Activities and Recommendations

Office of the Family & Children's Ombudsman

2006 annual report

STATE OF WASHINGTON

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN

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November 2007

To the Residents of Washington State:

I am pleased to present to you the 2006 Annual Report of the Office of the Family and Children's Ombudsman. This year marks our 10 year anniversary as a watchdog over the child welfare system serving children and families. Our priority continues to be child safety.

Naturally, this 10 year mark invites introspection. Although proud of OFCO initiated improvements to the system, we are woefully aware of improvements that have not been made and feature some of these in our report: the need for better case practice in Native cases; manageable caseloads; and a more effective response to children with developmental disabilities and mental health needs.

Governor Gregoire's keen leadership has resulted in several encouraging steps: quicker CPS response times on investigations; increased health and safety checks of children; and dedication of significant resources to address the disproportionate number of Native child fatalities (which we reported in last year's annual report). We appreciate her expertise in this field, which helps to support the work we do.

The Legislature had an extremely active and productive session in 2007. The Joint Task Force on Child Safety, on which we participated, submitted several key proposals to the Legislature which were adopted and then signed into law by the Governor. Among these were: Sirita's Law, which imposes greater scrutiny on caregivers; and the Rafael Gomez Act, requiring original documentation to courts to improve decision making. We thank the Legislature for its hard work as they gear up once again for a new legislative session.

This report discusses the critical work of the Braam Panel and DSHS' efforts to comply with benchmarks and action plans. The Panel, with input from the Plaintiffs and DSHS, has continued to play an instrumental role working to improve the conditions and treatment of children in care. The recently completed Foster Parent Survey provides an invaluable tool for identifying areas that need improvements.

Ten years ago the Legislature entrusted us with the mission of safeguarding children and families by vesting us with an oversight role. Throughout these years we have worked vigilantly with the help of citizens, community professionals, and Children's Administration staff to improve outcomes for children. As we mature as an agency, we are aware of our unfinished work. We greatly value our role as a voice for the families and children of Washington State. Please know that we will continue to rely on your guidance and support in the future. Thank you for contributing to the welfare of children and families.

Sincerely,

Mary Meinig
Director Ombudsman

Advisory Committee

Western Washington Committee

Teresa Berg
Pierce County Sheriff's Office,
Tacoma

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

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WORKETHICS, Seattle

Shirley Caldwell
Therapeutic Health Services,
Seattle

Daryl Daugs*
Families for Kids, Bremerton

Bryna Despar*
Amara Parenting and Adoption
Services, Seattle

Lynnette Jordan
United Indians of All Tribes
Foundation, Seattle

Linda Katz
King County Superior Court,
Seattle

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

Edith Owen
Relatives Raising Children Program,
Tacoma

Gary Preble
Private Attorney, Olympia

Nancy Roberts-Brown
Catalyst for Kids, Seattle

Lois Schipper
Seattle & King County Public Health,
Seattle

Jim Theofelis
The Mockingbird Society,
Seattle

Central Washington Committee

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Chelan/Douglas County
Court Appointed Special Advocate,
Wenatchee

Dan Fessler
Yakima County Department
of Assigned Counsel,
Yakima

Dann Flesher
Relatives as Parents,
Benton City

Laura Gaukroger
Central Washington Health Services,
Wenatchee

Lauri Leaverton
Yakima County
Court Appointed Special Advocate,
Yakima

Sherrie Mashburn
Parents Are Vital in Education,
Sunnyside

Dean Mitchell
Moses Lake Police Department,
Moses Lake

Patty Orona
Yakima County School District,
Yakima

Mary Ann Warren*
Catholic Family and Child Services,
Wenatchee

Eastern Washington Committee

Kelly Busse
Spokane Police Department,
Spokane

Ellen Cady
Northwood Middle School,
Spokane

Greg Casey
Private Attorney,
Spokane

Patrick Donahue
Spokane County
Court Appointed Special Advocate,
Spokane

Tara Dowd
The N.A.T.I.V.E. Project,
Spokane

Barb Feyh*
Community and Family Services,
Spokane Regional Health Division,
Spokane

Cathy Fritz*
Spokane Regional Health District,
Spokane

Art Harper
Foster Parent Liaison,
Spokane

Scott Stevens*
Spokane County
Court Appointed Special Advocate,
Spokane

Windy Telvin
Whitman County
Court Appointed Special Advocate,
Colfax

Rosey Thurman
Team Child,
Spokane

Dave Williams
Partners with Families and Children,
Spokane

Legislative Children's Oversight Committee

Senator Jim Hargrove, Chair
24th District

Senator Jeanne Kohl-Welles
36th District

Senator Val Stevens
39th District

Representative Ruth Kagi
32nd District

*Member through 2006

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Executive Summary

The Office of the Family and Children's Ombudsman ("OFCO" or the "Office") was established as a government "watch dog" 10 years ago in response to failures in the child welfare system that contributed to a high profile child fatality and abuse within a state facility. OFCO became operational in 1997 after the Washington State Legislature enacted Chapter 43.06A RCW in 1996. The law empowered the Ombudsman to investigate complaints about children and families receiving child protection and child welfare services, or about children reported to be at risk of abuse, neglect, or other harm. The Legislature directed the Ombudsman to recommend system-wide improvements in the area of child welfare to benefit children and families.

The Ombudsman's Role:

- Investigate and respond to complaints
- Recommend system-wide improvements
- Educate citizens about the child welfare process
- Act on behalf of children and families

The Role of the Ombudsman

OFCO is a small cabinet level state agency located organizationally within the Office of the Governor; the Director Ombudsman reports directly to the Governor. Our agency is independent and separate from the Department of Social and Health Services (DSHS), the main agency whose actions we investigate.

Acting as a fact finder, the Ombudsman provides families and citizens across the State an avenue through which they can obtain **independent and impartial review** of the decisions made by DSHS and other state agencies. The Ombudsman determines whether the state agency has violated law, policy, or procedure and persuades the agency to take corrective action if we make such a determination. OFCO maintains the confidentiality of complainants unless such confidentiality is waived by the citizen.

OFCO's most important feature is its independence. This feature allows OFCO to exercise its independent judgment in determining whether to investigate a matter or to decline a request to investigate if the Ombudsman determines that the request is not consistent with the criteria or priorities specified in law, rule, or OFCO policy.

The Ombudsman does not act as an advocate, but rather as a **neutral investigator** of complaints. This means that the Ombudsman is neither an advocate for citizens who bring their complaints to our attention, nor for the governmental agencies investigated. The ability of OFCO to review and analyze complaints dispassionately and make findings and recommendations free of political bias and influence gives the office its reputation for integrity and objectivity.

The Ombudsman performs its duties by focusing its resources—five and a half full-time staff and a biennial budget of nearly one million dollars for the reporting year this annual report covers[1]—on

[1] In the FY 2007-2009 biennium OFCO was appropriated additional monies by the Legislature. This allowed us to add another full time position and increased our budget to approximately $1.28 million over a two year period.

complaint investigations, complaint intervention and resolution, and system investigations and improvements. Each year we issue an annual report which contains our recommendations to reform the child welfare system and identifies specific issues of concern.

Inquiries and Complaints

A fundamental aspect of the Ombudsman's work is to respond to the needs of citizens by listening to their concerns, educating them about the child welfare process and referring them to appropriate resources to assist them with a particular issue. To respond effectively to citizens' questions and concerns, the Ombudsman first determines if their concern falls within the scope of the Ombudsman to investigate, or if there is another resource available to better assist them.

OFCO's reporting year runs from September 1st of a given year to August 31st. Between September 1, 2005 and August 31, 2006, the Ombudsman received 1513 inquiries from families and citizens who needed information and/or referrals to other resources. Over this time period, the Ombudsman received 511 complaints.

The Ombudsman handles inquiries and complaints from a broad variety of citizens across the State, spanning the 6 regions over which DSHS conducts its work. The greatest number of inquiries and complaints came from Region 4 which comprises King County and is the most densely populated region of the state; the least were from Region 2, which encompasses Yakima and its surrounding area.

The Ombudsman most frequently heard from parents and other family members. The top two issues citizens brought to the Ombudsman were 1) complaints about child safety, expressing concerns about the inadequate response by DSHS to reported maltreatment of children, and 2) complaints expressing concerns about family separations and reunification. In addition, a significant number of complaints involved the health, well-being and permanency of dependent children.

Complaint Investigation and Ombudsman in Action

One of the Ombudsman's top priorities is investigating and evaluating complaints. This activity takes up the majority of our time. Impartial investigation and analysis enable the office to respond effectively when action is necessary to facilitate resolution of a concern or induce corrective action by the agency.

Between September 1, 2005 and August 31, 2006, the Ombudsman completed 477 complaint investigations. This was a record high for the office. The majority of completed investigations (85%) were standard, non-emergent investigations. Approximately 1 out of 7 complaints, however, met the Ombudsman criteria for an emergent complaint. These most often involved issues of imminent child safety or well-being.

The annual report includes four main categories of Ombudsman actions: inducing corrective action, facilitating resolution, assisting the agency in avoiding errors and conducting better practice, and preventing future mistakes.

Review of Fatalities

The Ombudsman receives notice from DSHS/DCFS on every fatality within the State known to DCFS. This information sharing is a critical step in the Ombudsman's review of cases in which child abuse or

neglect is identified as a factor in the death of a child. The results of our review of child fatalities will be reported in our 2007 annual report, which will be issued in 2008.

Issues and Recommendations

In addition to our complaint investigations, the Ombudsman spends a significant amount of time identifying and investigating system-wide problems. The Ombudsman has identified and investigated three areas of concern that are the subject of findings and recommendations in this report:

1. **Compliance with the Indian Child Welfare Act.** This section is entitled: "Indian Children and Families: Is the Current System Fulfilling their Unique Recognition under the Law?

2. **Providing more effective wraparound services up front and better access to in-patient treatment for children who need long-term mental health treatment.** This section is entitled: "Families in Crisis: Fractured System Fails Children with Special Needs."

3. **Establish Manageable Workloads.** This recommendation has been put under the section entitled: "Response to OFCO 2005 Annual Report," as it strongly reiterates a recommendation that we made in last year's annual report and in prior annual reports as well and it includes Children's Administration's (CA) response to the recommendation.

Response to OFCO 2005 Annual Report

This section details the responses of CA to systemic recommendations made by the Ombudsman in our 2004-2005 Annual Report. These responses include a number of policy changes on the part of the Children's Administration to improve notification to caregivers of staffings and hearings, initiation of a foster parent survey (now completed and discussed under the Braam section of this annual report) and to revise CA's visitation policy to clarify who can participate in visits with a child and encourage visits between a child and people of significance to the child. Additionally, in response to the Ombudsman's recommendation that caseloads be reduced, this section also notes additional funding to the CA budget for additional caseworkers and that the CA is continuing to pursue accreditation for its offices through the Council on Accreditation. As noted above, this section includes our recommendation, once again, that caseloads be established at a manageable level.

Legislative Update

As part of the Ombudsman's duty to recommend systemic change, the Ombudsman reviews and analyzes proposed legislation, and testifies before the Legislature on pending bills. The 2007 legislative session was extremely active in the child welfare arena. This section highlights bills that were introduced and passed as well as some that were not enacted, but which the Ombudsman thought were significant.

Braam Panel

This section of the annual report reminds readers of the final settlement goals in the Braam v. State of Washington class action lawsuit and discusses highlights for 2007, particularly the results of the state-wide foster parent survey.

Appendices

Among the appendices are sections that feature "Ombudsman Activities" and "OFCO in the News." In addition to investigating complaints and investigating systemic problems, the Ombudsman is also charged with promoting public awareness and understanding of family and children services. The Ombudsman accomplishes this task by actively participating on committees established to critically examine child protection/welfare issues, presenting at conferences, reviewing and analyzing proposed legislation, testifying before the Legislature, and conducting site visits of state-licensed facilities. The Ombudsman Activities appendix lists such activities in the 2005-06 reporting year.

"OFCO in the News" profiles news articles in which the Ombudsman was featured and/or asked to provide an opinion.

Terms and Acronyms:

Dependent Child .....A child for whom the state is acting as the legal parent.
CA .....Children's Administration
CAMIS .....Children's Administration Care Management Systems
COA .....Council on Accreditation of Services for Families and Children
CPS.....Child Protective Services
CPT .....Child Protection Team
CWS.....Child Welfare Services
DCFS.....Division of Children and Family Services
DDD .....Division of Developmental Disabilities
DMH.....Division of Mental Health
DSHS .....Department of Social and Health Services
FRS.....Family Reconciliation Services
OFCO .....Office of the Family and Children's Ombudsman

The Role of the Ombudsman

The Ombudsman was established by the Washington State Legislature in 1996, following the death of three-year-old Louria Grace, who was killed by her mother while under the supervision of the Department of Social and Health Services (DSHS) and after years of youth-on-youth sexual abuse came to light at the DSHS-licensed OK Boys Ranch.

As well, the office was established during a time of growing concern about DSHS' participation in the Wenatchee child sexual abuse investigations. In each instance, families and citizens who previously had reported concerns about DSHS' conduct lacked an appropriate agency to turn to for an independent review when DSHS did not address their concerns.

In creating the Ombudsman, the Legislature sought to provide families and citizens an avenue through which they could obtain an independent and impartial review of DSHS decisions (See RCW 43.06A). The Legislature also intended for the Ombudsman to intervene to induce DSHS to revisit or change a problematic decision that has placed a child or family at risk of harm and to recommend improvements to system-wide problems.

The Office of the Family and Children's Ombudsman was established to investigate complaints involving children and families receiving child protection or child welfare services, or any child reported to be at risk of abuse, neglect or other harm.

The Ombudsman was also established to monitor the state's protection of children's safety in state-operated and -regulated facilities. In addition, the Legislature directed the Ombudsman to recommend system-wide improvements that benefit children and families. The Ombudsman carries out its duties with independence and impartiality.

Independence

The Ombudsman's independence allows it to perform its duties with freedom and objectivity. The Ombudsman operates as an independent agency under the Office of the Governor. The Ombudsman is located in Tukwila and conducts its operations independently of the Governor's Office in Olympia. The Ombudsman director serves a specified term of office and is required by law to work independently of DSHS.

Authority

The Legislature empowered the Ombudsman by providing it with broad access to confidential information, while also protecting the confidentiality of the Ombudsman's investigative records and the identities of individuals who contact the office. State law provides the Ombudsman with direct access to confidential DSHS records and the agency's computerized case-management system. The office is authorized to receive confidential information from other agencies and service providers as well, including mental health professionals, guardians ad litem, and assistant attorneys general.

State law also authorizes the Ombudsman to maintain the confidentiality of its investigative records and the identity of individuals who contact the office to request information or file a complaint. These provisions enhance the quality of the Ombudsman's investigations. They also encourage individuals to come forward with information and concerns without fear of possible retaliation by others.

While the Ombudsman is not authorized to make, change or set aside a law, policy or an agency practice or decision, the office can publish its investigative findings and system-improvement recommendations in public reports to the Governor and the Legislature. The Ombudsman's ability to identify and publicly expose a problematic law, policy, and agency practice or decision provides the office with significant influence.

In addition, the Ombudsman derives influence from its close proximity to the Governor and the Legislature. The Ombudsman director is appointed by and reports directly to the Governor. The director's appointment is subject to confirmation by the Washington State Senate. The Ombudsman's budget, general operations, and system improvement recommendations are reviewed by the Legislative Children's Oversight Committee.

Work Activities

The Ombudsman performs its statutory duties through its work in four areas.

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

- **Responding to Complaints.** The Ombudsman spends more time investigating complaints than on any other activity. The Ombudsman impartially investigates and analyzes complaints against DSHS and other agencies. Thorough complaint investigations and analyses enable the Ombudsman to respond effectively when action must be taken to change an agency's decision and to accurately identify problematic policy and practice issues that warrant further examination. They also enable the Ombudsman to back up the agency when it is unfairly criticized for properly carrying out its duties.

- **Taking Action on Behalf of Children and Families.** The Ombudsman takes action when it has determined that intervention is necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. The Ombudsman's actions include: prompting the agency to take a "closer look" at a concern; facilitating information sharing; mediating professional disagreements; and sharing the Ombudsman's investigation findings and analysis with the agency to correct a problematic decision. Through these actions, the Ombudsman is often successful in resolving legitimate concerns.

- **Improving the System.** The Ombudsman is responsible for facilitating improvements to the child protection and child welfare system. The Ombudsman works to identify and investigate system-wide problems, and it publishes its findings and recommendations in public reports to agency officials and state policymakers. Through these efforts, the Ombudsman helps to generate better services for children and families.

The Ombudsman utilizes virtually all of its resources – five full-time staff and a biennial budget of nearly one million dollars – to perform these activities[1]. The Ombudsman's work activities are described in more detail in the sections that follow.

[1] In the FY 2007-2009 biennium, OFCO was appropriated additional monies by the Legislature. This allowed us to add another full-time position and increased our budget to approximately $1.28 million over a two-year period.

Staff

Director - Ombudsman
Mary Meinig, Director of the Office of Family and Children's Ombudsman (OFCO), has served as an ombudsman with the office since it opened in 1997. Prior to joining OFCO, Ms. Meinig maintained a successful clinical and consulting practice specializing in treating abused and traumatized children and their families. Her previous experience includes working in special education, child protective services and children's residential treatment settings. Ms. Meinig is nationally known for her work developing Family Resolution Therapy, a protocol for the long-term management of relationships in abusive families. She is frequently asked to present her work at national conferences, and has authored several professional publications on this topic. Ms. Meinig is a graduate of Central Washington University, and received a Master of Social Work degree from the University of Washington. She is a Licensed Independent Clinical Social Worker and member of the Academy of Certified Social Workers.

Ombudsman
Colleen Hinton is a social worker with extensive experience working with children and families. Prior to joining OFCO in 2000, Ms. Hinton performed clinical assessments of children in foster care. At the same time, she worked at Children's Response Center (within Harborview Center for Sexual Assault & Traumatic Stress), providing education and training on child maltreatment. Prior to this work, Ms. Hinton helped to establish the clinical program at Children's Advocacy Center of Manhattan in New York City, and worked as a therapist for the Homebuilders intensive family preservation program in King County. She is a graduate of the University of Natal in South Africa, and received her MSW from the University of North Carolina at Chapel Hill. She is a Licensed Independent Clinical Social Worker and member of the Academy of Certified Social Workers.

Ombudsman
Linda Mason Wilgis is an attorney who before joining OFCO in 2004 served as an Assistant Attorney General for the State of Washington, where from 1991 to 2001 she gained extensive experience in dependency and guardianship cases involving both children and vulnerable adults. Before joining the Office of the Attorney General, Ms. Mason Wilgis was in private practice with a Seattle law firm. She is a graduate of Skidmore College and received her law degree from the University of Virginia. Prior to attending law school, Ms. Mason Wilgis served under Senator Henry M. Jackson as a professional staff member on the U.S. Senate Committee on Energy and Natural Resources.

Ombudsman
Keith Talbot is an attorney who before joining OFCO in 2005 served as a law clerk to the Honorable William W. Baker at the Washington State Court of Appeals and served as a bailiff/law clerk to the Honorable Charles W. Mertel in King County Superior Court. He received a joint J.D./Master of Public Policy from Duke University. Before graduate school, he provided direct service to at-risk youth through experiential education/ leadership training programs with the American Youth Foundation based in New Hampshire, and the Cornstalk Institute based in Albuquerque, NM. He also served two years as a volunteer in the United States Peace Corps working to reduce the infant mortality rate in the southwest of the Dominican Republic.

Ombudsman
Steven Wolfson is a social worker with extensive experience working with families and youth. Prior to joining OFCO in 2004, Mr. Wolfson served as a court appointed Guardian ad Litem, investigating and making recommendations to the court regarding child custody and visitation disputes. From 1990 to 2000, Mr. Wolfson served as Clinical Director at Kent Youth and Family Services. Mr. Wolfson is a graduate of Clark University in Worcester, Massachusetts and received his MSW from the University of Washington. He is a Licensed Independent Clinical Social Worker.

Special Projects/Database Coordinator
Rachel Pigott holds a Master's Degree in Social Work from Boston University. Before joining OFCO in 2005, she worked to improve attendance by working with families through the Boston Public Schools. She spent one year in the AmeriCorps working to strengthen families and to connect undergraduate students from Western Washington University to their community through coordinating service-learning projects. She was also a Program Specialist for the Boston Center for Adult Education.

Information Specialist/Office Administrator
Amy Johnson earned a Bachelor's degree in Communication and Sociology from Pacific Lutheran University. Prior to joining OFCO she worked as a Ticket Sales Coordinator for the Seattle Mariners. She also served as a case aide for DSHS Division of Children and Family Services in 2004. While attending PLU she completed an internship with the Prison Pet Partnership Program within the Washington Correctional Center for Women.

Inquiry and Complaint Profiles

The Ombudsman listens to families and citizens who **contact** the office with questions or concerns about services provided through the child protection and child welfare system. By listening carefully, the Ombudsman is able to respond effectively to their **inquiries** and **complaints**.

This section describes contacts made by families and citizens during the reporting period of September 1, 2005 to August 31, 2006.

Contacts

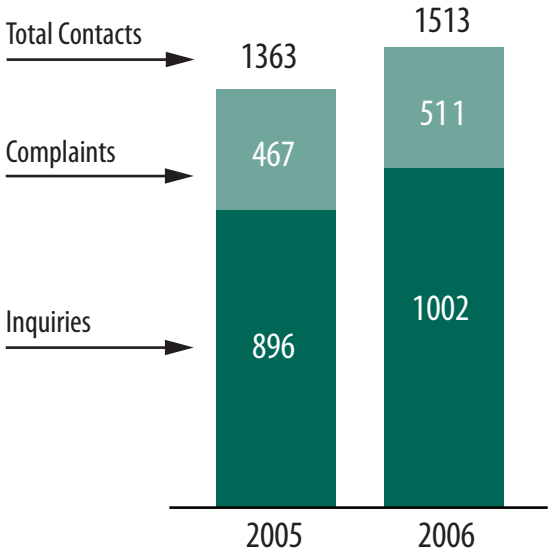
From September 1, 2005 to August 31, 2006, families and citizens contacted the Ombudsman **1513** times[1], representing an increase of 11% over the previous year (see table below). These contacts were primarily **inquiries** made by people seeking information and assistance. Approximately **one-third** of these contacts were formal **complaints** seeking an Ombudsman investigation.

Contacts. When families and citizens contact the Ombudsman, the contact is documented as either an inquiry or complaint.

Inquiries. Persons call or write to the Ombudsman wanting basic information on how the office can help them with a concern, or they have questions about the child protection or child welfare system. The Ombudsman responds directly to these inquiries, some of which require additional research. The office refers other questions to the appropriate agency.

Complaints. Persons file a complaint with the Ombudsman when they have a specific complaint against the Department of Social and Health Services (DSHS) or other agency that they want the office to investigate. The Ombudsman reviews every complaint that is within its jurisdiction.

Contacts to the Ombudsman



Source: Office of the Family and Children's Ombudsman, September 2006

[1] The Ombudsman no longer documents non-OFCO inquiries, due to workload constraints. OFCO staff refer non-OFCO inquiries to the appropriate resource, for example other ombudsman, landlord/tenant information line, children and family ombudsman in other states.

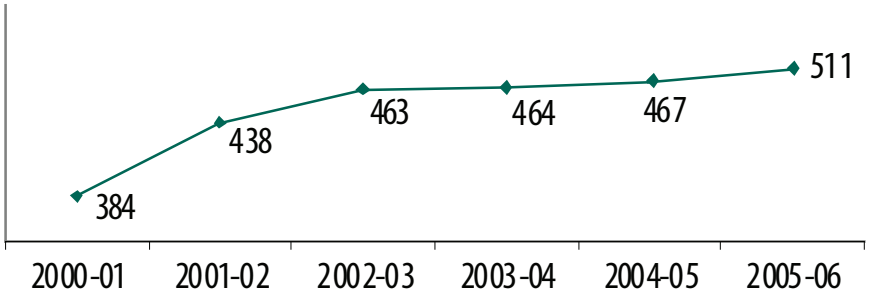
Complaints

A complaint to the Ombudsman must involve an act or omission by the Department of Social and Health Services (DSHS) or other state agency that affects:

- A child at risk of abuse, neglect or other harm by a parent or caretaker.
- A child or parent who has been the subject of a report of child abuse or neglect, or parental incapacity.

The Ombudsman received 511 complaints in 2006, an increase of almost 10% over last year. The table below shows the steady increase in the rate of complaints over the last several years.

Annual Complaints to the Ombudsman



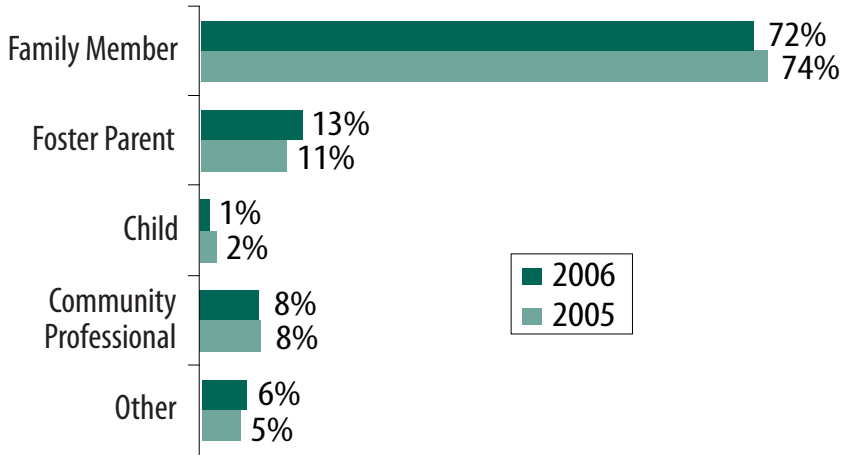
Source: Office of the Family and Children's Ombudsman, September 2006

Complainant Profiles

Persons who Complained

As in previous years, parents, grandparents and other relatives of the child whose family is involved with DSHS filed the vast majority of the complaints to the Ombudsman. We continue to have very few children contacting the Ombudsman directly on their own behalf, and would like to improve our outreach to children, particularly adolescents, to let them know of OFCO's existence and purpose.

Persons Who Complained to the Ombudsman



Source: Office of the Family and Children's Ombudsman, September 2006

Race/Ethnicity of the Person who Complained

OFCO's complaint form has an optional question asking complainants to identify their race or ethnicity, for the purposes of tracking whether the office is adequately serving and representing all Washington citizens. The State recently implemented a new system for collecting racial demographics, and OFCO has implemented the new categories in its database. We are therefore reporting this data for the first time in an annual report, in an attempt to accurately reflect who we are reaching and where we need to improve our outreach.

	OFCO Complainants*	WA State census data**
Caucasian	80.6%	85.0%
African American	8.6%	3.5%
American Indian or Alaska Native	9.0%	1.7%
Hispanic	3.9%	8.8%
Asian	1.4%	6.4%
Other	1.8%	
Multi-Racial	3.7%	3.0%
Declined to Answer	2.3%	

*Data adds up to over 100% because our complaint form allows people to select more than one race/ethnicity

**Taken from US Census 2006 estimate at http://quickfacts.census.gov/qfd/states/53000.html

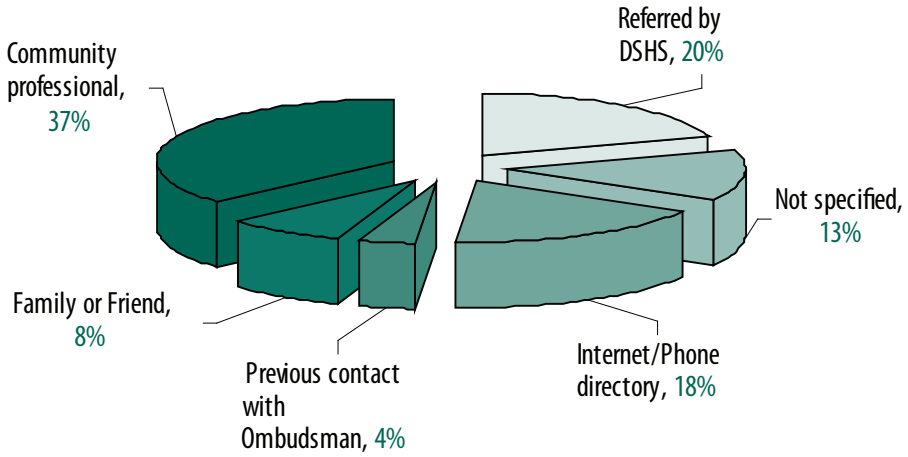
As seen in the table above, African Americans and American Indians are overrepresented in complaints made to OFCO as compared with their representation in state population data, while Hispanics and Asians are underrepresented. This indicates that OFCO may need to do better outreach to these population groups. However, when racial data regarding complainants is compared with that of children who were the subject of complaints, OFCO's data is more evenly representative of the population of children served by the Children's Administration (see page 13).

How they Heard about the Ombudsman

The majority (65 %) of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. These individuals reported that they were referred by a **community professional/service provider** (e.g., teacher, counselor, child care provider, doctor, private agency social

worker, mental health professional, attorney, CASA/GAL, legislator's office) or **DSHS worker.** Other individuals (8 %) were referred by a **friend or family member**. Four percent knew about the office from a **previous contact**, while 18 % said they found the office via the **Ombudsman web site or telephone directory**. The remaining 13% did not specify how they heard about the Ombudsman.

