

Activities and Recommendations

**An independent
voice for families
and children.**

Office of the
Family & Children's
Ombudsman
2000 Annual Report

"It's disturbing to know that children who are already in the state's care, need protection at times from the system designed to alleviate their suffering. I suppose one reveals a certain naiveté to be surprised by this. As a citizen, I am grateful to you and your staff for the efforts you make to hold a much-needed system accountable."

—Community Leader, Walla Walla

"Thank you for fulfilling the promise of the Ombudsman's office. You clearly are providing much needed policy direction, and the necessary background information and research, to help policy makers actually change how the system works. Your thorough and diligent work is greatly appreciated."

—Washington State Legislator, Olympia

Activities and Recommendations

Covering the period
through December 31, 2000

Office of the
Family & Children's
Ombudsman
2000 Annual Report

Table of Contents

Ombudsman —An independent voice for citizens.	
Regional advisory committees and mission statement	2
Features of the Family and Children’s Ombudsman	3
Making an inquiry	4
Filing a complaint	4
Ombudsman criteria for taking action.....	5
2000 Summary —September 1, 1999 to August 31, 2000.	
Inquiry and complaint summary	7
Who complained	8
Complaints involving DSHS Children’s Administration	9
Complaint issues	10
Complaint investigations	11
Completed investigations with no adverse findings	12
Completed investigations with adverse findings.....	14
Investigations closed prior to completion.....	16
Fatality review —Three year-old Zy’Nyia Nobles	19
Child safety recommendations	20
State law issues.....	21
System resource issues	24
DSHS administration issues	27
Foster care —What young people in the system say is working.....	29
The Ombudsman appreciative inquiry interviews	31
First theme: feeling normal.....	32
Second theme: feeling cared about	33
Third theme: feeling my opinions matter	38
Findings and recommendation	40
Young peoples’ ideas to improve foster care	42
The young people interviewed by the Ombudsman	44
The Ombudsman takes immediate action —to protect an infant from harm.....	46
Contacting the Ombudsman —Inside back cover	



STATE OF WASHINGTON

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN

January 2001

To the Residents of Washington State:

I am pleased to present the Year 2000 report of the Office of the Family and Children's Ombudsman.

The past year has been our busiest ever. We responded to a record number of citizen inquiries and complaints. Inquiries to our office increased by five percent, while the number of complaints we received increased by eight percent. For the first time ever, the issue most frequently identified in complaints to our office related to the safety of children.

It has also been a difficult year. The tragic death of three-year-old Zy'Nyia Nobles reminded us of the vulnerability of children that are served by the child protection system. At the time of her death, Zy'Nyia was dependent and living under state supervision with her mother. Her mother has been charged with homicide by abuse. Following her death, we reviewed her case and presented our findings to a community fatality review team convened by the Department of Social and Health Services (DSHS). We have included our findings in this report.

In light of our experience this year with child safety issues, we have developed several recommendations aimed at strengthening the state's protection of children. These include changes to state law, proposals to expand current resources, and suggestions for strengthening DSHS's administration of child protective services. These too are included in this report.

Finally, I want to share one of the year's most exciting projects: our Foster Youth Appreciative Interview Project. This project was designed to help us learn what's working best in the foster care system. We conducted individual interviews of 32 young people to elicit their stories about their best experiences in foster care. We were quite moved by the stories we heard. Our experience with this project, which is described in this report, has led us to conclude that this approach should be used by DSHS and other agencies as a means for improving the experience of young people while they are in foster care. We are extremely grateful to the young people who participated in these interviews, and to the foster parents and caseworkers who helped make them possible.

On behalf of all of us at the Office of the Family and Children's Ombudsman, I want to thank you for your interest in our work. We greatly appreciate the opportunity to serve the families and children of Washington State.

Sincerely,

A handwritten signature in black ink that reads "Vickie Wallen".

Vickie Wallen
Director Ombudsman

The Mission of the Office of the Family and Children's Ombudsman is...to protect children and parents from harmful agency action or inaction; and to ensure that agency officials and state policy makers are aware of chronic and serious problems in the child protection and child welfare system so they can improve services.

—Adopted 1998

Regional Advisory Committee Members

Western Washington Committee

Peter Berliner
The Children's Alliance,
Seattle

Martha Bird, M.D.
Child, Adolescent and
Adult Psychiatrist, Silverdale

Jane Boyajian
Children's Commission
of Pierce County, Tacoma

Shirley Caldwell
Therapeutic Health Services,
Seattle

Kikora Dorsey
Washington Council for
the Prevention of Child Abuse
and Neglect, Seattle

Lori Garvin
Parents Coping with
Child Protective Services, Tacoma

Jack Hill
Pierce County Department
of Assigned Counsel, Tacoma

Dennis Ichikawa
Casey Family Programs,
Seattle

Marie Jamieson
Washington Families
for Kids Partnership, Seattle

Susan Kemp
University Of Washington
School of Social Work, Seattle

Jane Koetje
Island County
Public Defense, Coupeville

Robert Lipke
Lummi Nation Child Protection
Project, Bellingham

John Neff, M.D.
Children's Hospital and Regional
Medical Center, Seattle

Valerie Norris
YWCA of Clark County
Court Appointed Special Advocate,
Vancouver

Edith Owen
Relatives Raising Children
Program, Tacoma

Gary Preble
Private Attorney,
Olympia

Virginia Wilkins/Carol Huard
Clallam County
Court Appointed Special Advocate,
Port Angeles

Larry Stephenson
Foster Parents Association
of Washington State, Anacortes

Central Washington Committee

Sue Baker
Chelan/Douglas County
Court Appointed Special Advocate,
Wenatchee

Dan Fessler
Yakima County Department
of Assigned Counsel, Yakima

Audrey Fetters
Yakima County Juvenile Court,
Yakima

Merja Kehl
Mental Health Therapist,
Wenatchee

Laurie Leaverton
Yakima County
Court Appointed Special Advocate,
Yakima

Sherrie Mashburn
Parents Are Vital in Education,
Sunnyside

Pat Nilson
Catholic Family Services,
Richland

Patty Orona
Foster Parents Association
of Washington State, Yakima

Mary Ann Warren
Catholic Family
and Child Service, Wenatchee

Ombudsman

A public official appointed to serve

as an independent voice for citizens
who believe they have been treated wrongly
or unfairly by a government agency.

The 1996 Washington State Legislature wanted to ensure that abused and neglected children and their parents are served reasonably and fairly by government agencies. The Legislature created the Office of the Family and Children’s Ombudsman to intervene when children or their parents are subjected to unauthorized or unreasonable agency decisions. The Legislature also empowered the Ombudsman to recommend changes for improving the system that serves children and families.

Eastern Washington Committee

Greg Casey
Private Attorney,
Spokane

Michelle Cutlip
Spokane County
Court Appointed Special Advocate,
Guardian Ad Litem, Spokane

Art Harper
Foster Parent Liaison,
Spokane

Senator John Moyer, M.D.
Former State Senator,
Washington’s Third District, Spokane

Miles and Joyce Stookey
Second Timers Support Group,
Spokane

Windy Tevlin
Whitman County
Court Appointed Special Advocate,
Colfax

Rosey Thurman
Team Child,
Spokane

Dave Williams
Casey Family Partners,
Spokane

The three most important features of an Ombudsman are:

Independence—Impartiality—Confidentiality.

With these three elements in mind, the Legislature made the Office of the Family and Children’s Ombudsman a part of the Office of the Governor, separating it from other agencies.

It established a three-year term office for the director Ombudsman, who is appointed by the Governor and approved by the Senate.

The Legislature intended for the Ombudsman to approach its duties with objectivity and impartiality. To encourage citizens to come forward with their concerns, the Legislature required the Ombudsman to protect their confidentiality, and exempted Ombudsman records from public disclosure requirements and the civil litigation process.

The Legislature also provided the Ombudsman with access to information and records held by the Department of Social and Health Services (DSHS), and authorized the Ombudsman to receive confidential information from other agencies and service providers.¹

1. Office of the Family and Children’s Ombudsman authorizing statute is RCW 43.06A.

Anyone can make an inquiry.

“Where do I go for help?”

An important responsibility of the Ombudsman is responding to inquiries. Citizens often do not know where to go with their questions or concerns about services provided by government agencies. Most inquiries are from families and local service providers requesting information or help with a problem involving the child protection or child welfare system. The Ombudsman responds to these inquiries directly. If an inquiry is outside the scope of the Ombudsman’s responsibilities, the caller is referred to an agency that can help.

The Ombudsman responds to an inquiry.

The Office of the Family and Children’s Ombudsman was contacted by a DSHS caseworker of an 11 year-old dependent child with severe mental health problems. The child had been exhibiting psychotic episodes and had many problems that needed to be assessed by a child psychiatrist. The caseworker explained that he’d been trying to obtain a psychiatric evaluation for the child for the past year, and was extremely frustrated. He had made an initial referral to a mental health agency in the county in which the child was living, who told him a month later that they could not provide the evaluation, and referred him to another mental health agency serving that county. The second agency told the caseworker after another month had gone by,

(continued on next page...)

Anyone can file a complaint.

“A child is at risk and I can’t get anyone to respond.”

More Ombudsman time is spent investigating complaints than any other task. A complaint to the Ombudsman must involve an act or failure to act by a government agency that affects:

- a child potentially at risk of abuse, neglect or other harm.
- a child or parent that has been the subject of allegations or findings of child abuse or neglect, or parental incapacity.

A complaint form is required to begin an Ombudsman investigation. It requests the name, address, and phone number of the person making the complaint. It asks the relationship of this person to the child. It includes questions about the family; custody or supervision of the child; steps taken to resolve the problem; the subject of the complaint; a statement of the facts; and the action requested. It also asks how the person heard about the Office of the Family and Children’s Ombudsman.

Complaint forms are available in English, Spanish, Russian, Vietnamese, and Braille. They may be obtained by contacting the Ombudsman office in Tukwila by phone, mail, or internet Web site.

The complaint form is not required in these circumstances:

Imminent Risk of Harm—Individuals who believe a child or parent is at risk of imminent harm caused an agency’s action or failure to act, may ask the Ombudsman for immediate assistance.

Individuals Requiring Assistance—Anyone who is unable to complete the form, or requires disability accommodation, may contact the Ombudsman for assistance.

Complaint and investigation records are confidential by law. Information given to the Ombudsman is not public information.

Names of people filing complaints are not revealed without their permission.

Complaint and investigation records cannot be subpoenaed for judicial or administrative proceedings, or obtained through civil discovery. Complaint and investigation information is entered into the Ombudsman's confidential data base to study complaint trends and patterns, as well as investigative findings and results. The charts and graphs published in this report were created from information collected in this data base.

Every complaint is investigated and reviewed by an Ombudsman team that includes two social workers, an attorney and the director Ombudsman. Investigations begin within 15 working days of receiving the complaint.

The lead Ombudsman assigned to the case contacts the individual to review the complaint. Agency staff and others are interviewed and agency records are examined. The lead Ombudsman writes an investigative report with findings and analysis on the agency's alleged conduct. This confidential report is available only to the Ombudsman team.

The Ombudsman acts as an impartial fact-finder, not as an advocate.

The Ombudsman will take action on a complaint if it determines the following three criteria are met:

1. The alleged action or failure to act did occur,
2. It violated law, policy, or procedure.
Or—it was clearly inappropriate or unreasonable, and
3. It was harmful to the child's safety, health, well-being, or right to a permanent family.
Or—it was harmful to appropriate family preservation, contact or reunification.

The decision is explained to the person who filed the complaint and a follow-up letter documents the decision. If the Ombudsman determines that action is not warranted, the person is directed to other resources that may be of assistance.

(...continued from last page.)

that they, too, could not provide this evaluation, and referred him to the nearest children's hospital. After some time, the hospital informed the caseworker that they did not have any child psychiatrists and could not provide this service either. The caseworker was referred back to the local regional service network (RSN). A full year later, the child still had no psychiatric evaluation, and was still exhibiting serious problems. The caseworker felt he had exhausted all of the avenues available to him to try and meet this child's needs. He had called the Ombudsman to see if there was anywhere else he might go to get services for this child.

An Ombudsman contacted the director of the RSN to find out why this child had been unable to receive needed services. Although the reasons for the delays were never clarified, the RSN director immediately arranged for an evaluation by a local private child psychiatrist. The Ombudsman is investigating possible systemic problems with obtaining mental health services for children in this and other areas of the State.

Action may involve:

Intervention—work with the agency to change the current course of action to one that is authorized and reasonable.

Administrative Notification of Findings—document and notify the agency of the Ombudsman’s concerns about past agency action or failure to act.

Systemic Investigation—examine law, policy, or procedures that may require change.

If action is taken, the person who filed the complaint is updated on progress and the outcome of the case. The investigative report remains confidential and is never released. However, this annual report includes investigation decisions, actions and recommendations from the reporting year.

The Ombudsman discovers a violation of legal procedure in terminating a parent’s rights.

A child’s birth mother contacted the Ombudsman to complain that the Division of Children and Family Services (DCFS) had failed to provide her with notice of proceedings to terminate her parental rights. The mother was living in Alaska, and her now 12-year-old child had been removed from her care in 1989 by Alaskan child welfare authorities when he was 14 months old, due to neglect and the mother’s substance abuse. He had later been placed with his father in Seattle. Mother and child had no further contact. The mother had been contacted by Washington State DCFS in 1997, informing her that her son was in foster care. She then received a notice by certified mail of the dependency proceeding. DCFS later contacted the mother by phone and informed her that the department was considering returning the child to his father’s care, or alternatively, placing him with a paternal relative. The mother expressed interest in having her son placed with her, and DCFS requested

a home study through Alaska DYFS. The mother told the Ombudsman that she completed the home study, but did not hear anything further from DCFS. She subsequently discovered that her parental rights had been terminated.

The Ombudsman reviewed the DCFS and court files, and found that the DCFS social worker had spoken to the mother several times in 1997, and in January 1998 spoke with the social worker in Alaska who was doing the home study. In September 1998, DCFS filed a petition to terminate the mother’s parental rights. The petition stated “the mother’s whereabouts have been unknown since she abandoned the child at six months of age.” Notice of the termination proceeding was published in an Alaska newspaper. There was no documentation of any attempt to notify the mother of this termination proceeding by phone or by letter. The Ombudsman notified DCFS, which agreed to investigate this matter further.

