



# **Office of the Family and Children's Ombuds**

*An Independent Voice for Families and Children*

## **2017 Annual Report**

**Patrick Dowd, *Director***

**[ofco.wa.gov](http://ofco.wa.gov)**



**STATE OF WASHINGTON**  
**OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS**

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To the Residents of Washington State:

I am pleased to submit the 2017 Annual Report of the Office of the Family and Children's Ombuds. This report provides an account of OFCO's activities from September 1, 2016 to August 31, 2017. 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 917 complaints, the most OFCO has ever received in a single year, and completed 956 complaint investigations regarding 1,393 children and 873 families. As in 2016, the separation and reunification of families and agency conduct and services 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:

- Strategies to better support foster parents;
- The use of hotels as emergency placements for children in state care and the need for a continuum of placement resources;
- The Department's involvement in family law disputes; and
- Helping families when a child cannot return or safely remain in the home.

In July 2018, the Department of Children Youth and Families (DCYF) assumes the duties and responsibilities of the Department of Early Learning and Children's Administration. In 2019 Juvenile Rehabilitation will also join DCYF. Integrating early learning, child welfare and juvenile justice in one agency will better align services and improve outcomes for children and families. The DCYF will be data driven with specific outcome measures related to child safety and well-being. Legislation establishing the DCYF also creates an independent Oversight Board to monitor and ensure that the DCYF achieves the stated outcomes and complies with laws, rules, policies and procedures pertaining to early learning, juvenile rehabilitation, juvenile justice, and children and family services. Restructuring our child welfare system presents a unique opportunity to improve service delivery 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 for the opportunity to serve the residents of Washington State.

Sincerely,

Patrick Dowd, JD  
Director Ombuds

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*Report prepared by Jessica Birkliid and Elizabeth Bokan*

# 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, 2016, through August 31, 2017, as well as 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:<sup>1</sup>

### **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.

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<sup>1</sup> 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.<sup>2</sup>

## **INQUIRIES AND COMPLAINT INVESTIGATIONS**

Between September 1, 2016 and August 31, 2017, OFCO completed 956 complaint investigations regarding 1,393 children and 873 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). Eighty-six complaints prompted intervention by OFCO in 2017. 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 56 complaints.

In 2017, OFCO made 52 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.<sup>3</sup>

## **FOSTER PARENT VOICES**

In the past year OFCO received concerning reports regarding CA’s treatment of foster parents, ranging from poor communication, to disagreements over a child’s case plan, to retaliation. In response to these complaints OFCO sought to obtain more information about the current foster care system, identify common areas of concern among foster parents, and develop recommendations to improve support. OFCO held a series of listening sessions with foster parents and advocates across Washington to learn more about their concerns, what works for them, and to get their ideas about how the child welfare system can improve support to foster parents.

## **WORKING TO MAKE A DIFFERENCE**

### **Foster Care Placement Shortage**

Washington has experienced a decline in the number of licensed foster homes since 2012,<sup>4</sup> yet the number of children requiring out-of-home care has increased.<sup>5</sup> 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 an appropriate placement. This report describes 824 “placement exceptions”

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<sup>2</sup> Child Fatalities and Near Fatalities in Washington State, August 2017. <http://ofco.wa.gov/wp-content/uploads/2017-OFCO-Critical-Incident-Report-.pdf>

<sup>3</sup> An inter-agency agreement between OFCO and CA was established in November 2009.

<sup>4</sup> Children’s Administration, Quality Assurance and Continuous Quality Improvement, Monthly Metric Trends. While it still remains below 2012 levels, there was an increase of 235 licensed foster homes from June 2016 to June 2017.

<sup>5</sup> Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 9/27/2017]. Children in Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/ooh-counts>.

involving 195 children. OFCO found that this is primarily a regional concern, occurring most frequently in DSHS Region 2. 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.

### **CA Involvement in Ongoing Family Law Disputes**

OFCO received a handful of complaints regarding DCFS either participating or refusing to participate in family law and related court proceedings. Over the course of the complaint investigations OFCO realized that decisions of how to respond to family law cases are made on an ad hoc basis by local offices, because current laws and policies do not clearly direct DCFS' conduct in these circumstances. OFCO recommends that the Department develop policy and procedures to guide caseworkers serving families involved in family court. The creation of this policy will not only provide direction to agency staff, it will also provide guidance to constituents and others impacted as to what DCFS is authorized to do, and potentially reduce frustration with the agency.

### **Helping Families When a Child Cannot Return or Safely Remain in the Home**

OFCO frequently receives complaints concerning families who encounter difficulty obtaining out of home placement for children with certain complex needs, such as developmental delays, or mental or behavioral health concerns, that cannot safely be managed at home without presenting a risk of harm to themselves or family members. When parents seek help with out of home placement and services for the child, it is not clear what agency is responsible for assisting these families. Recommendations to address this include:

- Develop policies and procedures to provide placement and services when a child's needs and behaviors are beyond the parent's abilities to manage.
- Improve access to Child in Need of Services (CHINS) proceedings and temporary out of home care.
- Develop placement resources and establish effective statewide protocols between state agencies to provide and expedite out of home care.
- Parents seeking help should not be threatened with abandonment.

### **Preparing for the Department of Children, Youth, and Families**

On July 1, 2018, Children's Administration and the Department of Early Learning will combine to form the Department of Children, Youth, and Families. This realignment of state agencies represents a fundamental change in the delivery of child welfare services with a focus on prevention, measurable outcomes, transparency and oversight. OFCO's duties will be expanded to provide information to individuals receiving juvenile justice, juvenile rehabilitation, and child early learning services. OFCO will establish the Oversight Board for Children Youth and Families, which will be made up of legislators and representatives from external stakeholder groups, and provide unprecedented accountability and guidance for our child welfare system.

# THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children’s Ombuds<sup>6</sup> (OFCO) in 1996 in response to two high profile incidents that indicated a need for oversight of the child welfare system.<sup>7</sup> 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.<sup>8</sup>

## 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, including mental health professionals, guardians ad litem, and assistant attorneys general.<sup>9</sup> OFCO

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<sup>6</sup> 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>.

<sup>7</sup> 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.

<sup>8</sup> The inter-agency agreement is available online at [http://ofco.wa.gov/documents/interagency\\_ofco\\_dshs.pdf](http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf).

<sup>9</sup> See also RCW 13.50.100(6).

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.<sup>10</sup>

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 employees* with an annual budget of \$673,158.

- **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.

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<sup>10</sup> See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(15).



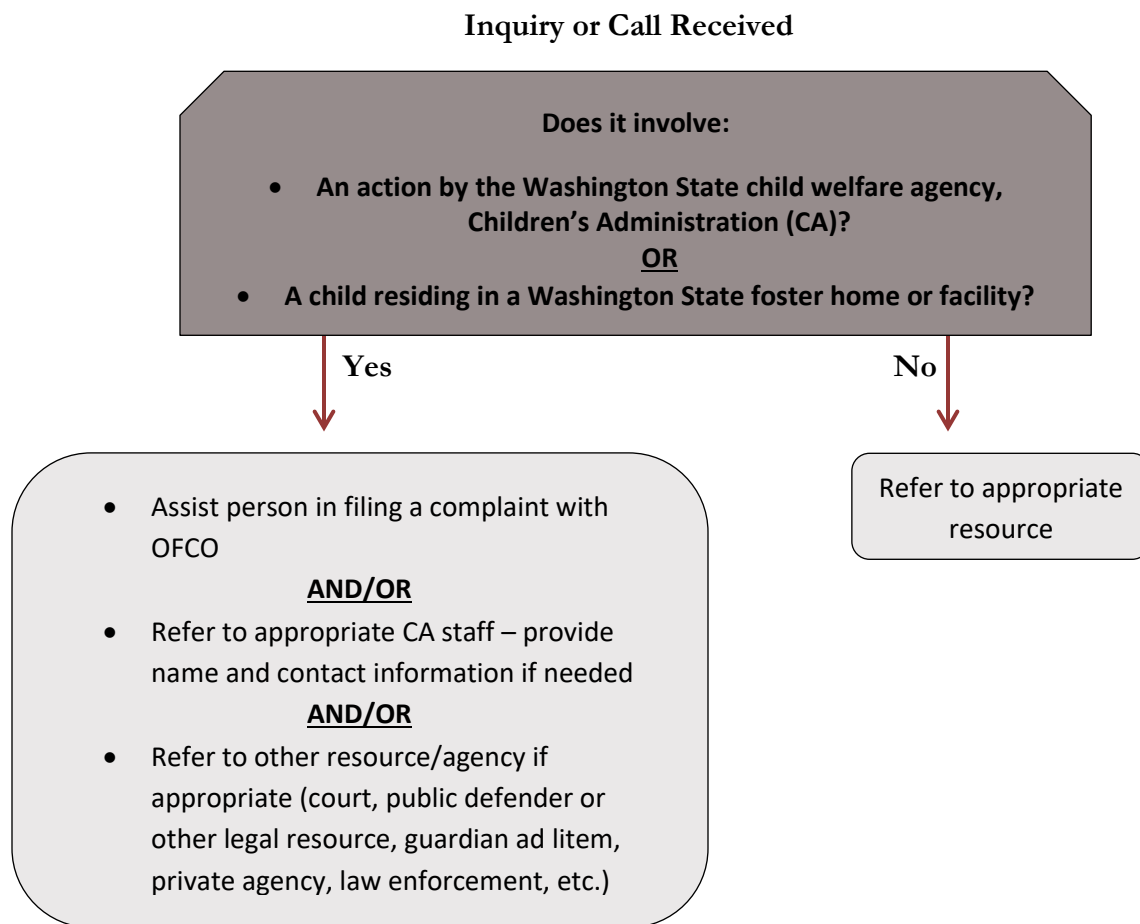
# **I. LISTENING TO FAMILIES AND CITIZENS**

- 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. Callers may want verification about whether OFCO can investigate their concern, or guidance in framing or identifying their complaint issue. Those whom OFCO cannot help directly are referred to the right place for information or support.

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



# COMPLAINT PROFILES

## COMPLAINTS RECEIVED

This section describes complaints filed during OFCO's 2017 reporting year — September 1, 2016 to August 31, 2017. **OFCO received 917 complaints in 2017**, by far the most OFCO has ever received in a single year. Figure 3 shows that 82 percent of complaints are submitted electronically, with less than 6 percent submitted through the mail and 9.7 percent taken over the phone.

Figure 2: **Complaints Received**<sup>11</sup>

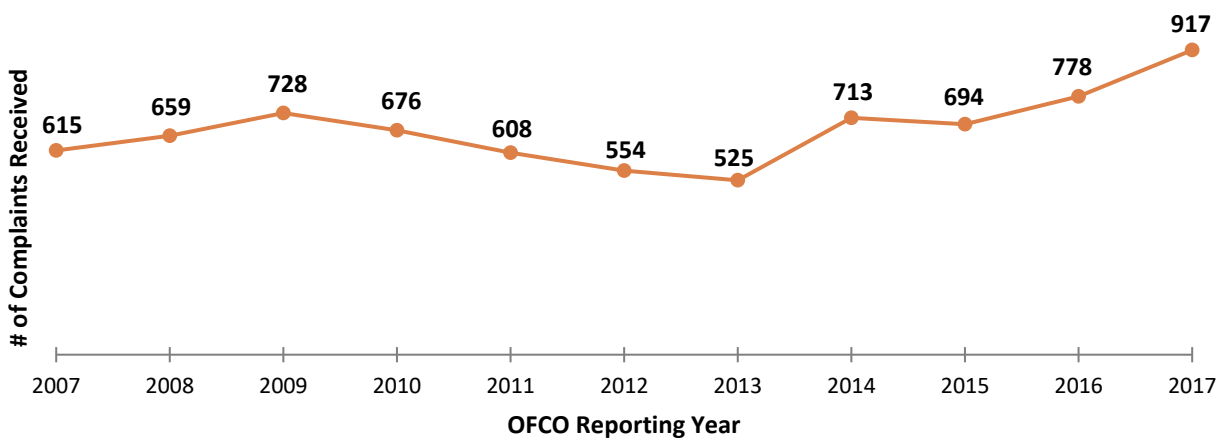
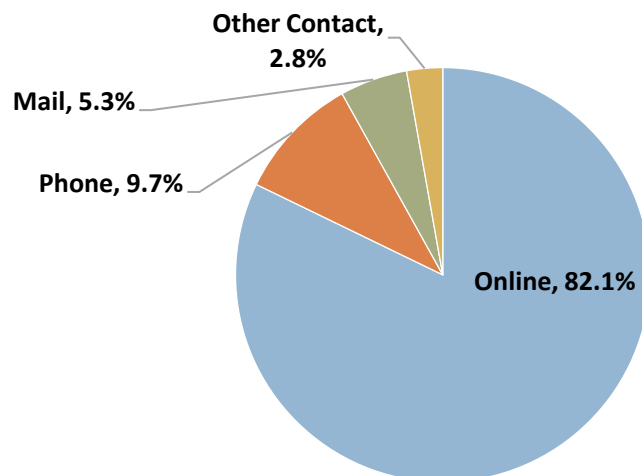


Figure 3: **How Complaints Were Received, 2017**

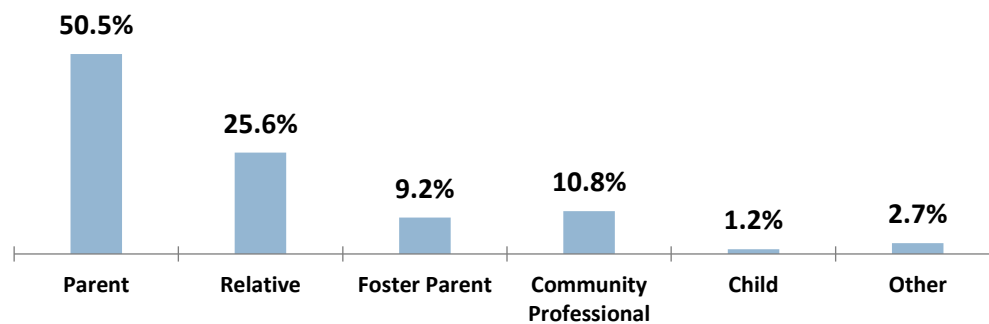


<sup>11</sup> The number of complaints directed at each DSHS region and office is provided in Appendix A.

## 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 2017 was no exception. As in previous years, few children contacted OFCO on their own behalf.

Figure 4: **Complainant Relationship to Children, 2017**



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, 2017**

	OFCO Complainants 2017	WA State Population <sup>12</sup>
Caucasian	70.1%	80.4%
African American or Black	8.0%	4.0%
American Indian or Alaska Native	3.7%	1.8%
Asian or Pacific Islander	2.1%	9.0%
Other	0.7%	-
Multiracial	5.2%	4.9%
Declined to Answer	10.3%	-
Latino / Hispanic	5.6%	12.6%
Non-Hispanic	94.4%	87.4%

<sup>12</sup> Office of Financial Management. Population by Race, 2016. <http://www.ofm.wa.gov/trends/population/fig306.asp>.

## CHILDREN IDENTIFIED IN COMPLAINTS

Nearly 40 percent of the 1,393 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).<sup>13</sup>

Figure 5: **Age of Children in Complaints, 2017**

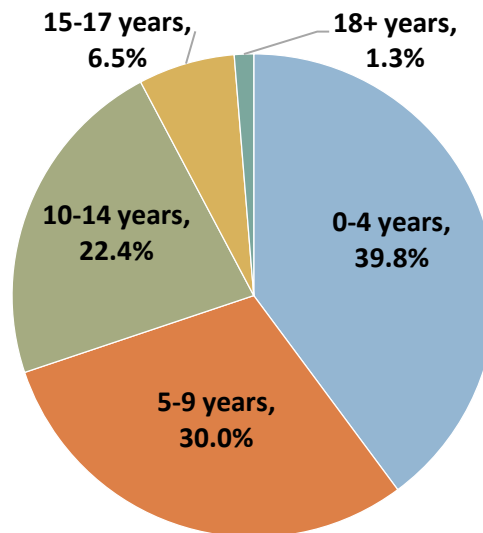


Table 2 shows the race and ethnicity (as reported by the complainant) of the children identified in complaints, compared with children in out of home placement through CA and the general state population.

