Office of the Family and Children's Ombuds

An Independent Voice for Families and Children

2016 Annual Report

Patrick Dowd, *Director*

ofco.wa.gov

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January 2017

To the Residents of Washington State:

I am pleased to submit the 2016 Annual Report of the Office of the Family and Children's Ombuds. This report provides an account of OFCO's activities from September 1, 2015 to August 31, 2016. OFCO thanks the parents, youth, relatives, foster parents, professionals and others who brought their concerns to our attention. We take their trust in our office most seriously.

During this reporting period, OFCO received 778 complaints in 2016, the most OFCO has ever received in a single year, and completed 727 complaint investigations regarding 1,121 children and 681 families. As in past years, the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints.

In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues discussed in this report include:

- Shortage of foster care placements and the use of hotels as emergency placements for children in state care;
- Child fatalities related to opioid use;
- Improving outcomes for children in group care; and
- Engaging incarcerated parents of children in state care.

Finally, in response to Governor Inslee's Executive Order, *the Washington State Blue Ribbon Commission on the Delivery of Services to Children and Families* released its report and recommendations to realign Children's Administration, Juvenile Rehabilitation and the Office of Juvenile Justice with the Department of Early Learning and establish the Department of Children Youth and Families (DCYF). The intent of these recommendations reaches far beyond simply reorganizing existing state agencies that serve children and families. Rather the DCYF would promote greater accountability, heighten the visibility of children's issues, and reduce barriers to improving service and outcomes for children and families.

On behalf of all of us at the Office of the Family and Children's Ombuds, I want to thank you for your interest in our work. I am grateful for the leadership and dedication of those working to improve the welfare of children and families and I am grateful for the opportunity to serve the residents of Washington State.

Sincerely,

Patrick Dowd, JD
Director Ombuds

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EXECUTIVE SUMMARY

The OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS (OFCO) was established by the 1996 Legislature to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. The office also promotes public awareness about the child protection and welfare system, and recommends and facilitates broad-based systemic improvements.

This report provides an account of OFCO's complaint investigation activities from September 1, 2015, through August 31, 2016. This report also provides recommendations to improve the quality of state services for children and families.

CORE DUTIES

The following duties and responsibilities of the Ombuds are set forth in state laws:[1]

Respond to Inquiries:

Provide information on the rights and responsibilities of individuals receiving family and children's services, and on the procedures for accessing these services.

Complaint Investigation and Intervention:

Investigate, upon the Ombuds' own initiative or receipt of a complaint, an administrative act alleged to be contrary to law, rule, or policy, imposed without an adequate statement of reason, or based on irrelevant, immaterial, or erroneous grounds. The Ombuds also has the discretion to decline to investigate any complaint.

System Oversight and Improvement:

- Monitor the procedures as established, implemented, and practiced by the Department of Social and Health Services (DSHS) to carry out its responsibilities in delivering family and children's services to preserve families when appropriate and ensure children's health and safety;
- Review periodically the facilities and procedures of state institutions serving children, and state-licensed facilities or residences;
- Review child fatalities and near fatalities when the injury or death is suspected to be caused by child abuse or neglect and the family was involved with the Department during the previous 12 months;
- Recommend changes in law, policy and practice to improve state services for families and children; and
- Review notifications from DSHS regarding a third founded report of child abuse or neglect, within a twelve month period, involving the same child or family.

[1] RCW 43.06A and RCW 26.44.030.

Annual Reports:

- Submit an annual report to the Legislative Children's Oversight committee and to the Governor analyzing the work of the office including recommendations; and
- Issue an annual report to the Legislature on the implementation status of child fatality review recommendations.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2015 and August 31, 2016, OFCO completed 727 complaint investigations regarding 1,121 children and 681 families. As in previous years, issues involving the separation and reunification of families were by far the most frequently identified complaint issues. The conduct of CA staff and other agency services comprised the next-highest categories of issues identified in complaints.

OMBUDS IN ACTION

OFCO takes action when necessary to avert or correct a harmful action or oversight, or an avoidable mistake by Children's Administration (CA). Forty-eight complaints prompted intervention by OFCO in 2016. OFCO provided substantial assistance to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation, in an additional 46 complaints.

In 2016, OFCO made 42 formal adverse findings against CA. OFCO provides CA with written notice of adverse findings resulting from a complaint investigation. CA is invited to respond to the finding, and may present additional information and request a revision of the finding. This process provides transparency for OFCO's work as well as accountability for DSHS.[2]

WORKING TO MAKE A DIFFERENCE

Shortage of Foster Care Placements

Washington has experienced a decline in the number of licensed foster homes since 2012,[3] yet the number of children requiring out-of-home care has increased.[4] As a result of limited placement resources, children in state care have been placed in hotels or Department offices, waiting for the Department to find them an appropriate placement. This report describes 883 "placement exceptions" involving 221 children. OFCO found that this is primarily a regional concern, occurring most frequently in Snohomish and King Counties. The ongoing practice of placing children in hotels indicates a shortage of foster homes and therapeutic placements.

This report discusses recommendations for addressing this placement shortage, including:

- **Provide an adequate supply and range of residential placement options to meet the needs of all children in state care; and**
- **Expand programs that support foster and kinship families and prevent placement disruptions.**

[2] An inter-agency agreement between OFCO and CA was established in November 2009.
[3] Children's Administration, Quality Assurance and Continuous Quality Improvement, Monthly Metric Trends.
[4] Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 1/6/2017]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

Engaging Incarcerated Parents of Children in State Care

State laws and Department policies protect the interests of incarcerated parents whose children are in state care. Yet several complaints to OFCO about incarcerated parents indicate that these laws and policies are not being consistently followed. OFCO's investigations also identified challenges that caseworkers face in engaging with incarcerated parents. This report discusses three key recommendations for working with incarcerated parents of children in care.

- **Incarcerated parents should receive heightened focus** throughout the child welfare case process;
- **CA and the Department of Corrections (DOC) should adopt policies and practices regarding and promoting communication with incarcerated parents**; and
- **Create an adequate array of services** within DOC for incarcerated parents.

Child Fatalities Related to Opioid Use

In April 2016 OFCO published a report of its administrative reviews of child fatalities and near fatalities occurring in calendar year 2015. This report described the increase in abuse of opioids and its impact on the child welfare system. Key recommendations from the Child Fatalities and Near Fatalities in Washington State report are highlighted in OFCO's 2015-2016 Annual Report and include:

- **Expand services for expectant mothers and mothers of newborns,** such as the Nurse-Family Partnership – a program that partners new and expectant mothers with a registered nurse who makes home visits; and
- **Provide DCFS caseworkers with additional training and support resources for addressing substance abuse by parents, and assessing child safety.**

Improving Outcomes for Children in Group Care

In 2016 OFCO visited nine Washington facilities licensed as group homes that provide services through a Behavioral Rehabilitation Services (BRS) contract. OFCO sought to learn from youth residing in these BRS-contracted group homes about their experiences in order to inform stakeholders about what is working and what needs improvement in group care. OFCO made several recommendations for improving group care, with select recommendations discussed in this Annual Report as well.

- **Increase caseworker contact with youth placed in group homes**;
- **Expand alternative placement options** so that more options are available to meet the needs of children with challenges in non-congregate settings though state care;
- **Enhance court oversight of children in group care**. Court review hearings should be held every three months for children placed in group care facilities; and
- **Appoint attorneys for children residing in group care**.

Meeting the Needs of LGBTQ+ Children and Youth

OFCO's report on Washington's group care identified specific issues and concerns facing LGBTQ+ children. These issues are not confined solely to children in group homes. Our entire child welfare system must ensure safe and supportive care and appropriate services for LGBTQ+ children throughout the child welfare system.

THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children's Ombuds[5] (OFCO) in 1996 in response to two high profile incidents that indicated a need for oversight of the child welfare system.[6] OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Social and Health Services (DSHS) decisions. OFCO is also empowered to intervene to induce DSHS to change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

- **Independence.** One of OFCO's most important features is independence. OFCO's ability to review and analyze complaints in an independent manner allows the office to maintain its reputation for integrity and objectivity. Although OFCO is organizationally located within the Office of the Governor, it conducts its operations independently of the Governor's Office in Olympia. OFCO is a separate agency from DSHS.

- **Impartiality.** The Ombuds acts as a *neutral investigator* and not as an advocate for individuals who file complaints, or for the government agencies investigated. This neutrality reinforces OFCO's credibility.

- **Confidentiality.** OFCO must maintain the confidentiality of complainants and information obtained during investigations. This protection makes citizens, including DSHS professionals, more likely to contact OFCO and speak candidly about their concerns.

- **Credible review process.** OFCO has a credible review process that promotes respect and confidence in OFCO's oversight of DSHS. Ombuds are qualified to analyze issues and conduct investigations into matters of child welfare law, administration, policy, and practice. OFCO's staff has a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice and is trained in the United States Ombudsman Association Governmental Ombudsman Standards. OFCO and DSHS operate under an inter-agency agreement that guides communication between the two agencies and promotes accountability.[7]

AUTHORITY

Under chapter RCW 43.06A, the Legislature enhanced OFCO's investigative powers by providing it with broad access to confidential DSHS records and the agency's computerized case-management system. It also authorizes OFCO to receive confidential information from other agencies and service providers,

[5] State law requires that all statutes must be written in gender-neutral terms unless a specification of gender is intended. Pursuant to Chapter 23 Laws of 2013, the term "ombudsman" was replaced by "ombuds". http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/5077-S.SL.pdf.

[6] The death of three year old Lauria Grace, who was killed by her mother while under the supervision of the Department of Social and Health Services (DSHS), and the discovery of years of sexual abuse between youths at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with growing concerns about DSHS' role and practices in the Wenatchee child sexual abuse investigations.

[7] The inter-agency agreement is available online at http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf.

including mental health professionals, guardians ad litem, and assistant attorneys general.[8] OFCO operates under a shield law which protects the confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature over the years regarding the reporting and review of child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment.[9]

OFCO derives influence from its close proximity to the Governor and the Legislature. The Director is appointed by and reports directly to the Governor. The appointment is subject to confirmation by the Washington State Senate. The Director-Ombuds serves a three-year term and continues to serve in this role until a successor is appointed. OFCO's budget, general operations, and system improvement recommendations are reviewed by the Legislative Children's Oversight Committee.

WORK ACTIVITIES

OFCO performs its statutory duties through its work in four areas, currently conducted by *6.8 full time employees*:

- **Listening to Families and Citizens.** Individuals who contact OFCO with an inquiry or complaint often feel that DSHS or another agency is not listening to their concerns. By listening carefully, the Ombuds can effectively assess and respond to individual concerns as well as identify recurring problems faced by families and children throughout the system.

- **Responding to Complaints.** The Ombuds impartially investigates and analyzes complaints against DSHS and other agencies. OFCO spends more time on this activity than any other. This enables OFCO to intervene on citizens' behalf when necessary, and accurately identify problematic policy and practice issues that warrant further examination. Impartial investigations also enable OFCO to support actions of the agency when it is unfairly criticized for properly carrying out its duties.

- **Taking Action on Behalf of Children and Families.** The Ombuds intervenes when necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. Typical interventions include: prompting the agency to take a closer look at a concern, facilitating information sharing, mediating professional disagreements, and sharing OFCO's investigative findings and analyses with the agency to correct a problematic decision. These interventions are often successful in resolving legitimate concerns.

- **Improving the System.** Through complaint investigations and reviews of critical incidents (including child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment), OFCO works to identify and investigate system-wide problems, and publishes its findings and recommendations in public reports to the Governor and the Legislature. This is an effective tool for educating state policymakers and agency officials about the need to create, change, or set aside laws, policies or agency practices so that children are better protected and cared for and families are better served by the child welfare system.

[8] See also RCW 13.50.100(6).
[9] See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(15).

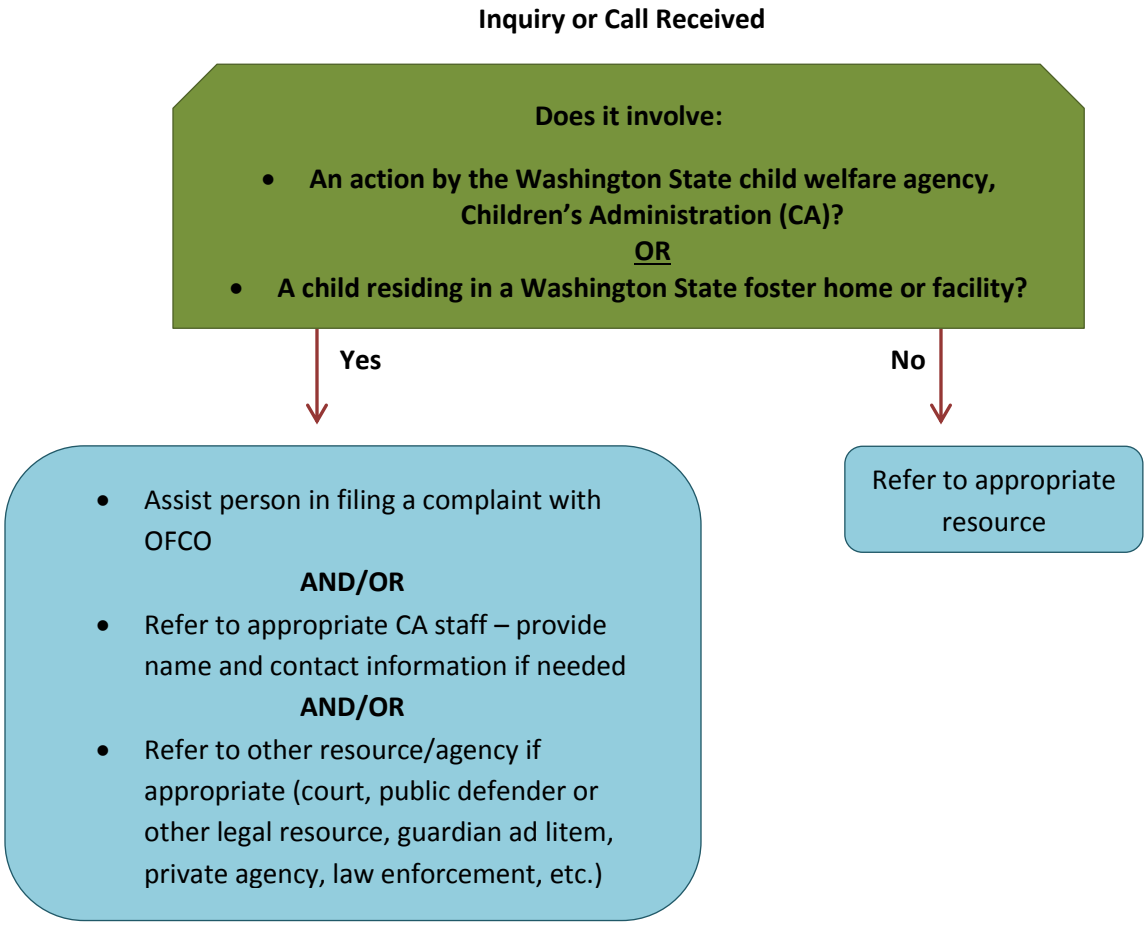
I. LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

INQUIRIES AND COMPLAINTS

The Ombuds listens to people who contact the office with questions or concerns about services provided through the child welfare system. Callers may include family members of children receiving such services, professionals working with families and children, or concerned citizens. By listening carefully, the Ombuds identifies what the caller needs and responds effectively. Callers may simply need information about Children's Administration's process and/or services, or they may want to know how to file a complaint. While OFCO's online complaint submission process (launched April 2014) has greatly expedited filing a complaint, OFCO still provides live telephonic assistance to complainants who want help with the process. For example, they may want verification about whether OFCO can investigate their concern, or guidance in framing or identifying their complaint issue. Callers whom OFCO cannot help directly are referred to the right place for information or support. OFCO makes every effort to have each incoming call answered by a live person rather than a voicemail or menu of options. We frequently hear from callers that this individualized service is highly valued.

