rollouts.

Interviewees identified some challenges related to training. One of the most frequently identified challenges was the timing of the trainings. In District 5 and District 11, DR training occurred around the same time as the OSM Refresh and the establishment of SPRF services. There seemed to be a "saturation" of trainings, especially including the meetings and discussions that occurred before the rollout began, as the following quotes indicate:

> *There was a saturation of DR before we actually started DR, meaning trainings and talking about it. I think people were thinking, "We don't want to talk about it anymore. We just want to do it."* (District administrator)

> *Essentially the Refresh ended up being a complete repeat of when we actually had to do our DR trainings and sit through, and then we did modules on top of that, and so it was a lot of repetition.* (District caseworker)

Another challenge was that as trainers were learning about DR, trainees would receive conflicting messages and need to call a third party to reach a resolution on an issue. A district caseworker detailed the difficulty that came with trying to resolve these discrepancies: "In having different trainers, one would say one thing and then another would say another thing. We were just pulled in so many different directions, and you had to call somebody to check to see whose information was correct."

An additional training issue that interviewees discussed was the integration of cultural competencies into general trainings for child welfare staff members. Interviewees indicated that child welfare training contains content that addresses caseworker bias; cultural responsiveness; and the link between poverty, neglect, and disproportionality. Interviewees suggested that additional efforts may be needed to address these issues. One caseworker provided insight into the challenges related to workforce diversity: "I'll tell you what, you go to any child welfare training and what you see is a sea, with few exceptions, of white women and some white men. You are never going to get disproportionality solved with that population of workers." Last, interviewees indicated that new caseworkers who completed core training shortly before the DR rollout in District 5 and District 11 were trained in the traditional child welfare model of practice, and would therefore need to adjust to DR shortly thereafter. Fortunately, as several administrators pointed out, all of these issues seem unique to the early implementation stage of DR practice and are likely to be resolved as other districts implement DR.

Focus group participants identified several areas for potential improvement of trainings. For districts that implement DR in subsequent rounds, District 11 administrators advised ensuring that staff are adequately trained in the OSM first before progressing to DR. Additionally, ensuring that supervisors are adequately trained is critical, as one administrator noted:

> *I think that really the staff development or the skilled development of the supervisors probably is one of the most crucial areas. You can put them together and say we'll all learn together, but really the supervisors need to show that leadership and step up. And if we had to do it over again, I think I would've insisted on that. I think we learned it but there was a cost to it.*

DR consultants wanted some of the trainings to be more complex, particularly regarding engagement and partnerships, because much of the material covered seemed too basic. Screeners in District 5 echoed the DR consultants' sentiment, noting that they wanted more help with assigning the more difficult "gray areas." In terms of training styles, staff members preferred the more hands-on methods compared to other methods. For example, case scenarios were named as a particularly helpful method because trainees were placed in specific situations to learn how to use the screening tool.

### 6.3.3 Coaching and DR Consultants

Ensuring that the knowledge gained through the training curriculum is translated into practice is as vital as developing a comprehensive training plan. Eight DR consultants filled a coaching role and helped facilitate the transition from training to application, making sure that the skills were being used appropriately in day-to-day activities. Consultants played a key role in developing the curriculum used in trainings by working in conjunction with central office and the hired third-party curriculum writer, as described above. The DR consultants then spent a considerable amount of time in the districts that were implementing DR, offering coaching services to district staff members. Consultants were also available remotely by phone to help answer district staff members' questions regarding DR practice.

District staff members often praised DR consultants for their availability: consultants arrived onsite prior to implementation and remained onsite for several months after implementation to ensure that staff members could easily ask for assistance when challenging situations arose. District 11 administrators indicated that prior to DR, generalist DHS consultants rarely came out to the branch offices. Because of the emphasis on coaching and consulting with the DR initiative, the DR consultants were much more present in the field. Their hands-on approach eased doubts and gave encouragement to staff; this approach was described as invaluable. Caseworkers reported that the consultants would go well beyond simply

telling caseworkers what to do and would instead help them learn by asking questions. Several district caseworkers discussed the benefits of working with the DR consultants.

> *They were sitting at our desk and really helping guide us through. We'd staff with supervisors when they were present, because it was just so much of a shift as far as thinking about how we do our assessments and how we conduct them.* (District caseworker)

> *Our consultant was really great. We have a conference table in where our cubicles are, so she would just kind of sit there, she would listen to what's going on, she'd put in input, she would go on assessments with us. She was always there for support.* (District caseworker)

Interviewees generally considered DR consultants to be highly engaged at multiple levels, often available to go out in the field with caseworkers or sit in on meetings with other staff members. Reflecting on the role of the consultants, participants from two separate interviews noted the convenience of having them physically present.

> *I think there's so many unknowns and so many questions that having them right there instead of sending an email or trying to call someone, I mean, they're right there and you can just ask them.* (District caseworker)

> *They seemed to have a lot more information about what that family interview looks like, whereas like with the new workers, I would go out there and kind of wing it off of what all the paperwork tells us to do, but we know that's not really reality. You get out there and that perfect family interview typically doesn't happen. So it was really nice to be able to have one of our consultants actually go with the workers and provide them some feedback about what it is he saw or learned out there that maybe we haven't.* (District supervisor)

The ability for DR consultants to learn from other states, as well as to talk with one another, appeared to greatly improve their responsiveness and overall effectiveness to specific issues that arose at the district level. One district supervisor noted the unique benefit of this coaching role: "We had the luxury of having onsite consultants when we implemented. Other states did not have that luxury. I think they were helpful…it was nice to have them here to bounce situations and such."

Although the caseworkers offered predominantly positive feedback about the coaching they received, some suggested the need to develop a better plan for determining how to phase out the presence of consultants in a district office after DR was successfully implemented.

> *There needs to be a plan...it relates to when I was teaching my kids how to ride a bicycle. You ran behind it for a while, but eventually you have to let go. But that was always the plan. I think at times we didn't know what the plan was. They were here. They were supportive and it was great. But I think having some clear outcomes from the very beginning would have been good, like, "I'm going to be here until this point."…We developed an exit strategy, but it was at the time of exit. I think that was something that, if we could do it over again, I probably would've said: "For month one, these are the goals. This is what we're going to see." But I think we were first at implementing and we didn't know what to expect month one.* (District administrator)

In addition to the lack of clarity regarding an exit strategy, interviewees revealed that consistency was also a challenge. Screeners in one district commented on the difficulty of maintaining trust in the

professional relationship after being incorrectly advised by a DR consultant, who later denied giving the screeners misleading information.

> *There was some other stuff too, but that was a big faux pas. And now that consultant, for us, has pretty much lost all credibility….So if you're going to send trainers out, you need to make sure they know what they're doing and that they have some integrity.*

Additional challenges arose out of concern that the consultants were not adequately trained for assignments that fell outside of their area of expertise. For example, screeners recommended that consultants have experience in protective services in order to provide consultation on those services.

Many of the reported challenges related to consultants not knowing exactly what the focus of their work would be in a given district until they arrived, largely because each district had its own strengths and areas for improvement. This is significant given that the aim of the consultant is to teach the district staff so that they become more self-sufficient, at which point the consultant would continue to assist upon request. Perhaps as a result of this challenge, some caseworkers seemed reluctant to ask the consultant for help, leaving their services occasionally underutilized. Given that supervisors were often overwhelmed, caseworkers in one district suggested empowering consultants to staff cases without a supervisor and enable them to do more with the caseworkers:

> *I think the agency needs to think differently. They need to empower these consultants who are specifically trained to do this, and let them staff the cases with the screeners. Also, I think that it would have been helpful if they had actually listened—like, plugged in and listened to some call taking and done a little bit more one-on-one coaching. Not everybody would love that because you don't always want somebody listening in. But I think that coaching on how to shift the call taking with the family-functioning questions would be helpful, more than just staffing the decision.* (District supervisor)

The sustainability of the consulting model was also a concern. DHS leadership indicated the importance of rotating consultants so as to prevent burnout from traveling. It would also be helpful to hire and maintain a pool of consultants who live in the district's vicinity. This proved to be difficult for District 11, a rural district, and will likely be an important consideration during implementation in the rural districts of eastern Oregon. One district administrator highlighted the importance of transitioning the lead role away from the consultants and to a supervisor prior to the departure of the consultant:

> *We had a struggle…we needed to make sure that the supervisors were the expert and not this random person (the consultant) who was going to leave. So that is something that we've continued to put forward. The person doing the coaching needs to work with the supervisors who are then going to work with our staff, not send the staff to work with somebody who's going to be leaving.* (District administrator)

Interviewees indicated that moving forward, communication will be key to the success of the coaching model. As the consultants become less physically present in the district offices, it is imperative that district staff are aware that consultants are still accessible. It is also important that the staff members of districts that have already implemented DR will be available to staff members in other districts undertaking DR implementation. This peer-to-peer consulting model can play a key role in the continuity of consulting and the improvement of the overall model.

### 6.3.4 Supervision

To be successful, multilevel interventions necessitate that a network of individuals take on specified roles. Although these roles may change over time, someone needs to ensure that staff are qualified and equipped to perform their tasks. In the context of DR, supervision can be thought of as the process by which staff receive feedback on the work they perform. Given that both the amount and source of supervision varies between districts and job descriptions, interviewees were asked to describe the role of supervision in their work toward the implementation of DR.

Interviewees generally described district supervisors as readily available to caseworkers. Caseworkers often depicted scenarios in which caseworkers had questions concerning an assignment and simply walked over to the supervisor, who was generally available to assist them immediately. Caseworkers are typically assigned to a specific supervisor, but caseworkers from District 5 and District 11 indicated that if their supervisor was unavailable, they could easily speak with another available supervisor. Interviewees also noted the willingness of the supervisors to be a helpful resource to the caseworkers; screeners in one district pointed out that if their supervisor was going out to lunch or to an appointment, the screeners would often be told that the supervisor could be reached by cell phone if nobody else was in the office. This environment was echoed by a caseworker from the other district: "You can usually find them by IM, text, phone, or office. If they're not, somebody else is. I mean, we're free to use whatever supervisor is available, so there's almost always somebody. It's very rare…that you can't find somebody."

This hands-on approach to supervision is reminiscent of the supportive role played by DR consultants. District caseworkers appreciated practical forms of assistance, especially for their day-to-day tasks. Even then, different caseworkers accessed supervisor assistance to differing extents. One district supervisor described this difference by comparing seasoned caseworkers and their newer counterparts: "A seasoned worker lets you know, 'I've got a new case, heading out the door, and this is kind of what's going on.' With newer workers, it's a little bit different. You have to actually sit down and walk through the process of what they're going to do."

Comments from the same interview revealed that caseworkers will occasionally receive different responses on a given issue from different supervisors. Supervisory concerns following the implementation of DR should be interpreted with caution, however. One screener explained that staffing issues can put supervisors in situations with which they have little experience, such as when an intake supervisor is covering screening. There has been an effort to cross-train supervisors to take on multiple roles, but the screening supervisor naturally knows the most about screening and would be the most appropriate person to fill the role. Additionally, DR has had a noticeable effect on the way supervisors conduct their work. According to one district administrator, supervisors may feel the pressure of learning a new system alongside their caseworkers, sometimes appearing to struggle with their new role.

> *When you talk about supervisory structure, you have a new model. I've heard this and you'll hear it if you haven't heard it: you have very competent supervisors, experienced supervisors. One day they're given praise for doing the job this way, and now you have a new model that you're going after that's different. So you have this level of so-called incompetence. That's their word, it's not mine, and I'm not saying they're incompetent.* (District administrator)

From information gathered in the course of interviews with district staff members, it appears that most supervisors are readily available to support their caseworkers, but struggle in providing expertise on a

model with which they are less familiar. Like others areas previously described, this issue is likely to improve over time, but it should be on the radar for other districts as they prepare to implement DR.

### 6.3.5 Performance Assessment

Similar to supervision, performance assessment is designed to improve the performance of DR implementation and practice. Assessing the performance of staff must be done thoughtfully and intentionally, maintaining a balance such that caseworkers feel supported but not overwhelmed.

Caseworkers gave mixed feedback when asked about performance evaluations. District 5 caseworkers, for example, said that they received feedback of some sort every day. Formalized evaluations, however, may not be completed regularly, possibly for years at a time. District 11 screeners reported that the screening supervisor conducted such an evaluation once per year. Caseworkers from both districts indicated that most of their overall performance assessment occurred in informal meetings with supervisory staff. Caseworkers reported that daily feedback on performance was common, and they appreciated the accessibility and hands-on supervising styles of their superiors. This appeared to be a welcomed practice: caseworkers enjoyed knowing the areas in which they could improve as they worked, rather than only hearing about these areas in their annual reviews.

