OREGON ALLIANCE OF CHILDREN'S PROGRAMS

IMPACTS RESULTING FROM PASSAGE OF NEW STATUTUES and ENACTMENT OF NEW RULES

Below are quotes and comments submitted by providers from a wide array of service sectors who are subject to new statutes, rules, regulations and implementation that affect Child Caring Agencies.

Service sectors include: Behavioral Rehabilitation Services (BRS), programs in behavioral health sectors including mental health and addiction recovery, runaway and homeless youth programs, and treatment foster care.

These bullets represent issues that include additional trauma on children, impacts on staff, fiscal impacts, unreasonable scope of investigations, and the administrative impacts in responding to investigations.

- Staff acknowledge they failed to report an incident as required by rule. An investigation is opened, and lasts six months. The only finding was the original failure to report. This investigation should have only taken a few days, far less than the 2.25 months allowed in OAR – and certainly not 6 months.
- When the OAAPI investigation report is given to the provider, it is "Redacted" and coded to create child and staff anonymous identifiers (ie M-12 and PA-3), so it is nearly impossible for the provider to know what investigative information was redacted, what information investigators are considering in their finding, what child they are talking about, what staff they are talking about, or what staff were believed to contribute to an issue.
- A provider who was not allowed to have new children assigned to his program (intake was closed) lost $80,000 in the first month of the investigation.
- When an investigation is opened, it is not uncommon for there to be multiple additional concurrent investigations. Some were up in the twenties. There doesn't appear to be a reasonable scope for addressing incident reports.
- A provider received a notice of a Licensing violation, but with no information on the violation. The provider called DHS and discovered the violation was for not providing Licensing the information OAAPI had and did not forward to Licensing when they sent the report over.
- For each DHS call since July of 2016, a minimum of 14 personnel hours is required. It takes 4 calls and 2 emails to determine the reason for a notification. The interviews, review of documentation, response and follow makes up the other 12 hours. This does not include expanded training, which our organization is delighted to provide when we have the accurate material, resources and notice. Accurate material, resources and notice have not been provided.

- A youth who struggles with both severe psychiatric illness and significant developmental delays, needs supportive hygiene care from our staff. We always have 2 staff members assisting. Another youth expressed concerns about this practice, which we reported to OAAPI. These staff were formally identified by the state as "alleged perpetrators of sexual abuse" and were placed on unpaid leave for 5 weeks pending investigation. Ultimately staff were fully cleared.
  But the damage was done: the youth who had such personal, around-the-clock care from staff who "disappeared," significantly regressed; the staff and their families were without income for over a month; and staff suffered from the labels as perpetrators.
- A foster parent was accused of being "aloof" and put under investigation.
- A foster parent was investigated for the allegation that they "might be placing a child at risk" because there was concern they were out of a hygiene product.
- A shelter had a serious incident which was reported. It was assigned to a DHS staffer. The DHS staffer has only been in contact periodically to conduct pieces of the investigation but no consistent work to resolve the investigation. Another DHS staffer called the shelter to ask for an update on the investigation; they were referred back to their own people for information.
- A youth made sexual misconduct allegations against a foster parent and said one of the foster parents was poisoning him. This was reported to OAAPI. They are to be in touch with the foster child within 24 hours, but it took more than a week before contact was made. In the meantime, the foster home (with 5 beds) is not allowed to have any children in them. I don't know what happened to those foster children who were moved again.
- In my organization, staff is now spending significantly less one-on-one therapeutic time with our youth, reducing the depth of treatment that, clinically, the child should be receiving.
- A provider had to cut $4 million from his organization budget and close a program before an investigation was even two months old.
- In this investigation, it took 4 months before investigators talked with staff. Even in criminal investigations, staff are one of the first interviewed. So law enforcement could conduct an investigation of the provider, and OAAPI another investigation, with conflicting processes.
- Investigators are submitting lists of employees for whom they want floor plans, months of emails, case notes and schedules – far beyond reasonable limits for the investigation. I know I submitted a thousand pages of information.
- Two proctor parent households have given notice to discontinue fostering. Having to go through an investigation in their home (unsubstantiated) was "deeply humiliating and disrespectful, and disrupted our home." "We don't need the income, and we surely don't need this."
- When foster parents quit, it takes us 6-12 months to recruit, certify, and provide all the training. So the home is empty while the investigation goes on, and with the recruitment time we can go 15 months or more without being able to serve the 5 children who would have been in the home. And nothing happened, except at least 5 kiddos are somewhere they shouldn't be.
- The loss of one of our proctor homes caring for 3 children that were removed for an investigation, and the loss of the parents who then quit, and recruiting another home for these high-end children – creates a loss of about $32,000.

