



**COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER**

CHILDREN'S GROUP HOME OMBUDSMAN
500 WEST TEMPLE STREET, ROOM 515
LOS ANGELES, CALIFORNIA 90012-2706
PHONE: (213) 974-4225 FAX: (213) 346-9020

J. TYLER McCAULEY
AUDITOR-CONTROLLER

February 2, 2004

TO: J. Tyler McCauley
Auditor-Controller

FROM: Carla Carr Signed by
Carla Carr
Children's Group Home Ombudsman

SUBJECT: **CHILDREN'S GROUP HOME OMBUDSMAN'S HOTLINE STATUS
ANNUAL REPORT**

Children's Group Home Ombudsman

The Office of the Children's Group Home Ombudsman (CGHO) provides a confidential and informal process to resolve concerns that arise for residents of group homes when other avenues of problem solving have not been effective. The Ombudsman works with children who need help in resolving issues in the child protection, probation and mental health systems.

The goal of the CGHO is to handle children's requests for Ombudsman assistance in a timely manner and to regularly monitor contract group homes to ensure they comply with State regulations and the County contract, in providing residents with a safe environment and nurturing care. The CGHO serves all Los Angeles County group home residents. The program contributes to the following outcomes: Good Health, Safety and Survival, Social and Emotional Well-being, Economic Well-being, and Education/ Workforce Readiness.

The Ombudsman conducts independent case-by-case investigations and assessments of complaints received regarding services to children placed in group homes. To resolve concerns, the CGHO may need to contact appropriate County and/or non-County staff to ensure that children are safe, needed services are delivered and children's rights are protected. The Ombudsman also negotiates and mediates with County staff, service providers, community groups and others to work together for the benefit of the child. To provide residents with the most effective outcome, the Ombudsman works collaboratively with the State Ombudsman and Licensing Analysts, County Probation Ombudsman, and Department of Children and Family Services Ombudsman and Group Home Support Unit.

"To Enrich Lives Through Effective and Caring Service"

The CGHO has identified several key performance measures to assess how effective the program is, and tracks the number of calls received and resolved from group home residents. This information is maintained on a customized database.

Based on an analysis of the data collected, the CGHO is successfully meeting the goal of advocating, problem-solving, and responding to group home residents, and exceeds the County expectations in terms of monitoring contract group homes and ensuring group home residents are in a safe and nurturing environment.

The Ombudsman Hotline generated a total of **1009 calls** during the reporting period beginning January 1, 2003 and ending December 31 2003, averaging 63.06 calls per month. Of the total number of calls, 44% were initial calls and 56% were follow-up calls.

Of the initial calls:

- 46% were requests for information only;
- 54% were opened for investigation.

Complaints/problems reported were classified as follows (*See Figure 1*):

- A. 20% Lack of respect shown by group home staff
- B. 19% Lack of contact with family/friends
- C. 11% Living conditions in group home
- D. 10% Threats, intimidation made by other residents
- E. 10% Social contact
- F. 9% Lack of medical treatment by group home
- G. 9% Food unsatisfactory
- H. 6% Emancipation issues (potential homelessness, etc.)
 - Work and job skills
 - Relationship
- I. 1% Substance abuse
- J. 5% Miscellaneous

Of the total number of calls received, three were referred to the Child Abuse Hotline for immediate action.

Of the total new calls received (*See Figure 2*):

- 74% were placed by females
- 26% by males

29% of the calls were placed in the morning; 71% in the afternoon/evening.

Of those callers who gave their ages, the eldest was 21; the youngest, 13. The average age was 16.

Examples of Calls and Resolutions

We received a call from a group home resident, in addition to an anonymous call from one of the group home's employees, to report concerns regarding personal items being stolen from the group home, insufficient supervision, transportation, lack of response from the group home administrator when contacted regarding care and medical attention for the residents, and the number of residents actually residing at the group home. We contacted DCFS Group Home Support, and the Community Care Licensing analyst. An investigation was initiated, and there was a meeting with the group home administration to address these concerns. Upon completion of the investigation, a corrective action plan was developed. To ensure that the group home is providing its residents with an on-going safe and nurturing environment, this facility will be regularly monitored.

A group home resident called to report that because she was on "cottage restriction," she was being prevented from having contact with her siblings who reside within the same group home, but in different "cottages." We contacted the group home supervisor, who explained that this resident was having on-going difficulty in her current living situation, which caused her to frequently be "on restriction." In order to give the resident a "fresh start," it was decided that this resident should be moved to a different cottage. The move was scheduled to take place by the end of the week, and the supervisor would ensure that the resident had regular contact with her siblings. This was discussed with the resident, who was in agreement with this plan. It was confirmed that the resident was moved, and was having daily contact with her siblings.

A former group home youth called to report that he was currently homeless and residing in a shelter in the New York area. This youth emancipated approximately one year ago and left Los Angeles to live with his grandmother and aunt in order to attend an automotive school in New York. Sometime thereafter his grandmother and aunt informed him that he could no longer reside with them as space was limited. His grandmother and aunt then moved, and left him without any provisions or contact information. He is currently working on the weekends in order to save money, and would like to return to the Los Angeles area where he has some connections with his former group home. We obtained information from the Emancipation Ombudsman, and connected this youth with his former Independent Living Planning Coordinator. Arrangements are being made for his return to Los Angeles within the next month, including assistance in obtaining housing.