When asked about performance reviews, interviewees frequently mentioned the Employee Development Plan (EDP). The EDP is part of a larger DHS effort focused on professional and leadership development. The EDP is a tool that employees complete in consultation with their supervisors to identify how employees can do their jobs better. The intent is that employees and supervisors will regularly meet to discuss the employees' progress toward their goals. Caseworkers' opinion of the EDP was almost exclusively negative. Many caseworkers believed that the EDPs had little utility and that they were updated too often. Although the EDPs are meant to be a reflection of a caseworker's career goals, some interviewees indicated that they had met with supervisors monthly to update their plan, which caseworkers described as "completely ridiculous" or "excessive." Supervisors conceded that they do not always update EDPs when they meet with employees, opting instead to make sure that the caseworkers feel supported, and that they are meeting overall goals. Two supervisors believed that the EDP was not very useful for their caseworkers:

> *I don't see where the EDP has made a difference. It hasn't motivated or encouraged. To be honest, it's one more thing they have to do.* (District supervisor)

> *I think sometimes it's so busy that sometimes it's hard for them to feel like they're fulfilling what they put on their EDP.* (District supervisor)

The amount of performance assessment that staff members receive is highly variable. Screeners in one district reported that they are "not evaluated and there isn't a consistency" with respect to how they do their work. Despite many caseworkers feeling well-supported by supervisory staff, some screeners indicated that they received little support or feedback until something went wrong.

Supervisors from District 5 and District11 offered differing reports on the level of supervisor assessment: one set of supervisors indicated that they are not evaluated or given ways to improve, in contrast to the other set of supervisors who reported receiving such evaluations.

Clearly, the assessment of staff performance is intended for more than simple evaluation. The sense of support that can accompany a well-balanced system of evaluation and feedback can create an

environment in which staff members are able to be confident in their work and remain focused on goals. It appears that caseworkers and supervisors at the district level could benefit from a more intentional and supportive performance assessment structure.

# 7. DR Practice

After years of exploration and planning, the two-track DR model was formally launched in Lane County (District 5) and Klamath and Lake Counties (District 11) in May 2014. During site visits, staff members described how the implementation of DR has changed the way that child welfare workers assess, interact with, and support families. Staff members also explained how the two-track system has changed workers' roles and responsibilities. This section of the report describes DR practice in these two districts approximately one year after the initial launch in May 2014, highlighting how AR families move through the child welfare system and how practice differs for cases in the two tracks. This section also describes how families access services in local communities and how the service array has changed with the availability of SPRF services and the implementation of DR.

## 7.1. Screening and Track Assignment

In Oregon, a child welfare case begins with the initial report to the child welfare agency. Designated screening staff are responsible for gathering initial information from the caller to determine whether a report is appropriate for further agency involvement. With the implementation of DR, if a report is screened in and constitutes an allegation of abuse or neglect that requires a CPS assessment, screeners must now determine whether the case is eligible for the AR track. To make this determination, screeners use a standardized track assignment tool (included in Appendix D); this tool provides guidelines to help the screener determine whether or not a traditional investigation of child abuse or neglect is required. If a traditional response is not required, the family must be served in the AR track.

Although the track assignment tool provides guidance in making this decision, the eligibility determination is not always clear. DR consultants indicated that the use of the track assignment tool has proven challenging for screeners because it is often used very literally. Consultants indicated that they would like screeners to be able to make more subjective decisions about track assignment and be less reliant on specific examples included on the track assignment tool.

> *People will look at—if it's not on [the track assignment tool], then it goes to the alternative track. So you really have to work with people on what is a severe allegation of neglect, what is a severe allegation of physical abuse. And we have severity defined on the tool. So those examples are just supposed to sort of get you thinking that way. But people really look at that and say, oh, not on here, doesn't apply.*

DR consultants also discussed their own confusion and difficulty clearly delineating the severity of cases.

> *It took us as consultants a couple of times to kind of get all on the same page, that strangling and choking is severe. So it's those kind of examples where people are second-guessing themselves.*
>
> *I think we're still figuring some of it out.*

In particular, DR consultants noted that one of the most challenging aspects of the tracking assignment tool was predicting whether a child will likely suffer severe harm because of a threat of harm:

> *The biggest issue you have right now with track assignment is in our rule it says that the child has suffered severe harm or could likely suffer severe harm….You have to predict. How do you predict in a screening?* (DR consultant)

When asked what was most helpful in their training, one screener said, "learning how to make decisions, not necessarily being given answers on a particular case, and figuring out the theory and the thought process behind the way the decisions are made." Even after they have completed the training, screeners continue learning about track assignment.

In an effort to address the challenges in making eligibility decisions about DR track assignment, both districts are now using group decision-making processes. These group meetings include screeners, caseworkers, supervisors, and other support staff who meet to make a decision regarding whether a case is assigned to the AR or TR track. Interviewees in District 11 said that this process was used in the district prior to DR implementation (District 5 did not specify). In District 5, this group decision-making meeting is referred to as the RED (Review, Evaluate, Direct) Team, as described below:

> *We use RED Team when we get stuck at screening, typically. So when the screener looks at it, and they're like "I don't know what to do," and they bring it to me, and I'm like, "it could go either way," then we'll shoot it to RED Team, which is an intake supervisor, ongoing workers, and then maybe some clerical staff, social work assistant, somebody else. They've got copies of our screening policy and the track assignment tool. They'll look at the case, case history, and then look at our policy, screening tool, and decide if it meets requirements to assign or not.* (District supervisor)

Interviewees from District 5 said that they only use RED Team when screeners are unsure of how to move forward and when input from others is needed, whereas District 11 staffs all cases at these group meetings. District 5 also mentioned using RED Team to discuss case closure if collateral calls are made and a report doesn't meet criteria for assignment.

District administrators were asked if there was anything about the screening process that was particularly successful. They spoke highly about the group meetings as an opportunity to discuss track assignment decisions for less clearly defined cases, as the following quotes illustrate:

> *You have that group learning. You have that group discussion....I've been a strong advocate that the new people get to hear the process—the thought process—on how to assign. I think that's been a real positive for us.* (District administrator)

> *I think it was a great learning [process] for everyone to talk out how we were assigning things and why.* (District administrator)

Screeners were also asked how their job responsibilities have changed since the implementation of DR. They indicated that they are spending a greater amount of time on each case, particularly in terms of making more collateral calls and doing more research on a family's history with child welfare, as the following statement exemplifies:

> *With DR, you need more information to properly assign cases—because, if you think about it, if something needs to be TR because there's a dangerous person involved and there's a particularly*

> *unsafe child, we need to have more information to make that determination. So, it takes more time and investigation to pull that information out of our callers. You know, if we had physical abuse, you have to talk about, "How does this alleged perpetrator normally interact with others? Are there other indicators of abuse? Are there other indicators of some neglect going on as well that help us decide what track to go on?" That takes time. Sometimes it takes collateral calls. And we have to review history. It used to be that although it's always been policy to review history, if somebody called me and they said, "This child has a bruise" and they said their dad spanked them, I would assign it. And I know I'm assigning it anyway, and I know the worker has to read the history to do their assessment, so I might do a brief synopsis.…We're reading more history and that, to me, is the thing that's taking the most time.* (District screener)

Many interviewees indicated a need for an adequate number of screeners to do the additional work that is now required for these positions:

> *[Reading more history] has to be done in order to truly, truly do the track [assignment] correctly, but we have to be staffed appropriately for that to happen. But we also have to get calls out. So you get put in this position where—you know, we actually had a consultant—I think he was trying to empathize with us that he understood that it's difficult, but it kind of came across like, "I know that that's not even doable." And we're like, "Then staff us appropriately so that it can be done."* (District screener)

> *I think that in order to support us, we need backup staff that are not screeners, that are trained to screen, who can back us up if our call volume is beyond what we can handle. Maybe it's supervisors that can get on the phone. Maybe it is intake workers that can get credit to get on the phones for us. But, people that will actually come and sit in a desk and take calls and complete the reports and do the whole thing to support us when our call volume is beyond what we can handle.* (District screener)

> *One of the challenges, too, is that we are not adequately staffed for screening statewide, because they're staff based on [the number of cases] closed at screening, so reports that don't require a CPS referral or CPS worker assigned.* (DR consultant)

Screeners also said that a lack of proper training for new screeners was contributing to screening inefficiency:

> *We're not getting very much training. I didn't get much training when I came to be a screener, but luckily, I had already done screening somewhere else. It's taking away from everybody who is up and running and working at a nice speed because they have to then also help [the new screeners]. Because if you don't help these new [screeners], then they're not going to ever be proficient at doing what they're doing. So, they're always going be like a thorn in your side or whatever. So, help them to get better, but yes, you are taking time away from what you are working on.*

> *Training is done by peers. So if a peer is training another peer, then we have two people taking half the amount of calls that trained staff normally would have taken.*

Screeners from one district expressed frustration with their workload because of these additional responsibilities. Two screeners described being more stressed since the implementation of DR:

> *I've actually had one day where I thought I could puke. In my 15 years here, I've never had that happen.* (District screener)

> *That support isn't there. We need more support. We need more staff. The people are leaving. We're losing people to sickness. We're losing them because of workload.* (District screener)

Although it is not easy to determine how much of this frustration is directly attributable to the implementation of DR, there is clearly a sense that DR has increased the workload for screeners, and that current staffing is not adequate to cover these additional responsibilities.

Caseworkers and supervisors were asked to reflect on the appropriateness of the track assignment decisions being made. Caseworkers indicated that AR works well for neglect cases, for families who have a history with the DHS, and for parents with mental health issues. When asked whether they believed there were cases that should not be assigned to AR, supervisors and caseworkers said that cases involving domestic violence, sex abuse, and substance abuse should be assigned to TR.

## 7.2. Initial Contact

After a case has been assigned as an AR or TR case, the caseworker is responsible for the initial contact with the family. From the perspective of caseworkers, one of the main differences in practice between AR and TR cases lies in the worker's initial contact with the family. Although TR families may receive an unannounced visit from their assigned worker, families assigned to the AR track will typically receive a phone call in advance to schedule a time to meet.

> *I think with AR, they're getting that phone call ahead of time saying, "What works good for you? Who can you bring with you? Who do you find as support?" and making that on their terms. On a traditional response, we're typically going to the school ahead of time, we've already interviewed their kids, and then we're knocking on their door either by ourselves or with law enforcement.* (District supervisor)

Caseworkers also encourage families to bring a support person with them to the initial meeting with the caseworker. One caseworker said, "it's easier to meet [families] with a friend or family [member] and identify that problem." Caseworkers in District 5 indicated that families bring a support person to the meeting approximately 50% to 80% of the time. Although interviewees generally considered it beneficial for the family to include a support person in the initial meeting, several interviewees reported that having a support person in the room can be unproductive in some circumstances because of the discomfort that arises when relaying details about the allegation.

> *I find a lot of times, you end up having to have another interview with the parent later without the support person, because a lot of times the support person is a friend or family member that they don't want to be completely honest in front of.* (District caseworker)

> *The feedback I'm getting from staff is we're asking, but maybe a mom or a grandma will show up. But a lot of times they don't want anybody to know their business.* (District administrator)

The DR model suggests that AR families have more decision-making power about who is at the initial meeting and when the meeting is held. Interviewees had mixed perceptions about the effects of this more collaborative type of initial contact with families. On the one hand, several caseworkers stated that calling before the initial contact has improved their relationships with families and has made their work easier because families are more engaged and less hostile:

> *I think the phone calls start off a better relationship. I don't know if it's more power or whatever, but I think it starts off a good relationship.* (District caseworker)

> *On the positive side, sometimes [families] are not so hostile to us when we call and say, "Hey, this is what we're doing, we're scheduling this," and they can yell at us on the phone instead of in person, usually. And it's a little easier and it doesn't feel like we're trying to catch them.* (District caseworker)

> *Well, I've found that in a lot of instances, it's made it a lot easier for me to work with the family and they will accept some of the services that I've offered where they wouldn't have before because they didn't want us to continue to be in their life.* (District caseworker)

A supervisor provided an example of a family's anger about the TR procedure lacking a phone call ahead of time, after having prior experience with the AR response.

