Public Report

Ombudsman Investigation — Alaska Department of Family and Community Services, Office of Children's Services

2022-03-0400

December 5, 2024

Ombudsman investigations are confidential according to law. The Ombudsman is permitted to disclose information that is necessary to carry out her statutory duties and to support recommendations (AS 24.55.160(b)).

Due to the extremely sensitive nature of the complaint, the Ombudsman is providing a limited summary of the complaint allegations and investigation. All identifying information has been removed to protect the privacy of the children and families involved.

Introduction

On March 10, 2022, the Ombudsman received a complaint from a foster parent who alleged that the Office of Children's Services (OCS) unfairly investigated a Protective Services Report (PSR) about them. The foster parent also alleged that OCS did not seek timely mental health services or placement for the child and that OCS made an inappropriate placement decision for the child.

Assistant Ombudsman Elizabeth Jenkins investigated this complaint.

Allegations

The Alaska State Ombudsman investigated six allegations and made the following findings:

1. Unfair:[1] The Office of Children's Services unfairly investigated a Protective Services Report about a foster parent. ***Not supported by the evidence.***

[1] In an ombudsman investigation, "unfair" means that the agency decision was not supported by reasons or by a statement of evidence relied on, or the agency applied standards or principles inconsistently in making a decision.

2. Unreasonable:[2] The Office of Children's Services did not conduct the required in-person visits to foster placements. ***Supported by the evidence.***

3. Unreasonable: The Office of Children's Services did not provide appropriate mental health interventions for a child with complex needs. ***Partially supported by the evidence.***

4. Unreasonable: The Office of Children's Services did not follow policy when making a placement decision. ***Supported by the evidence.***

5. Unreasonable: The Office of Children's Services did not fully explain a child's behaviors to a foster parent. ***Supported by the evidence.***

6. Unreasonable: The Office of Children's Services mishandled Protective Services Reports about child maltreatment. ***Supported by the evidence.***

Recommendations

The Ombudsman consulted with OCS Leadership on August 12, 2024 and September 18, 2024, and OCS agreed with all of the Ombudsman's findings. The Ombudsman made recommendations to resolve the issues identified in the complaint pursuant to AS 24.55.150(b). The following recommendations were proposed pursuant to AS 24.55.180 and 21 AAC 25.200. OCS was given the opportunity to respond to the recommendations pursuant to AS 24.55.180. The agency's response is incorporated into this final report.

Recommendation 1: The Office of Children's Services should implement the Ombudsman's previous recommendations.

In 2017, the Alaska State Ombudsman concluded an investigation of a complaint that OCS failed to respond to reports of child-on-child sexual abuse involving children in foster care, and that OCS failed to protect a foster child from a known risk of harm from child-on-child sexual abuse. Due

[2] In an ombudsman investigation, "unreasonable" means (A) the agency adopted and followed a procedure in managing a program that was inconsistent with, or failed to achieve, the purposes of the program; (B) the agency adopted and followed a procedure that denied the complainant's valid application for a program benefit; or (C) the agency's action was inconsistent with agency policy and thereby placed the complainant at a disadvantage relative to all others.

to the sensitive nature of the complaint, and to protect the privacy of the children involved, the Ombudsman did not publish a public report of that investigation.

The Ombudsman found the allegations justified and made six recommendations. OCS accepted five of the six recommendations. While OCS accepted most of the previous recommendations, the agency has not fully implemented the actions intended to address deficiencies in the agency's response to and mitigation of harm caused by a foster child/youth's problematic sexualized behaviors. The previous investigation and the 2024 investigation identified common issues within OCS's framework. Therefore, the Ombudsman reiterated the previous recommendations as described below:

Recommendation 1A: OCS should develop policy and procedures addressing the issue of child-on-child sexual abuse between children in OCS custody, to include:

- a standard definition of child-on-child sexual abuse;
- clarification of the agency's role and responsibilities with regard to incidents of child-on-child sexual abuse; and
- guidelines for responding to and managing these incidents as well as for assessing, treating, and providing services to children who are either victims or perpetrators in incidents of child-on-child sexual abuse.

Recommendation 1B: OCS should provide education and training to agency staff on the issues of child-on-child sexual abuse and children with sexual behavior problems.

