

**A Review of the Oklahoma Department of Human Services'
Child Welfare Practices from a Management Perspective**

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EXECUTIVE SUMMARY

The federal class action *D.G. v. Henry* charges Oklahoma's child welfare system, administered by the Oklahoma Department of Human Services (DHS), with numerous systemic failings that subject children to ongoing harm and risk of harm and violate their constitutional rights to be provided basic safety, protection, and care. I was asked by the Plaintiffs in this case to undertake an independent review of the management and administration of Oklahoma's child welfare system, to determine if DHS is meeting its mandate of protecting the children in its care.¹

I have over 40 years of professional experience working with and advocating on behalf of children and families. For the past 15 years, I have served as a chief executive officer for public child welfare. For eight years I was Secretary of the Cabinet for Families and Children in Kentucky. This agency has a service array almost identical to DHS. There were approximately 7,500 children in custody and the agency's budget was slightly less than \$1 billion. For the past seven years I was Commissioner of the Department for Children's Services in Tennessee, which serves approximately 5,500 foster children and has a budget of approximately \$650 million. In both positions, I led major reforms in organization, administration, quality assurance, and direct service delivery, taking both child welfare agencies to national accreditation by the Council on Accreditation.

This report provides expert opinion from a management perspective on the capability of Oklahoma's child welfare system to ensure that children are safe, are achieving stability and permanency in their lives, and are receiving necessary services. It is based on an extensive assessment of DHS's business records and federal child welfare performance data, as well as the testimony of key DHS officials, the February 17, 2011 Foster Care Case Review of the Oklahoma Department of Human Services by Dr. Jerry Milner (Dr. Milner's Case Record Review), and Plaintiffs' other expert reports that have been completed for this lawsuit. In forming my conclusions, these records were compared with nationally recognized standards of reasonable child welfare management practice and DHS's own policies and regulations.

I have concluded, based on my professional experience and expertise in child welfare management, that DHS management is failing to exercise professional judgment in its operation and administration of Oklahoma's foster care system. The key DHS management failures include:

- **A FRACTURED AND DISJOINTED ORGANIZATIONAL STRUCTURE:** DHS is plagued by a fragmented and disjointed organizational structure for child welfare that cannot enforce high-quality casework. Practice and policy are disconnected. Child welfare policy and service delivery are separated into independent divisions, and extensive communication failures exist both within and between the two divisions. As a result, field workers cannot effectively serve the children in their care. These problems, coupled with high turnover and recent reorganization of the child welfare policy division, create confusion and inconsistency across the agency.

¹ A copy of my retainer letter is attached to this report as Appendix A.

- **PERVASIVE LACK OF ACCOUNTABILITY AND INADEQUATE QUALITY ASSURANCE SYSTEM:** The lack of leadership and accountability that pervade DHS's child welfare programs prevent the agency from improving outcomes for children and families. There is no clear vision of the agency's child welfare priorities and not enough focus on high-quality casework. Moreover, DHS's internal quality assurance system is inadequate and is not effectively being used to improve practice. Although mock Child and Family Service Reviews are conducted annually in each county, these reviews are cursory, overemphasize strengths, and rarely uncover the improvements that are needed. Even when deficiencies are revealed, there is no mechanism to ensure that they are addressed.
- **INADEQUATE DATA INTEGRITY AND MANAGEMENT:** Although DHS generates a large number of child welfare reports, there is a high risk that many – if not all – of these reports contain unreliable information because the agency lacks important controls to ensure data accuracy. While DHS has itself admitted that there are serious problems with the accuracy of many of its child welfare reports, it has taken only the most limited steps to address this issue, and problematic reports are still actively being used by DHS management. In addition, there is a lack of understanding within DHS of the value of measuring outcomes and using those measures to drive practice improvement.
- **WORKFORCE MISMANAGEMENT:** The child welfare workforce is mismanaged and inadequately trained and supervised. Professional development is not tracked or used as a tool to continually strengthen practice, and the agency has no viable system in place to manage caseloads. Workers are not supported in, or held accountable for, their work. As a result, the turnover rate is extremely high, resulting in fragmented and unstable casework. In addition, DHS's fractured case assignment system is ineffective and caseworkers do not have access to the resources and information they need to properly serve children.
- **A DYSFUNCTIONAL PLACEMENT SYSTEM:** Every public child welfare system's first responsibility is to do no harm. DHS's overreliance on emergency shelters and short term placements is harmful to the children they serve. Children need stability in their lives, yet the agency's placement system as it currently exists actually drives instability. When a child is brought into care, caseworkers have no access to comprehensive information on available placement resources. Instead, information is fragmented and difficult to access. As a result, the workers take what they can get with little opportunity for thoughtful placement decision-making based on the needs of their children and families.
- **NO MEANINGFUL PROCESS TO HOLD PRIVATE PLACEMENT PROVIDERS ACCOUNTABLE:** Although many of the state's custody children are placed with private provider agencies, there is no meaningful process in place to hold these private providers accountable. Instead of applying performance-based measures, DHS's monitoring of private providers consists of a fractured, uncoordinated system that does not allow adequate oversight. Most troubling of all is the lack of a defensible process to effectively track and monitor the safety, permanency, and well-being of children placed in the care of private provider agencies.

These serious, agency-wide deficiencies are resulting in severe and ongoing harm and risk of harm to the children who rely on DHS for their basic safety and care, including:

- shockingly high rates of maltreatment while in care and inadequate and untimely investigations of abuse and/or neglect referrals;
- extreme placement instability;
- unsafe and inappropriate placements, including the overuse of shelter and emergency placements, even for very young children;
- unacceptably long stays in custody without any movement towards achieving permanency;
- the denial of access to essential services to ensure their well-being;
- poor efforts by DHS to maintain relationships with biological families, even when reunification is the goal; and
- inconsistent visitation by assigned caseworkers and poor-quality casework.

Until systemic reform of DHS is accomplished, children will remain in danger on a daily basis. In my opinion, an adequate foster care system in Oklahoma can only be achieved if, *at a minimum*, the agency:

- reconfigures its organizational structure with accountability at all levels;
- establishes a functional and integrated quality assurance system;
- vastly improves its data collection and management systems including, in particular, its collection and use of data on children who are maltreated in custody;
- develops a stable, well-trained, and well-supervised workforce with adequately monitored workloads and a focus on high-quality casework;
- changes its placement practices with an emphasis on safety, permanency, and well-being outcomes for children and families; and
- reallocates available resources to eliminate the routine use of shelters and other emergency placements, and develops a supported network of foster homes.

A comprehensive reform of the Oklahoma child welfare system is crucial if DHS is to keep children safe and meet the needs of vulnerable families and children.

INTRODUCTION

This report provides an in-depth assessment of the administration of Oklahoma's child welfare system and the ability of DHS to meet reasonable child welfare practice standards for the protection of the children for whom it is responsible. The analysis is done from a management perspective with a focus on the critical components of an adequate child welfare system.

Based on a review of the extensive documentation concerning DHS's operations that has been made available in the *D.G. v. Henry* federal class action, and a comparison with nationally recognized standards of child welfare practice, as well as DHS's own policies and regulations, this report concludes that DHS is failing at the most basic levels to administer an adequate and functioning child welfare system. Tragically, the result of this vast mismanagement means that the approximately 8,500 foster children currently in DHS custody are harmed or placed at serious risk of harm on a daily basis as DHS fails to meet their safety, permanency, and well-being needs.

Based on my professional experience, a functioning child welfare agency must meet at least six criteria:

- The agency must have leadership that embraces change and understands the power of engagement and teaming.
- The agency must have an organizational structure that can maximize resources and support efficient, effective service delivery.
- The agency must have a robust performance quality assurance system that is data-informed and includes a casework quality services review.
- The agency must have a data reporting, analysis, and utilization system that has integrity.
- The agency must have an adequately trained and supported workforce that is rewarded for quality service delivery and held accountable for good outcomes for children and families.
- The agency must have a network of alternative placement resources and services.

DHS fails to meet *any* of these criteria. The critical, systemic deficiencies in DHS management that I have identified in this report include the following:

- ***A fractured and disjointed organizational structure***
- ***Pervasive lack of accountability and inadequate quality assurance system***
- ***Inadequate data integrity and management***
- ***Workforce mismanagement***
- ***A dysfunctional placement system***
- ***No meaningful process to hold private placement providers accountable***

As a result of these serious, agency-wide failures in the operation of Oklahoma's child welfare system, children are routinely harmed and placed at risk of harm. Until systemic reform of DHS is accomplished, Oklahoma will continue to fail the very children it is responsible for protecting.

A. Qualifications

Essentially all of my 40+ years of professional experience has involved working with and advocating on behalf of children and families. Much of my early career was focused on special needs children, particularly the severely disabled. My research work included early childhood development with an emphasis in communicative and language development in young children, skills directly linked to early attachment and bonding. My doctoral work was in special education with a minor in early childhood development. Both my undergraduate and master's degrees were in Speech Language Pathology.

For the past 15 years, I have served as a chief executive officer for public child welfare. For eight years I was Secretary of the Cabinet for Families and Children in Kentucky. This agency has a service array almost identical to DHS. There were approximately 7,500 children in custody and the agency's budget was slightly less than \$1 billion. For the past seven years I was Commissioner of the Department for Children's Services in Tennessee, which serves approximately 5,500 foster children and has a budget of approximately \$650 million. In both positions, I led major reforms in organization, administration, quality assurance, and direct service delivery, taking both child welfare agencies to national accreditation by the Council on Accreditation. I have served on the executive committee of both the American Public Human Services Association and the National Association of Public Child Welfare Administrators. I have held numerous administrative positions over the years and done extensive work in organizational change management and leadership.