Table 2: **Race and Ethnicity of Children Identified in Complaints, 2017**

	OFCO Children	Children in Out of Home Care <sup>14</sup>	WA State Children (ages 0-19) <sup>15</sup>
Caucasian	68.4%	65.3%	74.3%
African American or Black	9.2%	8.8%	4.7%
American Indian or Alaska Native	4.7%	5.1%	2.4%
Asian or Pacific Islander	1.4%	1.9%	8.7%
Other	2.4%	0.01%	-
Multiracial	13.1%	18.0%	10.0%
Unknown	0.9%	-	-
Latino / Hispanic	13.0%	19.0%	21.0%
Non-Hispanic	87.0%	81.0%	79.0%

<sup>13</sup> For more information on the ages of children in out of home care, see Appendix B.

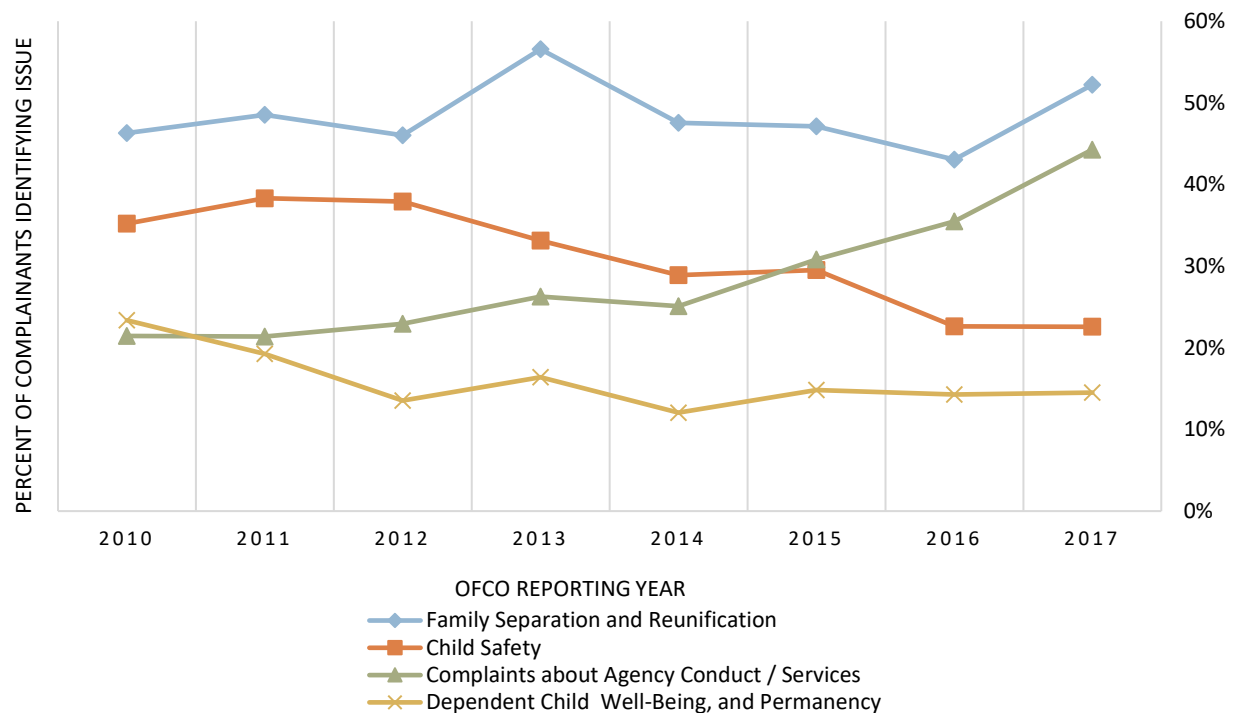
<sup>14</sup> Data reported by Partners for Our Children (partnersforourchildren.org, 2017). Based on 8,803 children in out of home care on January 1, 2017.

<sup>15</sup> Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2016. <http://www.ofm.wa.gov/pop/asr/default.asp>.

# 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 479 times in complaints) were the most frequently identified. Just over half (52.2 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:

- **Failure to ensure appropriate visitation or contact** between children and their parents, siblings, or relatives (identified in 126 complaints);
- **Children being improperly removed from their parents** (106 complaints) or other relatives (19 complaints);
- **Not placing children with relatives** (94 complaints) or with **siblings** (4 complaints);
- **Delays in or failures to reunite family** (81); and
- **Termination** of parental rights (6).

## Conduct of Children’s Administration Staff and Agency Services

Issues involving **the conduct of CA staff and other agency services** were the next-most identified concerns. 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:

- **Unwarranted or unreasonable CPS investigations** (131 complaints);
- Concerns about unprofessional conduct by agency staff (106 complaints) such as **harassment, retaliation, discrimination, bias, or conflict of interest**;
- **Communication failures** (97), such as caseworkers not communicating with parents or relatives;
- **Unreasonable findings** of abuse or neglect by CPS (26); and
- **Breach of confidentiality** by the agency (17).

## Child Safety

Complaints involving child safety have been steadily declining since 2012. Just over 40 percent of the **207 child safety** complaints focused on concerns that the agency was **failing to protect children from abuse or neglect** while in their parents’ care (91 complaints or 44 percent of all child safety complaints). Another 39 percent concerned **safety risks to dependent children in foster or relative care** (identified in 81 complaints). Eighteen complainants expressed concern 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 (133 complaints), yet 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 44 complaints). The agency’s failure to provide adequate services to a dependent child was a concern in 52 complaints this year. Nine complaints raised concerns about a child’s permanency plan, including **delays in permanency**.

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

	2017	2016	2015
<b>Family Separation and Reunification</b>	<b>479</b>	<b>335</b>	<b>327</b>
Failure to provide appropriate contact between child and parent/other family members (excluding siblings)	120	78	49
Unnecessary removal of child from parental care	106	100	89
Failure to place child with relative	94	42	73
Failure to reunite family	81	44	51
Other inappropriate placement of child	33	34	23
Unnecessary removal of child from relative placement	19	13	22
Failure to provide sibling visits and contact	6	3	7
Failure to place child with siblings	4	9	5
Inappropriate termination of parental rights	8	6	5
Concerns regarding voluntary placement and/or service agreements	3	3	0
Other family separation concerns	3	3	0

	2017	2016	2015
<b>Complaints About Agency Conduct</b>	<b>406</b>	<b>276</b>	<b>214</b>
Unwarranted/unreasonable CPS investigation	131	86	43
Unprofessional conduct, harassment, retaliation, conflict of interest or bias/discrimination by agency staff	106	86	71
Communication failures	97	55	43
Unreasonable CPS findings	26	21	23
Breach of confidentiality by agency	17	16	19
Poor case management, high caseworker turnover, or other poor service	14	4	1
Inaccurate agency records	13	8	13
Lack of coordination between DSHS Divisions	2	2	1



	2017	2016	2015
<b>Child Safety</b>	<b>207</b>	<b>176</b>	<b>205</b>
Failure to protect children from parental abuse or neglect	84	79	100
Abuse	40	41	53
Neglect	37	37	44
Failure to address safety concerns involving children in foster care or other non-institutional care	75	53	54
Failure to address safety concerns involving child being returned to parental care	18	21	31
Child safety during visits with parents	17	11	5
Child with no parent willing/capable of providing care	7	10	11
Child safety of children residing in institutions/facilities	6	0	
Failure by agency to conduct 30 day health and safety visits with child	5	3	3

	2017	2016	2015
<b>Dependent Child Well-Being and Permanency</b>	<b>133</b>	<b>111</b>	<b>103</b>
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	41	33	39
Failure to provide child with adequate medical, mental health, educational or other services	52	29	32
Inappropriate permanency plan/other permanency issues	16	13	14
Unreasonable delay in achieving permanency	9	12	3
Failure to provide appropriate adoption support services/other adoption issues	4	10	5
Inadequate services to children in institutions and facilities	4	4	0
Placement instability/multiple moves in foster care	3	0	2
ICPC issues (placement of children out-of-state)	1	8	5

	2017	2016	2015
<b>Other Complaint Issues</b>	<b>133</b>	<b>114</b>	<b>112</b>
Violation of parent's rights	24	34	23
Failure to provide parent with services / other parent issues	32	38	47
Children's legal issues	4	3	5
Lack of support / services to foster parent / other foster parent issues	18	15	7
Foster parent retaliation	8	4	1
Foster care licensing	17	13	13
Lack of support / services and other issues related to relative / suitable other / fictive kin caregiver	26	7	15
Violation of the Indian Child Welfare Act (ICWA)	4	1	8

## **II. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES**

- Investigating Complaints
- OFCO's Adverse Findings

# 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* was 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.

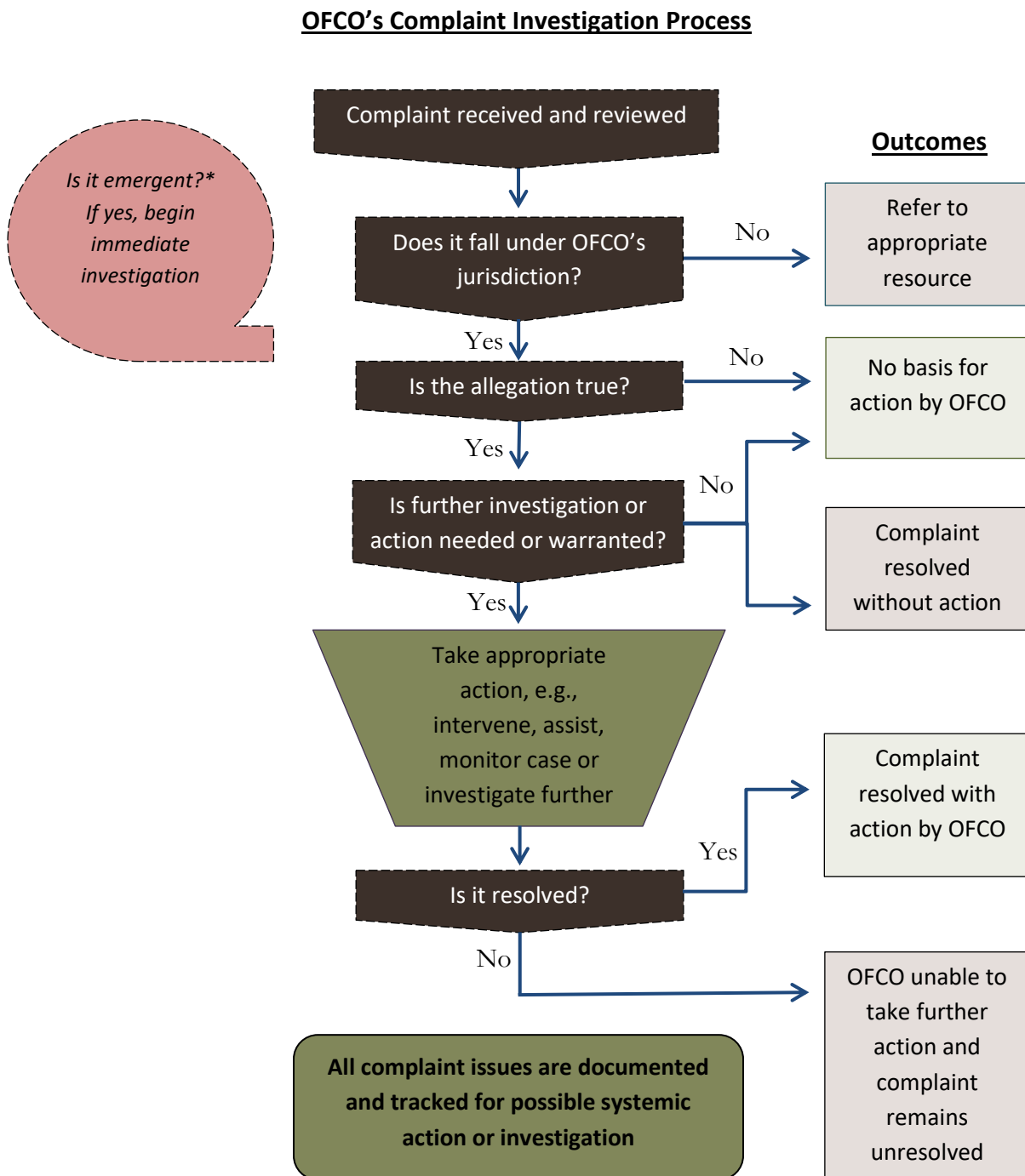
OFCO completed **956 complaint investigations** in 2017, over 200 more than the previous year (727 investigations were completed in 2016).<sup>16</sup> These investigations involved **1,393 children and 873 families**. As in previous years, the majority of investigations were **standard non-emergent investigations** (90 percent). Only about one out of every 10 investigations 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 2017 **OFCO intervened or provided timely assistance to resolve concerns in 24 percent of emergent complaints**, compared with **13.8 percent of non-emergent complaints**.

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<sup>16</sup> Some complaints received during the reporting year remain open for ongoing investigation, whereas some investigations opened during the 2015-2016 OFCO reporting year were completed during the 2016-2017 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:

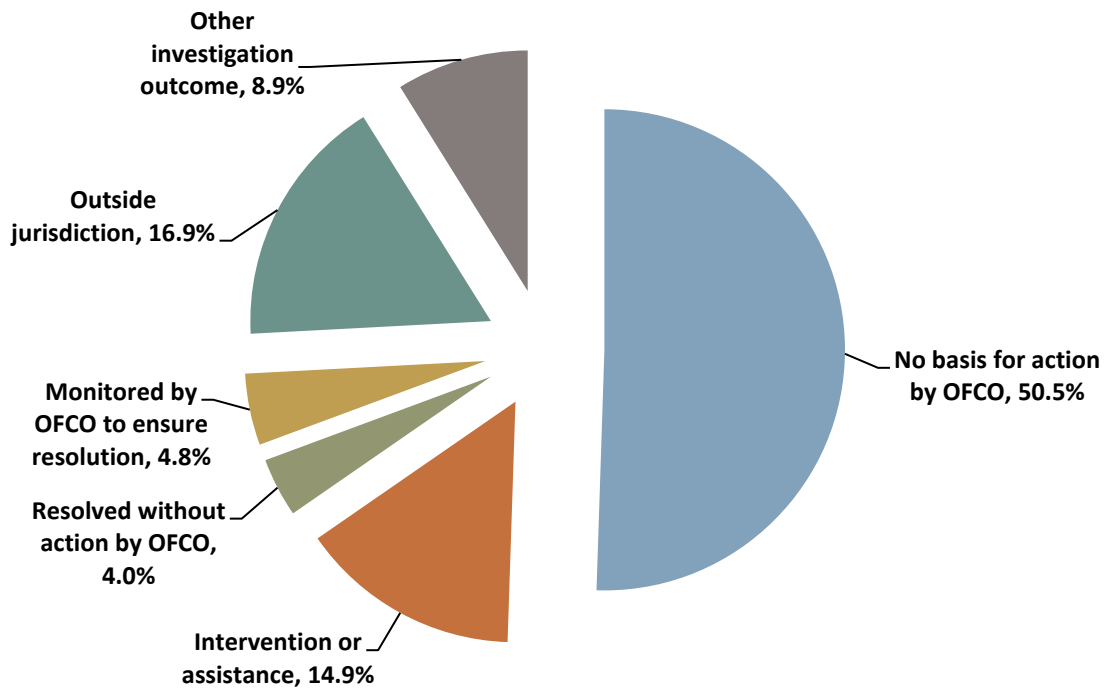
- **OFCO Intervention:**
  - OFCO substantiated the complaint issue and intervened to correct a violation of law or policy, or to prevent harm to a child/family; OR
  - OFCO identified an agency error or other problematic issue, sometimes unrelated to the issue identified by the complainant, during the 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 **15 percent of complaints** in 2017—this represents **142 complaints**. Interventions or assistance by OFCO almost always result in the substantiated issues in the complaint being resolved – in 2017, 95.1 percent of these complaints were resolved. **Forty-six complaints (4.8 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 (50.5 percent).