Figure 1: **What Happens When a Person Contacts OFCO?**



COMPLAINT PROFILES

COMPLAINTS RECEIVED

This section describes complaints filed during OFCO's 2016 reporting year — September 1, 2015 to August 31, 2016. **OFCO received 778 complaints in 2016**, the most OFCO has ever received in a single year. Figure 3 shows that 80 percent of complaints are submitted electronically, with less than 9 percent submitted through the mail and 7 percent taken over the phone.

Figure 2: **Complaints Received**[10]

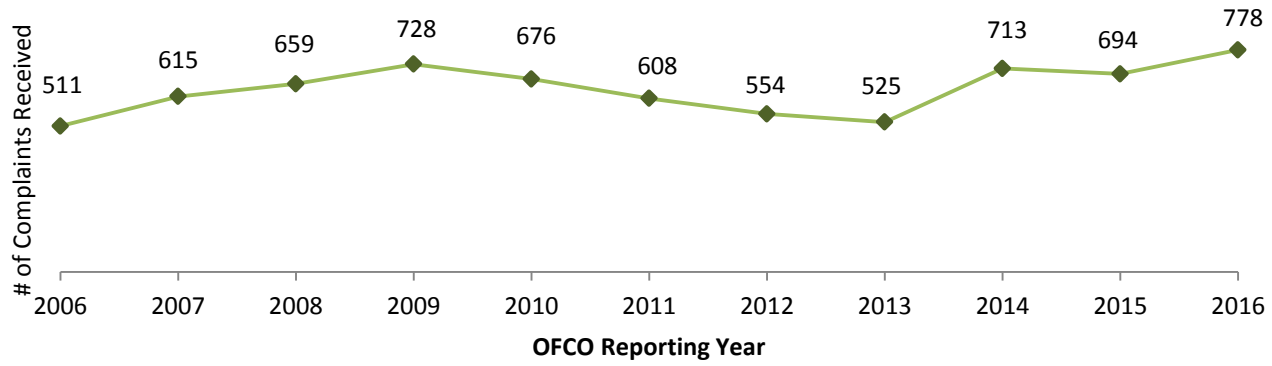
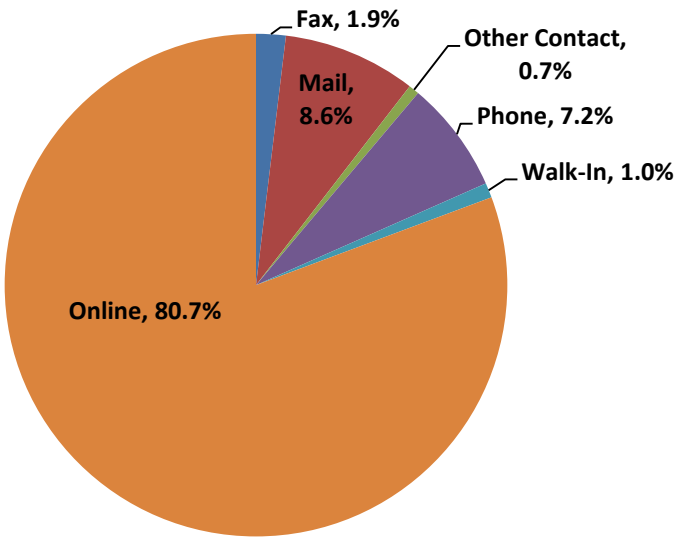


Figure 3: **How Complaints Were Received, 2016**

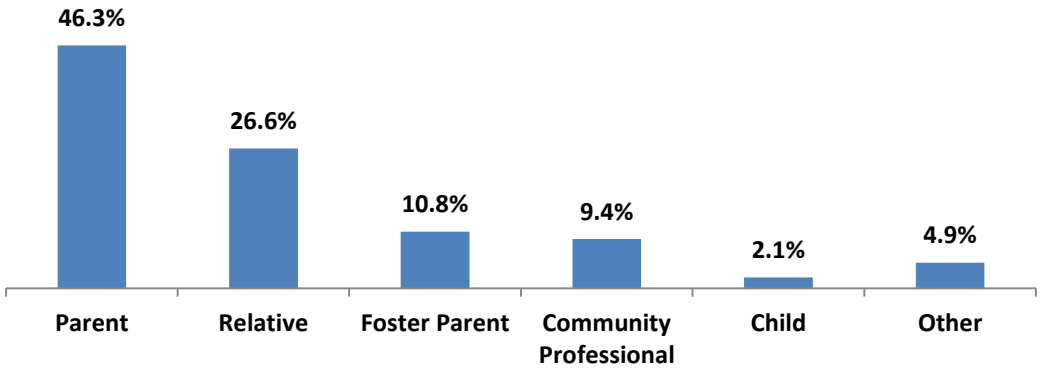


[10] The number of complaints directed at each DSHS region and office is provided in Appendix A.

PERSONS WHO COMPLAINED

Parents, grandparents, and other relatives of the child whose family is involved with Children's Administration (CA) have historically filed around three-quarters of complaints investigated by OFCO, and 2016 was no exception. As in previous years, few children contacted OFCO on their own behalf.

Figure 4: **Complainant Relationship to Children, 2016**



OFCO's complaint form asks complainants to identify their race and ethnicity for the purposes of ensuring that the office is hearing from all Washington citizens.

Table 1: **Complainant Race and Ethnicity, 2016**

	OFCO Complainants 2016	WA State Population*
Caucasian	69.2%	78.2%
African American	7.6%	3.6%
American Indian or Alaska Native	3.2%	1.4%
Asian or Pacific Islander	0.9%	8.1%
Other	1.2%	3.8%
Multiracial	6.2%	4.9%
Declined to Answer	11.8%	-
Latino / Hispanic	6.2%	11.7%
Non-Hispanic	93.8%	88.3%

**U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates*

CHILDREN IDENTIFIED IN COMPLAINTS

Nearly 40 percent of the 1,121 children identified in complaints were four years of age or younger. Another 30 percent were between ages five and nine. OFCO receives fewer complaints involving older children, with the number of complaints decreasing as the child's age increases. This closely mirrors the ages of children in out of home care through the Division of Child and Family Services (DCFS).[11]

Figure 5: **Age of Children in Complaints, 2016**

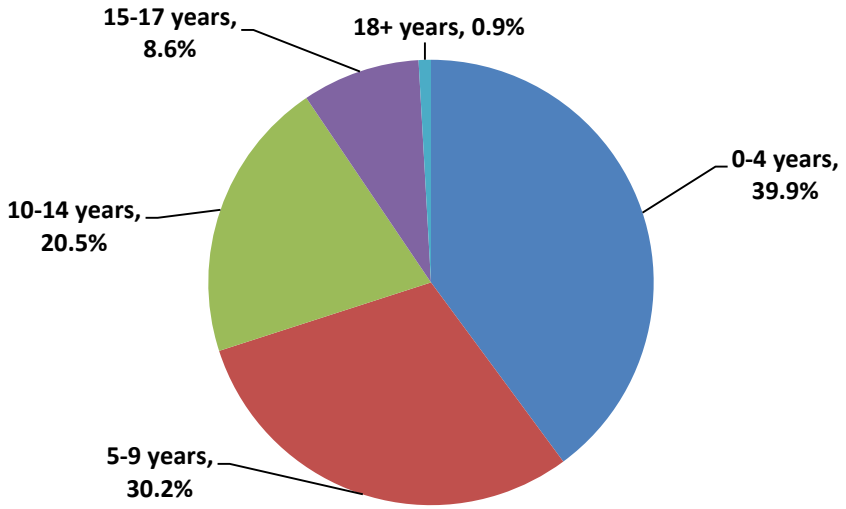


Table 2 shows the race and ethnicity (as reported by the complainant) of the children identified in complaints, compared with children in placement through CA and the general state population.

Table 2: **Race and Ethnicity of Children Identified in Complaints, 2016**

	OFCO Children 2016	Children in Out of Home Care*	WA State Children**
Caucasian	64.0%	66.9%	70.7%
African American	9.0%	9.0%	3.8%
American Indian or Alaska Native	4.0%	6.2%	1.7%
Asian or Pacific Islander	1.1%	1.5%	7.6%
Other	1.0%	0.1%	5.1%
Multiracial	16.3%	15.2%	11.1%
Declined to Answer	4.5%	-	-
Latino / Hispanic	13.0%	18.5%	20.5%
Non-Hispanic	87.0%	81.5%	79.5%

**Data reported by Partners for Our Children (partnersforourchildren.org, 2015)*

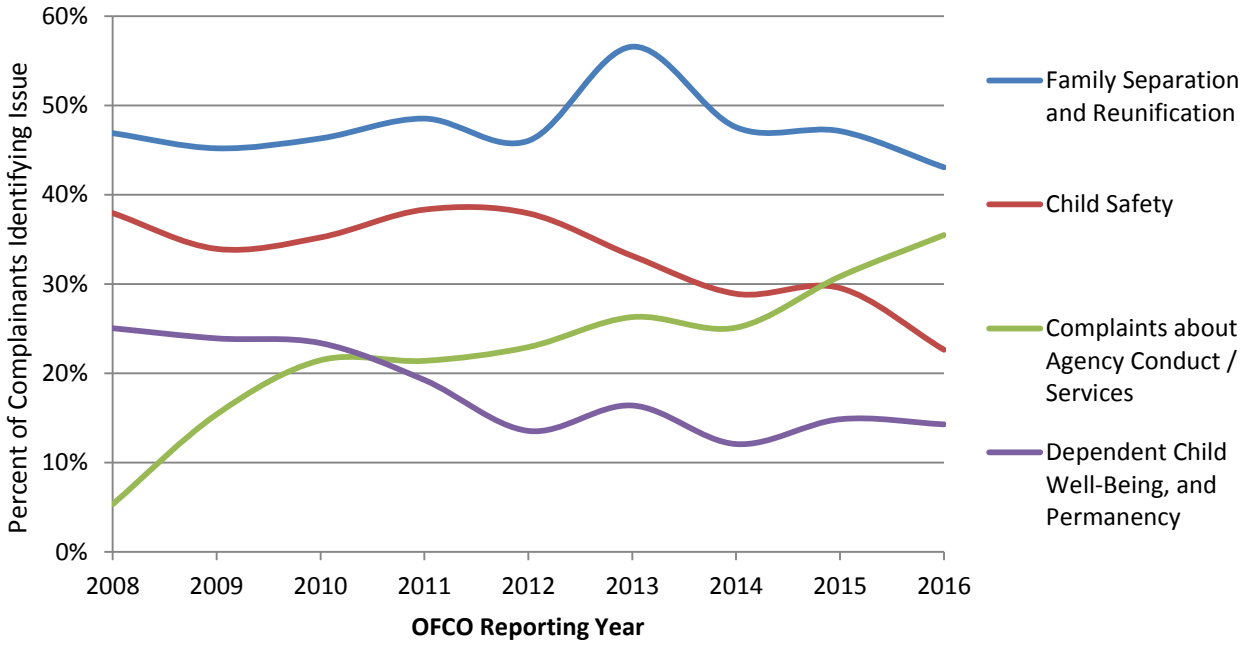
***U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates*

[11] For more information on the ages of children in out of home care, see Appendix B.

COMPLAINT ISSUES

Concerns identified in complaints to OFCO, while varying somewhat year-to-year, have remained largely consistent over time, as displayed below in Figure 6. Complaints can often be complex and complainants will identify multiple issues or concerns they would like investigated.

Figure 6: **Categories of Issues Identified by Complainants**



Family Separation and Reunification

As in previous years, issues involving the **separation and reunification of families** (raised 335 times in complaints) were the most frequently identified. Just over 40 percent (43.1 percent) of complaints expressed a concern about separating families and/or not reunifying with parents or other relatives. This category of complaints incorporates a broad spectrum of issues affecting family stability. Specific concerns include:

- **Children being removed from their parents** (identified in 100 complaints) or other relatives (13 complaints);
- **Not placing children with relatives** (44 complaints) or with **siblings** (9 complaints);
- **Failure to ensure appropriate visitation** or **contact** between children and their parents, siblings, or relatives (78);
- Delays in or failures to reunite family (42); and
- Termination of parental rights (6).

Conduct of CA Staff and Agency Services

Issues involving **the conduct of CA staff and other agency services** were the next-most identified concern in complaints. The number of complainants expressing these kinds of concerns has steadily been increasing since 2010, with a particularly sharp increase since 2014. Complaints about agency conduct or services incorporate a broad category including:

- Concerns about unprofessional conduct by agency staff (102 complaints) such as **harassment, retaliation, discrimination, bias, breaches of confidentiality, or a conflict of interest**;
- **Communication failures** (55), such as caseworkers not communicating with parents or other relatives;
- **Unreasonable findings** of abuse or neglect by CPS (21);
- **Unwarranted or unreasonable CPS investigations** (86); and
- Inaccurate agency records (13).