On account of my educational and professional background, I have extensive experience in the areas of children's services, social services agency management, quality assurance, and minimum practice standards. A current copy of my *curriculum vitae* is attached as Appendix B.

B. Methodology

I reviewed multiple sources to assess the overall organization and operation of DHS, including:

- DHS policy and regulations;
- DHS organizational charts;
- DHS training materials;
- DHS state and federal child welfare performance outcome data;
- DHS reports and audits;
- DHS budget documents;

- Deposition testimony of key DHS personnel provided in the *D.G. v. Henry* case;
- Plaintiffs’ other expert reports completed for the purposes of this case, including Dr. Milner’s Case Record Review; Mr. John Goad’s Review of the Response by DHS to the Suspected Child Abuse and Neglect of Children in its Care (Mr. Goad’s Review), and Dr. Zoran Obradovic’s Report on the KIDS System Review and Analysis (Dr. Obradovic’s Report).

A full list of the documents reviewed for the purposes of preparing this report is attached as Appendix C. The information provided in these documents was analyzed in the context of nationally accepted standards for child welfare practice; applicable federal and state laws, policies, and guidelines; and my professional experience and expertise.

C. Historical Background

Oklahoma has long been aware of the serious, ongoing deficiencies in the administration of its child welfare agency. Over the past ten years, a number of federal, state and third-party reports – as well as tragic and avoidable child deaths – have repeatedly highlighted serious failings in the system designed to protect and care for abused and neglected children, including:

- In June of 2001, the Governor’s Task Force on Children in Custody presented its Annual Report to the Governor and the Director of DHS, which focused on the lack of support given by DHS to foster parents throughout the state. The report found that children in DHS custody were frequently placed in homes without foster parents receiving adequate information about their needs, medical history, or family history; that DHS was performing only cursory face-to-face visits with children in custody; and that DHS caseworkers were not equipped to answer foster parents’ most basic questions about the status of their child’s case.²
- In the July 2002 federal CFSR for Oklahoma, conducted by the U.S. Department of Health and Human Services’ Administration for Children and Families, Oklahoma failed to meet five out of the six national standards reviewed – often by a wide margin. In addition, Oklahoma failed to meet any of the seven performance outcome measures used to evaluate the agency’s ability to meet the safety, permanency, and well-being needs of children in its custody. Noteworthy concerns included the fact that Oklahoma was “[n]ot investigating reports of child maltreatment in a timely manner,” “[n]ot preventing repeat maltreatment of children,” and “[n]ot making sufficient efforts to reduce the risk of harm to children.” Furthermore, DHS was “[n]ot providing stable placements,” “establishing appropriate permanency goals,” or preserving children’s connections to their family and community. The review also noted that DHS was not meeting the educational, physical, dental, and mental health needs of children, and services were not accessible to all children and families and were not individualized to serve unique needs.³
- In May 2007, Oklahoma published its own CFSR “Statewide Assessment,” which documented DHS’s continuing failure to protect children. For example, the reported

² Governor’s Task Force on Children in Custody, Annual Report, June 2001, at 1-5.

³ Dep. Ex. 174 (CFSR Key Findings Report, Oklahoma, 2002) at 3-4, 6.

frequency with which children were abused or neglected while in custody was nearly *four times* the federal benchmark and one of the worst rates in the nation.⁴ The Statewide Assessment repeatedly tied DHS's failures to worker turnover, inexperienced staff, excessive caseloads, and an insufficient number of foster homes.⁵

- On August 11, 2007, five-year-old DeClan Stewart was found unconscious in a white plastic laundry hamper with bruises on his body and a laceration to the back of his head. He died from a skull fracture the next day. At the time of his death, DeClan was in DHS custody, having begun a trial reunification with his mother and her boyfriend Marcus Clancy just two months prior. DeClan had previously been removed from the home and placed in custody in response to seven abuse and neglect referrals in 2005 and 2006, which indicated that DeClan had suffered from a skull fracture, sexual abuse, failure to obtain medical attention, and inadequate nutrition while living with his mother and Clancy, and that he had visited the emergency room on at least four occasions in 2005. Clancy was charged with first degree murder in connection with DeClan's death.⁶
- In March 2008, Oklahoma's second federal CFSR was published. This time, Oklahoma failed to meet *all six* national standards reviewed, and again failed with respect to each of the seven safety, permanency, and well-being outcomes.⁷ In fact, on five of the seven outcomes, Oklahoma's score was lower than it had been in the 2002 CFSR.⁸ The federal government again found that DHS needed improvement in initiating investigations of reports of child maltreatment, preventing repeat maltreatment, performing risk assessment and safety management, and providing services to children and families.⁹ It also identified as areas of concern DHS's inadequate performance in providing stability in children's living situations, achieving adoption in a timely manner, placing siblings together, and ensuring that children were receiving regular visitation with their families.¹⁰
- On January 20, 2009, Naomi Whitecrow, a two-year-old child in DHS custody, died of "blunt-force injury to the head, abdomen, and extremities" while placed in the foster home of Amy Holder. Following this incident, in March 2009 DHS received a second report on the household concerning Holder's biological children, who were present at the time of Naomi's death, but had not been brought into custody. DHS accepted the report as a Priority II Investigation, and closed the investigation in June 2009 after making a finding of "Services Recommended."¹¹ Criminal charges have been brought against Amy Holder in connection with Naomi's death.¹²

⁴ Dep. Ex. 161 (OKDHS Child and Family Service Review Statewide Assessment, May 2007) at 9. Furthermore, as discussed in Section IV.A of this report, the maltreatment rate that Oklahoma reports to the federal government actually underrepresents the number of children who have been abused or neglected while in DHS custody.

⁵ Dep. Ex. 161 (OKDHS Child and Family Service Review Statewide Assessment, May 2007) at 3, 25-27, 29, 30-31, 35, 40-41, 43, 45, 47, 50-52, 60, 62, 78, 86, 88.

⁶ PLAINTIFFS 05158-67.

⁷ OKDHS-CFSR-Final Report 3.08-00003, 00009, 00016, 00033, 00047, 00058, 00062.

⁸ OKDHS-CFSR-2008-ExecSum.3.08-00005-12 ; Oklahoma CFSR Summary of Findings (2002) at 4-10.

⁹ OKDHS-CFSR-Final Report 3.08-00005, 00007, 00014, 00050.

¹⁰ OKDHS-CFSR-2008-ExecSum.3.08-00003, 00007, 00009.

¹¹ PLAINTIFFS 03514-18.

¹² *Ibid.*; Randy Ellis, "Lawsuit filed in 2009 Edmond foster child's death," *NewsOK*, (October 20, 2010).

- In February 2009, Hornby Zeller Associates, Inc. conducted a performance audit of the child welfare operations of DHS (HZA Audit) at the request of the Oklahoma legislature. It found numerous systemic deficiencies at DHS, including the failure to adequately protect children in care from abuse and neglect; significant problems monitoring the safety of children in its custody, such as employee confusion about how to conduct safety assessments, the absence of a single safety standard by which to evaluate children's circumstances, and inadequate caseworker visits with children; insufficient placement options and the inappropriate use of shelters; and placement instability. The report also discussed concerns that the organizational structure of DHS was not conducive to effective and efficient operations, highlighting the fact that child welfare program and policy directives are set by the Children and Family Services Division and disseminated by field liaisons that do not have line authority over the workers in the field. The report further noted communication failures at the agency from the bottom up, the failure to involve workers in decision-making, and the pervasive "de-professionalization" of the front-line staff.¹³

These reports reveal an agency that has been placing, and continues to place, children at risk of harm every day. Yet, despite numerous opportunities for reform, DHS leadership has failed to take necessary action to change the course of its deficient and dangerous system. Until it does so, children in Oklahoma will continue to be hurt, abused, and even killed while in the care of the very agency that is charged with keeping them safe.

¹³ Dep. Ex. 173 (HZA Audit).

I. DHS'S ORGANIZATIONAL STRUCTURE IS UNSTABLE AND DISJOINTED

It is vitally important for child welfare agencies to have strong, consistent leadership that is able to build an effective workforce, provide the necessary guidance to caseworkers and supervisors, and articulate a clear vision of child safety, permanency, and well-being. DHS is a highly complex organization and has many levels of communication failure. Furthermore, high turnover and restructuring at the highest levels of the agency have led to discontinuity and confusion.

A. Overview of the Organizational Structure of DHS

DHS first came into being in 1936 through an amendment to the State Constitution.¹⁴ The agency is under the ultimate control of the Oklahoma Commission for Human Services (the "Commission"), a nine-member body appointed by the Governor to staggered nine-year terms.¹⁵ The Commission selects a Director of Human Services and is responsible for approving policies, procedures, budgets and funding, and adopting rules and regulations.¹⁶ Howard Hendrick, a former state senator, is the current Director of Human Services. He has served as Director since 1998.¹⁷ Today, DHS has offices in all 77 counties in Oklahoma,¹⁸ a staff of nearly 7,500, and a budget of \$2.1 billion.¹⁹

Within DHS, primary responsibility for providing child welfare services is split between two divisions: the Children and Family Services Division (CFSD), which is responsible for policy development,²⁰ and the Field Operations Division (FOD), which manages direct services for child welfare and other program areas.²¹ In order to understand how CFSD and FOD fit within DHS as a whole, it is necessary to describe the agency in more detail.

DHS is a large agency with responsibility for a diverse set of programs in addition to child welfare. The non-child welfare programs under DHS's umbrella include family support services (including Temporary Assistance to Needy Families, Food Stamp and Medicaid eligibility, and adult protective services), aging services, substance abuse services, child support services, and developmental disabilities services.²² In addition to its program functions, DHS also has a number of centralized support functions, including budget, legal, and human resources.²³

DHS's structure is unusual because its program areas are organized into two units which are structured very differently. First, there are the Human Services Centers, which include both

¹⁴ Okla. Const. art. XXV; OAC 340:1-1-2.