A resident called to report that she had been in a fight with another resident, and was in need of medical attention, as she had a headache and was feeling dizzy. We contacted the after hours group home shift coordinator and made arrangements for this child to be taken to emergency. In addition, we made a site visit to this facility in order to interview the child, and further discuss the details of this incident and subsequent follow-up with the group home administration and staff. The outcome of the visit was positive: the child had received documented medical care and was doing well; and the group home had completed their own investigation, and was in the process of

implementing changes with the nursing staff. The group home administration was also developing a more effective protocol for resident concerns.

The mother of two group home residents called to report that her children had recently been replaced into a foster home. During the transition from the group home to the foster home, some of the children's belongings were lost. We contacted the DCFS social worker to assist in replacing the children's lost items. In addition, each child was issued a new clothing allowance to ensure the purchase of necessary incidentals. Both children currently have sufficient amounts of clothing and items of necessity. There have been no further concerns reported by this parent.

We received an anonymous call from a group home employee, in addition to a number of calls from group home residents, to report concerns regarding facility problems, discipline, staff relations, care and supervision issues, and the lack of clinical services provided to the residents. We contacted the State and Probation Ombudsman offices, and the Community Care Licensing analyst. An investigation was initiated, and several meetings, including a meeting with the group home administration are being scheduled in order to address these concerns. Upon completion of the investigation, we will assist in preparing a corrective action plan to address all concerns, and to ensure that the group home is providing its residents with a safe and nurturing environment.

Observations

While many group homes have been the subject of complaints by group home residents, no particular group home in the reporting period has had a statistically significant number of complaints. However, we noted that some group homes utilize the Ombudsman service more than others.

There was a significant increase in the number of calls handled by the Ombudsman Hotline during this reporting period. It appears this increase is the result of the extended hours of the Hotline, increased group home visits, and endorsement by group home staff and other residents.

Coordination with Other Agencies

We made a concerted effort were made during this reporting period to develop and maintain linkages with DCFS and Probation staff responsible for inspection of group homes. These sections were able to make immediate visits to group homes to assist in the Ombudsman function.

We further developed relationships with the State, Probation, DCFS and out-of-County Ombudsmen in a continued effort to coordinate the resolution of group home residents' concerns. This has resulted in many cross-reported issues, which prove to highlight problems statewide. The data may serve the children of California as a whole well, perhaps leading to changes in legislation to improve the quality of life for children in care.

A new chart has been added to this report, one which represents the number of calls by year over the last four years. As mentioned previously, there was a marked increase in calls this year mainly due to an expansion of the hours available to group home residents, as well as an increase in group home visits.

Initiatives to Improve for the Office of the Children's Group Home Ombudsman in 2004

To continue to build on the success of the program, the CGHO has identified the following initiatives to improve advocating for residents of group homes:

1. Increased publicity with the publication and distribution of a new CGHO brochure;
2. Two mailings of brochures, posters, and Ombudsman business cards to include all Los Angeles County group home sites and residents;
3. Increased group home visits from the Ombudsman, announced and unannounced;
4. Continued extended hotline hours to coincide with residents' availability;
5. All complaints/concerns which are substantiated and which involve group home procedure, protocol, or management will continue to be communicated directly to the group home director/administrator, community Care Licensing, and placing agencies; and
6. Because 46% of the calls received on the hotline are information calls, we plan to recruit an Ombudsman Intake Worker to provide general referral and other assistance or otherwise provide for these duties. This would allow the Ombudsman greater opportunity to focus on the goal of addressing children's requests for ombudsman assistance.

The CGHO believes that this successful program plays a key role in ensuring the personal rights of group residents are respected, and ensuring group homes maintain an acceptable level of care for residents.

CC:cc

Attachments

- c: **Board of Supervisors**
Martha Molina-Aviles, Senior Deputy, First Supervisorial District
Miriam Simmons, Senior Deputy, Second Supervisorial District
Wendy Aron, Deputy, Third Supervisorial District
Linda Tarnoff, Deputy, Fourth Supervisorial District
Raine Ritchey, Deputy, Fifth Supervisorial District
Department of Children and Family Services
David Sanders, Ph.D., Director
Probation Department
Richard Shumsky, Chief Probation Officer
Suzy Moraes, Supervising Deputy Probation Officer
Department of Mental Health
Paul L. McIver, L.C.S.W./Program Head
Others

"To Enrich Lives Through Effective and Caring Service"