How They Heard About the Ombudsman



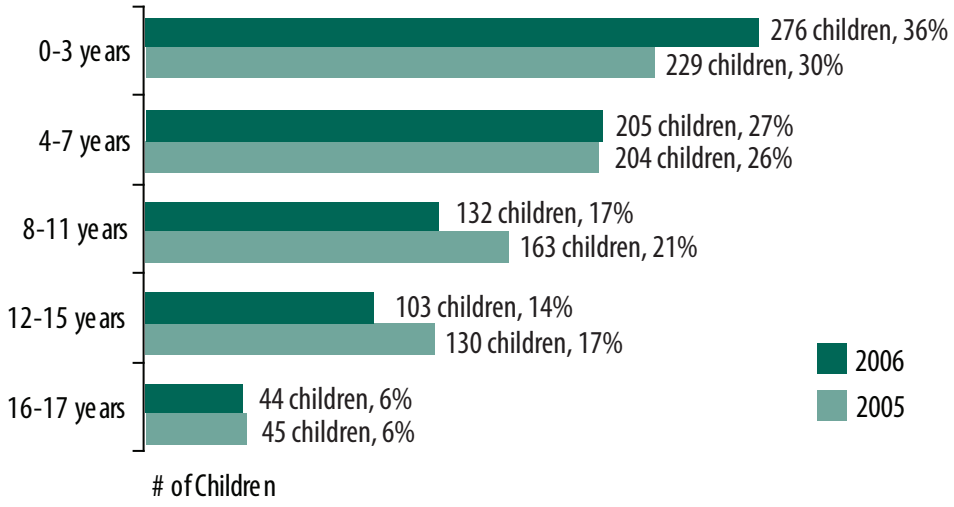
Source: Office of the Family and Children's Ombudsman, September 2006

Age of Children Identified in Complaints

As in previous years, most of the children identified in complaints to the Ombudsman were age seven or younger (63%, a higher proportion than last year's 56%). Older adolescents continue to be identified in much smaller numbers (6%).

Note: Some children were counted more than once because they were identified in more than one complaint.

Age of Children Identified in Complaints



Source: Office of the Family and Children's Ombudsman, September 2006

Race/Ethnicity of Children Identified in Complaints

Because children may be identified with more than one race, it is difficult to accurately measure whether OFCO is representing children of various races proportionately as compared with their representation in the general state population and in the total number of children in placement (as indicated in the table below). However, it does appear that Caucasian and African American children are overrepresented in terms of complaints to the Ombudsman, while all other groups appear to be fairly evenly represented. When these figures are compared with the general child population, however, both children in placement and children who are the subject of complaints to the Ombudsman are greatly overrepresented in the African American and American Indian population groups.

	OFCO*	Children's Administration**
Caucasian	78.9%	61.5%
African American	14.7%	10.5%
American Indian/Alaska Native	11.4%	11.9%
Hispanic	11.7%	14.4%
Asian/Pacific Islander	2.2%	1.2%
Other	1.7%	3.5%
Multi-Racial	9.3%	9.8%
Declined to Answer		1.5%

*Data adds up to over 100% because people may self-report more than one race

**Race of children in placement, taken from Children's Administration Performance Report 2006 (http://www1.dshs.wa.gov/ca/pubs/2006perfrm.asp)

DSHS Regions and Divisions Identified in Complaints

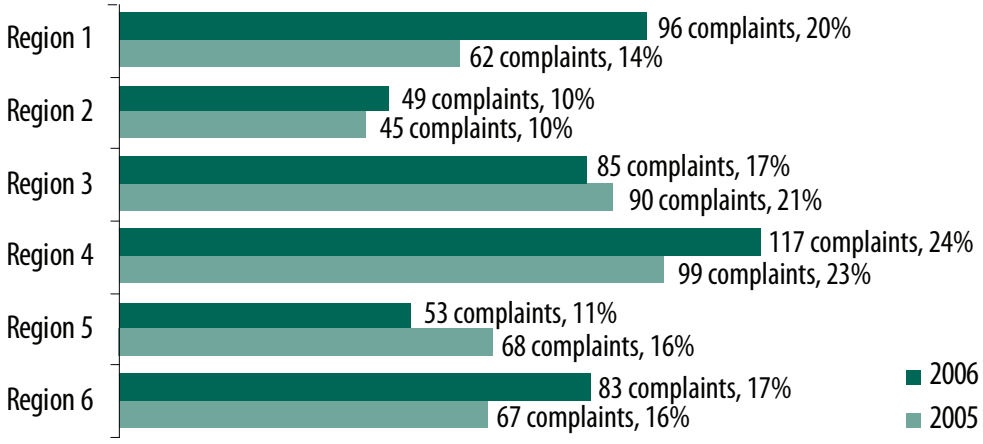
The Department of Social and Health Services' (DSHS) Children's Administration is the state's largest provider of child protection and child welfare services. It is therefore not surprising that the Children's Administration was the subject of 95% of complaints in 2006 to the Ombudsman.[2]

Of these, 91% were directed at the Division of Children and Family Services (DCFS), which includes Child Protective Services, Child Welfare and Adoption Services, and Family Reconciliation Services. A small percentage (4%) 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.

[2] The remaining complaints were directed against other DSHS divisions (such as Developmental Disabilities and Mental Health), Washington Courts, local CASA/GAL programs, DSHS contract providers, tribal welfare services, and Child Welfare agencies in other states.

From the 2005 reporting year to the current reporting year (2006), CA offices in Region 1 generated a large increase in complaints (55%). Region 6 had a smaller but still significant increase of 28%, and Region 4 had an increase of 18%. On the other side of the scale, complaints out of Region 5 decreased by 28%. Regions 2 and 3 remained relatively constant.

Complaints against the Children's Administration by DSHS Region*



*1% of the complaints were against Children's Administration Headquarters

Source: Office of the Family and Children's Ombudsman, September 2006

Regional Offices:
Region 1 – Spokane
Region 2 – Yakima
Region 3 – Everett
Region 4 – Seattle
Region 5 – Tacoma
Region 6 – Vancouver

	DCFS	DLR
Region 1 Totals	**93**	**3**
Clarkston	0	
Colfax	0	
Colville	10	
Moses Lake	11	
Newport	1	
Omak	5	
Republic	1	
Wenatchee	10	
Spokane	55	3
Region 2 Totals	**48**	**1**
Ellensburg	5	
Goldendale	0	1
Richland/Tri-Cities	13	
Kennewick	1	
Sunnyside	5	
Toppenish	1	
Walla Walla	16	
White Salmon	1	
Yakima	6	
Region 3 Totals	**85**	**0**
Alderwood / Lynnwood	19	
Arlington/Smokey Point	17	
Bellingham	5	
Everett	11	
Friday Harbor	0	
Monroe / Sky Valley	10	
Mount Vernon	21	
Oak Harbor	2	

	DCFS	DLR
Region 4 Totals	**105**	**12**
Bellevue / King Eastside	10	
Kent / King South	27	3
King West	30	
African-American Children's Services	16	
Office of Indian Child Welfare	13	
Seattle Centralized Services	4	3
Seattle Central Office	5	6
Region 5 Totals	**53**	**0**
Bremerton / Kitsap	9	
Tacoma	44	
Region 6 Totals	**80**	**3**
Aberdeen	20	
Centralia	3	
Forks	1	
Kelso	10	
Lacey / Olympia	7	
Long Beach	2	
Port Angeles	6	
Port Townsend	3	
Shelton	2	1
South Bend	0	
Stevenson	2	
Tumwater	4	
Vancouver	20	2
Statewide	**2**	**1**
Central Intake Unit	0	0
Children's Administration Headquarters	2	1

Most Frequently Identified Complaint Issues

ISSUE	NUMBER OF COMPLAINTS	
	2005	2006
Child Safety	**164**	**188**
Failure to protect children from parental abuse or neglect	109	108
Physical abuse	38	33
Sexual abuse	19	25
Emotional abuse	5	9
Neglect/lack of supervision	47	35
Other	--	6
Developmentally disabled child in need of protection	5	4
Children with no parent willing/capable of providing care	15	14
Failure to address safety concerns involving child in foster care or other substitute care	32	54
Failure to address safety concerns involving child being returned to parental care	3	8
Family Separation and Reunification	**186**	**236**
Unnecessary removal of child from parental care	34	54
Unnecessary removal of child from relative placement	16	25
Failure to place child with relative (including siblings)	36	43
Other inappropriate placement of child	5	19
Failure to provide appropriate contact between child and family	25	33
Failure to reunite family	50	46
Inappropriate termination of parental rights	11	8
Concerns regarding voluntary placement and/or service agreements for non-dependent children	8	3
Other family separation concerns	1	5
Dependent Child Health, Well-being & Permanency	**88**	**113**
Inappropriate change of child's placement, inadequate transition to new placement	19	33
Failure to provide child with medical, mental health, educational or other services, or inadequate service plan	26	34
Inappropriate permanency plan or unreasonable delay in achieving permanency	22	29
Failure to provide appropriate adoption support services / other adoption issues	16	14
Inappropriate placement / inadequate services to children in institutions and facilities	5	3
Other Complaint Issues	**18**	**79**
Foster care licensing / foster parent issues	9	10
Breach of confidentiality by agency	3	7
Unprofessional conduct by agency staff, harassment or retaliation	6	10
Children's legal issues	--	4
Violations of parent's rights	--	35
Communication failures	--	13

(many complaints identified more than one issue)

Complaint Issues

As in previous years, the safety of children living at home or in substitute care (raised in 188 complaints), as well as issues involving the separation and reunification of families (236 complaints), were by far the most frequently identified issues in complaints to the Ombudsman. The next most frequently identified issue involved the welfare and permanency of dependent children (113 complaints). All three of these categories showed an increase over the previous year's numbers. It should be noted that many complaints identified more than one issue.

The above table shows the number of times various issues within these categories were identified in complaints. Within the child safety category, there was a significant increase over the previous year in the number of complaints about the safety of children in out-of-home care and children returned to parental care. There was a significant decrease in complaints that CPS failed to protect children from neglect.

Within the other categories, there was a moderate to large increase in nearly all complaint issues.

Responding to Complaints

The Ombudsman reviews every complaint received, to determine whether an investigation is appropriate.[1] Through impartial investigation and analysis, the Ombudsman determines an appropriate response. In cases where the Ombudsman finds that the agency has properly carried out its duties, no further action is taken. In cases in which an adverse finding is made, the Ombudsman may work to change a decision or course of action by the Department of Social and Health Services (DSHS) or another state agency.

Analyzing Complaints

The objective of a complaint investigation is to determine whether DSHS or another agency has violated law, policy or procedure, and/or unreasonably exercised its authority. The Ombudsman then assesses whether the agency should be induced to change its decision or course of action.

After initial investigation, the lead Ombudsman presents a report for review by the team. Staff may pose questions, test assumptions, identify information gaps, identify problematic policy or practice issues, raise additional issues for investigation or analysis, or offer an alternative analysis by playing "devil's advocate". The investigation continues until it can be determined whether the allegations in the complaint meet one or more of the criteria for intervention by the Ombudsman (see sidebar). If these criteria are not met, no further action is taken and the complainant is notified by telephone and/or in writing. If the criteria are met, the Ombudsman decides what action to take to address the concerns raised by the specific complaint or any additional concerns uncovered during the course of the investigation. The complainant is informed of the progress and final resolution of the case.

Criteria for analysis by the Ombudsman

The Ombudsman acts as an impartial fact finder and not as an advocate, so the investigation focuses on determining whether the issues raised in the complaint meet the following objective criteria:

- The alleged agency action (or inaction) is within the Ombudsman's jurisdiction.
- The action did occur.
- The action violated law, policy or procedure, or was clearly inappropriate or unreasonable under the circumstances.
- The action was harmful to a child's safety, health, well-being, or right to a permanent family; or harmful to appropriate family preservation / reunification or family contact.

[1] The Ombudsman may also initiate an investigation without a complaint. During the reporting period, the office initiated two investigations and monitored the cases of two families as a result of information obtained by means other than a formal complaint, for example, by way of news reports. Three of these investigations/case monitors were closed without Ombudsman intervention after the concerns were resolved, and are not included in the data in this section. One investigation remained open at the end of the reporting period.

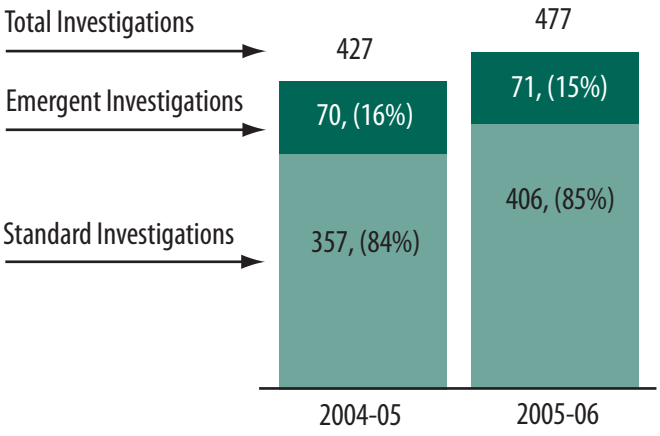
Investigation Outcomes

Completed Investigations

The Ombudsman completed 477 complaint investigations in the reporting period.[2] As in previous years, the majority of these were **standard non-emergent investigations** (85%). About one out of every seven investigations met the Ombudsman's criteria for initiating an **emergent investigation**: i.e., when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by the Ombudsman could significantly ease a child or family's distress.

Type of Investigations Completed

September 1 to August 31



Source: Office of the Family and Children's Ombudsman, September 2006

Ombudsman's Findings

The majority of complaint investigations resulted in no adverse findings (402, or 84%). About one-sixth of investigations (75 complaints, or 16%), however, did result in an adverse finding. These adverse findings fell into three broad categories:

- in 30 complaints, the Ombudsman found the agency had violated a law, policy or procedure;
- in 16 complaints, the Ombudsman found the agency's action or inaction to be clearly unreasonable under the circumstances;
- in 29 complaints, although no violation or clearly unreasonable action was found, harm to the child or family had occurred as a result of poor practice on the part of the agency.

The Ombudsman intervened in some way to resolve the situation in 29 of these 75 complaints; in the remaining 46, the action had either already occurred or did not require intervention for other reasons.

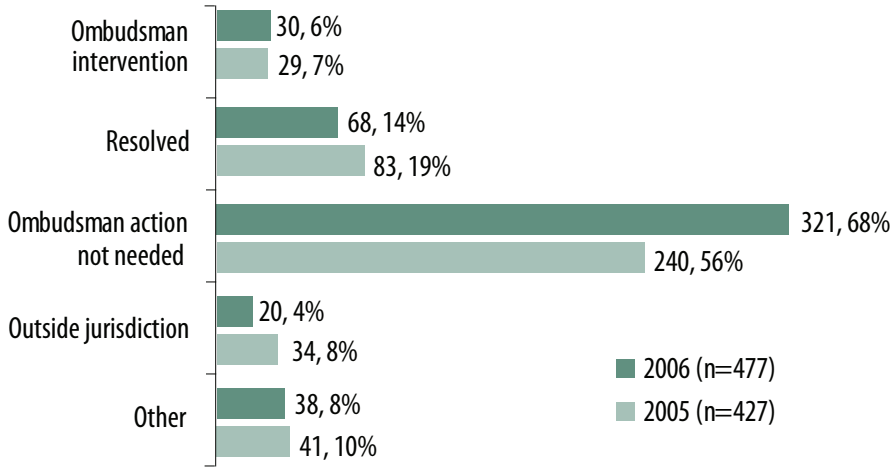
Investigation Results

Over 6% of all complaint investigations required direct intervention by the Ombudsman to induce the agency to correct an unauthorized or unreasonable decision or course of action. A further 14% of investigations were closed with the complaint issue having been resolved either with or without assistance from the Ombudsman. Examples of such cases include efforts to ensure that critical information wasobtained and considered by the agency, or facilitating timely communication among the peopleinvolved in order to resolve the problem. Almost 68% of investigations were closed after the

[2] Of these, 81 % were investigations of complaints received during the reporting year, while 19% were of complaints received in a previous year. At the end of the reporting year, 16% of complaint investigations remained open. For the purposes of this section, investigations of complaints raising identical issues involving the same child/family are counted only once. The actual number of complaints closed, including these identical complaints from more than one complainant, was 510.

Ombudsman either found no basis for the complaint, or found no unauthorized or unreasonable actions by the agency warranting intervention. Four percent of complaints fell outside the Ombudsman's jurisdiction, while the remaining investigations (8 %) were closed with no further action, either due to the complaint being withdrawn, becoming moot, or where further action was not feasible.

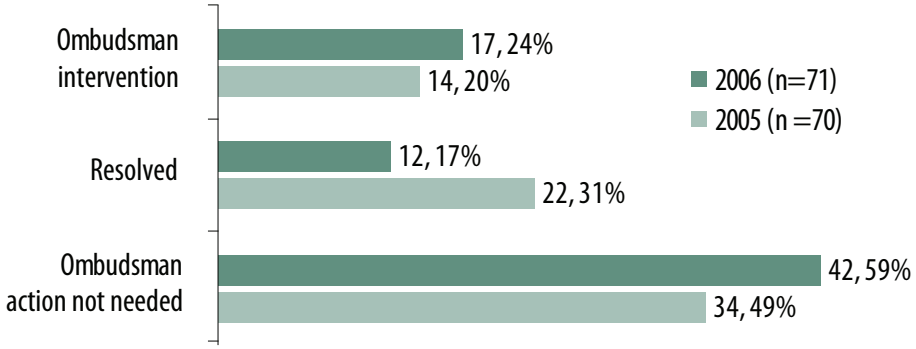
Total Investigation Results



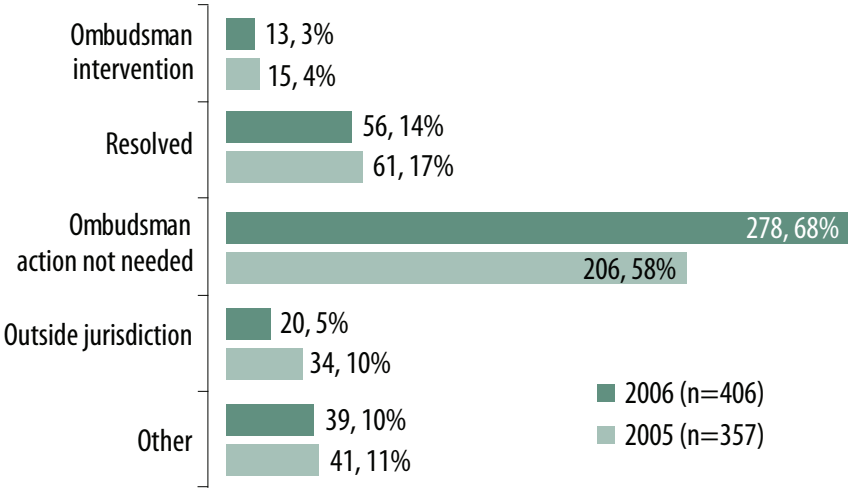
Source: Office of the Family and Children's Ombudsman, September 2006

The following charts depict the various outcomes for **emergent** and standard **complaint** investigations respectively.

Emergent Investigation Results



Standard Investigation Results



Source: Office of the Family and Children's Ombudsman, September 2006

Ombudsman in Action

The Ombudsman takes action when the findings of a complaint investigation indicate that action is necessary to avert or correct a harmful oversight or avoidable mistake by the Department of Social and Health Services (DSHS) or another agency.

After investigating the complaint, if the Ombudsman concludes that the agency's actions are either outside of the agency's authority or clearly unreasonable under the circumstances, and the action could cause foreseeable harm to a child or parent, the Ombudsman intervenes to persuade the agency to correct the problem. The Ombudsman shares the investigation findings and analysis of the problem with supervisors or higher-level agency officials to induce corrective action. In cases in which an agency error is brought to the Ombudsman's attention after-the-fact, and corrective action is no longer possible, the Ombudsman brings it to the attention of high-level agency officials, so they can take steps to prevent such incidents from recurring in the future.

The Ombudsman is often successful in resolving legitimate concerns by working with agencies to:

- Induce corrective action
- Facilitate resolution
- Avoid errors and conduct better practice
- Prevent future mistakes

Frequently, a concern is resolved before corrective action is necessary. In these cases, the Ombudsman actively facilitates resolution by ensuring that critical information is obtained and considered by the agency, and by facilitating communication among the people involved. In some cases, the Ombudsman finds that the agency's actions are not in clear violation of law or policy, but rather, represent poor practice. In these cases, if the complaint involves a current action, the Ombudsman intervenes to assure better practice. When it involves a past action, the Ombudsman documents the issue and brings it to the attention of agency officials.

The following section provides brief descriptions of 27 complaints in which the Ombudsman's investigation resulted in an adverse finding, and where the Ombudsman took further action in one of the following ways:

- induced corrective action
- facilitated resolution of a problem
- prompted better casework practice
- assisted the agency in preventing future mistakes.

Inducing Corrective Action

When necessary, the Ombudsman induces DSHS or another agency to correct a mistake by sharing its investigation findings and analyses with supervisors and higher-level agency officials.

COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS[1] failed to develop a written safety plan to protect a 7-year-old non-dependent child in a voluntary placement with a relative. The relative is disabled and the child's parent had previously abducted the child.	Recommended that CWS obtain the relative's agreement to a written safety plan clearly stating the agency's expectations for safe care, and steps to take if the parent tried to contact the child.	CWS followed this recommendation, ensuring a safer environment for the child.
CPS returned two physically abused non-dependent children (an infant and toddler) to their parent without resolving the problems leading to their voluntary placement. CPS then failed to remove the children after the parent violated the safety agreement set up to prevent further abuse.	Coordinated and facilitated sharing of information between two counties, CPS, CWS and the attorney general's office to ensure protective action.	CPS removed the children and filed a dependency petition.
CPS failed to investigate several referrals alleging physical abuse of a 17-year-old youth and endangerment of four younger siblings aged 5 to 13. The referrals were screened out based on the youth's age, without regard for the family's history of chronic domestic violence and CPS referrals.	Made a CPS referral, which was screened in for investigation. Requested that CPS obtain records from the state where the family previously lived.	CPS found an extensive history of domestic violence and CPS involvement, including a current no-contact order between the children and the alleged perpetrator of abuse. CPS monitored the family over the following months until the alleged perpetrator moved out of the home.
CPS returned a 1-year-old dependent child to a parent despite ongoing risk of physical abuse. The Ombudsman found that although CPS was highly concerned about the child, it was receiving ineffective legal representation, leading to a judicial decision to return the child home.	Contacted the attorney general's office to ensure that all the relevant information was available, and mediated to improve communication between CPS and the AAG.	After several months of monitoring and facilitation by the Ombudsman, during which the parent failed to comply with the service plan to reduce the risk of further physical abuse, the court agreed with CPS's recommendation to place the child in foster care.

[1] Abbreviations used for agency divisions/units: AAG=Assistant Attorney General; CA=Children's Administration; DCFS=Division of Children & Family Services; CPS=Child Protective Services; CWS=Child Welfare Services; FRS=Family Reconciliation Services; DLR=Division of Licensed Resources; OFCL=Office of Foster Care Licensing; CPT=Child Protection Team. CPS units within DLR are referred to as DLR/CPS.

Inducing Corrective Action *(continued)*

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CPS failed to accept a referral from a community professional alleging sexual exploitation of youths living with a man who had a criminal record and was using methamphetamine. One of the youths was a developmentally disabled 17-year-old whose own child had been removed and was therefore under agency supervision. CPS's rationale for not investigating the sexual exploitation was that the alleged perpetrator was a non-caregiver and the youth's parents could not be located. The man's 6-year-old child was also living in the home.	Contacted DCFS and caused a new CPS referral to be made, reporting the alleged sexual exploitation of the youths as well as the safety risks to the 6-year-old.	CPS reported the sexual exploitation allegations to the police, but declined to investigate the referral at the request of the police, who were monitoring the home closely and believed that CPS involvement might compromise the criminal investigation. The police removed the 6-year-old three months later, when the parent was arrested. The home contained evidence of extensive methamphetamine manufacture and use. No intervention occurred regarding the 17-year-old.
CPS failed to investigate a referral alleging physical abuse of a 3-year-old non-dependent child, after screening out the referral based on the opinion of a social worker providing services to the family, regarding how the child's injury occurred.	Requested a review of the screening decision based on the child's medical records indicating suspicions of abuse.	CPS obtained the records and decided to conduct an investigation.

COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CPS delayed in protecting two non-dependent children, aged 10 and 6, from parental neglect due to serious substance abuse. The parent was uncooperative with the investigation, thwarting CPS efforts to assess the children. In addition, law enforcement had declined to take the children into protective custody, believing that the children were not at risk of imminent harm.	Based on the clear risk of harm to the children, urged CPS to file a dependency petition and obtain a pick-up order to have the children taken into protective custody.	CPS filed a dependency and succeeded in placing the children with a relative.
CPS conducted inadequate investigations into alleged neglect of a 2-year-old non-dependent developmentally delayed child. The Ombudsman found numerous problems with CPS documentation, resulting in incomplete information regarding the child's health status and inadequate monitoring of the child's health and safety.	Requested that CPS collaborate directly with the child's medical providers to ensure adequate assessment and monitoring. The Ombudsman contacted the supervisor to discuss deficiencies in the CPS investigative assessment tool, as well as the need for additional caseworker training.	Additional communication between CPS and medical providers resulted in referral of the child to a specialist for further assessment. The supervisor provided training to caseworkers to improve investigative assessments.

Inducing Corrective Action *(continued)*

COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
OFCL conducted an inadequate investigation into an alleged licensing violation by a foster parent. OFCL relied on the private foster care agency's interview of the foster parent, accepting denial of the allegations without interviewing any of the foster children.	Requested that the children be interviewed as required by policy.	The children disclosed information regarding inappropriate use of discipline in the home, constituting licensing violations, and appropriate licensing action was taken.
CPS failed to screen in for investigation, allegations of physical abuse of an eight-year-old dependent disabled child by a foster parent. Instead, the referral was screened for follow up by OFCL as a licensing violation.	Requested a review of the screening decision.	The referral was screened in for DLR/CPS investigation. As a result of the investigation, the child was moved to a more appropriate placement.

COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CPS planned to send a 16-year-old non-dependent youth who was about to be released from juvenile detention, to the youth's out-of-state parent who refused to take the youth. The youth had assaulted the parent in the past, and had been brought back to Washington from an out-of-state group home to face juvenile charges. The group home was unable to take the youth back, and the parent refused to pick the youth up at the airport.	Requested that CPS reconsider its plan to send the youth back to their parent, as there appeared to be additional information the agency had not sought regarding the youth's relationship with that parent, as well as regarding the other (in-state) parent who wished to take the youth.	CPS reassessed the youth's situation and decided to place the youth in a youth facility in Washington.

COMPLAINT ISSUE: PARENTS' RIGHTS

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CPS facilitated an informal agreement between a parent and out-of-state relatives to care for a one-year-old non-dependent child while the parent was temporarily hospitalized due to mental illness. The relatives subsequently filed a petition for termination of the parent's rights. The parent could not afford legal representation and wished to resume caring for the child. The Ombudsman found that in order to protect the parent's rights, better practice would have been for the agency to file a dependency petition or at minimum, enter into a voluntary placement agreement with the parent. This would have enabled the parent to obtain legal representation and services to assist in family reunification, and would have provided clear conditions under which the child would be returned.	Discussed these concerns with the DCFS area administrator.	The administrator agreed to provide the parent with information regarding legal resources and possible legal options to explore in order to oppose the termination petition and have the child returned. The administrator also agreed to provide training for that DCFS office about appropriate procedures to follow in this type of situation.

Inducing Corrective Action *(continued)*

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS failed to provide court-ordered supervised visitation between a parent and dependent children. The court ordered four hours of visitation per week, while the agency had instituted a new policy providing two hours of supervised visitation per dependent child per week, due to budget constraints.	The agency's budget problems affected the visitation plan for many families, and the Ombudsman urged agency management to resolve its lack of compliance with court-ordered visits for these families.	The agency eventually developed a plan to address the problem, but violated the court order in this case for at least six months.

Facilitating Resolution

The Ombudsman frequently is able to resolve a concern before corrective action is necessary. The office accomplishes this by ensuring that critical information is obtained and considered by the agency and facilitating communication among the people involved.

COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
FRS insisted that a 15-year-old non-dependent sexually aggressive youth return home from a voluntary residential treatment program, while the youth's parents believed the youth was still at high risk of re-abusing younger siblings in the home. The parents based their opinion on information from the youth's treatment providers. Communication between the parents and FRS had broken down, and the youth was soon due to be discharged from treatment.	Reestablished communication between the agency and the parents.	A new caseworker was assigned to the case, and the agency communicated more closely with and obtained records from the out-of-state treatment program. The agency assisted the parents in obtaining a consultation with a local expert. As a result, the agency began working toward a safer out-of-home placement for the youth closer to home.
CPS was having difficulty keeping track of a family who moved around the state, where the children were at ongoing risk of sexual abuse by a parent. The family had moved out of the area covered by the CPS office with the latest open case. CPS was not aware of new information indicating that the children needed stronger protection, i.e. that the offending parent had pending criminal charges for multiple counts of child rape, and the non-offending parent was failing to follow the safety plan agreed to with CPS.	Requested that CPS transfer the case to the office covering the area where the family was now residing, and requested a review of the case by the area administrator.	Following this review, CPS filed a dependency petition regarding the seven children living in the home.
CPS failed to inform law enforcement of a referral alleging physical abuse of an 11-year-old non-dependent child, negating the possibility of a police investigation. In addition, even though the alleged perpetrator (the custodial parent) refused to comply with services recommended by the community Child Protection Team to prevent further abuse, CPS believed there were insufficient grounds to file a dependency petition, and closed its case.	Requested that CPS contact the protective (non-custodial) parent to determine whether any further abuse had occurred, and encourage the parent to report any future incidents.	The agency contacted the parent and assured these safeguards.