¹⁵ OAC 340-1-1-3.

¹⁶ Ibid.; Oklahoma Commission for Human Services (www.okdhs.org/divisionsoffices/okcom/default.htm).

¹⁷ Cabinet Secretary for Human Services Howard Hendrick (<http://www.okdhs.org/divisionsoffices/exec>).

¹⁸ H-Hendrick-PP-2010-000638-39.

¹⁹ Cabinet Secretary for Human Services Howard Hendrick (<http://www.okdhs.org/divisionsoffices/exec>).

²⁰ OAC 340:1-1-6.

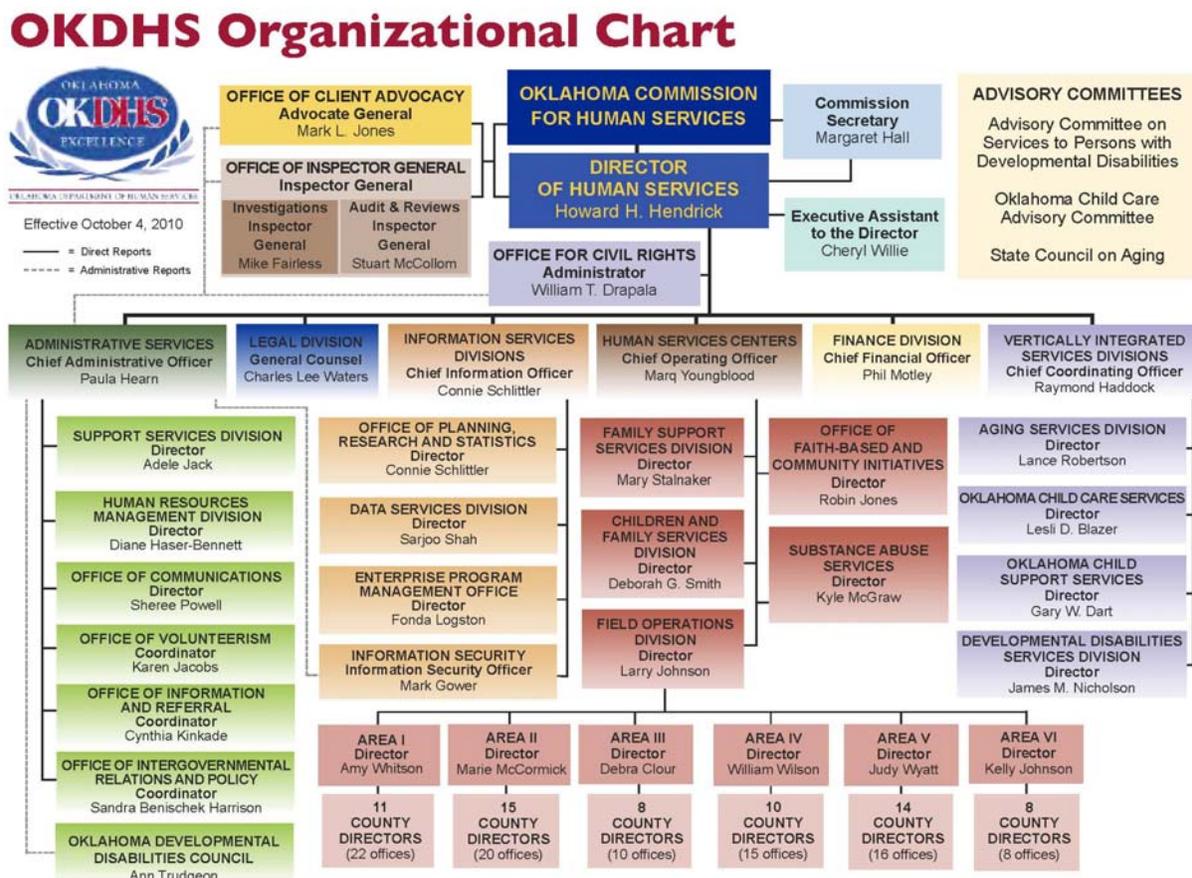
²¹ OAC 340:115-1-1-3. Other divisions within DHS have some responsibility for child welfare-related activities as well. For example, Oklahoma Child Care Services is responsible for licensing various facilities, including child placing agencies that place children in foster homes, adoptive homes, and other placements (Case Dep. 11/13/09 at 10, 18).

²² OAC 340:1-1-17; H_Hendrick-PP-2010-00782, 00863.

²³ OAC 340:1-1-17, OKDHS:2-11-1.1.

CFSD and FOD.²⁴ The other Human Services Centers are the Family Support Services Division, Faith-Based and Community Initiatives, and Substance Abuse Services. The directors of these divisions report to the Chief Operating Officer, Marq Youngblood, who reports directly to Director Hendrick. Second, there are Vertically Integrated Services, specifically the Aging Services Division, Developmental Disabilities Services Division, Oklahoma Child Care Services, and Oklahoma Child Support Services.²⁵ The Vertically Integrated Services Divisions report to a Chief Coordinating Officer.²⁶

The organizational chart below (the most recent one available) shows the overall organizational structure of DHS, with the Human Services Centers in red and the Vertically Integrated Services Divisions in light blue.²⁷



Turning to the first of the two primary child welfare divisions, CFSD, DHS policy sets out this division’s responsibilities as follows: (1) developing and modifying child welfare programs, policies, and procedures, based on state and federal law and best practices; (2)

²⁴ OAC 340:1-1-17.

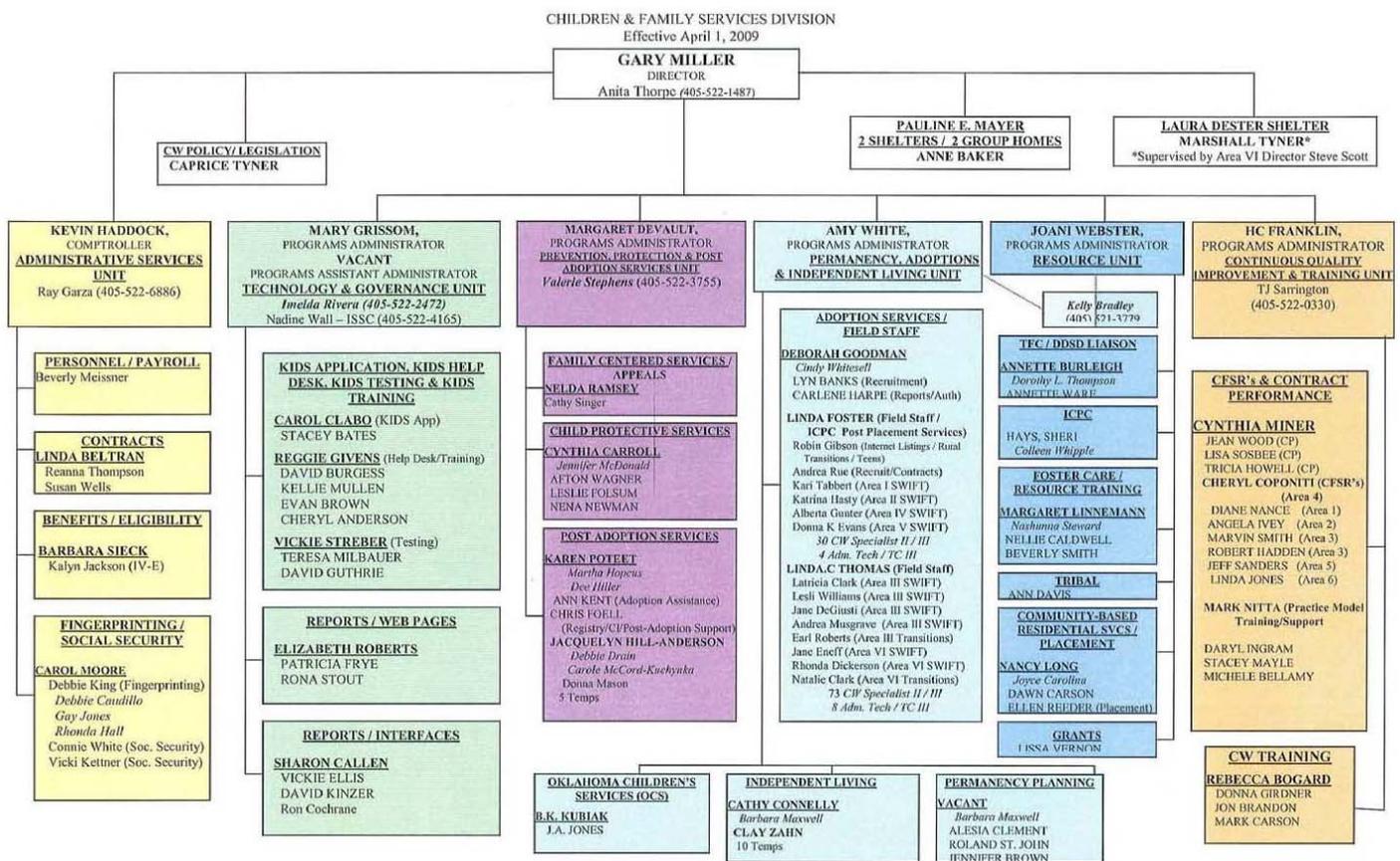
²⁵ Ibid.; OKDHS Organizational Chart.

²⁶ The primary difference between Human Services Centers and Vertically Integrated Services Divisions is the way in which field staff is supervised. With very few exceptions, FOD supervises the field staff in the Human Services Centers, while the central office program staff supervises the field staff in the Vertically Integrated Services (OAC 340:1-1-17; OAC 340:115-1-3; Dep. Ex. 173 (HZA Audit) at 100).