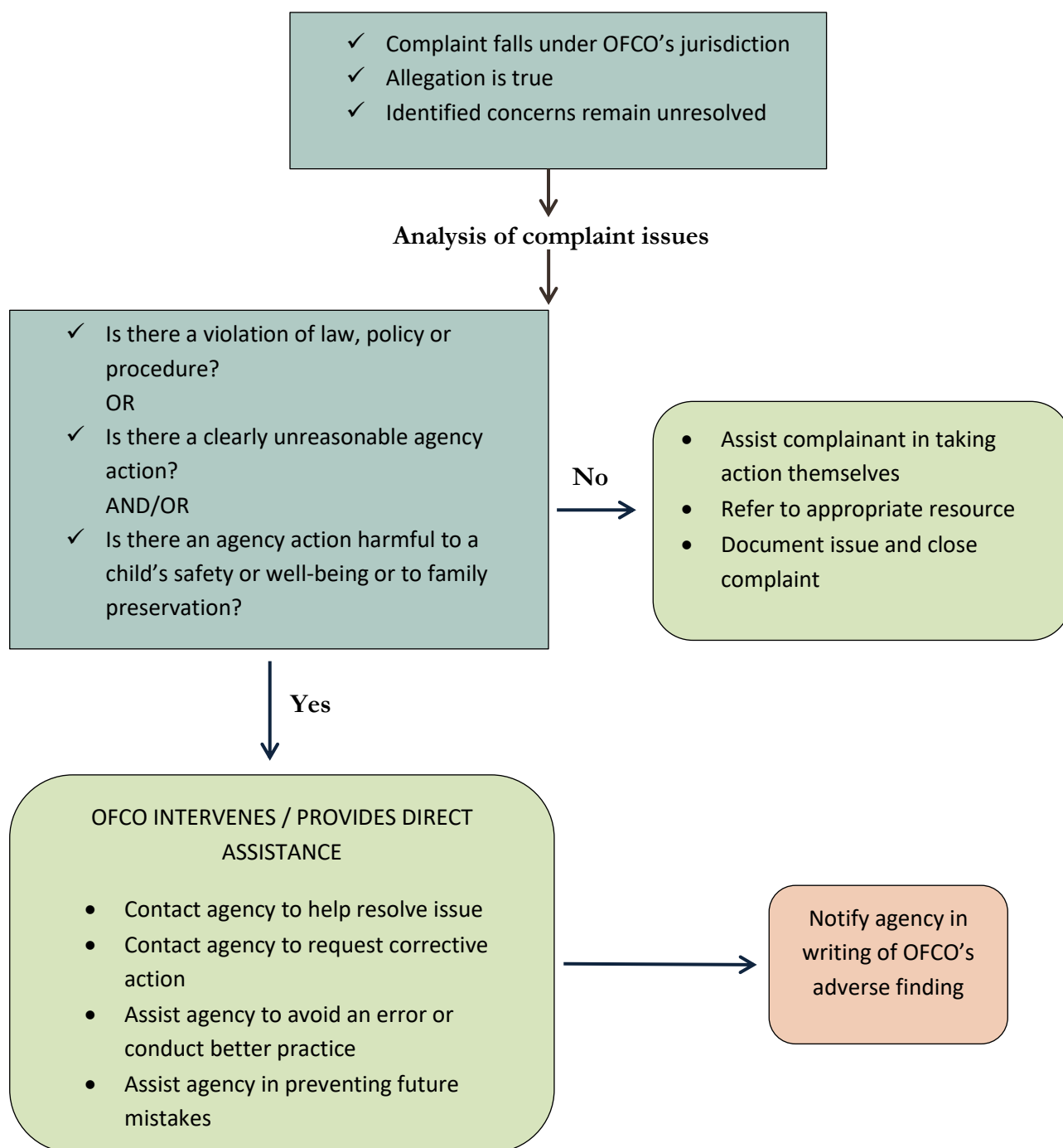
Figure 8: **Investigation Outcomes, 2017**



## 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 some 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 2017, OFCO made **52 adverse findings** in a total of 36 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,<sup>17</sup> 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 provided a written response to all findings, and **requested a modification of the finding in 11 complaint investigations**. OFCO **modified the basis of the finding or edited the facts of the case to reflect additional information in 8 complaints**. In addition to the above 52 findings, OFCO also made four other findings that, after more information was provided by the Department, were withdrawn.

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 2017** (a total of 52 findings) from 2016 (41 findings). Similar to last year, findings most often related to the safety of children (19 findings), as well as findings involving violations of parents' rights or services to parents (11 findings).

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<sup>17</sup> Available at [ofco.wa.gov/documents/interagency\\_ofco\\_dshs.pdf](http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf).



Table 4: **Adverse Findings by Issue**

	2017	2016	2015
<b>Child Safety</b>	<b>19</b>	<b>17</b>	<b>14</b>
Failure by DCFS to ensure/monitor child's safety:			
• Failure to conduct required monthly health and safety visits	6	4	6
• Unsafe placement of dependent child	5	5	2
• Other failures to ensure/monitor child safety	--	2	1
Inadequate CPS investigation or case management	3	2	1
Inappropriate CPS finding (unfounded)	--	--	1
Delay in notifying law enforcement of CPS report	--	1	1
Failure to complete safety assessment	4	3	1
Other child safety findings	1	--	1
<b>Family Separation and Reunification</b>	<b>7</b>	<b>2</b>	<b>2</b>
Failure to place child with relative	2	2	1
Failure to provide contact with siblings	3	--	--
Failure to provide appropriate contact / visitation between parent and child	2	--	--
Failure to make reasonable efforts to reunify family	--		1
<b>Dependent Child Well-being and Permanency</b>	<b>4</b>	<b>0</b>	<b>2</b>
Delay in achieving permanency	3		
Failure to provide child with medical, mental health, or other services	1	--	--
Unnecessary/multiple moves	--	--	2
<b>Parent's Rights</b>	<b>11</b>	<b>10</b>	<b>12</b>
Failures of notification/consent, public disclosure, or breach of confidentiality	2	1	6
Delay in completing CPS investigation or internal review of findings	9	5	3
Failure to communicate with or provide services to parent		2	1
Other violations of parents' rights	--	2	2
<b>Poor Casework Practice Resulting in Harm to Child or Family</b>	<b>3</b>	<b>10</b>	<b>2</b>
Inadequate documentation of casework	2		
Poor communication among CA divisions (CPS, CFWS, DLR)	--	5	2
Other poor practice	1	5	2
<b>Foster Parent/Relative Caregiver Issues</b>	<b>8</b>	<b>2</b>	<b>--</b>
Issues relating to child's removal from foster placement	7		
Failure to share information about child with caregiver	1		
<b>Other Findings</b>	<b>--</b>	<b>1</b>	<b>1</b>
Failure to provide meaningful assistance and services to adoptive family		--	1
Failure to protect referent's confidentiality		1	--
<b>Number of findings</b>	<b>52</b>	<b>42</b>	<b>33</b>
<b>Number of closed complaints with one or more finding</b>	<b>36</b>	<b>31</b>	<b>24</b>

Adverse findings involving child safety accounted for 36.5 percent of findings, with failures to complete required monthly health and safety visits and unsafe placement of a dependent child being the most common findings related to child safety. Just over one-fifth (21 percent) of overall findings involved parent's rights, with delays in completing CPS investigations representing 80 percent of the findings in this category. Compared to the previous years, there were substantially more findings in 2017 relating to family separation and reunification, as well as foster parent and relative caregiver issues.

## **FINDINGS OF UNREASONABLE ACTIONS OR INACTIONS**

When OFCO makes an adverse finding against CA it can fall into one or more of four categories: that the agency action or inaction violated law, violated policy, violated procedure, and/or that the agency acted clearly unreasonably under the circumstances. The vast majority of OFCO's adverse findings fall into one or more of the first three categories (80.3% of complaints in reporting years 2015-2017 can be categorized as violations of law, policy, or procedure). However, every year OFCO makes a handful of adverse findings based on the clearly unreasonable standard (19.7% of adverse findings made during reporting years 2015 - 2017).

This standard exists to address the rare circumstances where DCFS has acted or declined to act in such a way that does not violate a written standard, but has a harmful result. If OFCO determines that this harm could and should have reasonably been avoided, it may make an adverse finding that the agency acted clearly unreasonably under the circumstances.

### **DCFS Fails to Follow CHET Screen Recommendations**

A child came into DCFS care in 2015 and a worker timely completed the required Child Health and Education Tracking (CHET) Screening Report to assess for her physical, emotional, educational and other needs. The CHET report indicated that the child should receive a neuropsychological evaluation to determine her needs and how best to meet them. Over the next year and a half the child struggled with acting out and self-harming behaviors. Despite being placed in the same group home for nearly a year, her case worker did not arrange for her to complete a neuropsychological evaluation. OFCO received a complaint a year and a half after the CHET screen was completed, stating that DCFS had not arranged for the evaluation, and that if it had, appropriate medication and therapeutic interventions might have intervened and saved the child from some of her own behaviors. OFCO could find no persuasive reason why it had not been completed. However, while there is policy that requires CA to complete a CHET screen, there is no policy that requires them to follow the recommendations. OFCO determined that it is generally not reasonable to assess children for their basic needs but not follow up on those needs. Furthermore, in this case, where the child's ongoing behavior demonstrated the need for this evaluation, it was particularly unreasonable. OFCO made an adverse finding that failing to arrange for the evaluation throughout the year and a half period was clearly unreasonable under the circumstances.

DCFS contests adverse findings based on the clearly unreasonable standard more frequently than findings based on violations of law, policy, or procedure. During the 2015-2017 reporting years OFCO made 25 adverse findings based, at least in part, on the clearly unreasonable standard. DCFS requested

modification or reversal of 60% of these findings, compared to only 19.6% of the findings based on violations of law, practice, or policy. This is likely due to the more subjective nature of these findings.

This subjectivity is precisely why the clearly unreasonable standard exists. Despite legislative and administrative efforts to standardize and regulate much of DCFS's action there will always remain a measure of necessary latitude in the agency's work. Thus, a caseworker is required to exercise her judgment on a variety of matters throughout the life of a case. Because OFCO is an independent, uninvolved, and outside entity, it is able to assess these decisions free of investment or bias. OFCO considers the circumstances through an impartial lens, free from the influence of prior involvement or potential bias. It is a testament to the Department that OFCO makes so few clearly unreasonable findings, given the countless decisions caseworkers must make.

### **DCFS Misses Opportunity to Gather Investigative Information**

OFCC found that DCFS acted clearly unreasonably under the circumstances, and also in violation of practice and procedure, when it closed an investigation into alleged neglect of a child without completing necessary investigative steps. The allegation was that the parent was driving while impaired by with her child in the car and got into an accident, injuring them both. Without interviewing the child, or waiting on the pending toxicology report that would have established the mother's level of inebriation, the worker closed the investigation as unfounded based on the mother's denial that she was drunk. OFCC found that in this circumstance a supervisor approved extension to keep the case open long enough to gather this information would have been prudent, particularly as the child remained in the mother's care.

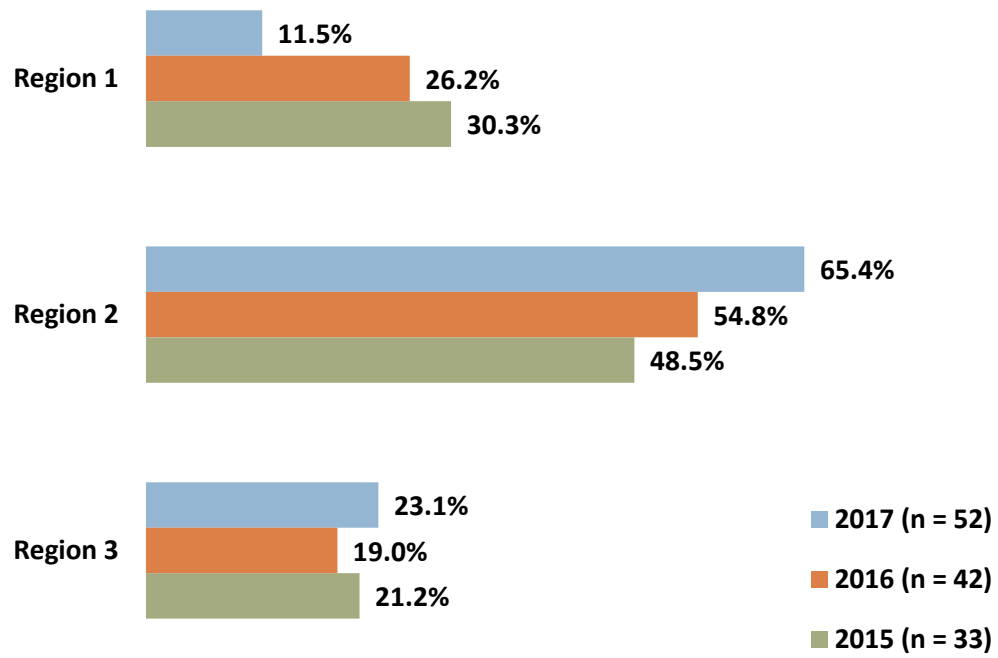
The clearly unreasonable standard allows OFCO the ability to identify decisions and practices that, while not in violation of explicit law or policy, had harmful impact which could potentially have been avoided. OFCO is uniquely positioned to access the information factored into decision making and, with a fresh perspective, determine if the decision was appropriate under the circumstances.

## **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 **52 adverse findings** OFCO made against the agency in 2017, **65 percent were in Region 2**, while only 36 percent of complaints made to OFCO were about Region 2 offices.

The number of adverse findings in **Region 1 totaled six (11.5 percent)** and in **Region 3 totaled 12 (23.1 percent)**. Bearing in mind that with such small numbers it is difficult to draw statistically significant 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. Region 2 has consistently had the most adverse findings for the past several years. The number of adverse findings are broken down by office in Table 11 in Appendix C.

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



### **III. FOSTER PARENT VOICES**

- Overview of Foster Care and Foster Parent Support
- Common Concerns Identified by Foster Parents
- Legislative Actions to Improve Foster Care
- Recommendations to Improve Support to Foster Parents

## INTRODUCTION

Our state child welfare system cannot function without dedicated, skilled and supported foster parents. On any given day, there are approximately 9,000 children placed in out-of-home care by the Division of Children and Family Services (DCFS). Approximately 55% of these children are placed in licensed foster care, and 40% in relative and kinship homes.<sup>18</sup>

Generally, children enter state care as a result of child abuse or neglect often related to family stress factors such as substance abuse, mental illness, domestic violence, and incarceration. Providing a safe and nurturing home to them is challenging, as many of these children have behavioral, developmental, or mental health issues resulting from the maltreatment they experienced.

Over the past year, the Office of the Family and Children's Ombuds received concerning reports regarding the Department's treatment of foster parents. Concerns ranged from poor communication, to disagreements over a child's case plan, to retaliation against foster parents. Some foster parents told OFCO they are reluctant to discuss these issues with a DCFS supervisor or file a complaint with OFCO or Constituent Relations because they fear the Department will remove a child in their care or take other adverse actions in response to their complaint.

In response to these concerns, OFCO sought to obtain more information, identify common areas of concern among foster parents, and develop recommendations. This effort included:

- A review of **existing internal and external complaint processes** and support services for foster parents.
- A review of the responses to **Children's Administration's foster parent survey**; and
- Discussions and **listening sessions with foster parents and foster care advocates** across Washington.