Child Safety

Nearly half of the **176 child safety** complaints focused on concerns that the agency was **failing to protect children from abuse or neglect** while in their parents' care (79 complaints or 45 percent of all child safety complaints). Another 30 percent concerned **safety risks to dependent children in foster or relative care** (53). Twenty-one complainants were concerned about the safety of children being returned to their parents' care.

Child Well-Being and Permanency

Complaints involving **the well-being and permanency of children in foster or other out-of-home care** increased this year (111 complaints), although this category of complaints continues to be identified at much lower rates than in the late 2000s. This category includes **inappropriate placement changes for dependent children**, as well as **placement instability** such as multiple moves in foster care or abrupt placement changes (raised in 33 complaints). Twelve complaints raised concerns about a child's permanency plan, including **delays in permanency**. The agency's failure to provide adequate services to a dependent child was a concern in 29 complaints this year.

Table 3 on the following page shows the number of times specific issues within these categories were identified in complaints.

Table 3: **Issues Identified by Complainants**

	2016	2015	2014
Family Separation and Reunification	**335**	**327**	**339**
Unnecessary removal of child from parental care	100	89	80
Failure to reunite family	42	73	83
Failure to place child with relative	44	51	71
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	78	49	52
Other inappropriate placement of child	34	23	20
Unnecessary removal of child from relative placement	13	22	11
Failure to provide sibling visits and contact	3	7	4
Failure to place child with siblings	9	5	3
Inappropriate termination of parental rights	6	5	11
Concerns regarding voluntary placement and/or service agreements	3	0	4

	2016	2015	2014
Complaints About Agency Conduct	**276**	**214**	**179**
Unprofessional conduct, harassment, retaliation, conflict of interest or bias/discrimination by agency staff	86	71	29
Unwarranted/unreasonable CPS investigation	86	43	38
Communication failures	55	43	44
Unreasonable CPS findings	21	23	28
Breach of confidentiality by agency	16	19	21
Inaccurate agency records	8	13	9
Heavy-handedness, unreasonable demands on family by agency staff	0	0	3
Poor case management, high caseworker turnover, other poor service	4	1	2
Lack of coordination between DSHS Divisions	2	1	2

	2016	2015	2014
Child Safety	**176**	**205**	**206**
Failure to protect children from parental abuse or neglect	79	100	122
Abuse	41	53	62
Neglect	37	44	56
Failure to address safety concerns involving children in foster care or other non-institutional care	53	54	41
Failure to address safety concerns involving child being returned to parental care	21	31	29
Child with no parent willing/capable of providing care	10	11	2
Child safety during visits with parents	11	5	10
Failure by agency to conduct 30 day health and safety visits with child	3	3	2

	2016	2015	2014
Dependent Child Well-Being and Permanency	**111**	**103**	**86**
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	33	39	19
Failure to provide child with adequate medical, mental health, educational or other services	29	32	28
Inappropriate permanency plan/other permanency issues	13	14	12
ICPC issues (placement of children out-of-state)	8	5	5
Failure to provide appropriate adoption support services / other adoption issues	10	5	11
Unreasonable delay in achieving permanency	12	3	5
Placement instability/multiple moves in foster care	0	2	3
Extended foster care; independent living service issues	0	2	1
Inadequate services to dependent / non-dependent children in institutions and facilities	4	0	2

	2016	2015	2014
Other Complaint Issues	**114**	**112**	**102**
Violation of parent's rights	34	23	15
Failure to provide parent with services / other parent issues	38	47	35
Children's legal issues	3	5	11
Lack of support / services to foster parent / other foster parent issues	15	7	15
Foster parent retaliation	4	1	1
Foster care licensing	13	13	8
Lack of support / services and other issues related to relative / suitable other / fictive kin caregiver	7	15	9
Retaliation against relative caregiver	0	0	0
Violations of the Indian Child Welfare Act (ICWA)	0	1	8

II. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

- Investigating Complaints
- OFCO's Adverse Findings
- Complaint Summaries

INVESTIGATING COMPLAINTS

OFCO's goal in a complaint investigation is to determine whether DSHS Children's Administration or another state agency violated law, policy, or procedure, or unreasonably exercised its authority. OFCO then assesses whether the agency should be induced to change its decision or course of action.

OFCO acts as an impartial fact finder and not as an advocate. Once OFCO establishes that an alleged agency action (or inaction) is within OFCO's jurisdiction, and that the allegations appear to be true, the Ombuds analyzes whether the issues raised in the complaint meet at least one of two objective criteria:

1. The action violates law, policy, or procedure, or is clearly unreasonable under the circumstances.
2. The action was harmful to a child's safety, well-being, or right to a permanent family; *or* harmful to the preservation or well-being of a family.

If so, OFCO may respond in various ways, such as:

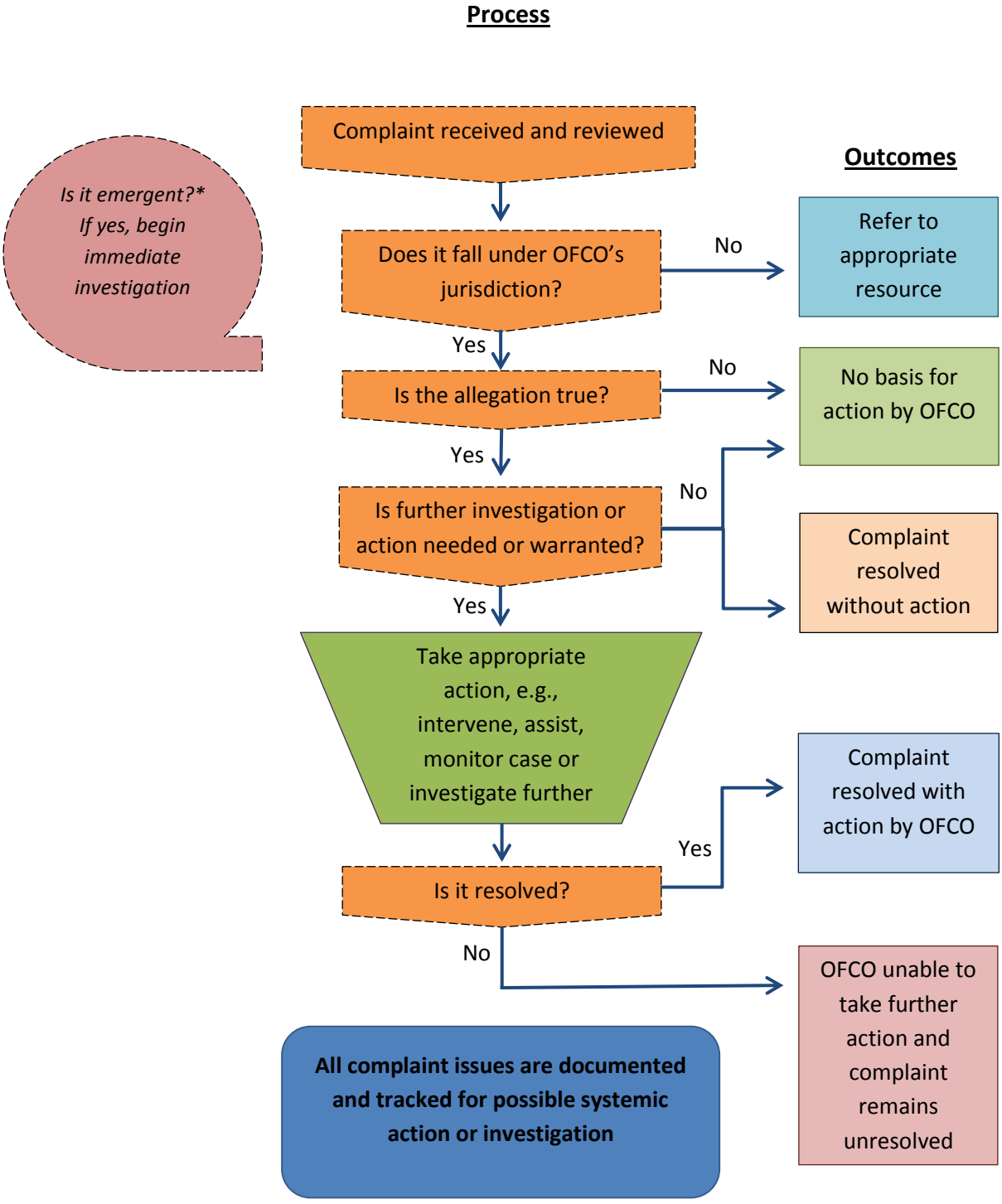
- Where OFCO finds that the agency is properly carrying out its duties, the Ombuds explains to the complainant why the complaint allegation does not meet the above criteria, and helps complainants better understand the role and responsibilities of child welfare agencies.
- Where OFCO makes an adverse finding regarding either the complaint issue or another problematic issue identified during the course of the investigation, the Ombuds may work to change a decision or course of action by CA or another agency.
- In some instances, even though OFCO has concluded that the agency is acting within its discretion, the complaint still identifies legitimate concerns. In these cases the Ombuds provides assistance to help resolve the concerns.

OFCO completed **727 complaint investigations** in 2016.[12] These investigations involved **1,121 children and more than 681 families**. As in previous years, the majority of investigations were **standard non-emergent investigations** (90.2 percent). Only about one out of every 10 investigations (9.8 percent) met OFCO's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child or family's distress. Once a complaint is determined to be emergent, OFCO begins the investigation immediately.

Over the years, OFCO consistently intervenes in emergent complaints at a higher rate than non-emergent complaints. In 2016 **OFCO intervened or provided timely assistance to resolve concerns in 18.3 percent of emergent complaints**, compared with **12.2 percent of non-emergent complaints**.

[12] Some complaints received during the reporting year remain open for ongoing investigation, whereas some investigations opened during the 2014-2015 OFCO reporting year were completed during the 2015-2016 reporting year.

Figure 7: **How Does OFCO Investigate Complaints?**



***Emergent complaints are those in which the allegations involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child's or family's distress.**

INVESTIGATION OUTCOMES

Complaint investigations result in one of the following actions:

- **OFCO Intervention:**
  - OFCO substantiated the complaint issue and intervened to correct a violation of law or policy, or to prevent harm to a child/family; OR
  - OFCO identified an agency error or other problematic issue, sometimes unrelated to the complaint issue, during the course of its investigation, and intervened to address these concerns.

- **OFCO Assistance:** The complaint was substantiated, but OFCO did not find a clear violation or unreasonable action. OFCO provided substantial assistance to the complainant, the agency, or both, to resolve the complaint.

- **OFCO Monitor:** The complaint issue may or may not have been substantiated, but OFCO monitored the case closely for a period of time to ensure any issues were resolved. While monitoring, the Ombuds may have had repeated contact with the complainant, the agency, or both. The Ombuds also may have offered suggestions or informal recommendations to agency staff to facilitate a resolution. These complaints are closed when there is either no basis for further action by OFCO or the identified concerns have been resolved.

In most cases, the above actions result in the identified concern being resolved. A small number of complaints remain unresolved.

- **Resolved without action by OFCO:** The complaint issue may or may not have been substantiated, but was resolved by the complainant, the agency, or some other avenue. In the process, the Ombuds may have offered suggestions, referred complainants to community resources, made informal recommendations to agency staff, or provided other helpful information to the complainant.

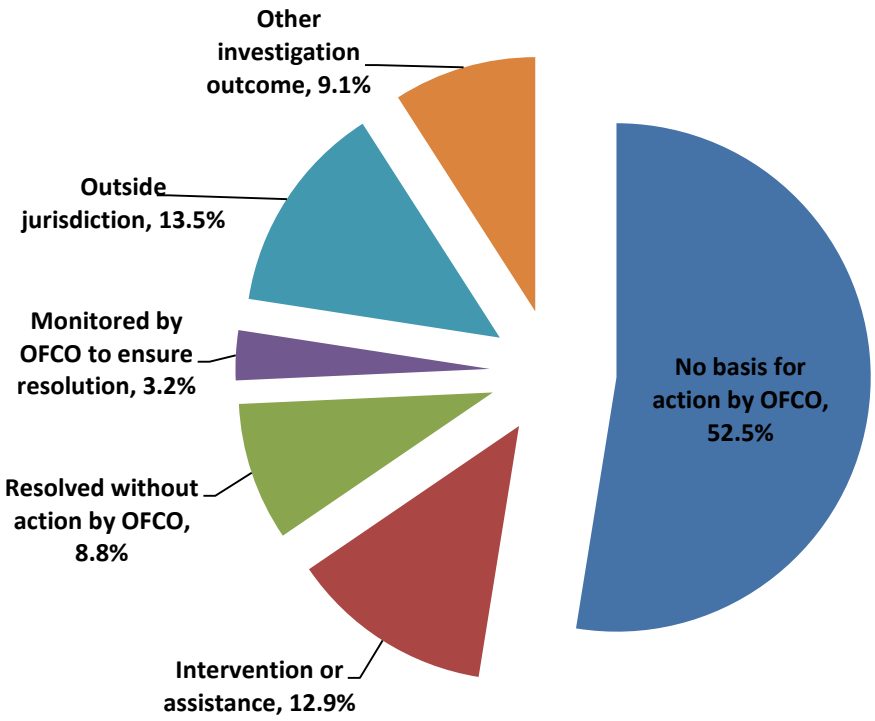
- **No basis for action by OFCO:**
  - The complaint issue was unsubstantiated and OFCO found no agency errors in reviewing the case. OFCO explained why and helped the complainant better understand the role and responsibilities of the child welfare agency; OR
  - The complaint was substantiated and OFCO made a finding that the agency violated law or policy or acted unreasonably, but there was no opportunity for OFCO to intervene (e.g. complaint involved a past action, or the agency had already taken appropriate action to resolve the complaint).

- **Outside jurisdiction:** The complaint involved agencies or actions outside of OFCO's jurisdiction. Where possible, OFCO refers complainants to another resource that may be able to assist them.

- **Other investigation outcomes:** The complaint was withdrawn, became moot, or further investigation or action by OFCO was unfeasible for other reasons (e.g. nature of complaint requires an internal personnel investigation by the agency – which is beyond OFCO's authority).

Investigation results have remained fairly consistent in recent years. OFCO **assisted or intervened** to try to resolve the issue in nearly **13 percent of complaints** in 2016—this represents **94 complaints**. Interventions or assistance by OFCO almost always result in the substantiated issues in the complaint being resolved – in 2016, 94.7 percent of these complaints were resolved. **Twenty-three complaints (3.2 percent)** required careful **monitoring by OFCO** for a period of time until either the identified concerns were resolved, or OFCO determined that there was no basis for further action. OFCO found **no basis for any action after investigating in just above half** of complaints this year (52.5 percent), a substantially smaller amount than in 2015 (66.7 percent).