> *The case that I was just with, we had done an assessment on them three months ago where it was AR, and this time it was TR and it was like, "How come you didn't call ahead? How come you didn't talk to my mom? How come you went to the school?" So they came in angry.* (District supervisor)

On the other hand, some interviewees also expressed some concerns about this practice. One community partner described that this first meeting can be overwhelming for some families because they are uncomfortable in the situation, in which they are not being told what they need to do.

> *Families who were on the [AR] track almost felt uneasy not having this set of, "Here's what you need to do" as kind of a policed structure of, "Here's what you've got to do if your kids want to stay in the home." I worked with a number of families who were like, "No one will tell me what I'm supposed to do?" This was interesting because really, it's supposed to be more about flexibility and we're going to honor your position as parent. But it really made them uneasy. I didn't really expect to see that with families. I expected them to be more like, "Oh, this is so personal and so different than what I expected and we have some freedom here." But we've talked a little bit about that in our team, as far as how you balance that. We're trying to have this avenue that's more family friendly, and yet, it's kind of freaking people out. They're worried when DHS is involved, if they don't do the right thing their kids are going to be gone.* (District community partner)

Caseworkers in one district also discussed concerns about caseworkers calling ahead on AR cases. The following conversation shows their dislike of the practice change.

> *In the beginning, I hated it. It was that mental shift of, "Now I have to call ahead and they have to do all these other things on top of the five million other things that they want us to do."* (District caseworker 1)

> *And I think when you call ahead, people say, 'well let's just get this over with now.'* (District caseworker 2)

> *Let's face it, half of our clients don't have phones, don't have working phones, the phones are changing. They're not calling you back, they know who it is; they all know our ghost number, let's*

> *face it. Then you're going to their house, leaving a card, trying to say "I'm here, this is why I'm here, but let's schedule a time." So that's not really feasible as it is.* (District caseworker)

Overall, there were mixed perceptions about calling ahead of the initial contact with the family. In some ways, this approach was viewed as more respectful to families involved with child welfare. On the other hand, it reportedly caused some confusion for families (because it is different from traditional child welfare practice), and it is more work for child welfare caseworkers.

Another difference between AR and TR cases is the response timeframe from when the report was received at screening to when the child welfare worker is required to make an initial contact with the family. For TR cases, initial contact must be made within 24 hours, unless there is an indication that child safety will not be compromised; in this situation, contact can be made within five calendar days. For AR cases, the timeframes are reversed: initial contact is required within five calendar days unless information indicates that a child is currently in danger or a child has a current injury as a result of the alleged abuse or neglect, in which case a 24-hour response is required.

Caseworkers raised some concerns regarding the five-day response for AR.

> *Suspicious means suspicious for physical abuse, not suspicious of how was it caused. That is something that has really worried me, too. Those should never be a five day, ever.*

> *There were concerns when our reported concern is drug use by the parents. Our report says parents have been observed using drugs around the children, and then it gets assigned as a five day and so we let them know that we're coming.*

## 7.3. Family Engagement

A key aspect of the DR model is the effort of caseworkers to engage the family, collaboratively working to identify and address family needs, as the following statement illustrates:

> *The implementation of Differential Response and particularly the Alternative Response perspective depends very much on a style of engagement and interaction with families that departs from the way old school used to be. Old school was they came and told you what you needed to do and told you when you needed to do it in order for you to even keep your child or get your child back. The attitude now is gradually changing to "You've got issues. How can I help you and what do we need to do?"* (DR State partner)

As part of DR's implementation, a family engagement subcommittee was created to develop an engagement toolkit for staff (adapted from Ohio's practice profiles). As a result, a family engagement module was incorporated into training to build the engagement skills of caseworkers. One caseworker shared the benefit of integrating family engagement training into their practice: "I feel like it's helped me to do the work that I wanted to do. Instead of a robot, it's really helped me grow, as part of my engagement skills, remembering that these are families and that we're not here to necessarily find out anything bad." In contrast, other caseworkers discussed how family engagement is not something that can be learned through training; engagement skills are instead learned through practice:

> *What they're trying to dictate through a process is really something that's the art of casework. You're not going to be able to put it on a piece of paper.*

> *Like most jobs, you either have it or you don't. You can't teach engagement and getting a curiosity to follow up on questions or to pick up on little things that they say and go back to that, not everyone has that.*

Despite some comments about the ineffectiveness of family engagement training, it appears that the shift in focus to engaging families has made a difference. During the site visits, interviewees were asked to reflect on how family engagement has been interwoven into practice. In general, there appears to be a sense that the family engagement practice has infiltrated broader child welfare casework practice, as the following quotes demonstrate:

> *It's more than just the TR and AR [tracks], it is how we engage with our families. I mean, I don't treat my families different, I don't have a softer approach on AR than TR. I treat the families the same on both sides. There's times that I call on traditional responses, give them a call. It's just how I practice, everybody's the same.* (District caseworker)

> *It really felt like [caseworkers] brought in full engagement on both tracks because it's good practice. It's not just good practice for some cases. It's good practice for all cases. By the end, it felt like the main difference was whether or not there was a dispositional finding.* (State partner)

Progress has also been made in terms of incorporating families when designing a safety plan for child welfare families. In particular, the child welfare system has tried to make safety assessments more accessible to families by making the language of the assessments more informal and understandable.

> *I think engaging families better...in the safety planning process and not telling them, "This is how it's going to be or I will remove your kids," helps us be creative in the ways we can be to make this as safe as possible for their kids and letting [the family] be a big part of that, which I think we've gotten better at. The language of [the safety assessment] is not too jargon-y, [families] can read them and understand…[The safety plans] are carbons—we write them in the field with the family, so we can work with them there and say, "We need to create a plan, let's work together."* (District caseworker)

From the perspectives of caseworkers, community partners, and supervisors, the implementation of DR has strengthened relationships between caseworkers and families, as the following quotes show:

> *We're building that relationship. I think that we spend more time with the families, so I have more phone time, more visits, and become more involved with the family, so it does feel like it takes more time.* (District caseworker)

> *It's been very successful—a whole different relationship now with these clients and the caseworker. For example, we've got a worker that rides her bike quite often…in that neighborhood area—clients are coming out anxious to see her. And we're trying to call ahead; we're trying to set up appointments. It's a much more intensified relationship in case management.* (District community partner)

A supervisor remarked on families having an increased level of trust with caseworkers:

> *I think there's a big drastic difference. There's a little more of a trust level, as much as they can trust us, that if we're saying, "We haven't done anything, we just want to get together, we want to meet with you, and we'll bring somebody from the community to talk to you." It always doesn't*

> *pan out to be the perfect scenario like people want it to be, but I think families feel like it's not as intense as what I would think.*

## 7.4. Disproportionality and the DR Model

As described in Section 5.7, DHS views DR as a mechanism that will help address issues of disproportionality in the Oregon child welfare system. Section 5.7 described the organizational efforts to address disproportionality; this section focuses on how the DR approach of working with individual families may positively affect disproportionality in Oregon.

*Focus on cases of neglect*: Because disproportionality is correlated with issues of poverty, the front-end approach to working with cases in which safety is not a factor leads to a preponderance of neglect cases in the AR track.

> *[Because of] the way that we were engaging folks, especially communities of color, we had a really high number of children who were coming into care because of neglect. We also knew that families who were overrepresented in being involved in poverty were also families of color from communities of color. So when we started really looking at kind of how we're going to have an impact on overrepresentation and right off the bat, we're talking about taking those allegations that come in about things that are probably correlated to poverty and putting them into a different track right off the bat. And then how do we engage with them in a different way? That was really the work that's been going on.* (DHS leadership)

*DR practice*: There are several aspects of DR practice that encourage families to engage with their caseworker and allow workers to have a better understanding of a family's culture, circumstances, and need. These practices include the initial contact families have with DHS and how families are linked to the most appropriate services and support, as described below:

> *We call ahead and we're talking with a family while giving them that opportunity to have a support person there, if they do have a different cultural background or whatnot. They could have somebody present as opposed to just us coming out and pretending to know who they are and where they're from. So I think that gives them a little bit of support.* (District supervisor)

> *I hope that when you look at the family engagement strategies and using those as tools, meeting with families, understanding families' needs, having family-driven plans, broadening your knowledge of community services or getting community providers to be able to provide services, that it will positively impact those families in our system.* (State partner)

> *When you have the opportunity to go out with tribes simultaneously, then that cultural need can be met because of the tribal piece and that kind of initial engagement. But I still think sometimes you have staff that really grasp onto that and do well in that area, and sometimes you don't. So I think that's still challenging.* (State partner)

Several service providers that worked on the early design of DR also described how they worked with DHS to develop a service model that is more responsive to communities of color:

> *There's a disproportionality that exists and it's just a matter of dealing with people and interactions with DHS. What we did as providers, we function as a bridge to mediate some of that*

> *interaction, and so what we do now is take a relatively strong role in being the upfront resources used to encounter people.* (State partner)

> *[We have taken on] more of a leadership role in the actual interfacing and contacting the people from the first contact, the first-response perspective. I had stationed staff that actually went out with first-contact workers and participated in the safety planning aspects of what happened with the clients. Our argument was that if we did not get a chance to participate in the upfront safety plan and individualized action plan for these cases, we would just simply be repeating the same things that were done for years before we got involved.* (State partner)

According to interviewees, aspects of DR (e.g., initial contact and family engagement) may allow the assigned worker to better assess and address the needs of minority populations. This, along with an effort to integrate service providers who serve communities of color into child welfare practice, may have the intended effect on disproportionality in Oregon. However, evidence of the impact of DR on disproportionality is still anecdotal and should be considered as an area of inquiry in future evaluation efforts.

## 7.5. Risk and Safety Assessment: the OSM

As described in Section 3.2, the OSM is Oregon child welfare's practice model used at all stages of a case from initial assessment to case closure for the purpose of ensuring child safety. The model was developed to create a decision-making process to, among other things, identify and differentiate between present and impending danger and to put an appropriate safety plan into action when present or impending danger is identified. Caseworkers assess safety threats by utilizing the OSM's safety threshold criteria: imminence, out of control, vulnerability, observable, and severity. After the safety threat is identified, safety planning must occur. If there is a determination that the child is safe and that families have moderate to high needs, they can be served by community providers as part of DR.

When asked to compare the CPS assessment process for AR and TR tracks, district staff and DR consultants indicated several differences. Although families in both tracks receive the same assessment, unlike an AR case, a TR case results in a dispositional finding. The manner in which information is collected is also different: for an AR case, information may be gathered through a group interview process with family members, whereas in TR cases, family members are often interviewed separately. One DR consultant perceived the assessment process for AR cases as more "family driven:"

> *We're asking them, "What's the best way to interview your kids? How would you guys want to talk to us? Would you like somebody to be there with you?" We don't necessarily do that in Traditional Response. We might tell them we're going to go interview their kids. [AR] is just more family driven.* (DR consultant)

Supervisors were also asked to describe how the safety assessment process has changed because of the OSM. The main difference is that information for the assessment is no longer recorded in chronological order and is now more of a summary, as described below:

> *Now we're dividing it up into the functioning, the disciplinary, and then it's kind of like the summary of what happened, and then the basis of why it happened, instead of just all kind of happening within one chronological assessment. I mean that's the major difference that I think is changed. Literally, it used to be date by date. "We did this on this date, we did this on this date."*

> *It's painful for me to now read our older versions, actually…You read all of the stuff and case note after case note, as opposed to just being able to jump to the extent section and understanding in about five paragraphs what happened in the course of this assessment.*

*OSM Fidelity:* DHS is particularly interested in the degree to which the OSM's policies, procedures, and core components are being implemented with fidelity. The state of Oregon had initially implemented the OSM in 2006; however, according to a district administrator, because the OSM was not being implemented with fidelity, they initiated the OSM Refresh in 2013. The goal of the Refresh was to work with caseworkers and supervisors to strengthen their use of the OSM. According to supervisors and consultants, the OSM modules have helped caseworkers understand the six domains of the OSM in greater depth.