²⁷ OKDHS Organizational Chart.

assessing child welfare programs through continuous quality improvement; (3) providing training and technical assistance to child welfare staff; (4) providing consultation and policy interpretation to child welfare staff; and (5) maintaining the Statewide Automated Child Welfare Information System (SACWIS), known as KIDS.²⁸ Simply put, CFSD is responsible for “planning, program and policy development, training, and all other child welfare administrative and management functions at the state level.”²⁹ Somewhat oddly, CFSD is directly responsible for supervising adoption workers.³⁰ Aside from the area of adoption, CFSD has no line authority over the field staff responsible for providing child welfare services.

The organizational chart below (the most recent available) shows the structure of CFSD.³¹ The current CFSD Director is Deborah Smith. As of April 1, 2009, CFSD was made up of six units, each supervised by a Programs Administrator who reports to the CFSD Director: (i) the Administrative Services Unit; (ii) the Technology and Governance Unit; (iii) the Prevention, Protection, and Post-Adoption Services Unit; (iv) the Permanency, Adoptions, and Independent Living Unit; (v) the Resource Unit; and (vi) the Continuous Quality Improvement and Training Unit.³² As will be discussed below, CFSD has recently undergone significant reorganization and upheaval.



²⁸ OAC 340:75-1-6.

²⁹ CFSP-2010-2014-10.22.09-00003.

³⁰ White Dep. 8/6/09 at 65, 90, 105, 168-69; Johnson Dep. 6/17/09 at 63-64, 66; CFSP-2010-2014-10.22.09-00003.

³¹ WhiteA-007612 at 25.

³² Ibid.

The primary responsibility of FOD, the other main child welfare division within DHS, is to ensure service delivery for all of the program areas for which it is responsible, including the two largest – child welfare and family support services.³³ In order to provide these services, the state is divided into “county” offices (confusingly also called Human Services Centers), most of which cover a single county but some of which cover more than one county (primarily in rural areas) and some of which cover less than a county (in Oklahoma and Tulsa Counties). Each county is assigned to one of six administrative areas (known as Areas I-VI), which cover anywhere from eight to 22 county offices.³⁴ There is also a small central office, headed by FOD Director Larry Johnson, with administrative oversight over all of the area and county offices.³⁵

The chain of authority for a child welfare caseworker begins with a child welfare supervisor, who reports to a county director or assistant county director, who in turn reports to an area director, who reports to the director of FOD, Mr. Johnson.³⁶ The front-line workers and supervisors for all of the other program areas in FOD also report to the county directors or assistant county directors and on up the chain. Mr. Johnson described the responsibility of area directors as primarily “overseeing administration,” whereas “the buck stops at the county director for all programs under field operations. . . . They’re responsible to ensure that all functions, whether they be program related or general operations within a county office are handled appropriately.”³⁷ This is consistent with the finding of the HZA Audit that “[a]rea offices are viewed largely as administrative in nature. . . . Virtually all program work occurs at the county level.”³⁸

The primary point of linkage between the program units at CFSD and FOD is through field liaisons. The field liaisons report to the area directors but “the intent is that they serve as the link between the central office program divisions [CFSD] and the line staff in the county offices.”³⁹ The field liaisons “are considered experts in the program to help staff with decisions” and are frequently approached for assistance with difficult cases and for help with training staff on policy.⁴⁰ The child welfare field liaisons have no line authority over the child welfare workers and supervisors, even though they often give input into their decisions.⁴¹

B. The Organizational Structure of DHS Creates a Disconnect Between Policy and Services

In my opinion, no specific structure is necessary to ensure efficient and satisfactory delivery of child welfare services to children in state custody. While the organizational structure of DHS is particularly complex, this, on its own, does not doom DHS to failure. However, when child welfare policy and service delivery are separated into two independent divisions – as they are at DHS with CFSD and FOD – this creates the potential for a serious disconnect between

³³ OAC 340:115-1-1, OAC 340:115-1-3; Field Operations Division: About Us (<http://www.okdhs.org/divisions/offices/hsc/fod/docs/aboutus.htm>); Johnson Dep. 6/17/09 at 29.

³⁴ OKDHS Organizational Chart.

³⁵ OAC 340:115-1-3; Dep. Ex. 173 (HZA Audit) at 101.

³⁶ WhiteA-007612 at 23; Poplin Dep. 10/10/08 at 24, 44-45; Johnson Dep. 6/17/09 at 17, 58.

³⁷ Johnson Dep. 6/17/09 at 47, 57-59; Johnson Dep. 2/15/11 at 21-22.

³⁸ Dep. Ex. 173 (HZA Audit) at 105.

³⁹ *Ibid.* at 102; OAC 340:115-1-3.

⁴⁰ Thompson Dep. 2/2/11 at 17-18; Clour Dep. 2/4/11 at 81-83.

⁴¹ Thompson Dep. 2/2/11 at 20-21, 39-40.

policy and practice. Extra effort must be taken to ensure that the policy-makers and those responsible for service delivery are communicating effectively and that those charged with service delivery are given enough authority to perform their role. Unfortunately, the level of communication both between CFSD and FOD, and within FOD, is woefully inadequate. Furthermore, FOD has been stripped of so many crucial responsibilities – including policy, budgeting, contracting, and adoptions – that it is unable to adequately serve the children in its care.

Unfortunately, the effectiveness of field liaisons, who are the primary points of connection between FOD and CFSD, is limited because they do not have line authority over child welfare workers and thus can only serve as consultants.⁴² When a field liaison makes a decision, or gives input to a child welfare worker, the county director or assistant county director must always act as an intermediary to ensure that input or decision is effectuated.⁴³ Therefore, field liaisons serve as an insufficient link between CFSD and FOD.

Another problem with the way DHS has organized its child welfare operations is that the field staff has been stripped of many important responsibilities, which are vital to their ability to deliver child welfare services to the children in DHS custody. These responsibilities have been handed over to CFSD, which is largely disconnected from FOD.

First and foremost, FOD has very limited involvement in decision-making about child welfare policy. This is problematic because child welfare workers and their supervisors are the individuals in the agency engaged directly with casework and direct service delivery and are likely to have valuable insight that should inform policy and practice decisions. Instead, policy decisions are made by CFSD, with some input from high-level administrative personnel at FOD and sign-off by the FOD director.⁴⁴ Front-line child welfare workers, their supervisors, and even county directors are not involved in developing child welfare policy.⁴⁵

A second example is the fact that FOD does not have control over the budget for child welfare services, with the singular exception of payroll costs.⁴⁶ As Area Director Debra Clour explained, CFSD controls “the purse strings” and decides what services within her area are funded.⁴⁷ Similarly, CFSD – not FOD – is responsible for the vast majority of contracts for child welfare-related services.⁴⁸ As with policy-making, county directors and the workers and supervisors who report to them are removed from the budgeting and contracting process. According to one county director, she does “not really” have any responsibility for her county’s budget and, with the exception of contingency funds, she does not monitor any money related to child welfare.⁴⁹ In my opinion, it is completely untenable for FOD to be responsible for service delivery but to lack control for budgeting and contracting for those services. It is precisely those

⁴² Johnson Dep. 6/17/09 at 66; Thompson Dep. 2/2/11 at 39-40; Clour Dep. 2/4/11 at 70-73.

⁴³ Thompson Dep. 2/2/11 at 20-21.

⁴⁴ Clour Dep. 2/4/11 at 80; Johnson Dep. 6/17/09 at 8-9.

⁴⁵ Thompson Dep. 2/2/11 at 75; OAC 340:75-1-6 (a)(1); Johnson Dep. 2/15/11 at 10, 18-20; Burleigh Dep. 2/3/11 at 29; Johnson Dep. 6/17/09 at 7-9; Poplin Dep. 10/10/08 at 40.

⁴⁶ Johnson Dep. 6/17/09 at 144-145.

⁴⁷ Clour Dep. 2/4/11 at 56.

⁴⁸ Ibid. at 55; Johnson Dep. 2/15/11 at 14-15.

⁴⁹ Thompson Dep. 2/2/11 at 73-76.

people who are most familiar with the needs of children in custody who should be given control over the purse strings.

One of the more disappointing aspects of this review has been the lack of trust DHS places in its front-line workers. One example of this is the reliance on field liaisons whenever there is a hard decision to make.⁵⁰ In addition, whenever there has been a need to enhance a service or expand some program, rather than expanding the workforce, training, and support, DHS seeks outside resources and places them under the direction of CFSD. Thus, for example, CFSD becomes involved in adoption work through the adoption transition unit and the adoption specialists either once parental rights have been terminated and children are legally free for adoption, or once a child has a case plan goal of adoption. Not only are these CFSD workers responsible for recruiting adoptive homes, but some of them also become the worker with primary responsibility for the children.⁵¹ Adoption work is not the type of work that is here today and gone tomorrow; it is one of the primary functions of child welfare, yet FOD's role is minimized.⁵² Another example is that the workers (contractors employed by the University of Oklahoma's National Resource Center for Youth Services) who assist with the provision of independent living services to eligible youth serve as "independent living consultants to the areas."⁵³ These workers are monitored by CFSD with no direct reporting to the FOD workers ultimately responsible for the children and families.⁵⁴

The lack of trust and decision-making authority placed in the field workers was described well in the HZA Audit:

There is a theme which emerges here as one examines OKDHS' operations. . . . [T]he agency tends to view field staff in both the Areas and the counties as responsible only for completing the most routine aspects of the work. Although their jobs necessarily involve . . . decisions which are quite significant . . . when a set of decisions is viewed by the administration as requiring extra care and attention, those decisions are taken out of the field. Staff in the field, including Area and County Directors, are not asked sufficiently often to address the issues the administration sees as most important.⁵⁵

The disconnect between CFSD and FOD is exacerbated by the fact that communication within FOD itself is very poor. Information fails to flow in both directions, from child welfare workers up to the FOD central office and from the FOD central office down to child welfare workers. Front-line workers receive information from a dizzying array of sources, including email, the DHS intranet, meetings, county directors, and field liaisons.⁵⁶ Recent focus groups revealed numerous complaints from front-line workers about the lack of effectiveness of these

⁵⁰ Ibid. at 37-40.