2000 summary.

Data in this report is based on information collected from September 1, 1999 to August 31, 2000.

Inquiries

Out of 1,580 contacts to the Office of the Family and Children's Ombudsman, 82 percent were inquiries, a five percent increase over the year before. The Ombudsman received 1,272 inquiries at an average rate of 25 inquiries per week.

Sixty-seven percent wanted basic information on how the Ombudsman could help, how to file a complaint, and how to get a complaint form. If their concern involved the Department of Social and Health Services (DSHS) Children's Administration, the right to contact the Office of Constituent Relations was explained.

About 13 percent concerned laws, policies, and procedures for child protection and child welfare services. The Ombudsman does not provide legal advice, however legal rights and responsibilities were explained.

About 20 percent concerned other government services. The Family and Children's Ombudsman found out who to contact, and referred these people to agencies that could help.

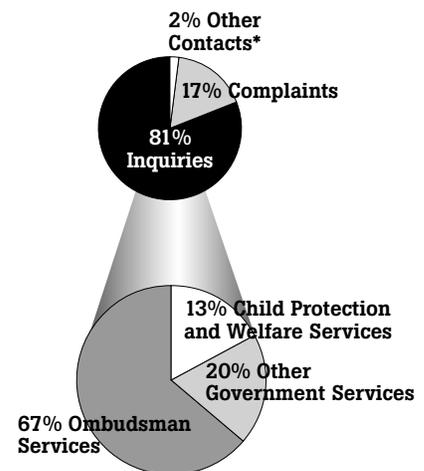
Complaints

Over the past year, complaints increased eight percent. The Office of the Family and Children's Ombudsman received 269 complaints. Complaints received from Eastern and Western Washington were in proportion to their populations.

During the reporting year, individuals contacted the Office of the Family and Children's Ombudsman 1,580 times.

1,272 of these contacts were inquiries.

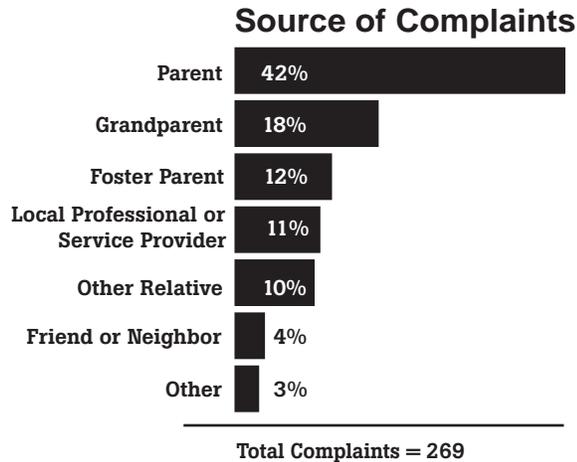
Contacts to the Ombudsman Office



* Other Contacts—includes information provided to the Ombudsman with no request for a response or further action.

Who complained.

Parents and relatives filed the most complaints.



Complaints filed by local professionals such as doctors, teachers, and other service providers increased by two percent from the year before.

The Ombudsman received just one complaint from a young person.

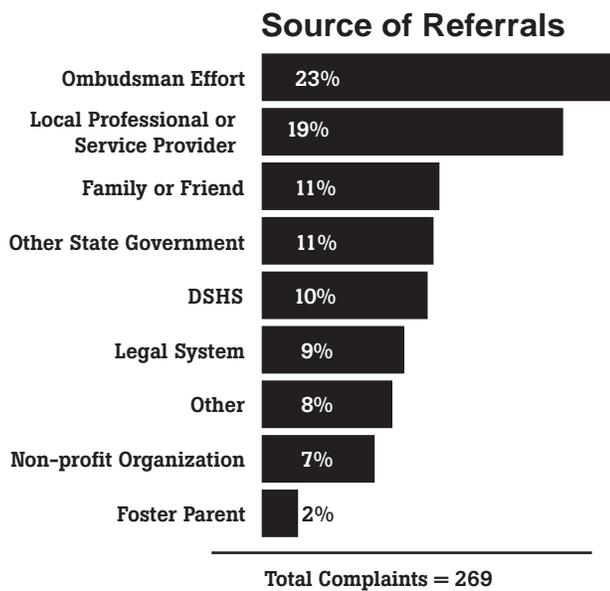
Other from Graph

Child, DSHS employee, court appointed special advocate, guardian ad litem, legal guardian, public defender, and state legislator.

How they heard about the Ombudsman.

Many individuals filing complaints indicated that they found the Family and Children’s Ombudsman as a result of the office’s own visibility and outreach efforts.

The number of individuals referred to the Ombudsman by local professionals and service providers nearly doubled from last year.



Categories from the Graph.

Ombudsman Effort: presentations, workshops, conferences, internet Web site, media, and former complainants.

Local Professional or Service Provider: doctors, teachers, counselors, mental health professionals, and day care workers.

Other State Government: Offices of the Governor and Attorney General, legislative offices, and agencies other than DSHS.

DSHS: caseworkers and other agency personnel.

Legal System: public defenders, private attorneys, court appointed special advocates, and guardians ad litem.

Other: telephone directory assistance, library, agency from another state, unaffiliated individual, and persons who did not identify who referred them.

Non-Profit Organization: American Civil Liberties Union, Northwest Justice Project, domestic violence organizations, and other advocacy organizations.

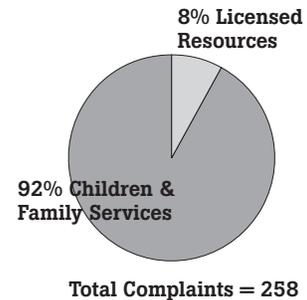
The majority of complaints involved the Division of Children and Family Services.

Ninety percent of all complaints involved the DSHS Children’s Administration.² Ninety-two percent of those complaints involved the Division of Children and Family Services (DCFS), which includes Child Protective Services, Child Welfare and Adoption Services, and Family Reconciliation Services. The remaining eight percent involved the Division of Licensed Resources (DLR), which licenses and investigates alleged child maltreatment in foster homes, group homes, and other residential facilities for children.

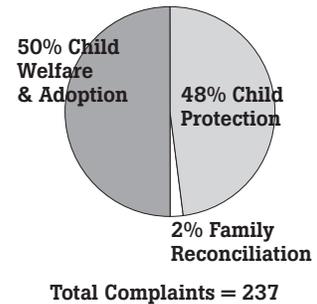
Complaints against the Children’s Administration by region.

	Children & Family Services	Licensed Resources		Children & Family Services	Licensed Resources
Region 1 Totals	34	0	Region 4 Totals	62	8
Spokane	17		Seattle South	16	1
Colville	7		Kent/King South	16	1
Wenatchee	4		Seattle Central	13	5
Moses Lake	4		Seattle North	10	1
Newport	1		Bellevue/King Eastside	7	
Colfax	1				
			Region 5 Totals	36	4
Region 2 Totals	28	6	Tacoma	20	2
Yakima	14	2	Bremerton/Kitsap	16	2
Richland/Tri-Cities	7	2			
Clarkston	2		Region 6 Totals	45	0
Ellensburg	2		Vancouver	6	
Toppenish	2	2	Centralia	5	
Walla Walla	1		Kelso	5	
			Port Townsend	5	
Region 3 Totals	32	3	South Bend	5	
Everett	11	3	Aberdeen	4	
Arlington/Smokey Point	5		Shelton	4	
Monroe/Sky Valley	5		Lacey/Olympia	3	
Bellingham	4		Tumwater	3	
Alderwood/Lynwood	4		Port Angeles	3	
Mount Vernon	3		White Salmon	1	
			Forks	1	

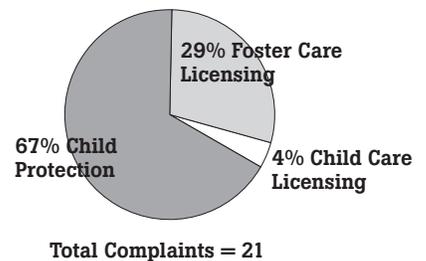
Complaints against DSHS Children's Administration



Children and Family Services



Licensed Resources



2. The remaining 10 percent involved: seven percent—Criminal Court, Dependency Court, Family Court, Regional Support Network, State-contracted Service Provider, State-licensed Child Placing Agency, and Washington State School for the Deaf; three percent—Other DSHS Divisions, including Community Services Division, Division of Child Support, and Division of Developmental Disabilities.

Safety of children was the number one complaint issue.

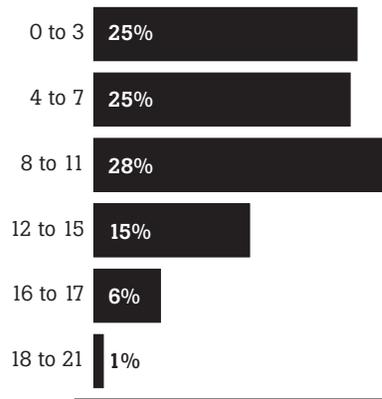
Safety of children was the issue most frequently identified in complaints to the Ombudsman. Of concern was the safety of children living in their parents' care, as well as the safety of children living in foster care, or in other substitute care. Half of the 456 children identified in complaints were age seven or younger.

Most frequently identified issues in complaints to the Ombudsman.

(Number of complaints follows each issue.³)

Child Safety...121	Family Separation and Reunification...92	Dependent Child Health, Well-being and Permanent Placement...48
<i>Children in their Parents' Care</i>		
Failure to protect children from:	Unnecessary removal of children from parents.....23	Inappropriate removal of children living with relatives..... 19
Physical neglect by parent24	Failure to provide appropriate contact between children and parents.... 17	Inappropriate removal of children from a non-relative foster home.. 13
Physical abuse23	Failure to place children with relatives..... 15	Failure to make mental health services available for children 8
Sexual abuse 12	Inappropriate removal of dependent children from parents' care..... 8	Unreasonable delay or opposition to adoption by relatives 4
Medical neglect by parent 9	Inappropriate termination of parental rights..... 8	Unreasonable delay or opposition to adoption by foster parents..... 4
Emotional abuse by parent..... 9	Failure to reunify families that have complied with court ordered services 7	
Failure to protect dependent children in their parents' care 6	Failure to provide access to family reunification services 7	
Failure to provide appropriate placement or services for children who may harm themselves or others 6	Inappropriate permanent placement plan (guardianship or termination of parental rights) for children 7	
<i>Children in Substitute Care</i>		
Failure to address safety concerns involving:		
Licensed foster home 11		
Relative's home 9		
Children being returned to parents' care 8		
Failure to provide appropriate placement or services for dependent children who may harm themselves or others 4		

Age of the Children



**Half of the children
identified in complaints
were seven or younger.**

Total Children = 456
18 to 21 includes dependent youth.

3. Some complaints identified more than one issue.

The Office of the Family and Children’s Ombudsman conducted 290 complaint investigations.⁴

Fifty-two percent were completed and resulted in findings. Thirty-one percent were closed prior to completion because the complaint was resolved or for another reason. Seventeen percent were still open at the end of the reporting period.

Completed investigations means sufficient information had been gathered to evaluate an agency’s action or inaction and to make findings. Details of the findings and outcomes of the 150 investigations completed by the Ombudsman are listed in the tables on the next four pages.

Findings:

Did the alleged action or inaction occur?

138 investigations supported complaint allegations that the agency was acting or refusing to act in a particular way. Example: *Child Protective Services was refusing to investigate a child abuse report as alleged.* Twelve investigations did not support complaint allegations about the agency’s conduct, or could not determine whether the alleged action or inaction occurred.

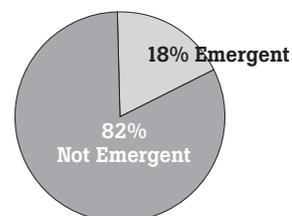
If so, was the action or inaction a violation of law, policy, procedure, or unreasonable exercise of authority?

127 investigations ended with no adverse findings. The agency’s action or inaction was authorized by law, policy or procedure, and constituted a reasonable exercise of discretion.

11 investigations ended with adverse findings. The agency’s conduct clearly violated a law, policy or procedure, or constituted an unreasonable exercise of discretion. In most cases, the agency acknowledged the violation and/or agreed to alter its course of action to address the Ombudsman’s concern.

One out of six complaint investigations opened in the period met Ombudsman criteria for initiating an immediate investigation.

Emergent Investigations



Total Opened Complaint Investigations = 260

Emergent Criteria—If true, the alleged agency action or inaction would place the safety or well-being of a child or family at risk of serious harm.

4. Of these, 260 investigations were opened during the reporting year, and 30 were ongoing investigations from a previous period. For purposes of this report, investigations of complaints raising identical issues are counted only once.

Completed investigations.

No Adverse Findings. One-hundred twenty-seven investigations resulted in no adverse findings against the agency. This table identifies the agency actions and decisions that the Ombudsman investigated and determined were authorized and reasonable. These actions and decisions are categorized by issue area. Some complaint investigations addressed more than one action or decision.