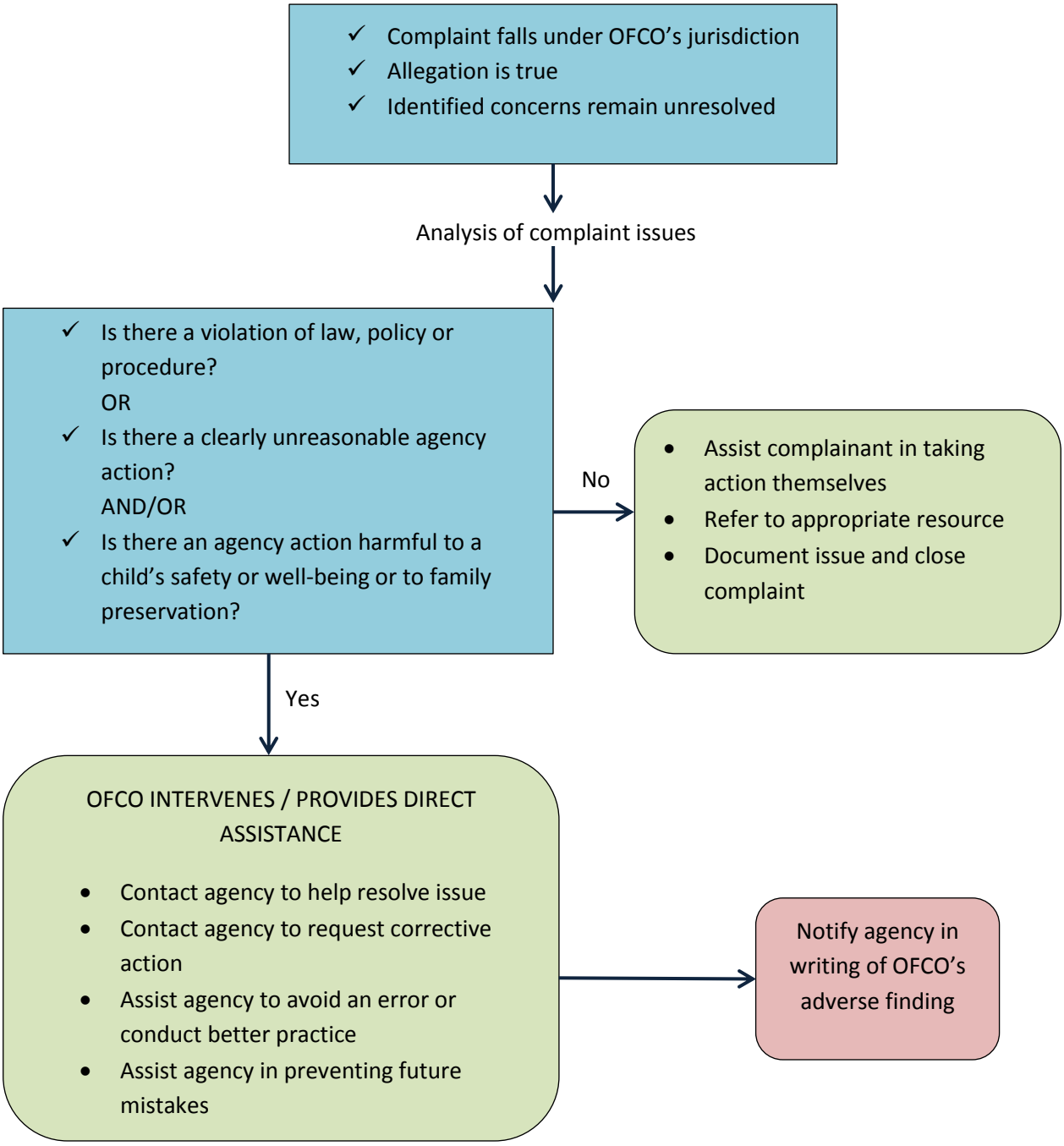
Figure 8: **Investigation Outcomes, 2015-2016**



OFCO IN ACTION

OFCO takes action when necessary to avert or correct a harmful oversight or avoidable mistake by the DSHS Children's Administration or another agency. The below chart shows when OFCO takes action on a case and what form that may take.

Figure 9: **When Does OFCO Take Action?**



OFCO'S ADVERSE FINDINGS

After investigating a complaint, if OFCO has substantiated a significant complaint issue, or has discovered its own substantive concerns based on its review of the child welfare case, OFCO may make a formal finding against the agency. In many cases, the adverse finding involves a past action or inaction, leaving OFCO with no opportunity to intervene. In situations in which OFCO believes that the agency's action or inaction could cause foreseeable harm to a child or family, however, the Ombuds intervenes to persuade the agency to correct the problem. In such instances, the Ombuds quickly contacts a supervisor to share the finding, and may recommend a different course of action, or request a review of the case by higher level decision makers.

Adverse findings against the agency fall into two categories:

- the agency **violated a law, policy, or procedure**;
- the agency's action or inaction was **clearly unreasonable** under the circumstances; and the agency's conduct **resulted in actual or potential harm to a child or family**.

In 2016, OFCO made **42 adverse findings** in a total of 30 complaint investigations. Some complaint investigations resulted in more than one adverse finding, related to either separate complaint issues or other issues in the case that were identified by OFCO during the course of its investigation. Pursuant to an inter-agency agreement between OFCO and DSHS,[13] OFCO provides written notice to the Children's Administration of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding, and may present additional information and request a modification of the finding. CA **requested a modification of the finding in 19 cases**. OFCO **modified its finding in one case**.

Table 4 shows the various categories of issues in which adverse findings were made. The number of adverse findings against the agency **increased slightly in 2016** (a total of 42 findings) from 2015 (a total of 33 findings). Similar to last year, findings related to the safety of children (14 findings), as well as findings involving violations of parents' rights or services to parents (12 findings), were by far the two most common issues resulting in adverse findings.

[13] Available at ofco.wa.gov/documents/interagency_ofco_dshs.pdf.

ADVERSE FINDINGS BY DSHS REGION

The number of complaint investigations resulting in adverse findings by OFCO varied across each of the three DSHS Regions. Of the **42 adverse findings** OFCO made against the agency in 2016, **over half (54.8%) were in Region 2,** the most populous of the three regions. The number of adverse findings in **Region 1 totaled eleven (26.2 percent)** and in **Region 3 totaled eight (19 percent)**. Bearing in mind that with such small numbers, it is statistically not meaningful to draw conclusions about increases or decreases in different regions, we nevertheless show OFCO's findings for the past three years by region, for stakeholders who are interested in tracking these numbers. These numbers are broken down by office in Table 12 shown in Appendix C.

Figure 10: **Number of Adverse Findings in Complaint Investigations, by DSHS Region**

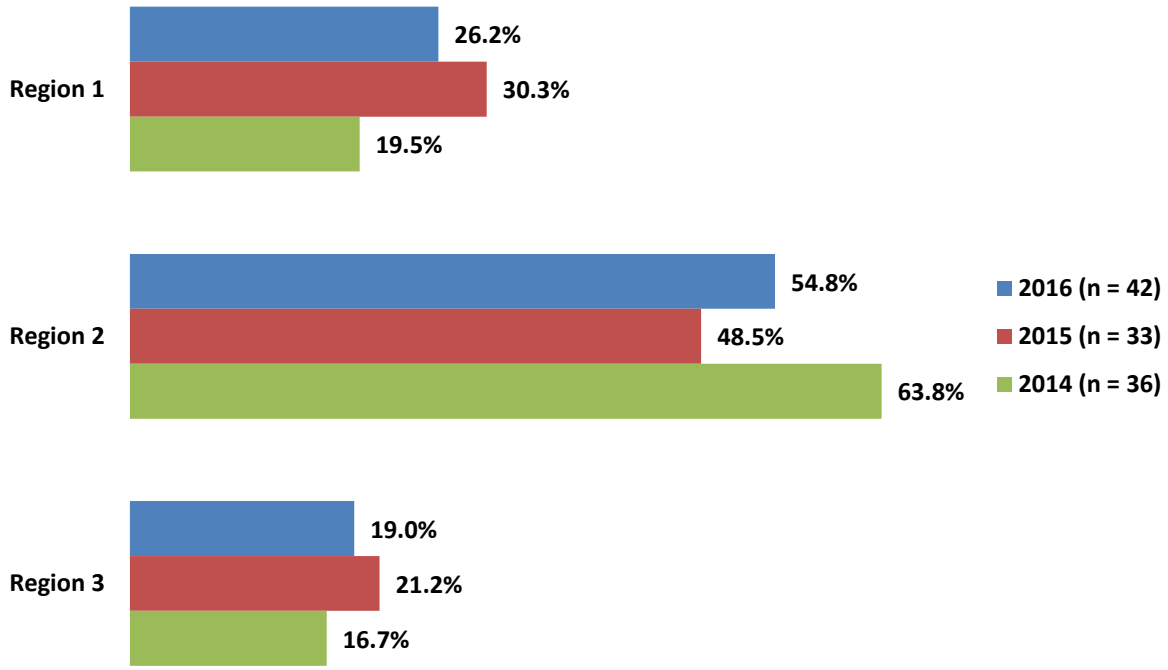


Table 4: **Adverse Findings by Issue**

	2013	2014	2015	2016
Child Safety	**10**	**12**	**14**	**17**
Failure by DCFS to ensure/monitor child's safety:				
• Failure to conduct required monthly health and safety visits	--	--	6	4
• Unsafe placement of dependent child	1	5	2	5
• Other failures to ensure/monitor child safety	2	3	1	2
Inadequate CPS investigation or case management	4	2	1	2
Inappropriate CPS finding (unfounded)	--	1	1	--
Delay in notifying law enforcement of CPS report	--	1	1	1
Failure to complete safety assessment	1	--	1	3
Other child safety findings	3	--	1	--
Family Separation and Reunification	**5**	**4**	**2**	**2**
Failure to place child with relative	3	3	1	2
Failure to make reasonable efforts to reunify family	--	--	1	
Other findings related to family separation/reunification	2	1	--	
Dependent Child Well-being and Permanency	**10**	**1**	**2**	**0**
Unnecessary/multiple moves	1	--	2	--
Other findings related to dependent child well-being/permanency	9	1	--	--
Parent's Rights	**9**	**13**	**12**	**10**
Failures of notification/consent, public disclosure, or breach of confidentiality	4	3	6	1
Delay in completing CPS investigation or internal review of findings	5	7	3	5
Failure to communicate with or provide services to parent	--	1	1	2
Other violations of parents' rights	--	2	2	2
Poor Casework Practice Resulting in Harm to Child or Family	**12**	**1**	**2**	**10**
Poor communication among CA divisions (CPS, CFWS, DLR)	--	--	2	5
Other poor practice	12	1	2	5
Foster Parent/Relative Caregiver Issues	**1**	**2**	**--**	**2**
Other Findings	**2**	**3**	**1**	**1**
Failure to provide meaningful assistance and services to adoptive family	--	--	1	--
Failure to protect referent's confidentiality	--	--	--	1
Number of findings	**49**	**36**	**33**	**42**
Number of closed complaints with one or more finding	**34**	**29**	**24**	**31**

Adverse findings involving child safety accounted for 40 percent of findings, with unsafe placement of a dependent child and failures to complete required monthly health and safety visits being the most common findings related to child safety. Nearly one-quarter (23.8 percent) of overall findings involved parent's rights, with delays in completing CPS investigations and internal reviews of founded findings representing half of the findings in this category.

There were substantially more findings in 2016 relating to poor casework practice that resulted in harm to children and families than in 2015. Half of these findings were the result of poor communication between divisions in CA. OFCO made no findings related to dependent children's well-being and permanency in 2016.

SELECT COMPLAINT SUMMARIES

An Incarcerated New Mother Had Never Spoken With Her Assigned Caseworker

An incarcerated mother gave birth in July 2015. The Department filed for dependency and placed the child in foster care. A new caseworker was assigned to the case in August of that year. OFCO received a complaint in March 2016 stating that the mother had not been contacted by her caseworker. When contacted by OFCO, the worker confirmed she had never spoken with the mother and had never attempted to contact the mother's correctional counselor in the facility. She knew nothing about the mother's engagement with services or placement preferences for her child. OFCO requested that the worker complete these tasks, as required by law and policy. Following OFCO's contact the worker spoke with the mother's counselor, and then with the mother. The mother also was able to participate by phone in a permanency planning meeting for her child, and provide her preferences on the child's placement. OFCO made a finding that DCFS failed to communicate with the mother, impacting the mother's engagement with services and the child's permanency.

OFCO Helps a Family With Limited English Proficiency Receive Information in a Language They Understand

A Spanish speaking parent was the subject of a CPS referral. The investigating worker went to the family home and discovered that the parents spoke Spanish, and did not have proficiency in English. Rather than ceasing the contact until she could return with an interpreter, the worker completed the interviews using an adult child of the parents as an interpreter. In all future contacts the investigating worker properly used an interpreter. However, upon completion of the investigation the worker's supervisor did not notice that the family was of limited English proficiency and sent a letter informing them the case was closing in English. The family complained to OFCO, which responded by contacting the supervisor and asking her to translate the letter and resend it to the family as soon as possible. She did so, and also assured OFCO she would remind the worker to use an interpreter in all contacts with families of limited English proficiency, including the first contact.

OFCO Helps a Teen Access Extended Foster Care

An eighteen year old former foster youth contacted OFCO because she wanted to reenroll in foster care through the Extended Foster Care program. While a minor, her DCFS worker told her she need only contact the office after she turned eighteen if she wanted to opt back in. By policy, however, she had only six months in which to make this change. Following her 18th birthday the young woman's housing circumstances had changed and she needed to move. She took the initiative to contact her former foster parent who said she was willing to welcome her back into her home so long as the young woman was enrolled in Extended Foster Care. The young woman agreed and called her former caseworker to request reentry, leaving a voicemail indicating that she wanted to enroll in Extended Foster Care. The young woman left multiple voicemails for the worker over the next several days and never heard back. Worried about the looming deadline, she contacted OFCO. OFCO responded by reaching out to the former caseworker. When the worker did not respond to OFCO's calls either, OFCO contacted the worker's supervisor. The supervisor said that she would personally ensure that someone would contact the young woman and enroll her in the program. Within a few weeks the young woman was signed up for the program and living with her former foster mom.