Facilitating Resolution *(continued)*

COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS and other DSHS agencies failed to arrange a timely placement for a 12-year-old non-dependent developmentally disabled child who was being discharged from hospital. The hospital was forced to call law enforcement for placement assistance on the day of discharge, as the child could not be safely managed at home. The child had a case manager with the DSHS Division of Developmental Disabilities (DDD) and with the Mental Health Division (MHD), as well as an extensive history of involvement with DCFS (including a current open case with CWS). Due to a clear lack of communication and coordination between these DSHS divisions, a placement had not been prearranged, and when contacted by law enforcement, CWS initially refused to place the child.	Requested that CWS collaborate with DDD and MHD to secure an appropriate placement for this youth. CWS took immediate responsibility for placing the youth temporarily until a longer term placement was found. Since this was not an isolated case of lack of coordination between multiple DSHS divisions serving the same family, the Ombudsman contacted the Secretary of DSHS requesting development of policy and procedures to improve coordination of services to these families	The Secretary responded that a debriefing of this case with the relevant parties would occur, and meetings of representatives of the various divisions were being planned to discuss improved coordination in such cases.

COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS planned to move a 17-year-old dependent disabled youth who had aged out of the therapeutic placement the youth had been living in for two years. CWS had been unable to secure another appropriate long term placement before the youth's birthday, and planned to place the youth in interim care. The youth's providers believed that an interim placement would be disruptive and harmful to the youth's progress and well-being.	Requested that DLR consider an administrative 30-day extension of the youth's current placement to allow CWS to secure an alternative long term placement for the youth.	The extension was granted and an alternative placement found.
OFCL delayed in granting a foster care license to a family seeking placement of a 5-year-old dependent child with whom they already had an established relationship. The delay was due to waiting for an FBI background check, and if not received in time, the child would have to go into an interim placement which would disrupt the child's schooling and mental health treatment.	Requested that OFCL make special efforts to expedite the background check.	OFCL succeeded in obtaining the FBI clearance in time to avoid the interim placement.
CWS had a primary permanency plan to return a dependent developmentally delayed infant to a parent whose parental rights to an older child had been terminated, and who was again pregnant. CWS reports to the court did not accurately reflect the parent's poor prognosis and lack of progress in court-ordered services. In addition, although CWS had considered and ruled out placing the infant with a relative, this was merely an informal decision mentioned in the ongoing case record rather than a formal home study.	Requested that CWS verify the parents' progress with various service providers and accurately describe this in its reports. CWS was also asked to conduct a home study to formally rule out the relative for current or future placement of the child, in order to expedite the permanency plan for this child.	Due to a lack of cooperation and progress by both parents over the next few months, CWS ultimately changed the permanency plan from reunification to petitioning the court for termination of parental rights.

Assisting the Agency in Avoiding Errors and Conducting Better Practice

In some cases, the Ombudsman does not find the agency's actions to be in clear violation of law or policy, but rather to be poor practice. If the complaint involves a current action, the Ombudsman intervenes to assure better practice. If it involves a past action, the Ombudsman documents the issue and brings it to the attention of the agency on an as-needed basis.

COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS planned to return a non-dependent 11-year-old child with behavior problems from a voluntary placement group home placement to their out-of-state parents, even though the parents were refusing to take the child. The agency planned to transport the child home without informing the child of the plan. The child had been making good progress in their current placement and the service providers believed this plan was harmful to the child's safety and well-being. The Ombudsman found this plan to be clearly unreasonable.	Requested a review of the plan by the area administrator.	CWS was not willing to reconsider its plan. The community professionals hired an attorney to file a petition for dependency, which was granted by the court. Once dependency was established, the agency began permanency planning for the child.

COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS failed to thoroughly investigate the cause of injuries to two dependent children, ages two and four, occurring in their foster home. CWS had neither done a home visit, nor informed the foster home licensor about the incidents; furthermore, CWS had not contacted the children's medical providers to corroborate the foster parent's explanation of the injuries, nor the children's day care to verify injuries reported by the foster parent to have occurred there.	Requested that CWS complete these tasks and if accidental injury was corroborated, that corrective action be taken with the foster parent to prevent similar injuries occurring in the future.	CWS and OFCL complied with this request, ensuring a more thorough investigation and follow-up.

Assisting the Agency in Avoiding Errors and Conducting Better Practice *(continued)*

COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS planned to move a 2-year-old dependent child from a pre-adoptive foster home where the child had been living since the age of two months, without any transition, to an out-of-state relative with whom the child had no relationship. Furthermore, the move was to occur prior to an adoptive home study being conducted on the relative. The Ombudsman found several concerns regarding the relative's appropriateness as a permanent placement option for this child, as well as several violations of federal and state permanency planning policy. The child's ethnicity appeared to be given the greatest weight in the permanency planning, superseding other critical factors such as attachment and bonding, opportunity to have contact with the parent with whom the child had a relationship, and the foster parents' concrete efforts to support the child's ethnic identity.	Requested a review of the case by the area administrator, to ensure that the agency was following the intent of the law and avoiding harm to the child.	Despite the Ombudsman's findings, no changes were made to the case plan. CWS moved the child to the relative after an expedited adoptive home study was approved by the out-of-state agency.
CWS moved two dependent half-siblings, ages two and four, from their pre-adoptive foster home to an out-of-state relative of the older child. The younger child had been living with the foster parents since the age of six months, and had been joined by their older sibling shortly after being placed there. While CWS believed it was following law and policy regarding preference for relative placements, the legislative intent of these laws is to maintain existing relationships between children and their relatives, and other factors such as the child's primary attachment to an unrelated caregiver may supersede preference for placement with a relative. Furthermore, the younger child was not related to the identified permanent caregiver.	Requested that CWS consider obtaining a bonding assessment to determine whether this move would be harmful to the children's well-being over the long term. Made a number of recommendations to improve communication between the agency and the foster-adopt parents as well as improve the overall case planning.	CWS declined to obtain a bonding assessment, citing budgetary reasons and time constraints. The children were moved to the relative without any transition.
CWS planned to place a 2-year-old dependent child with an 80-year-old relative and petition for dismissal of the dependency once the relative secured third party custody of the child through the family court. The rationale for this plan was that reunification with the parent was unlikely to occur, and the parent agreed to the plan, allowing the agency to avoid petitioning for termination of parental rights. The relative was in poor health and did not appear to be a viable long term placement option for the child.	Requested that CWS reconsider its plan. The agency did not change its position regarding placement of the child. The Ombudsman monitored the safety of this child for 15 months. After a new CPS referral was received regarding the relative, the Ombudsman requested that the case be reviewed by the new area administrator.	Following a thorough case review, the child was placed back with the foster parents who previously had the child in their care, with a permanency plan for adoption.

Preventing Future Mistakes

When corrective action is not possible, the Ombudsman brings the error to the attention of high-level agency officials, so they can take steps to prevent such mistakes from recurring in the future.

COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CPS failed to effectively communicate with law enforcement when placing a 3-year-old non-dependent child with a person identified as a relative by the parent, via a voluntary placement agreement with the parent. CPS did not realize law enforcement had taken the child into protective custody, making a voluntary placement agreement inappropriate. Furthermore, the caregiver chosen by the parent (who was later discovered to be unrelated to the child) was mistakenly cleared for placement by Central Intake despite having a history of 14 CPS referrals. Within three days of the child's placement, the caregiver violated the CPS safety plan by allowing the child to be taken out-of-state by a relative.	The Ombudsman alerted CPS to the history of CPS referrals regarding the caregiver and discussed the management of this case with the supervisor to prevent similar errors occurring in the future.	CPS immediately obtained a court order for the child to be picked up out-of-state and placed in foster care in Washington. The supervisor reported the inadequate background check of the caregiver to the area administrator, for follow up with Central Intake.

COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CWS moved a 15-year-old legally free youth from the foster parents the youth had been placed with for eight years, with a plan for adoption. The youth was moved when OFCL decided to revoke the family's foster care license, due to chronic concerns about the home (forty CPS referrals and thirty licensing complaints had been received by the agency). The Ombudsman had previously investigated a complaint regarding the care of this youth and the foster parents' suitability as adoptive parents. An initial adoption home study had recommended against adoption by these foster parents, but CWS decided to obtain a second home study, which recommended the adoption. The Ombudsman found several problems with the second home study and requested a review of the case by CA headquarters. CA ordered an addendum to the home study by a third adoption social worker, to address specific questions raised by the review. The adoption was ultimately recommended, but after further CPS and licensing referrals were received, the youth was removed. The Ombudsman found that leaving the youth in this marginal foster home for eight years without finalizing a permanency plan was clearly unreasonable.	Discussed the permanency planning and case management of this case with the area administrator to prevent similar errors occurring in the future.	The child was ultimately placed with a relative and a guardianship was established.

Additional adverse findings not requiring intervention

As mentioned in the previous section, in addition to the above 27 complaints in which the Ombudsman took some kind of direct action with the agency, there were 46 complaints in which there was an adverse finding by the Ombudsman, but because this involved either a past action or for other reasons, intervention by the Ombudsman was not required, these complaints were closed after the adverse finding was communicated to the agency and documented.

The following table shows the number of complaints with various adverse findings, with some examples of findings and the Ombudsman's response. Note that some complaints had adverse findings in more than one category, i.e. the totals for each category add up to more than the 46 complaints referred to above.

Violations of law, policy or procedure……..... 20 complaints

- Failure to provide court-ordered visitation
- Non-compliance with provisions of Adoption and Safe Families Act
- Violations of client rights to public disclosure (access to client records) or client rights to confidentiality
- Violations of parental or foster parents' rights
- Failure to follow agency procedures / documentation failures

Clearly unreasonable agency action ……..…….. 7 complaints

- CPS suspended an interview of a parent regarding allegations of child neglect and endangerment after discovering the race of the family, so that the case could be transferred to the culturally appropriate unit. The interview was only completed four days later, leaving two children ages one and three at risk of further neglect.
- CPS advised a parent to cease using a child care provider who reported suspected abuse of her one-year-old child. Although the CPS investigation resulted in an "unfounded" finding, the child was deprived of contact with an adult who had been monitoring the child's health and safety.
- CPS disclosed the contact information of a custodial parent to the non-custodial parent who was incarcerated for a violent crime, causing harm to the custodial parent. Although the information was part of the agency's report and service plan provided to the court, which is required to be provided to both parents, CPS could have informed the custodial parent about a process whereby confidential information regarding the parent could have been redacted from the copy of the record provided to the other parent.
- CPS declined to file a dependency petition with regard to a one-year-old non-dependent child who had been chronically neglected, even thought the community Child Protection Team recommended it. CPS believed the neglect did not meet the statutory requirement for filing a petition, of risk of imminent harm to the child. Services provided to the family did little to improve the parents' care for the child and the case was closed. In such cases, the agency can only wait for a new referral alleging neglect or abuse before it can offer further services to protect the child.

Poor practice by agency, resulting in harm or unfair treatment of child or family ….. …… 29 complaints

- CWS tried to persuade a service provider to alter the provider's assessment and recommendations to reflect more negatively on a parent than was justified by the facts.
- A dependent infant who was likely to become legally free within the minimum time period specified by ASFA, was placed in three different foster homes within the first few months after birth. The infant initially spent five months in a temporary foster home, was then placed in a foster-adopt home from which the infant was moved because the foster-adopt parents decided they did not want to adopt an infant; and was moved from a third home (also a foster-adopt home) because the infant had been placed there with another infant and the foster parents were unable to manage both infants. The infant's attachment and bonding may have been seriously compromised by these avoidable errors. Better practice would call for placement of a predictably adoptable infant in a potential permanent placement from the start; better screening of foster-adopt parents, and not placing two infants with inexperienced foster parents.
- CPS made a verbal agreement with a parent of three young children, to place them with a relative while the parent received treatment for a mental illness. Conditions for contact between the parent and the children were not specified; neither were conditions for the return of the children to the parent. Better practice would call for a formal Voluntary Placement Agreement between CPS and the parent, thereby clarifying a plan for safe visitation, services to the parent, and goals to work toward in order to have the children returned.
- CWS obtained permission from the non-custodial parent of a dependent child, to administer psychotropic medication prescribed by the child's doctor, after the custodial parent refused permission. While law and policy allows permission to be obtained by either parent, better practice would call for the agency seeking a decision by the juvenile court regarding whether to overrule a parent's objection to the medication.
- The Ombudsman documented several instances of poor communication with clients by state workers, and poor service administration such as a lack of continuity in casework services when a case is transferred from one office to another.

The Ombudsman Lends a Helping Hand

Finally, in many cases the Ombudsman provides practical assistance to children or families who contact the office, whether or not adverse findings are made. Some examples include:

- The Ombudsman assisted a youth who was unsure who to turn to, in contacting CPS to report being assaulted by a step-parent. The Ombudsman then followed up to ensure the youth had made the report and received assistance.
- The Ombudsman helped a grandparent resume contact with their dependent grandchild after losing touch with the youth due to several changes in the youth's placement. The Ombudsman contacted the youth's caseworker, who reconnected the youth and the grandparent.

- The Ombudsman provided information to the parent of a child with mental health problems about the purpose of and process for applying for admission to the Children's Long-term Inpatient Program. The child was successfully placed in a residential mental health treatment program where the child made good progress.

- The Ombudsman contacted a CA area administrator to ensure that serious allegations of child sexual abuse against a Court Appointed Special Advocate (CASA) and social work student were known to all agencies served by this individual. The administrator discovered the individual was still the appointed CASA for some children, and called a meeting with all administrators involved to ensure the individual was not having any contact with minors in a professional capacity.

Indian Children and Families: Is the Current System Fulfilling their Unique Recognition under the Law?

I. ISSUES IDENTIFIED BY THE OMBUDSMAN

Citizens who ask the Ombudsman to investigate child welfare cases involving Indian children are among the most impassioned that come to our office for help. Stakeholders from across the state have expressed concerns that Indian children are not granted permanent homes as soon as they deserve. In the process of reviewing and investigating numerous complaints concerning Indian children, the Ombudsman found there are a variety of factors that contribute to delays for children in need of permanent homes: cultural biases and assumptions by both non-Native and Native participants; broad philosophical differences over what constitutes "best interest" for an Indian child; and disagreement over whether a child qualifies as an "Indian child" under the Indian Child Welfare Act of 1978 (ICWA),[1] and consequently, ensuing confusion by stakeholders over which specific laws and policies apply to a case.

ICWA is the Federal law that governs and informs dependency cases of children who meet the definition of "Indian child" under that Act. ICWA defines "Indian child" as an unmarried person who is under age eighteen and is either (a) a member of an Indian tribe or (b) eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe.[2] Thus, whether a child comes under ICWA has far reaching implications for case planning, placement preferences, services, and other aspects of a dependency case.

ICWA is unique in that there is no other child welfare law that, by design, elevates the interests of a particular racial or ethnic group. From this unique recognition of the need to protect one particular racial or ethnic group comes a great deal of passion over how best to accomplish this. This section of the report makes several recommendations to improve decision making in Indian cases and promote safety and permanence for our Native children. These recommendations are based on analysis of data from complaints we have investigated, meetings and conversations with tribal representatives, and participation in the Department of Social and Health Service's (DSHS) Children's Administration (CA) staffings and conferences.

This section of our report also provides an overview of ICWA as well as a discussion of some of the highlights of state law, regulations, and policies that may affect dependency cases with Indian children. We also provide an update on DSHS CA's efforts.

A. ICWA-related Complaints Are on the Rise

The number of complaints the Ombudsman has received related to ICWA has grown steadily over the past several years: ICWA was identified as an issue in 15 complaints in 2004, 3.2 % of the complaints received that year; 29 complaints in 2005 (6.2% of total complaints); 37 complaints in 2006 (7.3% of complaints); and 52 complaints in 2007[3] (8.5% of complaints).

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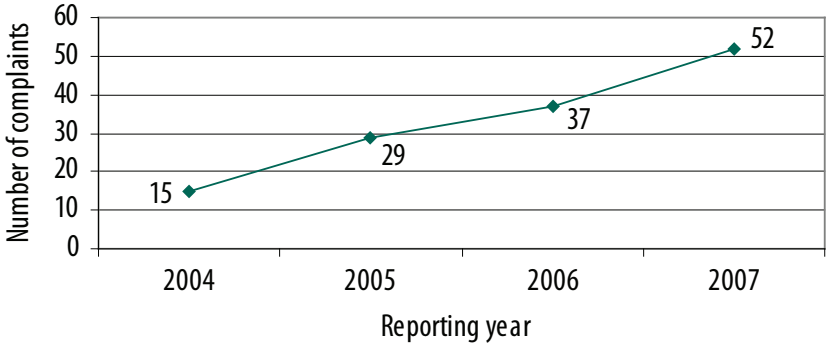
[1] The Indian Child Welfare Act, 25 U.S.C. §§ 1901 – 1923.

[2] 25 U.S.C. § 1903(4).

[3] OFCO's reporting year runs from September 1 to August 31. Consequently, 2007 complaints reported were from September 1, 2006 through August 31, 2007.

B. Indian Children are Disproportionately Represented in the Child Welfare System

Complaints to the Ombudsman involving ICWA



Source: Office of the Family and Children's Ombudsman, September 2006

Indian children are disproportionately represented in the child welfare system. According to a written statement submitted by the National Indian Child Welfare Association to the House Committee on Ways and Means in May 2007, "Native American children are placed in out-of-home placements [at]. . .a rate 2-3 times [the percentage of] their population."[4]

C. The Rate of Indian Child Fatalities is also Disproportionately High

Moreover, although child fatalities sweep every demographic, in Washington state these deaths are disproportionately represented among the population of Native children. In our 2005 Annual Report, we reported that although Native Americans made up only 2% of Washington State's population in 2000, Native children made up 17% of the unexpected child fatalities of children who were in the care of or receiving child welfare services from DSHS CA within one year of their death, or who died while in state licensed care.[5] The Governor, Legislature, and DSHS Children's Administration have recognized the need for additional resources to address the well-being of Native children in the foster care system. Specifically, the 2007 budget provided $1.782 million to address state and federal requirements to reduce the disproportionate number of fatalities for Indian children.[6] The Legislature enacted new law in the 2007 legislative session to analyze and remedy racial disproportionality and racial disparity in the child welfare system.[7]

[4] May 15, 2007 Statement of the National Indian Child Welfare Association before the House Committee on Ways and Means, relying on data from the National Data Analysis System, 2004, available at http://ndas.cwla.org/. http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=6194

[5] Office of the Family & Children's 2005 Annual Report, p. 53. Toni Lodge, executive director of the NATIVE Project/NATIVE Health Clinic of Spokane, a nonprofit that provides adolescent substance abuse, mental health, education and prevention services to youth of all ethnicities, in commenting on OFCO's fatality finding stated: "[This is] [u]nbelievable and unacceptable. As we are continually exposed to death, trauma, grief and loss, we perpetuate the concept of inter-generational trauma." http://www.spokesmanreview.com/ourkids/chats/transcript/?ID=70. Retrieved on 6/19/07.

[6] The rationale for this expenditure was as follows: "State and federal requirements to meet the needs of vulnerable and dependent children have increased, but funding to support Indian Child Welfare (ICW) has not grown. Additional funds are provided to address state and federal requirements and to reduce the disproportionate number of fatalities for ICW children." DSHS - Children's Administration Recommendation Summary: http://www.ofm.wa.gov/budget07/recsum/300010.pdf.

[7] SHB 1472 seeks to analyze and remedy racial disproportionality and racial disparity in the child welfare system. It is discussed in more detail under the Legislative Update section of this Annual Report.

D. Issues of Complaint

The most common complaint issues OFCO investigated related to whether DCFS: 1) accurately determined (based on the tribe's determination) whether the child meets the ICWA definition of an "Indian child"; 2) provided proper and timely notice to the tribe; 3) followed placement preferences under ICWA; 4) unreasonably removed a child from a non-Native placement; 5) maintained regular contact with the tribe and/or collaborated with the tribe; 6) made "active efforts" to prevent the breakup of the Indian family; and 7) adequately promoted the best interests of the child by presenting well stated and well reasoned recommendations to the court in cases where the tribe has jurisdiction and thus the case is before tribal court, but the state of Washington continues to provide child welfare services. Additionally, many complaints raised broad systemic concerns over whether the tribe or state superior court should have jurisdiction of a case and authority to make decisions.

When OFCO investigates a complaint, we first determine whether the complainant's allegations are true. If we find they are, we then determine whether the agency's alleged action or inaction constitutes a violation of law, policy, or procedure. The following provides some background on the Federal law that Children's Administration must comply with in handling Indian child cases and a brief discussion of state and local policies that come into play.

II. FEDERAL LAW: THE INDIAN CHILD WELFARE ACT

A. Legislative Intent

Almost 30 years ago, Congress passed the Indian Child Welfare Act of 1978 (ICWA)[8] in recognition of the need to provide greater stability and security for Indian tribes and families and protect the best interests of Indian children. The law was based on and included key congressional findings that:

> there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and that the United States has a direct interest, as trustee, in protecting Indian children who are members of or are eligible for membership in an Indian tribe; . . . an alarmingly high percentage of Indian families are broken up by the removal, often unwarranted, of their children from them by nontribal public and private agencies and that an alarmingly high percentage of such children are placed in non-Indian foster and adoptive homes and institutions; and . . .the States, exercising their recognized jurisdiction over Indian child custody proceedings through administrative and judicial bodies, have often failed to recognize the essential tribal relations of Indian people and the cultural and social standards prevailing in Indian communities and families.[9]

In *Mississippi Choctaw Indian Band v. Holyfield*, 490 U.S. 30, 36 (1989), the Supreme Court explicitly noted these findings and stated that "[a]t the heart of the ICWA are its provisions concerning jurisdiction over Indian child custody proceedings"[10] and that "[t]he most important substantive requirement imposed on state courts is that [ICWA] . . .absent 'good cause,' to the contrary, mandates that adoptive placement be made preferentially with (1) members of the child's extended family, (2) other members of the same

[8] 25 U.S.C. §§ 1901 – 1923.

[9] 25 U.S.C. § 1901(3), (4), (5).

[10] Mississippi Choctaw Indian Band V. Holyfield, 490 U.S. 30, 37 (1989).

tribe, or (3) other Indian families."[11] The Supreme Court made clear that the Act "'seeks to protect the rights of the Indian child as an Indian and the rights of the Indian community and tribe in retaining its children in its society'"[12] and that the procedural safeguards in ICWA are essential to carrying out this legislative intent.[13]

B. Applicability of ICWA

ICWA applies to any action involving an Indian child[14] in proceedings related to foster care placements, termination of parental rights, pre-adoptive placements,[15] or adoptive placements.[16] The Act protects the rights of parents, as well as the rights of the Indian child, and tribe.

C. Jurisdiction

1. Exclusive Tribal Jurisdiction of Indian Children Who Reside or are Domiciled within the Reservation

ICWA provides that an Indian tribe has exclusive jurisdiction over an Indian child who resides or is domiciled[17] within a reservation, unless a state has previously been given jurisdiction by Federal law.[18] The law also requires that the Federal Government, states, and tribes give "full faith and credit" to judicial proceedings of tribal court,[19] meaning that the orders of tribal court will be recognized and enforced by other courts.

2. Concurrent but Presumptive Tribal Court Jurisdiction for Indian Children not Domiciled or Residing within a Reservation

For an Indian child not domiciled or residing within the reservation of the child's tribe, 25 U.S.C. § 1911(b) grants both states and tribes jurisdiction over the Indian child. Although there is concurrent jurisdiction, the law presumes tribal court jurisdiction.[20]

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[11] *Holyfield*, 490 U.S. 30, 37-38 (1989).

[12] 490 U.S. at 38, quoting from H.R. Rep. No. 95-1386 (1978).

[13] 490 U.S. at 37.

[14] As set forth earlier in this section of the annual report, "Indian child" is defined as an unmarried person who is under age eighteen and is either (a) a member of an Indian tribe or (b) eligible for membership in an Indian tribe and is the biological child of a member of an Indian tribe. 25 U.S.C. § 1903(4).

[15] This includes "the temporary placement of an Indian child in a foster home or institution after the termination of parental rights, but prior to or in lieu of adoptive placement." 25 U.S.C. § 1903(1)(iii).

[16] 25 U.S.C. § 1903(1)(iv).

[17] The Supreme Court in *Holyfield* decided that the domicile of a child is determined by the domicile of the parents and that the domicile of the parents is determined by the parents' physical presence in a place in connection with a certain state of mind concerning one's intention to remain there (the court held that twins were domiciled on a reservation, even though they had never been there and had been voluntarily relinquished for adoption). 490 U.S. at 31-32.

[18] 25 U.S.C. § 1911(a).

[19] 25 U.S.C. § 1911(d).

[20] This dual jurisdictional scheme between the state and the tribe, for Indian children who do not reside on a reservation, is a common source of confusion and conflict in dependency cases.

a. Good cause provides a basis not to transfer a case to tribal court

If either parent, the Indian custodian, or the tribe petitions for the case to be transferred to tribal court, the case shall be transferred, absent good cause to the contrary, unless either parent objects to the transfer.[21] The burden of proving good cause to decline a transfer falls to the party opposing the transfer. Good cause must be demonstrated by clear and convincing evidence. Congress anticipated that the courts should consider the rights of the Tribe, the rights of the Indian child, and the rights of the Indian parents or custodian in making a good cause determination.[22]

Although "good cause" is not defined in ICWA, the Department of the Interior, Bureau of Indian Affairs (BIA), has issued guidelines in determining "good cause." These guidelines have not been adopted as Federal regulations, and do not have binding legislative effect. However, they represent the BIA's interpretation of ICWA and set forth factors that will likely be considered by a court interpreting good cause.[23] According to the BIA, good cause not to transfer a case may exist if:

1. the Indian child's tribe does not have a tribal court as defined by ICWA;

2. the petition to transfer was received at an advanced stage of the proceeding and the petitioner did not file the petition promptly after receiving notice of the hearing;

3. the Indian child is over twelve years of age and objects to the transfer;

4. the evidence necessary to decide the case could not adequately be presented in the tribal court without undue hardship to the parties or the witnesses; or

5. the parents of a child over five years of age are not available and the child has little or no contact with the child's tribe or members of the child's tribe.[24]

The BIA states that,"[s]ocioeconomic conditions and the perceived inadequacy of tribal or Bureau of Indian Affairs social services or judicial systems may not be used as a basis to determine that good cause exists."[25]

b. The court may decline to transfer a case to tribal court if either parent objects

If either parent objects to the transfer of a case to tribal court, this too may provide a basis for the court to decline transfer.[26]

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[21] 25 U.S.C. § 1911(b). According to the National Conference of State Legislatures, "State and tribal officials report that in many cases, transferring the case to tribal court would be preferable, but tribes often lack the resources to meet the needs of the affected parties." http://www.ncsl.org/programs/statetribe/ICWA.htm

[22] H.R. Rep. 95-1386 at 21 (1978).

[23] See http://jec.unm.edu/resources/benchbooks/child_law/miscellany/ch39_guidelines.htm.

[24] BIA Guidelines § C.3.

[25] *Id*.

[26] 25 U.S.C. § 1911(b).

c. Summary of basis not to transfer a case to tribal court

The court may decline to transfer a case to tribal court if good cause supports not transferring the case or a parent objects to the transfer. Transfer may also not occur if the tribal court declines jurisdiction. Debate over the right to transfer cases to tribal court remains at the heart of litigation over proper jurisdiction of dependency/ termination cases involving Indian children. The Ombudsman has encountered cases in which Department personnel were unaware that there was a "good cause" exception to the requirement that a case be transferred to tribal court or that a parent's objection to the transfer could be a basis for state court retaining the case. To be clear, it is the role of the court and not Children's Administration to transfer jurisdiction of cases. However, when caseworkers or supervisors are uninformed about these exceptions to transfer of a case, they may unwittingly misinform parents who then find that their objection to the transfer of a case comes too late in the proceeding. The lack of consistent understanding by workers about these concepts may lead care providers to feel that the outcome of court decisions affecting a child in their care is unpredictable and uncertain. This may heighten anxiety in what is already an emotional and difficult situation.