Safety of Child in Parents' Care...28

CPS decision not to take any protective action and/or close case after the investigation was complete..... 9

CPS decision to screen out or not investigate report of alleged child mistreatment..... 6

CPS decision not to seek removal of a child from parents' care..... 4

CPS decision not to remove a dependent child from parents' care..... 3

CPS decision not to interview particular individuals during investigation ... 2

CPS decision to close a case after services were provided..... 1

CPS decision to seek dismissal of a child's in-home dependency 1

CPS decision to seek voluntary placement agreement rather than dependency..... 1

CPS decision to place a child with the non-custodial parent despite allegations the parent is unsafe..... 1

Safety of Child in Substitute Care...11

CPS decision to return a dependent child to the parents' care..... 3

DLR determination that abuse or neglect allegation against the foster parent was unfounded..... 3

DLR decision not to seek removal of a dependent child from a foster home despite allegations that the home is unsafe 2

CWS decision to place a dependent child with a relative despite allegations the relative is unsafe..... 1

CWS decision not to place a dependent child in a residential facility 1

CPS decision to place a youth with an unlicensed "responsible adult" 1

Family Separation and Reunification...88

CPS decision to seek court authorization to remove a child from home and/or file for dependency..... 26

CWS decision to recommend or support a permanent plan for guardianship and/or termination of parental rights..... 11

CWS decision not to return a dependent child to the parent's care..... 8

CWS decision not to place a child with a relative 8

CWS removal of a dependent child from placement with a relative based on safety reasons..... 6

CWS removal of a dependent child from placement with a relative based on the child's long-term needs 5

CWS decision to prohibit or suspend contact between a parent/relative and a child 5

CPS determination that allegation of parental abuse was founded or inconclusive 4

CWS decision regarding the parent's selection of service provider 3

DLR determination that abuse allegation against a parent, who is also a licensed foster parent, was founded..... 2

**Family Separation
and Reunification** *(continued)*

**Dependent Child Health, Well-being,
and Permanent Placement...8**

Other Issues...10

CWS decision to place a child in a foster home that is distant from the family 2

CPS decision to investigate abuse or neglect allegations against a parent..... 2

CWS decision not to seek early dismissal of in-home dependency 1

CWS failure to notify a non-custodial parent of custodial parent’s voluntary placement of a child and to provide other confidential information 1

CWS removal of a child from foster adoption placement that was supported by the child’s birth parent when the parent relinquished parental rights1

CWS failure to obtain an open adoption agreement permitting ongoing contact between a child and relatives 1

CWS decision not to obtain a psychologist’s assessment of a dependent child to facilitate treatment of the child’s parent..... 1

CPS support of a youth’s court petition for substitute placement 1

CWS decision not to remove a child from a relative despite allegations that the relative cannot meet the child’s needs 2

CWS decision to change child’s non-relative foster placement based on the child’s long-term needs 2

CWS decision to change a child’s non-relative foster placement based on concerns about the child’s safety 1

CWS decision to place a child with relatives in another state 1

CWS decision not to place a child with a previous foster parent 1

CWS decision not to support adoption by a child’s previous foster parent..... 1

Financial disputes..... 3

Disputes about the accuracy of DCFS case file information 2

DLR decision to require evaluation of a foster parent..... 2

DLR decision to seek revocation of a foster license 1

Continuance of a 72-hour shelter-care court hearing 1

CWS response to a contracted in-home service provider error 1

Terms and Acronyms

Dependent Child...A child for whom the State is acting as the legal parent.

CPS.....Child Protective Services

CWSChild Welfare Services

DCFSDivision of Children and Family Services

DLRDivision of Licensed Resources

Completed investigations.

Adverse Findings. Eleven investigations resulted in adverse findings against the agency. This table identifies the agency actions and decisions that the Ombudsman investigated and determined to be unauthorized or unreasonable. It also identifies the outcome of the case.

Current Actions and Decisions

Past Actions and Decisions

1. Finding—CPS was unreasonably screening out report by relatives expressing concern about an unstable parent.

Outcome—At the Ombudsman’s urging, CPS reconsidered the decision and conducted an investigation. The parent admitted ongoing drug use and agreed to give his relatives legal custody of the children.

2. Finding—CPS was unreasonably screening out a report by a mental health professional expressing concern about an unstable parent.

Outcome—At the Ombudsman’s urging, CPS reconsidered the decision and conducted an investigation. In-home support services were provided. After receiving additional reports of concern from community professionals, the agency sought legal authority to remove the children from their parents’ care.

3. Finding—CPS and the Attorney General’s Office were unreasonably delaying the filing of a dependency petition on a 14 year-old mother and her infant, because of an inter-regional dispute regarding jurisdictional responsibility.

Outcome—At the Ombudsman’s urging, a dependency petition was quickly filed on the mother and infant.

4. Finding—Family Reconciliation Services was unreasonably deciding to send home a youth upon release from a crisis residential center (CRC) without first obtaining a mental health evaluation, after the youth had made suicide threats and despite a CRC staff recommendation that the youth not be sent home.

Outcome—At the Ombudsman’s urging, the youth was evaluated by a mental health professional who recommended in-patient treatment. The youth refused to enter treatment. He and his family were provided with in-home support services.

5. Finding—CWS had failed to conduct a search for relatives of a legally free child even though their interest and availability in caring for the child was documented in the case file. The agency placed the child with foster parents who now were seeking to adopt the child.

Outcome—DCSF acknowledged the error and agreed to consider the relatives as a potential permanent placement. However, the court ultimately approved adoption of the child by his foster parents.

6. Finding—CWS was requiring a relative foster parent to complete an intrusive parenting evaluation questionnaire. The agency was also relying on recommendations of a substandard parenting evaluation in determining a child’s permanent placement.

Outcome—At the Ombudsman’s urging, CWS agreed not to require the relative foster parent to complete the questionnaire, and agreed not to rely on the parenting evaluation recommendations. The child was eventually adopted by the relative foster parent.

7. Finding—CPS had unreasonably screened out reports by mental health professionals in 1996, expressing concern about an unstable parent.

Outcome—CPS had appropriately investigated subsequent reports and eventually provided the family with intensive in-home services. The Ombudsman took no further action.

8. Finding—CWS had briefly left two children alone with their mother during a supervised visit which allowed the mother to flee with the children.

Outcome—By the time the Ombudsman received this complaint, the family had been located in another part of the state. DCFS acknowledged the error and indicated it had reviewed the incident with the CWS worker. The Ombudsman took no further action.

9. Finding—CWS (after consulting with the Attorney General’s Office) had unreasonably decided not to issue a warrant for a 16 year-old dependent Washington State youth, who had run away to another state with her ten month-old infant, despite an earlier request by the other state’s child welfare agency.

Outcome—By the time the Ombudsman received this complaint, CWS had issued a warrant, and the youth and her infant were eventually returned to Washington State. The Ombudsman took no further action.

The Ombudsman challenges an agency's reliance upon an evaluation by a contracted provider.

10. Finding—CWS had unreasonably failed to provide support to a foster parent during the psychiatric crisis of a young child. The agency also had not provided timely access to appropriate psychiatric services.

Outcome—The child was ultimately moved from the foster home. The Ombudsman was informed that the CWS worker no longer worked in that office. The lack of support for foster parents and the difficulty in accessing children's mental health services are systemic problems that the Ombudsman has brought to the attention of state policy makers and agency officials.

11. Finding—CWS had unreasonably failed to notify a parent by certified mail about proceedings to terminate parental rights.

Outcome—The parent did not appear at the proceeding to contest the state's motion and her rights were terminated. The Ombudsman brought this matter to the agency's attention and CWS agreed to investigate it further.

A community professional contacted the Ombudsman after DCFS abruptly removed a 5-year-old legally free child from her foster home. The child had been living in the home since infancy and the foster parents, who were distant relatives, were planning to adopt her. The child's sibling, who had previously lived in this home but had since been moved to a different foster home, had made allegations of sexual abuse by an adolescent boy in the foster home. Similar allegations of physical and sexual abuse by a wide range of people in her life had been unfounded in the past, and the professional believed that DCFS held a bias against the foster parents and was not considering information provided by other professionals who knew the family well.

About six weeks after removing the child, and after initial investigation of the allegations, the agency requested that the foster parents undergo a parenting evaluation to assess their suitability as a permanent placement for the child. The foster parents agreed to an evaluation by the provider who was already supervising visits between the foster parents and the child, at DCFS request. The evaluation was completed, and recommended that the child not be returned to the home until a number of different evaluations, including psychological evaluations, and treatment gains had been made by the foster parents. Upon review of the evaluation, the Ombudsman found significant problems, bringing into question its validity and that of the recommendations. The Ombudsman obtained a blind peer review of the evaluation, which strongly validated and underscored these concerns. At this point, the Ombudsman recommended that the agency disregard the findings and recommendations of this evaluator. The agency agreed, but decided to request a psychological evaluation of the foster parents. The Ombudsman concurred with this plan but recommended that the evaluator be mutually agreed upon by the foster parents and the agency. The psychological evaluation was expedited, and the evaluator recommended immediate return of the child to the foster home. Meanwhile, the investigation of the sibling's allegations was concluded and determined to be unfounded. The child was returned to the foster home and has since been adopted by the foster parents.

Investigations closed prior to completion.

Ninety-one complaints closed before the Ombudsman’s investigation was complete.

Fifty-eight investigations were closed because the complaint was resolved during the investigation. In many cases, the Ombudsman’s efforts to ensure that critical information was obtained and considered by the agency and to facilitate communication among the people involved resolved the problem. In other cases, the Ombudsman monitored the situation while the agency reached a decision. The table below describes how these complaints were resolved.

Summary of Closed Investigations

Resolved Complaints 64%

Other 36%

Total Closed Investigations = 91

Safety of Child in Parents’ Care...18

Safety of Child in Substitute Care...13

Family Separation and Reunification...9

CPS obtained parental or court approval to place a child in substitute care 9

CPS conducted investigation and offered appropriate services 3

CPS removed a dependent child from a parent’s care..... 2

CPS ensured that a parent obtained clinical assessments of a child 1

CPS notified a Tribe about a report involving a tribal family 1

CPS and Prosecuting Attorney’s office increased the rate of dependency filings 1

Division of Developmental Disabilities provided appropriate in-home services to a developmentally disabled parent caring for a developmentally disabled child 1

Dependent child received appropriate psychiatric assessment and/or residential treatment 4

Developmentally disabled child provided with appropriate institutional or group care placement 2

Child removed from a foster home for safety reasons..... 2

Dependency petition filed on a child placed by a parent with a relative..... 2

Dependent child provided with appropriate therapeutic foster placement 1

Child provided with appropriate placement upon release from a mental health facility..... 1

CPS agreed not to allow a non-custodial parent to provide respite care for a dependent child 1

Child placed with or allowed to remain in the care of an appropriate relative 5

CWS agreed to consider a relative as a placement option and allow visitation 1

CPS allowed a parent to take a dependent child to a preferred place of worship..... 1

CPS confirmed that it did not screen in an inaccurate report that a developmentally disabled parent had abandoned a child 1

CWS provided a parent with culturally appropriate reunification services..... 1

The other 33 complaint investigations closed because nine complaints were withdrawn, while the complaint issue became moot in seven investigations. The remaining 17 investigations were closed because the complaint issues were determined to be outside of the Ombudsman’s jurisdiction. These individuals were referred to another agency that could help with the following concerns:

Legal Proceedings—Actions by judges, commissioners, guardians ad litem, parenting investigators, and attorneys.

Support Enforcement—Actions by DSHS not affecting a family involved with the state due to child abuse or neglect issues.

Actions by child welfare agencies from another state.

Clinical Decisions—by mental health or medical professionals.

Educator and Service Provider Decisions—to report child abuse or neglect as required by State law (RCW 26.44).

Dependent Child Health, Well-being and Permanent Placement...4

Other Issues...14

DLR allowed a youth to stay in a current foster placement while making arrangements for a new placement..... 1

CWS returned a child to a previous foster home as requested by the child and recommended by a counselor..... 1

Developmentally disabled youth (age 18) allowed to stay in a current foster placement until age 21..... 1

CWS held prognostic staffing to assess the long-term needs of a youth..... 1

DCFS agreed to assign a new caseworker to a family/child 7

Financial dispute resolved 3

CPS agreed to change a neglect finding..... 1

DLR provided a foster parent with investigative finding..... 1

DLR assisted a parent with a CPS reporting issue..... 1

DCSF acknowledged a caseworker’s performance issues and confirmed that the worker is no longer with the agency..... 1

Getting CPS to reconsider screening out a child abuse report for investigation

An aunt contacted the Ombudsman, requesting immediate action on her concern about the safety of her four nieces and nephews. The children’s parents had a history of domestic violence and substance abuse, and according to the aunt, their father had physically abused them in the past and was mentally unstable. The children had been in their grandparents’ care for the previous five years, until a couple of months prior, when the father arranged for the aunt to care for the children. Soon after placing the children with the aunt, the father was reported to have been driving a stolen vehicle, after vandalizing the mother’s car. He was allegedly in possession of a loaded gun, threatening to commit suicide and “take his children with him.” The aunt reported this information to CPS. Following this report, the father called the school to instruct the children to return to his home that day rather than go to their aunt’s. CPS told the aunt that they would not investigate the situation.

The Ombudsman checked the department’s automated database (CAMIS) and found a CPS history on the family dating back to 1993 with seven prior reports of chronic parental neglect and substance abuse. The children had previously been placed in state custody. The Ombudsman contacted CPS and found that the aunt’s report had in fact been screened out without an investigation. The Ombudsman expressed concern about the situation in light of the family’s CPS history, the father’s current stability, and other risk factors. CPS decided to screen in the referral for investigation. During the investigation, the father admitted to CPS that he was using methamphetamine and agreed to seek treatment. A month later, the father agreed to give the aunt and another relative legal custody of the children.

The Ombudsman persuades CPS to remove children from a dangerous home environment

The Ombudsman was contacted by a school counselor requesting immediate action on his concerns about the safety of four children whom he believed were living in a dangerous home environment. School professionals as well as mental health providers working with this family were extremely concerned that CPS was not intervening aggressively enough to ensure the safety of the children. These professionals had made numerous reports to CPS alleging physical abuse, neglect, and emotional abuse of the children by their parents. The family had a history of moving from place to place, and had moved to Washington from Oregon two years previously. CPS received 18 reports on the family in those two years. The 11 year-old had been placed in foster care for about six weeks under a voluntary placement agreement between DCFS and the parents, following physical abuse of the child by her stepfather. The child was returned home on condition that the parents participate in various services.

At the time that the Ombudsman was contacted, the parents were failing to comply with services, and the children were exhibiting a great deal of fear and stress. The 11 year-old had told the CPS caseworker that there had been a lot of yelling in the home and that she was afraid of her stepfather. The children had head lice, one child was vomiting at school, and the younger children were wetting and soiling their pants. The in-home service provider was in disagreement with other professionals involved with the family, regarding

the level of risk to the children and specifically, regarding whether the mother was actively using drugs.

When the Ombudsman contacted DCFS, the caseworker and supervisor stated that they'd been advised by the assistant attorney general to gather and document further information on the family as there was insufficient information supporting the need for substitute placement of the children. The Ombudsman raised concerns about the risk to the children's safety if they were left in the home while further documentation was obtained. DCFS agreed to increase the monitoring of the children in the home so that the DCFS worker and other professionals were visiting the home at frequent intervals, including on weekends. The Ombudsman then reviewed the DCFS case file. The Ombudsman learned that the family had a CPS history in Oregon, where the mother's parental rights to two older children had been terminated, and relinquished with regard to a third child. Three of the children had been placed in the state's custody there. The Ombudsman requested that CPS obtain the Oregon records as soon as possible and offered to assist in retrieving these. After completing this review, the Ombudsman strongly challenged the need to obtain further information. In response, and after learning that the mother had tested positive for methamphetamine and amphetamines, DCFS agreed without delay to seek court authorization to take the children into protective custody. The court approved the request, and the children were placed in foster care.