An Incarcerated Parent Has Ongoing Difficulties Communicating With DCFS

OFCO received a complaint in 2015 from the incarcerated parent of two dependent children that his assigned caseworker had never visited him, never called him, and had not responded to his numerous letters. OFCO made a finding based on this lack of communication and its impact on permanency for the children. Shortly thereafter, the father filed another complaint with OFCO. He had been assigned a new worker, and was once again incarcerated. The new worker discovered the father was incarcerated in July of 2015, and made no attempts to contact him while assigned to the case. Yet another worker was assigned to the father's case in November 2015. That worker left DCFS in early 2016. The first documented contact with the father in over six months occurred in mid-January 2016, when the father was released from custody and the caseworker's supervisor took over the case. During both periods of incarceration the father was not being provided visits with his children. OFCO made another finding based on lack of communication with this incarcerated parent, and the impact it had on permanency for the children. Since the father has been out of custody the Department has maintained communication with him for the first time. The children remain dependent, in out of home care.

OFCO Finds Current DCFS Involvement Inadequate to Protect a Child

OFCO reviews all DCFS cases where there have been three founded findings of child maltreatment against a subject, or a child has been the named victim in three founded findings, within the last year. In one such case OFCO found that an eight year old child reported to her teacher that a relative in the home was regularly threatening physical harm against her with a weapon. Law enforcement arrested the relative and he spent several days in police custody. CPS interviewed the mother who said she did not believe that the relative was threatening the child. Soon after, the child disclosed that another adult in the home sexually abused her. That relative was subsequently arrested as well. The mother did not express concern with this abuse either. The Department held a family meeting regarding the various allegations and developed a safety plan that required the mother to ensure there was no inappropriate contact between the child and the identified family members. She also agreed to participate in voluntary services.

OFCO was concerned that the parent who did not believe the child and failed to protect her in the past was responsible for enforcing the safety plan. OFCO contacted the voluntary services supervisor who also expressed concern for the mother's ability to protect the child. OFCO learned that the Department would hold an internal staffing regarding transferring the case back to CPS for further investigation, and would also speak with their Assistant Attorney General (AAG) about the possibility of filing a dependency petition. However, when the Department did not document any further action on this case OFCO contacted the Area Administrator. He did not feel that the Department could meet the requirements of a dependency petition and said that they were considering speaking with the non-custodial parent about seeking placement of the child. OFCO monitored these efforts over the next several weeks but saw little progress. OFCO eventually learned that CPS was unable to locate the non-custodial parent and had then staffed the case with their AAG. The AAG determined it was appropriate to file a dependency petition and obtained a court order to remove the child.

The voluntary services supervisor thanked OFCO for holding DCFS accountable for the well-being of this child. OFCO made an adverse finding based on failure to follow agency procedure and establishing a safety plan with a non-protective parent as its enforcer. DCFS did not request a modification of this finding.

DCFS Fails to Conduct a Thorough Relative Search, and Siblings Are Not Placed Together

OFCO received a complaint from the adoptive parents of a six year old formerly dependent child. The family was frustrated that DCFS was not placing their child's biological half sibling in their home. They said that DCFS was aware they were interested in taking placement of any of their child's siblings. The child's sibling had previously come into DCFS care and the family declined placement at that time because it appeared she would be returning to the mother. A few months later the child once again came into DCFS custody. This time, despite changed circumstances rendering the child unlikely to return to the mother again, DCFS did not contact this family for placement of the child. She entered foster care instead. Six months later, the family found out about the sibling being back in care. They immediately contacted the Department, and were told there would be an updated investigation into the family's ability to adopt. This update was completed over the next several months and concluded that the family was appropriate to adopt. DCFS then convened an adoption panel to decide if the child should remain with the foster family she had, by then, been living with for nearly a year, or if she should move into the home of her half sibling. The panel decided that the child should remain with the foster family due to the length of time she had lived there and her bond with the family. The adoptive parents of the half sibling were concerned that by not contacting them when the sister returned to care, DCFS had not followed protocol. Further, based on comments made during the decision making process, they had concerns that some of those involved in the decision were potentially motivated by anti-Semitic or homophobic sentiment.

OFCO contacted DCFS and asked whether or not the adoptive parents were contacted when the sibling came back into care, per policy. The worker acknowledged that they were not. He said he had not known that the child had a sibling in the care of this family until the family contacted DCFS. The adoptive parents ultimately petitioned the court to allow them to intervene in the dependency and request placement of the child. The court denied the petition. OFCO decided not to make a finding based on failure to place with the biological sibling despite policy directing DCFS to do so, based on the child's time in her foster home and bonding with that family. However, OFCO did make a finding that DCFS failed to complete an adequate relative search when the sibling came back into care; OFCO determined that had the relative search occurred in a timely fashion there was a strong likelihood that the sibling would have gone to the home of her brother.

Disclosure of Confidential Information Results in Harassment

OFCO received a complaint that DCFS improperly revealed the identity of a confidential referrer to the person accused of neglect of a child. The referrer was subjected to ongoing harassment by the person and ultimately had to leave her job and change her phone number. Relying on documents provided by the complainant OFCO made a finding that DCFS improperly disclosed the identity of the referrer. DCFS requested that the finding be overturned, as the subject of the complaint made a records request once the case was closed. DCFS surmised that the subject was able to determine the referrer's identity from the context of the complaint, not because the referrer's identity was improperly disclosed. OFCO responded that the complainant asserted the harassment started even before the case was closed. DCFS then requested the date that the subject sent the first harassing messages to check against the date of the records disclosure. With permission from the complainant OFCO provided this information. DCFS checked the date of the records release and found that the harassment pre-dated it by several months. Because the subject had information that he could only know if given access to the referral, months before proper records were released to him, DCFS accepted OFCO's finding of improper disclosure of confidential information.

A Caseworker and Group Home are Unable to Prevent Child from Repeatedly Running from Placement

A community provider working with a thirteen year old youth contacted OFCO with concerns regarding his placement. The youth was living in a large group home following two failed pre-adoptive placements. Before this placement, he was reportedly struggling with depression and challenging behaviors. Upon moving to this group home the youth started running from placement. His runs quickly increased in frequency until he was running away from placement almost every day. While on the run he started getting into fights and was injured. He began experimenting with drugs. He also engaged in a variety of low level property crimes and quickly developed a criminal history. Based on the frequency of runs and the youth's behavior, the provider felt that the current placement was not truly meeting the needs of the youth. As Washington does not allow lockdown facilities to house youth the only question before OFCO was whether or not this facility was an appropriate placement, not whether or not it should have been physically preventing the child from running. OFCO learned that the child had been legally free for several years. DCFS had previously identified potential adoptive homes, but each time the youth rejected adoption. He also received multiple diagnoses related to his mental health. His DCFS caseworker pursued a Behavioral Rehabilitative Services (BRS) designation for him so that he could access treatment and placements designed to meet his high level of needs. At the time of the complaint he was placed in a BRS facility, though his frequent running was an impediment to services and treatment.

OFCO contacted the child's assigned worker, who shared OFCO's concerns with the youth's behaviors. He stated that the problem was that the child appeared to need a more restrictive placement but was in the most restrictive kind of placement allowed in the State. He could not identify anything the group home could do differently to prevent the child from running, particularly when the child was not present enough to engage in treatment. However, he noted the child had a relative who had just made herself available for placement. The caseworker said the child's best option was to stabilize in his current placement enough that he could move in with the relative. OFCO monitored this complaint briefly but was unable to take action on the concerns named in the complaint. The facility was unable to physically stop the child from running and he was not engaging in the treatment that might address this behavior. DCFS was not violating law, policy, or procedure, or acting clearly unreasonably.

A Foster Home Requires a Teen to Leave by 6AM and not Return until 7PM

A seventeen year old dependent youth suffered from serious mental health issues including suicidal ideation and attempts. She was hospitalized on several occasions for this behavior. When DCFS filed a dependency petition she was initially placed in a foster home but was then hospitalized following another episode of suicidal ideation. When she was released from the hospital she was placed back in that foster home but shortly thereafter the foster parents asked DCFS to move her. She was then temporarily placed at a crisis residential center, and was then once again hospitalized for self-harming behavior. Upon her release DCFS struggled to find a placement for her. The Department eventually made an agreement with a foster parent who required this youth to be picked up from the home every day at 6:00 AM, and be dropped off again no earlier than 7:00 PM. They did not require this schedule of the other children placed in their home. By the time OFCO contacted the caseworker the child was in a new placement. OFCO concluded that a placement with this schedule restriction was not appropriate for any child, let alone a child struggling with mental health issues and suicidality. The caseworker shared OFCO's concerns. She said that the placement unit approved the home because it was better than staying in a hotel with two awake caseworkers, which was the only other option available. She said the child was only in this home briefly, but it was still concerning. A licensing investigation into this issue determined that it did not constitute a violation of the foster license, as the foster home had specifically made an agreement with DCFS to have this schedule for the child.

A Lack of Resources and Distance Hinder Communication Between an Incarcerated Parent and DCFS

OFCO received a complaint from an incarcerated mother of a two year old dependent child that her caseworker had not contacted her, and she was not receiving court ordered services to remedy her parental deficiencies. OFCO found that the recently assigned worker had visited the mother only once, and sent her two letters. OFCO encouraged the worker to visit the mother again, as policy mandates monthly visits. OFCO also found that the mother was not offered services while she was incarcerated in a county jail. OFCO closed this complaint after receiving information that the worker was planning to visit the mother. The mother filed another complaint shortly thereafter. The caseworker had visited her once, and then again lapsed into a period of non-communication. The mother was unable to receive calls from the worker due to her incarceration, and the worker was unable to accept collect calls from the mother through the DCFS phone system. OFCO once again contacted DCFS and asked them to follow policy and visit the mother monthly. DCFS responded that monthly visits were not feasible due to the mother's incarceration on the other side of the state; and the caseloads and resources of the office did not allow for in person contact. The supervisor noted that they were facilitating in person and video visits between the mother and child, however, and sending the mother monthly letters. OFCO closed the complaint without findings. The mother was unsatisfied with this outcome, and extremely frustrated that she was not receiving more and better contact from her caseworker. She told OFCO she felt like no one was helping her get her child back.

III. IMPROVING THE SYSTEM

- Shortage of Foster Care Placements
  - *Hotels Used as Emergent Placements for Foster Children*
- Engaging Incarcerated Parents of Children in State Care
- Child Fatalities Related to Opioid Use
- Improving Outcomes for Children in Group Care
- Meeting the Needs of LGBTQ+ Children and Youth
- Executive Order 16-03: Realign State Programs Serving Children and Families

SHORTAGE OF FOSTER CARE PLACEMENTS

HOTELS USED AS EMERGENT PLACEMENTS FOR FOSTER CHILDREN

> ***While Department policy specifically prohibits placement of a child at a DSHS office or in an "institution not set up to receive foster children", a Regional Administrator may approve a "placement exception" at a DSHS office, apartment, or hotel if no appropriate licensed foster home or relative caregiver is available, and as long as the child is adequately supervised.***

For the past two years, OFCO has been tracking the use of placement exceptions, specifically the use of hotels and Department offices, as emergency placements for children.[14] From September 1, 2015 to August 31, 2016, OFCO received notice of **883 placement exceptions involving 221 different children**. This is a dramatic increase from the year before where OFCO documented 120 placement exceptions involving 72 children. The vast majority of these placement exceptions (870) involved children spending the night in hotels/offices. There were thirteen known instances of children spending the night in DCFS offices.

For most hotel/office stays, at least two awake DCFS workers supervised the children overnight, and often times a security guard was also present. These stays followed unsuccessful attempts to locate an available relative caregiver or licensed foster home equipped to meet the child's needs. Some children had behavioral histories arising at group care facilities where they had previously stayed, such as fire setting or assaulting staff members, and therefore could not be placed at the same or other facilities. In several instances the children did not have extreme behaviors or therapeutic needs, but DCFS could not find any other placement options in time. Many of these children were also served by other state systems such as juvenile rehabilitation or mental health treatment facilities. In some cases children were taken into custody or disrupted from placement late in the evening, making the placement search even more difficult.

Examples of hotels being used for temporary placements include:

- A 15 year old youth came into DCFS care following allegations of physical and sexual abuse in the home. Since entering care the child was placed in a series of night-to-night placements and short-term group care facilities. Due to the child's behaviors, several group care facilities refused placement. Some nights DCFS identified a placement for the evening and the child would refuse to go, requiring placement in a hotel. The youth has a history of alcohol use, running from placements, property destruction, and assaultive behaviors. This child spent a collective 31 nights in hotels and as of this writing, resides in an out of state group home.

- A 17 year old dependent youth was placed in a BRS therapeutic foster placement but required a new placement when the family decided to stop providing this level of care. The child has a

[14] OFCO receives notification of placement exceptions and other critical incidents through CA's Administrative Incident Reporting System (AIRS).

history of suicidal ideations, threats of physical aggression towards peers and staff, and substance abuse. DCFS was unable to identify an ongoing placement so the child experienced different placements nightly, including 12 nights spent in hotels. Eventually a placement was secured at a BRS group home, but the child frequently ran from this facility. After two months on the run the child was picked up by law enforcement and brought back into care. DCFS was unable to find placement through a statewide search and the child was again placed in a hotel. The child spent a total of 27 non-consecutive nights in a hotel. The child has since turned 18 and exited state care.

- A four year old dependent child stayed in a hotel with two awake social workers. This child has disrupted from previous placements, struggles with calming himself, and has behavioral concerns that make him difficult to place. All available foster homes with openings declined to take him and a night in a hotel was required.

- A 17 year old dependent youth required an emergent placement after being abruptly discharged from a Crisis Residential Center for acting violently towards staff and property. DCFS was unable to immediately place this youth due to his long history of very challenging mental health needs. The child spent 10 nights in hotels during the review period and is now enrolled in extended foster care, and is attending a university.

Spending the night in a hotel or office, even just once, can be traumatizing for children who have experienced abuse and/or neglect, and is burdensome for Department staff. When a placement cannot be found children are often repeatedly handed from one caseworker to another as shifts change or caseworkers must tend to other responsibilities. Children often spend all day in a DCFS office before going to a hotel late in the evening, and are then taken back to the office or to school early the next morning. Placement exceptions and related instability put children at risk. In one example, two youth who had spent several nights in hotels gained access to restricted areas of a DCFS office and stole items, vandalized the office space, and became physically assaultive towards staff. In another instance a youth threatened to beat up two younger children who were also spending the evening in the hotel. Another youth displayed a knife and threatened the after-hours staff and a child. This youth was later taken to the hospital for a psychiatric evaluation.

