

Mission: The mission of Child Welfare is to provide safety, permanency and well being for the children of Oregon who are victims of abuse or neglect.

Need: Children who come into the foster care system have often experienced varying levels of child abuse and neglect. The very act of being removed from their families is traumatic and impacts each child differently. Children need thorough and timely assessments of their medical and mental health needs so they can be addressed as soon as possible. Parents and foster parents need a clear picture of the needs of the children they are caring for so they can provide care that is appropriate to each child. Children need to be healthy, safe and cared for to stabilize and eventually thrive. 2007 data demonstrated that as few as 26% of children over the age of three (3) received a mental health assessment within 60 days of DHS substitute care placement. Data also showed that approximately 32% of children in substitute care have been prescribed a psychotropic medication. Finally, analysis of 2007 foster care placement stability data shows that behavioral health issues are one of the most significant contributing factors to placement instability.

Initiative: Improve the capacity of Oregon's foster care system to ensure that the physical and behavioral health needs of children in substitute care are met.

Objective	Drivers	Strategies/Actions	Outcomes	Measurements	Cross Div./Dept. Impacts
<p>1. Every child receiving in-home or substitute care services will receive timely and appropriate medical and mental health assessments and seamless services and they will have a case plan that comprehensively addresses their physical and mental health needs without disruption and regardless of placement.</p> <p><u>Lead staff</u> Kevin George and Toni Peterson</p>	<p>1. Lack of or difficulty obtaining medical information upon intake in foster care.</p> <p>2. Barriers to disbursement of medical/mental health information to care givers.</p> <p>3. Lack of, or minimal communication between treating health care provider and DHS.</p> <p>4. Staff workload and training capacity.</p> <p>5. Lack of services available to parents, caregivers and children.</p> <p>6. Adequacy of federal and state funding.</p> <p>7. Structural issues relating to service delivery and funding for health services.</p>	<p>1. Medical and mental health information will accompany a child if placement change occurs, or when/if the child returns home.</p> <p>2. Obtain medical and mental health information for children in the legal custody of DHS and plan and advocate for culturally appropriate medical and mental health services which are a part of the case plan.</p> <p>3. CAF will adopt a policy requiring referral to the public mental health system for a MH or developmental assessment, depending on age, within 21 days.</p> <p>4. Local CAF and Community MH partners will have written MOUs memorializing their commitment to the timely referral, prioritization of those referrals, and scheduling of assessment appointments to meet the requirement that a MH assessment occur within 60-days of placement in substitute care.</p> <p>5. CAF will complete and follow through on recommendations from the policy compliance audit currently underway regarding psychotropic medication prescribing.</p> <p>6. CAF will work with FCHP and MHOs as well as and AMH to enhance case reviews focused on psychotropic prescribing practices.</p> <p>7. CAF will address the issue of informed consent based on recommendations from the CAF Medical Advisory Committee.</p> <p>8. CAF will work with AMH leadership to develop an implementation plan to outline steps required to fully implement the Wraparound Model for children receiving in-home or substitute care services who require the Wraparound approach.</p> <p>9. Caregivers will have the respite and other care supports required to maintain foster care placements for children with significant physical and behavioral health needs.</p> <p>10. Parents of children with significant physical and behavioral health issues will receive training and culturally appropriate supports to facilitate keeping those children at home or ensure safe transition home from foster care</p>	<p>1. Decrease fragmented and inadequate health care leading to further disruption in health services. Increase consistency in health care and access to medical services. (S#1, 2, 4, 8, 11, 12)</p> <p>2. Children who are at home or in substitute care placements will be connected to their community mental and physical health systems so that their physical and behavioral health needs are met (right care at the right time) while they are child-welfare involved, and so that their needs can continue to be met with child welfare is no longer involved with them or their permanent placement. (S#3, 4, 5, 6, 7, 8, 10)</p>	<p>1. Number/ percent of children who meet medication review criteria who have completed review. (O#1 & 2)</p> <p>2. Percent of children who receive services to meet their physical and mental health needs (through case file review). (O#1 & 2)</p> <p>3. Number/ percent of children in foster care who receive comprehensive mental health assessments within 60 days of placement in substitute care. (O#2)</p> <p>4. Federal permanency composite 4: Placement stability. (O#2)</p>	<p>1. Funding in AMH for children's mental health services.</p> <p>2. Transition Programs need coordination across Self Sufficiency JOBS/Medical/SSI Programs as well as Education, DD services, OVRs and others.</p>

