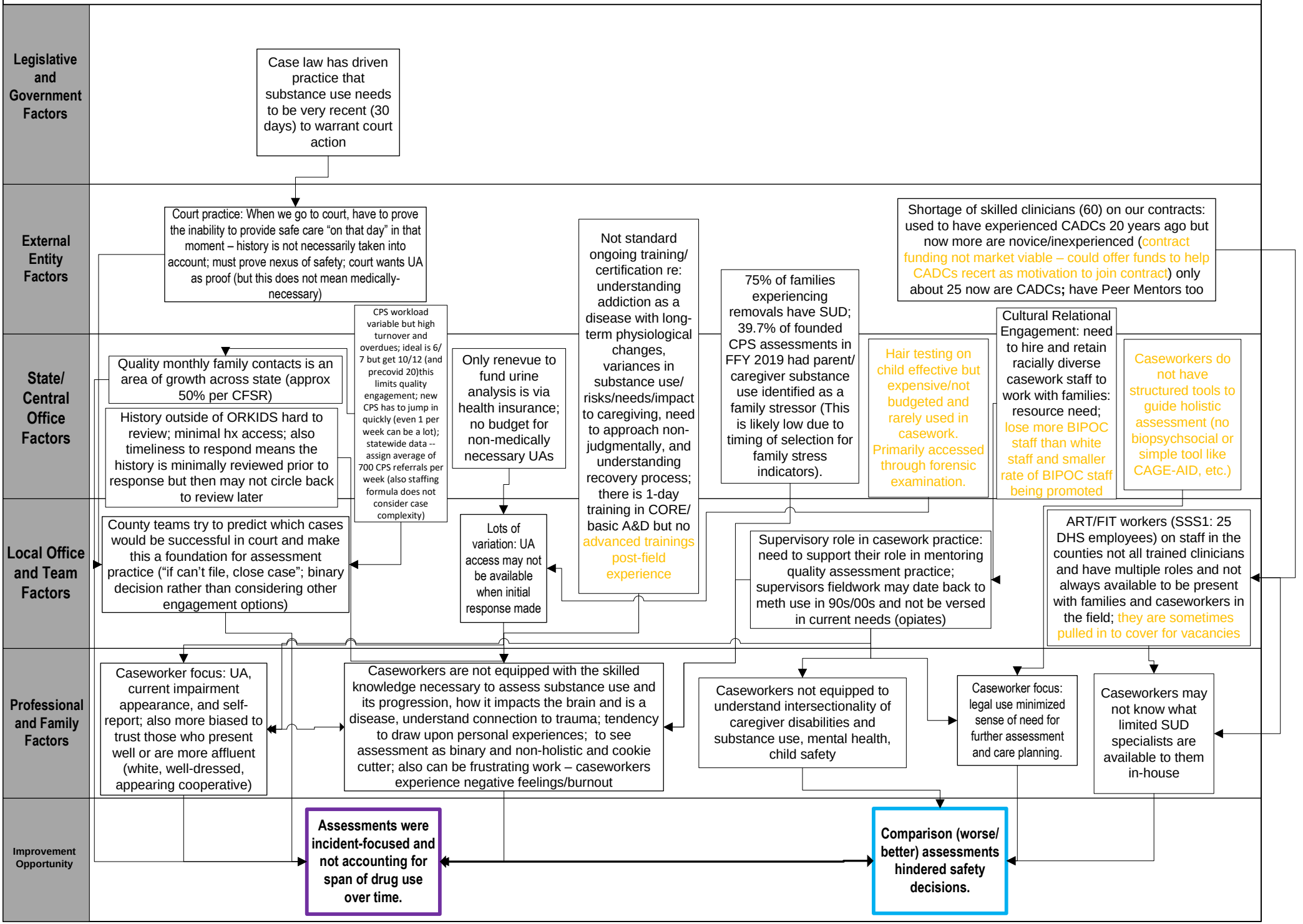
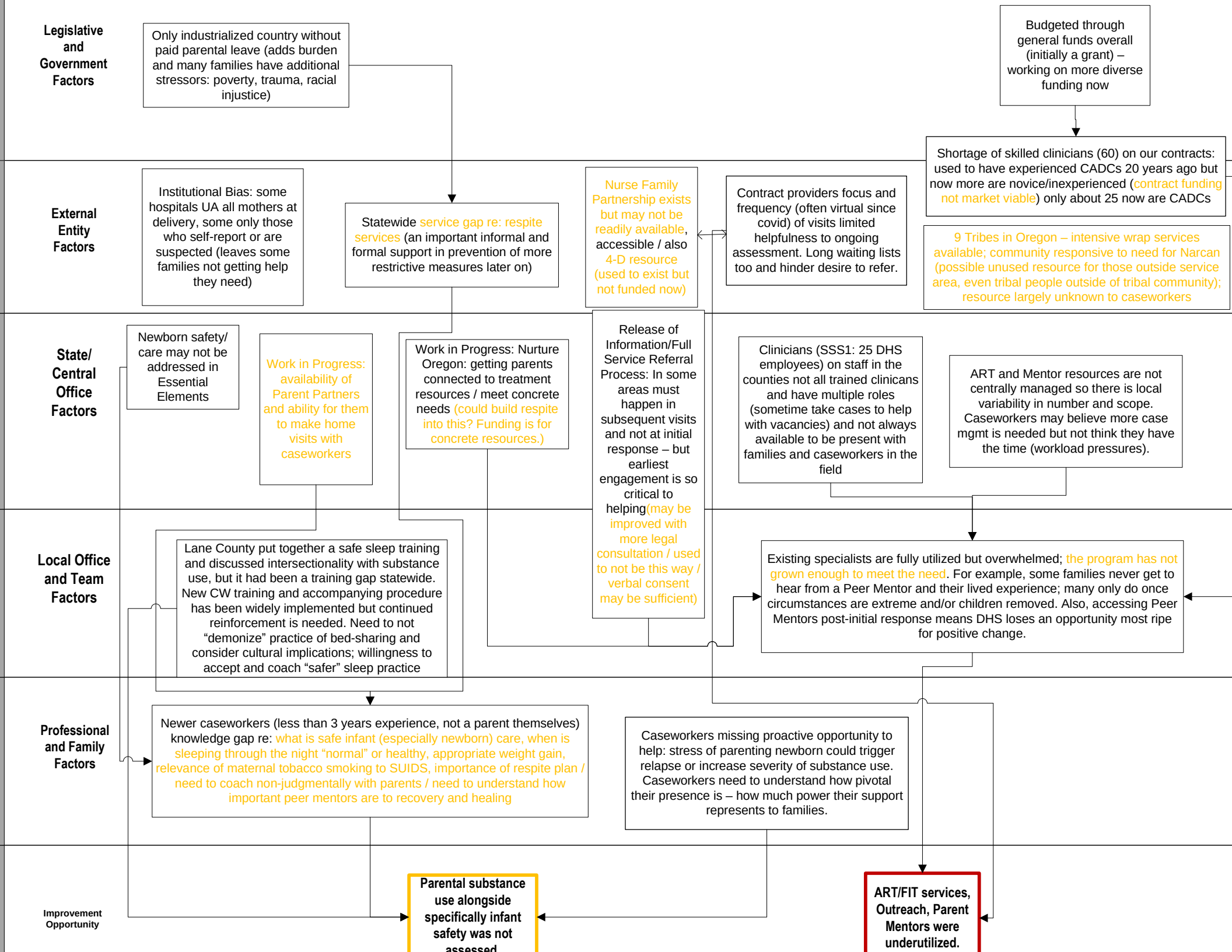
Systems Map


Legislative and Government Factors
External Entity Factors
State/ Central Office Factors
Local Office and Team Factors
Professional and Family Factors
Improvement Opportunity
Case law has driven practice that substance use needs to be very recent (30 days) to warrant court action
Court practice: When we go to court, have to prove the inability to provide safe care "on that day" in that moment – history is not necessarily taken into account; must prove nexus of safety; court wants UA as proof (but this does not mean medically-necessary)
Not standard ongoing training/ certification re: understanding addiction as a disease with long-term physiological changes, variances in substance use/ risks/needs/impact to caregiving, need to approach non-judgmentally, and understanding recovery process; there is 1-day training in CORE/ basic A&D but no advanced trainings post-field experience
Shortage of skilled clinicians (60) on our contracts: used to have experienced CADCs 20 years ago but now more are novice/inexperienced (contract funding not market viable – could offer funds to help CADCs recert as motivation to join contract) only about 25 now are CADCs; have Peer Mentors too
75% of families experiencing removals have SUD; 39.7% of founded CPS assessments in FFY 2019 had parent/ caregiver substance use identified as a family stressor (This is likely low due to timing of selection for family stress indicators).
Hair testing on child effective but expensive/not budgeted and rarely used in casework. Primarily accessed through forensic examination.
Cultural Relational Engagement: need to hire and retain racially diverse casework staff to work with families: resource need; lose more BIPOC staff than white staff and smaller rate of BIPOC staff being promoted
Caseworkers do not have structured tools to guide holistic assessment (no biopsychsocial or simple tool like CAGE-AID, etc.)
