

NATIONAL RESOURCE CENTER FOR CHILD PROTECTIVE SERVICES

Technical Assistance Site Report



Prepared for Oregon Children, Adults and Families
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Systematic Approach to Child Safety Intervention

Situation and Technical Assistance Request

Prompted by the Governor, recently Oregon CAF designed a Critical Incident Response Team (CIRT). This internal review team evaluates high profile cases in which the agency has been directly involved. The purpose of the case evaluations is to provide reports that can be used to effectively communicate the agency's involvement in these cases and to identify necessary program improvement that may be indicated.

In conjunction with the new CIRT process, CAF requested technical assistance from NRCCPS to provide expert opinion using various sources of information as touchstones to judge the adequacy of the approach to safety intervention. The information sources include the child welfare advisory group; state program staff; program managers; CIRT reviewers; and two cases recently reviewed by CIRT. The NRC technical assistance is expected to be related to and supportive of Safety Outcome #1 concerned with timeliness and recurrence and Safety Outcome # 2 concerned with services to prevent removal and risk of harm.

The request was formalized during a conference call between the state, the federal regional office, NRCCPS and the National Child Welfare Resource Center on Organizational Improvement with a plan to initiate TA with a three day diagnostic on site visit.

Site Visit

The site visit occurred January 12 – 14, 2005. Wayne Holder and Therese Roe Lund represented the NRCCPS.

Child Welfare Advisory Committee

The site visit began with a briefing meeting with the Child Welfare Advisory Committee. The committee is composed of various allied professionals involved in the community child welfare scene. The committee appeared to share the point of view that safety intervention could be improved within the agency and within the community. While the committee had much to observe concerning the CIRT process and the agency's effectiveness, the following were some of the major issues mentioned:

- Effective coordination of information sharing among sources involved in a case
- Effective coordination of case oversight
- Caseload management and division of labor

- Effective safety assessment by courts and citizen review boards
- Unscheduled case visits
- Easier caregiver access to treatment resources
- Accountable communication
- Nature and quality of face to face contact in cases
- The influence of foster care policies and rates on foster parent motives
- Implication of multiple workers in cases
- Lack of legal representation for the agency
- Competency of staff; implications for personnel policies and actions

CIRT Reviewers

CIRT reviewers provided an overview of findings and impressions from two recently reviewed high profile cases. A number of overarching concerns were discussed relative to how practice and decision-making in these cases may suggest challenges for improvement more broadly. Reviewers were concerned with the effects of underlying issues that are influencing practice such as support and workload management. The level of expectations that exists for workers and supervisors was explored including a focus on the need to assure that staff is able to prioritize their efforts, attention and investment. The discussion resulted in the identification of the following:

- A legitimate question exists as to whether safety intervention is systematic. Does the agency have a child safety intervention system?
- There is a need to establish clearer expectations concerning what information workers should collect and employ in safety assessment and decision-making. Does the agency have safety information standards?
- Responsibility for safety management seems to become less clear as a case continues deeper into CPS. Often many workers are involved in a case without clear expectations about safety management.
- In general, policies are silent regarding procedural requirements, particularly related to safety decision making.
- What should be the safety decision making expectations regarding foster and adoptive families, and what are the implications for the current staffing levels to achieve these expectations?

Governor's Representative

NRC met with Erinn Kelly-Siel with the Governor's office, Ramona Foley and Garry Weeks for a general discussion about current child welfare issues and technical assistance from NRCCPS.

Child Welfare Program Managers

Program managers provided observations to NRC concerning current practice in safety intervention. The lack of tenure among child welfare staff, including the

front line supervisors, was identified as an important influence on the quality of practice and decision-making. Specific issues that were raised included:

- Given the workload today's child welfare staff lack systematic ways of managing work; of determining priorities; of determining what is crucial and immediate.
- Practice and decision-making models may seem too complicated to staff.
- There is a need for unannounced visits particularly in out of home placement cases.
- Many cases contain people and problems not amenable to treatment.
- A social service – relationship oriented practice model may be unrealistic for current cases.
- Ongoing in home cases lack necessary oversight.
- Inexperienced staff may be “afraid” to make decisions.
- Ongoing intervention is not focused on how to get kids out of care; staff may not be able to figure out how to best facilitate a more provisional approach to out of home placements.
- Documentation has changed focus from pertinent case information for summarizing and decision-making to trackable information for federal revenue and court purposes.

Case Review

NRCCPS reviewed portions of the case records of the two cases recently reviewed by CIRT. Time did not allow for extensive reviews. The reviews did, however, result in some general observations:

- Record keeping, though extensive, seems overwhelming and lacks the capacity to direct or drive the case. It appears that the value of much of what is contained in records could be brought into question with respect to how it contributes to case decision-making and case practice. The approach to record keeping along with the huge volume of material results in it being a considerable challenge to use the record as a reasonable and responsive source for overseeing a case.
- Apparently expectations do not exist for collecting, documenting and analyzing specific information about adult functioning. The absence of such information limits one reviewing a case from understanding how safety is assessed and how case direction occurs.
- Staff appears to collect and document meaningful information indicative of threats to safety, however, it is not clear that staff understand the meaning of such information or calculate it within their analysis and safety assessment. Significant “pieces” of information such as the exceptional needs or provocative nature of a child can be mentioned within a record in descriptive ways but not addressed with respect to assessment or judging meaning.
- Ongoing child welfare staff does not appear to consider safety management as within their scope of responsibility – as the priority.

- The procedure that requires ongoing child welfare staff to report concerns for abuse or neglect as mandatory reporters likely contributes to the absence of responsibility they demonstrate as safety managers.
- Staff responsible for out of home placements likely do not include in their role the expectation that they should “assess” foster parents and safety; it is likely that for various reasons (e.g., foster parents are partners) child welfare staff are not particularly discriminating or judgmental about the quality and nature of care being given. There may be a tendency or state of behavior whereby staff simply are accepting of foster parents without much qualification.

CAF Program Manager/Staff Meeting

The site visit concluded with a discussion with CAF state office staff. NRCCPS provided observations and feedback while qualifying the limitations preventing conclusive judgments. However, a single conclusion was considered: CAF appears to have elements of a safety intervention system but may be lacking some critical components. It appears that safety intervention diffuses the further a case moves into the system. CAF staff members agreed that a fuller understanding of the strengths and limitations of its current approach to safety intervention is necessary in order to identify critical improvement areas. The discussion concluded that four objectives appeared to be indicated:

- To review and comment on policy and the newly revised Guided Assessment Process;
- To create and conduct a self assessment of the current safety intervention approach;
- To consider a revision to the logging practice occurring in intake; and
- To plan a training event for front line staff concerned with safety intervention.

Next Steps

- NRCCPS will prepare a technical assistance logic model and work plan to provide guidance to the work to be done and will submit these to CAF by January 19 for review, revision and acceptance.
- NRCCPS will convene a conference call the week of January 24 with John Henderson (federal regional office); Ramona Foley (Director of CAF); and Wayne Holder and Terry Roe Lund (NRCCPS) to discuss the current status of TA and projected plans.
- Upon acceptance of the work plan by CAF, NRCCPS will begin the review of policy and GAP and the design of the self-assessment.
- It is anticipated that the reviews will be completed within a month and submitted to CAF for feedback.
- It is anticipated that the self-assessment will be conducted in March.

- It is anticipated that the final product – a specification of an OR safety intervention system – will be available in April.