D. Notification of Court Proceedings

ICWA requires the tribe to be notified of court proceedings involving an Indian child and the right of the tribe to intervene.[27] BIA Guidelines provide that notice to a tribe should be provided under a broad range of circumstances:

- Whenever a party, tribe, or private agency informs the court that the child may be an Indian child;
- When a public agency has information indicating the child may be an Indian child;
- When the child believes he/she is an Indian child;
- When the child lives or is domiciled in an Indian community or the child's parent or custodian are from an Indian community; or
- When the court has information that the child is an Indian child.[28]

Consequently, it is vital that DCFS aggressively pursue steps to determine whether a child meets the definition of an Indian child under ICWA. If the agency does not gather from parents and relatives necessary information to make an inquiry to potential tribes at the front end of the dependency proceeding, this will delay tribes receiving proper notification of upcoming hearings. This has resulted in lengthy continuances of trials and delayed permanence.[29]

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[27] If the tribe is not identified, notice must be provided to the Department of the Interior (DOI). Notice must be by mail and must be received by the parent and the tribe or Secretary of DOI at least 10 days prior to the proceeding. Notice requirements are liberally construed so that if a court has "reason to believe" that a child is an Indian child, notice should be provided. 25 U.S.C. § 1912(a). This notice requirement does not prevent the emergency removal of an Indian child. 25 U.S.C. § 1922. Pursuant to chapter 6 of the DSHS ICW Manual, if a "social worker assesses the need for continuing placement [of a child] beyond 72 hours [i.e. beyond the 72 shelter care hearing]. . .the worker immediately contacts the Tribe to establish whether the Tribe wishes to request a transfer of jurisdiction to the tribal court." § 06.606.

[28] BIA Guidelines § B.5.

[29] In cases the Ombudsman has investigated, DCFS has attributed delays in notification, in part, to parents and relatives providing insufficient or inaccurate information which stalls an inquiry or to tribes not responding to the agency's inquiry on a timely basis.

E. Intervention

The Indian tribe has the right to intervene at any point in a state court proceeding for foster care placement or termination of parental rights as to an Indian child.[30]

F. Priority of Placement

The law requires that priority be given to placement of Indian children with relatives or tribal families, unless good cause exists not to follow such preferences.[31] For purposes of adoption, priority is with: 1) a member of the child's extended family[32]; 2) other members of the child's tribe; and 3) other American Indian families.[33] The issue of placement is one of the most common and highly contentious issues brought to the Ombudsman for investigation.

G. Active Efforts

ICWA requires that "[a]ny party seeking to effect a foster care placement of, or termination of parent rights to, an Indian child under State law shall satisfy the court that active efforts have been made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family and that these efforts have proved unsuccessful."[34] This is a higher standard than the "reasonable efforts" standard under the Adoption and Safe Families Act that applies to non-Indian children. BIA Guidelines set forth that "active efforts" should take into account "the prevailing social and cultural conditions and the way of life of the Indian child's tribe."[35]

H. Qualified Indian Expert

Under ICWA, evidence that the continued custody of a child by an Indian parent or custodian likely would result in serious emotional or physical damage to the child must include the testimony of "qualified expert witnesses."[36] The BIA has issued guidelines on what constitutes a "qualified Indian expert." Although some courts have refused to adopt these guidelines, they are considered instructive and the courts have relied on the general premise that a qualified Indian expert is someone who possesses special knowledge of social and cultural aspects of Indian life.

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[30] 25 U.S.C. § 1911(c). This is in contrast to transfers of jurisdiction, which a state court may not grant for "good cause." 25 U.S.C. § 1911(b).

[31] 25 U.S.C. § 1915(a) & (b).

[32] Native culture has generally a more expansive view of "family" than non-Native. This is an area susceptible to disagreement when different cultures have a role in decision making for the same child.

[33] 25 U.S.C. § 1915(a). Federal law, the Multi Ethnic Placement Act (MEPA) of 1991, as amended by the Inter-Ethnic Adoption Provisions of 1996 (MEPA-IEP), prohibits delaying or denying a foster or adoptive placement in order to place a child with a family based on the racial or cultural background of the child. However, ICWA is excluded from this prohibition. 42 U.S.C. § 1996b (3).

[34]The Indian Child Welfare Act, 25 U.S.C. § 1912.

[35] BIA Guidelines § D.2.

[36] 25 U.S.C. § 1912(f).

III. STATE AND LOCAL POLICIES AND PROCEDURES

In addition to the overlay of Federal law, there are state laws and regulations, state-tribal treaties and agreements, and DSHS CA policies that affect Indian child welfare cases.[37] The breadth and complexity of these laws make Indian child welfare cases susceptible to misinterpretation and confusion. Within some regions, Indian child welfare cases have been handled within specialized units or by specialized workers within the agency.[38]

A. WAC Definition of "Indian Child"

However, it is important for parties and stakeholders to understand that even if a dependent child does not meet the Federal definition of "Indian child" under ICWA, the child may still be considered Indian and be treated as an Indian child for purposes of foster care planning[39] under the Washington State Administrative Code.[40] This directly impacts the management of the case and may create confusion and many more opportunities to "drop the ball" on important case planning milestones.

B. LICWAC Staffing

CA policy determines staffing of Indian child cases. Under CA policy, a social worker must staff an Indian child's case in the following preferential order:

1. With representatives designated by the child's Tribe to staff the case with the social worker;

2. With a tribal Local Indian Welfare Advisory Committee (LICWAC) designated by the child's Tribe to staff the cases of all tribal children with the social worker;

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[37] RCW 13.32a; RCW 13.34; RCW 26.33; RCW 26.34; RCW 26.44; RCW 74.13; RCW 74.14a; RCW 74.14b; RCW 74.14c; RCW 74.14d; RCW 74.15; The State-Tribal Centennial Accord; Tribal-State Indian Child Welfare Agreement of 1987; Chapter 388 WAC; Treaties between Indian Tribes and the U. S. government; and Treaties between Indian Tribes and the state of Washington.

[38] According to the CA ICW Program, four regions currently have ICW units. Two regions do not have stand alone ICW units.

[39] The DSHS Indian Child Welfare Manual, which provides policy and procedural guidelines for CA staff, and state licensed or certified public and private child care and placing agencies, and providers that work with Indian children and families may be accessed at: http://ca.dshs.wa.gov/intranet/mnl_icw/chapter1.html

[40] WAC 388-070-091broadly construes the term "Indian" to include "an enrolled Indian," a "Canadian Indian," and "unenrolled Indian," which is defined as "A person considered to be an Indian by a federally or nonfederally recognized Indian tribe or urban Indian/Alaskan Native community organization." The CA Indian Child Welfare Manual includes the term "recognized Indian child." This is defined as "An unmarried person under age 18 who does not meet the definitions of Indian child, Washington State Indian Child, or Canadian First Nations Indian child. Regardless of enrollment or membership status, a recognized Indian child is a child considered to be an Indian by a federally or non-federally recognized Indian Tribe or off-reservation Indian/Alaska Native Community organization." Indian Child Welfare Manual, chapter 3, § 03.10 "Definitions of Indian Child." Chapters 7 and 11 of the CA Indian Child Welfare Manual provide that the Adoption and Safe Families Act (ASFA) (42 U.S.C. 629-629b and 42 U.S.C. 671a) does not apply to a child meeting the ICWA "Indian child" definition, but does apply to a child meeting the "Recognized Indian Child" definition. The United States Supreme Court and Washington State Supreme Court have not ruled on this question of law. State courts are divided on the extent to which ASFA guides cases where ICWA applies. See J.S. v. State, 50 P.3d 388, 392 (Alaska 2002) (ASFA guides cases in which ICWA applies), while other states have determined that ASFA does not override ICWA, People ex rel. J.S.B., 691 N.W.2d 611, 620 (South Dakota 2005).

3. With the CA LICWAC designated to staff cases involving Indian children in the custody of the CA and meeting the criteria of this section, when the child's Tribe is unavailable.[41]

In December 2004, a workgroup was established to revise policy to ensure that Indian children in placement, who meet the requirement for a LICWAC staffing under CA policy, have a permanency goal established within 60 days of their original placement date. The changes to the policy, which included establishing the 60 day timeframe, required social workers to support the engagement of Tribes in case planning by inviting Tribal representatives to each LICWAC staffing by telephone and by certified mail.

The changes in policy were designed to improve permanency planning and engage LICWAC and/or the tribes in this process. By engaging LICWAC and/or the tribes, the agency hopes to avoid the disruption of placement and unnecessary legal complications, and to facilitate good will and clear communication between DCFS and the tribes and LICWACs. It is also hoped that Indian children will be more likely to receive culturally appropriate services and permanent placements at an earlier stage of the case.

IV. EFFORTS BY CHILDREN'S ADMINISTRATION

According to the Governor's Office of Indian Affairs 2007 Centennial Accord Agency Highlights, "the Children's Administration's primary Indian Child Welfare goals have been to recognize a Government-to-Government relationship between the State and Indian Tribes/Nations through the maintenance and support of the:

- Indian Child Welfare Act
- Washington State Centennial Accord
- Washington State Tribal State Agreement
- Washington State Local Tribal State Agreements
- DSHS Administrative Policy 7.01"[42]

According to the Children's Administration, the highlights of the agency's actions are:

- 2007 legislative biennium budget increase of $1,782,000 for Indian Child Welfare (ICW) contracts
- Working draft of an ICW Local Tribal Agreement template
- Formal ICW Tribal Consultation on Tribal ICW allocations, distribution methodologies and Local Tribal Contracts
- Completed an agency wide Contracts Review including all Headquarters, Regional, and Local Tribal Contracts

[41] See RCW 13.70.150; WAC 388-70-091; 388-70-450; and 388-70-600 through 388-70-640.

[42] p. 48 of 2007 Centennial Accord Agency Highlights, Office of the Governor, Governor's Office of Indian Affairs. See http://www.goia.wa.gov/News/AgencyHighlights.pdf.

- Local Indian Child Welfare Advisory Committee state-wide training in response to priority set forth at the 2006 Indian Child Welfare Summit
- ICW case review training and pilot to be conducted June-August of 2007 and annually thereafter
- Monthly Tribal/State meetings addressing ICW Manual revisions, forms revision, updating policies on active efforts, Tribal/Nations notification process, 24 hour response time and its ICW implications, identification of Indian Child, Local Indian Child Welfare Advisory Committee (LICWAC) roles, responsibilities, and training needs, outreach and training needs for Court Appointed Special Advocates (CASAs), and Guardian Ad Litems (GALs) as it related to ICW, reorganization effort of CA through the development and implementation of the Practice Model, and other related issues.[43]

Additionally, CA recently completed case reviews of cases in Native American units. The agency, at the time this report went to print, had not yet released the results of these reviews.

Despite the agency's efforts to improve decision making for dependent Indian children, the Ombudsman believes there are significant shortcomings in the system and strongly urges the adoption of the following recommendations.

V. RECOMMENDATIONS

Recommendation 1: Increase Communication Among Stakeholders

- **Regular meetings should be established between tribal representatives, judges, tribal prosecutors, tribal welfare agency staff, care providers, the Attorney General's office, CASA/GALs, and Children's Administration to discuss procedures, issues, communication, and other issues of mutual concern.** [44]

OFCO finds that much of the dissatisfaction citizens express against DCFS stems from or is heightened by poor communication. Care providers describe not being informed about changes in the case plan, relatives describe not being contacted or considered for placement, DCFS complains that they are required to appear in tribal court without attorney representation or that tribes do not maintain communication with the agency, and tribal representatives complain that they are treated by DCFS as an obstacle rather than as a valuable member of the team. At least one tribal worker also recounted that DCFS disrespected the worker's role by contacting the Tribal Council directly, rather than recognizing the role of the tribal worker and working with that worker.

OFCO finds that some CA DCFS workers are either uninformed about their duties under ICWA or hold widely varying interpretations of the law. This leads to significant inconsistencies in how ICWA is carried out across the State. Collaboration among the various parties and stake holders in a case will promote better understanding of the law, policies and cultural nuances, and will promote good will among these entities.

[43] *Id.*

[44] The December 2006 Executive Child Fatality Review of Devon Miller endorsed the establishment of regular meetings between Native and non-Native stakeholders to discuss issues of mutual concern.

Lack of agreement in interpreting ICWA and various parties' roles

Three dependent children ages 4, 2, and 1, had been in out-of home care since infancy, the oldest child with one foster parent since the age of 4 months, and the younger two with another foster parent, essentially since birth. The tribe had been involved with the case in varying degrees throughout the dependency. In the previous year, the tribe had agreed to a case plan of adoption of all three children by their non-Native foster parents. The agency was in the process of negotiating an agreement by the birth parents to relinquish their parental rights when the tribe located an out-of-state relative who was a licensed foster parent and appeared qualified to pass an adoption home study.

At this point, the tribe recommended that all three children be placed with this relative. DCFS agreed to the change in plan. The guardian ad litem (GAL) did not agree, based on the young age of the children at the time they had been placed with the foster parents, the length of time they had lived with them, and the strong bonds that had developed. The agency's rationale for changing its case plan was that once a qualified relative was found, who was a member of the children's tribe, and the tribe proposed placement with that relative, the agency was obliged to place the children with that relative. When asked how disagreements between the agency and the tribe regarding placement recommendations were dealt with, the agency responded that it had never experienced a disagreement, and that in the past if the agency had any concerns about a tribe's placement recommendation, it had always been able to reach agreement with the tribe. The agency believed it was not its role to raise concerns to the court about a tribe's placement recommendation, because ICWA gave the tribe the ultimate authority to determine the case plan by allowing it to request transfer of the case to the tribal court. The GAL did not agree with the agency's interpretation of ICWA, arguing that either the agency or the GAL could ask the court to deny a motion by a tribe to transfer a case to tribal court based on the "good cause" exception outlined in ICWA:

"In any State court proceeding for the foster care placement of, or termination of parental rights to, an Indian child not domiciled or residing within the reservation of the Indian child's tribe, the court, in absence of good cause to the contrary, shall transfer such proceeding to the jurisdiction of the tribe, absent objection by either parent, upon the petition of either parent or the Indian custodian or the Indian child's tribe . . . ."[1]

The judge denied the transfer of the case to tribal court and ordered that the children remain with their foster parents permanently.

[1] 25 U.S.C. § 1911(b)

Lack of agreement regarding the definition of "Indian" leads to inadequate permanency plan and services

The relative caregiver of a 13 year-old non-dependent child was frustrated by a 'catch 22' situation created by a policy conflict between CA policy and tribal law. Although the child qualified as a "recognized Indian child" under CA policy, the child could not be enrolled in the tribe because the tribal requirements for enrollment were much narrower than the CA policy. The agency's permanency plan was for adoption of the child by the relative, but because of the child's Indian status under agency policy, Local Indian Child Welfare Advisory Committee (LICWAC) approval was required in order to file a petition for termination of the parents' rights. The LICWAC denied the plan to petition for termination of parental rights. The child needed specialized mental health services, which the relative was unable to access through the family's private health insurance or through the agency's adoption support program available for adopted children. On the other hand, because of the tribe's refusal to enroll the child, services available through the tribe, and which could have greatly benefited this child, were inaccessible. Instead, the child remained dependent and could only receive limited services accessible to dependent children through DCFS.

Recommendation 2: Identify Gaps in Resources and Services

- **DCFS shall conduct a comprehensive survey of resources and services available in Native communities to satisfy the requirement under ICWA that "active efforts have been made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family"**[45]:

  In the process of identifying resources, DCFS should also determine gaps in the system. Once these are identified, state and Federal resources need to be directed toward filling these gaps so that appropriate services are available in Native communities to serve Native children and families. Public funding for rehabilitative services such as substance abuse treatment and mental health counseling services needs to be increased.

Unless funding sources are improved so that more services can be delivered through Native communities, such communities and tribal governments will not be in a position to fully contribute their expertise to preserving the cultural heritage of Indian children and maintaining relationships between Indian children and their families and tribes.

According to the National Indian Child Welfare Association (NICWA), prior to the enactment of ICWA, "tribal governments . . . had access to very few federal funding sources to combat [the removal of Native children from their families]. . ." and "it was estimated that 25% of all Native American children were in

[45] 25 U.S.C. §1912(d) provides that "[a]ny party seeking to effect a foster care placement of, or termination of parental rights to, and Indian child under State law shall satisfy the courts that active efforts have been made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family and that these efforts have proved unsuccessful." OFCO recognizes that individual ICW units within DCFS may have a working knowledge of resources and services available in some Native communities. However, tribal community leaders continue to express the need for identifying gaps in the system.

some form of substitute care, most often away from their tribal communities and extended families."[46] After the enactment of ICWA, funding from federal sources was improved to support child welfare services. A competitive grants program through the then newly established Bureau of Indian Affairs was made available to tribal governments to support child welfare services. NICWA highlights that these grants, although a step in the right direction, were inadequate because they were discretionary, were not funded adequately, and were competitive so that "the majority of tribes never received any grant funds."[47]

NICWA has called for Congress to authorize tribes to 1) directly administer Title IV-E Foster Care and Adoption Assistance programs and to 2) expand the IV-E program to fund guardianship placements.[48] The Title IV-E program provides Federal reimbursement to the states for the cost of children placed in out-of- home care under a court order or a voluntary placement agreement.[49] Currently, Title IV-E Assistance extends only to state governments and entities with which states have agreements.[50] Thus, under the current statutory scheme tribes may access Title IV-E foster care payments only if they enter into an agreement with the state. There have been ongoing efforts by Congress to authorize tribal administration of Title IV-E programs, but these have not yet been enacted into law.

Consistent with the recommendation of NICWA, the Pew Commission in its 2004 report entitled *Fostering the Future: Safety, Permanence and Well-Being for Children in Foster Care*, has recommended preserving federal foster care maintenance and adoption assistance as an entitlement and expanding it to include all children, including Indian children.[51] NICWA highlights the limitations of these agreements, stating that "Many such agreements provide only the maintenance payment for the foster home, but not the training, administrative and other court-related work, and data collection that states receive."[52]

Until tribal communities and tribal government are within reach of a more level playing field, which translates into having greater and more consistent funding of child welfare programs, the full intent of ICWA will be stymied. As Marilyn Olson, the Port Gamble S'Klallam Tribe's Director of Children and Family Programs in our state emphasized in her contact with NICWA, '"Having access to Title IV-E funding gave us hope and resources to keep many more of our children in the community with their

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[46]May 15, 2007 Statement of the National Indian Child Welfare Association before the House Committee on Ways and Means, relying on data from the National Data Analysis System, 2004, available at http://ndas.cwla.org/. http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=6194

[47] *Id.*

[48]*Id.* The Child Welfare League of America (CWLA) has also endorsed providing direct tribal access to foster care and adoption assistance funding and services to Indian children in tribal areas and has supported legislative efforts to achieve this goal. http://www.cwla.org/advocacy/2004legagenda16.pdf.

[49]42 U.S.C. § 672(a)(1).

[50] "[T]he State child welfare agency is ultimately responsible for the proper administration of the title IV-E program and for assuring compliance." U.S. Department of Health and Human Services relying on 45 CFR 1356.71. Accessed on 10/23/07 at: http://www.acf.hhs.gov/j2ee/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=77#331.

[51] The PEW Commission on Children in Foster Care (May 2004). Executive Summary, *Fostering the Future: Safety, Permanence and Well-Being for Children in Foster Care.* Retrieved 10/22/07 at: http://pewfostercare.org/research/docs/FinalExecSum.pdf.

[52] May 15, 2007 Statement of the National Indian Child Welfare Association before the House Committee on Ways and Means, relying on data from the National Data Analysis System, 2004, available at http://ndas.cwla.org/. http://waysandmeans.house.gov/hearings.asp?formmode=printfriendly&id=6194

extended families.'"[53] Prior to entering into an agreement with the state, Olson reports, "'We were diverting significant amounts of funding that could have been used to provide child abuse prevention, treatment, and substance abuse treatment for the families. We also had to use over half of our tribal TANF fund in order to avoid our children from being placed with families outside our community.'"[54] The Port Gamble S'Klallam tribe is cited by NICWA as a success in procuring access to the Title IV-E program, but NICWA is quick to point out that it is one of a few number of tribes that have been able to access the program.

Recommendation 3: Avoid Long-Term Placement Disruption

- **The following steps should be implemented to minimize situations in which DCFS must choose between the loss of a long-term, committed, and stable foster home and the loss of an opportunity to place a child in a prospective Native home:**

  1. **Active inquiry at the front end into a child's Indian status at the time of initial out-of-home placement.** There should be consistent efforts to determine Indian status and to gather and document information from collateral sources, such as family members and professionals who may be knowledgeable about the child's Indian status, as well as any prior court proceedings, rather than solely from parents.[55]

  2. **Active recruitment and retention of Native foster homes with training and financial resources to support this goal.[56]**

  3. **Improved representation of Indian children through appointment of an attorney and/or a GAL to represent the child's best interest in all child welfare proceedings, whether in state or tribal court.** [57]

  4. **Avoid placement of Indian children in non-Native homes except for short term placements or respite care, and communicate this at the front end to foster parents so as to manage expectations.[58]**

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[53] *Id.*

[54] *Id.*

[55] The use of Family Team Decision Making meetings is growing and these have become a useful forum in which to make inquiries about Native status.

[56] According to data from DSHS Children's Administration, the number of active Native American Foster homes (homes are counted as Native American if any foster parent indicates Native American race) has steadily declined between FY 2003 when there were 336 and FY 2007 when there are 307. Comparing these two fiscal years, available Native foster homes declined in Regions 2, 3, 4, and 6; remained the same in Region 1 and increased in Region 5. See attached Appendix.

[57] OFCO recognizes that it does not have jurisdiction over tribes or tribal courts. However, we believe that improved representation for children needs to occur at all levels, not just in state court. Adequate resources need to be made available to make the appointment of an attorney and/or a GAL a reality for all dependent children. Washington CASA has supported three tribes to start CASA programs in their tribal court: Yakama, Spokane, and Kalispel. All three tribes have received a grant from the National CASA program. Additionally, the Children's Representation Workgroup, in which OFCO participates, has been charged by the Washington State Supreme Court Commission on Foster Care to make specific recommendations to the Commission on the issue of improving child representation. The workgroup has presented its recommendations to the Commission with the intent of triggering legislative action on the recommendations.

[58] This recommendation is only possible with an adequate number of Native foster homes and is driven, in part, by a desire to avoid scenarios we have investigated in which DCFS attempts to remove Indian children from long-term pre-adoptive non-Native foster homes, in which strong attachment bonds have formed, to place in a newly discovered Native home.

Delay in permanence and risk to safety of children due to concerns about non-Native placement

The Ombudsman investigated a complaint alleging that DCFS had treated non-Native foster parents of two dependent children, ages 3 and 4, disrespectfully and subjected them to racial discrimination, and that the agency was creating barriers to the foster parents assuming guardianship of the children.

The children had been placed in this foster home as newborn babies. The home was approved as a culturally appropriate home by the regional LICWAC and by other tribal leaders. They remained in this home, the older child for almost two-and-a-half years, and the younger child for six months, until the tribe assumed jurisdiction of the case and they were returned to their parents, against the recommendation of the LICWAC and the Tribal Council.

Seven months after the older child was returned home, the children were again removed. The parents were found to have severely neglected the children's medical needs and the children were suffering from malnutrition and poor hygiene. A second dependency was filed, and the children were returned to their previous foster home.

The foster parents regularly consulted with leaders in the Native community for advice on how to best maintain tribal connections and customs. They had the children participate in pow-wows and other spiritual ceremonies, and developed a relationship with a local Native leader who served as the children's "spiritual grandparent." Native legends and arts and crafts were integrated into the children's daily life. In addition to their efforts to promote the children's cultural development and connection, the foster parents made efforts to maintain a connection between the children and their relatives by facilitating visitation and having a gathering at their home for the relatives to renew their connections with one another.

As the case progressed, jurisdiction of the case was transferred from tribal court back to Superior court. The parents did not comply with court-ordered services to demonstrate that they had corrected parental deficiencies. The court ordered that a guardianship petition be filed to appoint the long-time foster parents as the guardians. Despite the court's order, the agency did not file the guardianship petition for six months. During this delay, the agency advocated for placement of the children with a relative with whom the children had only had a short term relationship. The agency facilitated visitation with this relative who was then discovered to be allowing contact between the children and a convicted felon who had not been cleared to have contact with the children. Despite the lack of viable relatives, the caseworker and supervisor continued to express concerns that permanent placement was being considered in a non-relative, non-Native home. Moreover, the agency minimized the bond between the children and their foster parents. Although the agency conceded it would be traumatic to remove these children after four years, it was the agency's position that it would be more traumatic for them to remain in a non-Native home. Prior workers in the Native unit had documented that the foster parents provided exemplary care for the children: "these are excellent placements for the children," "[they] have the best interests of the siblings in mind," "[t]his foster home is a very secure, safe, and protective home," "there is evidence of a very strong and a very healthy bonding between the siblings and foster parents . . .[and] the siblings are always well kept, clean and appear very stress-free and happy."

Ultimately, with the GAL as a driving force and the support of community tribal leaders, the agency filed the guardianship petition and the court ordered a guardianship with the foster parents. This was over five years after the original out-of-home placement and two-and-a-half years from the date of the second placement in this foster home.

The agency loses a foster parent through lack of cultural competence

A Native foster parent of several Native children chose to travel to an out-of-state Indian reservation to participate in a healing ceremony. The foster parent requested reimbursement for this as an alternative treatment. The agency considered the event to be a family vacation instead of a service to address the child's developmental delays and mental health. The manner of the agency's denial of the foster parent's request also caused the foster parent to feel that the cultural and overall health needs of the child were disregarded and disrespected. The foster parent eventually decided to no longer work directly with the state agency and now works exclusively through a private Native child welfare agency.

Recommendation 4: Clarify Applicability of Permanency Timeframes

- **Establish a workgroup to consider permanency time-frames, in particular, the extent to which the timeframes under the Adoption and Safe Families Act (ASFA)[59] apply to ICWA children. The workgroup shall recommend a policy for adoption by Children's Administration to guide the agency and provide greater clarity on the issue of permanence for Indian children.**

ASFA was enacted by Congress in 1997 to promote more timely permanence for children in foster care. It requires states to file a termination petition when children have been placed in foster care for 15 of the most recent 22 months.[60] The law also makes clear that the health and safety of a child is the paramount concern in making placement decisions.

Some Indian child welfare advocates take the position that Indian children are or should be exempt from ASFA timeframes. Still others believe that the timeframes set forth in ASFA, although arguably applicable, do not realistically provide enough time to carry out the notice and "active effort" requirements in ICWA. Lack of notice to the tribes is a common basis for continuances of ICWA cases. This in turn leads to delayed permanence. It can also lead to compromised safety for children due to confusion over who has responsibility for different aspects of case planning, particularly where there is more than one tribe involved or more than one DCFS office.[61]

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[59] The Adoption and Safe Families Act of 1997, Pub.L. No. 105-89, 111 Stat. 2115, amending 42 U.S.C. §§671-675.

[60] The law provides for some exceptions to this timeframe: the child is being cared for by a relative; there is a compelling reason that termination would not be in the best interest of the child; or the state has not provided the family with services or made reasonable efforts to reunify the child and family. The Adoption and Safe Families Act of 1997, 42 U.S.C. 675(5)(E).

[61] In the Devon Miller fatality, the Colville Tribe was not notified of the dependency action of the children. In contrast, the Yakama Nation was notified that the child was dependent. The child had Indian heritage from both of these tribes and both should have been notified of the legal status of the child. The tribe, not the state child welfare agency, determines if a child is considered an "Indian child" for purposes of a particular tribe's membership. The Indian Child Welfare manual section 03-30 (d) provides that: "If the child is affiliated with more than one Tribe, the social worker contacts each Tribe by telephone and sends each Tribe a written request for verification of the child's Indian status." DCFS was responsible for supervising the case and providing services to the family; however, the case was administered legally from Tribal Court. The case was further complicated by the fact that although the dependency petition was filed in Yakama tribal court, supervision of the case originated in the Toppenish office (Region 2) of DCFS which placed Devon in Spokane (Region 1). Spokane DCFS then provided courtesy supervision on the case.

Despite these competing priorities, **the Ombudsman believes that timely permanence for all children is an essential right that must be given priority.** Indian children, like other dependent children, are languishing in the foster care system and this is not in their best interest. Some critics argue that the timeframes in ASFA, particularly the requirement of filing for termination of parental rights, conflict with the concept of providing greater stability for Indian tribes. The Ombudsman has learned through complaint investigations and from speakers at meetings that at least some tribes are opposed to severing the relationship between a parent and child, no matter what the timeframe. Therefore, the dual objectives of ICWA, which are best interest of the Indian child and greater security and stability for Indian tribes and families, may be in opposition to each other in some cases.

The best interest of the child requires a clearer and less cumbersome path to permanence. By necessity this may mean termination of parental rights when continuing the relationship between a parent and a child is destructive to that child's safety or well being. Meanwhile, the stability of the tribe may dictate that parental rights remain intact and the child's connection to the tribe not be severed. The solution may lie in increased use of guardianships if termination of parental rights goes against a strongly held cultural norm as it does in many Native American communities.[62] When the stakeholders come together to examine ICWA, they should consider the apparent paradox that ICWA presents when examined through the lens of ASFA.

Delay in permanency resulting from failure to verify a child's Native heritage early in the case

The Ombudsman investigated a complaint alleging that DCFS had delayed in verifying a child's Native heritage despite the parent's claim to Native ancestry early in the dependency case. The Ombudsman found that there had been several delays in establishing the child's Native status. First, the alleged father informed the agency that he was Native, before paternity had been established. However, only after paternity was established did the caseworker initiate further inquiry with the father about his specific tribal affiliation. The father was uncooperative, and the process was delayed by his wanting to consult with his lawyer before answering questions. With an uncooperative father and a heavy caseload, the caseworker dropped the issue for several months. When the caseworker eventually renewed efforts to contact the tribe, the tribe was unresponsive to the worker's repeated contacts, and there was a delay of over a year in establishing permanency for the child. The Ombudsman found the agency had not complied with either ICWA (duty to verify Indian status immediately) or ASFA (establish permanency for children in foster care over 15 months).