Informed by these efforts, this section of the report describes:

- An overview of foster care and licensing;
- Existing support programs available to foster parents;
- Processes for addressing foster parent complaints;
- A summary of findings and concerns identified in the annual DSHS Foster Parents Survey;
- The frustrations, fears, and suggestions that foster parents shared with OFCO; and
- Recommendations to better assist and support foster parents.

## OVERVIEW OF FOSTER CARE AND FOSTER PARENT SUPPORT

### Foster Parents' Rights and Responsibilities

Foster parents provide placement and care for children when they cannot be safely maintained in their own homes. Foster care placement may be temporary or long term depending on the biological parents' progress towards family reunification, and/or the availability of a relative placement. Some individuals become foster parents to nurture and care for children who have suffered abuse or neglect, others

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<sup>18</sup> CA Report to the Legislature, Continuum of Care Report, December 1, 2016.

become foster parents in hopes of adopting a child, and yet others become foster parents to provide care for a specific child.

Foster parents are responsible for the protection, care, supervision, and nurturing of the child in their care. As an integral part of the foster care team, foster parents may: participate in the development of the service plan for the child and the child's family; assist in family visitation, including monitoring; model effective parenting behavior for the natural family; and be available to help with the child's transition back to the natural family.<sup>19</sup>

As the child's caregiver, foster parents have the authority to provide or withhold permission to allow a child in their care to participate in normal childhood activities based on a reasonable and prudent parent standard. A foster parent therefore does not need approval of the caseworker or court to allow the child to participate in extracurricular or social activities, including sleep overs, outside the direct supervision of the foster parent.<sup>20</sup>

Foster parents have the right to be free of coercion, discrimination, and reprisal in serving foster children, including the right to voice grievances about treatment or services provided or not provided to the foster child.<sup>21</sup> Additionally, state law recognizes that foster parents may engage in protected activities without fear of retaliation. Protected activities set forth in law include: filing a complaint and or cooperating with a complaint investigation, instituting a dependency proceeding, testifying in a dependency proceeding, advocating for services on behalf of a foster child, seeking to adopt a foster child in their care, or consulting with someone about the foster parent's rights.<sup>22</sup>

Foster parents may attend all court hearings and proceedings pertaining to the child in order to provide oral and written information about the child and the child's welfare to the court. The Department must notify foster parents of all court hearings related to the child, and of their right to be heard. The court is required to document whether the Department provided adequate notice and whether a caregiver's report<sup>23</sup> was received from the foster parents.<sup>24</sup> While foster parents may participate in case planning, decision making staffing, and court proceedings, they do not have standing as a party to the dependency action regarding the child in their care.

## **Foster Parent Support Programs**

### **Liaison and Peer Mentor Programs**

The Department contracts with both Olive Crest and Eastern Washington University (EWU) to provide support for foster parents. Olive Crest's Fostering Together Program calls their foster parent support positions "liaisons".<sup>25</sup> EWU's "Fostering WA" uses the term "Resource Peer Mentors" (RPMs).<sup>26</sup> These programs assist both prospective foster parents and those already licensed. They assist prospective foster parents as they inquire about foster parenting, move into training, and submit their application to

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<sup>19</sup> RCW 74.13.330; RCW 13.34.260.

<sup>20</sup> RCW 74.13.710.

<sup>21</sup> RCW 74.13.332.

<sup>22</sup> RCW 74.13.333.

<sup>23</sup> See, *Caregiver's Report to Court Template* provided to foster parents by the Department.  
[https://www.dshs.wa.gov/fsa/forms?field\\_number\\_value=15-313&title](https://www.dshs.wa.gov/fsa/forms?field_number_value=15-313&title).

<sup>24</sup> RCW 13.34.096; RCW 13.34.115.

<sup>25</sup> More information available at: <http://fosteringtogether.org/>.

<sup>26</sup> More information available at: <https://www.ewu.edu/css/fostering-washington>.

either DLR or one of the private licensing agencies. They also serve as supports once licensed and when a new foster family has their first child placement.

“Liaisons” and “Resource Peer Mentors” provide information and assistance on many issues, including: the child welfare system processes, the court process, caregiver reports to the court, Family Team Decision Making meetings, shared planning, mileage reimbursement, clothing vouchers, visitation, and transportation. Additionally, they attend and present at foster parent orientations and trainings, and staff many of the foster parent support groups across the state.

### **FIRST (Foster, Intervention, Retention and Support Team) PROGRAM**

Olive Crest and EWU also operate the FIRST Program providing neutral third party advice and support to foster parents. They provide information on Department policies, procedures, and regulations governing investigations of allegations of child abuse and neglect or licensing violations, and what foster parents can expect during the course of an investigation.

DLR provides written information about FIRST to foster parents involved in a DLR/CPS or licensing complaint investigation. FIRST staff are available to meet in person or by phone, at the foster parent’s request during an investigation. FIRST staff can:

- Respond to requests for assistance within 12 hours.
- Explain the investigation process, including time frames.
- Explain the differences between a DLR/CPS investigation and a licensing complaint.
- Assist the foster parent in communicating with agency staff.
- Meet with foster parents in person or by phone and provide ongoing support throughout the investigation.

### **Respite Care**

Respite care services play an important role in preventing placement disruption by providing a temporary break for foster parents, and helping them deal with emergent situations. Respite services are available for licensed foster parents, as well as unlicensed relative caregivers and other suitable persons caring for children. There are three categories of respite care: Retention Respite; Child Specific Respite; and Exchange Respite.<sup>27</sup>

Retention Respite provides licensed foster parents with regular "time off" from the demands of caregiving responsibilities and can also be used to meet emergent needs of licensed caregivers. Retention respite is earned by licensed caregivers at a rate of two days per month. The licensed caregiver home may accumulate a maximum of fourteen days of retention respite days to be used at one time. Licensed caregivers are encouraged to use retention respite as it is earned. The respite provider must have experience and/or training to deal with the particular special needs of the child in their care.

Child-Specific Respite (CSR) provides unlicensed relative caregivers, other suitable persons, and licensed foster parents with temporary relief from the caregiving responsibilities that are linked to the medical, behavioral, or special needs of an individual child. CSR is authorized on a case-by-case basis consistent with the written service plan for the child. The need for continued CSR service is reviewed at service re-authorization and during multidisciplinary staffing.

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<sup>27</sup> CA Practices and Procedures Guide, Section 4510.



Exchange Respite is the relief from parenting responsibilities, which is negotiated and arranged between licensed caregivers and does not include payment of CA funds. Foster parents must provide advance notice to the child's social worker of a scheduled exchange respite, so that the social worker may verify that there are no licensing complaints pending which would preclude the respite provider from caring for the child. When providing exchange respite, foster parents must remain within their licensing requirements for capacity, age, and gender.

The "Prudent Parenting Law" also allows foster parents to use family or friends they know and trust to provide care for a foster child for up to 72 hours.<sup>28</sup>

## **Existing Channels to Address Foster Parent Complaints**

Several formal avenues exist for foster parents to file complaints and address concerns. As described below, foster parents may bring issues to the attention of CA Constituent Relations, the CA Foster Parent Team, and the Office of the Family and Children's Ombuds.

### **Children's Administration Constituent Relations**

CA Office of Constituent Relations provides objective resolution of complaints regarding services or programs of the Department.<sup>29</sup> CA constituent relations staff also provide information about CA programs, policies, and procedures, and about other complaint resolution resources, including the Office of the Family and Children's Ombuds.<sup>30</sup>

Constituent Relations staff attempt to resolve complaints at the lowest level possible but believe all levels of the organization must be accountable.<sup>31</sup> If reasonable attempts to resolve the complaint have not adequately addressed the concern, CA administration or constituent relations may convene a panel to review the complaint and make recommendations. If the complainant is a foster parent, the panel must also include another foster parent who is not involved in the complaint. The panel submits written findings and recommendations and the CA Assistant Secretary issues a final written decision.<sup>32</sup> If CA constituent relations staff determines at any time during the complaint resolution process that the administration's actions were consistent with agency policy and procedures based on complete and correct information regarding the complainant's situation, the constituent relations staff terminates the resolution process and closes the complaint.<sup>33</sup>

The complaint resolution process does not apply when the complainant has the right to seek resolution through judicial review or an adjudicative proceeding; or to contract rate setting, contested rate payments, exceptional cost rates, disputes or decisions regarding written personal service contracts, or financial agreements.<sup>34</sup>

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<sup>28</sup> RCW 74.13.710.

<sup>29</sup> RCW 74.13.045, CA Operations Manual 2212.

<sup>30</sup> WAC 388-39A-060.

<sup>31</sup> RCW 74.13.045.

<sup>32</sup> WAC 388-39A-040.

<sup>33</sup> WAC 388-39A-035.

<sup>34</sup> WAC 388-39A-045.

Agency policies prohibit CA and its staff from intimidating, threatening, coercing, or discriminating against any person who has complained, provided information, assisted, or participated in any manner in the complaint review process.<sup>35</sup>

### **The Children's Administration Foster Parent Team (CAFPT)**

CA and foster parents meet quarterly, both regionally and state wide to ensure foster parent voices are heard. These meetings provide an opportunity for the Department to receive foster parents' perspectives on how it is meeting its duties and responsibilities, and specifically about the recruitment and retention of foster homes, effective training for foster parents, and the implementation of a coordinated and comprehensive plan that strengthens services for the protection of children.<sup>36</sup> The CAFPT team is composed of CA staff appointed by the Assistant Secretary and regionally elected foster parents and representatives from FPAWS.

### **The Office of the Family & Children's Ombuds (OFCO)**

OFCO investigates complaints regarding children and families involved with the state child welfare system because of allegations of child maltreatment.<sup>37</sup> OFCO's investigative authority allows broad access to the agency's records and case-management system. OFCO is required to maintain the confidentiality of this information, as well as the identity of individuals filing a complaint. The Ombuds is specifically authorized to investigate allegations of retaliation against foster parents, and identify trends which may indicate a need to improve relations between the Department and foster parents.<sup>38</sup> OFCO's complaint investigation process is described in detail in Section 2 of this report.

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<sup>35</sup> CA Operations Manual 3240.

<sup>36</sup> Chapter 413 Laws of 2007, RCW 74.13.031.

<sup>37</sup> RCW 43.06A.

<sup>38</sup> RCW 74.13.333.

## COMMON CONCERNS IDENTIFIED BY FOSTER PARENTS

### **Foster Parent Frustrated With Removal of Child and License Revocation**

OFCO received a complaint from a foster parent with a multitude of concerns regarding DLR actions. The foster parent felt that DLR was revoking their license due to behavior problems with a 7 year old child placed with them, not because of any shortcomings as providers. They felt this was particularly unfair as they believed DLR had not provided necessary services for the stabilization and success of the child in their home. Finally, they were frustrated that the child was being moved without providing the five day notice described in policy. The foster parent felt the revocation of their license was in retaliation for their speaking out about services and complaining about the lack of five day notice. OFCO intervened and was able to speak with the Area Administrator who agreed to delay the child's move to allow for the five day notice requirement. OFCO also successfully advocated for additional services for the child in the home. However, OFCO did not find that the services which had previously been provided were deficient, nor did it find evidence of a retaliatory motive. Instead, the agency was able to articulate a legal basis for the revocation, relating to ongoing concerns with improper discipline and supervision in the home. The family is appealing the revocation through the administrative process.

### **Review of DSHS Foster Parents Survey**

Each year DSHS conducts a survey of foster parents regarding their satisfaction with support, training, and information provided to them by CA and private placement agencies. In order to contextualize the concerns noted in foster parent complaints to OFCO, and to prepare for meetings with foster parents across the state, OFCO reviewed the findings from the recent DSHS surveys.

Between September 2015 and September 2016, DSHS surveyed 1,350 foster parents. The survey included a combination of structured and open ended questions that invite foster parents to further identify and explain concerns and to offer recommendations for change.<sup>39</sup> The survey report notes foster parents' responses "*paint a portrait of the complexities, successes, and struggles of Washington's foster care system*".<sup>40</sup>

Key findings from the survey include:

- Most foster parents are satisfied with the support they receive and have mostly positive perceptions of social workers.
- Responsiveness, communication, and consistent and fair processes are very important to foster parents.

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<sup>39</sup> 2016 Foster Parent Survey: Foster Parents Speak.

<https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-11-239.pdf>

<sup>40</sup> Id. Page 1.

- While most foster parents reported satisfaction with the information they receive about children in their care, they also report concern about the severe consequences of not sharing adequate information.
- Foster parents value opportunities to interact with one another and learn from their peers in training and support groups.

While most foster parents surveyed reported general levels of satisfaction, there were also some areas of concern and room for improvement. For example:

- Though the vast majority of respondents indicated they felt listened to and included as part of the foster care team, a significant number did not. Nearly one in five foster parents surveyed (19 percent) said that social workers do not listen to their input. One-fourth said they do not feel like they are part of the foster care team, and 28 percent said they are not included in meetings about the children in their care.<sup>41</sup>
- Twenty percent of foster parents said that they have difficulty accessing help when they ask for it.<sup>42</sup>
- Nearly one-third (30 percent) of foster parents said they seldom or never get adequate information about the needs of the children placed in their care. This information is often required by foster parents to support children's medical, educational, developmental and behavioral needs.

It is encouraging that the vast majority of foster parents surveyed indicated overall satisfaction with the support, training and information provided to them. However, too many feel they are not getting what they need.

The DSHS survey of foster parents asked a set of open-ended questions that allowed foster parents to comment in greater detail, identify strengths in the current system, and make specific recommendations for improvement. DSHS categorized foster parents' comments by several themes, a collection of which are briefly summarized below:

- **Inclusion** – Foster parents want to be included in the decision-making process, they want their opinions to be heard and matter, and they appreciate and notice when caseworkers show good listening skills. Foster parents say the consequences of excluding them from the case are that they miss important information about the children, their ability to provide quality care is hindered, and unsafe situations may result.
- **Processes** – While 93 percent of foster parents who commented about the foster care system's general or specific processes were negative, they also produced tangible suggestions for how the system could be improved, including:
  - Apply policies uniformly across offices and for different groups of people.
  - Communicate caseworker and supervisor changes to foster parents.
  - Develop a standard transition plan for children being returned to their biological family.

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<sup>41</sup> 19 percent said that social workers seldom, almost never or never listen to their input. 28 percent of those surveyed responded that they seldom, almost never, or never are included in meetings about the child in their care. 26 percent responded that they seldom, almost never or never feel like they are part of the team.

<sup>42</sup> 20 percent responded that they seldom, almost never, or never get help they need when they ask for it.

- Provide clear instructions and clarify how to complete mileage reimbursement paperwork.
- **Workforce** – Foster parents frequently mentioned the need for more caseworkers, recognizing that many times caseworkers cannot provide them or the children in their care with the attention and support needed because agency staff have such high caseloads and are spread too thin.
- **Information** – It is clear that foster parents value honesty and transparency in the information that is given to them about a child’s background and needs. Comments indicated that adequate and timely notice about meetings, court hearings, and visitation goes a long way to communicate respect for foster parents. Foster parents also noted that the frequency and quality of information varies greatly among caseworkers and offices.
- **Support** – Foster parents shared that a sense of community with other foster parents is important to them. Contact with other foster parents provides emotional support and practice advice about resources and navigating the foster care system.

### **Foster Parent’s License Is Closed**

A foster family became licensed in 2014 and provided care for two dependent children. When the children were reunified with their biological parent the foster family requested to keep their license open, though they were not planning on accepting any other placements, as they wanted to remain a resource for these children should the children need a foster home again. The foster parents were informed this was not possible and their license was closed. Two years later the children returned to foster care. The foster family informed the Department they wanted to provide placement again, but since they were no longer licensed they had to take in the children as a suitable adult placement. As such, they did not receive the financial support of a licensed foster parent. The family complained to OFCO that they should have been allowed to keep their license open as they originally requested. OFCO investigated and learned that their license was not through Department of Licensing Resources (DLR), but through a Child Placing Agency (CPA), a private entity that licenses homes to provide foster care and whose licenses are subject to final certification by DLR. CPAs may, at their discretion, require additional regulations for a foster home to become, or remain, licensed. DLR, on the other hand, cannot close a foster license without a legally recognized reason, and even then the foster parent is entitled to appeal this decision up to the level of review by an administrative law judge. This CPA did not wish to retain licenses of foster homes not accepting placements. Because the CPA is authorized to do so OFCO was unable to find fault with the Department’s handling of the matter.