DR consultants, state partners, and district supervisors shared their feelings about fidelity to the OSM in current DR practice. The majority of the discussion was about their concerns:

> *To be honest with you, I think the cases that we're opening or founded cases, there's probably more fidelity to [these cases]than to those that it's clearly not [a finding]….Because those are the ones that are going to get more attention, and we want to make sure we've covered everything that we're supposed to. Not saying that we do, because we don't, because the model is so comprehensive, but I know for myself, I pay much more time on [the founded cases] than on those that are clearly not founded or clearly an alternative response.* (District supervisor)

> *I really do think that, in some states, the blinded demarcation and the decisions about where children go in terms of…child safety is not as clear as it needs to be. So I would say that that's another area that they really need to give thought to.* (DR State partner)

> *I think what gets lost on many people is that, if Oregon really implemented their safety model the way it is designed and intended, their volume would drop about 30 or 40 percent of what they take into their formal system [because they wouldn't be opening as many cases].* (State partner)

Despite some concerns about fidelity, several interviewees spoke positively about the potential to improve fidelity to the OSM model.

> *I think that being the focus of DR, we got a whole lot of extra sort of intensive support. And we took three long OSM trainings in the course of the year, just because they happened to be rolled into different things. We beat to death, like the severity bar raising.* (District supervisor 1)

> *There's always progress to be made, but I do think that people are holding steady.* (District Supervisor 2)

> *I think people are trying, and I think from my perspective is that there's a difference—I think most of the people I talk to can understand the concept, but their ability to put it into action, they're still learning how to do that. But I think there's an absolutely more deliberate intention to use it. Before, people were just writing N/A, not applicable, in the domains, and they weren't using it at all. The effort is definitely there, and I hear new workers that are writing the six domains and saying, "Oh, it's becoming easier." And they're still learning how to do it. But people are definitely making an effort.* (DR consultant)

## 7.6. Services

Many families who are involved in the child welfare system need to be linked to services and support systems to ensure the safety of their children. It is important to accurately assess families' strengths and needs so that they can be referred to appropriate services within their communities. This section of the report describes how family service needs are assessed and provided, emphasizing how the implementation of DR has affected the local service array in District 5 and District 11.

### 7.6.1. Family Strength and Needs Assessment

If the CPS assessment indicates that no safety threats exist and the family is identified as having moderate to high needs, families are eligible for a voluntary strengths and needs assessment to determine which services might be appropriate to improve family functioning. An array of services can then be provided to the family to address those needs and build on existing strengths identified in the assessment process. As a result of SPRF funding, DHS has new resources available to provide families with services during their involvement with child welfare, even after case closure. In these situations, the child welfare agency can essentially close the case, but keep it open as an "admin-only" case and continue to pay for needed services.

The Family Strengths and Needs Assessment (FSNA) is the instrument used to assess family strengths and need. Both AR and TR cases are eligible for the FSNA, as long as the children have been determined to be safe and categorized as moderate to high needs. If children are unsafe, they are still eligible for the same services, however have an ongoing safety plan in place and an open child welfare case. They then receive a protective capacity assessment instead of the FSNA.

The FSNA is based on the family component of the nationally recognized Child and Adolescent Needs and Strengths (CANS) and Family Advocacy and Support Tool (FAST). Families are assessed in a variety of areas, including family status (household status, family strengths and support systems, and family relationships), parenting team status (parental commitment and parenting skills), parents' or caregivers' status (parent or caregiver health and well-being, life functioning, and social relationships) and child's status (child health and well-being, developmental needs, education, and high-risk behaviors).

Instead of the FSNA being completed by DHS caseworkers, families meet with local service providers (including navigators, mental health specialists, and housing providers) to complete the FSNA. District 11 supervisors said that this is beneficial because families are "more receptive to someone who is not child welfare." Additionally, the service provider who is conducting the FSNA is sometimes already working with the family, and may understand their needs better than someone who has no history with the family.

One caseworker said that the process of selecting a service provider to complete the FSNA and provide SPRF services is "a competition between service providers." Another caseworker described their own practice of making a referral for the FSNA:

> *Basically, when I'm going to do a referral for a strengths and needs, in my mind, I'm just going to send it to the person who I want to do the service and ask them to do the strengths and needs, and then they refer themselves to the service. I haven't seen a lot of branching out beyond that, and so it's sort of like whoever does the strengths and needs does the service.* (District caseworker)

Service providers have 15 days to complete the assessment. After the assessment is completed, the family, the provider, and the caseworker participate in a case closure meeting and discuss next steps. One service provider described the process as follows:

> *We'll go down, and I don't read straight from it because that's just really awkward. It does not personalize anything. You really want to try and draw the best answers you can out of the family. So I'll jump around, I'll involve the kids if they're old enough. We'll just chat. I try to make it personal. I have met with the kids after school; we try to do it the best we can, in a comfortable, familiar situation…Sometimes we try to meet with the family a second or a third time if anything else has come across. Then we have basically two weeks to complete this. We turn in a one-page assessment to the caseworker, and then the caseworker calls us and the family, and schedules a meeting with everybody involved, where we go over our recommendations.* (District community partner)

Site visit participants raised some concerns about the FSNA process. When the FSNA process first began, caseworkers estimated that they were referring approximately 70% of cases for the FSNA "because it was a good idea in theory." As of June 2015, however, caseworkers estimated that only about 5% to 10% of cases were being referred for an assessment. In response to questions about why workers were not referring families for the FSNA, a number of themes emerged. Some interviewees believed that the FSNA is unnecessary because caseworkers already work closely with the families and can identify their strengths and needs through those interactions, as the following quotes illustrate:

> *There's no magic assessment coming out of this. We could guess the services.* (District supervisor)
>
> *Most of the time I already know the family needs.* (District caseworker)
>
> *Well, and I think too I've had certain people that I've worked with over time and those are the services that I want to put back in because I have a good working relationship with them, and those people I know when I put them in there that can address these people's needs, it's like we do our own assessment while we're in there and we just don't check the boxes. But we figured it out.* (District caseworker)

Some caseworkers stated that families are less engaged during the FSNA because they have already experienced a form of assessment with caseworkers:

> *Those meetings that I've been at, when we talk about the strength and needs assessment, if it's been done with the family and provider all at the same time, they're kind of awkward. It's like well, we already talked about that, so I don't understand what the point of this is.* (District caseworker)
>
> *I've had a couple conversations with clients they're like, "Yeah, I did the assessment with you guys and then now I have to go do another assessment for strengths and needs. I've already talked to you, I've already told you my life story, I've already had that relationship with you, why am I sitting down with these people that I don't know to talk about this again?" And then sometimes they're just not opening up much.* (District caseworker)

Several individuals indicated that the FSNA process is inefficient.

> *It's taking a long time, our providers are just not with it and not understanding it, the resources families are getting referred to—I don't think the follow-through is happing, it's not working out the way it's supposed to in theory.* (District caseworker)

> *It's more of a pain to refer a family for a strengths and needs assessment because it takes umpteen months to get it back from the provider, it doesn't help me at all, by the time the family gets it and meets with the provider, they're like, I don't care anymore, I don't need services anymore, it's after the fact. I haven't been referring any in the last couple months, honestly.* (District caseworker)

Concerns regarding the timeliness of the completion of the assessment process and its effects on case closure are discussed further in Section 7.8.

Other interviewees suggested that service providers do not receive proper training to complete the FSNA:

> *First of all, the people that are doing the strengths and needs, I know that they had a course and took a test and scored better than we did. I don't think that they're qualified to do a strengths and needs assessment necessarily.* (District caseworker)

> *What would make sense to me would be if we had some kind of individual consultant who did all of our strengths and needs assessments…It should almost be a neutral third party with a lot of credentials, not a high school or college student who is supervising these.* (District caseworker)

> *If you are able to train the service providers in family dynamics and how to interact with families in our agency and kind of [our] agency's goals in a better way, it would be better.* (District Supervisor)

> *I noticed when I switched over to a service provider, there was not training on it. They have the computer-based training, which is a web test that you take and that was completely confusing on how it works. It doesn't explain engagement skills on how you're going to get the information. You don't know how to gather it. The only reason I knew how to gather it is because I was a caseworker and I'd done social histories with families for the last three years. So for me, it was easy, but my coworkers that were brand new to the social work career field were handed this computer-based training and they would learn from it and then you're certified by Dr. Lyons to do a strengths and needs, and it's not beneficial if you don't understand how to engage with people, you don't know how to get that information.* (District caseworker)

> *These are folks who don't have advanced degrees in this field, necessarily. These are people who took like a training, a couple hour training on this. And somehow this is going to be this great insight into their functioning? And it just doesn't. It's not working.* (District supervisor)

Although caseworkers had several concerns about the FSNA process, a small number of other interviewees provided a few positive comments when asked if the FSNA is helpful in identifying family needs. It is worth noting that these comments are all from individuals who are not direct services staff:

> *It's a great tool. I think it's great for child welfare workers to be looking at and to be broadening that perspective, because it's hard when a caseworker comes in and there is one safety concern. Let's say a home below community standards. Child welfare just wants the home cleaned up so the kids can stay in the home. But then we come in there and discover there's a whole lot of*

> *reasons that house is below community standards, and just cleaning it up in a week so the kid can go home is not going to solve this problem…[The assessment] asks about a whole lot of different realms of what's going on.* (District supervisor)

> *I think in a lot of the cases it is helpful because, like I said, we will in most cases refer for navigation, and they do find that helpful, in my opinion. And in a way, though, it's also eye-opening, "Oh, they saw that" or "Oh, they picked up on that" or "Hmm, I didn't think of it that way."* (Service provider)

> *The benefit on the other side, though, is it does get DHS out. So when you are the service provider and if you do a strengths and needs assessment efficiently in the way that it should be done and you identify the goals, you can work with that family to get them where they need to be.* (District supervisor)

#### 7.6.2. Strengthening, Preserving and Reunifying Families (SPRF) Services

SPRF services support DR efforts by enhancing the foundational child welfare service array aimed at preventing children from coming into the foster care system or returning them more quickly when they were removed from their homes. SPRF services also aim to reduce re-abuse and re-entry into the child welfare system. SPRF services are available to all families, regardless of track assignment. Prior to receiving SPRF funding, each district was required to complete a gap analysis to document the array of services, or lack thereof, in the local community. This process involved gathering information from child welfare staff members and community partners through surveys, meetings and/or focus groups to help identify strengths and weaknesses of the local service system and to discuss the integration of DR and SPRF. The gap analysis was used to inform the development of SPRF contracts with local service providers to create new services or enhance existing ones in local communities.

The introduction of SPRF funding has improved service availability in District 5 and District 11 by providing access to more services and encouraging partnerships that did not exist prior to funding, as the following statement shows:

> *I've been really impressed, because when I was a caseworker, we had three [services in the community], and if they didn't fit in the three things, too bad. So being able to work with Head Start, OIT class, and just the creativity of trying to figure out the different programs to bring into this, I've been really impressed with it. This town is historically lacking in services, just because it's a small town and it's rural, and I think that's always going to be a problem. But for dealing with the rural nature and the lack of a huge array of providers, I think [the district manager] has been really creative and proactive, trying to do what he can with what he's got here in this town. It's been really impressive.* (District service provider)

The following are some examples of the types of services that have been funded through SPRF contracts:

*Housing*: In District 5 and District 11, housing support services are available to families because of SPRF funds. Prior to SPRF funding, families lacked housing support services. The SPRF housing program can assist families in quickly finding affordable housing and repairing their homes, and the program provides transportation to drop off applications. SPRF funds can also be used for paying rent, security deposits, and other fees associated with moving in.

*Mental Health*: SPRF has been used to fund mental health services for families in District 5. Mental health specialists are now located in DHS buildings and meet with families once a week for five weeks. These specialists help families in crisis and provide direction and affordable resources to help overcome barriers along the way (i.e., figuring out the appropriate therapy and accompanying families to complete comprehensive mental health assessments). Additionally, mental health specialists go out in the field with intake workers when a report notes concerns about mental health issues.

*Family Navigators*: Family Navigators help address family needs and safety concerns by linking families to community resources, mitigating barriers, and helping families create and accomplish their goals. In District 5, Navigators serve approximately half of the AR families are referred to Navigators in this district. (District 11 did not specify the number of cases that Navigators were involved in). Navigators spend between two and ten hours a week with each family, and families can reach Navigators on a 24/7 crisis line. Interviewees listed a range of ways in which Navigators can support families: medical appointments, vaccination appointments, obtaining birth certificates and identification cards, homelessness prevention, legal issues, filling out paperwork, obtaining childcare, transportation, energy assistance, representative payee, housing rental assistance, and first-time rental assistance.

