recommendations.

State Law Issues

Recommendation

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

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

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

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

1. *Office of the Family and Children's Ombudsman 1999 Annual Report:* **www.governor.wa.gov/ofco**.

2. Chronic child neglect refers the ongoing and serious deprivation of a child's basic physical needs, including abandonment, inadequate nutrition or a lack of supervision.

3. Earlier this year, in a study funded by the National Institute of Justice, the Children's Administration Office of Research (OCAR) found that children neglected early in life, are as likely as abused children to be arrested later. English, D., & Widom, C., Brandford, C., *Preliminary Findings on Childhood Victimization and Delinquency, Adult Criminality and Violent Behavior*. Moreover, a recent study conducted in 11 California counties found that children who were referred to CPS for neglect were more likely to be incarcerated than children referred for physical or sexual abuse. Jonson-Reid, M. & Barth, R.P. (2000), From Maltreatment Report to Juvenile Incarceration: The Role of Child Welfare Services. *Child Abuse and Neglect*, 24, 505-520.

4. Trauma, Violence and Abuse, Vol. 1, No. 1, January 2000, at p. 103.

5. See, for example, Esposito, S. "19 calls about boy, siblings: DSHS received repeated complaints about mother of 7 year-old who drowned unsupervised," *Tacoma News Tribune*, September 6, 2000.

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

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

6. RCW 26.44.020(15).
7. National Clearinghouse on Child Abuse and Neglect Information, *Child Abuse and Neglect State Statutes Elements* (December 31, 1999): **www.calib.com/nccanch**.

Recommendation

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

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

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

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

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

State Law Issues
(continued)

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

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

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

12. Alaska State Statute, 47.17.020, 022; California Penal Code, Section 11166; 32 Illinois Compiled Statutes 514; Iowa State Statute, 232.69(3); Oregon Revised Statutes 418.749.

13. Additional information may be obtained by contacting the Children's Justice Interdisciplinary Task Force at: (360) 902-7996.

Recommendation

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

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

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

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

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

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

System Resource Issues

Recommendation

1 Ensure that caseworkers have a reasonable workload.

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

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

Recommendation

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

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

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

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

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

Recommendation

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

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

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

Recommendation

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

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

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

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

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

Recommendation

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

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

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

17. RCW 43.06A.030(4).

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

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

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

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

DSHS Administration

Recommendation

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

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

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

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

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

Recommendation

2 Clarify and strengthen the role of supervisors.

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

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

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

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

Foster care.

What young people in the system say is working.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Ombudsman appreciative interviews.

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

The Ombudsman identified several topics of study.

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

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

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

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

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

The Interview Questions

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

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

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

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

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

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

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

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

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

First theme: feeling normal.

What matters most? Feeling like part of a family.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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