## **OFCO's Outreach and Listening Sessions with Foster Parents**

In conjunction with training conferences organized by the Foster Parents Association of Washington State (FPAWS) OFCO held a series of listening sessions with foster parents throughout the state to learn more about their issues, concerns and experiences as foster parents.<sup>43</sup>

Not surprisingly, in OFCO's listening sessions foster parents identified similar themes as those raised in the DSHS foster parents survey. For example, many foster parents described: feeling excluded from the case planning process regarding the child, poor communication from the Department, and a general lack of appreciation and respect showed to foster parents. Some foster parents also expressed a fear of retaliation if they voiced disagreement with a child's case plan or advocated on behalf of the child. Summarized below are the primary concerns identified by foster parents in OFCO's listening sessions.

### **Excluded from the Case Process and a Lack of Respect**

Foster parents are an integral part of the foster care team and the Department is required to consult with the foster parent regarding the child's case plan.<sup>44</sup> The Department must also notify foster parents of court hearings regarding the child, and foster parents have the right to submit a "Caregiver's Report" to court. Yet many foster parents said they are not notified of court hearing dates, and when they are notified, they do not know if their court reports are shared with the parties and court or even read by the caseworker. While agency policies dictate including foster parents in shared planning meetings, foster parents described being excluded from case planning events, and said when they are allowed to attend, they often feel their input carries little or no weight and the case plan has already been decided.<sup>45</sup> Some foster parents said that even though they are told that they are "part of the team" and "partners" with the Department, they feel they are treated as babysitters and feel invalidated and ignored. Several foster parents stated that the only person involved in their foster child's case who thanked them for their work was the judge or commissioner at court review hearings.

One foster parent said they had been told throughout the case that they would be able to adopt the child. Yet, at a court hearing, all the legal parties to the case, including the Department, reported that they had agreed to return the child to the parent's care. The foster parent was not informed they might not be adopting the child until the child was moved from their home without a transition. When the foster parent asked the caseworker what prompted the change in the case plan, they were told "that's just the way it is."

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<sup>43</sup> OFCO met with foster parents at FPAWS training conferences in Bremerton, Port Angeles, Centralia, Bellingham, Tacoma, Spokane, and Yakima.

<sup>44</sup> CA Case Services Policy Manual, Section 4110; RCW 13.34.120; RCW 26.44.030; RCW 74.13.280; RCW 74.13.330.

<sup>45</sup> CA Practices and Procedures Guide, Section 1710; Guide to Shared Planning Meetings DSHS 22-1688.

### **Department Fails to Hold Required Shared Planning Meetings**

OFCO received a complaint from a foster parent that DCFS was failing to hold required Shared Planning Meetings regarding a two year old dependent child. OFCO investigated and found that at least three mandatory meetings had been triggered by case activity yet the Department had not held any of these required meetings. OFCO also found that the foster parent had sent several requests for these meetings to the Department and other stakeholders and that the Department never responded. OFCO contacted the supervisor of this unit and she admitted that they had not held any meetings regarding this child, attributing this to the unit having a higher number of cases than normal while being extremely understaffed. She said that given this situation they were almost entirely responding to crises rather than engaging in prospective planning. She also agreed to hold a meeting as soon as possible. OFCO made an adverse finding regarding the failure to conduct shared planning meetings. The Department did not contest this finding.

### **Inadequate Information Provided About the Child at Time of Placement**

Whenever a child is placed in out-of-home care, the Department must share information with the caregiver about the child and the child's family, and consult with the caregiver regarding the child's case plan. The Department has broad authority to share information about the child including high risk behaviors, mental health disorders, and a history of sexual or physical abuse. A foster parent receiving such information must maintain confidentiality.<sup>46</sup> Some foster parents report they often receive little to no information regarding the child's background, needs, or behavioral issues when a child is placed in their home, leaving them ill prepared to care for the child. Foster parents said they understand that caseworkers need to find a placement for a child, but feel in some cases foster parents are misled regarding the child's history in order to secure them as a placement.

One foster parent said she was given the wrong name for a child and they did not find out the child's correct name for a week. Another foster parent reported she was not told that the foster child only spoke Spanish. No one else in the foster home spoke Spanish, and because the child could not communicate with her, the foster parent thought the child was hearing impaired or developmentally delayed. Another foster parent said she was chastised by the case worker and supervisor for repeatedly asking for information and records about child's previous school. The foster parent said she needed this information to enroll the child in her new school. Other examples foster parents shared include:

- Foster parent not told that an adolescent girl had history of running from placement.
- Foster parent not informed the child had history of aggression towards younger children.
- Foster parent was not given information about a three year old child's behavioral issues, assaultive and destructive behaviors, and ten previous placements.
- A caseworker placed two siblings with a foster parent even though this foster home had a single bedroom for a foster child. According to the foster parent, the caseworker said this was not a problem and the foster parent accepted the placement on this basis. Later, the foster parent's

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<sup>46</sup> RCW 74.13.280.

licensor threatened a licensing action against her because of the bedroom arrangement, and both children were removed from her home.

### **Retaliation and Threat of Retaliation**

Some foster parents described threats of retaliation by the Department and said they are often afraid to file complaints with OFCO or Constituent Relations, or to bring their concerns to the attention of a supervisor or area administrator. They described “retaliation” as the threat of an adverse action against them, for instance the removal of a child from their care, or a report of a licensing infraction. Foster parents shared the following examples:

- A foster parent disagreed with a plan to transition a child to the parent’s care. The case worker responded “if you keep this up we may have to consider a different foster placement.”
- When foster parents want to adopt a child in their care they are even more afraid of “rocking the boat” and fear the child will be removed from their care. As a result, they do not speak out on behalf of other foster children in their home. They do not want to ask questions or advocate for services because they are afraid of being seen as “too much trouble” or “not worth the headache”.
- A foster parent disagreed with the caseworker over the selection of a counselor to work with a child. Based on a past experience, the foster parent did not wish to work with this therapist and explained that any other provider would be fine. The case worker still scheduled the child’s therapy with this counselor and, when the foster parent objected, the caseworker threatened to remove the child.
- A foster parent had been caring for a child since her birth. The court order increased parent child visits, adding a visit each week. The foster parent was happy to accommodate an additional weekly visit, but for family and religious reasons did not want to schedule visits on Saturday or Sunday. The Department threatened to remove the child if they did not agree to a weekend visit. The foster parent’s private agency intervened and additional visits were scheduled on a weekday.

### **Poor Communication**

Foster parents identified communication problems as a source of frustration that contribute to a lack of confidence in the child welfare agency and caseworkers. They described agency professionals not answering phone calls, returning voicemails, or responding to e-mails. In some instances, foster parents report they are unable to even leave a phone message because the case worker’s voicemail box is full.

Furthermore, information from foster parents is not effectively shared among different branches of the Department. As a result, foster parents said they have to tell the same information to multiple individuals. For example, a foster parent may share information with the child’s caseworker, but the information is not relayed to the foster parent’s licensor.

Foster parents also told OFCO that information is not always provided in a timely manner. One foster parent said she was notified only a few hours in advance that she needed to have the child ready for a visit. If she did not comply or pushed back, the foster parent said she feared the child might be removed from her care or a licensing violation would be reported for not supporting the case plan.



## **Lack of Support**

Foster parents said that in some cases, requests for services to help meet the child's needs are ignored. Then when the child's behavior escalates and the foster parent can no longer care for the child, the foster parent is blamed because he could not properly care for the child. In these situations, foster parents state the placement could have been maintained and a crisis averted if the agency had provided appropriate services when requested.

### **Foster Parent Feels Department Retaliated for Complaint Made Against Caseworker**

A foster parent contacted OFCO because their five year old foster child was recently removed from their home. They felt the removal was in retaliation for complaints they made about the child's caseworker. Several months prior, the child's caseworker attempted to move the five year old and his sibling without holding a Family Team Decision Making (FTDM) meeting as required by policy. The foster parent raised an objection with the supervisor and the worker then held the meeting. Only the child's sibling ended up being moved. More recently, the remaining child presented with bruising consistent with intentional physical abuse. DCFS immediately moved the child to another placement. DLR conducted an investigation and determined that while the child had been the victim of physical abuse, the agency could not conclude who perpetrated the abuse, and the investigation was closed as unfounded. The foster parents assumed the child would be returned, as the allegation was unfounded. However, DCFS chose not to return the child to their home. The foster parent believed the decision not to place the child back with them was in retaliation for their earlier complaint about the FTDM. OFCO investigated and learned that while the investigation resulted in an unfounded finding, DLR had serious concerns about the foster parents due to the medical conclusion that the child was a victim of physical abuse while in their home. Although DLR did not revoke their license DCFS issued a stop placement order on the license due to this concern. OFCO could not find evidence that the agency retaliated against the foster parents, as there was evidence that the child had been physically abused while in their care. Although OFCO did not make an adverse finding in this instance, it did note that this was a frustrating outcome for all, since the foster parents were unable to appeal the stop placement action without an outright revocation, and the agency retained responsibility for maintaining a foster home license it could not employ.

## LEGISLATIVE ACTIONS TO IMPROVE FOSTER CARE

Legislation passed and signed into law in 2017 aims to address many of the concerns raised by foster parents and discussed in this report such as improving respite care, support services, grievance procedures, licensing procedures, and communication and consultation with foster parents.<sup>47</sup> For example, the legislation:

- Requires the Department to design a respite care program including case aides through non-profit community based organizations who provide temporary assistance to foster parents;
- Directs the Department, in consultation with foster parents and other stakeholders, to identify a system of support services for foster parents including counseling, educational assistance, respite care, and hands-on assistance for children with high risk behaviors, and to identify a plan to implement these services statewide;
- Requires the Department to design and implement an expedited foster licensing process for applicants meeting certain criteria, with the goal of completing the license within forty days;
- Requires the Department, in partnership with foster parent representatives, to create a list of the rights and responsibilities of foster parents. This list must be posted on the Department's website and provided to foster parents at the time of licensure;
- Includes foster parent representation in the Oversight Board for Children, Youth and Families, as well as stake holder advisory bodies and committees established by the Office of Innovation, Alignment and Accountability;
- Identifies foster parent retention and recruitment as one of the outcome measures for improving child and youth safety, permanency and well-being; and
- Requires the Office of Innovation, Alignment and Accountability to review the current process for addressing foster parent grievances, examine deficiencies, and recommend ways to enhance the current system to improve child welfare, the experience of foster parents, and the overall functioning of the child welfare system.

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<sup>47</sup> 2ESSB 5890, Chapter 20, Laws of 2017 (<http://lawfilesexternal.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/5890-S.SL.pdf>) and 2E2SHB 1661, Chapter 6, Laws of 2017 (<http://lawfilesexternal.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/1661-S2.SL.pdf>).

## **Delay in Permanency, Arranging Services for Child, and Lack of Communication from Caseworker**

A foster parent complained to OFCO that a DCFS caseworker was unreasonably delaying permanency for two children, did not arrange for counseling as requested for one of the children before he started having visits with his father, and failed to respond to the foster parent's phone calls and emails. OFCO investigated and found that the children's case had been delayed, but it was not due to the fault of the Department. Rather, the parents had pending criminal charges related to allegations of child maltreatment, which delayed the dependency proceeding. OFCO also determined that while there was a several week delay in scheduling the child's counseling, he was enrolled by the time OFCO received the complaint.

OFCO was also unable to conclude that the caseworker failed to adequately communicate with the foster parent. There was no record of their communication or attempted contact and OFCO did not have a history of complaints regarding this caseworker and poor communication to rely on. OFCO did not intervene and was unable to make an adverse finding about these concerns, but did document the concerns and will continue to watch for similar complaints about the caseworker.

## **RECOMMENDATIONS TO IMPROVE SUPPORT TO FOSTER PARENTS**

### **Expand Support Programs for Foster Parents**

#### **Foster Parent Liaison/ Peer Mentor and FIRST Programs**

In one study, "poor relationship" with the child welfare agency was identified as the primary reason foster parents left fostering.<sup>48</sup> Foster parent liaisons and peer mentors enhance the working relationship between the Department case workers and foster parents, and provide expedited assistance for the unique needs of children in foster care.<sup>49</sup> Many of the concerns raised by foster parents could likely be resolved quickly and informally with the assistance of a liaison or mentor.

Additionally, the Department should establish foster parent liaison positions within each office to respond to inquiries and concerns from foster parents in a positive and constructive manner. Improving communication and conflict resolution at the local level could enhance foster parent retention.

#### **Foster Parent Support Groups**

Foster parents cited various peer support programs as an essential element to successful fostering. These programs include support provided by the Foster Parents Association of Washington State (FPAWS)<sup>50</sup>, Fostering Together<sup>51</sup>, and through the foster hub home and constellation within the Mockingbird Family Model.<sup>52</sup> State and private child welfare agencies should build on these programs

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<sup>48</sup> Perspectives of foster parents: what influences their motivation to become and continue to be foster parents? (2012) Bridget D. Conway. <http://scholarworks.smith.edu/cgi/viewcontent.cgi?article=1954&context=theses>.

<sup>49</sup> CA Case Services Policy Manual, Section 8110. <https://www.dshs.wa.gov/ca/8000-caregivers/8110-foster-parent-liaison>.

<sup>50</sup> <https://www.fpaws.org>.

<sup>51</sup> <http://fosteringtogether.org/>.

<sup>52</sup> <http://www.mockingbirdsociety.org/index.php/what-we-do/mockingbird-family-model>.

and dedicate resources to ensure local support groups are accessible to all foster parents throughout the state. New foster parents should be informed of and connected to existing groups and organizations and encouraged to network with other foster parents.

### **Increase Collaboration with Foster Parents in Case Planning Process**

Implement steps to maximize foster parent participation in case planning events such as case staffing, permanency planning, Family Team Decision Making meetings, and review hearings, and let foster parents know their contributions are valued.

The supervisor's monthly case reviews should discuss and document communication with the child's caregiver and include: issues or concerns identified by the caregiver, services requested by the caregiver to help meet the child's needs, and the caregiver's participation in case planning activities. Collaboration with foster parents should also encompass encouraging contact between foster parents and the child's parents and relatives, and foster parent involvement with family reunification and a child's transition to a new placement. Foster parents' satisfaction is related to their perceptions about teamwork, communication, and confidence in relation to both the child welfare agency and its professionals.

### **Improve Communication with Foster Parents**

Foster parents deserve a timely response to their telephone calls and e-mails, questions and concerns. While Department policy requires that case workers return calls within 48 hours or the next business day,<sup>53</sup> many foster parents report this often does not occur. The implementation of mobile technology should enable caseworkers to answer calls and e-mails while in the field. Department administration should identify and address workload or other barriers that impact case workers' abilities to communicate with foster parents in a timely manner. Information from the foster parent survey should be used to determine if this is a statewide issue, or concentrated in certain areas.

The Department is developing an "Our Kids App" which will allow foster parents to access a child's medical and educational records. The Department should continue to pursue these kinds of technological solutions to improve communication with foster parents and provide them with current case related information.

The Department should hold quarterly meetings with foster parents in each DCFS office so foster parents, private agency staff, area administrators and supervisors can discuss local issues and developments impacting foster parents and children in state care. This would improve communication, help build professional relationships between foster parents and the Department, and improve the level of trust and confidence in the Department.