Fatality review.

Three year-old Zy’Nyia Nobles died at home on May 27, 2000. Zy’Nyia’s brother saw their mother beating his sister. The mother was arrested and charged with homicide by abuse. The children had been dependent and living in foster care since February 1997. The Division of Children and Family Services (DCFS) returned them to their mother in February 2000, and the family remained under state supervision.

The Family and Children’s Ombudsman reviewed case records to learn why the children had been returned to their mother, and to find out what services had been in place to support the family and monitor the children’s safety.

Zy’Nyia’s death was also reviewed by a Community Fatality Review Team convened by DCFS. The Team included a physician, attorney, mental health and substance abuse professionals, guardian ad litem, foster parent, legislators, and others. At the Team’s first meeting on July 13, 2000, the Ombudsman presented its completed investigation summary and identified several performance and system issues.¹

The Ombudsman asked the Community Fatality Team to consider these issues in a review of Zy’Nyia’s death:

Performance Issues

Lack of Assessments—Case records showed that the DCFS caseworker had returned the children to their mother without obtaining a psychiatric/psychological evaluation or parenting assessment—despite documented concerns about the mother’s mental health and parenting capacity.

Non-compliance—During the three-year period before the family was reunited, case records show the mother had not completed court-ordered substance abuse services or parenting classes. In addition, there was no evidence that she had completed or made progress in court-ordered mental health counseling. Yet, the caseworker returned the children to their mother.

Family Support and Monitoring—In-home services and requirements to support the family and monitor the children’s safety either failed or were never put into place by the caseworker.

Child Safety Concerns—There is no evidence that anyone involved with the family—including the caseworker and other individuals required by law to report child abuse or neglect—acted on documented concerns about the children’s possible abuse in their mother’s care.²

System Issues

Caseworker Bias—The Ombudsman asked the Team to consider how the system can better protect against caseworker bias. Bias occurs when a caseworker develops an initial belief about a person or event and then becomes resistant to altering that belief—even in the face of conflicting information.³

System Checks and Balances—The Team was asked to consider how the system’s checks and balances were overcome. The Ombudsman noted that inaccurate and incomplete information from the caseworker undermined oversight by the court and Child Protection Team. The guardian ad litem did not appear to fulfill his independent investigation and monitoring duties. There was no evidence that supervisory or prognostic staffings occurred after 1998.

In-home Service Providers—The Ombudsman asked the Team to assess the role of in-home service providers. DCFS relies heavily upon in-home providers to monitor the safety of children. Yet, many service providers do not see safety monitoring and reporting as part of their role in working with families.

Mandated Reporting—The Team was asked to assess the system for reporting child abuse and neglect. Specifically whether: the categories of service providers required by law to report abuse or neglect should be expanded; mandatory reporters should be required to receive training on their reporting duties; and DCFS should modify its internal system for handling abuse reports made to caseworkers in open cases.

The Community Fatality Review Team released its report on November 29, 2000. The report addressed many of the issues pointed out in the Ombudsman review.⁴

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1. Ombudsman July 2000 Review of Zy’Nyia Nobles Fatality, (edited to protect confidentiality): www.governor.wa.gov/ofco.
 2. RCW 26.44.030 requires specified categories of professionals and service providers to report suspected child abuse and neglect.
 3. Munro, E. (1996) Avoidable and Unavoidable Mistakes in Child Protection Work, *British Journal of Social Work*, 26, 793-808.
 4. Zy’Nyia Nobles Fatality Review (edited to protect confidentiality): www.wa.gov/dshs.

Child safety

Recommendations Overview

In addition to investigating complaints, the Office of the Family and Children's Ombudsman is required by state law to develop recommendations for improving the child protection and child welfare system. The recommendations in this section are based on Ombudsman analysis of information derived from investigations, surveys and research. They are aimed at strengthening the state's protection of children.

State Law Issues

1. Modify the state law definition of neglect.
2. Require training for professionals and service providers that are mandated by state law to report child abuse and neglect.
3. Require DSHS to disseminate descriptive information about the Ombudsman.

System Resource Issues

1. Ensure that caseworkers have a reasonable workload.
2. Provide a guardian ad litem or volunteer court-appointed special advocate for every child that is the subject of a dependency proceeding.
3. Provide an adequate supply and range of placement options for children who cannot live safely at home.
4. Improve children's access to community mental health and residential treatment services.
5. Provide the Ombudsman with the capacity to monitor agency supervision of children's health and safety in residential settings.

DSHS Administration Issues

1. Implement key provisions of the *Kids Come First Action Agenda*.
2. Clarify and strengthen the role of supervisors.

recommendations.

State Law Issues

Recommendation

1 Modify the statutory definition of neglect by deleting the reference to “clear and present” danger and clarifying that neglect may result from “a pattern of conduct.” Permit the court to consider cumulative harm to a child in determining whether the child is dependent.

Background: The *Office of the Family and Children’s Ombudsman 1999 Annual Report*¹ identified the State’s failure to timely intervene in chronic child neglect cases as a major issue of concern.² The Ombudsman found that the child protection system is often ineffective in preventing or protecting children from parental neglect that is ongoing and serious. By the time the system intervenes, children often are already showing signs of developmental and/or physical harm. According to research cited in the report, children who are chronically neglected often experience lasting adverse effects on their physical, emotional and cognitive development. The Ombudsman noted “the impact of chronic neglect on children—especially young children—can be devastating. We know from research on children’s early brain development that the first few years of life are critical. Chronic neglect can severely damage the potential of children to grow and learn.”³ Further, child neglect accounts for an estimated 40 percent of child maltreatment fatalities.⁴

The Ombudsman has found that Child Protective Services (CPS) often screens out reports of child neglect without an investigation. This issue was highlighted earlier this year with the death of a seven-year boy who drowned in a lake while playing unsupervised with his brother and several other children. The boy and his eight-year old brother had been the subject of 19 reports to CPS. Many of the reports were from community professionals expressing concern about the boys’ speech delays, the mother’s mental instability, and her failure to provide the boys with appropriate care and supervision. CPS screened out 14 of these reports without an investigation.⁵ According to CPS, neglect reports are often screened out because the specific act or omission alleged in the report does not meet the legal definition of neglect, i.e., does not constitute a “clear and present” danger. Thus CPS often will not investigate a neglect report despite being aware of a documented pattern of conduct indicating that the child may be at risk. Further, CPS caseworkers report they often feel they lack a sufficient basis to invoke a legal intervention to protect neglected children.

Many caseworkers have told the Ombudsman that they have been advised by their legal counsel (assistant attorneys general or prosecuting attorneys) that clear evidence of a neglectful act resulting in imminent danger is required to justify the filing of a petition in court to compel parental participation in services or remove the child. Consequently, these workers say they feel that until they have such evidence, they have no option but to pursue less aggressive and effective interventions.

1. *Office of the Family and Children’s Ombudsman 1999 Annual Report:* www.governor.wa.gov/ofco.
2. Chronic child neglect refers the ongoing and serious deprivation of a child’s basic physical needs, including abandonment, inadequate nutrition or a lack of supervision.
3. Earlier this year, in a study funded by the National Institute of Justice, the Children’s Administration Office of Research (OCAR) found that children neglected early in life, are as likely as abused children to be arrested later. English, D., & Widom, C., Brandford, C., *Preliminary Findings on Childhood Victimization and Delinquency, Adult Criminality and Violent Behavior*. Moreover, a recent study conducted in 11 California counties found that children who were referred to CPS for neglect were more likely to be incarcerated than children referred for physical or sexual abuse. Jonson-Reid, M. & Barth, R.P. (2000), From Maltreatment Report to Juvenile Incarceration: The Role of Child Welfare Services. *Child Abuse and Neglect*, 24, 505-520.
4. Trauma, Violence and Abuse, Vol. 1, No. 1, January 2000, at p. 103.
5. See, for example, Esposito, S. “19 calls about boy, siblings: DSHS received repeated complaints about mother of 7 year-old who drowned unsupervised,” *Tacoma News Tribune*, September 6, 2000.

State Law Issues

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6. RCW 26.44.020(15).
7. National Clearinghouse on Child Abuse and Neglect Information, *Child Abuse and Neglect State Statutes Elements* (December 31, 1999):
www.calib.com/nccanch.
8. *Office of the Family and Children's Ombudsman 1999 Annual Report*:
www.governor.wa.gov/ofco.
9. Zellman, G.L. (1990) Child abuse reporting and failure to report among mandated reporters. *Journal of Interpersonal Violence*, 5: 3-22.
10. Delaronde, S., King, G., Bendel, R., & Reece, R. (2000). Opinions among mandated reporters toward child maltreatment reporting policies. *Child Abuse and Neglect*, Vol. 24, No. 7: 901-910.
11. See, for example, King, G., Reece, R., Bendel, R., & Patel, V. (1998), The effects of socio-demographic variables, training, and attitudes on the lifetime reporting practices of mandated reporters, *Child Maltreatment*, 3(3): 276-83; Reiniger, A., Robinson, E., & McHugh, M. (1995), Mandated training of professionals: A means for improving reporting of suspected child abuse. *Child Abuse and Neglect*, 19(1): 63-69.

Rationale: State law defines child neglect as “an act or omission that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the child’s health, welfare and safety.”⁶

Washington is one of only five states whose statutory definition of neglect specifies that the risk of harm to a child must be imminent.⁷ Because the danger or harm from neglect is often cumulative, and thus may not be immediately apparent, the Legislature should delete this language. Consideration should be given to amending the definition to state clearly that neglect may result from an act or omission, or a pattern of conduct, that constitutes a substantial danger to the child’s health, welfare or safety. These changes would provide CPS with clear authority to pursue more timely investigations and interventions. In addition, RCW 13.34 should be amended to authorize courts to consider cumulative harm when determining whether a child is dependent. This change would help the system address and prevent ongoing harm to chronically neglected children.

Recommendation

2 Require “mandated reporter” training for professionals and service providers that are required by state law to report child abuse and neglect as a condition for receiving a professional license or certification, foster-care license or contract to provide in-home services.

Background: In the 1999 Annual Report, the Ombudsman identified the failure of professionals and other service providers to report suspected child abuse and neglect, or cause a report to be made, to Child Protective Services (CPS) or law enforcement as required by state law (RCW 26.44.030).⁸ The Ombudsman has encountered several situations in which professionals required by state law to report suspected child abuse or neglect (including physicians, dentists, mental health professionals, and teachers) have failed to do so, thus leaving children at risk, and in some cases, subjected to ongoing abuse or neglect. This issue was highlighted in the Zy’Nyia Nobles fatality case in which a foster parent, family support worker, and DSHS contracted in-home day care provider failed to report their suspicions that the three-year old girl was being abused by her mother. Research surveys indicate that reports from mandated reporters are much more likely to be substantiated than reports from other individuals.⁹

Rationale: Research surveys repeatedly indicate that one in three mandated reporters who have had contact with suspected child abuse or neglect have declined to report. Research also indicates that one of the primary reasons for the failure of individuals to report is that they lack knowledge about the indicators of abuse, the legal mandate to report, what to report, and the procedures for reporting. In addition, many professionals express concern about the implications of reporting, the impact on their relationship with their clients, and the perceived difficulty in interacting with CPS.¹⁰ Many researchers have concluded that training and continuing professional education is the best way to address these issues.¹¹

With the exception of certified teachers and some State-contracted in-home service providers, mandated reporters in Washington State are not required to receive notice or training on their duty to report child abuse and neglect. Moreover, for most professionals—including physicians, nurses, and mental health professionals—child maltreatment and reporting is an optional training topic for continuing education credit. Most mandated reporters therefore receive

little or no training on their duty to report suspected child maltreatment. As a result, they are not fully aware of their legal responsibilities, what, when, and how to report, or to whom a report must be made.

Alaska, Iowa and New York, require mandated reporters to complete training on the identification and reporting of child maltreatment within six months of initial employment (Alaska and Iowa), or to fulfill their professional licensing requirements (New York). Alaska and Iowa also require completion of two hours of additional training every five years. California and Illinois require mandated reporters to sign a statement acknowledging their duty to report as a prerequisite to employment. Oregon requires professional licensing, registration and certification boards to notify mandated reporters every two years of their duty to report. The notice, which is developed by the state social services agency, must include what the person is required to report, where to make the report, symptoms of child maltreatment, and a contact number for further information.¹²

Implementation of notice and training requirements would greatly strengthen ongoing efforts by the Children's Justice Interdisciplinary Task Force to increase education and awareness about the child abuse reporting law among mandated reporters. The Task Force recently developed a 20-minute mandated reporting informational video. The video was developed in an attempt to provide a standard and consistent informational resource for Washington's mandated reporters. Under the Task Force's distribution plan, mandated reporters will have "ready access" to the informational videos through the groups and organizations with which they have regular contact.¹³

Recommendation

3 Require DSHS to disseminate descriptive information about the Family and Children's Ombudsman to:

- Children age 12 and older residing in licensed foster care; and state-licensed, certified and operated facilities and institutions;
- Licensed foster parents, and;
- DSHS-contracted providers of in-home services.

Background: The Office of the Family and Children's Ombudsman was established by the Legislature to act as a safety net for vulnerable children. The Legislature was particularly concerned about the safety of children living in substitute care, as well as those living with their parents under State supervision because of abuse or neglect issues.

Rationale: Very few young people residing in foster care or other residential facilities or institutions know about the Ombudsman. The same is true for foster parents and DSHS contractors who provide in-home services to families under State supervision. Only 12 percent of the complaints filed with the Ombudsman during the current reporting period were filed by foster parents, while one complaint each was filed by a young person and an in-home service provider. A young person in foster care recently told the Ombudsman "I think kids need to have somebody on the outside like you to talk to." Moreover, a foster parent reported that she did not know the Ombudsman was available as a resource when a caseworker allegedly failed to respond to her concern about the safety of Zy'Nyia Nobles after she'd been returned to her mother.