Commission for Children and Families

Complaints/Problems Report

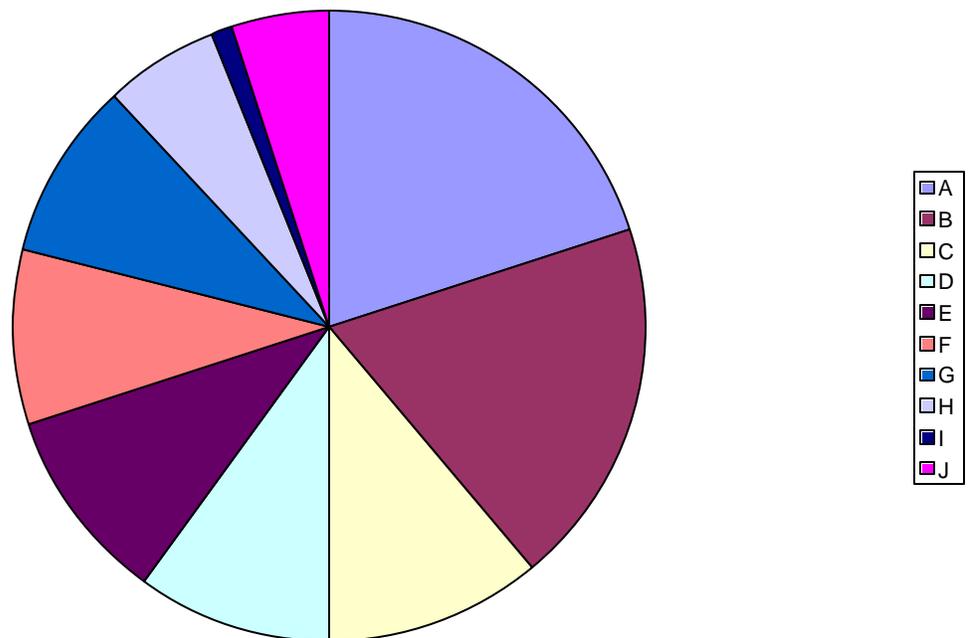


Figure 1

Gender

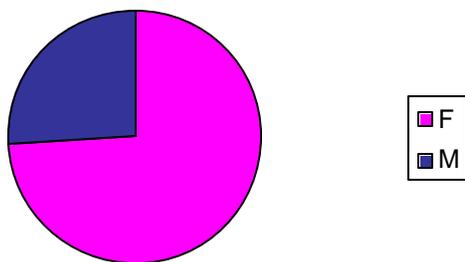


Figure 2

Time of Calls

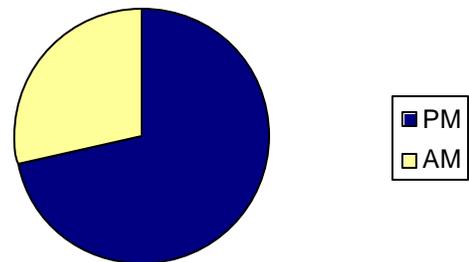


Figure 3

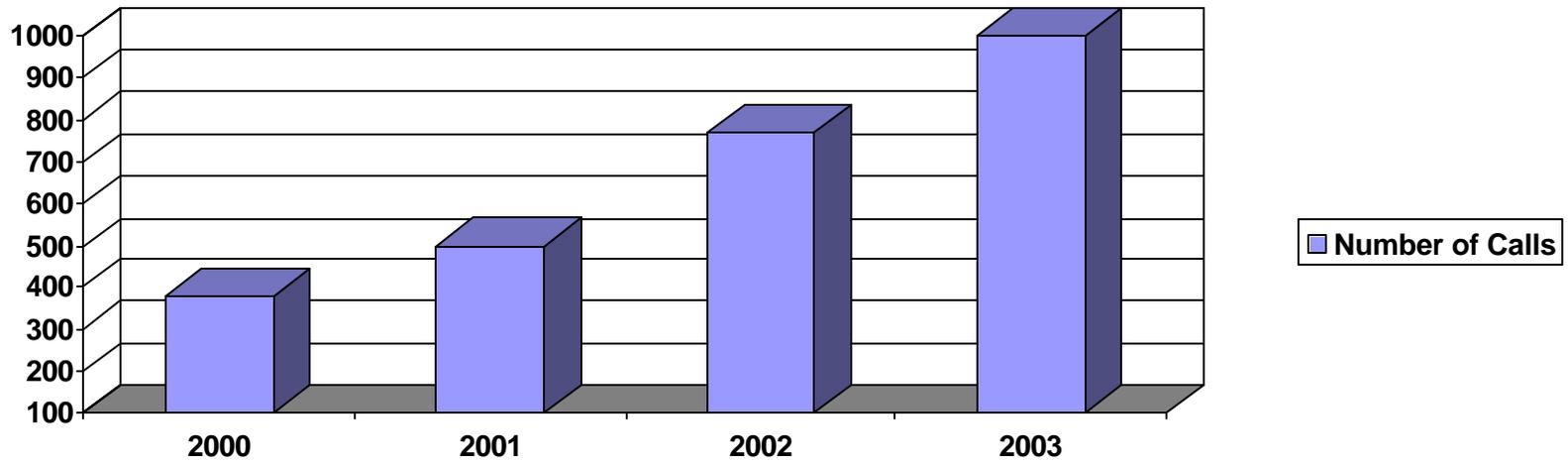


Figure 4