### **Support and Retain Case Workers**

Increase efforts such as mentoring, heightened supervision, and ongoing training to reduce workload and retain caseworkers. Many of the issues discussed above are related to the caseworker's workload and/or caseworker turnover. In order to support foster parents and serve the children in their care, case workers must have the time to establish professional relationships with foster parents and must be

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<sup>53</sup> CA Operations Manual, Section 2421. <https://www.dshs.wa.gov/ca/2420-telephone-calls/2421-response-times>.

available when foster parents need them. Manageable caseloads for case workers and appropriate ratios of supervisor to case workers are essential to achieving positive outcomes for children and families, and supporting caregivers. Turnover rates among caseworkers state wide is approximately 20%. This has a significant impact on vulnerable children. One study found that a child with one caseworker throughout her case has a 75% likelihood of placement in a stable and permanent home within one year. If the case is transferred to a new caseworker within one year, the percentage drops to 18%.<sup>54</sup> Washington State was recently selected as one of eight sites to partner with the Quality Improvement Center for Workforce Development (QIC-WD)<sup>55</sup> to address and study potential solutions to specific workforce issues. The goal is to build a stronger workforce with less turnover and a more supportive organizational environment that improves outcomes for vulnerable families and children.<sup>56</sup>

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<sup>54</sup> Review of Turnover in Milwaukee County Private Agency Child Welfare Ongoing Case Management Staff (2005), Flower, McDonald and Sumski. [http://www.uh.edu/socialwork/\\_docs/cwep/national-iv-e/turnoverstudy.pdf](http://www.uh.edu/socialwork/_docs/cwep/national-iv-e/turnoverstudy.pdf).

<sup>55</sup> The QIC-WD is led by the University of Nebraska and funded through the Children's Bureau.

<sup>56</sup> Eight Child Welfare Systems Selected to Test Workforce Strategies, <http://www.qic-wd.org/eight-child-welfare-systems-selected-test-workforce-strategies>.

## **IV. IMPROVING THE SYSTEM**

- Foster Care Placement Shortage
- CA Involvement in Ongoing Family Law Disputes
- Helping Families When a Child Cannot Return or Safely Remain in the Home
- Preparing for the Department of Children, Youth, and Families

# FOSTER CARE PLACEMENT SHORTAGE

## HOTELS USED AS EMERGENT PLACEMENTS FOR FOSTER CHILDREN

*While Department policy specifically prohibits placement of a child 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 three years, OFCO has tracked the use of “placement exceptions”, specifically the use of hotels and Department offices, as emergency placements for children.<sup>57</sup> From September 1, 2016 to August 31, 2017, OFCO received notice of **824 placement exceptions involving 195 different children**. This is a slight decrease from last year where OFCO documented 883 placement exceptions involving 221 children. The vast majority of these placement exceptions (773) involved children spending the night with social workers in hotels. There were 47 known instances of children spending the night in DCFS offices.<sup>58</sup>

For most hotel and office stays, at least two awake DCFS workers supervised the children overnight, and in some cases 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. Many of these children were also served by other state systems such as juvenile rehabilitation, Developmental Disabilities Administration, or mental health treatment 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. 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 16 year old youth was removed from out of home placement due to allegations of physical abuse by the caregiver. The youth was non-verbal and diagnosed with an intellectual disability. The youth requires very close supervision and needs daily support with bathing, eating, and hygiene. The Department was assessing an out of state relative who was willing to provide care. While waiting for the approval no other placement could be identified and the youth spent a total of six nights in a hotel. The youth is now placed with this relative.
- ❖ A 6 year old child came into DCFS’s care following allegations of physical abuse in the home. In the early months of out of home care the child experienced a variety of short term and night-to-

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<sup>57</sup> OFCO receives notification of placement exceptions and other critical incidents through CA’s Administrative Incident Reporting System (AIRS).

<sup>58</sup> There were four known instances where a child was approved to spend the night in a hotel but due to staffing and transportation limitations spent the night with a CA social worker in a location other than a hotel or office.

night placements. Sometimes this would be the same foster home for a few days, sometimes a different foster home each night, and other times the child spent the night in a hotel. The child was noted to be very active, engage in self-harming behaviors, and be aggressive towards caseworkers. Over the course of the 2016-2017 reporting year, the child experienced a combined total of 38 placement exceptions.

- ❖ A 17 year old youth required emergent placement after he was discharged from a secure crisis residential center. Department staff contacted all available placement resources, including local and out of region foster homes, as well as group care facilities. Placement options were limited as the youth is a registered sex offender and has restrictions around younger children. Available placements were either full or declined to accept the youth. The youth also has a history of theft and running away from placements. After spending one night in a DCFS office a foster home was identified.

Spending the night in a hotel or office, even just once, can be traumatizing for children who have experienced abuse and/or neglect, and creates unreasonable demands for Department staff. When a placement cannot be found children are often handed from one caseworker to another as shifts change or caseworkers 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, youth were being transported to a hotel for the night when one child began unbuckling the seatbelt and assaulting another child in the car. In another instance, while awaiting placement a youth became aggressive towards another child in the office. When the caseworker and security guard stepped in to separate the two, the youth began hitting, kicking, and throwing office supplies.

### **Youth Profile: Finding Placement for Teen Who Recently Entered Care**

A 15 year old youth entered foster care through a voluntary placement agreement due to conflict between the youth and her family. She was initially placed in a crisis residential center but was accused of pushing the staff and taken to juvenile detention. After her release she was temporarily placed in a foster home on a night-to-night basis, where she was only allowed to reside during sleeping hours, and had to be picked up in the morning and return in the late evening. After a few days, she ran from this placement. When she returned to care she once again was placed in a foster home that only allowed her to be present for sleeping hours. After several days of this she was once again arrested on new assault charges.

Without a clear path forward with her family, who was no longer willing to allow her to return home, the agency filed a dependency petition. The child said she wanted to be in a consistent foster home where she could attend school. Instead, upon release from detention she was taken to a crisis residential facility. From there she again went to night to night, sleeping hours only, foster placements.

When she began refusing placement in these temporary foster homes she started spending her nights in a local hotel with awake social workers and security guards. Her days were spent in the local CA office. She was no longer attending school. CA staff called law enforcement

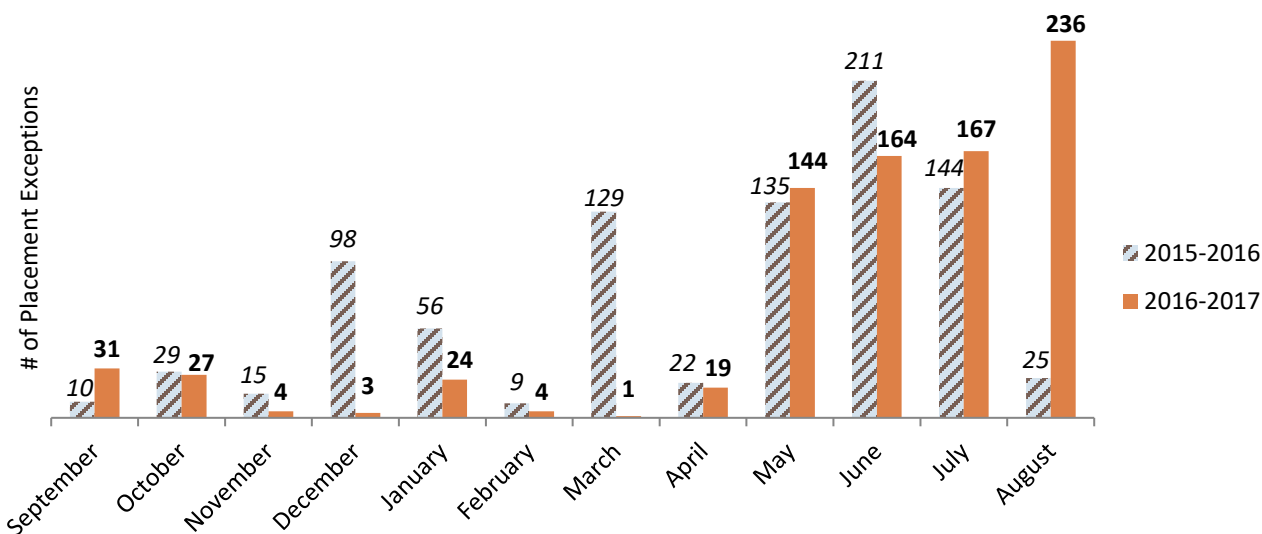


multiple times to intervene when her behaviors became out of control, and when she ran from the office or hotels. She was assaultive to CA staff tasked with supervising her. During one run episode she was physically assaulted. During others she was hospitalized for intoxication. At times her transportation to a hotel room would take so long that she would not go to bed until 3 AM, only to be awoken at 6 AM to return to the CA office. She consistently complained that sitting in the CA office all day was boring, and pleaded to go home. During a period of three months she spent 30 nights in hotels, as well as several night to night foster homes. Eventually CA determined they could not find her a placement in Washington and she was moved to an out of state group home.

## PLACEMENT EXCEPTIONS DATA

The number of placement exceptions varied widely month to month, as shown in Figure 11. August 2017 saw the most placement exceptions with 236, the most in any one month since OFCO began tracking this information. This year the vast majority of placement exceptions occurred over the summer months (May to August). Many children spent only one night in a hotel before a more suitable placement could be identified (103 children, or 52.8 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.<sup>59</sup> The most nights any individual child spent in a hotel or office was 38 (six children had at least 30 placement exceptions). Table 5 provides a further breakdown of the number of placement exceptions per child.

Figure 11: Placement Exceptions by Month



<sup>59</sup> The number of nights a child spent in a hotel or DCFS office is the total number observed for that child over a one year period – not necessarily consecutive nights in a row.

Table 5: **Number of Placement Exceptions per Child, 2017**

Children with Number of Placement Exceptions	Number of Children (n = 195)	Percent of Children
Only 1 placement exception	103	52.82%
2 to 4	41	21.03%
5 to 9	31	15.90%
10 to 20	11	5.64%
21 or more	9	4.62%

OFCO reviewed the 824 placement exceptions reported by CA from September 1, 2016 to August 31, 2017, and the data reveals that this is primarily a **regional issue**, that most of the children involved in placement exceptions have **significant mental health or behavioral needs**, and that a large number of children being placed in hotels or offices were **under the age of ten**.

### A Regional Issue

This placement crisis continues to be most apparent in DSHS Region 2. Just over 85 percent of nights spent in a hotel during the 2016-2017 OFCO reporting year were spent by children with cases assigned to a DCFS office in Region 2.<sup>60</sup> Just over 45 percent of Washington households with children are located in Region 2.<sup>61</sup> In previous years OFCO observed almost no placement exceptions outside of Region 2. This year however, there was an increase in the need for placement exceptions in Region 3. There were no placement exceptions observed in Region 1 and 14.8 percent of observed placement exceptions were in Region 3.<sup>62</sup>

Table 6: **Placement Exceptions by Region, 2017**

Region	# of Placement Exceptions	% of All Placement Exceptions	% of Washington Households with Children
Region 1 North	0	0.0%	12.4%
Region 1 South	0	0.0%	9.7%
Region 2 North	174	21.1%	16.9%
Region 2 South	528	64.1%	28.6%
Region 3 North	77	9.3%	16.3%
Region 3 South	45	5.5%	16.1%

<sup>60</sup> Region 2 North had 174 placement exceptions (21.1 percent). Region 2 South had 528 placement exceptions (64.1 percent).

<sup>61</sup> Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 9/26/2017]. Count of All Households with Children. Retrieved from <http://www.vis.pocdata.org/maps/hh-populationregions>.

<sup>62</sup> Region 3 North had 77 placement exceptions (9.3 percent). Region 3 South had 45 placement exceptions (5.5 percent).

## Demographics of Children Experiencing Placement Exceptions

Of the 195 children OFCO identified who spent at least one night in a hotel or DCFS office, **68.2 percent were male and 31.8 percent were female**. Figure 12 shows that **most of the children were at least ten years of age** (57.9 percent). Just over 42 percent were nine years or younger, with 21 children under the age of four requiring placement in a hotel.

The average number of placement exceptions per child who spent at least one night in a hotel or DCFS office was 4.22. The average number of placement exceptions by age is shown in Figure 4. Compared to the previous reporting year, younger children averaged more nights in hotels/offices. In OFCO's 2015-2016 report, the average number of nights spent in placement exceptions for children ages four and younger was 1.3, but in 2016-2017 it was 4.5 nights. For children ages five to nine the average increased from 2.7 placement exceptions in 2015-2016 to 5.1 placement exceptions in 2016-2017.

Figure 12: **Child Age in Placement Exceptions, 2017**

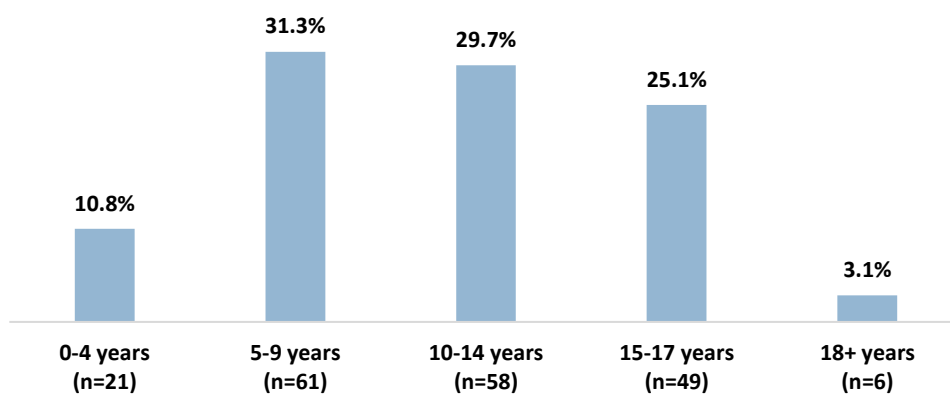
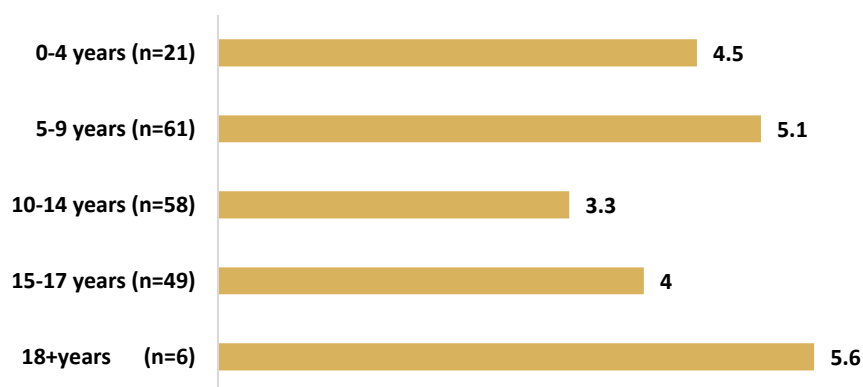


Figure 13: **Average Number of Placement Exceptions of Children by Age, 2017**



Children of color are disproportionately represented in the placement exception population when you look at the out of home care population statewide, as well as when you look at only the Region 2 population. Over 22 percent of children spending a night in a hotel or office were African American or Black compared to 13 percent of the Region 2 out of home care population. Children identified as multiracial are also overrepresented: 23.6 percent of youth in placement exceptions were identified in

the Department's case management system as multiracial, compared to 18 percent of the statewide out of home care population and 14.7 percent of Region 2.

**Table 7: Child Race and Ethnicity, 2017**

	<b>Placement Exception Population</b>	<b>Entire Out of Home Care Population*</b>	<b>Region 2 Out of Home Care Population**</b>
Caucasian	45.64%	65.3%	49.6%
African American or Black	22.56%	8.8%	12.9%
American Indian or Alaska Native	4.62%	5.1%	5.5%
Asian or Pacific Islander	2.05%	1.9%	4.2%
Multiracial	23.59%	18.0%	14.7%
Unknown/Other	1.54%	-	-
Latino / Hispanic	10.26%	19.0%	13.0%

\* *Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 9/26/2017]. Entering Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/ooh-entry-counts>.*

\*\**Region 2 South encompasses Whatcom, Skagit, Snohomish, San Juan, Island and King 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, supervision, 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:

- Physically aggressive or assaultive behaviors (36.4% of children involved in placement exceptions)
- Significant mental health needs (31.8%)
- History of running from placements (23.4%)
- Sexually aggressive behaviors that require high levels of supervision or placement without younger children (21.0%)
- Developmental disabilities (19.0%)

Based on information in placement reports, OFCO observed seventy-nine percent of children have at least one of these characteristics, and 38.4 percent of children were noted to have least two of these characteristics.<sup>63</sup> 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 other placement could be identified. Twelve of the children were in need of respite care but no respite provider was identified.