State Law Issues

(continued)

12. Alaska State Statute, 47.17.020, 022; California Penal Code, Section 11166; 32 Illinois Compiled Statutes 514; Iowa State Statute, 232.69(3); Oregon Revised Statutes 418.749.
13. Additional information may be obtained by contacting the Children's Justice Interdisciplinary Task Force at: (360) 902-7996.

14. A handbook given to young people entering foster care (DSHS, *Surviving Foster Care*), includes the Ombudsman in a lengthy list of helpful agencies, but does not describe the Ombudsman function or services.

Like many other foster parents, this foster parent reported that she did not receive information about the Ombudsman during her mandated foster parent training. Children residing in substitute care, licensed foster parents, and contracted providers of in-home family support services often know best when a child's health or safety is in jeopardy. Yet, DSHS is not required to provide them with information about their right to contact the Ombudsman if they believe that the department is not adequately addressing a child health or safety issue.¹⁴ The need for such a requirement is underscored by the fact that only 11 percent of all individuals that filed a complaint with the Ombudsman during the current reporting period indicated that they had been referred by DSHS.

System Resource Issues

Recommendation

- 1 Ensure that caseworkers have a reasonable workload.

Background: According to the Children's Administration, caseworkers carry on average 29 cases. This average caseload size far exceeds the national standards established by the Council on Accreditation (COA) for Children and Family Services of 20 cases per caseworker. The Zy'Nyia Nobles Community Fatality Review Team found that the current average caseload "severely limits social workers' ability to thoughtfully manage each family's case." Moreover, the committee "strongly" recommended that the Children's Administration hire "sufficient clerical and paralegal staff to allow social workers to focus on case management and family contact." In their contacts with the Ombudsman, caseworkers often report feeling overwhelmed and stressed by their workload.

Rationale: The child protection system can no longer be expected to meet its demanding and vitally important responsibilities without adequate resources. At a minimum, the system needs caseworkers with sufficient time to carefully investigate and appraise their cases.

Recommendation

- 2 Provide a guardian ad litem or volunteer court-appointed special advocate for every child that is the subject of a dependency proceeding.

Background: Although State law requires the appointment of a guardian ad litem (GAL) or volunteer court-appointed special advocate (CASA), the Ombudsman found in a 1999 report that about one-third of the children who were the subject of a dependency proceeding did not have GAL or CASA representation.¹⁵ Over one-half of the children involved in proceedings in King, Snohomish, and Spokane counties did not have a GAL or CASA. Moreover, the Ombudsman found that the caseloads of GALs in some counties, including Pierce, Spokane and Yakima, were exceedingly high. The Ombudsman recommended the appropriation of funds to establish or expand volunteer CASA programs as a means for ensuring representation for all children. The 1999 Legislature responded by appropriating one million dollars to recruit, train

15. Office of the Family and Children's Ombudsman, (January 1999) *Guardian Ad Litem Representation of Children in Child Abuse and Neglect Proceedings*: www.governor.wa.gov/ofco.

System Resource Issues

(continued)

and support additional volunteer CASAs. This helped to increase the number of children represented by a CASA, although many children still lack representation. More recently, the Zy’Nyia Nobles Community Fatality Review Team found that the Pierce County GAL assigned to Zy’Nyia’s case was carrying about 144 cases at the time of the child’s death. According to the Review Team, “this caseload clearly does not allow enough time for the assigned GAL to adequately investigate cases and simultaneously attend to other case obligations.” The Review Team recommended that Pierce County “aggressively seek to expand its volunteer CASA program,” noting that the National CASA Association recommends three cases per volunteer CASA.

Rationale: The child protection system can no longer be expected to meet its demanding and vitally important responsibilities without adequate resources. At a minimum, the system needs an independent GAL or CASA for each child to obtain first-hand information about the child’s situation and report it to the court.

Recommendation

3 Provide an adequate supply and range of placement options for children who cannot live safely at home.

Background: In its 1999 Annual Report, the Ombudsman identified as a major concern the lack of available and appropriate family foster homes, group homes and residential treatment facilities for children. The Ombudsman noted that the lack of this resource often results in children being left or placed in unsafe situations. For example, children for whom a placement is not available have been and continue to be housed overnight in DCFS office buildings in Everett, Seattle, and Vancouver. The Washington State Institute for Public Policy is conducting a study on children’s placement needs. The study is intended to help policymakers and agency officials identify what resources are needed to ensure an adequate range and supply of placement options for children.

Rationale: The child protection system can no longer be expected to meet its demanding and vitally important responsibilities without adequate resources. At a minimum, the system needs an adequate range and supply of placement options for children who cannot live safely at home.

Recommendation

4 Improve children’s access to community mental health and residential treatment services.

Background: Community mental health services for children are provided through a complex system comprised of county-based regional support networks (RSN). Currently there is a chronic lack of community mental health resources available through RSNs for dependent children across the State. This problem has become acute in some areas. Children in the Spokane area reportedly must wait two months or longer for mental health assessments

System Resource Issues

(continued)

16. Multiple placements experienced by young people in foster care is the subject of *Braam et al. v. State of Washington*, a class action lawsuit that has been filed against the state.

Access to children’s residential treatment services is even more daunting. The Ombudsman encountered several cases in the last year in which dependent children were left with or returned to abusive parents, or placed in other unsafe or inappropriate situations, due to the unavailability of residential assessment and treatment services. Further, the Ombudsman has found that the extreme difficulty of accessing long-term psychiatric residential care through the Children’s Long Term Inpatient Program (CLIP) discourages and often prevents caseworkers from obtaining this service for dependent children. Washington State currently funds 96 beds through the CLIP program, which serves both voluntary and involuntary admittees. Like other children seeking voluntary admission to a state-funded CLIP facility, dependent children often have to wait three months or longer for admission. Many dependent children experience acute crisis and/or behavioral problems while waiting for a residential opening to become available, often leaving themselves and others at significant risk of harm. In addition, children often experience one or more disruptions in their foster placement.¹⁶

Rationale: The state mental health system is not providing children with adequate access to appropriate services. At a minimum, the state should ensure that it meets the mental health needs of children who are dependent because of abuse or neglect.

Recommendation

5 Provide the Family and Children’s Ombudsman with the capacity to monitor agency supervision of children’s health and safety in residential settings.

Background: The Family and Children’s Ombudsman was one of several reforms instituted by state policymakers in the wake of reports of child maltreatment that occurred over a period of years at the OK Boys Ranch, a state-contracted group home.

In an effort to prevent similar problems in the future, the Legislature established the Ombudsman office and directed it to “review periodically the facilities and procedures of state institutions serving children, and state-licensed facilities or residences.”¹⁷ The Legislature intended for an independent entity to periodically review and assess agencies’ oversight, monitoring and investigations of children’s health and safety in residential care.

The Ombudsman recommends adding a children’s residential health and safety ombudsman to the Ombudsman staff to carry out these mandated reviews. The review process would include periodic assessments of agency policies, procedures, and practices relating to the oversight, monitoring and investigation of children’s health and safety in residential settings, as well as periodic site visits. The additional ombudsman would have expertise and experience in children’s residential health and safety issues and work under the direction of the director Ombudsman.

Rationale: Several state agencies operate, contract, certify and/or license institutions, group home facilities and residences for children. These include: DSHS Children’s Administration, DSHS Juvenile Rehabilitation Administration, DSHS Health and Rehabilitative Services Administration, Department of

17. RCW 43.06A.030(4).

Corrections, Washington State School for the Deaf, and the Washington State School for the Blind. The oversight, monitoring and investigations of these institutions and facilities vary within and across agencies.

This recommendation would help establish consistency and improved coordination within and across agencies by providing the Ombudsman with the capacity and expertise to identify and recommend steps to address inconsistencies, duplication and gaps. No other entity currently performs this independent, cross-agency monitoring function.

Recommendation

1 Prioritize implementation of key provisions of the Kids Come First Action Agenda. Specifically, those provisions relating to the child safety directive and the improved use of Child Protective Teams.

Background: In October, the new DSHS Secretary, Dennis Braddock, released the *Kids Come First Action Agenda*.¹⁸ The Agenda includes a directive establishing that the safety of children takes top priority over other goals related to children and their families. It also includes a number of provisions aimed at improving the safety of children. One of these is to improve the use of Child Protective Teams (CPTs) by “clarify[ing] expectations” and “tracking their performance,” as well as “providing training and new tools to improve their effectiveness.”

Rationale: Secretary Braddock’s focus on child safety is timely and appropriate. The Ombudsman has grown increasingly concerned about the lack of clarity within the Children’s Administration about the agency’s mission. Lacking clear direction, casework practice has varied greatly across the State with respect to the sensitivity and response given to child safety issues. Secretary Braddock’s child safety directive is a vitally important first step in addressing this situation. The next step is for Children’s Administration leadership to work closely with managers, supervisors and caseworkers across the state to develop a clear and collective understanding of the meaning, implications and expectations of this directive in their daily work.

The use and effectiveness of CPTs have also varied widely and are of great concern to the Ombudsman. CPTs are often used as intended—to assist caseworkers with risky or complex placement and case planning decisions. However, CPT members from across the state report that they are also often used to rubber stamp placement or case planning decisions that caseworkers have reached on their own. This issue was highlighted by the Zy’Nyia Nobles Fatality Review Team, which noted that the caseworker presented information to the CPT and others “in a manner to support [the caseworker’s] belief that the children should be returned to their mother.” This practice, which is not uncommon, clearly undermines the purpose and value of CPTs, and it can place children in serious danger. The Agenda’s provisions to improve the use and effectiveness of CPTs are critical, and their implementation should be given high priority by the Children’s Administration. Of particular importance are those provisions aimed at clarifying expectations and training caseworkers and CPT members on the use of CPTs.

DSHS Administration

18. DSHS, *Kids Come First*:
www.wa.gov/dshs.

Recommendation

2 Clarify and strengthen the role of supervisors.

19. *Riveland Report: Child Protective Services in Washington State:*
www.wa.gov/dshs.

Background: In July, Riveland Associates completed an administrative assessment of CPS.¹⁹ The assessment, which was requested by Governor Locke, contains several recommendations for improving CPS. One of these focuses on the role of supervisor. The assessment found that “many [supervisors] do not consider themselves as part of management. We would argue that supervisors are managers” and should be given the responsibilities, authority and accountability needed to carry out “what needs to be done to assure a high level of performance from their staff.” The assessment recommended that DSHS “clarify the management responsibilities and roles for supervisory staff. Create greater alignment between authority, accountability and responsibility for supervisors. Supervisors are the critical link in the chain of accountability that begins with the CPS worker and goes through the DSHS Secretary to the citizens. Increase the time for supervisors to guide and grow staff.”

Similarly, the Zy’Nyia Nobles Community Fatality Review Team found that “supervisors must take an active role in questioning the conclusions that social workers make about a given family, and in reviewing and challenging the social worker’s case plan.” The Fatality Review Team recommended that the Children’s Administration convene a Continuous Quality Insurance team “to address issues such as how the supervisory role can encourage critical thinking and consideration of alternative points of view.”

Rationale: Supervisors play a pivotal role in ensuring the protection of children. As the Riveland assessment stated “They are the glue that binds staff and management by effectively translating management expectations into staff performance.” Yet the Ombudsman has found that supervisors’ views about their role vary greatly, as do their supervision practices. DSHS leaders should follow up on the Riveland and Fatality Review Team recommendations by initiating a serious and comprehensive effort to explore how to clarify and strengthen this key position.

Foster care.

What young people in the system say is working.

Introduction—The State’s foster care problems are well known, and they are receiving considerable attention and study by state policy makers, agency officials and children’s advocates.

Less known is what aspects of the foster care system are working well. Unlike its shortcomings, the system’s strengths have received little attention or study. Efforts to improve the foster care system therefore have been and continue to be devoted almost exclusively to fixing problems. Few attempts are underway to support, reinforce, and amplify those things that are working well.

With these thoughts in mind, the Ombudsman undertook a project earlier this year aimed at learning what is working best in the foster care system. The Ombudsman approached this task by seeking out the perspectives of young people in foster care—it is their lives that are the most directly affected by the system, yet their voices are often missing.

Nearly everyone has heard what is wrong with the foster care system:

Acute shortage of family foster homes, as well as other placement options, for children.

Foster parents often do not receive the training, support and respect they need to adequately care for children.

Needs of many children coming into foster care are not timely assessed or addressed with appropriate services.

Children too often experience numerous and abrupt placement changes during their stay in foster care.

Many young people in foster care feel stigmatized, sensing that they are outsiders who are treated differently because they’re in foster care.

Many children in foster care continue to experience prolonged uncertainty about their future.

Many youth “age out” of foster care lacking adequate preparation for adulthood.

The Ombudsman approach was based on the belief that young people in foster care have the most to teach adults about what in the system is working well and matters most to them.

The primary objective in this project was to explore the potential effectiveness of a strength-focused approach as a means for creating foster care system improvements. Historically the Ombudsman has pursued the mission of promoting improvements by identifying and analyzing system problems and gaps through complaint investigations and system reviews. In this project, the Ombudsman intentionally sought to move away from this analytic, deficit-oriented approach to see what could be learned about system change and foster care through direct communication with young people about their best experiences.

**The Ombudsman initiated
this project, because
change can be achieved by
identifying what works
and focusing energy on
doing more of it.**

The Power of Stories—The Ombudsman project was heavily influenced by a system change approach called *Appreciative Inquiry*. This approach starts with the assumption that any human system is filled with powerful and largely untapped stories of effectiveness, high performance, strengths and emerging possibilities. It asserts that by engaging the system in a comprehensive discovery of these “success” stories and the conditions that make them possible, the system is able to create and focus energy on replicating and enhancing strengths and successes in unprecedented ways.

The Ombudsman appreciative interviews.

The first step in an Appreciative Inquiry process is to determine what topics are to be studied. Positive, open-ended questions about these topics are then developed and used by the system's participants to interview each other. Sometimes hundreds and even thousands of participants are involved in the interview process. The interviews elicit stories that provide a glimpse of what kinds of experiences are possible when the topics of study are most evident and alive. When the interviews are completed, the stories are synthesized (usually by the interviewers themselves) to identify prominent or compelling themes, as well as to uncover the conditions in the system that made the stories possible. This step is followed by a period in which the system's leaders and participants design and then implement an ideal vision of the future that is grounded in the best of what is already working in the system.¹

The Ombudsman identified several topics of study.