⁵¹ White Dep. 8/6/09 at 65, 90, 105, 168-169; Johnson Dep. 6/17/09 at 63-64, 66.

⁵² Johnson Dep. 6/17/09 at 63-64, 66.

⁵³ White Dep. 8/6/09 at 178.

⁵⁴ Ibid. at 177-181, 192; OAC 340:75-6-110.

⁵⁵ Dep. Ex. 173 (HZA Audit) at 104.

⁵⁶ BR-Grant-00576-77, BR-Grant-00579.

multiple modes of communication,⁵⁷ and about the serious communication problems within FOD.⁵⁸ Below are some telling comments from the focus groups:

- “Right now, communication is something that is done to us. . . . There is an increasing disconnect between day-to-day work of field staff and State Office. It’s an ‘us versus them’ mentality. Communication is completely one way, and our voices are not heard. The people in State Office are so far removed, they do not know the issues we face every day.”⁵⁹
- “Regular workers are not allowed to contact administration without doing [so] through the supervisor or field liaison. It’s only an open door for leadership, like field liaisons and County Directors. . . . Employees do not trust administration”⁶⁰
- “There needs to be true two-way communication. Have a true open-door policy for all staff rather than having this hierarchical procedure. . . . It’s hard for employees to feel like they are a part of this thing called OKDHS, especially when we are not heard and we don’t have any influence.”⁶¹
- “There are too many places where information is lost in translation because there are too many levels between the front line and the people who make decisions. [The FOD central office] needs to come to the field and talk to real workers – not Field Liaisons [and] not Area Office staff. . . . Unfortunately, the picture on the web is the only time [workers] see leadership.”⁶²
- “There are so many different layers of OKDHS, and things (policy, information, etc.) get lost in the layers. There are some very bright people, but because of all the bureaucracy, a lot of things just don’t happen.”⁶³

The huge gap in communication between the FOD central office and the county offices makes it almost impossible for policy to be effectively translated into practice.

The separation of the program and service delivery functions of DHS requires extra attention to communication. However, DHS has failed to nurture the required inter-connections between CFSD and FOD, and instead has stripped FOD of much of its authority. This situation is only made worse by poor communication within FOD itself. In sum, this structure has created a very troubling disconnect between policy and service delivery.

⁵⁷ While they consistently read the intranet and email messages, employees reported that the intranet is “not user-friendly” and “very frustrating” because “[y]ou can’t find anything!” and “[t]he policy search engine is a joke.” They also felt that the broadcast e-mail messages sometimes fail to convey the importance of the information because it is “just another email” (BR-Grant-00576-77).

⁵⁸ BR-Grant-00901.

⁵⁹ BR-Grant-00577.

⁶⁰ BR-Grant-00577-78.

⁶¹ BR-Grant-00578.

⁶² BR-Grant-00578-79.

⁶³ BR-Grant-00582.

C. Significant Turnover and Reorganization Has Led to Discontinuity and Confusion

DHS has recently experienced significant turnover of senior personnel at CFSD and reorganization of that division. While some turnover is unavoidable, and change can be productive, too much is damaging and can have a number of deleterious effects. Precious time is spent planning, implementing, and training, and the focus is taken away from a primary mission of the child welfare agency: providing the best possible service to Oklahoma's children and families. Institutional knowledge is often lost and continuity is compromised. It can become very difficult to ensure that a consistent message is passed down when the messengers at the top are constantly reshuffled. In my opinion, too much change has occurred recently at CFSD, and it has almost certainly adversely affected the functioning of this division.

CFSD has had four directors since February 2008 (Linda Smith left DHS in February 2008; Gary Miller left in February 2010; Chief Operating Officer Marq Youngblood served as interim director until August 2010; and Deborah Smith serves as the current director). Bill Hindman served as Programs Director at CFSD – an intermediary position between the director and the programs administrators – for a few months in 2008 before retiring. As far as I am aware, his position has never been filled and appears to no longer exist.⁶⁴

Significant turnover at CFSD has also occurred at the level of the programs administrators, who report directly to the director of CFSD. Three of the six have been replaced in less than two years, since April 1, 2009:

- Kelli Litsch replaced Margaret DeVault as the Programs Administrator for the Prevention and Protection Services Unit.⁶⁵
- Amy White replaced H.C. Franklin as the Programs Administrator for the Continuous Quality Improvement (CQI) and Training Unit.⁶⁶
- Carol Clabo has replaced Mary Grissom as Programs Administrator for the Technology and Governance Unit.⁶⁷

Further, Deborah Goodman was recently appointed Programs Administrator to oversee a new unit for Adoption and Post-Adoption Services.⁶⁸ There has also been significant turnover within the individual units of CFSD since April 1, 2009.⁶⁹

This kind of organizational disruption is very problematic because transitions are hard – both for the people who have to adjust to a new position and also for the people who report to

⁶⁴ Webster Dep. 1/6/10 at 7:14-24, 8:14-16; Webster Dep. 9/23/09 at 27:6-17; “Associate District Judge To Head Oklahoma's Children's Programs” (http://www.okdhs.org/library/news/rel/2008/02/hsc_02092008.htm); “Smith Named Children and Family Service Director at OKDHS,” (<http://www.okdhs.org/library/news/rel/2010/08/hsc08052010.htm>); Org P&P-4-00001.

⁶⁵ Litsch Dep. 2/4/11 at 11, 26.

⁶⁶ Ibid. at 26-27.

⁶⁷ Howell Dep. 2/15/11 at 114-115.

⁶⁸ Litsch Dep. 2/4/11 at 27-28.

⁶⁹ Ibid. at 25-29; Roberts Dep. 11/9/10 at 41-43.

them. An example is Ms. Litsch, who became the Programs Administrator for the Prevention and Protection Services Unit in September 2010.⁷⁰ Six months later, she was still not up to speed on the responsibilities of her new position (*e.g.*, Ms. Litsch was “still learning” about a grant for training through the child abuse and neglect office;⁷¹ was still “learning” about her responsibility for reporting maltreatment statistics to the federal government, and did not know what was included in those statistics;⁷² had a “vision” to regularly meet with her direct reports, but these meetings were “not in place yet;”⁷³ had not “yet” reviewed a report that shows the number of children subject to multiple referrals of abuse or neglect;⁷⁴ and was not familiar with the national screen-out rate for abuse and neglect referrals, and had not “[t]o date” compared Oklahoma’s screen-out rate to the national average⁷⁵).

In addition to the turnover, there have also been a number of very troubling organizational changes within CFSD. Most problematic is the recent combination of permanency, independent living, CQI, and training under the supervision of Programs Administrator Amy White.⁷⁶ Before this change, permanency, adoptions and independent living made up one unit, while CQI and training made up another, each with its own programs administrator. This new combined unit is simply too big, with too many difficult and very different program areas for one person to properly supervise. Moreover, as I discuss further below, it is troubling that continuous quality improvement is combined with, and reports to the same person as, one of the other program units because it is essential that the CQI Unit maintain a certain level of autonomy.

Also concerning is the fact that DHS has recently separated adoptions from the rest of permanency, and created a new, stand-alone unit that focuses only on adoption and post-adoption services.⁷⁷ Adoptions are integral to permanency and it makes no sense – except perhaps to reduce the burden on Ms. White – to divide adoptions from the rest of permanency planning.

II. DHS FAILS TO ENSURE ACCOUNTABILITY AT ANY LEVEL OF ITS OPERATIONS

One of the most alarming findings of this report is that DHS lacks an integrated, functional system of accountability and quality assurance. I am well aware of how difficult it is to implement proper accountability and quality assurance processes. In order to work, accountability and quality assurance must be formalized, consistent, data-driven, and a top priority of the agency’s leadership. Both individual and agency accountability must be built into the operational system. Without accountability and quality assurance, an agency like DHS is doomed to repeat the same mistakes over and over again.

⁷⁰ Litsch Dep. 2/4/11 at 11.

⁷¹ *Ibid.* at 20-21.

⁷² *Ibid.* at 53-55.

⁷³ *Ibid.* at 73, 76.

⁷⁴ *Ibid.* at 90.

⁷⁵ *Ibid.* at 90-92.

⁷⁶ *Ibid.* at 26-27, 74.

⁷⁷ *Ibid.* at 26-28.

There can be no doubt about the importance of accountability and quality assurance.⁷⁸ I wholeheartedly agree with the principles espoused in Olivia Golden's seminal work, *Reforming Child Welfare*, which examines three jurisdictions, Alabama, Utah, and the District of Columbia:

[I]n all the jurisdictions, leaders and observers defined a consistent vision for the reformed agency's role and outlook: the agency should see itself as active, not passive, shaping its own future and improving results for children, rather than being the victim of external actors; the agency should be open to learning and not defensive; and the agency should take responsibility for its own failures and mistakes, rather than blaming others. . . . I quickly concluded that the blame-ridden system with its incentives for everyone to avoid responsibility had prepared the ground for stagnation and failure.⁷⁹

Golden goes on to say that “[g]athering and analyzing information, setting measurable targets, tracking progress, giving individuals and units feedback on their performance, and reviewing individual cases in detail were all at the heart of reform.”⁸⁰

DHS has failed on many levels to ensure adequate accountability and quality assurance. First, at every level of DHS's leadership, there is a disturbing lack of effective oversight over both people and the child welfare program. Second, DHS focuses on compliance with timelines rather than high-quality casework. Third, DHS's internal continuous quality improvement (CQI) process is inadequate and overemphasizes strengths. Finally, DHS's child welfare data and reports lack integrity and workers, supervisors, and managers cannot rely on the reports that are available to them.