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<p>1. Every child receiving in-home or substitute care services will receive timely and appropriate medical and mental health assessments and seamless services and they will have a case plan that comprehensively addresses their physical and mental health needs without disruption and regardless of placement.</p> <p><u>Lead staff</u> Kevin George and Toni Peterson</p>	<p>1. Lack of or difficulty obtaining medical information upon intake in foster care.</p> <p>2. Barriers to disbursement of medical/mental health information to care givers.</p> <p>3. Lack of, or minimal communication between treating health care provider and DHS.</p> <p>4. Staff workload and training capacity.</p> <p>5. Lack of services available to parents, caregivers and children.</p> <p>6. Adequacy of federal and state funding.</p> <p>7. Structural issues relating to service delivery and funding for health services.</p>	<p>1. Medical and mental health information will accompany a child if placement change occurs, or when/if the child returns home.</p> <p>2. Obtain medical and mental health information for children in the legal custody of DHS and plan and advocate for culturally appropriate medical and mental health services which are a part of the case plan.</p> <p>3. CAF will adopt a policy requiring referral to the public mental health system for a MH or developmental assessment, depending on age, within 21 days.</p> <p>4. Local CAF and Community MH partners will have written MOUs memorializing their commitment to the timely referral, prioritization of those referrals, and scheduling of assessment appointments to meet the requirement that a MH assessment occur within 60-days of placement in substitute care.</p> <p>5. CAF will complete and follow through on recommendations from the policy compliance audit currently underway regarding psychotropic medication prescribing.</p> <p>6. CAF will work with FCHP and MHOs as well as and AMH to enhance case reviews focused on psychotropic prescribing practices.</p> <p>7. CAF will address the issue of informed consent based on recommendations from the CAF Medical Advisory Committee.</p> <p>8. CAF will work with AMH leadership to develop an implementation plan to outline steps required to fully implement the Wraparound Model for children receiving in-home or substitute care services who require the Wraparound approach.</p> <p>9. Caregivers will have the respite and other care supports required to maintain foster care placements for children with significant physical and behavioral health needs.</p> <p>10. Parents of children with significant physical and behavioral health issues will receive training and culturally appropriate supports to facilitate keeping those children at home or ensure safe transition home from foster care</p>	<p>1. Decrease fragmented and inadequate health care leading to further disruption in health services. Increase consistency in health care and access to medical services. (S#1, 2, 4, 8, 11, 12)</p> <p>2. Children who are at home or in substitute care placements will be connected to their community mental and physical health systems so that their physical and behavioral health needs are met (right care at the right time) while they are child-welfare involved, and so that their needs can continue to be met with child welfare is no longer involved with them or their permanent placement. (S#3, 4, 5, 6, 7, 8, 10)</p>	<p>1. Number/ percent of children who meet medication review criteria who have completed review. (O#1 & 2)</p> <p>2. Percent of children who receive services to meet their physical and mental health needs (through case file review). (O#1 & 2)</p> <p>3. Number/ percent of children in foster care who receive comprehensive mental health assessments within 60 days of placement in substitute care. (O#2)</p> <p>4. Federal permanency composite 4: Placement stability. (O#2)</p>	<p>1. Funding in AMH for children's mental health services.</p> <p>2. Transition Programs need coordination across Self Sufficiency JOBS/Medical/SSI Programs as well as Education, DD services, OVRs and others.</p>

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