These included learning about young people's best experiences in the following areas:

1. **Generally.**
2. **Feeling cared for and accepted.**
3. **Taking initiative and responsibility.**

The Ombudsman was also interested in soliciting young people's ideas for ways to make their experiences in foster care the best they could be.

With these topics in mind, the Ombudsman developed the interview questions on this page, through which to elicit young people's stories. Ombudsman staff, and one contract interviewer, conducted individual interviews of 32 young people, aged 11 to 17 years old, residing in licensed family foster homes. All had been living in foster care for at least one year. Average length of stay was four years; average number of placements was four. The interviews were conducted privately, and most occurred in the young person's foster home. For a complete description of the interview process, see page 42.

The Interview Questions

1 During your time in foster care, you have probably had some tougher times and some better times. For now, I'd like you to remember one of the really good times you've had. It might be a particularly good day or week, or any time when things were going really well for you. Or it might be a great talk you had with someone; or any time you remember as being really special—a time when you felt really good and happy.

2 Think about a time while you've been in foster care when you felt really taken care of by an adult. This could have been a time when someone was really kind or caring, or a time when someone listened to you or helped you get what you wanted.

3 Think about a time while you've been in foster care when you felt really taken care of by an adult, who seemed to just understand what you wanted or needed without you even asking.

4 This next question is an important question for most people and you may need a moment to think about it. It can be a great feeling to be accepted, included in things. Think of a time during your foster care experience when you felt a part of things. This could be a person who made you feel accepted or a part of a group where you felt included.

5 Now I'd like you to think for a moment about your own strengths and gifts. Specifically, I'd like you to remember a time that you went after something that you wanted. It might have been something big or something quite small. Anyway, there was something that you realized that was important to you, and you said to yourself, "Go for it," and, as a result, you made something good happen for yourself.

6 Imagine that you had magic wand and could make anything happen. What three wishes would you have that, starting right now, would make the rest of your time in foster care the best experience you can imagine?

7 The last thing we want to ask you is how adults—who would really like to help—could make a difference for kids that are in foster care. I'd really like to hear your ideas.

Prominent Themes—In each story there is truth from a young person's perspective about something in the system that works for them.

After synthesizing all of the high point stories and ideas elicited through the interviews, the Ombudsman identified three prominent themes. The identified themes reflect the Ombudsman interpretation of the participants' collective perspective on what in the foster care system is working well and matters most to them. The themes are followed by the stories or ideas that best reflect them.

1. For more information about Appreciative Inquiry see OD Practitioner: Journal of the Organization Development Network, Vol. 32, No.1 (2000).

First theme: feeling normal.

What matters most? Feeling like part of a family.

From the perspective of the young people interviewed, success in foster care happens when they feel and are seen by others as not being different. They describe success primarily in terms of feeling and being treated like a regular part of their foster family.

“When I moved in, [my foster parents] made me feel real comfortable. They showed me my room and asked how I wanted to decorate it.”

“I feel like I’m part of the family. When we go to family events, my [foster] brother will say, ‘Come on, be a part of this. You are part of the family.’”

“When I got here it felt...like a normal family. There were four kids and two adults... The home I was in before—the foster mother was too old. There were no other kids in that home. I feel very accepted and included now in my foster home. I am treated like a member of the family. They don’t treat me different—for example, if I do something special, like I was in a play last summer, they didn’t all show up to come and see me in the play. Whoever could make it came to see me, and I liked that because that’s the way it would be for any other family member.”

“My foster mom would make me pull weeds or she would ground me when I was bad. But she didn’t treat me differently from the way she treated her grandkids.”

“Being with my guardian makes me feel like a normal kid. It was hard getting moved around, and now I know I’m going to stay here.”

“The first foster home I was in, we were a family. They were mom and pop. My brother was in the foster home with me, which is probably what made it the best. We always did stuff together. It didn’t matter what we did, we did it together. It was just that you had their [foster parents’] attention and it couldn’t be taken away, not by the phone or any interruptions. What we were doing could not be interrupted. It didn’t matter what we were doing, just that we were doing it together as a family.”

“My foster parents now are great. They don’t treat me like a foster kid. I call them mom and dad. They let me do things like this is my home. They let me paint my room any color I wanted. They give me money to buy things.”

“My [relative foster parent] made me feel accepted in numerous ways: by teaching us the rules of the house; taking us places with her, like to family gatherings; going on family trips to visit relatives; being told ‘I love you’ and getting hugs; having two dogs and two cats.”

“I don’t feel like an outcast. When you first enter a home, you feel like you’re interfering. That’s hard. Here, I feel like part of the family. Here, it’s not so much what they do, it’s their attitude. They don’t treat me like a foster kid. I feel like I can just be myself and they don’t have expectations that I have to live up to. They include me when they go places, like to family get-togethers, and when they introduce me they say, ‘This is my daughter.’ They believe that blood doesn’t have anything to do with being part of a family, and that is what I believe too.”

“At Thanksgiving, our [foster family’s extended family] came over and treated us like we were their own cousins, or nieces and nephews. They gave us hugs, they did stuff with us, and bought stuff for us.”

“My first Christmas in foster care. There were lots of people and everyone made me feel welcome. They treated the foster children the same as their own children. They didn’t introduce us as ‘Oh this is a foster child.’ They seemed to know what we were going through and made us feel welcome. My foster parents introduce me to people as their ‘granddaughter.’”

“The thing is, this [foster] family knows me. Holidays, Christmas, birthdays—they always include me. Even if I’m in a bad mood, I get included. I am included and part of everything. When we have the family picnic, I don’t know everyone, but everyone acknowledges that I’m part of the whole scheme. All the relatives just accept me as family.”

“Last year at Christmas [my foster family’s] whole family was here and their grandchildren. I actually felt like part of the family. I really liked that. They were nice and treated me like a brother.”

“The first two weeks after I moved in [to this foster home], one of the coolest times I’ve ever had is when I got to stay up late playing video games and watch TV and stuff. It felt normal. My foster parents were easy, lots of cats and two dogs. They accepted me and said I am the best kid they ever had and would like another kid like me.”

Second theme: feeling cared about.

"We have been working on [my foster parents'] second house in Ocean Shores. Everybody helped fix up the house. One of my foster brothers and I built a pathway. It was fun. It felt good to be included, and part of the family."

"I feel like family when we all get to go out to dinner. One time we went to Sizzler because it was my foster mom's cousin's birthday. The cousin was going to pay for all of us, but [my foster mom] said 'I'll pay for [me] and [my sister].' This felt really great, like she was saying, 'No, I'll pay for my kids.'"

"At this foster home, they would take me out to eat with their family. They had two little kids, and they would take me with them on their family activities. What probably made it easy for them to include me was that they took a lot of kids for a few days. I was the only one who was there long-term. I was there six months."

What matters most? **Feeling cared about.**

Young people said that success in the foster care system also occurs when they feel truly cared about. They describe success in the following ways: experiencing simple expressions of interest and caring about their feelings and needs—including their need for a connection with their birth family; being able to count on adults for security, structure and guidance; and having opportunities to discover and develop their potential. These experiences were touched upon in many high point stories.

"Show kids lots of love! I wish that other kids could be lucky like me and find good homes."

"Put kids in a family that really cares."

"I wish that all [foster] parents would be nice to foster kids. Be good to them—just like it was her child."

Experiencing simple expressions of interest and caring.

"My [foster] mom knows what I need without me asking. When my mom died, my [foster] mom held me tight. She got me through it and held me tight."

"I grew up taking care of myself. The most I've ever felt taken care of by an adult is here. Just little things make a difference, like [my foster mom] noticed my new pants and asked if I wanted to get my pants hemmed."

"Last year for my birthday [my foster mom] bought me some CDs that she knew I wanted. I didn't have to ask her, she just bought them for me."

"Once when I was really sick, my [foster mom] came down and slept with me. She washed my forehead with a wash towel, gave me aspirin, took my temperature and was really caring. It felt like she was my mom. I sit in [my foster mom's] lap and she will rock me and I can talk to her. I can share my problems and fears and tell her anything. I'm not used to so much attention. I think she understands what it is like because she was a foster kid too. Like after I visit my mom, sometimes my mom says stuff to me, and my [foster mom] will tell me, 'she doesn't mean it, it's just the drugs talking.'"

"When my older sister moved away to Arizona about a month ago, I was really upset. My foster father gave me a card. In the card, he wrote that he was sorry my sister was moving, and that he cared about me. I don't know how he knew what I needed. I was really upset, and I was crying. I was really happy when I read the card. It meant a lot. I just said thanks."

"When I first entered foster care, I was having a really difficult time with my mom. She has a personality disorder with, like, five different personalities, and it's hard to deal with. I didn't talk to anyone about things that were bothering me, and instead I just had a bad attitude. [My foster mom] knew something was wrong. Even though I had only been in placement with [her] for a month or two, I felt comfortable talking to her about my feelings. Before, I never opened up because no one listened. I just acted different and kept things inside. But [my foster mom] listened to me. I felt comfortable talking to her, and she showed me that other people cared about me too. Now it's easier talking about things that are bothering me."

Second theme: feeling cared about.

Experiencing simple expressions of interest and caring. *(continued)*

"It's a little thing, but I'm in sports and I get leg cramps. My foster mom always makes sure there are bananas because they help get rid of the leg cramps."

"My foster mother calls me into the kitchen and gets me to help her, and she talks to me."

"Last year at Christmas, I got everything I really wanted, and felt that I was loved. Not that I didn't before, but I didn't think they would really spend that much on me."

"When I'm mad, my [foster] mom knows and tries to get me talking. She keeps asking even if I have a hard time talking. It shows me she cares about me."

"Foster parents should not be afraid to show affection and bond with foster kids, even if they might move."

"In my first foster home, the first few days I was there I was feeling bad because I was missing my family. My foster mom called my caseworker and asked if I could have a visit with my family. My caseworker arranged it right away. We had a visit at the [DCFS] office, me and my five brothers and sisters, and my grandma. I don't know how my foster mother knew what I wanted, but I suppose she saw I was feeling sad."

"My dad died, and I was really sad and down. My [foster] mom was really nice telling me it was OK, and I would be all right. We talked about my feelings and that she would always be there to help me. She listened to me a lot and took me to lunch."

"I felt really happy on my last birthday. My foster family made it really special for me. They brought cake and ice cream, and sang to me, and we just sat around and talked. What made it so special was just having people around me that really loved me. It was different from my other birthdays because when I was living with my dad, he would make me plan my own birthday and he didn't really plan anything special. This was different because they just surprised me, and I didn't have to do anything."

"My foster mother recently—for a surprise because I am on the Honor Roll at school—bought me a new king size comforter and some special deep pocket sheets for my bed. She took me shopping, and I picked out what I wanted and the sheets go perfect!"

"At Christmas, my foster parents bought me a CD Walkman, a Tweetie sweater, and some overalls. They knew I wouldn't be getting anything for Christmas. It made me feel good inside because I wasn't expecting anything, and no one had done that for me before. I said, 'thank you very much.' I felt like crying. It was very nice. I just let them know I appreciated it."

"The first day I came here, I was nine. It was almost Christmas. At Christmas I got a Super Nintendo. It was special. I got a lot of stuff. I didn't expect any of that."

"One day, my [foster] mom and I spent the day together. It was just a regular weekend day. We cleaned the house together, then we went to the store together. Then we made dinner for everyone at home, and we went to a restaurant for dinner and to see a movie, just the two of us. What made it so special was spending time together by ourselves."

"My foster mom gets me things without me having to ask, and she seems to know when I need something. Like, she just seems to know when I need more socks—and I don't know how because I do my own laundry. I will just come home from school and there will be a bag of socks. Sometimes she'll buy me new clothes or stuff for my hair. She always gets the right size of clothes."

"My foster mother had six foster kids in her home. She would buy us all our own toiletries, shampoo and deodorant and things, and she would put our name on the things so it was just for us. It's the only foster home I've been in where we didn't have to share things like that. When I went to my last foster home, I didn't have any thick, warm socks to walk around the house in, and my foster mother just bought me some and set them on my bed like a gift. I guess she knew I needed them as I was walking around barefoot in the winter!"

"My social worker sent me a clothing voucher in the mail without me asking for it. It was August, with plenty of time before school started, and I wasn't expecting it at all. I was really happy I could get new clothes for school. Next time I saw my caseworker was when he did a health and safety visit, and I thanked him."

"I have a good caseworker. She always gets back to me when I call and remembers things, like if I need a bus pass or a clothing voucher, she doesn't forget. She also went out of her way for me to arrange my counseling so I could stay with this counselor. It has been a lot of hassles with insurance, but she did it."

"Last year, I was starting at a new school and moving into a foster home at the same time. My Spanish teacher just sensed something was wrong and asked if I was okay. She was new at the school, and I didn't know her, but we talked and I could relate to her. At Christmas, she gave me a little angel anonymously. I knew she gave it to me, and I asked her. But she said she didn't and that it must mean I have a guardian angel."

"My teacher last year recognized that I shouldn't be in special-ed classes. He got me out of special ed into the regular school program. Now being in special ed won't work against me when I'm in college or whatever. Now I am taking all the right classes, and I'm fine with my pre-college requirements. He moved me to sophomore English too. If it wasn't for that teacher, I probably wouldn't have gotten out of special ed. To make it simple, it felt good."

Supporting connections with my birth family.

"When I first moved into foster care they let me go see my mom. I really needed to see my mom...I wish I could visit [my adult sister] more often."

"I wish I could be out of foster care and be living with my sister and she would be my legal guardian."

"Last year, during the summer, my foster mom and my [foster] family—my sisters and my uncle—went to Louisiana for a week to visit my 101 year-old grandmother. She was healthy and just great! She didn't seem 101. She was so happy to see us. There was also an 80 year-old uncle. We just wanted to go see relatives."

"When I first moved to my aunt's [foster home], I thought it was another foster home. I had not met her before and didn't know she was my aunt. Immediately everything was different. She wanted to get to know me and my brother, and she told us all about our family. Because of my aunt, I have gotten to know my grandmother, great-grandmother, aunts, uncles, and cousins. Every other year we visit relatives in California. I am happy to be with family."

"I would see [my grandmother] every two weeks or so, and she would always plan ahead for things for us to do. She knew us and the things we were interested in and what we liked to do. It makes me feel good that someone knows what I like and cares enough to want me to be happy."