PLACEMENT EXCEPTIONS DATA

The number of placement exceptions varied extensively month to month, as shown in Figure 11. June 2016 saw the most placement exceptions by far with 211. Many children spent only one night in a hotel before a more suitable placement could be identified (99 children, or 44.8 percent). Just over ten percent of children involved in placement exceptions spent a total of ten or more nights in a hotel or DCFS office. The most nights any individual child spent in a hotel or office was 34. Figure 4 provides a further breakdown of the number of placement exceptions per child. The average number of placement exceptions per child who spent at least one night in a hotel or DCFS office was four.

Figure 11: **Placement Exceptions by Month**

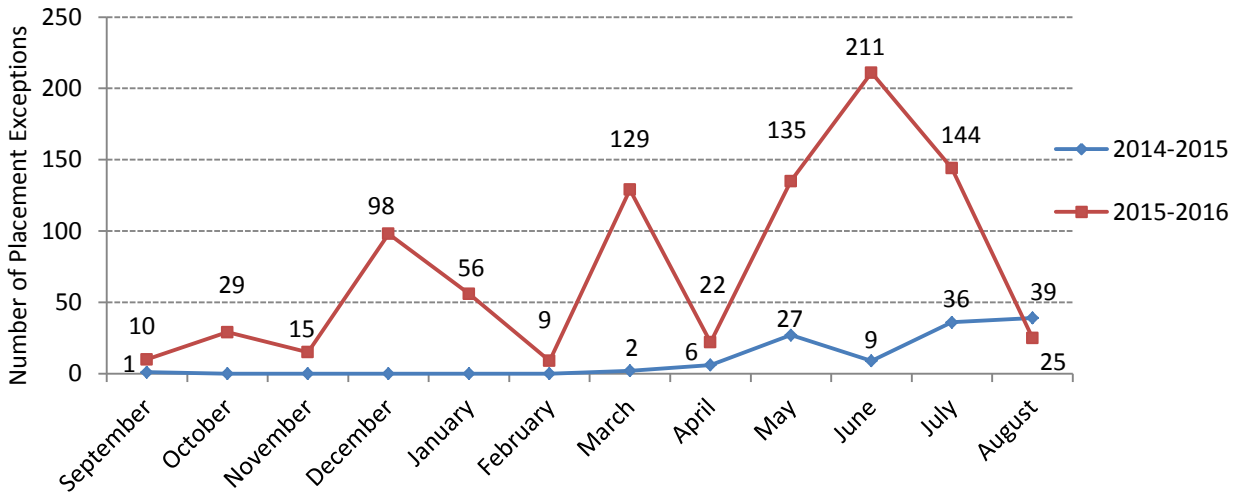


Table 5: Number of Placement Exceptions per Child**, 2015-2016**

Children with Number of Placement Exceptions	# of Children (n=221)	% of Children
Only 1 placement exception	99	44.8%
2 to 5	73	33.0%
6 to 9	25	11.3%
10 to 20	18	8.1%
21 or more	6	2.7%

OFCO reviewed the 883 placement exceptions reported by CA from September 1, 2015 to August 31, 2016, and our analysis of this data reveals that this is primarily a **regional concern,** that most of the children involved in placement exceptions have **significant mental health and/or behavioral needs**, and that a startling number of kids being placed in hotels were **under the age of ten**.

A Regional Concern

This placement crisis is most apparent in DSHS Region 2. Nearly 99 percent (98.9%) of nights spent in a hotel during the 2015-2016 OFCO reporting year were spent by children with cases assigned to a DCFS office in Region 2. Although children from King County make up 17 percent of children in out of home care in Washington, they were involved in 65 percent of the placement exceptions.[15] Children with cases in Snohomish County represent 9.7 percent of children in out of home care, but were involved in 25.7 percent of placement exceptions. Together, cases from these two counties account for 90.6 percent of overnight hotel/office stays.

[15] Partners for Our Children Data Portal Team. (2016). [Graph representation of Washington state child welfare data 10/13/2016]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

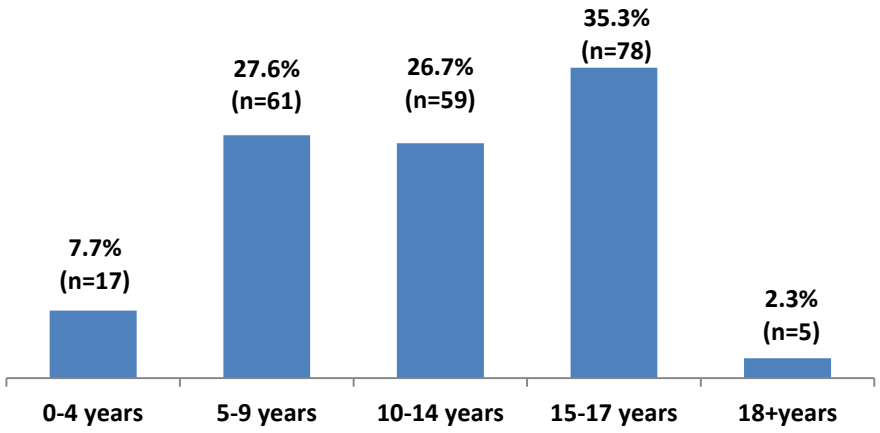
Table 6: **Placement Exceptions by County, 2015-2016**

County	# of Placement Exceptions	% of All Placement Exceptions	# of Children in Out of Home Care[16]	% of All Children in Out of Home Care
King *(Region 2)*	573	64.9%	1460	17.0%
Snohomish *(Region 2)*	227	25.7%	833	9.7%
Whatcom *(Region 2)*	44	5.0%	221	2.6%
Skagit *(Region 2)*	23	2.6%	140	1.6%
Clark *(Region 3)*	7	0.8%	480	5.6%
Island *(Region 2)*	6	0.7%	57	0.7%
Thurston *(Region 3)*	2	0.2%	362	4.2%
Pierce *(Region 3)*	1	0.1%	1333	15.6%

Demographics of Children Experiencing Placement Exceptions

Of the 221 children OFCO identified who spent at least one night in a hotel or DCFS office, **60.2 percent were male and 39.8 percent were female**.[17] Figure 12 shows that **most of the children were at least ten years of age** (64.3 percent). Over one-third (35.3 percent) were nine years or younger, with 17 children under the age of four requiring placement in a hotel. Younger children tended to average fewer nights in hotels/offices; the average number of nights spent in placement exceptions for these children ages four and younger was 1.3. Two children who experienced placement exceptions were under the age of two. Both of these children required immediate placement after being taken into protective custody by law enforcement, and both only stayed one night in either a hotel or DCFS office before a more suitable placement was identified. Children ages 15-17 averaged the most nights in hotels (5.8). Five children were over the age of 18 and were participating in the extended foster care program. The average number of placement exceptions by age is shown in Figure 4.

Figure 12: **Child Age in Placement Exceptions, 2015-2016**[18]



[16] Data from Partners for Our Children. Total number of children in out of home care on January 1, 2016 was 8569.
[17] Several children experienced multiple hotel stays during the review period. There were 221 children involved in 883 placement exceptions.
[18] One child's age was not identified

Figure 13: **Average Number of Placement Exceptions of Children Who Experienced at Least One Placement Exception by Age, 2015-2016**

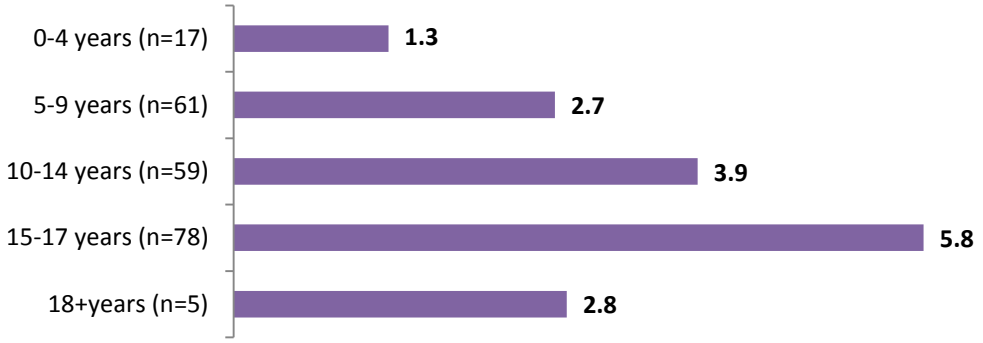


Table 7: **Child Race and Ethnicity**

Nearly 20 percent of children spending a night in a hotel or office were Black/African American. Caucasian children were slightly underrepresented, while American Indian or Alaska Native, Asian or Pacific Islander and Hispanic children required hotel placement at levels consistent with the out of home care population.

	Placement Exception Population	Entire Out of Home Care Population*	Region 2 Out of Home Care Population**
Caucasian	52.0%	66.1%	58.6%
African American	19.9%	8.7%	13.4%
American Indian or Alaska Native	5.0%	5.7%	6.7%
Asian or Pacific Islander	3.2%	1.2%	3.8%
Multiracial	16.7%	16.8%	16.65
Unknown/Other	3.2%	0.05%	0%
Latino / Hispanic	17.6%	19.6%	17.4%

**Data reported by Partners for Our Children. Number of children in care on January 1, 2016 (partnersforourchildren.org, 2016). Retrieved October 17, 2016.*
***Region 2 encompasses King, Snohomish, Skagit, Whatcom, Island, and San Juan counties.*

Children with Significant Mental Health and Behavior Rehabilitation Needs are at Risk of Placement Exceptions

Many of the children experiencing placement exceptions have significant treatment and placement needs which pose barriers to locating and maintaining an appropriate placement. Foster families, relatives or group homes may not feel equipped to look after children with significant needs. The children temporarily placed in hotels often shared several characteristics, including:

- Significant mental health needs (42.5% of children involved in placement exceptions)
- Physically aggressive or assaultive behaviors (38.5%)
- History of running from placements (24%)
- Past attempts or threats of suicide (20.4%)

- Substance abuse struggles (18.1%)
- Sexually aggressive behaviors (15.8%)
- Developmental disabilities (12.2%).

OFCO also noted a number of children without any identified significant behavior or mental health needs who nonetheless required temporary placement in a hotel or a DCFS office when no placement could be identified.

The ongoing practice of placing children in hotels and state offices indicates a shortage of foster homes and therapeutic placements in Washington State. The foster families that remain may not feel equipped to look after children with significant mental health or behavioral concerns. Unless required by contract, a foster parent or licensed facility may decline to accept or keep a child in their care for these reasons.[19] The inadequate number of homes, and ability of remaining homes to opt out of accepting children with significant challenges, makes placing children with mental health or behavioral needs especially difficult.

To Enhance Placement Stability and Reduce the Use of Placement Exceptions, OFCO Recommends:

Provide an adequate supply and range of residential placement options to meet the needs of all children in State care

Children's Administration recently contracted with private agencies to provide an additional 20 receiving care beds located in King and Snohomish Counties to address the need for emergency placements and to avoid placement exceptions. Since the opening of these short term receiving beds the number of placement exceptions has dramatically decreased. However, DSHS must develop a continuum of placement options, including more BRS group care and therapeutic foster homes, to meet the long term needs of children in state care. The ongoing use of hotels as placement resources for children is not acceptable.

Expand Programs that Support Foster and Kinship Families and Prevent Placement Disruptions

Programs Supporting Caregivers

Supporting caregivers and children can improve caregiver retention, prevent placement disruption, and avoid emergency placement in hotels or office buildings. One example of creative efforts to try to improve placement stability and support caregivers is The Mockingbird Family Model (MFM).[20] MFM is a foster care delivery program designed to improve the safety, well-being, and permanency of children and youth in foster care. The MFM consists of a constellation of six to ten foster, and/or kinship families with a central "Hub Home" which provides support, including: assistance with systems navigation; peer support for children and caregivers; social activities; and planned and emergent respite care. Fourteen Mockingbird constellations are established in Washington State, some funded privately and others by

[19] WAC 388-148-1395.

[20] Mockingbird Family Model 2009 MANAGEMENT REPORT ON PROGRAM OUTCOMES, October 2010. At: http://www.mockingbirdsociety.org/images/stories/docs/MFM/2009_mgmt_report_final_fullreport.pdf.

the state. In 2016, the Legislature directed The Washington State Institute for Public Policy (WSIPP) to evaluate the impact and cost effectiveness of the Mockingbird Family Model.[21] Stakeholders and policymakers should continue to explore ways to support caregivers and expand programs shown to improve caregiver retention, child safety, permanency and placement stability.

Enhance Respite Care for Foster Parents and Relative Caregivers

Respite care services provide temporary relief from the demands of parenting responsibilities and can be crucial in preventing placement disruption and reducing the likelihood of child abuse and neglect. Retention respite provides licensed foster parents with regular "time off" from the demands of caregiving responsibilities and can also be used to meet any emergent needs of licensed caregivers. Retention respite is earned by eligible licensed caregivers at a rate of two days per month. Foster parents may accumulate up to 14 days of respite care to be used at one time. CA pays the cost of retention respite for foster families licensed through the State. Additionally, foster parents may arrange for unpaid exchange respite with other licensed foster parents.[22] Too often however, caregivers report that they are unable to access respite care when needed. Factors contributing to this include a paucity of approved respite providers, and also that overworked and overwhelmed caseworkers do not have the time to identify and facilitate respite stays.

The Department should facilitate respite care for foster parents and address respite care needs in the child's case planning. Key elements of the respite care case plan should provide that:

- Respite care is available in emergent situations as well as pre-scheduled events. The case plan should identify respite care arrangements before a crisis occurs;
- The child knows and is comfortable with the person providing respite care; and
- Whenever possible, respite care should occur in the foster parent's and child's own home.

Recruit, Train and Compensate "Professional Therapeutic Foster Parents"

Policymakers should explore recruiting, training and compensating a select group of therapeutic foster parents, to devote their full time and attention to the care of high needs children and youth with mental health conditions and or challenging behaviors. These foster parents would be required to complete additional training and be expected to take on greater responsibilities in caring for these children. This would provide a family like placement for these children, decrease the need for congregate care, and increase placement stability.[23]

While foster parents receive maintenance payments to help meet the needs of the foster children in their care, these payments are not intended to cover the full cost of caring for a child or to compensate the foster parents for their time or efforts. These maintenance payments are determined through use of the Foster Care Rate Reimbursement schedule. Foster parents are also required to have a sufficient outside source of income to support themselves without relying on foster care payments, and, as a result, one or both foster parents are often employed outside the home.