[62] The PEW Commission in its 2004 report noted that guardianship may be the best permanent option for a child in "[a] family where termination of parental rights goes against a strongly held cultural norm, as in Native American cultures." See http://pewfostercare.org/docs/index.php?DocID=57

Delay in permanency resulting from failure to identify all potential relative placements early in the case

A relative of a dependent two-year-old child alleged that the agency failed to place the child with Native relatives, as required by ICWA. The Ombudsman found that the agency had considered several relatives but found them unsuitable for placement; however, one promising relative had not been pursued because that relative lived outside the United States. The case was assigned to a new caseworker about the time that the Ombudsman began investigating, and this worker aggressively pursued the foreign relative. The relative was found to be suitable, but ultimately decided not to accept placement of the child due to the child's special needs. At this point the tribe agreed to termination of parental rights and adoption by the long-time Native foster parent. Almost a year and a half had passed from the time the child entered dependency before the agency began exploring the relative. By the time the relative was approved, ASFA time-frames were well surpassed. If the agency had investigated possible placement with all of the child's available relatives in a timely manner, the child's permanent plan could have been achieved at least a year earlier.

Recommendation 5: Implement a Weighted Caseload

- **Implementation of a weighted caseload which recognizes that Indian child welfare cases due to notification requirements, legal complexities, cultural considerations, and a higher burden of proof under the law, are more labor intensive and time consuming.**

These cases must be well staffed and adequately supervised to check for consistent compliance with ICWA requirements. Sufficient time must be provided for the agency to make necessary tribal inquiries, provide tribes with required notice, allow tribal intervention in state court proceedings where appropriate, identify appropriate remedial services and rehabilitative programs available in Native communities or that serve Native children and families and to provide these services, and to meet the higher standard of proof.

Recommendation 6: Be An Active Player

- **Require DSHS CA through training, improved policies and procedures, and a shift in the culture of the agency, to remain actively engaged in all dependency cases whenever the agency continues to provide child welfare services, regardless of the entity deciding the case.**

By active engagement, the Ombudsman means that the agency should be able to clearly articulate verbally and in writing to the court and other parties to the proceeding, its recommendations as to case plan services, permanence, and placement and that such recommendations should be well reasoned and supported by the social worker's casework. The casework should be based not only on contacts with the tribe and family, but on collateral contacts with professionals including the CASA/GAL and service providers.

The Ombudsman found that in cases in which the tribe intervened as a party or asserted jurisdiction, DCFS frequently assumed a passive role even when it continued to serve as the child welfare agency. The

agency discounted the importance of its recommendations to tribal court. Agency staff, in the course of our investigations, articulated a perspective that regardless of what the agency was recommending, the tribe would make its own decision, thus implying that there was no point in strongly setting forth an opinion or highlighting concerns. This was especially true if agency concerns were perceived as undermining the direction in which the tribal court was headed.

Collaboration should not be confused with capitulation. The state of Washington has an independent duty to safeguard children and the agency should not mistake what it means to work cooperatively with the tribes. Although there may be cases in which the tribe does not accept a DCFS recommendation, the agency should not assume that the tribe will not factor into its child welfare decisions safety concerns brought to its attention by DCFS. These concerns could result in the court imposing conditions on a party that could result in greater safety for children. It does a disservice to the tribes to not make them fully aware of concerns so that the tribal Court can make an educated decision.

Passivity by agency prolonged lack of permanence and risked safety and well being of children

The Ombudsman investigated a complaint that DCFS/CWS recommended to tribal Court that three dependent children, ages 13, 12, and 11 be returned to a parent with a history of severely neglecting and physically abusing them. The children had been placed in the same foster home for close to four years, and this recommendation was a sudden change in the case plan, which had been to pursue guardianship with the foster parents.[1] The parent had a history of substance abuse and domestic violence and had not completed treatment for either problem. There were also allegations that the parent had sexually abused an older sibling who was now living independently. The parent had not undergone assessment or treatment to address this allegation.

The children had developmental delays as a result of the maltreatment they suffered. These caused significant social and educational challenges, requiring a great deal of individualized instruction at home and at school. Although the children had made significant strides in their foster home, professionals anticipated they would need ongoing specialized services.

The Ombudsman found that CWS had not gathered sufficient information to determine whether the children would be safe if returned to the parent. The agency suggested that the parent would be living with the grandparents and that this would ameliorate safety concerns. This did not make sense for several reasons. Medical professionals believed that the children's delays were likely caused, at least in part, by exposure to lead poisoning while living with their parents in their grandparents' home, and this exposure remained an ongoing risk due to the grandfather's hobby. Furthermore, the grandparents had failed to protect the children from maltreatment while they were previously living in their home, had contributed to their suffering, and failed to report concerns about the children to CPS. CWS had not investigated the grandparents' current circumstances nor confirmed with the tribal housing authority whether their housing was adequate for the children, and had

[1] The children had two siblings in another foster home, who were not the subject of this complaint, who were also affected by the actions of CWS.

not obtained a criminal background check of the grandparents. Moreover, the agency had not gathered sufficient information about the parent's current situation. Finally, the Ombudsman found that the children had neither a CASA/GAL nor attorney representation, nor had CWS asked these older children about their living preferences.

The Ombudsman requested that CWS gather necessary information, including the parent's participation in services to address parental deficiencies since the children were removed. DCFS did gather additional data, which indicated that the parent had not complied with services or remediated parental deficiencies, and found that the parent and grandparents' representation that the parent would be living with the grandparents upon the children's return to the parent was false. Moreover, the housing authority expressed concerns about the condition of the grandparent's home.

Although CWS gathered the data requested by OFCO and understood the risk factors of returning the children to the parent, the agency initially continued to support the tribe's plan of return of the children to the parent. When pressed by OFCO about why the agency was supporting return of the children to the parent and/or grandparents, the agency suggested that the tribe was going to return the children to the parent or grandparents regardless of the agency's position. This suggested to the Ombudsman a sense of futility on the agency's part, whichundermined its motivation to formulate an independent recommendation that might run counter to the tribe's position. OFCO found that this was poor practice and violated the spirit of the law and policies designed to protect children and keep them safe. The Ombudsman recognizes that DCFS has limitations on its role in tribal court. However, it is incumbent upon the Department to formulate a recommendation about placement of the children and a permanent plan that is well informed and based on the children's best interest.

Eventually, after ongoing intervention by OFCO, CWS clearly documented in writing and in a meeting with the newly assigned tribal worker, the ongoing concerns and risks associated with returning the children to the parent and/or grandparents. At the time of complaint closure, approximately 2 months after the case was transferred to the tribal worker, the children remained in the long term foster care placement and were safe. Although the children have now been in this home continuously for almost 5 years, the permanent plan is uncertain and a guardianship has still not been established.

VI. CONCLUSION

ICWA was intended to reform the handling of cases involving Indian children. Although there are numerous examples of Children's Administration making efforts to improve compliance with Federal law and to generally improve decision making for Indian children, this continues to be an area of great discord and confusion. There is no philosophical consensus on what "best interest" of an Indian child means. Is it to continue placement of a child in a stable, long term pre-adoptive non-Native home, or to seize the opportunity to move that child to a Native home discovered late in the proceeding? You will find strong advocates on either side of this question. The goal should be to avoid such questions by having the agency more effectively determine the child's Indian status up front. This sets the stage procedurally for what is to follow and establishes whether state or tribal court will have jurisdiction.

Improving the availability of Native and relative homes will help to address some of these issues.[63] Better communication, as well, with an eye toward cultural sensitivity will help in gathering crucial information and managing expectations. Unless tribes and non-tribal entities can be more responsive to each other, there will continue to be gaps in the provision of services, confusion over jurisdiction, and conflicts that result in risky decisions for children.

The agency must resolve its apparent ambivalence about its role in cases where the tribe has asserted jurisdiction, but the state of Washington continues to provide child welfare services. This is the worst of all worlds because it creates an expectation that DCFS is monitoring a case and asserting strong recommendations when this may not be happening.

Our recommendations to improve the system will fall short unless they are accompanied by continued and improved training to understand the legislative intent behind ICWA and cultural differences between Natives and non-Natives, and by greater clarity on the applicability of child welfare laws, such as ASFA, that exist in concert with ICWA. We believe that all children, regardless of their race and ethnicity, deserve safety and timely permanence.

[63] The shortage of Native homes was identified as a significant factor that affected placement of children subject to ICWA in an April 2005 report completed by the U.S. Government Accountability Office (GAO). The purpose of this report was 1) to examine factors that affect placement of children subject to ICWA; 2) the extent to which placement for such children has been delayed; and 3) Federal oversight of state implementation of ICWA. Although nationwide data was not available, Washington state was one of four states whose data was examined by the GAO. The GAO concluded that: "[the data] showed no consistent pattern in how long children subject to ICWA remained in foster care or how often they were moved to different foster homes compared to other children. In general, most children leaving foster care in fiscal year 2003 in the four states were reunified with their families, although children subject to ICWA were somewhat less likely to be reunified or adopted and were somewhat more likely to leave through a guardianship arrangement." This report may be accessed at http://www.gao.gov/highlights/d05290high.pdf.

Families in Crisis: Fractured System Fails Children with Special Needs

A Clear and Consistent Protocol to Promote Multi-Agency Cooperation

RECOMMENDATION 1: Establish a Protocol to Expedite Placement

- **Require DSHS to establish a protocol between the Division of Children and Family Services (DCFS), the Division of Developmental Disabilities (DDD), and the Mental Health Division (MHD) to simplify and expedite access to services and placement of children with mental health needs and/or developmental disabilities that can no longer be managed at home.**

BACKGROUND

In our 2003 annual report, we found that the needs of children with a combination of mental health issues and developmental disabilities were not being adequately addressed by DSHS. At that time, we recommended the following:

- Require DSHS to provide an adequate supply and range of residential placement options for children with developmental disabilities or other serious handicaps;
- Require DSHS to develop and implement a coordinated protocol between Children's Administration, DDD, and MHD to address the placement and service needs of families with developmentally disabled children and children with serious handicaps;
- Require DSHS to submit to the Legislature a report setting forth protocol to coordinate placement and services for these children.

As a basis for these recommendations we provided background, which stated in part that:

Complaints to the Ombudsman indicate that in many cases, the Division of Developmental Disabilities, the Division of Children and Family Services and the mental health system are not equipped to meet the needs of families requesting an out-of-home placement for their delayed/handicapped child. **As a result, services and placement resources are not provided in a uniform and consistent manner.** Often, the success of accessing such services has depended on an individual parent's ability to advocate for their child and to navigate the intricacies of the system.[1]

In January 2005, DSHS responded to OFCO's recommendations as follows:

Children's Administration Response (responses are taken verbatim from a CA report from Jan. 2005 and are cited in OFCO's 2004-05 Annual Report)[2]*:*

[1] See pp. 5-8 of OFCO's "Issues and Recommendations" section of its 2003 Annual Report at: http://www.governor.wa.gov/ofco/03rpt/issues.pdf.

[2] CA response to OFCO recommendations available at: http://www.governor.wa.gov/ofco/05rpt/response.pdf.

- *DDD continues to have statutory authority for services to children with developmental disabilities. The DDD Voluntary Placement Program was capped due to budgetary concerns;*
- *DDD & CA have implemented an Intra-Agency Agreement for providing services jointly to children with acute needs using existing funds;*
- *To date 25 children have been placed through this agreement. Most of these children are not [Title] IV E eligible and placement is supported through state funds;*
- *To date, CA has committed $1.5 million annually to support these placements;*
- *DDD has submitted a decision package requesting funds for 24 new placements;*
- *CA is in the process of implementing new performance based contracts for the recruitment of foster homes based on regional needs assessment and resource management plans;*
- *CA has completed regional service agreements with regional support networks (RSNs) to improve access to children's mental health services for children served by CA, including children with developmental disabilities; and*
- *CA, Mental Health Division (MHD), and Juvenile Rehabilitation Administration (JRA) are collaborating to develop an improved system for children's mental health services.*

RATIONALE

Despite the apparent steps set forth by CA in its response to OFCO's 2003 recommendations, the Ombudsman has continued to receive complaints from biological and adoptive parents, CASA/Guardians ad Litem, and social service professionals that families encounter ongoing difficulty in obtaining out-of-home placement for their special needs children. These are children who have developmental delays and/or mental health problems that can no longer be managed at home without presenting a significant risk of harm to themselves or other family members.

Exacerbating these issues, the Ombudsman finds that a culture has developed within the agency that frequently shames families who cannot manage special needs children at home. We have observed this agency mentality even in cases in which the family seeks out-of-home placement because the child has jeopardized the safety and well being of other family members in the home by being physically assaultive to the parents and siblings. One case involved physical abuse by a teen against an older sibling who had developmental disabilities and was confined to a wheelchair. In a number of these cases, the agency's response has been to refuse to place the child and then to threaten the parents with charges of parental abandonment or neglect either through the dependency process or by contacting law enforcement and suggesting that criminal charges be brought. This adds to the stress and anxiety of parents who are already in a state of crisis and feel under siege from the system.

Throughout 2006, the Ombudsman contacted DSHS through meetings, and via written and verbal communication to express our ongoing concerns that DSHS as the umbrella agency for CA, DDD, and MHD was not providing adequate services or accessible placement for youth with developmental delays and/or mental health problems. We stated this shortcoming had reached "crisis proportions." In October 2006, DSHS Secretary Robin Arnold-Williams assured the Ombudsman that DSHS is "committed to making improvements by examining our practice and service delivery" and that CA, DDD, and MHD

would be meeting "to discuss coordination between administrations for children and families who receive services across multiple systems."[3] The Ombudsman asked to participate in this meeting but was told that this initial meeting would be internal. We were then notified that a meeting was convened, as promised, and that a protocol was in the process of being developed to improve access to placement and services. Specifically, DSHS informed us that a proposal was submitted to the three Assistant Secretaries of the relevant administrations.[4] We recently learned from DSHS that this protocol has not yet been established. We think this is an area of vital importance that affects many families and that this protocol is overdue.

Throughout this section, we provide case examples from actual complaints we have investigated about the lack of coordination between administrations for children and families who receive services across multiple systems. The purpose of these case examples is to highlight shortcomings in the system or to profile an example of the agency complying with the law and exemplifying sound practice. Typically we profile the reason the Ombudsman was contacted by the complainant, what type of assistance the citizen was seeking, and what action, if any, the Ombudsman took to resolve or improve the situation.

In approximately 80% of **all** complaints in which OFCO intervenes, DSHS, CA takes the corrective action we recommend. In contrast, the effectiveness of OFCO's intervention in the cases presented here is less than our typical high rate of success. Our ability to trigger change is lessened by our lack of direct oversight and jurisdiction over

What good is Case Management if no one is willing to manage?

The inadequacies of the system are highlighted by a complaint involving a 12-year-old non-verbal autistic youth. OFCO was contacted by a community professional when the youth was due for discharge from a regional hospital after psychiatric treatment. Law Enforcement (LE) requested that Children's Administration (CA) place the youth upon discharge, but CA refused so LE took the youth into protective custody. The youth was developmentally delayed, had extremely violent behaviors, and was physically difficult to manage, to the point that it was not feasible to keep the youth at home.

DSHS CA, MHD, and DDD knew of this youth and family for many years. Since 1997, there had been over 30 referrals on the family. These focused on the parents' inability to care for the youth, the youth's increasingly out-of-control behavior, the youth's repeated assaults of the parents, destruction of property in their home and at school, and assault of police officers. The youth had case managers within DDD and MHD. Despite the family's history and the agencies' involvement, the agencies did not anticipate the youth's placement needs.

Moreover, even when informed that the hospital was preparing to discharge the youth imminently, none of these agencies offered a placement solution to the hospital or law enforcement until it became a pressured, crisis situation requiring intervention by the Ombudsman and the expenditure of considerable time and effort by LE, and the hospital. Prior to our intervention with the Deputy Administrator for CA who then consented to place the youth, this youth had been brought into area hospital emergency rooms on numerous occasions when the youth's behavior became unmanageable. Case management of children exhibiting extreme behaviors should not fall to our area hospitals. Nor should families be left to shoulder this extreme burden alone. DSHS needs to more effectively marshal its resources through its coordinated divisions to help needy children and families.

[3] October 24, 2006 letter from Robin-Arnold Williams, Secretary of DSHS, to Mary Meinig, Director Ombudsman of OFCO.

[4] Cheryl Stephani, Assistant Secretary, Children's Administration; Kathy Leitch, Assistant Secretary, Aging and Disability Services Administration (DDD); and Doug Porter, Assistant Secretary, Health and Recovery Services Administration (MHD).

the administrations that govern mental health and developmental disabilities.[5] Consequently, even when we are successful in getting DSHS CA to take action, the systemic response may still fall short because DDD or MHD may not be in agreement. We have also found that the willingness of CA to demonstrate leadership in these cases often falls to the willingness of a single leader within a particular region. DSHS CA may recognize that the system is not adequately serving a child and family, yet CA upper management does not respond consistently. Some regions simply appear better poised than others to respond to children with issues that cut across multiple systems. The frustration families experience who are stalled in trying to get their children's' needs met is keenly felt by the Ombudsman. We, too, experience frustration over the same issues in trying to get DSHS to respond effectively.

As the following case involving a mentally ill teen illustrates, when leadership steps in to take responsibility, the short-term immediate needs of a family can be met:

Agency's Lack of Cooperation extends to Law Enforcement: Situation salvaged by Efforts of Area Administrator

OFCO was contacted by law enforcement after DSHS DCFS refused to place a 15-year-old non-dependent youth with mental health issues. The youth had recently been released from a 72 hour stay in a private non-profit agency's respite care center and, upon return to home, the parent would not let the youth into the home. The parent had been experiencing prolonged difficulty managing the youth's assaultive and emotionally volatile behavior. The youth had injured the parent and had assaulted a disabled sibling on more than one occasion. When DCFS refused to place the youth, law enforcement negotiated with the private agency to house the youth for one more night. This compromised the private agency as it allegedly did not have authority to house the child for another night and worried about losing its license. However, the private agency cooperated with law enforcement in order to provide the youth a safe place to sleep.

OFCO intervened with a Children's Administration's Area Administrator (AA) to request that DCFS ensure placement of the youth and collaborate with law enforcement. The youth was transitioned to a therapeutic foster home.

The Area Administrator acknowledged that the agency did not initially assist law enforcement as the agency should have. The AA convened supervisors after the incident to brief them on how the agency should have responded to this situation. According to the AA, DCFS should have had a field response worker meet with the parent to have the parent sign a voluntary placement agreement, and take the child to a Crisis Residential Center for admission.

In addition to arranging placement for the youth, and briefing supervisors on the proper protocol, the AA collaborated with law enforcement to clarify each entity's respective roles and responsibilities with regard to child custody and placement. The AA also committed to providing future joint training between CA and law enforcement.

[5] OFCO's duty to investigate "administrative acts" includes: "an act, decision, recommendation, or omission made by a: (a) Government agency or its contracting entity; or (b) State-licensed, or state-certified, agency or facility, that affects: (i) A child who was, is, or may be, in need of state protection due to child abuse or neglect; (ii) A family who was, or is, under state supervision or receiving state services due to allegations or finding of child abuse or neglect; or (iii) A child who was, is, or may be in need of services under RCW 13.32A.030." RCW 43.06A.030; WAC 112-10-020. The acts of certain entities, such as a Judge and Guardian ad Litem, are specifically excluded from the definition of "administrative acts" in WAC 112-10-020.

Adopted Children with Special Needs: An Exceptional Case

RECOMMENDATION 2: Convene a Task Force to Develop a More Effective Response to Requests for Services from Adoptive Parents

- **Children's Administration should convene this task force to address the special needs of formerly dependent children who require additional adoption support services.**
- **A system of services to meet the needs of these families should include crisis intervention and wraparound services, as well as a protocol for collaboration between CA and other DSHS divisions (such as DDD and MHD) in order to quickly access and coordinate needed services and/or placement.**

BACKGROUND

The Ombudsman has dealt with a significant number of complaints involving children with special needs who have been adopted through the foster care system. Parents who have adopted these children with varying degrees of developmental disabilities and/or serious mental illnesses, report great difficulty accessing needed services not already agreed upon through the adoption support program, especially when the parents are requesting temporary out-of-home placement. Many of these adoptive parents feel unreasonably pressured to accept further or different services in an attempt to maintain their child at home; at worst, they report feeling punitively treated, or shamed, in response to any hesitance on their part to continue trying to manage these children at home.

The following examples illustrate the distress experienced by adoptive parents attempting to access services for their children in crisis.

Accessing Services for Children in Crisis

The Ombudsman was contacted for assistance with accessing mental health services for a 14-year-old adopted child. The child suffered from schizophrenia and autism, and was developmentally delayed. The child was in a psychiatric hospital after threatening to kill the parent and detailing a plan to do so. The hospital believed the child to be stabilized on medications, and planned to discharge the child, even though the child was still talking about wanting to kill the parent. A referral was made to DDD, who prioritized the case for immediate attention; DCFS already had an open case for adoption support services. The parent believed it was unsafe for the parent, the child, and the child's younger sibling, for the child to return home, until the child's mental health issues had been thoroughly evaluated (beyond a short-term hospitalization to stabilize the child's acute symptoms). The mental health professionals involved insisted that the child return home and further services be attempted, and although DDD and DCFS felt the risks were too high for the child to return home, both of these DSHS divisions felt powerless to access longer-term inpatient mental health care for the child, and neither agency could locate a suitable placement within their placement resources that would address the child's mental health needs, prior to the child's discharge. The child returned home, with no mental health services in place. DCFS purchased door alarms for the parent to monitor the child's movement in the home, to ensure a basic level of safety. Over two weeks passed before the child was seen by a counselor at the local mental health center, who informed that it would be another 3-4 weeks before the child could see a psychiatrist for medication monitoring. Meanwhile, the child expressed feeling unsafe in the home, repeatedly asking the parent to obtain help. Almost 7 weeks later, DDD located a placement in a residential treatment center for developmentally disabled children.

Lack of Resources for Parents of Adopted Children

The Ombudsman was contacted with a concern about the lack of out-of-home placement resources for parents of adopted children with mental health disorders. The 14-year-old child in question had been adopted at age two, and upon entering puberty began to exhibit violent behavior. The parents maintained the child in the home for two years, exposing their other children to much chaos resulting from this child's violent rages. One of the other children was diagnosed with Post Traumatic Stress Disorder. After the youth was arrested for the second time for assaulting the father, and placed in juvenile detention, the parents decided they were unable to have the youth back in the home. The parents requested placement assistance from DCFS. The youth is placed in a therapeutic group home through a voluntary placement agreement with the parents. The agency expects the youth to return home after six months of treatment, but the parents believe that given the youth's diagnoses and the previous trauma to the family caused by the youth's presence in the home, that this is an unrealistic expectation. An application has been made for the CLIP program, but the decision regarding approval remains unknown at this time. The parents have been told by the agency that if they vacated the adoption, the child would have many more services accessible. The parents are unwilling to do this, and want to see the State empowered to assist families in such situations, without further victimizing the family.

The following two examples of complaints investigated by the Ombudsman illustrate the punitive response adoptive parents are sometimes faced with when they seek agency assistance during crises with their mentally ill adopted children.

Case A: A finding of "founded" for alleged abandonment by a parent

The Ombudsman was contacted for assistance in obtaining mental health treatment for a 13-year-old adopted child. The parent was a single parent with four other adopted children, two older and two younger than the subject child. The child was currently in a psychiatric hospital after assaulting an older sibling. The child was developmentally delayed, and had been diagnosed with numerous disorders over the years, including Intermittent Explosive Disorder, Oppositional Defiant Disorder, Mood Disorder, Fetal Alcohol Syndrome, Attention Deficit/Hyperactivity Disorder, and Post Traumatic Stress Disorder. The child had been adopted at age 6, and both the child and the family had been participating in mental health and developmental disability services for several years, but the child's behaviors had been escalating. The child was due for discharge from the hospital, and DCFS/CWS (who had an open case on the family) planned to return the child home, offering the parent in-home services to assist in managing the child. The parent refused further in-home services, as she feared for the safety of the other children.

In response, DCFS made a CPS referral alleging abandonment of the child by the parent, and a dependency petition was filed. The child was placed in specialized foster care. The case was staffed by a Child Protection Team several days later, which recommended that the child not return home and a CLIP placement be pursued. The CPS investigation regarding the alleged abandonment resulted in a founded finding, based upon the parent's choice "not to deal with [the child's] special needs." This caused the parent significant distress over now having a permanent record of child abandonment. Intensive services were provided to the child and family, and the child's functioning improved significantly, such that a CLIP placement was no longer deemed necessary. The child's permanency goal is reunification with the adoptive family.

Case B: A finding of "unfounded" for alleged abandonment by a parent

The Ombudsman was contacted for assistance in obtaining mental health services for a 14-year-old adopted child. The parents were in their sixties and had two younger adopted children in addition to this child. The child had lived with the family since the age of 3, and was adopted at age 7. The child was developmentally delayed and had Attention Deficit Hyperactivity Disorder (ADHD), Mood Disorder, and Anxiety Disorder. The child had aggressive outbursts at school, to the extent that students had to be evacuated from the classroom; the child had also threatened to kill a teacher. The child was being brought home by police after escaping from home at night without the parents' knowledge. Following a sentence to juvenile detention for stealing the family car and totaling it, the child was temporarily placed at a Crisis Residential Center (CRC). DCFS planned to return the child home, offering the parents services to assist them in managing the child. The parents were unwilling to try further in-home services; the family and youth had participated in mental health services for several years, and the mental health provider as well as the school recommended against returning the child home. The parents believed they could not keep the other children in the home safe if the child were to return home.

In response to their refusal to have the child return home, DCFS directed the CRC to make a CPS referral alleging abandonment, which it did. The CPS investigation resulted in an unfounded finding, based upon evidence that the parents were attempting to seek an appropriate placement for their child. The agency filed a dependency and the child was placed in a therapeutic foster home. After three months the child returned to the CRC after exhibiting behaviors that could not be managed in foster care, and was moved to a group home.

RATIONALE

The Ombudsman believes that the State of Washington is indebted to families who have chosen to adopt dependent children with special needs, and DSHS should devote special attention to families who later experience great difficulty managing these children and accessing effective services. These families should receive the highest level of service available, given the invaluable gift -- a permanent commitment -- they have provided to a former foster child.

The Ombudsman has certainly seen cases in which this level of service has occurred. To illustrate the range of cases reviewed by the Ombudsman, the following is an example of a complaint we investigated, where CA initiated and coordinated highly effective inter-agency assistance for a child and family.

Effective case management between DSHS divisions

The Ombudsman was contacted for assistance in accessing specialized services for an adopted 15-year-old youth with developmental disabilities and autism. The youth was currently in 72-hour respite care, after the youth's behavior had become increasingly aggressive at home and at school, to the extent that the school had pressed charges of assault, and the family had called 911 to the home several times, and taken the youth to the emergency room. The parents had contacted the DSHS Mental Health Division, who referred them to the Developmental Disabilities Division. When they contacted DDD, they were told it was a mental health issue. The parents contacted CA and were initially told they would be invited to a monthly meeting. The parents felt they needed immediate assistance with possible out-of-home placement. The Ombudsman contacted the CA supervisor, who had already heard about the situation and had begun to take appropriate crisis intervention. CA initiated contact with MHD and DDD as well as the private agency providing respite care, and a series of meetings were arranged, resulting in a voluntary placement of the youth in specialized foster care, with wrap-around services. The youth and family made good progress and the youth was returned home with continued wrap-around services.

The Herculean Task of Accessing Long-Term Inpatient Treatment

RECOMMENDATION 3: Eliminate Waiting Lists for Children who qualify for Long-Term Inpatient Care in a Children's Long-Term Inpatient (CLIP) Facility.

- **Provide better wraparound services[6] up front to children to meet their mental health needs so as to reduce the number of children and adolescents in need of CLIP placement.**
- **Direct DSHS to inventory supplemental wraparound services[7] and therapeutic foster and group home placement options; identify children currently on a CLIP waitlist and provide these children with intensive therapeutic placement and supplemental wraparound services[8] until either the child's clinical situation has improved to a degree that CLIP placement is no longer necessary or placement in a CLIP facility is available.**
- **Direct DSHS to seek appropriations for additional CLIP beds and/or facilities to meet the demands for CLIP placement.[9]**

RATIONALE

The child welfare system needs to make the mental health needs of children and adolescents as much of a priority as their physical health needs. In a report by the Office of the Surgeon General, the Surgeon General concluded that, "[w]hile 1 in 10 children and adolescents suffer from a mental illness that causes some level of impairment, it is estimated that in any given year, fewer than 1 in 5 children and adolescents receive needed mental health treatment or services."[10]

Likewise, research on the mental health needs of Washington State children finds that a significant number of children have unmet mental health needs. In March 2006, the Washington State Department of Health, Office of Maternal and Child Health (OMCH) completed a state wide assessment of the mental health of children to document the prevalence of mental illness and the need for mental health services

[6] Wraparound service coordination is described by the Mental Health Division as "a set of individually tailored services to the child and family using a team-based planning process. The process focuses on strengths and includes a balance between formal services and informal community and family supports. Wraparound is not a treatment in itself, but a coordinating and planning intervention. The National Wraparound Initiative has identified ten core Wraparound Principles that guide the implementation of this planning model." See: http"//www1.dshs.wa.gov/pdf/hrsa/mh/sti_community_forum_3_best_practices_for_children_families%20_5_15_07.pdf.