The interviewees' overall opinion of Family Navigators was positive. As a District 5 supervisor stated, Navigators are essentially "hand holders," because they go through different processes step by step and accompany families to courthouses, for example. One supervisor indicated that families are more receptive to Navigators than they are to the DHS:

> *I think for us, we've been finding that we could say, "We can offer mental health services. We can help you get there," and a lot of families are less receptive if it's coming from us, whereas when the Navigators go in, they can talk about it and bring it up and help them fill the paperwork out, and they actually go. They're more receptive to someone who's not child welfare.* (District supervisor)

*Relationship Building Program*: This District 11 SPRF program provides parent services, training, and education. Participating families are provided with mentors who meet with them five to six hours a week for three to six months. Family mentors help set basic behavioral goals to improve parenting, and they act as coaches to observe, chime in, roleplay, and give feedback. This program also allows parents to visit children outside a visitation center while still being supervised.

### 7.6.3. Culturally Responsive Services

Because of the focus on disproportionality in the child welfare system, district staff members were asked to reflect on the availability of culturally responsive services in their communities. District 11 has a variety of culturally responsive services for the Native American population. For example, there is an in-home navigation provider who is "culturally appropriate" for tribal cases, according to a caseworker. Additionally, there is open communication with the director of Tribal Health and Family, an organization that provides health care services to the Native American population in District 11. Native American families also have a DHS child welfare worker and an Indian Child Welfare Act caseworker. When asked what has changed since the implementation of DR, a state partner responded positively about how it has strengthened the relationship between the tribes and the DHS:

> *I think active efforts to prevent removal will improve because [DR] is the model that you'll be looking at wrapping support services around, and only when safety is imminent, intervening in a*

> *more formal kind of way. So I think that kind of fidelity to the Indian Child Welfare Act and the work that the tribes do will look different. So that relationship between the tribal worker and DHS will become stronger or less adversarial at times because both have the same kind of value set that we're working with families.*

Although District 11 has made strides to address culturally responsive services within the Native American population, supervisors reported that few services were available for the Hispanic community in District 11. Two caseworkers said that there were few to none Spanish-speaking staff members.

> *We don't have anyone that speaks Spanish. We have nobody. So we have a family now that would probably benefit from that, but we can't offer it to them because there's nobody that could work with them.*

> *Even at our visit center, I've got a Hispanic family where dad only speaks Spanish and mom is limited English. They know our one staff person that is bilingual that could supervise at the visit center, so we've actually had to pull staff off the floor here or actually have the family come [to the DHS office].*

Interviewees in District 5 indicated that many agencies have been addressing cultural competency, specifically for the Hispanic population. In the past, District 5 has heavily relied on one provider, but they plan to start branching out to other organizations to develop culturally appropriate services. District 5 has also identified bilingual service providers in almost every service category. Although many culturally responsive services are available in District 5, an interviewee indicated that more services are still needed:

> *I think cultural diversity understanding services tailored for diverse groups is a work in progress. I mean, we're aware that work needs to be done in that area, and while we're not necessarily as diverse as Multnomah, our Latino/Spanish speaking population is growing, I think that it is the biggest group in the state.* (District community partner)

One community partner discussed the value of having staff who are culturally competent and understand the culture of poverty:

> *On our team and in our organization, we want to have workers available who are fluent Spanish speakers, who can understand the different cultural challenges that come with being undocumented, all of those kinds of things that our families are facing. And we also have [Name] who grew up in poverty, so she has a great understanding of the culture of poverty and speaks to that. I think that that helps us all, you know, just having people on staff who have lived.* (District community partner)

#### 7.6.4. Service Array Challenges

Although SPRF funding has increased the availability of services, there are still limitations to service availability in District 5 and District 11. Interviewees mentioned several challenges that are directly related to accessing SPRF services. A district manager described the "complicated, bureaucratic payment system" as one of the barriers to service provision. Another challenge with SPRF funding is the sustainability of providing housing for families. In District 5, funding for housing can only be given to families who are able to maintain their income, which is difficult because families are often unemployed and homeless, as stated below.

> *It's been hard because [a family] has been either kicked out of SPRF services because we referred them or that they're not even qualifying for it. So there's kind of a gap there now since we rolled this out.* (District caseworker)

Aside from accessing SPRF services, interviewees described several general concerns about service availability in District 5 and District 11. One of the most prominent barriers is the many waitlists that families encounter. Long waitlists still exist for important services such as housing; however, a supervisor claimed that the wait time for housing has decreased to only several weeks at most, when it used to take "forever." Another challenge for child welfare agencies is helping families utilize health care services. District 5 service providers said that their county lacks enough medical providers, resulting in long waitlists for mental health treatment and medication management.

Families are also in need of services that are not available through DHS or SPRF funding, such as child care, services for adolescents, and transportation. To address the lack of transportation services, District 5 community partners said that they were collaborating with Lane Transit District public transit to plan ways in which they could overcome this barrier.

It has been a challenge to provide services for families who live in more rural areas, particularly in District 11. Services in these areas are limited, and there tend to be longer waitlists. Connecting families to ongoing services or support systems is also difficult. Because of the lack of community resources in rural areas, families must travel to access services, which in turn increases the cost of providing services. In District 11, staff members mentioned that their office is a small branch that serves a large area. The DHS has to spend a lot of money in gas vouchers because services are provided two hours away. This presents an even greater issue for families in crisis.

#### 7.6.5. Relationships with Community Service Providers

The introduction of SPRF funding has affected relationships between the community partner organizations and the DHS in a positive way. From the perspective of community partners and service providers, DR has strengthened previous relationships and created new ones. In District 5, there are more meetings with open communication and according to one community partner, "it has been more about creating a conversation." Interviewees reported greater collaboration as a result of DR, as evidenced by the following quote from a service provider.

> *It seems like it's just a better collaboration in general for the fact that there's actually funding from DHS to help support these agencies that are working with these families already in a lot of ways, and that there's better communication now between DHS and the agencies, and there's not a lot of separation. There's more inclusiveness.* (District partner)

Multiple community partners and service providers remarked on how the collaboration of community organizations and the DHS is beneficial for families.

> *I think that sometimes when everybody sits down together, and says, "Okay, here's the things that are important. How can we prioritize those things and make it workable for your life and have everybody not just on the same page, but giving the same information to the family?" It's just so helpful and it helps them feel like, "Okay, I can do this."* (District partner)

> *Because now it feels like, not necessarily a culture shift, but everyone is starting to align with what the true needs of the family are.* (District partner)

Supervisors in District 5 and District 11 said that they did not hear about significant concerns about the implementation of DR. Much of the pushback they did experience seemed to stem from confusion about the shift in practice, as the following interviewees described:

> *I think the pushback is [because of the] difficulty in differentiating the raising of the severity bar, creation of the severity bar, and the harm category, with the CPS light. So I have felt at times some pushback from the community around frustration or confusion.*

> *We experienced some [pushback]. I mean the schools, I think, feel awkward at times. Law enforcement feels awkward at times that we're doing things a little bit different than we have. But it's just some change where it's been talking through the situations as opposed to these other conversations where basically people were saying, "We're not buying in, we're not working with you."* (District supervisor)

Caseworkers in District 5 described greater pushback from law enforcement in rural communities, despite including them in trainings on what DR is and how AR and TR cases differ in practice. Multiple caseworkers indicated that law enforcement still believes that they should be accompanying the DHS caseworker to visit families, even with AR cases.

> *[Law enforcement] will call and complain to a supervisor if they find out you went out and made contact with a family without them. Half the time, [law enforcement] will go out because we cross-report them as soon as they come into screening. They'll go out and talk to the family before we've even called them or anything, like they're doing our job.*

When community partners in one district were asked to elaborate on their initial concerns about DR, they described apprehensions that were raised by child welfare caseworkers at the start of DR.

> *I think at the very beginning there was some hesitancy to let go of some of these families, allow for someone else to help them. I think there was a little bit of resistance in cases where you wanted to just, you know, keep this family safe, and it was difficult to allow someone else to kind of take them out of the visit center to do something new or different. There were a few caseworkers that struggled with that because they just wanted to keep them safe. But I think that's improved a lot over time, where they're more comfortable with, "Okay, take them and yeah, you can do home visits. No one's inspected the home," or "You can go to a new setting." There's been a lot more flexibility in trusting the community more to take on some of these families that maybe previously they just wanted to guard real carefully.*

## 7.7. Reassignment

Over the course of an AR case, safety threats may arise or new allegations may emerge that require a TR and caseworkers must reassign an AR case to the TR track. Interviewees were asked whether unsafe children were being appropriately reassigned from AR to TR. Interviewees from all positions in the child welfare system perceived that families are being appropriately reassigned. One supervisor noted that the vast majority of track changes occur when there is a positive toxicology screen for methamphetamine- or heroin-exposed infants.

Although there are few track changes, one caseworker noted that when a track change occurs and moves a family's case from AR to TR, it usually dissolves the positive relationship built with families because of their initial expectation that they were not going to receive a dispositional finding: "We don't change a lot, but when we do, it messes up your relationship with your client totally."

A supervisor indicated that track changes do not necessitate a change in intervention, and it is more of an administrative change in their data system rather than a practice change. This was echoed by a DR consultant: "Track changes are really something we just do in the computer. If we are going to intervene and protect children, the way that looks in the field is pretty much the same."

Interviewees were also asked how they handle cases that are transferred from non-DR districts to districts that have implemented DR. One screener indicated that the information documented about cases from non-DR districts is often very brief and incident-based. Screeners said that they either call the district from which the case was transferred or make a decision based on the limited information provided. Although they are unable to formally change the track assignment in these cases, caseworkers can still respond in the same manner that they normally would for an AR case (i.e., a phone call ahead). If a case is transferred between two districts that have implemented DR, the new district could change the track assignment from AR to TR.

### 7.8. Case Closure

The guidelines that outline the length of time cases should be open have changed since DR was implemented. Prior to DR, CPS assessments were to be completed within 30 days, and if needed, cases could be extended to 60 days. With DR's implementation, the timeframe has changed to 45 days: 30 days for the CPS assessment and an extra 15 days for the FSNA. Similar to practice prior to DR, cases can be extended to 60 days if needed.

As stated previously, it is standard for a service provider to complete the FSNA with a family. Once the FSNA is completed, both the service provider and caseworker meet with the family to discuss the FSNA results and services. Managers described this as a longer process than the timeline allots "because they're having to coordinate with families and appointments get missed or they can't meet for two weeks or they're serving other families." Interviewees expressed many concerns about overdue CPS assessments, which they reported as being inevitable now. For both districts, the case closure process is a source of stress for providers and child welfare. To address this, District 11 has asked service providers to set up the assessment as soon as the referral is made to speed up the process.

## 8. Recommendations

The DR model in Oregon has continued to evolve since its inception. Some interviewees considered this to be a strength of the DR model in Oregon, whereas others described their frustration with the evolving nature of DR practice. Adaptation of the model offers the potential for DR enhancements as implementation continues throughout the state. As such, this final section provides recommendations for the further enhancement of DR practice in Oregon, based on feedback gathered through this round of focus groups and interviews. This information is useful for central office staff and districts new to

implementation, providing "lessons learned" that afford other districts the opportunity to learn from the experience of those who went first.

Communication: The intentional implementation of three new (or refreshed) initiatives in Oregon child welfare contributed to the strength of the DR model. Described as a three-legged stool, DR, the OSM Refresh, and the allocation of SPRF resources provided vital support to the new approach to working with families assigned for CPS assessment. The overarching vision of a new approach to child welfare practice was well-articulated by DHS leadership and the individuals who were very involved in the DR design work. However, this vision was not always well-understood among those who were more tangentially involved in DR.

DR staff from central office made a significant effort to relay information about DR and the other initiatives in the early stages of implementation. Several interviewees viewed these efforts as valuable. Interviewees recommend that these communication efforts continue as DR is implemented in other districts. These efforts should involve child welfare staff and child welfare partners in the local communities. One district manager indicated that such communication did not occur in their community:

> *There's nothing really official on the follow-up with all the community partners. We do it with the [partners] we have constant contact with, that's how we always have our updates and stories. But to some of the other [service providers] we may not reach out again like we did at the beginning when we had people trained to go out and do presentations.* (District manager)

Initiative Fatigue: Although interviewees viewed the combination of DR, the OSM and SPRF as integrally linked in a new approach to serving families in the child welfare system, the implementation of three new initiatives at the same time resulted in confusion and initiative fatigue among line staff. This, along with a history of slow implementation of previous initiatives, left some individuals skeptical that change would in fact occur.