The Foster Care Rate Reimbursement schedule has four levels. These levels are based on the age of the child; the behavioral, emotional, physical and mental health needs of the child; and the foster parents'

[21] An interim report is due to the legislature January 15, 2017, and a final report is due June 30, 2017. http://wsipp.wa.gov/CurrentProjectsPdf/1.

[22] CA Practices and Procedures Guide, Section 4510.

[23] The Foster Care Recruitment and Retention Crisis, (August 2016) Dee Wilson. http://www.uwcita.org/the-foster-care-recruitment-and-retention-crisis/.

ability to meet those needs. A basic rate payment (Level 1) is paid to all foster parents for costs related to food, clothing, shelter, and personal incidentals. In addition, there are three levels of supplemental payments (Levels 2, 3 and 4) which are paid to foster parents who care for children with varying degrees of physical, mental, behavioral or emotional conditions that require increased effort, care or supervision that are above the needs of a typically developing child.

Table 8: **Foster Care Rate Reimbursement**[24]

AGE OF CHILD	BASIC	LEVEL II (includes Basic Rate)	LEVEL III (includes Basic Rate)	LEVEL IV (includes Basic Rate)
0 to 5 years	**$562.00**	**$739.92**	**$1,085.51**	**$1,364.30**
6 to 11 Years	**$683.00**	**$860.92**	**$1,206.51**	**$1,485.30**
12 & Older	**$703.00**	**$880.92**	**$1,226.51**	**$1,505.30**

Many of the children who experience placement exceptions have significant mental health needs and/or challenging behavioral issues which exceed existing resources within our foster care system. Even with the current tiered levels of maintenance payments, foster parents are not fully compensated for the cost of providing for these children or for the work involved in meeting their needs.

[24] Becoming a Foster Parent. Washington State Department of Social and Health Services. Found at: https://www.dshs.wa.gov/CA/fos/becoming-a-foster-parent.

ENGAGING INCARCERATED PARENTS OF CHILDREN IN STATE CARE

State laws and Department policies protect the interests of incarcerated parents whose children are in state care. For example, case plans must: enable an incarcerated parent to participate in case conferences and shared planning meetings, include consideration of available treatment within the correctional facility, and provide for parent-child visits.[25]

Complaints to OFCO about incarcerated parents indicate that these laws and policies are not consistently followed. OFCO complaint investigations found that caseworkers had not:

- Communicated regularly with incarcerated parents, or had sent only a perfunctory letter to the parent, or had only communicated with the DOC counselor and not the parent;
- Provided parent-child visits;
- Involved the parent in case planning; and/or
- Coordinated available services or treatment for the parent.

These complaint investigations also identified challenges that case workers face in engaging incarcerated parents such as: difficulties receiving collect phone calls from a parent or directly calling a parent; difficulty arranging visits or meeting with a parent who is at a correctional facility outside of their region; and only limited remedial services made available to the parent within the correctional facility.

Recommendation: Incarcerated parents should receive heightened focus throughout the child welfare case process

Caseworkers, as well as other professionals such as attorneys, CASA/GALs, and the court, should each take steps to ensure incarcerated parents are engaged in the child's case. Involving these parents is not solely a question of protecting the parent's rights but it also impacts placement decisions, reunification efforts, and permanency and stability for the child. For example, at monthly case reviews, DCFS supervisors should assure that: the interests of incarcerated parents are being met; court ordered visits and services are provided; and that the parent is included in case planning. Other parties, and ultimately the court, should monitor compliance with court orders pertaining to incarcerated parents. Incarcerated parents should be able to participate in court hearings and case planning meetings by teleconference or videoconference.

Recommendation: CA and DOC should adopt policies and practices regarding and promoting communication with incarcerated parents

An incarcerated parent's ability to communicate with their caseworker is limited. An inmate can (to a limited degree) initiate, but cannot directly receive calls. As a result, in some cases, caseworkers rely solely on sending letters providing general information to the parent, or they contact the parent's DOC counselor, but do not speak directly with the parent.

[25] RCW 13.34.136; RCW 74.04.800; CA Practices and Procedures Guide 43091; CA Practices and Procedures Guide 4254; and CA Practices and Procedures Guide 1710.

Instead, CA policy should require direct communication each month between the case worker and the parent. The case worker should contact the DOC counselor to schedule a date and time for either a special visit or phone call with the parent. Additionally, the case worker should work with the DOC counselor to schedule the parent's participation in court hearings or case planning meetings by teleconference. CA and DOC should establish an interagency agreement to work together on behalf of incarcerated parents with children in state care.

Recommendation: Create an adequate array of services within DOC for incarcerated parents

Like other parents involved in the child welfare system, incarcerated parents often require a variety of services in order to reunite with their children. Court ordered services frequently include substance abuse evaluation and treatment, mental health counseling, domestic violence treatment, and/or parenting education. Complaints to OFCO demonstrate that obtaining services while incarcerated is often difficult. Administrators and policymakers should ensure that treatment resources within DOC are sufficient to allow parents to engage in court ordered remedial services. This would entail an expansion of available services in correctional facilities, and the development of a method of communication between the correctional facility service providers and the caseworkers.

CHILD FATALITIES RELATED TO OPIOID USE

OFCO's 2016 Report on Child Fatalities and Near Fatalities in Washington described the increase in abuse of opioids and its impact on the child welfare system.[26] Washington crime lab data for police evidence testing indicate that there has been an 85 percent increase in statewide opioid use from 2002-2004 to 2011-2013.[27] In Washington, prenatal exposure to opioids increased from 11.5 percent of all drug-exposed neonates in 2000 to 24.4 percent in 2008. Additionally, 41.7 percent of infants diagnosed with Neonatal Abstinence Syndrome[28] were exclusively exposed to opioids.[29] One recent study found that opioid use appears to blunt a person's natural parenting instincts and may affect the bonds a parent feels for a child.[30]

From calendar year 2012 to 2015, OFCO identified **32 maltreatment-related fatalities of children ages 0 to 3 years where a caregiver's opioid use was a known risk factor**. Some examples include:

- A one-month old infant died when the mother fell asleep while breastfeeding and the child aspirated. The mother was involved with methadone maintenance treatment at the time of death.
- A one-month old infant died while co-sleeping with the mother on a couch. The child spent time in the NICU after birth for methadone withdrawal.
- A three-month old infant died while co-sleeping with the mother. Both the mother and the infant tested positive at delivery for opiates.
- A three-year old child died after ingesting the mother's methadone.
- An eighteen-month old child died after being left alone in a car for several hours. The mother had a known history of using opiates and morphine. The child's three-year-old sibling tested positive for both these drugs immediately after the fatality.

OFCO Recommendations

<u>Recommendation</u>: Expand services for expectant mothers and mothers of newborns

Additional programs are needed to assist vulnerable mothers and those who may be struggling with substance abuse. For example, the Nurse-Family Partnership® (NFP) is a community health program that works with mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child's second birthday. NFP improves family outcomes including: increased time between births and fewer children; more stable parent partner relationships; less engagement in risky behaviors, less

[26] Full report available at: http://ofco.wa.gov/reports/.
[27] *Opioid Trends across Washington State*. April 2015. University of Washington Alcohol & Drug Abuse Institute. http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf.
[28] Neonatal Abstinence Syndrome refers to a constellation of behaviors and symptoms in newborns exposed in utero to addictive illegal or prescription drugs.
[29] Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, (2014) http://www.astho.org/prevention/nas-neonatal-abstinence-report/.
[30] Opioids May Interfere with Parenting Instincts, Study Finds, NYTimes, DelaCruz, Donna, Oct. 13.2016. http://www.nytimes.com/2016/10/13/well/family/opioids-may-interfere-with-parenting-instincts-study-finds.html?hpw&rref=health&action=click&pgtype=Homepage&module=well-region&region=bottom-well&WT.nav=bottom-well&_r=0.

substance abuse during pregnancy and reduced role impairment; mothers are less reliant on public assistance; children are less likely to be maltreated or abused; and the program leads to reductions in emergency room visits, hospital stays and childhood mortality.[31]

Recommendation: Provide DCFS caseworkers with additional training and support resources addressing substance abuse by parents, and assessing child safety.

Child fatality and near fatality review recommendations have previously identified the need for additional caseworker training on issues related to parental chemical dependency, and in particular, opiate use and methadone treatment, and assessing child safety when this issue is present.[32] Prior recommendations have also identified the need for a chemical dependency professional to provide DCFS caseworkers with case consultation, guidance for client engagement, and information on community resources. The Department should continue efforts to provide ongoing training to caseworkers and assure that professional case consultation regarding substance abuse is available, either located in the DCFS office, or through community partners.

[31] Olds DL, Kitzman H, Hanks C, et al. *Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial*. Pediatrics. 2007;120(4):e832-45; Olds DL, Kitzman HJ, Cole RE, et al. *Enduring effects of prenatal and infancy. home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years*. Archives of Pediatrics & Adolescent Medicine. 2010;164(5):419-24; Small SA, Reynolds AJ, O'Connor C, Cooney SM. *What works, Wisconsin: What science tells us about cost-effective programs for juvenile delinquency prevention: A report to the Wisconsin governor's juvenile commission and the Wisconsin Office of Justice Assistance*. Madison: University of Wisconsin-Madison; 2005; and Karoly LA, Kilburn MR, Cannon JS. *Early childhood interventions: Proven results, future promise*. Santa Monica: RAND Corporation; 2005: Monograph Report 341.

[32] See Appendix C for the full text of these recommendations.

IMPROVING OUTCOMES FOR CHILDREN IN GROUP CARE

In 2016, OFCO visited the nine group homes with BRS contracts located across Washington.[33] OFCO wanted to learn from youth residing in BRS-contracted group homes about their experiences in order to inform stakeholders about what is working and what needs improvement in group care. OFCO believes this will allow us to better serve our youth with the greatest service needs.

Each site visit included: a tour of the facility; a presentation about OFCO and how youth could access services; a confidential written survey about youths' experiences in group care; one-on-one youth interviews; and written surveys for staff. A few key recommendations discussed in OFCO's Group Care report include:

Recommendation: Increase caseworker contact with youth placed in group homes:
Youth were clear that more time and contact with their caseworker is a priority. When caseworkers have smaller caseloads and remain assigned to a family/child for an extended period of time, they have the capacity to develop and maintain relationships with youth. For youth in group care, who often have complex transition and treatment plans, continued and sustained interaction is even more important. The Department has made significant progress in providing mobile technology to caseworkers. These tools should be used to increase contact with children in group care through phone calls, correspondence and audio-video conferencing such as Skype or FaceTime. Specifically, assigned case workers should complete one additional contact per month with children who are placed in BRS group care. This could be accomplished through in person visits or by phone or video chat.

Recommendation: Expand alternative placement options:
Although high quality group care can be essential to ensure a child's safety and stabilization, youth, especially young children, are best served in family-like settings. In addition to improving the quality of care and life in existing group homes, our child welfare system must also explore and expand a continuum of non-congregate care placement options that can meet the needs of some of our state's must vulnerable and needy children. This should include additional BRS foster homes.

Recommendation: Enhance court oversight of children in group care
Courts play a powerful role in reviewing and assuring the appropriate use of group care in individual cases. When children are placed in group care facilities, court review hearings should be held every 3 months. Further, the children should be encouraged to attend, either in person or by phone.

Recommendation: Appoint attorneys for children residing in group care
Because the fundamental liberty interests and rights of children in group care are at greatest risk of infringement, state law **should require that children placed in group care be represented by attorneys**. An attorney can advocate for the child's stated interest and protect their rights.

[33] Youth's Perspectives on Group Care: Outreach to Youth Living in Washington's Group Homes (2016). Office of the Family and Children's Ombuds. The full report and further recommendations are available at: http://ofco.wa.gov/reports/

MEETING THE NEEDS OF LGBTQ+ CHILDREN AND YOUTH

OFCO's Group Care Report identified specific issues and concerns facing LGBTQ+ children. These issues are not confined solely to children and youth in congregate care. Our child welfare system must ensure safe and supportive care and appropriate services for LGBTQ+ children throughout the child welfare system. Child welfare practice should: prohibit discrimination against LGBTQ+ youth and ensure these youth are respected; increase cultural competency among agency staff, foster parents, and service providers; provide child welfare services that address the specific needs of LGBTQ+ youth and their families: and effectively manage information on the sexual orientation and gender identity of youth in the child welfare system.[34] CA is aware of this need and is presently creating a LGBTQ+ Program Manager position to develop policies and practice to support LGBTQ+ children and youth in state care.

As a framework for developing policies, the Department should consider recommended practices identified by the Child Welfare League of America[35] that:

Prohibit discrimination against and harassment of youth, staff and foster and adoptive families, ranging from physical violence to denial of services to the use of slurs, on the basis of actual or perceived sexual orientation, gender identity, or gender expression.

Ensure Safe and Supportive Foster, Group Care, and Adoptive Placements for LGBTQ+ Youth

- When seeking a foster or adoptive home placement for an LGBTQ+ young person, child welfare staff should ensure that the home is accepting of LGBTQ+ people.
- All foster and adoptive parents should receive training on caring for an LGBTQ+ young person, as any child may be LGBTQ+ yet not comfortable sharing that information with DCFS.
- Child welfare staff should not put LGBTQ+ youth into placements, services, schools or programs where they will be unsafe or unsupported.

Support Access to Appropriate Medical and Mental Health Care Services for LGBTQ+ Youth

Child welfare agencies should ensure that health care providers who treat LGBTQ+ youth are trained and educated on the heightened risks these youth may face. Health care providers should be able to discuss sexual orientation, gender identity and sexual behaviors openly and comfortably.

Adopt Confidentiality Policies

Child welfare agencies should adopt strict policies for managing confidential information about a young person's sexual orientation and gender identity, in addition to other sensitive information. Child welfare

[34] LGBT Populations and the Child Welfare System: A Snapshot of the Knowledge Base and Research Needs, , 2015. Available at: http://www.acf.hhs.gov/sites/default/files/opre/chapter_brief_child_welfare_508_nologo.pdf.