[7] One idea that was suggested to the Ombudsman was that children on a CLIP waitlist qualify for a mental health case aide having skills comparable to a psychiatric nurse and that the case aide be available to the child based on the child's needs.

[8] Wraparound service coordination is described by the Mental Health Division as "a set of individually tailored services to the child and family using a team-based planning process. The process focuses on strengths and includes a balance between formal services and informal community and family supports. Wraparound is not a treatment in itself, but a coordinating and planning intervention. The National Wraparound Initiative has identified ten core Wraparound Principles that guide the implementation of this planning model." See: http"//www1.dshs.wa.gov/pdf/hrsa/mh/sti_community_forum_3_best_practices_for_children_families%20_5_15_07.pdf

[9] Despite the continuing growth in Washington State's population and the corresponding increase in children with mental health needs, the number of CLIP beds available has declined since the closure of the Martin Center in Bellingham. This represented a loss of 5 beds.

[10] http://www.mchlibrary.info/KnowledgePaths/kp_mentalhealth.html referring to the President's New Freedom Commission on Mental Health, 2003; Office of the Surgeon General, 2000; Office of the Surgeon General, 2001).

among children and youth. The assessment, which began in 2004, concluded that, "in the Washington State dataset results of the National Survey of Children's Health 2003 approximately 8.0% of children needed mental health services in the last year. Of those children, about 42.7% did not receive the mental health services that they needed." [11]

Mental illness significantly impacts the lives of dependent children and foster children. These vulnerable children are more likely to suffer from mental illness than children drawn from the general population.[12] The Ombudsman is routinely contacted by families, Guardians ad Litem, and other community professionals who complain that it is very difficult for families to obtain long-term inpatient treatment or other specialized residential care for their children with ongoing and severe mental health needs.[13]

As a result of our investigations, we find that:

- The mental health system is designed to avoid out-of-home placement and to meet the needs of the family in the community;
- Families do not get the help they need early enough in the process so that by the time they come to the Ombudsman's office they can no longer cope with their mentally ill child remaining in the home regardless of the services belatedly being offered;
- Families often are uninformed about the availability of the Children's Long-Term Inpatient Programs (CLIP) program for long-term inpatient mental health treatment;
- Families who are aware of the CLIP program report they are discouraged from seeking access to the program. They have great difficulty navigating the system without the intervention of OFCO, an attorney, or other knowledgeable professional because the system is too complex, time-consuming, and fraught with hurdles;[14]
- Families are anxious because they cannot afford the expense of inpatient treatment;[15]

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[11] Department of Health, Children's Mental Health Assessment, p. 39. Accessed 7/23/07 http://www.doh.wa.gov/cfh/mch/documents/CMH_Needs_Assessment.pdf.
OFCO has been informed that the OMCH report is in the process of being revised and has temporarily been removed from the website where we accessed it. We look forward to its release.

[12] According to a report by the U.S. Surgeon General, although mental disorders and mental health problems appear in families of all social classes and of all backgrounds, there are certain factors that increase the risk of such disorders and problems. Among these are "caregiver separations" and "abuse and neglect." *Mental Health: A Report of the Surgeon General*. Available at: http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec4.html#chap3.

[13]According to the CLIP Administration website, "[a]pproximately 95% of all voluntary applications are approved, indicating that RSNs and their partners are referring only those children most in need of this kind of treatment." Accessed on 10/30/07 at: http://clipadministration.org/inpatient_info.html. This approval rate is high and OFCO does not believe it fully captures the gap in the system. In addition to hearing from complainants who presumably fall within the 5% whose voluntary applications have not been approved, we hear from many complainants who have not managed to navigate the system well enough to submit a voluntary application. They either are uninformed about the CLIP program or, according to their account, have met with so much resistance trying to access the program that they have not submitted a written application.

[14] The Mental Health Ombudsman is another program available to citizens needing assistance. The MHO in your region may be determined by consulting the list of regional MHOs at: http://www1.dshs.wa.gov/mentalhealth/ombuds.shtml.

[15] See the Ombudsman's Commentary on *In re Dependency of Schermer* following this section of our report.

- Families whose children have met the criteria for inpatient treatment in a CLIP facility and been accepted into the program are not obtaining a CLIP bed on a timely basis;
- Waitlists for CLIP placement are routine, the wait affects children as young as age 6, and the wait is lengthy.[16]

Waiting for CLIP: The State as a Neglectful Custodian

The Ombudsman was contacted for assistance in obtaining mental health services for a 9-year-old legally free child. The child had been in relative, foster and group care since infancy, and had been diagnosed with ADHD, Post-Traumatic Stress Disorder, Anxiety Disorder, Oppositional Defiant Disorder, and enuresis. The child had assaulted staff in group homes as well as a teacher, and had experienced several psychiatric hospitalizations. The child was currently in a Behavioral Rehabilitative Services (residential treatment) placement, but had engaged in serious self-injurious behavior twice in the last week, and was posing a danger to self and others. A CLIP placement had been recommended by his Treatment Team, but there were barriers to such a placement. There was a long waiting list for a bed, and the gatekeeper for the CLIP application was advocating for stronger efforts to stabilize the child's current placement in order to avoid a CLIP placement. This left advocates for the child feeling that the crisis the child was experiencing was being ignored, and that the system was endangering the child and others by failing to provide the child with the level of treatment needed.

LEGAL FRAMEWORK

Chapter 71.34 RCW sets forth the intent of the law governing mental health services for children. The purpose of the law is to provide children:

> in need of mental health care and treatment . . . an appropriate continuum of culturally relevant care and treatment, including prevention and early intervention, self-directed care, parent-directed care, and involuntary treatment. To facilitate the continuum of care and treatment to minors in out-of-home placements, all divisions of the department that provide mental health services to minors shall jointly plan and deliver those services.[17]

As evident by the intent of the law, the mental health system provides a continuum of care and treatment for children with mental health issues and a range of options for families to pursue in accessing such treatment. These include both voluntary and involuntary access to treatment.[18]

Voluntary Access to CLIP

The complaints received by the Ombudsman relate to families seeking **voluntary** inpatient mental health care and treatment in the Children's Long-Term Inpatient Programs (CLIP). The CLIP Administration

[16] According to an RSN representative, as of July 2007, there were 19 children on a waitlist for a CLIP bed, with the longest wait being 10 months. Eleven of the children on the waitlist were from ages 6 to 12 years old.

[17] RCW 71.34.010.

[18] There are three statutory options to access treatment: minor-initiated (RCW 71.34.500 to .530); parent initiated (RCW 71.34.600 to .660); and involuntary treatment (State initiated) (RCW 71.34.700 to .795). For a comprehensive summary of the statutes governing children's mental health and access to treatment in the state of Washington, see *Children's Mental Health – A Statutory Perspective* by Sonja Hallum, Staff Counsel OPR & Indu Thomas, Staff counsel SCS. Available at http://www.leg.wa.gov/documents/joint/mhtf/2006/10-24_OPR-SCS.pdf.

is the clinical and administrative authority which decides whether a child qualifies for admission to one of the 91 beds in Washington State's 4 inpatient treatment facilities.[19] The CLIP Administration is within the Mental Health Division (MHD) of the Department of Social and Health Services (DSHS) and serves both dependent and non-dependent children.[20]

In 1989, Regional Support Networks (RSNs) were created to manage Washington State's mental health program. RSNs contract with local mental health agencies to provide outpatient services and short-term inpatient services in community hospitals to residents of that county.[21] DSHS pays the RSNs for mental health services for citizens eligible for state funded services or covered by Medicaid.

In 1992, the CLIP Administration entered into intersystem agreements between the RSNs and the CLIP facilities to "require identification of a local intersystem collaborative team to assess the strengths and needs of an individual child and family, and plan individualized services and supports to meet those needs." [22] Under this system, the RSNs became the gatekeepers to accessing the CLIP program. There are 13 RSNs throughout the state. Access to CLIP must be initiated locally through the RSN and the local RSN reviews voluntary CLIP applications.[23] The RSN is responsible for referring children to CLIP for long-term inpatient care after conducting a mental health assessment to determine the child's mental health needs and after determining if alternative services in the community have been attempted first.[24]

The mental health assessment is performed by the mental health agency in the county in which the family resides.[25] The assessment is used not only to determine medical necessity, but also the length and level of care needed. To be assigned to inpatient care, a child must meet the following criteria:[26]

- The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders;

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[19]"Inpatient treatment" refers to "twenty-four-hour-per-day mental health care provided within a general hospital, psychiatric hospital, or residential treatment facility certified by the department as an evaluation and treatment facility for minors." RCW 71.34.020 (9). The CLIP website, which provides valuable information on the availability of CLIP programs and how to access the program, may be accessed at: http://clipadministration.org/northwestprograms.html.

[20] This is distinguished from group and therapeutic foster care which is administered by Behavioral Rehabilitation Services (BRS). BRS is under contract with Children's Administration and only serves dependent children in state care. BRS is designed for children with behavioral needs that exceed the supervision or service capacity of mainstream foster care.

[21]http://www1.dshs.wa.gov/mentalhealth/parentfaqs.shtml; RCW 71.24.015 sets forth the intent of the legislature to establish a community mental health program which "encourage[s] the development of regional mental health services with adequate local flexibility to assure eligible people in need of care access to the least-restrictive treatment alternative appropriate to their needs, and the availability of treatment components to assure continuity of care. To this end, counties are encouraged to enter into joint operating agreements with other counties to form regional systems of care.

[22] http://clipadministration.org/washingtonstate_health.html; RCW 71.24.015.

[23] For more information on how to apply for CLIP, see: http://clipadministration.org/inpatient_info.html.

[24] http://clipadministration.org/county_mentalhealth.html. The RSN also contracts with local mental health agencies served by the RSN in a particular county to provide direct out patient services and short-term inpatient treatment in community hospitals.

[25] Families may call the Regional Support Network (RSN) that serves the county in which they reside and request the name and phone number of the mental health agency that serves their area. http:// www1.dshs.wa.gov/mentalhealth/parentfaqs.shtml.

[26] http://www1.dshs.wa.gov/mentalhealth/parentfaqs.shtml; see also WAC 388-865-0575.

- The individual's impairment(s) and corresponding need(s) must be the result of a mental illness;
- The intervention is deemed to be reasonably calculated to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness;
- The individual is expected to benefit from the intervention; and
- The individual's unmet need would not be more appropriately met by any other formal or informal system or support.

There are four inpatient treatment facilities across the state, providing a total of 91 publicly funded beds:[27]

- Child Study and Treatment Center (CSTC) located in Lakewood (47 beds). This is the only state operated hospital for children and adolescents.
- McGraw Center in Seattle (19 beds)
- Pearl Street Center in Tacoma (12 beds)
- Tamarack Center in Spokane (13 beds)

Involuntary Access to CLIP

In situations where voluntary treatment is not an option, involuntary treatment may be an alternative in limited circumstances. RCW 71.34.750 provides that children ages 13-17 may be committed for up to 180 days of involuntary inpatient psychiatric treatment[28] if they are deemed by clear, cogent, and convincing evidence to be suffering from a mental disorder; to present a likelihood of serious harm or be gravely disabled; and to be in need of further treatment that only can be provided in a 180 day commitment.[29] The court will order that the child be committed if this criteria is met and less restrictive treatment in a community setting is not appropriate or available.[30] Under the court order issued from the 180 day involuntary commitment petition, the child becomes eligible for admission to a CLIP program.

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[27] There were previously five facilities, with 96 beds available, until the Martin Center in Bellingham was closed.

[28] The DSHS Mental Health Division defines "inpatient treatment" as "Twenty-four-hour-per-day mental health care provided within a general hospital, psychiatric hospital, or residential treatment facility certified by the department as an inpatient evaluation and treatment facility for minors." http://www1.dshs.wa.gov/menatlhealth/definitions.shtml

[29] RCW 71.34.750(6)(a)-(c); According to Jeff Howard, the Mental Health Ombudsman serving clients in the North Central and Chelan/Douglas RSN counties, involuntary CLIP admission requirements may create a "Catch-22." He stated that, "CLIP requires admission to a community hospital for the civil commitment process, called ITA assessments. Only 6 hospitals in the state are able to conduct ITA assessments for children. These 6 community hospitals . . . routinely decline admission for various reasons. If all 6 hospitals decline admission, or are full, this leaves no route to involuntary CLIP admission for some children. Those children likely need treatment for severe mental illness and are at risk of harming themselves or others." 10/31/07 e mail communication with Ombudsman, Linda Mason Wilgis at OFCO. The Mental Health Ombudsman (MHO) program is designed to advocate for individuals having problems accessing public mental health services, including CLIP placements. RCW 71.24.350 provides that: "The department shall require each regional support network to provide for a separately funded mental health ombudsman office in each regional support network that is independent of the regional support network. The ombudsman office shall maximize the use of consumer advocates." The MHOs are de-centralized and are set up on a regional, rather than state-wide, basis. A list of regional MHOs may be accessed at http://www1.dshs.wa.gov/mentalhealth/ombuds.shtml.

[30] RCW 71.34.750(7).

The child's name is placed on the statewide waiting list as of the date of the 180 day involuntary inpatient treatment order. It is not uncommon for a child who was admitted involuntarily to convert to a voluntary placement after the length of involuntary stay runs its course.

Conclusion

Mental health services for children are vitally important and must be made more accessible to families. OFCO's investigation of complaints involving parents seeking CLIP placement shows a pattern of either families whose children are not accepted to the CLIP program (these families are not provided adequate therapeutic placement alternatives); or families whose children are accepted into CLIP, but then made to wait an inordinate amount of time for an actual bed in a CLIP facility.

The Ombudsman recognizes that the intent of the mental health system serving children is to try to avoid out-of-home placement and to meet the needs of the family in the community. Fulfillment of the law's stated purpose requires intensive and effective wraparound services before a family reaches its breaking point. While this statutory intent is laudable and should be the goal, we have concluded that there remain a certain number of children for whom treatment within the community while remaining in the home is simply not intensive and/or effective enough to meet their needs. We believe it is this segment of the population that is not adequately served by the current CLIP process. The process, while well intended, wears families down. It is unduly complex, and has too many barriers. Coordinated and timely efforts should be made to help families when it is no longer viable to care for a child in the home due to unreasonable health and safety risks to the child and other members of the family. The CLIP waitlists are unacceptable and this crisis needs immediate attention. The priority needs to be on not only providing better services up front, but on improving access to the CLIP program and expanding its capacity. Until more effective services can be provided early in the process to stabilize mentally ill children in their own homes, more capacity in CLIP facilities must be created.

The good news is that once a child is in a CLIP facility, most families who receive services agree that the CLIP program helps their children to make progress in treatment[31] and helps families to improve skills and strategies to cope.[32]It is our hope that children who demonstrate a need for inpatient treatment will have their needs met on a more consistent and timely basis.

[31] According to the CLIP Satisfaction Survey 2006 conducted by the CLIP Program's Parent Advocate, 76% of respondents "reported that their child made progress in treatment." The survey "represents the combined results of surveys from all four CLIP programs. However, in 2006 no surveys were conducted from McGraw Center, and only one survey was completed for Child Study & Treatment Center. Accessed on 10/30/07 at: http://clipadministration.org/Surveys/Satisfaction2006.pdf. OFCO notes that the statistical sampling is quite small, with responses ranging from 13 to 17 parents and/or legal guardians.

[32] According to the CLIP Satisfaction Survey 2006, 69% of the respondents "reported that the program helped them to gain skills and strategies to cope."

COMMENTARY ON *IN RE DEPENDENCY OF SCHERMER*[1]

A recent Washington State Supreme Court opinion, *In re Dependency of Schermer*,[2] is relevant to the issues addressed in this section of our report: the inability of a parent to adequately care for a child due to a child's severe mental illness or other special needs and the role, if any, that the dependency process should play in providing a mechanism for placing such children out of the home and making services available to the family.

The Washington Supreme Court affirmed the Washington State Court of Appeals' decision to reinstate a dependency petition filed by Stephen and Margaret Schermer on behalf of their son (referred to as "H.S."), and remanded the case for a full evidentiary hearing.[3] The Schermers filed the petition under RCW 13.34.030(5)(c), which alleged that H.S. "has no parent, guardian, or custodian capable of adequately caring for the child, such that the child is in circumstances which constitute a danger of substantial damage to the child's psychological or physical development."[4] The trial court had dismissed the Schermer's dependency petition and concluded "there was insufficient evidence to establish dependency because H.S. was currently safe at the treatment facility and his parents could finance six additional months of in-patient care if they sold their family home."[5]

H.S. was an adolescent who suffered from severe mental health issues, including sexually deviant behavior. His parents had spent years attempting to safely handle H.S. at home, seeking professional help, until it no longer remained viable to have H.S. remain in the home. The family feared that H.S. would harm himself or the family based on threats he had made to injure or kill them, and threats of suicide and other self injurious behavior. The father reported that he was unable to adequately supervise H.S. both due to being out of the home during the day while at work and because of H.S.'s physical size and strength. The mother had been traumatized by H.S.'s threats, remained extremely fearful, and was unable and unwilling to care for him as a parent. H.S. was placed in residential treatment facilities. The father testified that the family could no longer pay for their son's residential treatment and that the family was on the verge of bankruptcy. They sought help from DSHS because they would soon exhaust their finances and would not be able to keep H.S. at the residential treatment facility. DSHS declined to offer an out-of-home placement for H.S.[6]

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[1] The Ombudsman was asked to investigate the Department of Social and Health Services' actions in the Schermer case.

[2] *In re: Dependency of Schermer*, No. 79440-5, slip op. (Wash. October 11, 2007).

[3] *Id.* at 1-2.

[4] *Id.* at 1.

[5] *Id.* at 2.

[6] *Id. at 2-11.*

The Washington State Supreme Court based its decision to affirm the Court of Appeals' decision to reinstate the dependency petition and remand to the trial court for an evidentiary hearing on the following grounds:

A Dependency Finding May Be Based Solely on the Child's Mental Illness

Schermer stated that, "[i]t is now well established that a parent's inability to provide necessary medical care, including mental health care, may support a dependency finding."[7]

Parental Unfitness is Not a Prerequisite to Dependency

The *Schermer* Court noted that although a dependency determination requires a showing of "parental deficiency," it is distinguished from termination proceedings in that it does not require a showing of "parental unfitness."[8] In determining parental deficiency, RCW 13.34.030(5)(c) "allows consideration of both a child's special needs and any limitation or other circumstances which affect a parent's ability to respond to those needs."[9]

A Parent's Inability to Meet a Child's Special Needs Is an Appropriate Basis for Dependency

The Washington Supreme Court cited RCW 74.13.350 as legal authority which "makes evident that a parent's inability to meet a child's special needs in the home is an appropriate basis for a dependency petition."[10] The Court highlighted the Legislature's decision in 1997 to repeal RCW 13.34.030(2)(d) which formerly provided a basis for dependency based on developmental disability of the child and the parents' and DSHS' determination that services could not be provided in the home.[11] The Legislature transferred responsibility for developmentally disabled children to the Division of Developmental Disabilities and provided for out-of-home placement for developmentally disabled children through voluntary agreements under RCW 74.13.350.[12] However, the legislative history on the bill amending chapter 74.13 RCW made clear that "a developmentally disabled child may be found to be dependent because the parents are unable to meet the child's special needs"[13] and that "[a] finding of dependency 'makes the child eligible for certain state and federally funded programs for which the child would not

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[7] *Id.* at 21.

[8] *Id* at 16.

[9] *Id* at 17.

[10] *Id* at 24.

[11] *Id.* at 22.

[12] *Id.* at 22. The impetus for this change in the law appears to have been twofold: 1) DSHS represented, based on a management report, that "cases could be handled more efficiently within the Division of Developmental Disabilities" (*see* S.B. Rep. on S.B. 5710, 54th Leg., Reg. Sess. at 2 (Wash.1997)); and 2) use of a voluntary placement agreement would "avoid requiring [parents] to say they are unable to care for their child (*see* Final H.B. Rep. on H.B. 2557, 55th Leg. Sess. (Wash. 1998)); From the Ombudsman's perspective, the process many parents go through to place a mentally ill child has strayed from the intent of the law. As DSHS noted in its response to our 2003 Annual Report, "the DDD voluntary placement program was capped due to budgetary concerns." (Response may be accessed at http://www.governor.wa.gov/ofco/ 05rpt/response.pdf). Furthermore, families are now faced with what appears to be a greater stigma in trying to access placement for their children than under the prior statutory mechanism of using a (2)(d) dependency.

[13] *Schermer,* slip op. at 23.

otherwise be eligible.'"[14] Thus, the *Schermer* court concluded that the Legislature intended under RCW 74.13.350 for a parent to be able to petition for dependency under RCW 13.34.030(5)(c) if the parent cannot meet the special needs of the child in the home and cannot reach an agreement with DSHS for voluntary out-of-home placement."[15]

Conclusion

The Ombudsman believes that the Washington State Supreme Court's ruling in *Schermer* provides needed clarity on the use of the dependency process for parents who are incapable of meeting a child's special needs and their inability to meet these needs presents a danger of substantial damage to the child's psychological or physical development. It is our hope that this case will herald a change in the culture and practice of DSHS so that the agency more readily assists families to place children out of the home when it becomes unfeasible for them to maintain children with special needs at home. This hope is tempered, however, by the court's clear statement that "[a]lthough a finding of dependency transfers *legal* custody of a child to the State, it does not absolve a parent of *financial* responsibility for a child."[16]

[14] *Id.*

[15] *Id*. At 23-24.

[16] *Id*. at 30 (italics in original).

Response to OFCO 2005 Annual Report

In addition to responding to specific complaints, the Ombudsman is statutorily charged with developing recommendations for improving the state child protection and child welfare system. This section presents the recommendations included in our 2005 Annual Report, and the Children's Administration's responses to these.

In this year's report, the Ombudsman is taking the unusual step of strongly echoing a recommendation made in the 2005 report: to reduce caseloads of caseworkers and supervisors. The Ombudsman believes that the steps taken by the agency to address high caseloads have not been sufficient, and now recommends that urgent action be taken to establish manageable workloads throughout the agency.

In 2005, the Ombudsman developed recommendations in the following areas:

- ✓ Establishing manageable workloads
- ✓ Increasing opportunities for caregivers to be heard
- ✓ Providing relatives with ongoing contact

Establishing Manageable Workloads

Ombudsman's 2005 Recommendation: *Reduce caseloads of caseworkers and supervisors.*

- Direct DSHS to develop and submit a proposal to the state Legislature that would create a method for reducing caseloads and keeping them at a level that is consistent with standards established by the Child Welfare League of America (CWLA) or the Council on Accreditation of Services for Families and Children (COA).

Children's Administration Response: (taken verbatim from letter of response to OFCO's annual report, from Assistant Secretary, Children's Administration (Cheryl Stephani) to Mary Meinig, Director Ombudsman, dated January 31, 2007)

> *CA has received funding for FY 2007 to hire additional caseworkers, first-line supervisors, and clerical support FTE's. These new staff are being hired and put into service according to the FTE phase-in provided in the budget allocation.*
>
> *In addition, the Governor's 2007-09 budget includes funding for an additional 71 caseworker and supervisor FTE's. If the additional resources identified in the Governor's budget request are provided to CA, we should be close to achieving the COA caseload standard of 1 caseworker to 18 cases by the end of FY 2008.*
>
> *CA is in the process of achieving accreditation through the Council on Accreditation. This includes meeting the COA social worker caseload standard and supervisor-to-staff ratio standard. We believe the COA standards are widely accepted in the field of child welfare, and are selected through a rigorous process based on literature review and field experience, and have evolved to become increasingly outcome-focused and evidence-based.*

CA has contracted with Walter McDonald and Associates to undertake a prospective workload study. The study will be done in collaboration with the American Humane Association. They have considerable experience in this area and have conducted similar workload studies for California and New York. This study will focus on the current and projected expectations of caseworkers and supervisors. The study will be conducted in February 2007 and the results will be available in June 2007. The study will provide objective data upon which to determine staffing requirements.

OMBUDSMAN'S 2006 RECOMMENDATION: ***Urgently implement recommendations previously made by the Ombudsman, the Joint Task Force on Child Safety, and a number of child fatality reviews, to address a workload crisis widely reported by caseworkers and supervisors across the state.***

Rationale

In addition to the Ombudsman's 2005 recommendation to reduce caseloads, in four out of five child fatality reviews conducted by Children's Administration between 1995 and 2005, the fatality review team recommended reducing caseloads to improve outcomes for children[1]. The issue of Children's Administration employees' workload was also addressed by the Joint Task Force on Child Safety that met during 2005-2006. This Joint Task Force was created in 2005 by the Legislature (SHB 2156) to review several issues to make recommendations to the Governor and the Legislature to improve the health, safety and welfare of children in DCFS custody. The final report of the Task Force was issued in January 2007 and identified the following issues pertaining to agency workloads, along with its recommendations:

Issue: The ability of social workers to adequately staff cases to ensure child safety and permanency is greatly impacted by the workload of the social worker. Currently, caseloads are high, there is little support to assist with work that does not require a caseworker's knowledge and experience, and there is too great a delay in filling vacant positions which leads to even greater caseloads for the remaining caseworkers.

Recommendation: The CA should create a hiring waiting list. There should be a list of applicants who have been prescreened, interviewed using a standardized interview process, and are ready to be hired and begin training.

Recommendation: The CA should create an overhire pool that consists of trained workers who are available to fill temporary vacancies and to manage caseloads by assisting when caseloads exceed the maximum caseload standards. The overhire pool should be funded using the funds not utilized when a social worker position is vacant.

Recommendation: Non-case carrying workers should be hired to provide support to social workers. Support for workers should be in three areas: 1. Case Aide: provides in-office support that does not require the level of education and training held by a caseworker such as providing transportation, gathering documents, and delivering information. 2. Discovery Disclosure Expert: a person with training in records and public disclosure to assist with court discovery requests and public disclosure requests. 3. Home Support Services: provides concrete in-home services to families to teach basic skills in order to enable the family to support and care for the child.

[1] Fatality reviews listing such recommendations included those of Lauria Grace, Zy'Nia Nobles, Emerald Champagne-Loop, and Justice & Raiden Robinson.

Issue: [excerpt pertaining to workload] ... Additionally, the workload of supervisors is such that it is unrealistic to expect that supervisors will have the time available that is required to perform the oversight and management (of casework) functions effectively.

Recommendation: DSHS should require training for supervisors regarding how to manage new employees, as well as personnel and discipline issues.

Recommendation: The Legislature should mandate a supervisor ratio of no greater than 1 to 6.

Issue: [excerpt pertaining to workload] …High caseworker caseloads have been specifically cited as an issue in several high profile child fatalities in Washington. The Legislature has made an effort to reduce the high caseloads in 2005 by appropriating a significant amount to fund additional caseworkers.

Recommendation: The Legislature should statutorily establish maximum caseload standards in accordance with accreditation standards and legal obligations and provide funding to reduce caseloads when caseloads exceed the standards.

Recommendation: The Legislature and DSHS must invest in the CA workforce to recruit, retain and build a skilled workforce. The DSHS should incentivize skill building in areas of expertise needed in child welfare.

Since making its recommendation regarding caseloads in 2005, the Ombudsman has conducted periodic, random reviews of caseloads in each region in order to monitor the agency's progress toward establishing manageable caseloads[2]. In addition to these random reviews, in the course of investigating any given complaint, the Ombudsman frequently checks on the current caseload of the workers involved. Using the case-counting guidelines issued by the COA[3], the Ombudsman has consistently found high caseloads, regardless of whether the particular DCFS office has passed accreditation by COA[4].

One such review conducted in March 2007 found an average caseload of 30 children in CWS units reviewed (with the highest being 44 children and the lowest, 24) and an average of 30 families in CPS units (with a high of 54 and a low of 17). Of note was the fact that the highest caseload of 54 CPS cases was found in an office that passed COA accreditation a few years ago.

In another random review of caseloads in September 2007, the Ombudsman found an average CPS caseload of 30 families (with a high of 42 and a low of 17) and an average CWS caseload of 28 children (with a high of 59 and a low of 17).

[2] In counting caseloads, OFCO relies solely on case assignments listed for a worker on CAMIS, the agency's automated case record system.

[3] For CPS cases, the entire family is counted as one case, while for CWS cases, each child has a separate case.

[4] These reviews do not take into account whether the worker is employed full-time or part-time; therefore, the actual caseload per FTE may be even higher.

These caseloads all far exceed the COA standards of:

- For CPS cases: 15 investigations or 15-30 open cases, depending on complexity[5];
- For CWS (foster care) cases: 18 children, or 8 children with therapeutic special needs[6];
- For CWS (adoption services) cases: 12-25 families, depending on complexity[7].