CPS workload variable but high turnover and overdues; ideal is 6/ 7 but get 10/12 (and precovid 20)this limits quality engagement; new CPS has to jump in quickly (even 1 per week can be a lot); statewide data -- assign average of 700 CPS referrals per week (also staffing formula does not consider case complexity)
Quality monthly family contacts is an area of growth across state (approx 50% per CFSR)
History outside of ORKIDS hard to review; minimal hx access; also timeliness to respond means the history is minimally reviewed prior to response but then may not circle back to review later
Only renevue to fund urine analysis is via health insurance; no budget for non-medically necessary UAs
County teams try to predict which cases would be successful in court and make this a foundation for assessment practice ("if can't file, close case"; binary decision rather than considering other engagement options)
Lots of variation: UA access may not be available when initial response made
Supervisory role in casework practice: need to support their role in mentoring quality assessment practice; supervisors fieldwork may date back to meth use in 90s/00s and not be versed in current needs (opiates)
ART/FIT workers (SSS1: 25 DHS employees) on staff in the counties not all trained clinicians and have multiple roles and not always available to be present with families and caseworkers in the field; they are sometimes pulled in to cover for vacancies
Caseworker focus: UA, current impairment appearance, and self-report; also more biased to trust those who present well or are more affluent (white, well-dressed, appearing cooperative)
Caseworkers are not equipped with the skilled knowledge necessary to assess substance use and its progression, how it impacts the brain and is a disease, understand connection to trauma; tendency to draw upon personal experiences; to see assessment as binary and non-holistic and cookie cutter; also can be frustrating work – caseworkers experience negative feelings/burnout
Caseworkers not equipped to understand intersectionality of caregiver disabilities and substance use, mental health, child safety
Caseworker focus: legal use minimized sense of need for further assessment and care planning.
Caseworkers may not know what limited SUD specialists are available to them in-house
Assessments were incident-focused and not accounting for span of drug use over time.
Comparison (worse/ better) assessments hindered safety decisions.


Legislative and Government Factors
Only industrialized country without paid parental leave (adds burden and many families have additional stressors: poverty, trauma, racial injustice)
Budgeted through general funds overall (initially a grant) – working on more diverse funding now
Shortage of skilled clinicians (60) on our contracts: used to have experienced CADCs 20 years ago but now more are novice/inexperienced (contract funding not market viable) only about 25 now are CADCs
External Entity Factors
Institutional Bias: some hospitals UA all mothers at delivery, some only those who self-report or are suspected (leaves some families not getting help they need)
Statewide service gap re: respite services (an important informal and formal support in prevention of more restrictive measures later on)
Nurse Family Partnership exists but may not be readily available, accessible / also 4-D resource (used to exist but not funded now)
Contract providers focus and frequency (often virtual since covid) of visits limited helpfulness to ongoing assessment. Long waiting lists too and hinder desire to refer.
9 Tribes in Oregon – intensive wrap services available; community responsive to need for Narcan (possible unused resource for those outside service area, even tribal people outside of tribal community); resource largely unknown to caseworkers
State/ Central Office Factors
Newborn safety/ care may not be addressed in Essential Elements
Work in Progress: availability of Parent Partners and ability for them to make home visits with caseworkers
Work in Progress: Nurture Oregon: getting parents connected to treatment resources / meet concrete needs (could build respite into this? Funding is for concrete resources.)
Release of Information/Full Service Referral Process: In some areas must happen in subsequent visits and not at initial response – but earliest engagement is so critical to helping(may be improved with more legal consultation / used to not be this way / verbal consent may be sufficient)
Clinicians (SSS1: 25 DHS employees) on staff in the counties not all trained clinicans and have multiple roles (sometime take cases to help with vacancies) and not always available to be present with families and caseworkers in the field
ART and Mentor resources are not centrally managed so there is local variability in number and scope. Caseworkers may believe more case mgmt is needed but not think they have the time (workload pressures).
Local Office and Team Factors
Lane County put together a safe sleep training and discussed intersectionality with substance use, but it had been a training gap statewide. New CW training and accompanying procedure has been widely implemented but continued reinforcement is needed. Need to not "demonize" practice of bed-sharing and consider cultural implications; willingness to accept and coach "safer" sleep practice
Existing specialists are fully utilized but overwhelmed; the program has not grown enough to meet the need. For example, some families never get to hear from a Peer Mentor and their lived experience; many only do once circumstances are extreme and/or children removed. Also, accessing Peer Mentors post-initial response means DHS loses an opportunity most ripe for positive change.
Professional and Family Factors
Newer caseworkers (less than 3 years experience, not a parent themselves) knowledge gap re: what is safe infant (especially newborn) care, when is sleeping through the night "normal" or healthy, appropriate weight gain, relevance of maternal tobacco smoking to SUIDS, importance of respite plan / need to coach non-judgmentally with parents / need to understand how important peer mentors are to recovery and healing
Caseworkers missing proactive opportunity to help: stress of parenting newborn could trigger relapse or increase severity of substance use. Caseworkers need to understand how pivotal their presence is – how much power their support represents to families.
Improvement Opportunity
Parental substance use alongside specifically infant safety was not assessed
ART/FIT services, Outreach, Parent Mentors were underutilized.