[35] Recommended Practices To Promote the Safety and Well-Being of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and Youth at Risk of or Living with HIV in Child Welfare Settings, CWLA, 2012. Available at: https://www.lambdalegal.org/sites/default/files/publications/downloads/recommended-practices-youth.pdf

staff should always respect and maintain a LGBTQ+ young person's privacy and never disclose confidential information about sexual orientation or gender identity without the child's permission.

Collect and Evaluate Data

State child welfare agencies should include participants' sexual orientation and gender identity status in demographic data elements and evaluation tools to determine accessibility and outcomes specific to LGBTQ+ youth.

EXECUTIVE ORDER 16-03: REALIGN STATE PROGRAMS SERVING CHILDREN AND FAMILIES

On February 18, 2016, Governor Jay Inslee established the Washington State Blue Ribbon Commission on the Delivery of Services to Children and Families to recommend a structure for a state department focused solely on improving services and outcomes for children, youth and families.[36] The Commission's report was released on November 8, 2016 with the unanimous recommendation to integrate Children's Administration, Juvenile Rehabilitation and the Office of Juvenile Justice with the Department of Early Learning and establishing Department of Children Youth and Families (DCYF).[37] Key findings supporting the creation of DCYF and discussed in the Commission's report include:

- State services are not currently organized in a way that achieves the best outcomes for children, youth and families. There should be a single department whose mission is centered on child safety, early learning, and the social, emotional and physical well-being of children, youth and families — supporting and strengthening families before crises occur.

- Parents and families who are facing challenges must be offered needed and appropriate services earlier to improve the healthy development of children and youth, protect them from harm, and disrupt multigenerational trauma.

- We should improve the effectiveness of how and when services are delivered, with a much greater focus on prevention and recognition of the importance of caregiving to healthy brain development.

- We should prioritize those children and youth most at risk of neglect, physical harm, sexual abuse and other adverse factors most often linked to low rates of kindergarten readiness, dropping out of school, substance abuse, incarceration, homelessness and other negative outcomes later in life.

- We should ensure focused attention on adolescents, with this new agency having primary responsibility for helping the state achieve better outcomes for youth.

- We should ensure that the programs and services are tightly aligned or integrated with essential services such as economic supports that address poverty, and access to behavioral health services.

- We should strengthen the linkages to K–12 schools to ensure that children and youth who are struggling or disengaged from school are identified early and that resources in the new

[36] Executive Order 16-03.
[37] "Improving the Well-Being of Washington State's Youth, Children and Families", http://www.governor.wa.gov/issues/issues/health-care-human-services/blue-ribbon-commission-children-and-families.

department, schools and communities are mobilized and coordinated to support students' continued progress toward graduation.

- We should build on current strengths and successes of the Department of Early Learning (DEL).

As stated in the Executive Order, a separate Department of Children, Youth and Families "has the potential to promote greater accountability, heighten the visibility of children's issues, and reduce barriers to improving service and outcomes for children and families."

The recommendations of the commission also present an opportunity to redesign our child welfare system to: engage families proactively before child abuse or neglect occurs; prevent adverse childhood experiences; improve child development and school readiness; reduce involvement with the juvenile justice system and recidivism; and align services to strengthen families.

IV. APPENDICES

APPENDIX A:

Complaints Received by Region and Office

APPENDIX B:

Child Demographics

APPENDIX C:

Adverse Findings by Office

APPENDIX A: COMPLAINTS RECEIVED BY REGION AND OFFICE

The following section provides a detailed breakdown of CA regions and offices identified in OFCO complaints.

Image 1: **Map of DSHS Regions**

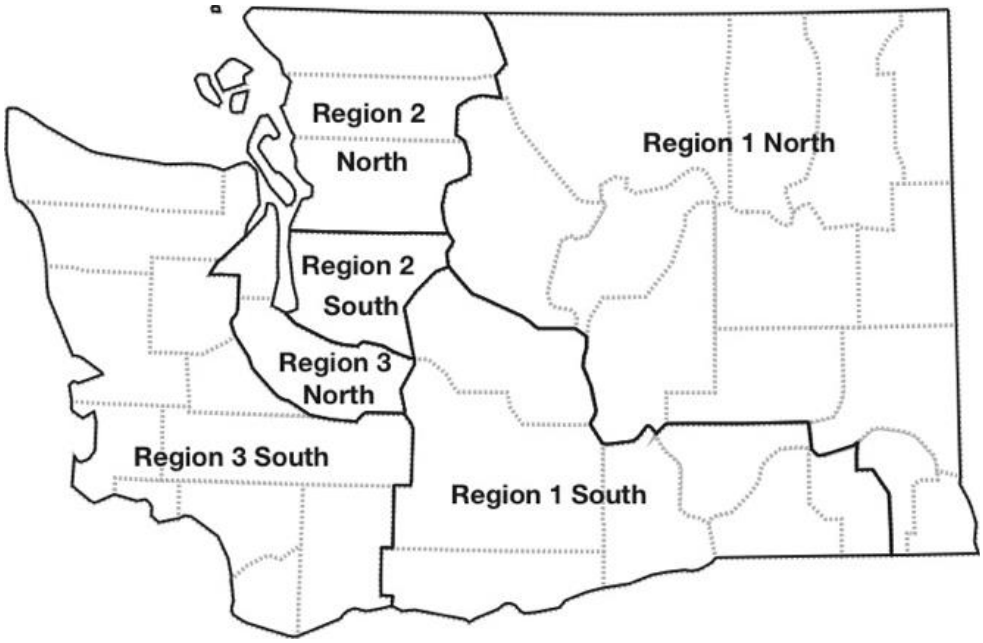


Table 9: **Populations by DSHS Region**[38]

	Children Under 18 Years Residing in Region	Percent of Washington State Children Under 18 Years
Region 1 North (Spokane)	208,855	13.2%
Region 1 South (Yakima)	175,566	11.1%
Region 2 North (Everett)	263,539	16.6%
Region 2 South (Seattle)	418,141	26.4%
Region 3 North (Tacoma)	256,552	16.2%
Region 3 South (Vancouver)	264,157	16.6%

[38] Partners for Our Children Data Portal Team. (2016). [Graph representation of Washington state child welfare data 11/4/2016]. Count of All Children. Retrieved from http://www.vis.pocdata.org/maps/child-populationregions.

Figure 14: **OFCO Complaints Received by DSHS Region**

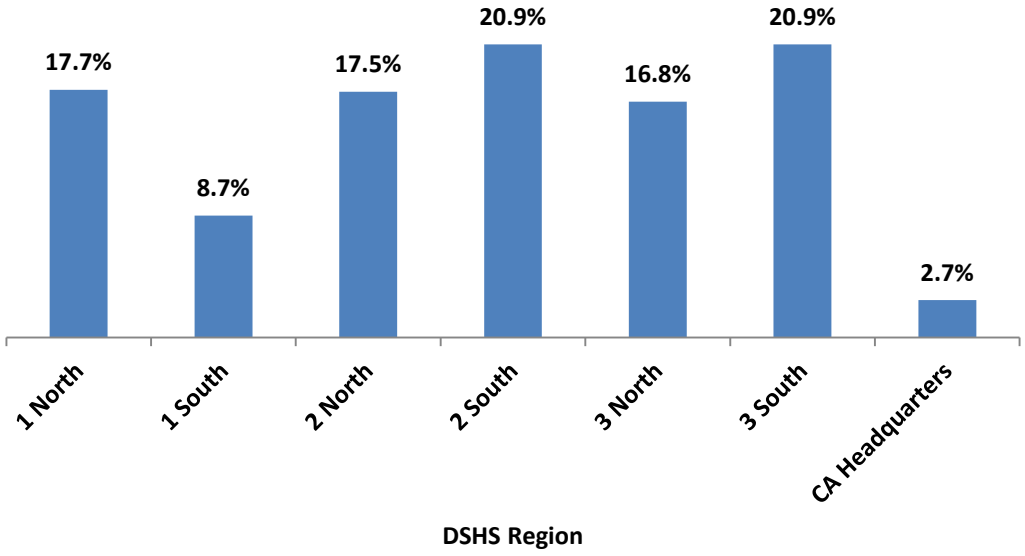


Table 10: **OFCO Complaints Received by Office**

REGION	OFFICE	
1 North	Spokane DCFS	59
	Moses Lake DCFS	20
	Colville DCFS	20
	Wenatchee DCFS	7
	Omak DCFS	6
	Newport DCFS	4
	Republic DCFS	3
	Colfax DCFS	3
	Clarkston DCFS	2
	DLR (Region 1 North)	2
1 South	Yakima DCFS	23
	Richland/Tri-Cities DCFS	22
	Walla Walla DCFS	12
	Ellensburg DCFS	3
	Toppenish DCFS	1
	DLR (Region 1 South)	1
2 North	Everett DCFS	25
	Arlington/Smokey Point DCFS	24
	Bellingham DCFS	22
	Monroe/Sky Valley DCFSA	21
	Mount Vernon DCFS	19
	Alderwood/Lynnwood DCFS	10
	Oak Harbor DCFS	3
	DCFS Central Office (Region 2 North)	1
2 South	King South DCFS	73
	King West DCFS	22
	King East DCFS	18
	Office of Indian Child Welfare	17
	Martin Luther King Jr. DCFS	13
	White Center DCFS	3
	DLR (Region 2 South)	2
	DCFS Central Office (Region 2 South)	1
3 North	Pierce South (Lakewood) DCFS	37
	Pierce East (DCFS)	27
	Bremerton/Kitsap	24
	Pierce West DCFS	20
	DCFS Central Office (Region 3 North)	6
	DLR (Region 3 North)	5
3 South	Vancouver DCFS	40
	Aberdeen DCFS	22
	Tumwater DCFS	21
	Kelso DCFS	19
	Centralia DCFS	12
	Shelton DCFS	11
	Port Angeles DCFS	9
	Port Townsend DCFS	4
	Stevenson DCFS	4
	South Bend DCFS	3
	Long Beach DCFS	1
	DLR (Region 3 South)	3
Other	Central Intake Unit	10
	DLR-CPS	5
	Adoption Support Services	2
	Children's Administration Headquarters	2
	Complaints about non-CA agencies	29

APPENDIX B: CHILD DEMOGRAPHICS

The ages of children identified in OFCO complaints closely mirrors that of the entire DCFS out of home care placement population, as shown below in Table 9.[39] Youth over 18 years of age identified in complaints might be participants in the Extended Foster Care Program (eligible youth may participate until they turn 21 years) or they may reflect a historical complaint about Department actions that happened when the youth was under 18.

Table 11: **Child Age, 2015-2016**

	2016 OFCO Complaints	2016 Out of Home Care Population
0 - 4 Years	39.9%	43.3%
5 - 9 Years	30.2%	26.1%
10 - 14 Years	20.5%	18.1%
15 - 17 Years	8.6%	12.5%
18 Years and Older	0.9%	-

[39] Partners for Our Children Data Portal Team. (2016). [Graph representation of Washington state child welfare data 11/4/2016]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.

APPENDIX C: ADVERSE FINDINGS BY OFFICE

The following section provides a breakdown of CA offices identified in adverse findings.

Table 12: **Adverse Findings by Office**

REGION	OFFICE	#
1 North	Moses Lake DCFS	3
	Spokane DCFS	3
1 South	Richland/Tri-Cities DCFS	1
	Walla Walla DCFS	1
	Yakima DCFS	1
2 North	Mount Vernon DCFS	1
	Everett	1
	Alderwood/Lynwood DCFS	1
	Arlington/Smokey Point	1
2 South	King South DCFS	12
	King East DCFS	9
3 North	Pierce West	1
	DLR – Region 3 North	1
3 South	Port Townsend	4
	Port Angeles	2

OFCO STAFF

Director Ombuds

Patrick Dowd is a licensed attorney with public defense experience representing clients in dependency, termination of parental rights, juvenile offender and adult criminal proceedings. He was also a managing attorney with the Washington State Office of Public Defense (OPD) Parents Representation Program and previously worked for OFCO as an ombuds from 1999 to 2005. Through his work at OFCO and OPD, Mr. Dowd has extensive professional experience in child welfare law and policy. Mr. Dowd graduated from Seattle University and earned his J.D. at the University of Oregon.

Ombuds

Cristina Limpens is a social worker with extensive experience in public child welfare in Washington State. Prior to joining OFCO, Ms. Limpens spent approximately six years as a quality assurance program manager for Children's Administration working to improve social work practice and promote accountability and outcomes for children and families. Prior to this work, Ms. Limpens spent more than six years as a caseworker working with children and families involved in the child welfare system. Ms. Limpens earned her MSW from the University of Washington. She joined OFCO in June 2012.

Ombuds

Mary Moskowitz is a licensed attorney with experience representing parents in dependency and termination of parental rights. Prior to joining OFCO, Ms. Moskowitz was a dependency attorney in Yakima County and then in Snohomish County. She has also represented children in At Risk Youth and Truancy proceedings; and has been an attorney guardian ad litem for dependent children. Ms. Moskowitz graduated from Grand Canyon University and received her J.D. from Regent University.

Ombuds

Elizabeth Bokan is a licensed attorney with experience representing Children's Administration through the Attorney General's Office. In that position she litigated dependencies, terminations, and day care and foster licensing cases. Previously, Ms. Bokan represented children in At Risk Youth, Child In Need of Services, and Truancy petitions in King County. Prior to law school she worked at Youthcare Shelter, as a youth counselor supporting young people experiencing homelessness. Ms. Bokan is a graduate of Barnard College and the University of Washington School of Law.

Ombuds

Melissa Montrose is a social worker with extensive experience in both direct service and administrative roles in child protection since 2002. Prior to joining OFCO, Ms. Montrose was employed by the Department of Family and Community Services, New South Wales, Australia investigating allegations of misconduct against foster parents and making recommendations in relation to improving practice for children in out-of-home care. Ms. Montrose has also had more than five years of experience as a caseworker for social services in Australia and the United Kingdom working with children and families in both investigations and family support capacity. Ms. Montrose earned her MSW from Charles Sturt University, New South Wales, Australia.

Special Projects / Database Administrator

Jessica Birklid is a public policy professional with experience in child welfare policy and research, health care, and organizational development. Prior to joining OFCO she helped hospital patients navigate the healthcare system and understand their rights and responsibilities. She also spent time conducting research and administratively supporting the Washington Commission on Children in Foster Care, with the goal of improving collaboration between the courts, child welfare partners and the education system. Ms. Birklid is a graduate of Western Washington University and the University of Washington Evans School of Public Policy and Governance.