Reports issued by the Children's Administration typically report a lower average caseload[8]. A report issued in February 2007 reports a statewide average of 22 CPS cases per FTE in December 2006. In a case count reported by the agency for the month of August 2007, the average caseload for CPS cases across all regions was 20.5, with the highest average in a region being 31.23 and the lowest, 14.12. For CWS cases, the average was 18.8, with a high of 21.34 and a low of 17.33.

CWS workers are experiencing unprecedented workload increases since the agency's redesign involving CPS cases now being transferred to CWS within 72 hours when a dependency petition is to be filed. These cases require intensive work. In the course of investigating complaints over the past year, the Ombudsman has repeatedly heard that caseworkers and supervisors are feeling overwhelmed by their workloads. Staff report extremely low morale as a result of workers' fear of retribution by management because of untenable workloads, workers putting in unreasonable amounts of overtime, and widespread incidence of stress-related physical illness and mental fatigue.

During the Ombudsman's informal reviews in March 2007, in addition to high caseloads, agency managers expressed concerns about inefficient and ineffective hiring practices. Major problems were experienced after the new E-recruiting electronic job application system was implemented by the Department of Personnel (DOP) in the fall of 2006. Although one region reported improvements in this system over the months, in another region, by April 2007, this system was still not working successfully, i.e. applicants as well as hiring officials reported access to the system was unreliable. Furthermore, applicants who successfully registered with this system reported that it took extraordinary effort and perseverance to do so.

In addition to the E-recruiting system difficulties, in one office, it was taking 3-5 months to replace a worker, and supervisors were reporting an inability to hire temporary staff when they were short-staffed. Since the elimination of the "emergency hire" job class (per a collective bargaining agreement two years ago), temporary workers may only begin work once they have completed the six-week training required for CA workers. Even if the supervisor can wait six weeks, once hired workers complete the academy training, they are often offered permanent positions to fill existing vacancies and are no longer available on a temporary basis.

Moreover, changes in state hiring procedures have reportedly increased the hurdles in the hiring process. Supervisors are no longer able to draw from the same pool of applicants when they are interviewing for one position and another position becomes available; a separate request is required for each available

[5] http://www.coastandards.org/standards.php?navView=public&core_id=416

[6] http://www.coastandards.org/standards.php?navView=public&core_id=269

[7] http://www.coastandards.org/standards.php?navView=private&core_id=924

[8] It should be noted that the agency's case count includes all workers across the state over a defined period of time, while the Ombudsman's periodic case count represents a snapshot of the caseloads of a random sample of workers at that moment in time.

position. Furthermore, supervisors are no longer provided with replacement candidates when applicants on the initial candidate list are no longer available or cannot be reached. Getting a new candidate list is delayed by another two to three weeks as DOP does not review applications or verify qualifications of applicants until after a request is received. In at least one region, however, since these changes were implemented, improvements were noted in that once an applicant list was received from DOP, the candidates were generally qualified and available. Nevertheless, given the high turnover of caseworkers, the lengthy and time-consuming hiring process is affecting workloads of entire units.

The Children's Administration's prospective workload study has been conducted by the American Humane Association, but the report has not yet been released as of early November 2007. A primary goal of this study is to "estimate the amount of time required to engage in child welfare practice for it to be considered 'best practice'."[9] The results of this study are expected to be a valuable tool for establishing realistic caseloads, thereby ensuring adequate staffing.

Conclusion

The Ombudsman strongly echoes recommendations previously made from a number of different sources since 2005, to establish manageable workloads for agency staff charged with protecting children and promoting their welfare.

Other recommendations made by the Ombudsman in 2005, and the agency's response, are summarized below.

Increase Opportunities for Caregivers to be Heard

Ombudsman Recommendation: *Provide caregivers with a greater and more consistent opportunity to be heard.*

- Direct the Washington State Institute for Public Policy (WSIPP) to study and propose improved procedures for providing caregivers of dependent children a greater and more consistent opportunity to be heard in court hearings related to dependency cases.
- Require DSHS to survey foster parents and relative caregivers as to how consistently they are notified of hearings, the manner of notification, whether notification was timely, and what it means to "be given an opportunity to be heard" (written input to the court, in person presentation), and what changes, if any, could improve the notification process (e.g. access to online form for providing written input).
- Require DSHS to modify and improve its procedures for providing caregivers of dependent children a greater and more consistent opportunity to be heard in dependency court hearings, taking into account the results of the survey and implementing the recommendations for improved procedures and best practices recommended by WSIPP.

Children's Administration response (verbatim from Assistant Secretary's written response):

> *In 2006 CA developed and implemented new policy regarding notifying caregivers of staffings and court hearings. The policy outlines the written notification requirements including timelines for*

[9] http://www.americanhumane.org/site/PageServer?pagename=pc_systems_research#WAWorkload

notification. The written notice includes the date, time and location of the court hearing and their opportunity to be heard regarding the child in their care. The notice encourages caregivers to attend the hearing or to provide a written report if they are unable to attend the hearing or if they are uncomfortable about speaking in court. A Caregivers Report to the Court has been developed and made available to caregivers. The report is a guide for caregivers to provide information about how the child is adjusting to the placement, visitation with family/siblings, peer and school adjustment and progress, the needs of the child and the caregiver's thoughts on how these needs can be met.

CA also implemented a revised policy to notify caregivers of all staffings related to the child in their care. The policy requires caregivers to be notified as soon as possible and to receive a minimum of 5 days notice of the staffing. In addition, the policy requires the social worker to work with the caregiver to support their participation. The policy requires social workers to provide copies of the decisions made at staffing meetings to the caregiver.

The new policies became effective in July 2005. Written information about these new policies has been provided to all caregivers and is posted on the CA foster parent website.

New federal legislation "Safe and Timely Placement of Foster Children Act of 2006" was recently enacted. This legislation includes the right of foster parents to notification and the right to be heard in proceedings held regarding children in their care. The current Washington state RCW includes the requirement that foster parents be notified of the opportunity to be heard. The new federal legislation makes notification and being heard a right. CA submitted request legislation seeking to amend the current RCW to bring it in line with the new federal legislation. The intent is to implement the RCW change in July 2007.

As you may know the Children's Administration is implementing the Family Team Decision Meeting (FTDM) model statewide. The FTDM approach emphasizes an inclusive approach to decision making and makes a special effort to involve parents, relatives and caregivers in the process. Currently FTDM's are operational in the following CA offices: Spokane, Yakima, Tri-Cities, Vancouver, Tacoma, Bremerton, Kent and OACCS. FTDM's have resulted in greater foster parent participation in case planning meetings. Additional offices will be implementing the model in 2007.

CA is in the process of choosing and implementing a Practice Model. The Practice Model will require a consistent approach to case practice. One aspect of this approach is the inclusion of key people in the child's life in the assessment and decision making process. The Practice Model will strengthen the expectation that foster parents will be encouraged to participate and provide input in decisions affecting the child they are caring for. We expect to begin the implementation of the Practice Model in late 2007.

CA has contracted with Washington State University to conduct an annual foster parent survey. The survey is being developed through an Advisory Committee composed of foster parents, external stakeholders and CA staff. Focus groups have been conducted with focus groups of caregivers and CA staff in each region. At this time it is expected that the telephone survey will be piloted in January 2007 and then administered statewide in March 2007. The first survey report should be available in June 2007. The survey will include questions regarding foster parent notification of hearings and case planning meetings.

Providing Relatives with Ongoing Contact

Ombudsman recommendation: *Provide relatives who have an established relationship with a child, ongoing contact after the child has been placed out of the home pursuant to a dependency action.*

- Direct DSHS to facilitate regular and consistent contact between dependent children and their relatives with whom they have a relationship.

Children's Administration response (verbatim):

> *In 2006 CA revised its visitation policy. The new policy includes the requirement for a written visiting plan for each child, direction regarding the frequency of visits, the location and duration of visits, and the supervision of visits. The policy also addresses who should participate in visits and indicates that visits with people of significance to the child should be encouraged. CA also developed a "Social Worker's Practice Guide: Visits Between Parents and Children" to accompany and support the new policy.*
>
> *The revised visitation policy and the Practice Guide are currently being piloted in the offices using the FTDM model. Based on the results of the pilot, CA will move forward with statewide implementation. Written visiting plans will be required as part of the revised Voluntary Care Agreement policy which will take effect January 2007 in conjunction with the implementation of the CPS/CWS Redesign.*
>
> *CA has proposed a legislative change to expand the definition of "relative" to include a wider range of relatives and also persons who have an established relationship with the child. If this legislative change is made, it will provide greater opportunity for children to be placed with relatives and friends. Widening this definition will also support the continuity of relationships, including visitation, between persons known and familiar to the child.*

Legislative Update

The Ombudsman is responsible for facilitating improvements to the child protection and welfare system. Each year, the Ombudsman identifies systemic problems throughout the state and publishes its findings in its annual report which is submitted to the Governor, the Legislature, agency officials, and the public. Our findings and recommendations frequently become the basis for legislative initiatives to improve the system.

The Legislature had an extremely active legislative session in 2007. The Ombudsman played a significant role in providing input to the Legislature through its participation in the Child Safety Task force[1] and through written and oral testimony on numerous bills, which were subsequently enacted into law. A number of these bills incorporated recommendations the Ombudsman has made in its annual reports and fatality reviews.

The following provides a summary of some of the major areas of legislative activity in 2007:

Legislation Passed into Law[2]

SHB 1333 known as "Sirita's Law" (effective 7/22/07): Makes comprehensive changes to current law relating to child safety and welfare. **It incorporates recommendations from the child safety task force as well as a number of the Ombudsman's recommendations from our child fatality reviews. The Ombudsman also provided testimony in support of many of the provisions in this bill, most notably those that provided for greater scrutiny of all adults in the home in which a dependent child will be placed. Specifically, the bill:**

- Requires DSHS, prior to returning a child home, to identify all care providers in the home, determine if they need services, and notify the court if the care providers fail to participate in recommended services. **In its August 2005 Fatality Review of Sirita Sotelo[3], the Ombudsman recommended heightened assessment of adult caregivers in the home, including non-parents. The Ombudsman deemed this critical after finding that DCFS did not seek further assessment or evaluation of Sirita's stepmother's ability to care for her when her personal history clearly indicated the need for further assessment.**

- Requires DSHS to conduct background checks on all adults in the home in which a child is to be placed. **OFCO recommended that there be greater assessment of all adults in a home who are likely to be providing care for a dependent child on a regular basis.** We found that a criminal

[1] After the death of Sirita Sotelo, the Legislature convened the Joint Task Force on Child Safety to make recommendations to improve the health, safety, and welfare of children receiving services from or in the custody of the state of Washington. The Task force was created in 2005 by SHB 2156 and it issued its final report in November 2006. The Ombudsman participated in all of the task force subcommittees which addressed: 1) intake and investigation; 2) workload; 3) services; 4) internal and external review, including oversight and accountability; and 5) caseworker and supervisor training and support.

[2] For more information on specific bills, bills and accompanying legislative reports may be accessed at http://www.leg.wa.gov/legislature/.

[3] http://www.governor.wa.gov/ofco/sotelo/report.pdf

background check and a general home study, while essential, are not sufficient to fully address other important issues such as the extent and nature of care that will be provided by other adults in the home, bonding and attachment between the child and adults, and whether further evaluation/ assessments of an adult caregiver is warranted.

- Provides that parents in dependency cases receive priority for court ordered services and that they are within the priorities set by the Regional Support Networks for mental health services. **The Ombudsman found in its review of the Sirita Sotelo fatality that a predominate area of concern was the lack of services to Sirita, her father, and her stepmother following her placement in their home.**
- Requires DSHS to pay for court ordered services to the extent funding is available.
- Mandates that DSHS notify the court if a parent is unable to meet the requirements of the court order due to an inability to access services, e.g. funding is not available.
- Requires each county to revise and expand its existing child sexual abuse investigation protocol to address investigations of child fatality, child physical abuse, and criminal child neglect cases and to incorporate the statewide guidelines for first responders to child fatalities developed by the criminal justice training commission.
- Requires the protocols to address the coordination of child fatality, child physical abuse, and criminal child neglect investigations between the county and city prosecutor's offices, law enforcement, children's protective services, local advocacy groups, emergency medical services, and any other local agency involved in the investigation of such cases. The protocol revision and expansion shall be developed by the prosecuting attorney in collaboration with applicable agencies.
- Requires revised and expanded protocols to be adopted and in place by July 1, 2008 and to be reviewed every two years after adoption to determine whether modifications are needed.
- Authorizes foster parents to assist with transitioning a child back to the natural family if appropriate and the foster family wants to be involved in the transition.
- Requires the court to hold a hearing within 30 days from the date a child is removed from the home after having been returned home subsequent to initial removal.
- Makes explicit that the court must apply the best interest of the child as the guiding principle in determining what action to take.
- Requires the Criminal Justice Training Commission to develop a child abuse and neglect curriculum as part of basic law enforcement training.
- Requires the courts to report annually to the Legislature on cases that have not met statutory guidelines for permanency.
- Requires the Joint Legislative Audit and Review Committee to analyze gaps in the availability and access to services in dependency cases and report to the legislature by December 1, 2007.

2SHB 1334 known as the "Rafael Gomez Act" (effective 7/22/07): Requires source documentation. This law incorporates recommendations from the child safety task force in which the Ombudsman participated. The Ombudsman testified to the importance of providing source documentation.

- Requires DSHS to provide the court with the documents upon which a recommendation, opinion, or assertion is based when recommending a new placement or a change in placement.

The Ombudsman has long advocated for providing decision makers with source documents so that they can make better informed decisions.[4] The Ombudsman testified in the 2007 legislative session that providing such documentation reduces bias in presenting information to the court, reduces the likelihood that important information will be filtered out or misinterpreted, and promotes fair and impartial decision making. This requirement should apply to the presentation of information to fatality review teams and Child Protection Teams as well.

HB 1052: Modifies the Legislative Youth Advisory Council (the Council) (effective 5/22/07): In 2005, the Council was established to examine issues of importance to youth, including education, employment, civic engagement, and health:

- Provides that appointments to the Council by an application process rather than by selection. It specifies that the Council may accept grants and donations from public and private sources to support its activities.

HB 1088 (effective 7/22/07): Improves access to mental health services for children. Children's mental health services in Washington are provided by the state through Regional Support Networks (RSNs) established to develop local systems of care. New law:

- Revises the legislative intent statement for children's mental health services to emphasize early identification, intervention, and prevention with a greater reliance on evidence-based and promising practices.[5]
- Establishes that the goal of the Legislature is to create a children's mental health system by 2012 that promotes these elements.
- Directs DSHS to revise the access-to-care standards to assess a child's need for services based on behaviors exhibited by the child and interference with a child's functioning in family, school, or the community, as well as a child's diagnosis.

In our 2003 Annual Report, the Ombudsman called on DSHS to convene a multi-disciplinary Evidence-Based Services Summit to examine a broad range of evidence-based assessment and service

[4] In 2003, after reviewing DCFS case records, the Ombudsman expressed concerns that information provided to the CPT by the DCFS worker accentuated the parents' progress and minimized deficiencies. As a result OFCO asked the Community Fatality Team reviewing Rafael Gomez's death to consider whether the DCFS worker failed to provide the CPT with vital information such as medical reports documenting the child's injuries and reports of maltreatment after the child was returned home.

[5] The Final House bill report on 2 SHB 1088 states that: "In 2003 the Legislature directed the Washington State Institute for Public Policy (WSIPP) to review research assessing the effectiveness of prevention and early intervention programs concerning children and youth. The Legislature requested the WSIPP to identify specific research-proven programs that produce a positive return on the dollar compared to the costs of the program. As a result of the study, the WSIPP found that some prevention and early
intervention programs for youth can give taxpayers a good return on their dollar. The study identified several programs, including some mental health programs, likely to reduce taxpayer and other costs in the future if properly implemented." Revisions to the law are derived in part from the report of WSIPP. http://www.leg.wa.gov/pub/billinfo/2007-08/Pdf/Bill%20Reports/House%20Final/1088-S2.FBR.pdf

models[6] for children and families in the child welfare system. The Ombudsman has also called for improved protocols between DCFS, the Division of Developmental Disabilities and the Mental Health Division so that families may more easily and more directly access mental health services for their children.

HB 1131 (effective 7/22/07): Assists former foster care youth to gain postsecondary education by creating the "passport to college promise program" and provides scholarships to former foster care youth for this purpose.

HB 1201 (effective 7/22/07): Extends Medicaid coverage for foster care youth who were in foster care on their 18th birthday, up to age 21, irrespective of continuing placement in foster care.

2HB 1287 (effective 7/01/07): Modifies child placement provisions and:

- Requires the agency to provide foster parents, pre-adoptive parents, and relative caregivers with notice of their right to be heard in court proceedings for children in their care. **The Ombudsman in its 2005 Annual Report recommended that care providers be provided with a greater and more consistent opportunity to be heard in court hearings.**[7]
- Requires the court to enter an order granting DSHS access to health, medical, mental health, and education records of children within the custody of the agency without further consent.
- Authorizes DSHS or its designee to notify the school that the child is in out of home placement and to participate in and authorize school related activities.
- Provides that information received about a child or child's family shall be kept confidential.
- Revises the written notice and custody provided to parents prior to a shelter care hearing to include notification to the parent that orders will be entered by the court that authorize DSHS or its designee to notify the school if the child is placed out of the home and to participate in and authorize school related activities.
- Requires the court to determine at dependency review hearing whether in-state and out-of-state placements for the child have been considered.

HB 1377 (effective 7/22/07): Expands the definition of relatives for purposes of court ordered placement of a child in the custody of DSHS.[8]

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[6] Evidence-based assessments and treatment refers to tools and methodologies whose validity and effectiveness are supported by scientific evidence.

[7] Office of the Family and Children's Ombudsman 2004-2005 Annual Report, at pp. 81-84. http://www.governor.wa.gov/ofco/05rpt/index.htmwep.

[8] In 2001, the Washington State Institute for Public Policy (the Institute) was directed by the Legislature in ESSB 6153, chapter 608(5), chapter 7, Laws of 2001, to "study the needs and prevalence of families who are raising related children. . . ." The Institute convened a series of kinship caregiver focus groups and a stakeholder's work group to gather information for its report. OFCO actively participated in the stakeholder's workgroup to provide input and advice on data for this report. In 2002, HB 1397 (chapter 74.13 RCW) directed DSHS to "'convene a kinship caregivers working group' to brief the Legislature by November 1, 2002, on 'policy issues to be considered in making kinship care a robust component of the out-of-home placements spectrum.'" OFCO served on this Kinship Care Workgroup which made a series of recommendations for legislative and administrative action. A copy of this report is available at http://www1.dshs.wa.gov/pdf/ca/kinshipcare.pdf.

- Authorizes DSHS to place a child with non-relatives who, subject to court review and a finding that such a placement is in the child's best interests, if 1) the child or child's family has a preexisting relationship; (2) the required criminal background check has been completed; and (3) the person otherwise appears to be suitable and competent to care for the child.

In its 2003 Annual Report, the Ombudsman made specific recommendations to enhance and facilitate placement of children with relative and kinship care providers.[9]

HB 1422 (effective 7/22/07): Relates to children and families of incarcerated parents.

- Adopts legislative findings that there need to be better policies and programs to help support children of incarcerated parents.

- Requires DSHS, DEL, DOC and OSPI to review current department policies and assess the adequacy and availability of programs targeted at inmates with children.

- Requires the secretary of these agencies to adopt polices and programs that encourage contact between inmates and their children with the goal of facilitating normal child development, while reducing recidivism and intergenerational incarceration.

HB 1472 (effective 7/22/07): Relates to analyzing and remedying racial disproportionality and racial disparity in child welfare.

- Directs DSHS to convene an advisory committee to analyze and make recommendations on the disproportionate representatation of children of color in the child welfare system. The advisory committee shall report to DSHS by June 1, 2008.

- Directs DSHS to work with the Washington State Institute for Public Policy and private sector agencies to develop a methodology for analyzing data to determine racial disparity and disproportionality.

- Requires DSHS to report on the results of the analysis and remediation plan to the Legislature by January 1, 2008 and to report annually beginning January 1, 2010.

The Ombudsman has recognized and reported on varying aspects of racial disproportionality in the child welfare system. Of particular concern, was the Ombudsman's finding that while Native Americans comprise only 2 % of the state's total population, they made up 17% of the child fatalities that occurred in the fatalities we reviewed in 2004.[10] The Governor proposed and the House and Senate approved, in the 2007 budget, $1.782 million to address state and federal requirements and to reduce the disproportionate number of fatalities for children that come under the Indian Child Welfare Act.

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[9] OFCO recommended that DSHS Children's Administration (CA) improve the agency's ability to identify and support relative and kinship caregivers through 1) development of a statewide protocol for identifying relative/kinship placement resources; 2) development of an objective assessment process for evaluating the suitability of relative/kinship caregivers; 3) development of criteria to assist workers in making relative/kinship placement decisions; and 4) promoting family involvement in the agency's case planning process.

[10] The Ombudsman reported on this in its 2004 and 2005 Annual Report which may be accessed at http://www.governor.wa.gov/ofco/childfatality/report.pdf (see p. 55 for specific information on the race of child victims).

HB 1565 (effective 7/22/07): Relating to public access to "child in need of services" (CHINS) and "at-risk youth" (ARY) hearings.

- Provides that a CHINS hearing must be open to the public unless the court determines that it is in the best interest of the child to close the hearing to the public.
- Provides that an ARY hearing is open to the public unless the court determines that it is in the best interest of the child to close the hearing or if either parent requests that the hearing be closed to the public.

ESHB 1624 (effective 7/22/07): Relates to reinstatement of parental rights.

- Authorizes a dependent child who is 12 or older to petition the court to reinstate previously terminated parental rights if three years have passed since parental rights were terminated and the child has not achieved permanency.
- Provides good cause exception for children under age 12 to file the petition.
- Clarifies the purpose of shelter care, review, and permanency planning hearings.
- Directs DSHS to work with the University of Washington to study the need and feasibility of establishing tiered classifications for foster parents and report to the Legislature by January 1, 2008.
- Requires DSHS to consult with foster parents quarterly on the performance of the agency.

The Ombudsman testified on the benefits to youth of reinstating parental rights in limited circumstances.

2SHB 1922 (effective 7/22/07): Creates an independent youth housing program.

- Establishes the Independent Youth Housing Program (Program) within the Department of Community, Trade and Economic Development (DCTED) for the purpose of providing housing stipends and case management services to youth, ages 18 to 23, who have exited the state dependency system. Its purpose is to facilitate an easier transition from foster care to independent living.

SB 5317 (effective 7/22/07): Relating to child care safety.

- Revises current law to make it clear that the health, safety, and well being of children receiving child care and early learning assistance **is paramount over the right of any person to provide care.**
- Provides tools to promote the hiring of suitable providers of child care by providing parents with access to information about providers; providing parents with child care licensing action histories regarding child care providers; and requiring background checks of applicants for employment in any child care facility licensed or regulated.

The Ombudsman has been a vocal proponent of increasing transparency in the licensing of child care facilities and improving communication with families about licensing history so that they may make a well informed decision about child care. In 2006, the Ombudsman contacted the precursor agency to the Department of Early Learning (DEL) to suggest improvements to the publicly accessible website so that the information on licensed child care facilities would more accurately reflect their licensing status and history. DEL's website addresses concerns that the Ombudsman identified and may be accessed at http://www.del.wa.gov/MAP/MAP1.shtml.

SB 5321 (effective 7/22/07): Relates to the screening and investigation of child abuse/neglect referrals and the sharing of child welfare information.

- Amends or establishes definitions related to the screening, investigation, and finding of child abuse and neglect referrals.
- Removes the designation of an "inconclusive" finding on a child abuse and neglect referral.
- Establishes that DSHS must complete an investigation within 90 days and make a finding that the referral was either founded or unfounded.
- Provides that if a court considering the same facts or circumstances as CPS finds by a preponderance of the evidence, or a higher burden of proof, that the subject of a pending CPS investigation abused or neglected a child, DSHS must adopt this finding in its investigation.
- Establishes timelines for the destruction of child abuse and neglect referrals and investigative records based on the classification of the referral. DSHS shall destroy unfounded or inconclusive referrals, prior to the effective date of this act, within 6 years of completing the investigation unless a prior or subsequent report has been received; within 3 years for a screened out report; and an unfounded, screened out, or inconclusive report may not be disclosed to DSHS licensed providers or used to deny a license or employment.
- Provides for penalties and attorney fees for person harmed by unauthorized disclosures of records relating to child abuse and neglect.
- Requires sharing of information with foster parents regarding high-risk behaviors and medical and mental health diagnoses, such as sexual reactivity or fetal alcohol syndrome, of children placed in foster care.
- Provides that a foster parent will not be found to have abused or neglected a child or denied a foster care license, based on failure to supervise, if the allegations are substantially similar to prior behavior and it was not disclosed to the care provider that the child was sexually reactive, physically aggressive/assaultive, or exhibited high risk behaviors.
- Also provides that a foster parent will not be found to have abused or neglected a child or denied a foster care license, if the child was not within reasonable control of the provider and the provider was acting in good faith and did not know that reasonable control was needed to prevent harm to the child or others.

SB5774 (effective 7/22/07): Revises background check processes.

- Provides that the DSHS, prior to placing a child in a home, must conduct the following background checks on any prospective foster parent, adoptive parent, kinship care provider, and any other adult living in the home: (1) finger print criminal background check against the national crime information database; (2) search in the state's child abuse and neglect registry; and (3) if the adult resided in a different state(s) in the preceding five years, any other state's child abuse and neglect registry.

- Includes Department of Early Learning (DEL) employees as mandatory reporters of suspected child abuse and neglect.

- Allows for the exchange of information between Washington State Patrol and DEL to conduct mandatory background checks for child care licensing and approval.

The Ombudsman has consistently advocated for more comprehensive background checks of individuals whose work brings them into regular contact with children, such as day care workers and foster parents.

E2SSB 5828 (effective 7/22/07): Relating to early child development and learning.

- Requires DEL, subject to the availability of funding, to implement a Voluntary Quality Rating and Improvement System applicable to licensed or certified child care centers and homes and early education programs. Its purpose is to provide parents with clear and easily accessible information about the quality of child care and early education programs, and to support improvement of such programs.

- Requires DEL to report to the Legislature prior to implementation of the rating system.

- Requires DEL to provide parents with timely inspection and licensing action information about child care and early learning programs once an early learning information system is developed.

SB 5830 (effective 7/22/07): Relating to home visitation services for families.

- Renames the Washington Council on the Prevention of Child Abuse and Neglect to "the Children's Trust of Washington."

- Provides that within available funds, the Children's Trust of Washington must fund evidence-based and research-based home visitation programs for parents to improve parenting skills and improve outcomes for children.

- Defines "Evidence-based program," "home visitation," and "research-based program."

SB 5839 (effective 7/22/07): Revises provisions related to nonmandatory reporting of child abuse or neglect.

- Removes the term "malicious" from the false reporting statute. The statute provides that a person who intentionally and in bad faith makes a false report of alleged abuse or neglect shall be guilty of a misdemeanor.

- Requires CPS to include a warning against false reporting in any materials relating to the reporting of abuse or neglect.
- Requires CPS to send a certified letter to individuals determined to have made a false report warning that a subsequent false report will be referred to law enforcement for investigation.

SB 5952 (effective 7/22/07): Relates to correcting provisions for the Department of Early Learning (DEL). When DEL was established in 2006 to implement early learning policy and coordinate, consolidate, and integrate child care and early learning programs, certain functions and powers were transferred from DSHS to DEL in the newly added 43.215 RCW. Certain functions were not replicated in this chapter of the law, which needed to be.

- Adds additional powers, duties, and functions for DEL to the appropriate section of the law, including the authority of DEL to deny, suspend, revoke, modify, or not renew a license or assess a civil monetary penalty when an agency has failed or refused to comply with the licensing requirements.

Legislation Introduced but not Enacted

In addition to the OFCO activity on the enacted bills discussed above, OFCO testified regarding the intent behind the following bills:

HB 1335: Relates to a pilot program to utilize a team approach to child welfare cases. The Ombudsman provided oral testimony on 2/16/07.

HB 1425: Relates to permanency planning hearings. The Ombudsman provided oral testimony on 2/09/07.

HB 1780: Relates to creating a Unified Family Court. The Ombudsman provided oral testimony on 2/06/07.

HB 1912: Relates to improving court hearings in dependency proceedings. The Ombudsman provided oral testimony on 2/16/07.

SHB 2075: Relates to termination of parental rights. The Ombudsman provided written comments.

SSB 5754: Relates to creating a Family and Youth Administration within DSHS. OFCO provided written comments on 2/12/07.

Braam Update

The Braam Panel continued to have quarterly meetings on the implementation of measures to achieve the *Braam v. State of Washington*[1] settlement goals. In fulfillment of its legislative mandate to monitor Children's Administration's duty to deliver family and children's services to ensure children's health and safety and preserve families,[2] OFCO attended these meetings and monitored the agency's progress.

Braam v. State of Washington – Final Settlement Goals July 31, 2004

In 2004, both parties through their counsel agreed to specific, measurable and enforceable goals to improve the conditions and treatment of children in the custody of DCFS in relation to six areas: [3]

Placement Stability

1. Each child in the custody of the Department shall have a safe and stable placement with a caregiver capable of meeting the child's needs.