A. There Is a Fundamental Lack of Accountability and Leadership at All Levels of DHS

At DHS, the lack of accountability and oversight begins at the very top. Neither Director Howard Hendrick nor Chief Operating Officer Marq Youngblood properly supervises the Director of FOD, Larry Johnson. Mr. Youngblood, Mr. Johnson's direct supervisor, holds monthly one-on-one meetings with Mr. Johnson with no formal agenda, no note-taking and no formal process for following up on issues that are raised beyond Mr. Johnson's "rough notes."⁸¹ Mr. Youngblood does not require Mr. Johnson to provide him with any regular written reports or to review any specific child welfare reports.⁸² When asked whether there was anything that Mr. Youngblood specifically sets out for him to do as part of his responsibilities over FOD, Mr. Johnson replied:

⁷⁸ CWLA Standards of Excellence for Management and Governance §§ 2.7-2.10; National Technical Assistance and Evaluation Center for Systems of Care, "Accountability," 2010, <http://www.childwelfare.gov/pubs/acloserlook/accountability/accountability1.cfm>

⁷⁹ Olivia Golden, *Reforming Child Welfare*, at 132-133 (2009).

⁸⁰ *Ibid.* at 144.

⁸¹ Johnson Dep. 2/15/11 at 66-67.

⁸² *Ibid.* at 67.

I believe he has a great expectation for me to closely monitor the budget as well as staffing levels to ensure that we have enough staff where we need to have them, but at the same time balance it out with trying to control payroll costs.⁸³

I am somewhat shocked that Mr. Youngblood has not instituted any specific performance goals related to child welfare and that his focus is on staffing and budget rather than vulnerable children and families.

Director Hendrick exercises even less formal supervision over Mr. Johnson. Mr. Johnson provides him with no regular written reports,⁸⁴ and Mr. Johnson's description of his ad hoc one-on-one meetings with Mr. Hendrick indicates that they are just an informal opportunity to discuss issues.⁸⁵ At his deposition, Mr. Johnson stated:

[T]he most communication I have directly one on one with [Mr. Hendrick] occurs about once a week for an hour after work. . . . I either am hoping he's still in his office and have something I want to run by him before I, you know, pursue it as an idea or just to speak with him before I leave.⁸⁶

Mr. Hendrick and Mr. Youngblood should have a great deal more engagement with FOD, particularly with respect to the child welfare program, which is the most complicated and difficult to administer.

1. Lack of Accountability in FOD

In turn, Mr. Johnson's oversight over the child welfare program and the area and county directors in FOD is extremely limited. The largest portion of Mr. Johnson's time (70 percent) is dedicated to various administrative duties, with only 25 percent focused on child welfare program issues.⁸⁷ Mr. Johnson does not require regular written reports from area directors,⁸⁸ who report directly to him, and has regularly-scheduled individual meetings with them only on a quarterly basis.⁸⁹ His other meetings with area directors occur in larger groups.⁹⁰ When Debra Clour, the Director of Area III (the largest area in the state, it includes Oklahoma County) was asked whether Mr. Johnson instructed her to hold specific meetings with her staff or require them to provide her with certain reports, she responded that he does not: "[I]t's just part of my job. . . . [H]e doesn't need to [specify]. . . . I don't need that kind of specific direction."⁹¹ To the contrary, "specific direction" is a necessary component of leadership and accountability.

⁸³ Ibid. at 68.

⁸⁴ Ibid. at 72.

⁸⁵ Ibid. at 68-70.

⁸⁶ Ibid. at 68-69.

⁸⁷ Ibid. at 9-10. Mr. Johnson described his non-administrative, child welfare specific tasks as "working directly with . . . [CFSD] staff on policy revisions, the impact of policy revisions, planning meetings for initiatives, work with outside entities such as Casey Family Services" (Ibid. at 11).

⁸⁸ Johnson Dep. 2/15/11 at 43-45; Clour Dep. 2/4/11 at 75.

⁸⁹ Johnson Dep. 2/15/11 at 24.

⁹⁰ Ibid. at 42, 24.

⁹¹ Clour Dep. 2/4/11 at 78.

Despite his view that the “buck stops with the county director,”⁹² Mr. Johnson hardly ever discusses child welfare issues with them. He “make[s] an effort to call each county director around their birthday”⁹³ and visits each county approximately once every three years.⁹⁴ His meetings with county directors are even less frequent than with area directors, occur in very large groups, and do not always include a discussion of child welfare issues.⁹⁵ Even Mr. Johnson’s e-mail communication with the county directors is somewhat infrequent and does not really involve “back-and-forth discussions” because his expectation is that county directors will raise issues with their area directors before approaching him.⁹⁶

Even more troubling, while Mr. Johnson has laudable expectations that both area and county directors should be regularly reviewing reports on certain process and outcome indicators,⁹⁷ he does not confirm whether, in fact, these reports are being reviewed, even though he “would be concerned” if they are not monitored.⁹⁸ Part of the problem may be that Mr. Johnson himself could not articulate exactly what reports area and county directors need to monitor:

There are so many reports out there that if you look at one report, it may mean that you need to go look at another report that you wouldn’t always look at. That’s why it’s difficult to answer this question.⁹⁹

In fact, area and county directors are *not* monitoring many of the reports that Mr. Johnson was able to name,¹⁰⁰ and Mr. Johnson had no idea this was the case, an egregious lapse of oversight. Furthermore, certain crucial process and outcome indicators are not even on the list of those Mr. Johnson expects area and county directors to monitor regularly, including maltreatment in care; visitation between children and their parents; shelter usage; and placement stability. At a minimum, Mr. Johnson should be taking steps to ensure that area and county directors are closely and regularly monitoring reports on a range of key process and outcome indicators.

Another indication that accountability is seriously lacking is that even when one of Mr. Johnson’s area or county directors is aware of a child-welfare related problem, there appears to be no urgency to address it. For example, since at least October 2008, Area III, which includes Oklahoma County, has had the lowest rate of children reunified with their birth parents in less

⁹² Johnson Dep. 2/15/11 at 22:8-19.

⁹³ Ibid. at 60.

⁹⁴ Ibid. at 65.

⁹⁵ Ibid. at 62-64.

⁹⁶ Ibid. at 61-62.

⁹⁷ Including reports on the following indicators and outcomes: referrals and removals; the timelines of investigation and assessment initiation and completion; workloads; average length of stay in care; worker-child visitation; family/child assessments; eligibility for SoonerStart; and termination of parental rights. Ibid. at 7, 46-47, 49-50, 52-58, 70, 73, 75, 87-88, 91, 96, 101, 103, 126.

⁹⁸ Ibid. at 51.

⁹⁹ Ibid. at 48.

¹⁰⁰ For example, when one area director was asked what reports Mr. Johnson requires her to review, she listed only three, reports on staffing and workload, reports on visitation, and a report on prevention (Clour Dep. 2/4/11 at 76-78). Similarly, the only reports regularly reviewed by one county director are on visitation, exits and removals, and workloads (Thompson Dep. 2/15/11 at 59-60, 104).

than 12 months, and this rate has been getting worse.¹⁰¹ However, it was not until the fall of 2010 that Ms. Clour, the Area III Director, first raised it with Director Hendrick and began “reviewing cases” and “looking to see what services we can improve.”¹⁰² Ms. Clour was unable to explain why the length of time to reunification was not improving despite her efforts, and has not discussed any consequences with anyone as a result of these continuing poor results.¹⁰³

Area directors display the same lax approach to accountability over their direct reports, the county directors. At her deposition, Ms. Clour displayed a dismaying lack of attention to crucial process and outcome indicators.¹⁰⁴ Like Mr. Johnson, she does not receive any regular written reports from her staff, except for a quarterly report on workers with workloads over 25 children.¹⁰⁵ Ms. Clour was unable to recall all of the reports that her county directors are required to review, and did not know whether they are actually doing so.¹⁰⁶ Ms. Clour also stated that she learns about child welfare-related problems in a number of ad hoc ways:

[I]f I get a complaint from the public . . . [w]hen I’m meeting with my staff in the field, meeting with my county directors, my field liaisons . . . I listen to what everyone’s saying. . . . I look at reports to see where things don’t look quite right.¹⁰⁷

With the exception of looking at reports, none of these methods is adequate for monitoring child welfare service delivery because all are passive; they rely on someone else to notice and raise problems. Furthermore, Ms. Clour regularly reviews only a small number of reports – staffing and workload reports, a referrals and removals report, and visitation reports – and only monitors a few key indicators: “[p]rimarily investigation timeliness, visitation, length of time in out of [home] care.”¹⁰⁸ No attention is paid to reports on a number of key child welfare issues, such as maltreatment in care, placement stability, shelter usage and visits with parents and siblings. Ms. Clour clearly does not have an adequate process in place to learn about child welfare performance deficiencies in her area.

The accountability lapses are magnified at the county director level, which is where virtually all program work occurs. Thus, for example, the only reports that are regularly monitored by Nancy Thompson, an Oklahoma County Director, are reports on visitation, exits and removals, and workloads.¹⁰⁹ While she was Director of Oklahoma County 55F (a region within Oklahoma County), she performed no case reviews at all.¹¹⁰ Ms. Thompson relied on her assistant county director to create the agenda for monthly meetings with all supervisors and to

¹⁰¹ From October 2008 to September 2009, 59% of the children in Area III who were reunified were reunified in more than 12 months (Dep. Ex. 389 (CFSR-PO-P1.4-00373)). From October 2009 to September 2010, 65% of the children in Area III who were reunified were reunified in more than 12 months (Dep. Ex. 390 (CFSR-PO-P1.4-00381)).