As other districts begin to plan for the implementation of DR, there will be less of an issue with the overlapping of implementation of DR, OSM, and SPRF services. However, there are certain to be new child welfare initiative that will be implementing in the upcoming years. Based on the experience in District 5 and District 11, it will be important to be cognizant of the timing of implementing of other new initiatives that coincide with the implementation of DR.

Adaptation: The implementation of DR was an intentionally evolutionary process. DHS leadership recognized that the DR model as it was first developed would continue to be refined as the model was integrated into existing child welfare practice. DHS leadership and DR consultants were open to adaptations and appreciated the feedback provided by state stakeholders and district staff as the model continued to evolve. This aspect of DR implementation is considered a success; the model will continue to be fine-tuned as more districts implement a two-track system.

It is important to note, however, that the evolutionary nature of the implementation process was also challenging for some interviewees. While DR practice was developed in terms of rules, procedures, and tools, when DR was implemented in the first two districts, central office staff and district staff were gaining experience with the model alongside each other. For this reason, staff members occasionally had questions about how AR practice should function, but the answers were not always clear, even to central office DR staff.

Because issues will continue to arise over the next few years of DR implementation, it will be important to ensure that there is clear communication about adaptations that are made, especially as more of the state begins to function with a two-track system. The central office DR team appears to be the hub of expertise about DR practice in Oregon. It will be important to create a system in which this team is responsible for systematically communicating information about changes in the model to the community and handling questions raised in the field. Interviewees indicated that they appreciated the regular communication from the DHS child welfare director; this communication process should be continued and potentially enhanced as additional counties plan for and implement DR across the state.

Consultants: Staff members in the district offices appreciated the hands-on and applied coaching model that DR consultants used for implementation of the model, and the consultants were considered an asset to the implementation in Oregon. Staff members were interested in how DR would change their day-to-day work; DR consultants were able to provide staff members with this information. Interviewees viewed DR consultants as valuable resources and appreciated their onsite presence.

As DR continues to be implemented statewide, the need for consultation resources is likely to be significant. It will be important to have a clear plan about how these positions can best support the increasing number of districts that may need assistance. In particular, one concern is that the staff in these positions will be stretched too thin in terms of travel and knowledge of the district offices they are supporting. It will be important to anticipate when DR consultants will be available and for how long and to be aware of the impact on consultants (e.g., amount of travel and burnout). One district manager recommended the development of a timeline and exit strategy so that everyone is clear on the availability of DR consultation. Given that DR consultants may be less available in districts that implement DR later, it will also be important to develop a peer-support network in which district staff members in neighboring or similar communities can offer support and assistance to staff members in districts commencing implementation.

Training: Central office DR staff used feedback from DR trainings evaluations to enhance DR training materials (adding Oregon scenarios and new tools) so that the training process was iterative and continually improving. However, training an entire workforce within District 5 and District 11 on the DR model has been a challenge. The DR model evolved during implementation, so training also evolved and changed. From the state's perspective, this evolution created an improved training process. At the same time, this was sometimes frustrating for district workers, as they would sometimes hear different information from different trainers, as trainers were gaining experience and encountering new scenarios.

In general, interviewees believed that there were redundancies in the training process that could be eliminated. Interviewees made several suggestions:

> *You could probably figure out everything you need to know in a half-day training. I mean, it's the fundamental difference of calling before you go out and offering community supports and then a couple hours to tell you how to fill out your request for services and the difference between the high to moderate needs family.*
>
> *[Training] should've been more like a job fair, so we could've gone around and introduced ourselves and learned.*

> *It should've been like a meet and greet kind of thing, like hey, these are the providers you're going to be working with, just introduce yourselves.*

> *I would have it be part of our core training. I would've liked to see them do it as part of core training from that point forward so that new workers are getting it as they come on.*

After the DR training was utilized in a few districts, it was refined based on feedback from trainees. Additional scenarios were also added to the training as experience with DR were acquired. It is anticipated that most of the modifications to the training have already been made, although there may be small adjustments in the future as needed. Because experience with the model continues to build a better understanding of DR practices, it might also be useful to provide a regular "DR Refresh" in districts that have implemented DR; this would allow central office to share the progress of statewide implementation, reiterate important components of the DR model, and address questions that staff members may have.

Another important lesson that the first implementers learned with regard to training and coaching is the importance of ensuring that supervisors have a solid understanding of the DR model. Adequate supervisor training is crucial to their ability to support their workers in adopting this new practice model. From information gathered in interviews with district staff members, it appears that most supervisors were readily available to support their caseworkers, but they struggled to provide expertise on a model with which they were less familiar. This may be an area in which additional training and mentoring opportunities could be developed to support future rounds of implementation.

Staffing: Interviewees stated that caseworkers were spending more time with families because of the DR practice model. Although interviewees viewed this as beneficial for the families, they expressed concern about the adequacy of staffing resources. Initially, staff in district offices assumed that the adoption of a DR model would decrease caseloads. However, it now seems that this assumption was erroneous, or at least that caseloads may not decrease until DR is more established.

When DR was first implemented in District 5 and District 11, both adopted a staffing model of AR- and TR-specific caseworkers. However, the districts realized fairly quickly that this initial configuration was difficult for workers, supervisors, and managers. Managers and supervisors found it difficult to maintain evenly distributed caseloads for AR and TR caseworkers, and some staff members were resentful that other workers carried easier caseloads. As a result, both District 5 and District 11 changed their staffing model to a configuration in which caseworkers carried both AR and TR cases. Now that workers carry both types of cases, the abovementioned challenges have been addressed. Interviewees perceived mixed caseload staffing as benefiting families in both tracks because of DR's focus on family engagement.

Staffing configuration is an important consideration for new districts as they implement DR. The first two districts found that mixed caseloads eased some of the staffing tensions experienced immediately after DR implementation. Districts that are planning to implement DR should consider this when determining their own DR staffing structure.

Another staffing concern that interviewees identified was that screening staff members shouldered additional responsibilities when DR was implemented. Screening staff raised concerns about being asked to gather more information and complete the track assignment tool without additional staffing positions being allocated to screening; they also believed that new screening staff members lacked adequate training to perform some of their responsibilities. Screening staff members indicated that their job

responsibilities seemed overwhelming after DR was implemented. It is not easy to determine how much of this frustration is directly attributable to the implementation of DR, but there is clearly a sense that DR has increased the workload for screeners and that pre-DR staffing levels are not adequate to cover the additional post-DR responsibilities. As districts begin to plan for DR rollout, managers should give adequate attention to their screening units, in terms of ensuring adequate staffing levels, adequate training for screening staff, and eliciting feedback during the implementation process to see how the screeners are doing.

Screening: The process of determining the eligibility of cases for the AR track has been difficult for the first two districts implementing DR because not all the possible scenarios had been experienced and thus were not included in the training and coaching models. Therefore, screeners would often apply the examples which were included in the track assignment tool very literally. Over time, central office has become more precise in clarifying which types of cases are appropriate for AR, but understands that this decision-making process is still difficult for screeners and even DR consultants. This is why central office is encouraging districts to use RED teams to help with the most difficult screening decision reports.

Interviewees made several recommendations about the eligibility decision-making process. First, now that the criteria are clearer, training for screeners can be enhanced to ensure that they understand the process and make consistent screening decisions. District 5 and District 11 adopted a group decision-making process to help determine track assignments. This was especially helpful when DR was first implemented, providing an opportunity for group learning and help for screeners in making track assignment decisions.

Family Engagement: District staff members reported that the implementation of DR led to caseworkers spending more time with families and giving families greater decision-making opportunities. The higher level of family engagement that caseworkers reported ultimately benefits the caseworker-family relationship. The AR practice of engaging and working collaboratively with families is starting to blend into and be adopted by TR practice. Interviewees considered this engagement to be a success of the DR model, and family engagement should continue to be a focus of DR implementation statewide.

The OSM: The evaluation team asked interviewees if they think that the OSM is being implemented as intended. Although the OSM is still a work in progress, the interviewees noted improvements in implementing the OSM with fidelity. However, these responses are very subjective. One component of this DR evaluation is to conduct a fidelity assessment of the OSM. This is necessary in order to fully comprehend the degree to which the model is being implemented with fidelity, especially among different types of cases.

Family Strengths and Needs Assessment (FSNA): During the site visit process, a consistent theme was that the implementation of the FSNA has been a challenge. Caseworkers and supervisors questioned the utility and value of the assessment, and they described it as an unnecessary step for families that often negatively influences family engagement. Additionally, it has been difficult to adhere to the 15-day timeline to complete the assessment because of scheduling, causing the assessments to be overdue. In general, the interviewees agreed that the process of assessing families for individualized service needs was cumbersome and duplicative, creating frustration for workers and managers. Overall, the evaluation team recommends that this assessment process be revisited and refined to re-examine the function and purpose of the tool.

Overall, these recommendations are based on information gathered during the focus groups and interviews that were conducted in the summer of 2015. As districts continue to implement DR statewide, many of these issues may be lessened as challenges are worked out and processes are improved over time. The first round of site visits to District 5 and District 11, in addition to the interviews with DHS leadership, DR consultants, and state partners, provided insight into the implementation process of DR in Oregon. In conversations with DHS leadership and DR consultants, it became clear that many of the themes that were discussed are already evident. It is our hope that in summarizing what was learned during these site visits, this information can be used to enhance the implementation of DR statewide. We look forward to visiting District 5 and District 11 again in Fall 2016 and conducting site visits with District 4 and District 16 in February 2016 and February 2017, to observe how the model has continued to evolve over time.

# Appendix A: Site Visit Guide: District Administrator

## Appendix A: Site Visit Guide: District Administrator

***District:***
***Date:***
***Participants:***

**EXPLORATION**

How were the first counties selected to implement DR? Was any sort of readiness assessment done prior to DR implementation? Can you describe that process?

Were there other initiatives and programs that were also considered at that time? If so, what were they?

Were there any dissenting voices heard during the exploration process?

- If yes, what were their concerns?
- How were those concerns addressed before moving forward?

**INSTALLATION**
**DR Model**
Once the decision was made to move forward with DR in your county, what were the next steps that were taken to begin to implement the DR model?

What internal and external implementation teams were created to implement the DR model? Do those teams continue to meet?

**Community "Buy In"**

What community stakeholder groups did you identify for DR? (mandated reporters, law enforcement, service providers, lawyers/judges, etc)

What outreach, if any, was done to involve these community stakeholders in DR? What was the purpose of the outreach? (education, buy-in, involvement)

What has worked well in the community outreach process? Were there any attempts at outreach that did not work well?

Were there any groups not brought into the process initially that should have been?

- If yes, which groups? Why?

Have suggestions from community stakeholders been incorporated into the DR model? Please provide examples

## IMPLEMENTATION DRIVERS

### Organizational and Contextual Factors/Systems Intervention

Have there been any organizational or contextual factors that have enhanced or hindered DR implementation?

### Systems Intervention

How is information about DR communicated to county staff? Can you give some examples?

How is it communicated to external stakeholders and community partners? Can you give some examples?

Have these communication strategies been effective?

Has the communication from DHS to CPS stakeholders changed following the implementation of DR?

Have there been any social, political, or economic factors that have affected the implementation of DR?

What funding sources have been leveraged during the implementation of DR?

### Leadership

Who have been the champions of DR during the initial implementation stages?

Who has been directly responsible for leading the implementation efforts and addressing issues as they arise and spreading successes as they are achieved?

### Facilitative Administration

Who is responsible for the ongoing development and/or modifications of DR

What adjustments, if any, have been made to DR since the initial implementation? Why were these adjustments made?

### Decision Support Data Systems

How are outcomes in your county monitored to assess how your county is performing?

How are these results used to inform ongoing practice? Who receives the results?

### Staff Selection

Can you describe the staffing structure for DR? Can the same workers carry both AR and TR cases? If different:

## Appendix A: Site Visit Guide: District Administrator

Have there been any tensions between AR and TR workers?

Were new CPS staff (screeners, caseworkers, supervisors) hired prior to implementing DR? If so, can you describe the selection process? Did the selection process change as a result of DR implementation?

Is DHS adequately staffed to practice the DR model?

How were private agency partners or service providers selected?

**Training**
Were workers provided with additional training prior to the implementation of DR? Can you describe the training? [Probe: content, length, attendees, trainers, method]

How would you improve the current DR training?