Recommendation 1C: OCS should implement a standardized alert or flagging system in ORCA (OCS's case management system) to identify children in state custody who are victims of sexual abuse or who exhibit sexualized behaviors.

OCS declined to implement Recommendation 1C in 2017, stating that, while ORCA has this flagging function, "flagging this particular behavioral pattern (as opposed to other specific behaviors) is problematic and could lead to an overwhelming number of flagged children in the

system, labeling children unnecessarily, and a diluting effect over time." OCS agreed to take this recommendation "under advisement."

ORCA is an antiquated case management system that no longer supports the efficient or effective management of Alaska's child welfare system. OCS estimates that a new comprehensive child welfare information system (CCWIS) will cost $50-80 million dollars. Any new case management system must include timely and accurate information about children in state custody to achieve compliance with federal data requirements. 45 CFR §1355.52(b) requires that all states' child protection agencies maintain a CCWIS that collects "data that supports the efficient, effective, and economical administration" of the child protection program, which includes "data to support federal child welfare laws, regulations, and policies;" "case management data to support federal audits, reviews, and other monitoring activities;" "data to support state or tribal child welfare laws, regulations, policies, practices, reporting requirements, audits, program evaluations, and reviews;" "data to support specific measures taken to comply with the . . . Indian Child Welfare Act;" and "data for the National Child Abuse and Neglect Data System." As discussed in this report, OCS failed to meet state and federal statutory requirements in the provision of services to the child and their foster parents, due in large part to the lack of complete and easily accessible information in ORCA. Therefore, the Ombudsman encourages OCS to implement a tool for clearly identifying children with safety concerns, challenging behaviors, and complex needs in ORCA and the replacement CCWIS.

Recommendation 1D: OCS should take steps to improve collaboration between caseworkers and licensing workers when making placement decisions for children who are victims of adult sexual abuse, victims or perpetrators in incidents of child-on-child sexual abuse, or who exhibit problematic sexualized behavior.

Agency Response to Recommendation 1:

OCS partially accepted this recommendation.[3] OCS noted that Alaska lacks the regulatory authority to investigate a child as the perpetrator in situations of child-on-child sexual abuse.[4] The agency, therefore, believes it would not be meaningful to adopt a standard definition of child-on-child sexual abuse at this time.[5] OCS responded that it will consider implementing a flagging system to identify children in state custody who are victims of sexual abuse or who exhibit sexualized behaviors in the new CCWIS.[6] OCS also shared with the Ombudsman the agency's efforts to improve collaboration between caseworkers and licensing workers.[7]

Recommendation 2 : The Office of Children's Services should adopt a foster parent agreement.

OCS is required to discuss a child's "special problems or needs" with the foster parent at the time of placement, and that information must be provided to the foster parent as part of the child's routine documentation, known as the "red packet" or "red folder." OCS should document the foster parent's acknowledgement that they understand the child's known behaviors (within 24 hours or the next business day) after the placement occurs. The Ombudsman recommends that OCS implement a foster parent agreement that does both of these things and provides a record of compliance. The State of California Health and Human Services Agency agreement is an example that OCS could use as a template to develop its own.

Agency Response to Recommendation 2:

OCS accepted this recommendation.[8]

Recommendation 3: The Office of Children's Services should strengthen state partnerships.

[3] Office of Children's Services Response to Preliminary Report, Ombudsman Complaint 2022-03-0400 (June 26, 2024).
[4] *See* Ombudsman Consultation Meeting with OCS Leadership (August 12, 2024).
[5] *See id*.
[6] *See id*.
[7] *See id*.
[8] *See id.*

OCS should implement practices that streamline and strengthen how the agency supports foster children and youth with complex disabilities. OCS can do this by leveraging existing programs and strategies within the Department of Family and Community Services (DFCS) and Department of Health (DOH). Given that foster children and youth with complex disabilities and challenging behaviors are most often Medicaid recipients and can be placed in state facilities like Alaska Psychiatric Institute or Division of Juvenile Justice facilities when their behaviors escalate beyond what a foster home can manage, it seems wise for the departments to coordinate efforts and work together to serve these children.