The ongoing practice of placing children in hotels and state offices indicates a shortage of foster homes and therapeutic placements. The foster families that remain may not feel equipped to look after

<sup>63</sup> Children's Administration states 96% of children experiencing a placement exception have at least one of these listed characteristics.

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.<sup>64</sup> 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.

### **Youth Profile: No Placements Available for Siblings**

- An eleven year old girl in state custody was released from a nine months stay in a treatment facility and placed in a therapeutic foster home. She was asked to leave that home, and then another, due to assaultive behaviors and emergency expulsions from schools. She left her next foster home when she reported she was sexually abused in the home by a foster parent. These allegations were substantiated by the agency. For the next five months she lacked a stable placement, and instead rotated between hotel stays, night-to-night foster homes, and overnight stays with a relative. Her caseworker identified her school as the only source of stability in her life. Throughout this period staff from the supervising office drove the child to and from school most days, despite occasionally significant distances. This constituted many hours in the car every day for CA staff and the child but was noted to have a positive impact on her behavior and happiness. After spending 31 nights in hotels and additional time in night to night foster placements, she was placed in an out of state group home.
- Her younger brother, who is now eight, was placed separately from her during this time. Previously, he spent two years with a relative before they could no longer manage his behaviors. He is a very intelligent and gifted child who suffers with behavioral issues tied to his experiences of trauma. He was moved to a potential adoptive foster home. He was eventually asked to leave this home due to his behaviors as well, and then another, before being placed in a local group home. After successfully completing their program he moved to his younger sister's foster home. He was not successful there and required hospitalization for out of control behaviors. Upon his release he was stable but no longer had a placement. He then spent his first night in a hotel, supervised by CA staff, without incident. Shortly thereafter he was expelled from school and he began to spend his days in CA offices. Because his sister had also disrupted from placement around this time they occasionally spent the day together in the office and/or nights together in a hotel. Meanwhile, at night he bounced between hotels, hospitalizations, and foster homes for several months before moving to another residential group care facility. Overall he spent a total of 37 nights in hotels.

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<sup>64</sup> WAC 388-148-1395.

## OFCO RECOMMENDATIONS

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

Increasing the number of licensed foster homes alone will not address this problem. Rather, our child welfare system must increase the capacity of placements able to meet the needs of all children in state care. Therefore, the Department 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.**

Many of the hotel stays involve children who were placed in a foster home and the placement disrupted. Services to support foster parents and help them meet the needs of children in their care can improve stability and reduce the number of children experiencing a placement crisis. As discussed in Section III of this report, the legislature took action to: expand respite care; provide case aides to temporarily assist foster parents; and identify a system of support services for foster parents including counseling, educational assistance, respite care, and hands-on assistance for children with high risk behaviors.

### **Ensure that Children in State Care Receive Appropriate Mental Health Services.**

The vast majority of children placed in hotels have behavioral issues and/or mental health needs which contribute to placement instability. Our child welfare and behavioral health systems must ensure that children entering care receive treatment and services tailored to their needs. The impact of providing necessary mental health services go far beyond efforts to reduce placement exceptions. These services are essential to child well-being and improved outcomes. When a child's behavioral and psychological problems are effectively treated, the prospects of attaining a safe, stable, and permanent home increase.

### **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.<sup>65</sup>

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.

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<sup>65</sup> The Foster Care Recruitment and Retention Crisis, (August 2016) Dee Wilson. <http://www.uwcita.org/the-foster-care-recruitment-and-retention-crisis/>.

# CA INVOLVEMENT IN ONGOING FAMILY LAW DISPUTES

## Department Shares Concerns About a Parent With the Family Court

OFCO received a complaint that DCFS wrote a letter that was provided to the family court hearing a motion to modify a parenting plan. The letter stated that the non-moving parent was unstable, had mental health issues, and had informed the worker as well as others multiple times that she was no longer interested in parenting the child. The non-moving parent felt this letter was improperly provided to the court and unfairly biased the court's decision in the modification. OFCO contacted the supervisor and she said the practice in that office is to deny all requests for involvement in family court and direct the parent to seek a subpoena if they wish the agency to participate. In this case, however, she felt that the concerns for child safety were serious enough to warrant agency involvement. Furthermore, the agency had records regarding the mother's mental health from earlier interventions in this family, and so the supervisor felt that the information was reliable. Finally, the mother made the statements about no longer wanting the child in front of and to the worker, so he could present that information as a first hand observer. OFCO agreed with the supervisor that the concerns with the mother rose to a level that allowed the worker to properly share this carefully considered information with the family court. OFCO did not make an adverse finding.

OFCO frequently receives complaints regarding DCFS either participating, or refusing to participate, in a variety of family law and related court proceedings. Caseworkers have been asked to speak at, or provide documents for, legal matters including parenting plan disputes, No Contact Order hearings, and Non Parental Custody Petition hearings. In some of these cases DCFS has appeared against the wishes of a party. In others it has not appeared or provided information despite requests that it do so. The decision of how to respond to these family law cases is made on an ad hoc basis by local offices, because current laws and policies lack clarity in directing DCFS' conduct in these circumstances.

Laws and policies generally call for the confidentiality of DCFS case records, subject to many exceptions.<sup>66</sup> For example, as a juvenile justice or care agency<sup>67</sup>, the Department may release records to a court hearing a case involving the child in question.<sup>68</sup> CPS is also empowered to share information with a family or juvenile court hearing a Non Parental Custody petition, when the child has been an

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<sup>66</sup> "Records retained or produced are confidential. The records may be disclosed for purposes directly related to the administration of the program or as otherwise provided by law. Records may be released to other juvenile justice or care agencies only when an investigation or case involving the juvenile is being pursued by the other agency or when that agency is assigned the responsibility of supervising the juvenile," Children's Administration Case Services Policy Manual, Child Protective Services, 2150. Records and Reviews. See also Children's Administration Case Services Policy Manual, Case Planning, Requirements for all Case Planning, 4120, RCW 26.44.030, and WAC 388-15-057.

<sup>67</sup> RCW 13.50.010(10)(b).

<sup>68</sup> RCW 13.50.100(3).

alleged victim of abandonment, abuse, or neglect in a CPS investigation.<sup>69</sup> However, this exception is not specifically made for child custody proceedings between parents, which are the source of the majority of OFCO complaints.

There are some instances where DCFS must appear in a court hearing to which it is not a party, such as when it is subpoenaed, or when a court orders it to appear. When DCFS is properly called to appear before a court it generally does so without issue. There are occasions, however, when a concerned parent informally asks a caseworker to share information about an ongoing case with a family court. In this instance the Department usually refuses to do so and informs the parent they may request their records from the Public Disclosure Unit.

Sometimes, however, most often when there is an identified safety threat to a child, a caseworker will prepare a statement for a family court hearing describing the agency's involvement and child safety concerns. While the caseworker's disclosure may assist the family court in making an informed decision, it often alienates the other parent, and negatively impacts any ongoing investigation and the Department's ability to engage the whole family. Furthermore, parents have complained to OFCO that they are unable to find any legal authority authorizing DCFS to disclose confidential information in this setting. When OFCO has discussed this issue with DCFS management, they described engaging in a cost benefit analysis weighing the privacy of the concerning parent versus the safety of the child.

In other instances a caseworker has prepared a statement for family court when there is no imminent safety threat. This usually occurs when a parent asks the caseworker to provide a letter to the court, either explicitly supporting one parent, or sharing concerns about the other. When OFCO has discussed these situations with DCFS management the Department generally is not supportive of disclosing case information and attribute caseworkers' actions to a lack of training and a failure to seek advice from superiors.

These complaints to OFCO identify a gap in the information available to family courts under these circumstances. Parents are unable to obtain records through the Public Disclosure Unit while the CPS case remains open. However, often a parent files for a modification of a parenting plan contemporaneous with an ongoing CPS investigation.

## **OFCO RECOMMENDATION:**

### **Develop Policy and Procedure to Guide Caseworkers Serving Families Involved in Family Court**

Some CA supervisors OFCO has contacted say that absent clear directives on this issue they advise their staff not to provide any information to family courts unless there is an imminent safety concern that the protective parent would otherwise have difficulty proving. Other supervisors follow a practice of only providing information in a family court case after receiving a subpoena or court order.

Consistent with existing state laws governing the release of confidential records, DCFS should develop clear policies and guidelines directing supervisors and caseworkers on sharing relevant case information with a court hearing a case involving a DCFS involved child. These policies should recognize both the privacy interests involved as well as the need to provide information impacting child safety. It should

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<sup>69</sup> RCW 13/50/100(4)(a).



guide workers on what kind of information is appropriate to share, focusing any disclosure on factual, objective and unbiased information, and should discourage workers from sharing opinions. It is unlikely a policy could adequately address all possible family court scenarios workers might be asked to participate in, thus the policy should be a flexible framework that allows some discretion on the part of the worker and supervisor. The creation of this policy will not only provide direction to agency staff, it will also provide guidance to constituents and others impacted as to what DCFS is authorized to do, and potentially reduce their frustration with the agency.

### **Caseworker Provides Information to Family Court Without Consulting Supervisor**

A new caseworker was investigating a referral alleging abuse and neglect of three non-dependent children. The mother of these children motioned the family court for a modification of the parenting plan at the same time the investigation opened. The worker quickly established that no abuse or neglect appeared to have occurred, but continued to complete a thorough investigation, including interviews with all of the children. The mother asked the caseworker to prepare a statement for family court indicating that he was supportive of the court amending the parenting plan so as to separate these children's visits with their father from their step siblings' visits to the home, based on complaints the children had about their step siblings. The caseworker wrote this letter without consulting with his supervisor. In the modification hearing the request for that change to the visitation plan was granted (OFCO did not have access to any record indicating the court relied on this statement in making its decision, however the father stated it had). OFCO investigated and confirmed that the letter was created and disseminated by the worker. The local Area Administrator informed OFCO that the worker was newly hired at the time and had not consulted with a supervisor before taking these actions. She agreed to train her unit on circumstances when providing information to family court might be appropriate and when it would not, and for them to always consult with supervisors on these matters. Because of the lack of clear direction to workers and the amenability of the office to address this as a training issue OFCO did not make an adverse finding against the unit.

# HELPING FAMILIES WHEN A CHILD CANNOT RETURN OR SAFELY REMAIN IN THE HOME

OFCO frequently receives complaints concerning families who encounter difficulty obtaining out-of-home placement for children with certain complex needs. Some of these children have developmental delays, while others have behavioral or mental health concerns that can no longer be managed at home without presenting a significant risk of harm to themselves or family members. In other cases, the child sexually abused a sibling and a protection order prevents the child from re-entering the home. These cases reach a crisis point when the child is released from detention or juvenile rehabilitation, or discharged from a hospital or other treatment facility, and the parent refuses to pick up the child. When parents then seek help with out-of-home placement and services for the child, it is not clear what agency is responsible for assisting these families.

The summaries of two complaints made to OFCO illustrate the challenges in obtaining out of home placements for children with special behavior and mental health needs:

- ❖ *A teenager was placed in a Juvenile Rehabilitation Administration (JRA) facility for a sexual offense against a younger sibling. An order also prohibited contact between the youth and this sibling. Prior to the youth's release date from the JRA facility, the parent contacted Child Protective Services (CPS) and JRA seeking assistance finding a placement for the older child and asking about potentially pursuing a dependency case. The Department told the parent that this was outside its jurisdiction and that it is the parent's responsibility to secure a placement. On the youth's discharge date, the parent had not found a placement for the child and was unable to take the youth home due to the order. CPS then investigated the parent for abandonment/neglect. CPS also provided funds for the parent to stay temporarily in a hotel with the youth. Efforts to locate a long term placement for the child were not successful, and the parent placed the child at a youth shelter. An attorney filed a dependency petition on behalf of the youth and the petition was approved by the court.*
- ❖ *The parent of a teenager repeatedly contacted CPS requesting placement and services to address the teen's history of mental health issues, drug and alcohol abuse, running away, and criminal behavior. The parent asked CPS about filing a Child in Need of Services (CHINS) petition<sup>70</sup> and was reportedly provided incorrect information that a parent cannot file a CHINS. The youth was subsequently detained for a juvenile offense. When the parent failed to pick the teen up from detention, CPS investigated the parent for abandoning the child. The parent later obtained in-patient substance abuse treatment for this youth.*

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<sup>70</sup> RCW.13.32A.

## **LEGAL BASIS FOR A DEPENDENCY ACTION WHEN A PARENT IS NOT CAPABLE OF CARING FOR A CHILD**

A child dependency proceeding provides oversight and structure for the out-of-home placement of a child, and services for the family, when parents cannot adequately protect or care for their children. While a dependency case is usually based on allegations of child abuse or neglect, a dependency petition may also address circumstances where a child requires out-of-home placement because there is no parent, guardian, or custodian capable of adequately caring for the child.<sup>71</sup> In such cases, a dependency does not turn on allegations of maltreatment or parental unfitness, rather, it allows consideration of both a child's special needs and any limitations or other circumstances which affect a parent's ability to respond to the child's needs.<sup>72</sup> A parent's inability to provide necessary medical care, including mental health care, may support a finding of dependency.<sup>73</sup> Nonetheless, DCFS is often unwilling to file for dependency absent allegations of child abuse or neglect.

### **OFCO RECOMMENDATIONS:**

#### **Develop Policies and Procedures to Provide Placement and Services when a Child's Needs and Behaviors are Beyond the Parent's Abilities to Manage**

While a dependency case can address circumstances where a child requires out-of-home placement because the parent is not capable of adequately caring for the child, DCFS is often unwilling to file for dependency absent allegations of child abuse or neglect. The Department should develop and implement policies that recognize circumstances where a dependency proceeding is appropriate when the child's needs are beyond the parent's abilities, yet no abuse or neglect is present, and guide agency practice in a fair and consistent manner.

#### **Improve Access to Child in Need of Services (CHINS) Proceedings and Temporary Out-of-Home Care**

A CHINS placement provides for temporary out-of-home care designed to provide the family and the youth the opportunity to resolve conflict, where out-of-home placement is in the best interests of the youth and the family.<sup>74</sup> When a CHINS petition is filed, the child may be placed by the Department in a licensed foster family home, licensed group home facility, Crisis Residential Center or any other suitable residence. A CHINS intervention is time limited<sup>75</sup> and provides a temporary placement which can enable the Department and family to identify a long term plan and appropriate services to meet the child's needs. The Department must, upon request, assist either a parent or child in the filing of the petition. Reports to OFCO, however, describe DCFS workers discouraging parents and youth from seeking a CHINS, telling parents and youth they cannot file a CHINS petition, and/or telling parents and youth that they must find their own out-of-home placement. Child welfare policies, training, supervision and practice must ensure the Department fulfills its duty to assist families seeking a CHINS proceeding.

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<sup>71</sup> RCW 13.34.030(6)(a)-(c).

<sup>72</sup> In re Schermer, 161 Wn.2d 927, 169 P.3d 452 (2007).

<sup>73</sup> In re Schermer.

<sup>74</sup> RCW 13.32A.

<sup>75</sup> Out-of-home placement cannot be continued beyond 180 days of the first review hearing.