¹⁰² Clour Dep. 2/4/11 at 123.

¹⁰³ Ibid. at 124-126.

¹⁰⁴ Ibid. at 101, 104-107, 109-112, 116, 119

¹⁰⁵ Ibid. at 63.

¹⁰⁶ Ibid. at 69-70.

¹⁰⁷ Ibid. at 84.

¹⁰⁸ Ibid. at 85-86.

¹⁰⁹ Thompson Dep. 2/2/11 at 61, 95-96, 104.

¹¹⁰ Ibid. at 27.

follow up on any issues that were raised at these meetings.¹¹¹ Despite this heavy reliance on her assistant county director, Ms. Thompson has never required any regular written reports from her,¹¹² nor has she ever specified that child welfare supervisors or workers must provide regular written reports to their superiors.¹¹³

Ms. Thompson further testified that she learns about child welfare-related problems only from various third parties:

I might get a phone call from a foster parent. I might get a phone call from another county director or my supervisor. My assistant county director might tell me, a supervisor might contact me, a worker may contact me.¹¹⁴

As discussed above, these passive methods are inadequate. Given her admitted failure to have any formal process for learning about problems, it is no surprise that Ms. Thompson was not “necessarily monitor[ing]” placement stability,¹¹⁵ which she readily acknowledged was important.¹¹⁶ When asked what steps, if any, were being taken to improve the low placement stability rates in her counties,¹¹⁷ Ms. Thompson could not describe any concrete steps aside from discussions about placing children with kin and inappropriately blamed blown placements on children “who don’t want to be there and know how to blow a placement.”¹¹⁸ Ms. Thompson was also unaware that from one year (July 2008 to June 2009) to the next (July 2009 to June 2010), the percentage of children in her county who remained in a shelter for longer than 30 days increased by 50%, from 12% to 18%. She testified that had she known, she would have been concerned.¹¹⁹ These kinds of oversight lapses simply should not occur.

County Director Jeri Poplin also displayed a dismaying lack of attention to crucial elements of her child welfare responsibilities. Ms. Poplin could not even guess how many children in her county had been in care for more than 24 months, and stated that she does not run a report on this subject “on a routine basis.”¹²⁰ When Ms. Poplin was asked how she would find information about the homes in which children in her county are placed, she did not know where this information is maintained or how to access it.¹²¹ She was not familiar with the providers who perform home studies,¹²² where to look for licensing information,¹²³ or where a caseworker

¹¹¹ Ibid. at 25-27, 30-31.

¹¹² Ibid. at 59.

¹¹³ Ibid. at 63, 65.

¹¹⁴ Ibid. at 94.

¹¹⁵ Ibid. at 115-116.

¹¹⁶ Ibid. at 114-115.

¹¹⁷ From October 2008 to September 2009, of children in out-of-home care less than 12 months, approximately 31% in Oklahoma County 55F and 39% in Oklahoma County 55B in out-of-home care had three or more placements. (Dep. Ex. 372 (CFSR-PO-P1.2-00023)). From October 2009 through September 2010, of children in out-of-home care less than 12 months, approximately 31% in Oklahoma County 55F and 48% in Oklahoma County 55B had three or more placements (Dep. Ex. 373 (CFSR-PO-P1.2-00030)).

¹¹⁸ Thompson Dep. 2/2/11 at 119-121.

¹¹⁹ Ibid. at 124-126; Dep. Ex. 375 at 3 (YI624-07898); Dep. Ex. 376 at 3 (YI-624-10130).

¹²⁰ Poplin Dep. 10/10/08 at 56.

¹²¹ Ibid. at 96-101.

¹²² Ibid. at 88-89.

¹²³ Ibid. at 89.

would find information about placement types and availability.¹²⁴ Overall, she seemed to depend heavily on her assistant county director and was unfamiliar with DHS policy on basic child welfare issues.¹²⁵

2. Lack of Accountability in CFSD

These accountability and leadership issues also infect CFSD. Senior administrators take an extremely narrow view of their responsibilities and fail to have a grasp on information that is basic to their program areas. For example, Joani Webster, Programs Administrator of the Resource Unit, does not review a report that tracks abuse by caretakers in facilities that fall under her purview.¹²⁶ She stated that there are so many reports about placements that “it’s very difficult to keep them straight,” and admitted that she did not even know which reports are being run regularly.¹²⁷ Ms. Webster could not even estimate how many children in Oklahoma are placed in group home care.¹²⁸ For Ms. Webster – who is the most senior administrator with responsibility for the homes and other facilities where children are placed – to not be familiar with these vital pieces of information is simply shocking.

The programs managers who report to Ms. Webster are similarly lacking in knowledge concerning fundamental aspects of their responsibilities. Program Field Representative Dawn Carson, who is responsible for shelter diversion contracts, did not even know whether children are currently being diverted from DHS-operated shelters under these contracts.¹²⁹ Annette Burleigh, Therapeutic Foster Care (TFC) Programs Manager, did not know how many children are waiting for TFC, whether the number of children waiting is increasing or decreasing,¹³⁰ or about a recent increase in the current reimbursement rate for TFC agencies.¹³¹ Ms. Burleigh does not even maintain a list of the children who are waiting for TFC.¹³² Given that Ms. Webster, to whom Ms. Burleigh and Ms. Carson report, does not require her direct reports to provide her with any regular written reports, these failings are not surprising.¹³³

There are similar problems in the Prevention and Protection Unit of CFSD, which is responsible for Child Protective Services (CPS). Programs Administrator Kelli Litsch is not required to provide her supervisor, CFSD Director Deborah Smith, with any regular written reports.¹³⁴ Nor does she receive any such reports from her own staff¹³⁵ or conduct regular meetings with her direct or indirect reports.¹³⁶ The only reports that Ms. Litsch regularly reviews are a log of child deaths and near deaths,¹³⁷ referral and removal data which she “tr[ies] to look

¹²⁴ Ibid. at 104.

¹²⁵ Ibid. at 49-51, 57-58, 80, 82, 91.

¹²⁶ Webster Dep. 1/6/10 at 61-62.

¹²⁷ Webster Dep. 2/4/10 at 154, 157.

¹²⁸ Ibid. at 142-143.

¹²⁹ Carson Dep. 10/8/10 at 14.

¹³⁰ Burleigh Dep. 2/3/11 at 82, 93.

¹³¹ Ibid. at 120-123.

¹³² Ibid. at 82.

¹³³ Ibid. at 33.

¹³⁴ Litsch Dep. 2/4/11 at 65.

¹³⁵ Ibid. at 66.

¹³⁶ Ibid. at 73, 76.

¹³⁷ Ibid. at 66.

at,” the number of child abuse and neglect referrals received and assigned, and the number of days to initiation for investigations.¹³⁸ She only “[o]ccasionally” looks at the number of days it takes to complete child abuse and neglect investigations and assessments.¹³⁹ Ms. Litsch also does not track the caseloads of CPS workers in any way.¹⁴⁰ Not only did Ms. Litsch display a lack of basic knowledge and oversight, she also stated that if she sees a report which shows that a particular area is doing poorly, for example, in initiating investigations, her only responsibility is to notify FOD; she would not take any steps on her own to fix the problem.¹⁴¹ This is yet another example of DHS’s pattern of passing responsibility rather than grappling with it head-on.

Similar problems permeate the Permanency Planning and Independent Living Unit of CFSD. Tricia Howell, the Permanency Planning Programs Manager, does not provide her supervisor, Amy White, with any regular written reports¹⁴² and does not require her staff to provide her with any regular written reports.¹⁴³ Ms. Howell was asked about a number of reports regarding permanency outcomes for children in care, including timely filing of petitions for the termination of parental rights (TPR),¹⁴⁴ reunification within 12 months,¹⁴⁵ visitation with parents,¹⁴⁶ and placement stability.¹⁴⁷ Ms. Howell readily admitted that these matters are all important to a child’s permanency, but for many of these, she does little more than a cursory review. She was unable to explain why the data on each of these factors has either gotten worse or not improved over a two-year period. Nor does she monitor the percentage of sibling groups who are placed together while in DHS custody, or whether siblings who are placed apart receive visits in accordance with policy,¹⁴⁸ although she was aware that this was an area in need of improvement.¹⁴⁹

My examination of accountability within FOD and CFSD reveals a dismaying picture. There appears to be an almost total lack of oversight and accountability at every level. Managers provide their direct reports with little specific direction and no one pays sufficient attention to the necessary outcomes. There is no systematic method for ensuring that problems are spotted, and once they are, that they are adequately addressed. All of this is exacerbated by a “pass the buck” mentality; I was constantly struck by an overarching failure to take responsibility for problems, which is the necessary first step to fixing them. Leadership and accountability are crucial to a properly functioning child welfare agency and they are sorely lacking at DHS.

¹³⁸ Ibid. at 76.

¹³⁹ Ibid.

¹⁴⁰ Litsch Dep. 2/4/11 at 55-57.

¹⁴¹ Ibid. at 77-78.

¹⁴² Howell Dep. 2/15/11 at 51, 68.

¹⁴³ Ibid. at 68.

¹⁴⁴ Ibid. at 74-86.

¹⁴⁵ Ibid. at 87-95.

¹⁴⁶ Ibid. at 97-100, 104-105.

¹⁴⁷ Ibid. at 126-133.

¹⁴⁸ Ibid. at 38-41.

¹⁴⁹ Ibid. at 39-40.