- Notifications going out do not have follow-up notifications that the investigation is completed. This is a logic error – if you think they need to know something might be amiss, why wouldn't you want them to know that you have completed appropriate evaluation and action?
- A .25 FTE for my Clinical Director is required to do administrative work, pulling records, coordinating interviews, meeting with the investigator, doing requested follow-up. Usually when they come into investigate a report they open more investigations. Then my Clinical Director is now spending nearly .75 FTE essentially working for the state and not able to take care of staff and children here -- when they need it the most.
- As far as cost, the policy is the staff are unpaid during the investigation until resolved. However, the staff may file for unemployment after 2 weeks (or so). If the investigation comes back as unsubstantiated, then the staff member is paid for hours they would have been scheduled to work. The larger cost is we are paying twice for 1 person to cover the shift for unfounded investigations. Also, the morale impact of a staff member suddenly losing their full paycheck for often weeks is also immense. This impacts clients, as on-call or less experienced staff are covering during absences impacting care and provider/client relationships.
- The primary impact has been on staff. For example a treatment foster parent accepted a child with a long history of false accusations with the understanding we would stand behind the family if it happened again. It happened again, we had to remove the child due to the investigation only to have the child falsely accuse the next family. The first family went through Thanksgiving, Christmas and Valentines Day before it was resolved and we could do nothing to support them. Three other staff who were investigated are no longer with us. Were the investigations and vulnerability of losing a career factors? Probably.
- We are pressured all the time to take kids who are not really within the scope of what we are contracted to care for, and even when we are, we can't take too many of them or they will collapse the program and impact other kids. I'm not as concerned with serious matters, because we supervise closely and had a good record. It's the risk of a founded abuse or neglect for administrative errors that can kill us.
- Our board reviews the cases of kids we take. They are very worried that we ensure we are taking children who are appropriate for us and our circumstances, which change daily. We are seeing more cases referred to us who are not really appropriate for outpatient as case workers seek supports due to the downward pressure of a shrinking continuum of care. Our foster parents are also experiencing higher levels of stress as they are feeling the pressure and stress from the system. Which is also a concern as you know we do not have enough DHS foster parents either. These are big workforce issues, both for retention and recruiting. Long story short, the distress is so significant it is leaking down to all levels of care and impacting many.
- This is an example of a case that would have been closed at screening until recently, but now turns into a formal investigation: A 7 year old child saying he was sexually abused in a particular place over a four month period by a dark haired male with a big beard who works in the kitchen, and a female was involved (with the same unusual name as his mother). The child was not in this location when this was supposed to have been happening, and there is no male who works in the kitchen or any male matching this description and no female with the same unusual name as his mother.
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- One of our foster parents was investigated for allegedly having "made" their foster youth use their uninjured hand to fill out the pre-appointment medical form at a doctors office. This youth had been in 40+ placement prior to this placement. He has been stable here for over four years, for the first time in his life. The youth and his foster siblings were removed from the placement over 2 months ago, and we are still waiting to hear the outcome.
- The single time an investigator visited our facility, it involved 50 personnel hours and dragged on for months. The 50+ hours does not include the involvement of our Executive Director. The accusation was found to be unsubstantiated and the report was finally submitted in excess of 3x the allowed investigation time in the rules (45 work days).
- A lack of thoughtful, professional implementation is responsible for a continued climate of fear within DHS, foster homes and residential facilities. We do not have a contract to serve DHS youth because of the current climate. It has weakened the systems put in place to protect and nurture children in our communities. Good programs and families treated as guilty, labeled offenders without any concept due process.
- We have had multiple youth contacted in our program about situations/accusations and investigations in previous placements. Youth do not know the investigators and are often unwilling to speak with DHS, they think they are in trouble because they do not know investigations are open. One investigation was from more than a year previous. The information has been passed from one DHS staff to the next and a harried investigator with no experience with trauma informed care, further victimizes a child because they lack the information to do their jobs. It is not a safe or empowering experience for a boy in our program. It often results in confusion, sadness, and anger.
- SB 1515 is costing kids stable supportive homes in programs. We hear over and over from good families that they are discouraged from becoming involved in fostering kids because of regulations that punish them for taking difficult, unstable youth. It isn't the safety goals, it's the regulations and the penalties that keep people from wanting to try fostering.
- A medication mistake in our program resulted in CPS investigating an employee's home and own children.