OCS should establish a monthly meeting with the Complex Care Systems Coordinator in the DFCS. The Coordinator is responsible for ensuring that the divisions within DFCS work together to support Alaskans experiencing complex needs due to behavioral health and intellectual and developmental disabilities (IDD). The Coordinator is also responsible for improving communication and coordination of efforts — within DFCS and with DOH — to identify service and placement needs for individuals with complex needs.

OCS should assign qualified staff to participate on the Case Response Team, part of the new Complex Care Coordination Infrastructure established in 2023. The Case Response Team was created to "support individual cases and meet regularly to communicate, coordinate care, and align payment for emergent individual cases not served by existing complex care groups."[9]

OCS should establish a partnership with the Complex Behavior Collaborative (within DOH) to connect foster parents and providers of services to children/youth with challenging behaviors to experts who can help address those behaviors. The Complex Behavior Collaborative has operated since 2012 to help reduce the institutionalization of people with complex needs who demonstrate aggressive, assaultive, and other challenging behaviors that make it difficult for them to live at home or in the community. The Complex Behavior Collaborative offers consultation and training to providers and clients' natural supports (which would include foster parents).

[9] *Overview of Alaska's Behavioral Health System of Care for Children,* Department of Family and Community Services (April 2023).

OCS should partner with the Division of Senior and Disabilities Services (within DOH) to streamline the application process for foster children and youth eligible for home and community-based Medicaid Waiver Services. OCS should designate a team of staff members responsible for collecting medical, educational, and other records necessary to apply for Waiver Services. This centralized team should be trained and equipped to assemble the record, complete and submit the application, and shepherd the application through completion. This team should also build and maintain relationships with care coordinators qualified to serve children and youth with the most complex disabilities, in order to eliminate as many barriers to accessing services as possible.

Agency Response to Recommendation 3:

The Ombudsman held a consultation with DOH on September 17, 2024 and DFCS on September 18, 2024. The Departments provided evidence that collaboration is occurring within the newly established Complex Care Coordination infrastructure to improve outcomes for children and youth requiring services. The Ombudsman is persuaded that the Complex Care Coordination infrastructure meets the intent of Recommendation 3 as it relates to DFCS and DOH.

Recommendation 4: The Office of Children's Services should establish a Language Access Plan.

OCS asks prospective foster parents their language of origin and whether translation services are needed. However, this investigation showed that this is not sufficient to ensure that OCS staff and foster parents with limited English proficiency are communicating effectively. The Ombudsman recommends that OCS establish a Language Access Plan to address how OCS workers can effectively communicate information to foster parents with limited English proficiency. This plan could be broadened to include application to children and biological families as well.

According to the Centers for Medicare and Medicaid Services, "a language access plan is a document that spells out how to provide services to individuals who are non-English speaking or have limited English proficiency. Language access plans should be tailored to individual

organizations, but may include similar sections, such as a needs assessment, language services offered, notices, training for staff, and evaluation."[10]

Agency Response to Recommendation 4:

OCS rejected this recommendation, but informed the Ombudsman of other language services the Department was providing.[11]

Recommendation 5: The Office of Children's Services should refresh staff's training on emergency response.

OCS should implement training for after-hours on-call workers, intake workers, and supervisors on the legal and policy requirements for responding to emergency situations involving sexual abuse or serious harm to a child/youth in foster care. OCS should include and coordinate with the child advocacy centers, law enforcement agencies, emergency departments, mental health agencies, and victim services that respond to cases of serious child abuse, including sexual abuse.

Agency Response to Recommendation 5:

OCS's response to this recommendation acknowledged the issue without committing to implementing a solution: "Over the past year it has been noticed OCS staff, at all levels, would be best served by a refresher training about Child Advocacy Centers, why they exist, how we work together, and what our shared mission would be. This is something we will continue to engage in pursuing."[12]

[10] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf (last visited May 15, 2024).
[11] *See* Email from Kim Guay, OCS Director, to Elizabeth Jenkins, Assistant Ombudsman (September 5, 2024).
[12] Office of Children's Services Response to Preliminary Report, Ombudsman Complaint 2022-03-0400 (June 26, 2024).

Recommendation 6: The Office of Children's Services should coordinate with law enforcement to hasten the response to sexual abuse allegations.