"A really special time was about two weeks ago when I met my brother for the first time. Actually, he last saw me when I was three years old but I don't remember him. My foster parents really care about my family. I told them I wanted to meet my brother, and they talked to my caseworker about it. My sister knew where he was living. My brother is 32 years old now. He has his own family. His whole family came over here to my foster home and we had a two-hour visit. Meeting him and his family was great. I had talked to him on the phone a couple of times. He was really funny. He made me laugh. I really like that [my foster parents] care about my family and they made this happen for me."

"My grandma lives nearby and my foster mother let me go see her. She said, 'I don't want to hold you back from your family.'"

"I'm happy when I visit my sisters. It's fun, and we like to see each other."

"I am happy whenever I go down and see my sister and her family. They accept me for who I am. My brother-in-law asked me why I hide my feelings. He thinks about me. They are very much a part of my life, and I can talk to them about anything. They both treat me like a person. They love me, and they show it."

"My older sister (age 17) would come and find me when I had a fight with my foster mother. I would usually go up to the school, which was only about four blocks away. My sister would come and talk to me. She would give me advice and make me feel more comfortable. She would talk me into going back. My sister knew I needed someone to talk to, someone who cared about me. I would feel much better after talking to her."

"My only wish is for them to hurry up and get the visits with my mom figured out. We are going to have visits at my grandpa's house and he will supervise them. My grandfather, my mom and my [foster] Dad are going to sit down and talk about rules and guidelines for the visits. I want to have visits with my mom, but this won't be that often, just once every three months or so."

"I wish my brother could live me. He's in foster care with a relative in Idaho. We were very close when we were younger, but we grew apart. I think they should put brothers and sisters together in the same home."

"Sometimes the State will say you can't have contact with your brothers or sisters—at one time I wasn't allowed to talk to my brother, except for once a year. That's way too little, and I got out of touch with my brother."

Second theme: feeling cared about.

Supporting connections with my birth family.

(continued)

"I wish I could stay with my sister and brother who is in the system some other place. He's 16, and I wish that him and me and my sister could be together."

"I think that caseworkers should help kids find their parents. My caseworker says, 'I'll do it' but then he doesn't do anything. I tell him how to find my dad and he says, 'That's a good idea,' but when I ask him again, he hasn't done the good idea or anything else. I think he has some information that he does not tell me, but I don't know for sure."

Being able to count on adults for security, structure and guidance.

"I've been [in this foster home] for seven years. I feel safe here."

"I used to be afraid of losing this placement, but now I'm more secure because I'm in a guardianship."

"Last year I was having trouble in math and my foster dad showed me so many steps until I just learned it."

"One day while I was working this past summer, I missed the last transit bus and I was really scared I would be left there all alone. I called home and my foster mother answered. I was worried no one would be home. She said right away that she would come and pick me up and told me not to worry. When she picked me up she gave me a big hug. What I needed was for someone to tell me it was going to be OK. I was so relieved. It made me know she cared because she came right away."

"My very first foster mom accepted me. I was really scared when I first went into foster care, and I locked the keys in the car one time. She didn't get mad. One time I was sick, and she let me stay home, and didn't get mad."

"They were going to put me in a foster home in Ellensburg, but I said I would wait at the [crisis residential center] because I didn't want to move away and change schools. It was near the end of school when I finally moved to my new foster home in Yakima. It was very scary because I didn't know where I was going or who would be there. I found out I knew [my new foster mother's son] from school, so then I felt better. I wish that I could stay here in this foster home for the rest of my time in foster care."

"If had a foster child, I'd make sure they had discipline. Make sure they do their homework. Someone has to be in charge, someone has to make sure things get pulled back in line, and to provide some consistency. Consistency, structure and organization. That's what kids need to have the home be complete."

"In this foster home, we know what the schedule is going to be, we know what happens each day and what we need to do. Some kids are lost, they don't know whether they are coming or going, and they are put in so many different foster homes."

"My foster mother walked me to my class the first day of school and introduced me to my teacher. She talked to him for a while and made it easier than I thought it would be. She hand-picked my teachers. New schools are always hard. I was worried, but things turned out OK."

"My foster parents paid attention to my grades. They wanted progress reports from school about how I was doing, and they were willing to help me with my homework. They put me on a homework schedule where I could play after school but at some point I had to get down to my homework. They gave me a lot of attention and a lot of love. They helped me with my social life too. They taught me good skills for making friends and asking girls to dance and stuff."

"My foster mom got me help with my phonics. My foster mom's friend got me into a reading program, and it helps me a lot. She knew I needed help reading. I can read chapter books now. I just read the first page of a Harry Potter book. The only things I want for my birthday are chapter books. My foster mom's friend comes to the house to help me with my reading."

"In sixth grade, I was getting really bad grades. I wasn't doing my homework. My [foster] Mom helped me get better grades. She helped me everyday after school and, in the seventh and eighth grade, I got better grades. Now I do my homework every day after school, and my grades are good. It's not hard."

"When I first moved into foster care, I had a negative attitude. I did okay at home, but at school I was getting Fs. I was rude, had a smart mouth and would tell teachers, 'F-you.' But every night, my [foster mom] would sit here at the table and make sure I worked at my homework. I got straight As and won a citizenship award at the end of the year, and then won it again the next year. I never thought I was smart, but now I've turned into this good student, 'Ms. Preppy'."

"My [foster] mom showed me how to budget money so I won't overspend."

"Science is my hardest subject. My aunt encouraged me. She told me that she knew I could try harder and as long as I tried hard, she could accept that. I worked hard at my science class and got a B."

"I trust [my foster parents]. They keep their promises; they are solid and consistent people. Kids should be able to trust their foster parents."

"I've been going to my counselor for seven years. Whenever I have problems I talk to her. She gives me advice on how to keep out of trouble, and she has been helping me prepare for [the] Casey [program], telling me about the questions they might ask me."

"I waited four years to get my Lego set. I was fascinated with the motors and the fiber-optics system. It had lights that go on and off, and a crane that goes up and down. I had a subscription for a Lego magazine, and I used to dream of what I would get. When I went into foster care, my foster dad gave me a job as a general contractor's helper—working for him! I earned \$4 an hour, and he taught me how to hammer nails, do demolitions and set-ups, clean up, and all sorts of things. My Lego set cost \$158 so [gets out his calculator], let's see, I worked about 39.5 hours to get enough money."

Having opportunities to discover and develop my potential.

"Change the perception of foster care. It's not a bad thing. Foster care can be a good opportunity for people. I wouldn't be running or playing soccer if I were with my mom."

"I wish I could get into [the] Casey [program]. They help you with college, and they have groups and activities."

"Last month, in my sixth period, the teacher handed me an envelope, and it was a letter from the US Track and Field Association inviting me on a trip of student athletes to China. There will be a 5K race and a 10K race in Beijing on New Year's Day with over 10,000 runners. The trip costs \$2000. When I got home and showed [my foster mom] the invitation, she was really excited and is trying to help me put the trip together and work on ways to get the money for the trip. I started running cross-country just to stay in shape for soccer, but found that I really like it."

"I got a summer job, my first job. I've always wanted a job, and I've always wanted to work with kids. My foster dad helped me fill out all the forms and took me to the orientation and other classes I had to do. My [Independent Living Program] case manager also helped set it up. I was the first person they called to offer me a job! I was a counselor in training over the summer, and next year I will be a counselor! I did really good. Usually people only become counselors after two years. This might lead to other jobs, and I'm really glad I did it."

"I wanted to be in football, and my [foster] dad helped me so I could do it. He said anything I needed, he would help me with it. I knew I would have to practice a lot. I told myself to just do my best and try to get it. It was hard. There were so many other fast kids. But I had a lot of help. My PE teacher helped, my coach, and my friends. My PE teacher let me run laps during PE so I could catch up on my speed and stay there. My coach let me stay after practice, and he helped me with my passing, blocking and my speed. My [foster] dad picks me up because I miss the bus since I stay so late after school. He picks me up, and he helps coach me, and just helps me."

"Last year I was on the sixth grade track team. I really wanted to break the 200 meter Spring record. In the last meet of the season, I broke the record for the whole district by one-tenth of a second. My final time was 27.2. I wouldn't have played sports if I didn't come [to this foster home.] I love playing sports. The [foster] family cheered me a lot, and my foster brother helped me lift weights and run to get ready to break the record."

"In seventh grade, I ran for [student body] president. I wasn't popular and didn't have a lot of friends, but decided I wanted to run. The first thing I had to do was to get 200 signatures to get on the ballot. I got the signatures, and then I made up banners, cards and gave out stickers to get the votes. I wrote a speech, which was approved, and gave it to the student body. Everyone respected my speech, and I met a lot of people. I lost by four votes out of 750. So I felt good about how I did. I had the strength to overcome the fear of not being popular and took a risk to be what I wanted to be."

"I've been dancing ever since I was little—I was always dancing. The summer I moved [to this foster home], my mentor asked me what activity I would like to get involved with. I told him I wanted to do dancing, so we went and signed up. I joined this dance group—a performing drill team at the community center."

"I made the varsity basketball team in seventh and eighth grade. In seventh grade, I didn't think I would make the team; about 20 kids tried out and a lot of them were eighth graders. I hustled and played as hard as I could and made the team. Our coach was good. My aunt went to a lot of our games and encouraged me."

Second theme: feeling cared about.

Third theme: feeling

Having opportunities to discover and develop my potential. *(continued)*

"I'm doing cross-country for the first time. I didn't even really know what it was. I run cross-country—and when the pressure is on—I step myself up. I meet the competition. I keep beating the guys that are ahead of me. I keep getting better. I strive to do better. I keep up my motivation and enthusiasm. My [foster] parents help too. They come to some of the games, and they help with transportation."

"The first day of football practice, the coach was teaching everyone how to run plays. We were all running around doing exercises. We did this for three days after. This is the first time I ever played tackle football. It's been great. It opened a door. You could find out how fast you are. I work at learning the plays, and can diagram plays like the coach does. The coach would tell you that you did a good job. He helps us to get it right. I made the first tackle in the game Thursday. My foster parents came to the first game."

"I told my caseworker and [foster parent] that I wanted to go to cheer-leading classes. They weren't sure about it, but they went and checked out the people who were teaching the class, and then decided that I could take the classes. I had a lot of fun and learned to do cartwheels, and we made pyramids."

"At church we have a choir, and I am with that choir. I sang in front of a whole bunch of people. In Yakima, I sang at the Foster Care conference. I gave a speech and sang there."

"During track last year, we had overnight trips to Spokane and Cashmere, and I really wanted to get to go, but needed permission from the State. So [my foster mom] talked to my caseworker for me and handled stuff so I could go. I went to the state meet last year in track. I work out and jog every day. I want to play football for UNC; it's my goal."

"I signed up for Explorer Cadet to be a cop. I took the test to go to the academy and made it. I go twice a year to training at Fort Lewis and Yakima. I get to go on shift with the local police and can go out on non-dangerous calls with them. I got my social worker to pay for my cadet training, my books, clothes and equipment. I just had to give her a list of what I needed and prices."

What matters most? Feeling like my opinions matter.

Young people said that success in foster care occurs when they feel like adults listen to and respect their opinions. They describe success primarily in terms of feeling that they are able to influence what is happening to them. This seems to be particularly important to young people in foster care because decisions about their lives are often made by a cadre of adults with varying degrees of interest in or familiarity with their individual needs and interests.

"It's easier to get along when I'm given more respect and trust."

"My foster parents trusted me from day one. They showed me the bedroom upstairs, but when I said I wanted to sleep downstairs they didn't say, 'Why, so you can run?'"

"Listen to what kids have to say and look at things from their point of view."

"If kids want to do something that is healthy, let them do it. Let them have a say and support their interests."

"They shouldn't force kids to visit their parents if they don't want to."

"My foster parents have a second house in Ocean Shores, and they thought about moving there. [My foster mom] asked me if it was okay with me if we moved and, if it was, she told me to give her five reasons why it would be good to move to Ocean Shores. Before, my mom moved all the time, and I never had any input. I had to change schools every year. [My foster mom] wanted everyone on board if we decide to move."

like my opinions matter.

“There was a case planning with my caseworker, counselor and parents, and [my foster mom] was there. They were saying things that I didn’t want to happen and made me feel like my opinion didn’t matter. They were saying things like I was irresponsible and manipulative. I was trying to say something, but no one was listening, and I thought I had thought of something really good to say. [My foster mom] got up and leaned over the table and told everyone to stop and listen—that [I] had something to say. I told them that staying at [my foster mom’s] was the best placement, that it was structured and that it was better than staying with a single, male bachelor, and that if they moved me it would set me back, and I would get angry. Everyone was surprised that I said anything because I rarely spoke. I thought no one would listen.”

“I really wanted to leave my [previous] foster home. I wanted to move because I knew it would never work out. My foster mother would not get help. My counselor would come to our house and ask her to participate in counseling or go to a support group, but my foster mother didn’t think she needed it. I would talk to my counselor about it, and she talked to my caseworker. My caseworker said they would only move me if my counselor recommended it. Then my counselor talked to my foster mom about it but she didn’t want to give up the guardianship. So I talked to my counselor some more and she put in her reports that it would be better for me to move. She let me write a letter to [my DCFS caseworker and his supervisor.] They used the letter in court and I got what I wanted. My sisters are happy that I am happy in a new home.”

“Something I really wanted was to get out of my old foster home and guardianship. I didn’t get on well with my foster mother. It just wasn’t working out. I had wanted to get out of there for a year or two. My foster mom was 63. I called her grandma because she said I had to—all the kids had to call her mom or grandma—but I didn’t like it. I complained to my counselor at school, and I kept bugging [my caseworker]. My foster mom didn’t want to give up the guardianship, but then she said she didn’t know how much longer she could take me. [My caseworker] arranged for me to meet [my current foster parents.] I was scared at first, but we all got along as soon as we met. I visited with [my current foster parents] a few times, and then I came to live here. I’m very happy here.”

“[My guardian] really helped me to get off my meds. I was on a bunch of different meds since I was about four years old, for ADD, ADHD, and the meds had lots of side effects. Like I would get migraines and an upset stomach. I had been asking for years to go off the meds, and no one listened to me. They would just change my prescription. But the side effects never went away. At first, [my guardian] told me I had to take my meds, but then he supported me and told the caseworker and everyone else to take me off my meds, which they did. It was kind of cool that he stood up for me. I’ve been off my meds now for six or seven months.”