Mental Health

1. The children in the custody of DCFS shall have an initial physical and mental health screening within 30 days of entry into care.
2. Plans to meet the special needs of children in the custody of DCFS will be included in the child's Individual Service and Safety Plan (ISSP).
3. Children in the custody of DCFS shall receive timely, accessible, individualized and appropriate mental health assessments and treatment by qualified mental health professionals consistent with the child's best interests.
4. Continuity of treatment providers will be maintained, except when it is not in the best interest of the child.

Foster Parent Training and Information

1. Caregivers shall be adequately trained, supported, and informed about children for whom they provide care so that the caregivers are capable of meeting their responsibilities for providing for the children in their care.
2. The Department shall offer and provide accessible pre-service and in-service training to all caregivers sufficient to meet the caregiving needs of children in placement.

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[1] Braam v. State of Washington, 150 Wn.2d 689, 712, 81 P.3d 851 (2003) (class action suit brought by current and former foster children who sought damages for harm suffered as a result of multiple placements while in the custody of DCFS).

[2] WAC 112-10-040.

[3] Braam v. State of Washington Final Settlement, July 31, 2004, available at: http://www.wsipp.wa.gov/braampanel/SettlementAgreement.pdf

Unsafe/Inappropriate Placements

1. All children in DCFS's custody shall be placed in safe placements.
2. The State will continue to meet or exceed the federal standard for out-of-home care safety measure.

Sibling Separation

1. Placement of siblings together is presumed to be in the children's best interest, unless there is a reasonable basis to conclude that the health, safety or welfare of a child is put in jeopardy by the placement.
2. Frequent and meaningful contact between siblings in foster care who are not placed together and those who remain at home should occur, unless there is a reasonable basis to conclude that such visitation is not in the best interest of the children.

Services to Adolescents

1. Improve the quality and accessibility of services to adolescents in the custody of DCFS consistent with the allegations set forth in Section II, Paragraph 2.3 of the Plaintiffs' Fifth Amended Complaint.[4]
2. Improve the educational achievement of adolescents in the custody of DCFS and better prepare them to live independently.
3. Reduce the number of adolescents on runaway status from foster care.

The settlement agreement requires the Braam panel to issue progress reports regarding the settlement every six months.[5]

Braam Panel Established Professional Standards

The Braam Panel has established professional standards, after input from all parties, to be used in the event of enforcement proceedings. These are standards of practice for DCFS that establish clear expectations for the treatment of children in foster care.[6]

Compliance with Annual Benchmarks

On January 22, 2007, the Department released comprehensive statistics showing the agency's level of compliance with annual benchmarks set by the Braam Panel in the Braam Implementation Plan. The data showed that the Department failed to reach all measurable statistical benchmarks that it was required to meet by June 30, 2006, in the following areas:

- **Foster homes** - Increasing the number of beds available to children in care;
- **Placement stability** - Decreasing the number of youth experiencing less than three placements in their first few years in care;

[4] http://www.wsipp.wa.gov/braampanel/Complaint.pdf

[5] Monitoring reports were issued by the Braam Panel on March 2006; September 20, 2006; April 17, 2007; and October 4, 2007. These may be accessed at http://www.wsipp.wa.gov/braampanel/reports.asp.

[6] Braam professional standards may be accessed on the "Panel reports" section, "Braam Oversight Panel Professional Standards (March 2007)" of the Braam website at www.braampanel.org.

- **Kinship care** - Increasing the number of kinship care providers;
- **Sibling separation** - Increasing the number of siblings placed together;
- **Health care** - Increasing the timeliness of health screening, assessment and services;
- **Runaways** - Reducing runaway events and time as a runaway; and
- **Foster parent training** - Increasing the in-service training to foster caregivers.

The Department asserted that it was making progress in child safety, but acknowledged that there was "little movement yet in Braam measures."[7] Cheryl Stephani, Assistant Secretary for DSHS Children's Administration expressed hope that improvements would occur "as we have additional trained social work staff who use consistent practice across the state, a new management information system and additional services that help families stay together." [8]

Highlights of 2007

Foster Parent Survey

One of the key activities of the Braam panel was to commission a comprehensive survey of foster parents, as part of the Braam Settlement Implementation Plan, to gather information about caregivers' experiences to ensure that caregivers are receiving the type of support and training they need from DSHS.[9]

Poor Contact Information on Care Providers

Washington State University's Social & Economic Sciences Research Center (SESRC), the entity that was contracted to conduct the survey, interviewed over 1200 foster parents and relative care providers between April 2007 and July 2007. SESRC reported that it attempted to contact 3,800 care providers, but 986 (more than 25%) were unable to be contacted because the phone number provided by the Department was not a working phone number and the foster parents were not listed. The Department responded that there were several possible reasons for some of the numbers not being current. The survey included some individuals who had previously provided care and were no longer active so they had not provided the agency with updated numbers and the information in the agency's computerized data base does not automatically update the licensing file of care providers and that the State is working to address this problem.[10]

Both DSHS and the Plaintiffs prepared summaries of the survey results. The Plaintiffs' summary highlights information specific to the Braam benchmarks.[11] DSHS prepared the following document that highlights some of the results of the survey:[12]

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[7] http://www1.dshs.wa.gov/mediareleases/2007/pr07003.shtml

[8] http://www1.dshs.wa.gov/mediareleases/2007/pr07003.shtml

[9] The foster parent survey may be accessed on line at: http://www.wsipp.wa.gov/braampanel/survey.asp

[10] See Iwasaki, John. "Foster care survey 'good news' overall, says DSHS." Seattlepi.com 20 Sept. 2007.

[11] The Plaintiffs' summary may be accessed at: http://braamkids.org/FPSurveyBenchmarkSummary9-20-07final.pdf

[12] DSHS 2007 Foster Parent Survey Highlights may be accessed on line at: http://www1.dshs.wa.gov/pdf/ca/2007Highlights.pdf

2007 Foster Parent Survey Highlights (09/20/07 final)

Areas of strength–caregivers report: *(Braam benchmarks are in italics)*

Received the respite care they requested in a timely manner	77% of all caregivers report receiving the respite care they need
Are treated professionally and with respect	85% of all caregivers by their social workers; 89% of all caregivers by their licensors
Children needing mental health services received it in a timely manner	86% of foster parents
Have at least monthly telephone or email contact with child's social worker	79% of foster parents; 77% of all caregivers (61% of all caregivers report social worker contact several times each month)
Return calls within the next working day most of the time	68% of all caregivers from their social workers; 76% from their licensors
Child having only one or two different social workers	75% of foster parents; 71% of all caregivers
Caregivers who accessed the CA foster parent website found it useful	81% of all caregivers
Licensed caregivers receive adequate training for their roles	88.6% of licensed caregivers
Licensed caregivers receive adequate support for their roles and responsibilities	76.3% of licensed caregivers
Licensed caregivers receive adequate information about the needs of children placed with them	72.8% of licensed caregivers
Receive adequate support in caring for medically fragile children	74.9% of all caregivers
Receive behavioral health services from the same individual provider	75.4% of all caregivers

Areas for improvement–caregivers report: *(Braam benchmarks are in italics)*

Rarely or never receive the five-day notice about shared planning meetings	40% of all caregivers (51% report they are not encouraged to attend)
Unmet training needs (child development, dealing with biological families, discipline and behavior management)	45% of foster parents; 40% of all caregivers
Relative caregivers attending training in previous three years	59% of relative caregivers reported attending no training in previous three years
Dissatisfied with how CA communicates with them	33% of all caregivers
Not familiar with the after hours support line for foster parents	47% of all caregivers
Not familiar with the new educational programs to help foster children	Over 50% of all caregivers
Monthly face-to-face visits of caseworker with child	37.9% of all caregivers reported children received monthly visits
Meeting and documenting protective measures for children with history of sexually aggressive and physically assaultive behavior	44.7% of all caregivers reported all protective measures in place
Children not placed with siblings have two or more visits or contacts per month	48.4% of all caregivers reported children having 2 or more visits/contacts with siblings each month

OFCO Areas of Concern

The information provided in the Department's "Foster Parent Survey Highlights," (hereafter "Survey Highlights") while helpful, is limited and omits several areas that the Ombudsman considers critical and in need of reform. The following are two key areas of concern:

1. Inadequate Notice of Court Hearings

For example, the Department's Survey Highlights fail to mention that 22% of care providers reported that they were rarely or never notified of court hearings, and 8% reported that they were notified only about half the time. Another 22 % reported that there were no court hearings in 2006.[13] Under the law,

[13] See p. 51 of hard copy of report, which is available online (p. 54 online) at: http://www.wsipp.wa.gov/braampanel/ParentSurvey07_DataApp.pdf.

dependency review and/or permanency planning hearings occur every 6 months. Consequently, this raises the question of whether there were, in fact, scheduled hearings, but the Department failed to notify care providers about them so the care providers assumed there were no hearings.

When asked how often the agency advised care providers that they would have an opportunity to be heard, approximately 25 % reported "never," approximately 12 % reported "rarely," and approximately 6 % reported "about half the time."[14]

The agency's omission of data regarding notification of court hearings in its Survey Highlights is significant for several reasons. The Ombudsman has investigated and found in numerous cases that DSHS CA failed to notify care providers of upcoming court hearings, or did not notify them on a timely basis so that their opportunity to provide the court with a care provider's report or other meaningful input was lost. Additionally, many complainants report that even when they have had notice of a court hearing, they are not provided information by the agency about how to submit written information to the court. Some have resorted to giving their written comments to CASA/GALs to present to the court when they have met with resistance or passivity from DCFS workers. In OFCO's 2004-05 annual report, we recommended that care givers be provided a greater and more consistent opportunity to be heard in court hearings.[15] In fact, we recommended a survey of foster parents to inquire about this issue and are pleased that there is now such a comprehensive body of work.

2. Health and Safety Checks

The survey revealed that 37.9% of children in care received a private and individual face-to-face visit from the caseworker for each full placement month.[16] The Braam Implementation Plan[17] required that by June 30, 2006, 70% of children in foster care were to have monthly visits by case workers.

Over 60% of all survey respondents said the child in their care did not receive a monthly private and individual face-to-face visit from a caseworker. In fact, the survey indicates that 17% of survey respondents reported that their foster child *did not receive a single visit* in all of 2006.[18] Currently, the Department's efforts have focused on providing monthly health and safety checks of those children returned home to their parents pursuant to an in-home dependency.[19]

The Ombudsman believes that irregular and/or inadequate health and safety checks create missed opportunities for the agency to intervene with children before devastating things happen. Health and safety checks provide a chance for the case worker to observe first hand the environment in which the foster child

[14] *Id.*

[15] OFCO's recommendations may be accessed on line at: http://www.governor.wa.gov/ofco/05rpt/issues.pdf

[16] This measured the response of licensed and unlicensed caregivers combined. See p. 49 of hard copy of report, which is available online (p. 52 online) at: http://www.wsipp.wa.gov/braampanel/ParentSurvey07_DataApp.pdf.

[17] The February 2006 Braam Implementation Plan may be accessed at http://www.wsipp.wa.gov/braampanel/ImpPlanFeb06.doc

[18] See p. 49 of hard copy of report, which is available on line (p. 52 on line) at: http://www.wsipp.wa.gov/braampanel/ParentSurvey07_DataApp.pdf.

[19] Secretary of Children's Administration, Robin Arnold-Williams, stated that: ""There's no way we can hire and bring all staff on at one time . . . We chose to prioritize monthly visits to those children most vulnerable in our eyes." Iwasaki, John. "Quarter of state's foster parents can't be reached – Study cites flaws in state foster care program." Seattlepi.com 20 Sept. 2007. Available at: http://seattlepi.nwsource.com/local/332428_foster20.html.

is living and the interaction between the child and the care provider, and to develop a relationship of trust with the child so that if neglect or abuse is occurring, the child feels comfortable to disclose this to the worker.

Issues of Concern Identified by Plaintiffs

Plaintiffs highlight several areas of concern based on the foster parent survey results in specific regard to Braam benchmarks:[20]

- **Visits by Caseworkers:**

The Plaintiffs report that 37.9% of children in care received a private and individual face-to-face visit from the caseworker for each full placement month and that one in four youth received no more than one visit by a caseworker in 2006.

- **Sibling visits:**

The Plaintiffs highlight ongoing concerns about sibling visits, noting that "the majority of all children who are placed apart from their siblings do not have more than monthly visits with their siblings. Furthermore, almost 10% of all children separated from their siblings re not seeing their siblings *at all*."[21]

- **Sexually Aggressive Youth (SAY) and Physically Assaultive Youth (PAY):**

The Plaintiffs state that "it is clear the Department's performance related to this outcome falls below any acceptable measure–55% of responses indicate the Department is out of compliance in providing appropriate assessment for these vulnerable children and/or specific training for caregivers who have youth who are sexually aggressive or physically assaultive placed in their home."[22]

Areas Identified by Plaintiffs as Nearing Compliance with Benchmarks or Showing Improvement

- **Medically Fragile children:**

Most medically fragile children (74.9%) were reported to be connected to appropriate and ongoing medical care and placed with caregivers who receiving training about the child's medical condition.

- **Adequate Training & Support:**

The majority of licensed relative and non-relative care providers reported receiving adequate training (88.6%) and adequate support (76.3%) for their role as a care provider.

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[20] The issues of concern as well as areas of improvement noted in each bullet are set forth in more detail in "Plaintiffs' Summary of Benchmark Report for the 2007 Survey of Foster Parents and Caregivers in Washington State," available at: http://braamkids.org/FPSurveyBenchmarkSummary9-20-07final.pdf. Foster parent survey results related to Braam benchmark data are presented in the Benchmark Report 07-054 available at: http://www.wsipp.wa.gov/braampanel/ParentSurvey07_Benchmark.pdf

[21] "Plaintiffs' Summary of Benchmark Report for the 2007 Survey of Foster Parents and Caregivers in Washington State," available at: http://braamkids.org/FPSurveyBenchmarkSummary9-20-07final.pdf.

[22] *Id.*

- **Adequate Information**

Most licensed care providers (72.8%) reported receiving adequate information about the needs of the children in their care.

- **Behavioral Health Services**

The Plaintiffs, while acknowledging that 75.4% of respondents reported that children in care received behavioral health services from the same provider in 2006, point to the requirement that the Department reach a benchmark of 90% by June 2006.

Plaintiffs Indicate Intent to Return to Court for Enforcement

At the September 10, 2007 Braam Panel meeting, Plaintiffs informed the Panel and DSHS that they intend to return to court in the months ahead to seek additional enforcement of the Braam settlement agreement. The key issue that is likely to be highlighted is the agency's ongoing failure to conduct 30 day health and safety checks on all dependent children.[23] The Panel has rejected three consecutive compliance plans from the agency on caseloads, 30 day visits, and emergency respite care.

Meeting Status

The last Braam Panel Meeting was held on September 10 and 11, 2007. A copy of the Panel's most recent October 4, 2007 "Monitoring Report # 4" is available at http://www.wsipp.wa.gov/braampanel/reports.asp. The "Panel's Decisions on Children's Administration's Revised Compliance Plan #3" is available at this same web link. The next Panel meeting is scheduled for December 11th. The time and location may be accessed at http://www.wsipp.wa.gov/braampanel/schedule.asp.

[23] Plaintiffs believe caseload size is a factor in this.

APPENDICES

APPENDIX A–OMBUDSMAN ACTIVITIES

The Ombudsman is charged with promoting public awareness and understanding of family and children services and with identifying systemic issues that need improvement. The office accomplishes this by actively participating on committees established to critically examine such issues; presenting at conferences; reviewing and analyzing proposed legislation, and providing oral or written testimony where appropriate; and conducting site visits of state licensed facilities pertaining to placement, supervision, and treatment of children in the state's care. The following provides a list of the Ombudsman's community outreach and legislative action in 2006 and 2007.

COMMITTEES/TASK FORCES

Joint Task Force on Child Safety, established by SHS 2156. OFCO participated and made recommendations on each of the 4 subcommittees established in the following areas:

- Caseworker and Supervisor Training, Workload & Support
- Intake and Investigation
- Review, Oversight & Accountability
- Services

Joint Task Force on the Administration and Delivery of Services to Children and Families, established by SSB 5872. Workgroup on Children's Representation: Charged with making recommendations to The Washington State Supreme Court Commission on Children in Foster Care to improve representation of children in dependency proceedings.

Braam Oversight Panel: Quarterly Meetings were held by the Braam Panel. OFCO continued to monitor implementation of the Braam settlement agreement and DSHS's compliance. For more information see the "Braam Update" in this report.

LEGISLATION

The Legislature had a busy and productive legislative session in 2007 marked by the enactment of comprehensive amendments to existing child welfare laws. The Ombudsman provided ongoing input to the Legislature by providing written and oral testimony on many of these bills. The bills incorporated several recommendations the Ombudsman has made over the years in its annual reports and fatality reviews. Those bills on which we provided oral or written testimony or comments are listed below. A more comprehensive discussion of specific provisions in enacted legislation is provided under the "Legislative Update" section of this report.

House Committee on Early Learning and Children's Services:

- Testimony on HB 1425
- Testimony on HB 1333
- Testimony on HB 1334
- Testimony on HB 1912
- Testimony on HB 1624

- Testimony on HB 1335
- Testimony on SHB 2075

House Judiciary Committee:

- HB 1780

Senate Human Services and Corrections:

- SSB 5754
- SSB 5807
- SB 5381
- SHB 1333
- 2SHB1334

CONFERENCES

Annual Children's Justice Conference

Annual Northwest Alternative Dispute Resolution Conference

Indian Child Welfare Summit

Governor's Leadership Conference

Reasonable Efforts Symposium

Washington State Ethics Conference

Diversity Meeting

Annual U.S. Ombudsman Association Meeting, 2006 & 2007

Child Welfare Ombudsman Meeting (Director Ombudsman Mary Meinig is co-chair of the Family and Children's Chapter of USOA)

Evidence Based Practice NWICF

PRESENTATIONS

Annual DSHS Children's Justice Conference

Annual Statewide CASA Conference

Seattle University School of Law Mediation training

Annual Northwest Alternative Dispute Resolution Conference

Guardian Ad Litem (GAL) In-Service

Foster Parent Association of Washington (FPAWS) Meeting

TRAINING ATTENDED

Child Fatality Investigation, WA State Criminal Justice Training

Investigator Training

Advanced Investigator Training

APPENDIX B–OFCO IN THE NEWS 2006

"Mother of dead child misled officials, probe finds 7 year-old died last year of dehydration." –*Adam Wilson, The Olympian, February 4, 2006*

- ✓ "Tyler DeLeon had complained to adults of abuse and neglect at his home in Stevens County. He died in January 2005 of severe dehydration and weighed 28 pounds."

- ✓ "'We had a youngster saying over and over that something bad was happening to him, but the caregiver was successful in making this youngster seem to be a liar,' said Mary Meinig, director of the Office of the Family and Children's Ombudsman. 'At a certain point . . . the youngster just stopped telling what happened.'"

"Neighbors of slain toddler question agency's role." –*Kathie Durbin, The Columbian, May 28, 2006*

- ✓ "The 2005 Legislature strengthened CPS' hand in dealing with cases in which the mental condition of a parent may threaten a child's safety. But the reforms don't take effect until Jan. 1, 2007 more than seven months after Bryce Meining's death. The [chronic neglect] bill allows CPS to act promptly to remove a child from a home where abuse or neglect is suspected. It also requires that in cases where a parent's substance abuse or mental illness contributed to a child's removal, the parent must agree to take part in continuing treatment in order to get the child back. Failure to take part will be grounds for removing a child from the home."

- ✓ "The changes were recommended by a separate watchdog agency, the Office of the Family and Children's Ombudsman, which reviews CPS child fatality cases and makes recommendations to the agency, the governor and the Legislature on needed reforms."

"Ombudsman office finds fault with children's agency." –*Kathie Durbin, The Columbian, May 28, 2006*

- ✓ "Over the past 10 years, an independent state agency has investigated the deaths of hundreds of children who were in state custody or under state supervision when they die. The reviews by the Office of the Family and Children's Ombudsman, housed in the governor's office, have revealed serious flaws in the way Child Protective Services investigates child fatalities."

- ✓ "The Ombudsman has recommended reduced caseloads for investigators, more attention to abuse and neglect cases involving adolescents and better screening of stepparents before they are entrusted with custody."

"Our view: System leaves too many deaths uninvestigated" –*Editorial, Spokesman Review, October 9, 2006*

- ✓ "In several of the 87 fatalities studied in Washington in 2004, says Families and Children Ombudsman Mary Meinig, her office found that abuse or neglect clearly contributed to children's deaths that coroners had attributed to SIDS or 'unidentified infant death.' Meinig has called for the state to restore the uniform statewide review of child deaths. The information they produce would help officials and agencies identify patterns and devise appropriate responses. That's a worthy task for the state to undertake, and Meinig's plea should not go unheeded."

"Abuse, neglect may factor in kids' deaths, Welfare official dispute ombudsman's findings." –*Benjamin Shors, Spokesman Review, May 31, 2006*

- ✓ "'We had a potential opportunity -- that's the key,' said Mary Meinig, director of the ombudsman's office. 'We could have possibly prevented those deaths. Did we do enough?'"

"Report suggests many child deaths involve neglect and abuse." –*The Associated Press, Tri-City Herald; Seattle Post-Intelligencer, May 31, 2006*

- ✓ "A . . . report [from the state's Office of the Family and Children's Ombudsman] found that far more children die in Washington state of abuse and neglect than was previously thought."

- ✓ "In its 108-page report, the ombudsman's office said it found several gaps in fatality investigations, particularly in rural counties served by coroners. A review of several cases that coroners concluded were 'unidentified infant death' found that abuse or neglect had 'clearly contributed' to the deaths according to the report."

"Foster parents: Union adds clout." –*Adam Wilson, The Olympian, May 31, 2006*

- ✓ "The problem [with the drop in foster parents] was emphasized by the release of an annual report by the independent Office of the Family and Children's Ombudsman. 'There is a critical shortage of foster homes for children throughout the state. The crisis needs to be recognized and prioritized,' wrote the ombudsman, Mary Meinig."

"When children die, it's too late; Report looks at role state plays in helping those at risk." –*Claudia Rowe, Seattle Post-Intelligencer, May 31, 2006*

- ✓ "The grim finding [of 87 child fatalities in 2004], announced in a report by the ombudsman charged with monitoring outcomes at the state Children's Administration, prompted officials to point out that child fatalities have been higher in previous years and that many of the deaths were because of natural, medical, accidental or undetermined causes. . . .But Mary Meinig, ombudsman for the Office of Family and Children, found little comfort in that rationale. 'What we're asking is: Are these preventable deaths? Can we be doing more? All these kids were known to the Children's Administration -- or their families were -- so what does that mean?' Th[ese] and other, similar cases prompted the ombudsman to call for greater attention to such child-welfare basics as reduced caseloads for social workers -- a measure that officials at the Children's Administration insist is under way."

"Report: Abuse missed in children's deaths; Ombudsman Review; State child welfare system criticized." –*Maureen O'Hagan, The Seattle Times, June 1, 2006*

- ✓ "The state isn't taking into account clear signs of abuse or neglect when kids involved with the child-welfare system die, according to a report by the Office of Family and Children's Ombudsman."

- ✓ "The report, released Tuesday, is an intensive examination of child deaths and complaints from 2004 and 2005. It says 87 children who either had an open case or were the subject of a complaint to the child-welfare system died in 2004. Abuse or neglect were 'clear' factors in 25 cases and were 'concerns' in an additional 36 cases, according to the report. Other children died of illness or in accidents."

- ✓ "The report included a number of recommendations, including lower caseloads, better support for foster parents and more access to relatives for kids removed from their homes.

"Abuse, neglect 'clearly connected' to some kids' deaths, report says." –*Associated Press, Tacoma News Tribune; The Bellingham Herald, The Olympian, June 1, 2006*

- ✓ "Although state officials disagree with the ombudsman's finding, Meinig said the histories cannot be discounted when reviewing the deaths."

- ✓ Meinig said she had 'grave concerns that the recommendations that arise from fatality reviews are not being sufficiently and consistently implemented. [These] could be life-saving.'"

"Foster Care: Failing our kids." –*Editorial, Seattle Post-Intelligencer, June 4, 2006*

- ✓ "[I]n her annual report, Meinig found shortcomings in systems for ensuring the welfare of children. Her office found overloaded caseworkers, failures to keep relatives in touch with children in foster care and unresolved questions about the deaths of children."

- ✓ "[A]s the ombudsman's report points out, the state leaves determinations about the causes of a child's death somewhat to chance. If a child dies in some urban areas, there is much more likelihood of a wide-ranging investigation. Even when the state conducts its most far-reaching fatality reviews aimed at finding out how the deaths could have been prevented, Meinig said, the implementation of the lessons can be uncertain."

- ✓ "The Family & Children's Ombudsman work gives officials and the public an independent look at how well children are being treated. Among the office's valuable suggestions this year are calls for looking at other states' innovations in assuring caseloads are reasonable, recruitment of more foster parents and giving foster parents and relatives voice in court decisions about children."

"Our View: Road to Reform, Report shows Children's Administration Progress." –*Editorial, Spokesman Review, June 5, 2006*

- ✓ "A watchdog agency released a report last week on how well the state of Washington is protecting children under its auspices. The report from the Office of the Family and Children's Ombudsman is replete with depressing details about the neglect and abuse suffered by children, and it contains pointed criticism for the state agency that is ultimately responsible."

"State faces foster home pinch." –*Benjamin Shors, Spokesman Review, July 25, 2006*

- ✓ "The number of licensed foster homes in Washington has gradually declined in the past three years, dipping to the lowest numbers since 1998. The decline has created a critical shortage of homes for the 9,600 children who are in out-of-home placement on any given day, a state ombudsman said this spring. 'They need better training for foster parents in terms of what to expect,' Meinig said. 'We're asking them to bond and attach to and love this child. We need to figure out better ways to keep them and keep them happy.'"

APPENDIX C–DATA ON NATIVE AMERICAN PLACEMENTS

ORGANIZATIONAL WELL BEING
SUPPORTING CLIENT OUTCOMES

FH TYPE	(All)
RACE OF FOSTER PARENT	Nat Amer
ACTIVE HOMES	(All)
HISPANIC	(All)
ETHNIC	(All)
COUNTY	(All)

Counts of active foster homes (currently open licenses based on business ID). Home counted as Native American if any foster parent indicates Native American race.*

	REGION						
REPORT PERIOD	1	2	3	4	5	6	Grand Total
FY 2003	67	56	42	43	61	67	336
FY 2004	62	52	42	42	62	69	329
FY 2005	69	50	42	40	60	58	319
FY 2006	63	51	38	33	72	63	320
FY 2007	67	44	35	28	73	60	307

Added to total counts in Reg 5:
FY05 - Added 3 Port Gamble to total counts
FY06 - Added 12 Port Gamble to total counts
FY07 - Added 12 Port Gamble to total counts

**Data provided to OFCO by Nancy Dufraine, Children's Administration, ICW Program Manager. Original document modified to delete decorative logos.*

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
CHILDREN'S ADMINISTRATION

Number of Children with any race Native American receiving a Rehabilitative Treatment Service (BRS) payment (any 3400 series SSPS service code) during FY
Unique count by State
Data Source: Payment & Placement.mdb_0907

	REGION						Statewide
YEAR	1	2	3	4	5	6	Total
FY2003	33	15	62	60	67	19	**256**
FY2004	24	13	55	68	64	18	**241**
FY2005	23	19	40	86	71	12	**251**
FY2006	23	23	41	87	40	16	**230**
FY2007	24	23	47	94	53	18	**257**

Rehabilitative treatment includes payment for services to children with special needs, including emotionally/behaviorally disordered, sexually agressive, developmentally disabled, or medically fragile children. DCFS contractors provide rehabilitative treatment services that include enhanced in-home services, therapeutic foster care, and group care.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
CHILDREN'S ADMINISTRATION

Total Number of Children with any race Native American in an Open Placement Event as of 8/31/07.
Data Source: Placement & Placement Events.mdb_0907

		Region						Statewide
Placement	Custody	1	2	3	4	5	6	Total
CRC	State				3			3
	Tribal*				3		2	5
	Tribal IV-E			1				1
CRC Total				1	6		2	9
Detention	State	1	2	1	3	2	3	12
	Tribal*	2			1			3
	Tribal IV-E			1			2	3
Detention Total		3	2	2	4	2	5	18
Group Home	State	5	7	17	25		2	56
	Tribal*	2		3	2	1	2	10
	Tribal IV-E			4			1	5
Group Home Total		7	7	24	27	1	5	71
Non-Relative	Combine Tribal/Private Agency					3	1	4
	Combine Tribal/State	4		1	2		1	8
	Other State					2		2
	Private Agency		1		3			4
	State	179	192	177	230	142	212	1132
	Tribal*	75	69	68	40	63	70	385
	Tribal IV-E			60		17	33	110
Non-Relative Total		258	262	306	275	227	317	1645
Relative	Combine Tribal/Private Agency						1	1
	Combine Tribal/State		10					10
	Other State	2				4		6
	State	146	124	157	167	148	93	835
	Tribal*	54	13	34	9	22	21	153
	Tribal IV-E			48		26	37	111
Relative Total		202	147	239	176	200	152	1116
Grand Total		470	418	572	488	430	481	2859

*Tribal custody includes children in episodes closed as Transfer of Authority with open placement events for payment only through camis. They do not necessarily reflect Tribal open cases receiving TANF family of one.