OCS should invite the primary law enforcement agencies that investigate reports of sexual abuse to help develop a step-by-step process for responding to reports of sexual abuse in a way that supports effective and timely investigation. With assistance from law enforcement partners, OCS should:

1. establish a protocol for responding to a report of sexual abuse that preserves evidence and assures that the victim is connected to appropriate medical services;

2. adopt a procedure for effectively sending Protective Services Reports to criminal investigators as soon as practicable; and

3. adopt a decision-making tool and checklist that documents how OCS decides whether to refer a Protective Services Reports to law enforcement and ensures that all the necessary steps are taken to ensure that law enforcement receives the Protective Services Report.

Agency Response to Recommendation 6:

OCS accepted this recommendation.[13] OCS responded that the agency has engaged in these conversations and is committed to continuing the discussion with law enforcement to make improvements.[14]

Recommendation 7: The Department of Family and Community Services and the Department of Health should develop a more robust network of care to serve children with complex needs.

[13] *See* Supra 4.
[14] *See* id.

Children and youth in state custody can need an intermediate level of care so they can safely and successfully transition to live with a foster parent or be reunited with family. Youth with intellectual and/or physical disabilities face barriers to accessing these services. Children with complex needs have been taken to hospital emergency rooms, monitored by private contractors in hotels, and endured stopgap living arrangements that do not address the child's underlying trauma or behavioral concerns.

This investigation revealed that OCS contacted several care providers, but all refused to accept the child into their facility or home because of the child's complex needs. There were also delays with getting the child enrolled in additional sources of Medicaid funding (Medicaid Waiver Services).

The Ombudsman stresses that congregate care settings should only be used on a time-limited basis when youth require services that are unavailable in a less restrictive environment. The evidence from this investigation has shown that a treatment model for this population of children – children who experience co-occurring behavioral, emotional, and intellectual disabilities and/or co-morbid health conditions and physical disabilities – is still desperately needed.

Prior to the split of the Department of Health and Social Services (DHSS) into DFCS and DOH, the Ombudsman recommended that the agency develop intermediate care facilities for people with developmental disabilities. DHSS partially accepted the recommendation, stating that the agency would "discuss the development of community-based less restrictive placement options for individuals with IDD/dementia and related disorders, who currently do not experience an acute psychiatric crisis and do not carry a psychiatric diagnosis."[15]

DFCS explained to the Ombudsman that the agency believes changes to the licensing structure could improve the system of care – specifically, the creation of a person-centered license type or process to secure a variance to current regulations for children/youth for up to 12 months.[16] OCS pointed to models found in Pennsylvania and Iowa, where there are group home settings for youth who cannot be served anywhere else.[17] OCS explained that the modification would need oversight

[15] DHSS Response to Preliminary Ombudsman Report J2018-0134 (March 15, 2019).
[16] *See* Letter from OCS Director Kim Guay to Ombudsman Kate Burkhart on October 2, 2024.
[17] *Id.*

from a multi-disciplinary team to transition youth to a least restrictive placement in a family or community setting.[18]

While the Ombudsman acknowledges this as a potential pathway, the Ombudsman maintains that current state law and regulation would permit the implementation of the person-centered placements OCS described. The Ombudsman also notes that OCS had funds to spend on costly private security that could have been used to pay for care delivered by a licensed provider of services for people experiencing behavioral and/or intellectual disabilities. The State can fulfill its legal obligation within the current framework by recruiting providers who can serve children with intellectual and/or physical disabilities while pursuing future systems improvements.

Conclusion

OCS struggled to find effective solutions for a foster youth with complex needs and challenging behaviors. When the youth's behaviors escalated, OCS did not offer resources to the foster parents for crisis intervention, intensive mental health treatment, or stabilization – a recurrent theme in this investigation. Some of the issues identified in this complaint were due to mistakes by OCS staff, while others are part of a systemic problem: service gaps for children with complex and co-occurring intellectual and/or physical disabilities. However, that does not abrogate OCS's legal obligation to provide services to the children in its custody.

The Alaska State Ombudsman has made recommendations designed to address the deficits identified in this investigation, and to protect the state's most vulnerable children. The Ombudsman appreciates OCS's cooperation and the Department's commitment to better serving foster youth with complex needs and the foster parents who care for them.

[18] *Id.*