What further training needs do the DR staff have? Are there plans to modify or add to existing training?

**Coaching**
Please describe the coaching model used during DR implementation. [Probe: content, length, recipients, method]

How would you improve the coaching model? Are there any plans to modify or add to existing coaching?

Can you tell us about peer-to-peer support and if and how it is being used with DR? Are you seeing this occurring? With whom?

**Supervision**
How is caseworker/CPS worker performance supervised? [Probe: frequency, type (individual versus group, clinical consultation)]

Do supervisors receive mentoring or supervision? Do they receive feedback on their supervision from workers?

**Performance Assessment**
Who evaluates caseworker performance? Supervisor performance?
How often is it evaluated?

If performance is not acceptable what, if anything, happens?

## DR PRACTICE

**General:** In general, how has worker practice changed in counties that have implemented DR?

**Screening**

Please describe the process for determining AR eligibility/ineligibility.

Is the track assignment tool used consistently by workers?

Are there any aspects of the screening process or track assignment tool that you would like to see change?

Do you think there are cases being assigned to AR that should not be? Please give examples.

Do you think there are cases not being assigned to AR that should be?

**Assessment**

Can you describe what happens during a comprehensive CPS assessment in the AR track? How does it differ from a comprehensive CPS assessment in the TR track?

Are staff using the Oregon Safety Model with fidelity? Which aspects of the OSM have been most difficult for staff to implement with fidelity? What strategies has DHS taken to increase staff fidelity to the OSM?

Are families involved in the comprehensive CPS assessment process?

**Reassignment**

Are unsafe children being appropriately reassigned from the AR to the TR pathway?

**Needs assessment**

Are families with moderate to high needs being appropriately identified? Why or why not?

Are families with moderate to high needs being referred to a Strengths and Needs provider? Why or why not?

Does the Strengths and Needs assessment process adequately identify the types of services that families need?

**Services**

How is the service array supporting the vision and goals of DR?

## Appendix A: Site Visit Guide: District Administrator

Are service providers available for all families, including those in rural regions?

Are culturally responsive service providers available for all families, including those in rural areas?

What are the barriers to families receiving and completing services?

**Case Closure**

What are the guidelines for how long AR and TR cases should be open? Do you feel that this is an adequate amount of time for these cases?

**Community Partnerships**

How has DR changed the nature of the relationships between DHS and community organizations?

Are the roles of DHS and community partners in keeping children safe clearly defined?

Is the coordination between DHS and community partners effective? How can it be improved?

**Other**

What processes are being used to prevent reentry into foster care?

What processes are being used to enhance permanency?

How will DR affect the disproportionate representation of minority children in the child welfare system?

**General**

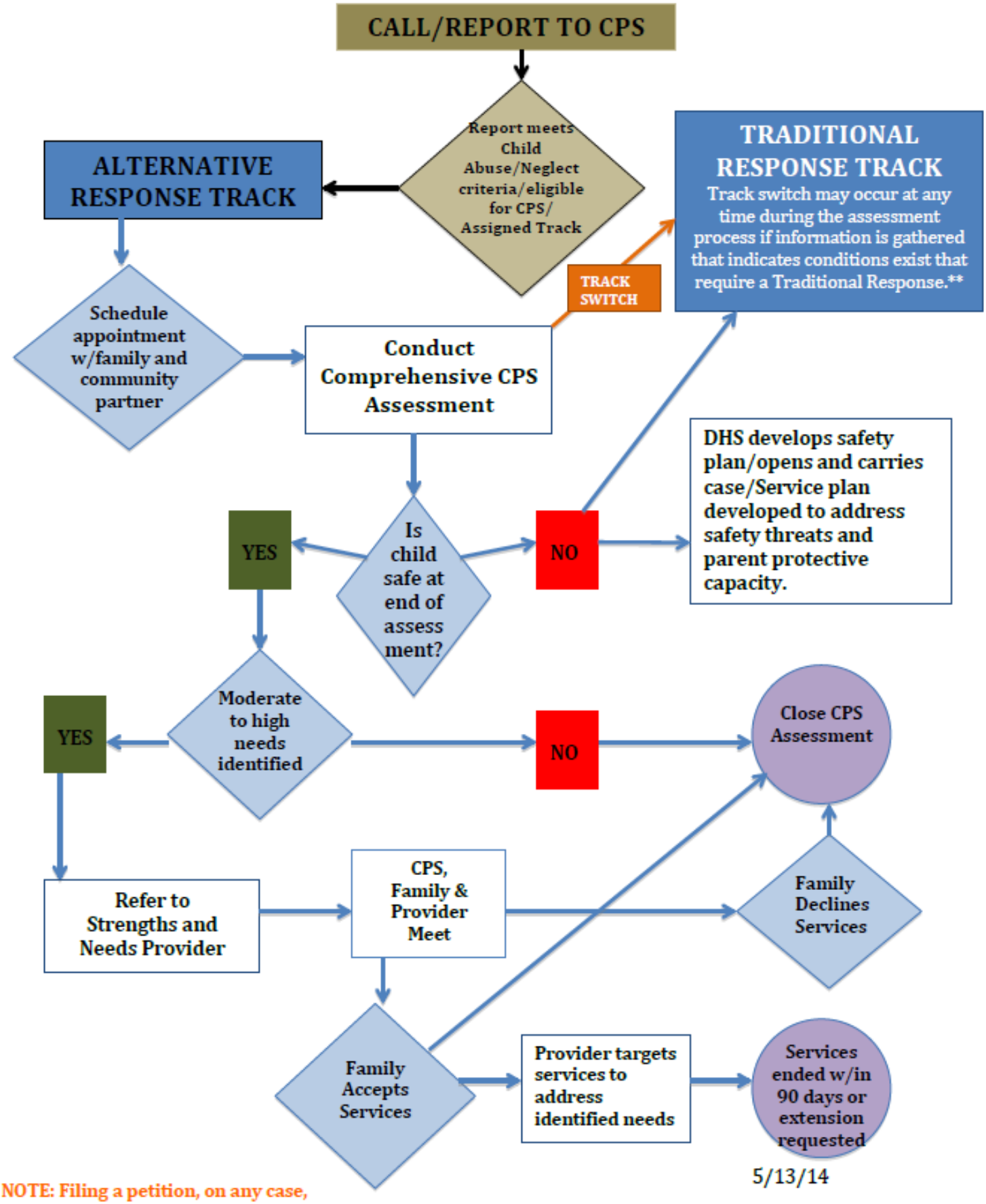
What have been the biggest successes of DR implementation so far?

What have been the biggest challenges of DR implementation so far?

Is there anything about current DR practice that you would like to see change?

# Appendix B: AR and TR Flow Charts

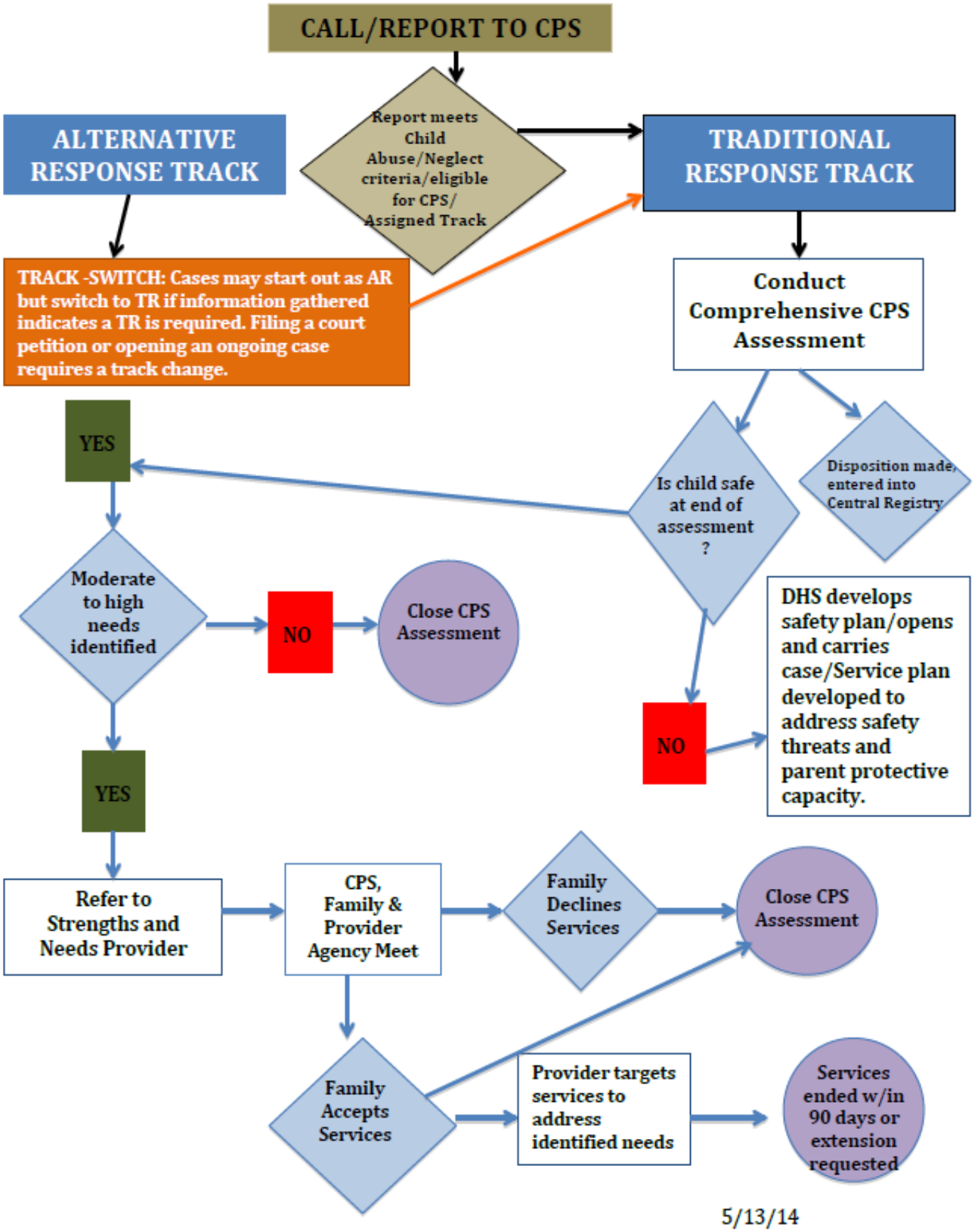
Alternative Response Process and Decision Flow




5/13/14

** NOTE: Filing a petition, on any case, also requires a track change.

Traditional Response Process and Decision Flow




5/13/14

# Appendix C: DR Implementation Team and Subcommittees

**DR Steering Committee** – Meets monthly.

| Name | Role |
|---|---|
| Lois Day | Child Welfare Director |
| Jerry Waybrant | Field Operations Director |
| Dana Ainam | Confederated Tribes of Grand Ronde |
| Renee Duboise | District Manager 3 and now interim for 2 |
| Linda Olson | District Manager 12 |
| Melissa Sampson-Grier | Cross-systems Equity Coordinator |
| Ryan Vogt | Deputy Field Operations |
| Maurita Johnson | Deputy Child Welfare Director |
| Traci Savoy | Casey Family Programs |
| Margaret Carter | Community Engagement Director |
| Emily Hutchinson | National Resource Center for Child Protective Services |
| Stacey Ayers | Child Safety Manager |
| Jodi Sherwood | Project Manager |
| Stacy Lake | Child Safety/Differential Response Manager |

**DR Early Implementation/Installation Team** – Meets monthly.

| Name | Role |
|---|---|
| Julie Taylor/Robert Miller (D12) | Confederated Tribes of the Umatilla Indian Reservation |
| Nan Silver (D8) | Program Manager |
| Dr. Alvin Ellerby (D2) | Community Provider |
| Michael Ware (D2) | Equity Team Member |
| Jason Walling (CO) | Training/IT |
| Shary Mason | State level judiciary entity |
| Jane McKenzie (D3) | Self-sufficiency |
| Jennifer Kelly | Parent |
| Miriam Green (D2) | Hotline/Screening Staff |
| Alex Jackson (D4) | Protective Services caseworker |
| Shannon Biteng | CW/SS/Field Operations |
| Tyler Flaumitsch (D9) | District Manager |
| Maria Walberg (D10) | In-home worker |
| Emily Hutchinson | National Resource Center for Child Protective Services – Part-time member/Consultant |
| Traci Savoy<br>Russell Woods<br>Justin Lee/Erwin McEwen | Casey Family Programs technical assistance team<br><br>Part-time as needed |
| Stacy Lake<br>Stacey Ayers<br>Deena Loughary<br>Chuck Nyby<br>Dana Torrey<br>Kristin Khamnohack<br>Jodi Sherwood | DR Support team – Both child safety managers & several DR/Child Safety consultants<br><br><br><br><br><br>Project Manager |