## **Develop Placement Resources and Establish Effective Statewide Protocols between State Agencies to Provide and Expedite Out-of-Home Care**

The cases above illustrate that families often struggle to access necessary out-of-home treatment or care when a child is discharged from a state system other than the child welfare system, and that CPS is nonetheless left responding to this crisis. The various agencies serving these families must close this gap. DCFS, JRA, the Developmental Disabilities Administration (DDA), Behavioral Health and Service Integration Administration (BHA), and other agencies serving children must coordinate efforts to ensure that necessary and timely residential and treatment services are provided to children. The ongoing use of detention facilities, emergency homeless shelters, and hotels as crisis placement resources for children is not acceptable and likely contributes to youth homelessness.

## **Parents Seeking Help Should Not Be Threatened with “Abandonment”**

Our child welfare system should help parents who are actively seeking services and placement for a child when circumstances dictate that the child cannot return home, not threaten them with allegations of child abandonment<sup>76</sup>. In these situations, the parent has no intent to forego parental duties and responsibilities, in fact, they are trying to fulfill those duties by seeking appropriate care and services for their child. The Department should develop procedures and practices to engage families in a solution based manner, particularly when the child is involved in multiple systems, such as child welfare, mental health, or juvenile justice.

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<sup>76</sup> RCW 13.34.030 defines “abandoned” as an intent to forego, for an extended period, parental rights or responsibilities despite an ability to exercise such rights and responsibilities. No contact between the child and the child's parent, guardian, or other custodian for a period of three months creates a rebuttable presumption of abandonment.

WAC 388-15-011 defines “child abandonment as: “(1) A Parent or guardian abandons a child when the parent or guardian is responsible for the care, education, or support of a child and:

- (a) Deserts the child in any manner whatever with the intent to abandon the child;
- (b) Leaves a child without the means or ability to obtain one or more of the basic necessities of life such as food, water, shelter, clothing, hygiene, and medically necessary health care; or
- (c) Forgoes for an extended period of time parental rights, functions, duties and obligations despite an ability to exercise such rights, duties, and obligations.

# PREPARING FOR THE NEW DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

In July 2017 legislation establishing the Department of Children, Youth and Families (DCYF) was signed into law.<sup>77</sup> This represents the culmination of efforts spanning decades to redesign child welfare services in order to protect children from abuse and neglect, strengthen families, and improve outcomes. Beginning July 1, 2018, Children’s Administration and the Department of Early Learning will combine and form the DCYF. The governor and legislature will also review recommendations regarding whether the Juvenile Rehabilitation division and the Office of Homeless Youth Prevention should be integrated into the DCYF by July 2019.

This blueprint for the DCYF, however, goes far beyond realigning and consolidating existing state agencies, and represents a fundamental change in the delivery of child welfare services to **protect children from harm**, and promote healthy development by providing high quality **prevention, intervention** and **early education services**. Included in the design of the DCYF is a focus on measurable outcomes, transparency and oversight with the goal of improving public accountability for the child welfare agency. To ensure transparency, the DCYF is required to make performance and outcome data available to the public. Enhanced oversight of the DCYF includes a diverse external stakeholder committee to advise the DCYF on priorities for practice, policies and system reform, and the creation of the Oversight Board for Children Youth and Families.

## DCYF Goals and Outcome Measures

The DCYF must report on outcome measures and progress towards specific goals including:

- ❖ Preventing child abuse and neglect
- ❖ Improving child safety, permanency and well-being
- ❖ Reducing criminal justice involvement and recidivism
- ❖ Improving kindergarten-readiness
- ❖ Improving family reunification
- ❖ Increasing graduation rates and successful transitions to adulthood
- ❖ Reducing racial and ethnic disproportionality and disparities

## OFCO’s Expanded Role in the Oversight of DCYF

OFCO’s duties will be expanded to provide information on the rights and responsibilities of individuals receiving juvenile justice, juvenile rehabilitation, and child early learning, and on the procedures for these services. OFCO is also charged with establishing the Oversight Board for Children Youth and Families. This board represents a level of agency oversight unparalleled within the national child welfare

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<sup>77</sup> HB 1661; Chapter 6, Laws of 2017. <http://lawfilesexternal.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/House/1661-S2.SL.pdf#page=1>.

landscape. The board's diverse membership includes legislators, subject matter experts,<sup>78</sup> and representatives from stakeholder groups involved in child welfare. In order to measure DCYF's progress in meeting performance goals, as well as general system oversight, the board has broad authority to: obtain data and information from the DCYF, request investigations by OFCO and access relevant OFCO records, meet with and receive feedback from stakeholders, and review DCYF contracts with service providers. The oversight board is further empowered to review, overturn, modify or uphold certain DCYF licensing compliance agreements. The first meeting of the oversight board will be on or after July 1, 2018, and the initial annual report to the legislature and the governor is due December 1, 2019.

The first step to establish the Oversight Board is to identify membership. During the 2018 legislative session, four legislative members, two senators and two representatives, will be appointed by the two major caucuses of the Senate and the House of Representatives. The remaining members of the board are nominated by the Governor and approved by the appointed legislators. OFCO will begin working with the Legislature, Office of the Governor and stakeholder groups to identify candidates for nomination to the board. The purpose, board membership, powers and duties of the oversight board are outlined in more detail below.

## **OVERSIGHT BOARD FOR CHILDREN YOUTH AND FAMILIES**

### **Purpose**

Monitor and ensure that the DCYF achieves the stated outcomes and complies with laws, rules, policies and procedures pertaining to early learning, juvenile rehabilitation, juvenile justice, and children and family services.

### **Membership of Oversight Board (18 members)**

- 4 Legislators: 2 senators and 2 representatives with one member from each major caucus.
- 1 non-voting representative from the Governor's Office.
- 4 subject matter experts encompassing: early learning; child welfare; juvenile rehabilitation and justice; reducing disparities in child outcomes by family income, race, and ethnicity.
- 2 tribal representatives: one from western Washington and one from eastern Washington.
- 1 current or former foster parent.
- 1 representative from an organization advocating for "Best Interest of the Child".
- 1 representative from a parent stakeholder group.
- 1 law enforcement representative.
- 1 child welfare caseworker representative.
- 1 early childhood learning program implementation practitioner.
- 1 judicial representative presiding over juvenile/ child welfare proceedings.

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<sup>78</sup> Legislation requires a total of four subject matter experts, one expert for each for the following fields: early learning; child welfare; juvenile rehabilitation and justice; and reducing disparities in child outcomes by family income and race and ethnicity. Chapter 6, Laws of 2017 (SESSHB 1661), Section 101(10)(a).

### **Powers of the Oversight Board**

Powers exercised by a majority vote of the Board include:

- Select officers and adopt rules for orderly procedure.
- General oversight over the performance and policies of the DCYF and provide advice and input to the DCYF and governor.
- Receive quarterly reports from the Office of Innovation, Alignment, and Accountability regarding the implementation of the DCYF (July 1, 2018 to July 1, 2019).
- Request investigations and receive reports from OFCO.
- Obtain access to all relevant records in OFCO's possession.
- Request and receive information, outcome data, documents, etc., from DCYF.
- Determine whether the DCYF is achieving its performance measures.
- Review DCYF decisions regarding licensing compliance agreements that do not involve a violation of health and safety standards, with the authority to overturn, change, or uphold DCYF's decision.
- Conduct annual reviews of a sample of DCYF contracts for services to ensure they are performance based and assess measures included in contracts.

### **Duties and Responsibilities of the Oversight Board**

- The first meeting will be on or after July 1, 2018.
- The Board will immediately assume the duties of the Legislative Children's Oversight Committee (LCOC).
- Assumes the full function of the LCOC by July 2019.
- Convene stakeholder meetings at least twice a year to allow feedback regarding contracting with DCYF, the use of local, state, private and federal funds, and other matters related to DCYF's duties. The oversight board's meetings are open to the public (RCW 42.30).
- Review existing surveys of providers, customers, parent groups, and external services to assess whether DCYF is effectively delivering services, and conduct additional surveys as necessary.
- Issue an annual report to the governor and the legislature reviewing DCYF's progress towards meeting performance measures and outcomes, and review DCYF's strategic plan, policies and rules.

The creation of DCYF and fundamental changes in the delivery of child welfare services to the people of Washington State provide an opportunity for innovation informed by measurable outcomes. Independent system oversight by both OFCO, the Oversight Board, will monitor and guide the development of this agency and its impact on Washington's citizens.

## **V. APPENDICES**

### **APPENDIX A:**

Complaints Received by Region and Office

### **APPENDIX B:**

Child Demographics

### **APPENDIX C:**

Adverse Findings by Office



# APPENDIX A: COMPLAINT INVESTIGATIONS COMPLETED 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

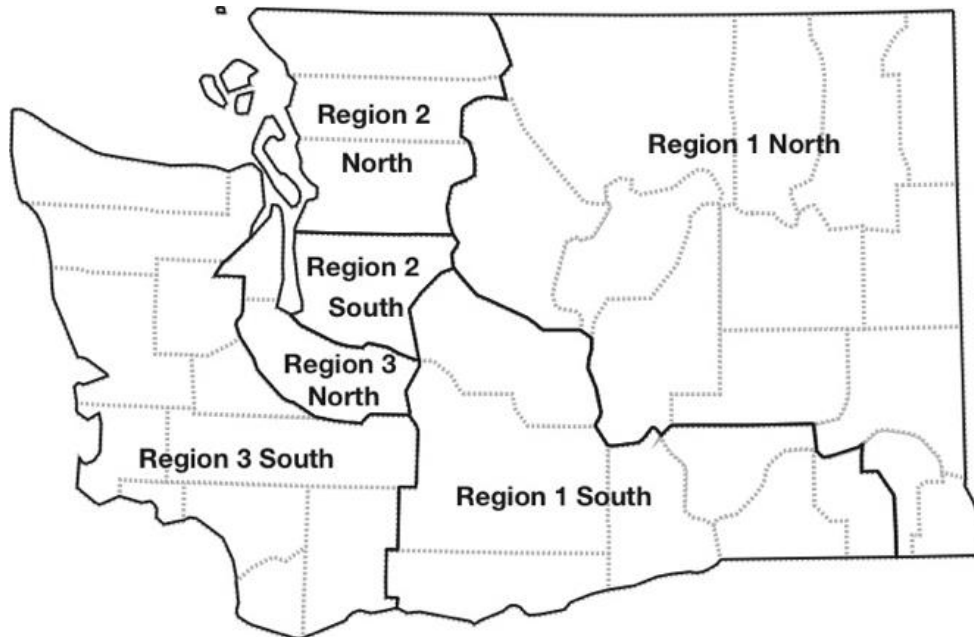


Table 9: Populations by DSHS Region<sup>79</sup>

	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%

<sup>79</sup> Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 9/20/2017]. Count of All Children. Retrieved from <http://www.vis.pocdata.org/maps/child-populationregions>.

Figure 14: **OFCO Complaint Investigations Completed by DSHS Region, 2017**

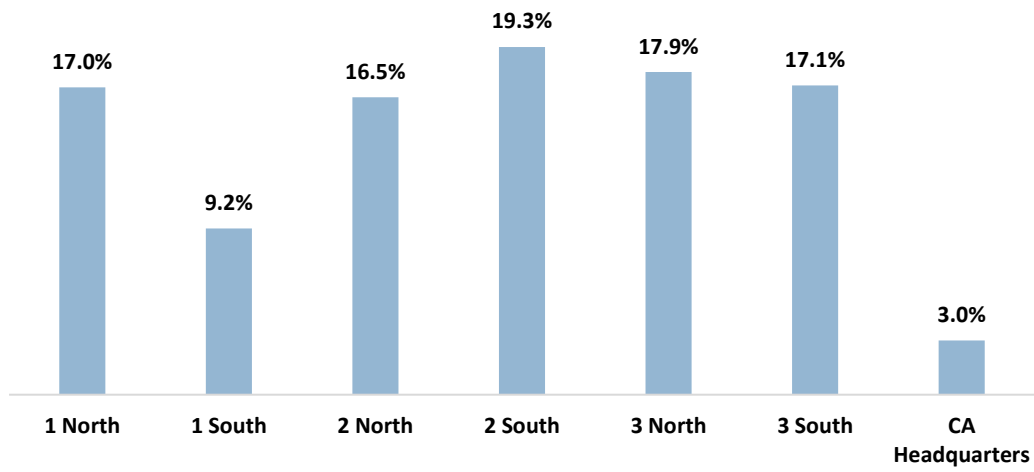


Table 9: OFCO Complaint Investigations Completed by Office, 2017

REGION	OFFICE		REGION	OFFICE	
<b>1 North</b>	Spokane DCFS	85	<b>2 South</b>	King South DCFS	96
	Colville DCFS	23		King West DCFS	25
	Wenatchee DCFS	21		Office of Indian Child Welfare	21
	Moses Lake DCFS	15		King East DCFS	17
	Omak DCFS	4		Martin Luther King Jr. DCFS	10
	Newport DCFS	4		White Center DCFS	3
	Colfax DCFS	4		DCFS Central Office (Region 2 South)	7
	Clarkston DCFS	3		DLR (Region 2 South)	1
<b>1 South</b>	Yakima DCFS	27	<b>3 North</b>	Bremerton/Kitsap DCFS	62
	Richland/Tri-Cities DCFS	18		Tacoma/Pierce West DCFS	46
	Walla Walla DCFS	16		Lakewood/Pierce South DCFS	30
	Ellensburg DCFS	13		Puyallup/Pierce East DCFS	24
	Goldendale DCFS	3		DCFS Central Office (Region 3 North)	1
	Sunnyside DCFS	3		DLR (Region 3 North)	4
	Toppenish DCFS	3	<b>3 South</b>	Vancouver DCFS	51
	DLR (Region 1 South)	3		Tumwater DCFS	20
<b>2 North</b>	Arlington/Smokey Point DCFS	34		Kelso DCFS	19
	Bellingham DCFS	29		Aberdeen DCFS	14
	Everett DCFS	23		Centralia DCFS	13
	Mount Vernon DCFS	22		Shelton DCFS	12
	Monroe/Sky Valley DCFS	16		Port Angeles DCFS	7
	Alderwood/Lynnwood DCFS	13		Stevenson DCFS	5
	Oak Harbor DCFS	7		Port Townsend DCFS	3
	Friday Harbor DCFS	1		South Bend DCFS	3
	DLR (Region 2 North)	6		Forks	3
	DCFS Central Office (Region 2 North)	3		Long Beach DCFS	2
				DCFS Central Office (Region 3 South)	3
				DLR (Region 3 South)	5
			<b>Other</b>	Central Intake Unit	10
				Children's Administration	8
				Headquarters	
				DLR-CPS	7
				Adoption Support Services	3
				Complaints about non-CA agencies	21

## 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.<sup>80</sup> 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 10: **Child Age, 2017**

	2017 OFCO Complaints	2017 Out of Home Care Population
0 - 4 Years	39.8%	43%
5 - 9 Years	30.0%	26%
10 - 14 Years	22.4%	18%
15 - 17 Years	6.4%	13%
18 Years and Older	1.2%	-

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<sup>80</sup> Partners for Our Children Data Portal Team. (2017). [Graph representation of Washington state child welfare data 11/9/2017]. Children in Out-of-Home Care (Count). Retrieved from <http://pocdata.org/>

# APPENDIX C: ADVERSE FINDINGS BY OFFICE

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

Table 11: Adverse Findings by Office, 2017

REGION	OFFICE	#
1 North	Spokane DCFS	3
1 South	Ellensburg DCFS	1
	Walla Walla DCFS	1
	Yakima DCFS	1
2 North	Mount Vernon DCFS	2
	Monroe/Sky Valley DCFS	2
2 South	King South DCFS	13
	Indian Child Welfare Office	9
	MLK Jr. DCFS	3
	King East DCFS	2
	King West DCFS	3
3 North	Lakewood DCFS	1
3 South	Kelso DCFS	7
	Vancouver DCFS	3
	Oak Harbor DCFS	1

# 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 Birkliid** 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. Birkliid is a graduate of Western Washington University and the University of Washington Evans School of Public Policy and Governance.