“I wanted to change schools, and everyone said it wouldn’t happen. I finally asked my case manager, and she went to school with me. I did most of it myself, but she cared and came with me. I got a waiver and went to the school I wanted to go to.”

“If I have a problem, my sister and brother-in-law are there for me. They try to see it from my point of view. They get both mine and my foster mother’s point of view—and don’t totally disregard my point of view. They take my questions seriously and respect my ideas. If I feel upset, I know I can talk to them and be listened to.”

“They stopped my mental health treatment because someone stopped payment, so I’m going to have to get a new therapist, and I don’t want a new therapist. I like the one I have now. My foster mother is going to try to get it fixed so I can still see her.”

2. This process also reinforced our pre-existing belief that foster care should be temporary, and that what young people need most is a family to call their own. The Ombudsman therefore strongly supports ongoing efforts to: prevent the need for young people's entry into foster care; expedite decisions about the future of those who must be placed in foster care, and; ensure that those young people who cannot be reunified with their birth family are provided with an alternative permanent family. To this end, the Families for Kids Partnership has developed and is working to implement the Washington Permanency Framework, a five-year plan for improving policy and practice to ensure that all children in foster care have permanent families. For more information about the Washington Permanency Framework, contact Families for Kids Partnership, (206) 695-3238, www.FFKPartnership.org.

3. The topics to be studied at an Appreciative Summit could include those developed for this project. Moreover, they could be expanded to address those experiences that the young people interviewed by the Ombudsman said they wished could be improved. See: *Young peoples' ideas for improving their experience in foster care on page 42*.

Findings—The Ombudsman found the appreciative interview process to be a powerful and rewarding experience. Our images of young people in foster care shifted subtly during these interviews. We came out of the process with a renewed sense of their individuality, vulnerability, resilience, and awareness. We also experienced a heightened appreciation of foster parents' contributions to the well being of the young people in their care. Further, we were moved and surprised by the young people's interview responses; specifically, by the utter simplicity of their best experiences and wishes, and by the unexpected commonalities and coherence in what they said matters most to them. Finally, the Ombudsman was left feeling energized and hopeful about the possibility of improving young people's experience in foster care. The Ombudsman has concluded that the successes discovered through this process could be replicated and expanded throughout the system if sufficient attention and energy were devoted to such an effort.²

The Ombudsman has developed a single recommendation aimed at enhancing young people's positive experiences while they are in foster care.

Recommendation—The Children's Administration should focus concerted attention, energy and resources on identifying, replicating and enhancing the positive experiences of young people in foster care. Consideration should be given to bringing together a large cross-section of key participants in the foster care system, including young people, public and private-agency leaders and case-workers, foster parents, and guardians ad litem, in an "Appreciative Summit." The purpose of the Summit would be to engage participants in a mutual discovery of what's working best in the foster care system and design specific ways to replicate and amplify these successes throughout the system. Bringing the "whole system into the room" for this purpose not only would generate new possibilities for action, but also would inspire an unprecedented level of trust and commitment to carrying out those actions on behalf of young people.³

Appreciative Inquiry is being used in a variety of systems and organizations throughout the world to accomplish large-scale positive system change. Those employing this approach include private corporations, non-profit organizations, grass roots initiatives and federal and state government agencies. For example, the Washington State Utilities and Transportation Commission (UTC) earlier this year initiated an Appreciative Inquiry process aimed at helping that agency improve the recruitment, satisfaction and retention of its employees. The child welfare system is in great need of a positive change intervention like Appreciative Inquiry. Washington State could serve as a national leader by bringing this innovative approach to the field of child welfare.

An Appreciative Summit would help generate the energy and momentum necessary for achieving powerful and long-lasting change. According to two of the founding practitioners of this method, David Cooperrider and Diana Whitney, the Appreciative Inquiry Summit: *"brings out the best in people, it facilitates the 'whole story' coming together and it inspires highly committed actions on behalf of the whole. Since the inception of The Appreciative Inquiry Summit...we have watched, over and over again, tension turn to enthusiasm, cynicism to collaboration and apathy to inspired action."*⁴

4. Whitney, D., and Cooperrider, D., The Appreciative Inquiry Summit: An Emerging Methodology for Whole System Positive change, OD Practitioner: *Journal of the Organizational Development Network*, Vol. 32, No. 1 (2000), pp. 13-26.

Reactions from people who have participated in Appreciative Summits.

- "It evokes trust."
- "It lets people see and experience a purpose greater than their own or their department's."
- "You get a sense that you are connected to a goodness that comes from the power of the whole. You realize you really need each other."
- "It establishes credibility in the outcomes. When everyone is part of the decision you know it will stick."
- "New norms form quickly. You start to value relationships and getting the whole story."
- "People transcend the 'I' and become a 'we.' What's common becomes apparent."
- "It eliminates false assumptions about other people and other groups. When you get to know someone you realize they aren't exactly what you imagined them to be. You develop compassion for different people instead of judgments."

Young people's response to the Ombudsman Appreciative Interviews.

- "I think it's best to get ideas from kids by talking to them—like you are talking to me. I don't really like talking in a group because I'm afraid to talk in groups."
- "I like that you are talking to kids. Adults need to take the time to talk to kids and find out what's happening with them. To get ideas from kids—it would be good to talk to them like you are."
- "I think it would be best to get ideas from foster kids by having these interviews."
- "How to improve foster care? By asking us. Bring kids in to be interviewed. See if they like foster care. The caseworker could ask kids what could be better."
- "I'd interview kids. I know you can't interview everyone in the whole state, but maybe half."
- "Go and ask kids what they need, like this."
- "It would be best to get ideas from kids by coming and talking to them one on one."

Young peoples' ideas to improve foster care.

The Ombudsman interview protocol included two questions that were designed to elicit young people's wishes and ideas for improving their experience in foster care. Their answers focused on three main areas: transitions into new homes; communication with adults; and participation in ordinary activities.

1 Transitions into a new foster home.

"When a kid first comes into foster care, they should be given a stuffed animal or a toy or something, because they don't have anything with them except the clothes on their back. That's what happened to me—I got to pick out a stuffed animal. I still have it."

"Have stuff ready for the kids ahead of time so when they get [to their new foster home] there are things for them to do -like a play station, TV or boom box. Have a loving family to greet them."

"Caseworkers should give kids information about the foster home they are going to. They should have us meet the foster parents before we get placed there, and let us get to ask them questions with our social worker there, before we just get taken there. That is the scariest part of foster care, when you don't know where you are going or anything about the people you are going to."

"Caseworkers should help kids get adjusted to a new [foster] home—they shouldn't just put them in a new home and leave them there. They should come and visit to see how you are doing, or at least call. It's scary going to a new home."

"Make sure the child likes the [foster] home. Don't just put them there and say 'It's good just because the state and the foster family says it's OK.'"

"I would ask foster kids, do they like the foster mom? Are they doing OK?"

2 Communication with adults.

"I think caseworkers should explain more to kids about what's going to happen to them. When I got removed, the cops came, my mom was crying and then I was in a different home. Just talk to the kids more. I e-mail my caseworker a lot."

"When the police came to our house with two ladies to take us away, they said, 'Just grab enough stuff for three days, and you'll come home in three days.' I think they should not have told us that because we didn't come back."

"I think caseworkers should tell kids what the foster parents can and can't do. Some foster parents say it's OK for them to hit kids as long as they don't leave a bruise. My [previous] foster mom would say that when she hit me. I did tell my counselor she was hitting me and my counselor told me it's not OK but I wish I would have known sooner."

"I think foster kids need a direct way to communicate to be heard. Kids should be able to talk to one adult, who should have a meeting with the kids. Or they could have younger kids talk to older kids and the older kids could talk to caseworkers."

"Caseworkers should talk to kids more. My caseworker hardly ever talks to me. They rely too much on counselors and foster parents to talk to us. They should find out how we are doing directly from us."

"Foster kids should be able to e-mail their caseworkers and they should have to e-mail us back."

"I think caseworkers make judgments about what's best for us without asking us what we want. Caseworkers sometimes say they know how you feel, when how can they know? They should be like you [the interviewer], just asking questions and accepting our answers."

"I think caseworkers and GALs (guardians ad litem) forget about kids after a while. My caseworker hasn't called me once since I have been here, except to ask me to do this interview. My GAL has never called me."

"Keep promises! I was told that I would get to stay with my brother. Lie. I was told that I would get to stay in my first foster home. Lie."

"There are some really weird foster parents out there. I think kids need to have somebody on the outside like [the Ombudsman] to talk to, not the caseworker. I might not want to tell my caseworker something because she might get mad or hold a grudge."

3 Participating in ordinary activities.

Staying overnight at a friend's house.

"I wish I didn't always have to get permission from the state to be able to stay overnight at a friend's house."

"The guardianship took me out of the agency system. With the guardianship, I have more freedom. I can go over to a friend's house, or have a friend come over to my house without having to wait for a background check. Those decisions are left up to [my guardian] and me."

"Foster children should be able to spend the night over at a friend's house without everybody having to get background checks."

"The system is too afraid of what might happen that it can't trust itself. Like getting background clearances and criminal background checks just to stay over at a friend's house or have a friend over at my house."

"The system should make exceptions to all the rules for kids that don't need the rules. Like with the background checks before you can stay over at a friend's house. I never stay overnight at my friend's. I just tell them that I can come to their party but I can't stay over night."

Getting a driver's license.

"They should change the law that says foster kids can't get a driver's license until they are 18, unless the foster parents can put them on their insurance. This is not fair on the foster parents or the kids. This does not give foster kids a chance to be like other kids."

"They should help foster kids get their driver's license. I would like to be able to drive to my appointments, as now I have to take the bus and since it only runs out here every hour, I have to leave for my appointments an hour and a half ahead of time. Foster kids should be able to drive at 16 with an adult in the car, at least for a probation period until they think we can drive alone."

"I wish I could drive when I'm 16. Pass a bill so foster kids can drive, if you have good grades and are doing OK. We should be able to take risks like every kid."

"Foster children shouldn't be punished for one child's mistake. One [foster] kid got in a car wreck... now no foster child can take driver's ed until they are 18."

Buying new clothes.

"I wish kids could get checks for clothes, like \$50 a month or something. I like to have new clothes, but my foster mom can't afford it, and I don't like to ask her for a lot of money."

"Kids should get more clothes than once a year. My foster parents give me money and help me. I bought my last pair of shoes myself. Clothes vouchers don't pay for hardly anything. They don't even pay for underwear—just a pair of pants and a couple of shirts."

"I think foster kids should get a small amount of money per month for themselves. Sometimes the foster parents don't give the kids an allowance. I know it can't be a big amount, and it should be based on the kid's age and their behavior. Older kids like me could get about \$75 just to get some of the things they need."

"If I were an adult trying to help the foster care system, I would do fund raising to help foster care programs. Then I would work with the foster parents and foster child directly with clothing, books and sports equipment that the foster child needed. I would tell the foster child that there was a money limit that could be spent, but if he needed new football cleats, books, clothes, etc., he could buy them."

"I wish I could get an allowance. I always need money—for things like going to the movies, going bowling, buying shoes or earrings. I have been sitting around here with not a lot to do because I don't have any money to do stuff like that."

The young people interviewed by the Ombudsman.

The 32 young people whom the Ombudsman interviewed as part of its Foster Youth Appreciative Inquiry Project were selected with the assistance of DCFS and private agency caseworkers. The Ombudsman contacted DCFS and agency staff to help identify young people on their caseloads with the demographic characteristics sought by the Ombudsman. Each young person agreed to be interviewed after reviewing information about the purpose and nature of the project. Ombudsman staff (and one contracted interviewer) conducted individual interviews at or nearby the young person’s foster home.

Interview Participants

Sex:

Female: 17
 Male: 15

Age:

11-12 5
 13-14 12
 15-16 13
 17 2

Race:

Caucasian 22
 African American 6
 Asian 2
 Biracial (including
 Native American) 2

Ethnicity:

Non-Hispanic 25
 Hispanic 7

Cumulative Years in Out of Home Placement:

1-2 yrs 1
 3-4 yrs 7
 5-6 yrs 6
 7-8 yrs 6
 9+ yrs 2

Number of (Non-Respite) Placements:

1-2 15
 3-4 6
 5-6 5
 7-8 3
 9+ 3

Current Placement Information:

Placement Licensed By:
 DSHS 23
 Private Agency 9

Placement Type:

Non-Relative or Kinship 30
 Relative/Kinship 2

Geographic Location:

Region 1 5
 Region 2 5
 Region 3 5
 Region 4 9
 Region 5 5
 Region 6 3

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The Ombudsman takes immediate action to protect an infant from harm.

A community professional contacted the Ombudsman with her concern that DCFS was not moving to protect an infant whose mother was being discharged from a residential drug treatment facility. The mother was planning to leave the facility, with her infant, that day. The mother had a history of substance abuse, domestic violence, mental health problems, and extreme drug-seeking behavior. She was planning to take a bus to her home in another part of the state, and be picked up at the other end by her boyfriend, who was also considered a danger to the child. The professional believed that the DCFS office in this city was hesitant to intervene because it wanted the DCFS office in the mother's home city to retain responsibility for this family. (Two of the mother's children were currently in foster care in that city, with petitions filed for terminating her parental rights.)

The Ombudsman immediately contacted DCFS, which informed the Ombudsman that it had directed the treatment facility not to allow the mother to leave with the child, and to call the police if she attempted to do so. Unbeknownst to DCFS, however, the facility had in fact decided to allow the mother to leave with the infant and had decided against calling law enforcement or CPS in order to avoid upsetting the mother. The professional was unable to reach DCFS to report this development, and again contacted the Ombudsman. The Ombudsman immediately contacted DCFS, which swiftly intervened to prevent the mother from taking the infant on the bus. In the course of investigating this complaint, the Ombudsman learned that when DCFS received the professional's CPS report earlier that day, a dispute ensued between that office and the DCFS office in the mother's home city regarding which office should be responsible for placing this infant. In sharing information showing that the infant was at imminent risk of harm, the Ombudsman assisted the two offices in refocusing their priorities on swift intervention to protect the child.

Contacting the Ombudsman.

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The report is also available at the Ombudsman Web site:
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