**Stakeholder Advisory Group** – Child Welfare Advisory Committee

**Subcommittees**– Meet every two weeks or as needed and decided upon by subcommittees.

**Screening and Eligibility**

| | |
|---|---|
| Deena Loughary – Chair | DR/Child Safety Consultant |
| Karen Gibbs | Child Safety Consultant |
| Miriam Green | Hotline Manager D2 |
| Angela Ward | OR Kids |
| Heather Higgs | Social Service Specialist – screener D4 |
| Sonya Faulkner | Screening Supervisor D3 |
| Amanda Fromdahl | Social Service Specialist – screener D6 |
| Abigail Carroll - SEIU | SSS1 child abuse intake screener – D1 |
| Kirby Crawford | Screening Supervisor – D2 |

**Strengths and Needs Assessment**

| | |
|---|---|
| Deena Loughary – Chair | DR/Child Safety Consultant |
| Nicole Parada | Community Provider D3 |
| Tom Progin | CANS Assessment Manager |
| Dawn Cottrell | Community Provider D3 |
| Cathy Wansley | Community provider D12 |
| Dana Ainam | Confederated Tribes of Grand Ronde |
| Ashley Woodcock – Co-chair | Community Provider D2 |
| Natasha Chapman | Research/Office of Business Intelligence |

**Communications**

| | |
|---|---|
| Temre Yann (D3) | DHS ICWA Supervisor |
| Margaret Carter | Community Engagement |
| Gene Evans – Chair | DHS Communications Director |
| Lee Lower | CW/SS/Field Operations |
| Shary Mason – Co-chair | Judiciary |
| Laurie Potts (D7) | Community Provider |
| Mazie Goggles | Burns Paiute Tribe |
| Jennifer Kelly | Parent |
| Chuck Nyby | DR/Child Safety Consultant |

**Workforce Readiness**

| | |
|---|---|
| Shirley Vollmuller (D16) | Program Manager |
| Shannon Biteng – Chair | CW/SS/Field Operations |
| Neil Friedrich (D2) | DHS In-home/Permanency caseworker |
| Karlee Vetter (D15) | Protective Services caseworker |
| Tara Holmes (11) | SEIU/Protective Services caseworker |
| Ormond Fredericks (D16) | DHS Permanency Supervisor |
| Wendy Hill – Co-chair | District Manager |

| | |
|---|---|
| Chuck Nyby | DR/Child Safety Consultant |

**Provider and Child Welfare Roles**

| | |
|---|---|
| Ashley Woodcock (D2) | Community Provider |
| Ruth Taylor (D2) - Co-Chair | Community Provider |
| Paula Warr (D7) | CPS Supervisor |
| Chris Phillips (D14) | Program Manager |
| Lawrence Piper (CO) | Self-Sufficiency |
| Leslie Johnson (D2) | Resource Development Manager |
| Larry Merritt | HR |
| Jeremy Player (D11) – Chair | District Manager |
| Phillip Blea (D3) | Community Provider |
| Dana Torrey | DR/Child Safety Consultant |

**Training and coaching**

| | |
|---|---|
| Marty Lowrey | Child Welfare Partnership PSU |
| Linda Bello – Co-Chair | Child Welfare Partnership PSU |
| Karyn Schimmels – Chair | DHS Training Manager |
| Tami Kane | CPS Program Coordinator |
| Susan Lopez (D5) | Academy Supervisor |
| Taylor Kohn (D8) | Self-sufficiency |
| Chris Black (D13) | Program Manager |
| Ryan Vogt | CW/SS/Field Operations |
| Randy Joiner (D2) | SEIU Rep/In-home caseworker |
| Kristen Khamnohack | DR/Child Safety Consultant |

**Outcomes and Evaluation (Quality Assurance/Continuous Quality Improvement)**

| | |
|---|---|
| Maria Dureya<br>Natasha Chapman – Chair | Research/Office of Business Intelligence |
| Kirsten O'Dell | PSU |
| Carrie Furrer | PSU |
| Susan Bechtold | Quality Assurance |
| Patrick Ring | Self-sufficiency |
| Tony Loman | Institute for Applied Research (Consultant) |
| Adam Darnell | Casey Family Programs (Consultant) |
| Dana Torrey – Co-chair | DR/Child Safety Consultant |

**Information Technology**

| | |
|---|---|
| Stacey Daeschner (D3) | Program Manager |
| Angela Skyberg – Chair | OR Kids |
| Lacey Stephens | OR Kids |
| Angela Ward | OR Kids |
| Ashley Beatty – Co-chair | DHS Training |
| Will Murray (D5) | Protective Services caseworker |
| Natasha Chapman | Research/Office of Business Intelligence |

| | |
|---|---|
| Judy Helvig | |
| Kathryn Naugle | Office of Information Services |
| Kristen Khamnohack | DR/Child Safety Consultant |

**Rule and Procedure**

| | |
|---|---|
| Deb Carnaghi | CPS Program Coordinator |
| Cathy Ostrand-Ponsioen – Chair | CPS Rule Writer |
| Jason Bromley (D1) | Protective Services Supervisor |
| Joni Gallinger (D10) – Co-chair | Policy Council member |
| Greg Thomas (D15) | Permanency Supervisor |
| Jeni Rucker (D3) | SEIU Rep/Permanency caseworker |
| Kristen Khamnohack | DR/Child Safety Consultant |

**Family Engagement**

| | |
|---|---|
| Dana Ainam - Chair | Confederated Tribes of Grand Ronde |
| Nadja Jones - Community Engagement Coordinator, Youth Development Council | Community advocate |
| Caly Turman (D1) | Permanency/In-home caseworker |
| Christine Kamps | Central Office ICWA Consultant |
| Kim Keller (D15) – Co-chair | Program Manager |
| Kristi Johnson (D8) | Family Unity Meeting staff |
| Dan Garris | PSU |
| Mary Ann Johnson | Central Office Permanency Consultant |
| Dana Torrey | DR/Child Safety Consultant |

*10/13*

# Appendix D: Oregon DR Track Assignment Tool

# Track Assignment Tool

Family Name: _____ Date Report Accepted: ____/____/_____

Case Number: _____

*This tool is applied after the decision is made that the report constitutes an allegation of abuse or neglect and requires an assessment. The following are **allegation types used to** dictate track assignment.*

| TRADITIONAL RESPONSE REQUIRED | YES |
|---|---|
| Reports containing allegations regarding a child fatality where abuse/neglect is alleged | |
| Severe Physical Abuse allegations which include but are not limited to: NOTE: "Severe harm" means: Significant or acute injury to a child's physical, sexual, psychological, cognitive or behavioral development or functioning; Immobilizing impairment; or Life threatening damage.<br>• Burns, scalds<br>• Extensive bruising or abrasions on any part of the body<br>• Bruising, swelling, or abrasions on the head, neck, or face judged to be severe, including punches to face or stomach<br>• Serious injuries could result in or have resulted in dislocations, unconsciousness, internal injuries, severe cuts, etc. (presence of injury is not required.)<br>• Torture<br>• Fractures<br>• Strangulation, choking<br>• Loss of the ability to walk or move normally according to the child's developmental ability<br>• Confinement/restraints<br>• Poisoning<br>• Electric shock<br>• Multiple injuries of different types<br>• Allegations of physical abuse on children age 5 and under or older children who are non-verbal (presence of injury is not required) | |
| Threat of Harm, Physical Abuse - Example includes but is not limited to:<br>• Substantiated report of severe physical abuse and the perpetrator of that abuse has access to a child.<br>• Currently the subject of a physical abuse investigation | |
| Threat of Harm, Domestic Violence - Examples include but are not limited to:<br>• The alleged batterer has killed, and/or severely harmed, any person or animal in the family<br>• The alleged batterer has used weapons in the violence<br>• The alleged batterer has strangled or choked any person in the family<br>• The alleged batterer has made threats of kidnapping, hostage taking, suicide or homicide<br>• The alleged perpetrator has a pattern of severe abusive behavior that is reported and/or documented by criminal history and/or social service agency<br>• Information provided establishes a pattern of power and control present in the family home which is believed to have a severe impact on the family condition. | |

| | |
|---|---|
| Mental Injury - Examples include but are not limited to:<br>• Cruel or unconscionable acts or statements made, threatened to be made, or permitted to be made by the parent or caregiver which has a severe impact on the child's functioning<br>• Extreme viewpoint or perception of child is extremely negative that has a severe impact on the child's functioning | |
| Threat of Harm, Mental Injury - Example includes but is not limited to:<br>• Previous substantiated report of mental injury and/or alleged perpetrator has access to other children which exposes them to potential threat of harm/mental injury. | |
| Medical Neglect<br>• Failure to seek, obtain, or maintain necessary medical care serious conditions that if left untreated will likely have severe impact on the child's health | |
| Neglect which is severe (Significant or acute injury to a child's physical, sexual, psychological, cognitive or behavioral development or functioning; Immobilizing impairment; or Life threatening damage.) - Examples include but are not limited to:<br>• Cruelty<br>• Starvation<br>• Permitting a child to enter or remain in or upon premises where methamphetamines are being manufactured<br>• Child selling/buying<br>• Life threatening living environment<br>• Child who tests positive for controlled substance and is experiencing severe affects | |
| Threat of Harm, Neglect - Example includes but is not limited to:<br>• Previous substantiated report of severe neglect which has not been mitigated and perpetrator has access to children. | |
| Sexual Abuse – Examples include but are not limited to:<br>• Adult sexual activity with a minor - Includes incest, rape, sodomy, sexual penetration, fondling, and voyeurism.<br>• Sexual exploitation - Includes the use of a child in a sexually explicit way for personal gain, (to make money, in exchange for drugs, or to gain status). It also includes using children in prostitution or using children to create pornography.<br>• Sexual activity by a minor towards another minor when the activity includes force or coercion, involves threats, weapons, or grooming behavior and/or involves victim children who have developmental disabilities | |
| Threat of Harm, Sexual Abuse - Examples include but are not limited to:<br>• A person who has access to child/children when they:<br>  ○ Have been convicted of a sexual offense;<br>  ○ Have a history of sexual offending behavior;<br>  ○ Have a Founded disposition for sexual abuse of a child in a child welfare system database, and/or;<br>  ○ Are currently the subject of a sex abuse assessment or investigation. | |
| Child abuse or neglect reported to have occurred in a day care facility, the home of a Department certified foster parent or relative caregiver, or a private child caring agency. | |

| | |
|---|---|
| Employee of the Department of Human Services. | |
| There is an open Department case with an identified safety threat (excluding CPS assessments). | |
| There is an open Traditional Response CPS assessment. | |

| **ALTERNATIVE RESPONSE REQUIRED** | ***YES*** |
|---|---|
| Physical Abuse when the injury is not judged to be severe (presence of injury is not required). | |
| Threat of Harm, Domestic Violence not assigned traditional | |
| Threat of Harm, Physical Abuse not assigned traditional | |
| Mental Injury not assigned traditional | |
| Medical Neglect which includes:<br>• Failure to seek, obtain, or maintain necessary medical care for NON life threatening conditions | |
| Neglect<br>• Reports of neglect not otherwise specified in traditional track (Including drug exposed infants, vulnerable children who are currently left unsupervised now) | |
| Threat of Harm, Neglect<br>• Parent/Caregiver has a history of neglect that is not judged to be severe and has children out of their care and has given birth to a new baby or has access to a child<br>• Parent/Caregiver's behavior is out of control and threatening to a child's safety due to their mental/emotional instability (i.e. parent/caregiver threatening suicide, substance abuse, etc) | |
| Sexual Abuse and Threat of Harm Sexual Abuse when alleged perpetrator is a child in these instances:<br>• Child on child sexual activity with no force or coercion with both children being under the age of 12<br>• Does not include children with disabilities<br>• No indication of parental sanctioning<br>• Sexual activity appears exploratory and not extreme in nature | |

Pathway Assigned (check one): TR____ AR____ Date Assigned: ____/____/_____