B. DHS Focuses on Compliance with Timelines Rather Than High-Quality Casework

The backbone of any child welfare agency is the day-to-day casework practiced by its front-line workers. While it may sound obvious, high-quality casework must be prioritized, nurtured and rewarded. DHS does not pay sufficient attention to the quality of the casework performed by its front-line workers. Instead, DHS seems to focus its attention on whether certain easy-to-measure tasks are performed within specific timeframes. This problem was recognized in the HZA Audit:

[Staff] are held accountable for the most concrete items, primarily meeting timelines. When client outcomes are measured, they do not appear to be taken with the same seriousness that meeting timelines are, because the latter can be monitored on a weekly or even daily basis, while client outcomes take time to develop and are, in any event, difficult to measure reliably on a caseworker specific basis.¹⁵⁰

While this kind of quantitative focus may be appropriate for managing an eligibility program like Medicaid or Food Stamps, it is not at all appropriate for managing a child welfare program.

The managers at DHS pay close attention to only a small number of key indicators. One of the most heavily monitored indicators is worker-child visitation. Oklahoma law requires that each child in custody must be visited at least monthly.¹⁵¹ The statute specifies that “[e]ach child shall be interviewed, or if an infant observed, alone without the foster parent present at least one time per quarter.”¹⁵² DHS policy further specifies that there be “at least three successful unannounced contacts per year,” a contact “within the first two weeks of each placement” and that “[c]ontacts increase in times of change and stress.”¹⁵³

Visitation between workers and children is critically important because it is the primary mechanism workers have to monitor children’s well-being and build a relationship with them. As Mr. Johnson acknowledged, effective visits by caseworkers to children in out-of-home care require a substantive face-to-face contact by the child’s responsible caseworker. Mr. Johnson stated that ideally, each visit would include “an hour spent with the child discussing . . . the child’s interests so that the worker can get a sense of the child’s current emotional status” and “some observation of interaction [of the child] with a care giver [or] teachers.”¹⁵⁴

Managers and supervisors are held strictly accountable for worker-child visitation, and reports on this indicator are closely tracked even when few others are.¹⁵⁵ DHS managers use two reports to monitor visitation by workers.¹⁵⁶ One tracks the percentage of children in out-of-home care who have received a visit every month during the last 12-month period. Federal law

¹⁵⁰ Dep. Ex. 173 (HZA Audit) at xi.

¹⁵¹ 10A Okla. Stat. 1-7-113.

¹⁵² Ibid.

¹⁵³ OAC 340:75-6-48, Instructions to Staff 4-5.

¹⁵⁴ Johnson Dep. 2/15/11 at 59-60.

¹⁵⁵ Ibid. at 53-54, 57-58, 126; Thompson Dep. 2/2/11 at 59-61, 65-66, 95; Clour Dep. 2/4/11 at 69, 86; Howell Dep. 2/15/11 at 68-69.

¹⁵⁶ Johnson Dep. 2/15/11 at 57-59.

requires that 90% of children meet this standard.¹⁵⁷ The second – the YI 616 report – tracks the percentage of children who have received a face-to-face visit in a given month. DHS’s performance varies significantly depending on which of these two measures is used: According to the federal measure, approximately one-third of children in care had at least one missed visit within the last 12 months.¹⁵⁸ In contrast, during the month of December 2010, 98% of children received a face-to-face visit in “any location.”¹⁵⁹

Managers at DHS strongly prefer to use the YI 616 report that shows near-perfect compliance. Indeed, in December 2010, DHS decided to use the YI 616, not the report tracking compliance with federal law, to manage staff’s completion of visits.¹⁶⁰ In an affidavit provided by Mr. Johnson, he described the federal standard as a “distort[ion of] what is really going on in the field,”¹⁶¹ and others at DHS have complained that it sets the standard too high because it “seems aimed at perfection, not approximation.”¹⁶² These complaints miss the point that federal law, Oklahoma law, DHS policy – and of course good child welfare practice – all require monthly visits *every month*.

Even more troubling, there is evidence that senior managers have massaged these reports to make the numbers look better, knowing full well that the reports are, as a result, less effective at tracking quality visits. Former Permanency Planning Programs Manager Mark Carson proposed in an email that DHS include visits where workers “do[] not have a significant amount of interaction” with children, *i.e.*, “at the office, briefly at the placement, at court, etc.”¹⁶³ Mr. Johnson did not tell Mr. Carson not to go forward with this plan, and DHS currently includes these insignificant visits both in its internal reporting and in its reports to the federal government.¹⁶⁴ Similarly, Program Analyst Stephen Hobbs proposed that DHS move “to looser definitions” and count visits made by any worker instead of limiting the reports to visits made by the assigned worker.¹⁶⁵ DHS does, in fact, include visits made by any child welfare worker, even if they are not assigned to the child’s case, in both of its visitation reports.¹⁶⁶ These changes make a big difference in the reported results. For example, for the 12-month period ending in January 2009, only 45% of children in out-of-home-care were visited every month during the preceding 12 months by an assigned worker.¹⁶⁷ When visits by non-assigned workers and case aides were included, this percentage jumped up to 61%.¹⁶⁸

¹⁵⁷ 42 U.S.C.A. § 624 (2)(A).

¹⁵⁸ Dep. Ex. 416 (Affidavit of Larry Johnson, 1/18/11); Johnson Dep. 2/15/11 at 125. This was confirmed by Dr. Milner’s Case Record Review, which found that in 31% of the cases, the child’s caseworker or supervisor did not visit the child at least monthly while the child was in custody during the review period of June 2009 to May 2010.

¹⁵⁹ YI616A-00605.

¹⁶⁰ JonesM-008371.

¹⁶¹ Dep. Ex. 416 (Affidavit of Larry Johnson, 1/18/11).

¹⁶² Dep. Ex. 417; Dep. Ex. 418.

¹⁶³ Dep. Ex. 417.

¹⁶⁴ Johnson Dep. 2/15/11 at 126-128.

¹⁶⁵ Dep. Ex. 418.

¹⁶⁶ Johnson Dep. 2/15/11 at 58-59, 129-130. This includes visits made by a child’s secondary worker in its visitation reports, even though its own consultant found that visits by secondary workers “creates significant problems with assessment of a child’s safety” because children in care do not trust easily and “the child in care may have no relationship with the worker visiting.” Safety-17-00082-83.

¹⁶⁷ Dep. Ex. 256 at 1 (Placement-24-00153).

¹⁶⁸ Dep. Ex. 256 at 2 (Placement-24-00162).

In addition to ignoring the quality of its visits, DHS also fails to track whether workers are increasing visitation during times of stress (as required by policy),¹⁶⁹ whether visits are done in private (also a policy requirement), or the length of visits.¹⁷⁰ Nor does DHS appear to track whether unannounced visits or visits within two weeks of each placement are taking place as policy dictates.¹⁷¹ In sum, DHS's reports do not track whether children are receiving substantive, private visits from their caseworkers, or whether they are simply "drive by" contacts done in order to demonstrate compliance. In the words of Mr. Johnson: "[T]he report is intended to report visits regardless of the . . . quality or characteristic[s] of the visit."¹⁷²

Case reviews are another critical method for evaluating the quality of visits and of casework generally. Unfortunately, the case reviews conducted by DHS's senior leaders are inadequate in a number of ways. Every month, Director Hendrick conducts case reviews, via conference call, and reviews three to five randomly selected cases from each area of children that have been in care for over 24 or 36 months.¹⁷³ The purpose is primarily

to try and brainstorm solutions to help get the child to permanency, see what barriers can be overcome. And sometimes we find systemic issues that arise in those that help us then make a decision on, well, do we need to change policy? Do we need to do something differently?¹⁷⁴

The first problem with this process is the small number of cases reviewed and the random way in which those cases are selected. The agency would be better served if its leaders focused on problematic areas or counties, or specific types of problematic cases, and reviewed all of those cases. This type of approach would be much more likely to reveal systemic challenges. It is also a mistake to focus solely on those children who have been in custody for a long period of time because children who have been in custody for only a few months will eventually become long-stayers unless any problems are caught early. Finally, this process is set up in a way that makes it unlikely behavior will ever change because key leaders, like area directors, participate only when cases they are responsible for are being reviewed.¹⁷⁵ It is crucial for senior managers to learn from each other's successes and failures, therefore they should participate in all of the reviews.¹⁷⁶

¹⁶⁹ Howell Dep. 2/15/11 at 144.

¹⁷⁰ White Dep. 12/18/09 at 76.

¹⁷¹ Howell Dep. 2/15/11 at 145.

¹⁷² Johnson Dep. 2/15/11 at 131.

¹⁷³ Ibid. at 30; Clour Dep. 2/4/11 at 37-39.

¹⁷⁴ Clour Dep. 2/4/11 at 38.

¹⁷⁵ Ibid. at 38.

¹⁷⁶ While other forms of quality review are conducted at the agency, the same problems permeate these reviews. For example, DHS policy requires child welfare supervisors to conduct at least one comprehensive case review per review period for each worker he or she supervises, plus focused reviews on items related to service refinement that are noted in the Program Improvement Plan (OAC 340:75-18-13). Yet these reviews appear to be conducted on an ad hoc basis. Child welfare supervisor Justin Hoenshell testified that "there's no guarantee of what specific cases we may discuss It's handled case by case" (Hoenshell Dep. 9/18/08 at 77). Similarly, at least one assistant county director has weekly case reviews that each supervisor is required to attend, with child welfare workers, at least once every five weeks to discuss "hard" cases, but number and selection of cases discussed are left to the supervisor's discretion (Thompson Dep. 2/2/11 at 27-29). In addition, at least one Area Director conducts annual case reviews in each county office (Clour Dep. 2/4/11 at 21). However, this review only covers about five to ten cases, and is

C. DHS's Internal Quality Improvement Process Is Seriously Flawed

DHS's CQI process is seriously flawed. While annual reviews of each county are conducted by the CQI Unit of CFSD, those reviews are cursory and rarely uncover improvements that are needed. Even when deficiencies are revealed, there is no mechanism to ensure that they are addressed.

Child welfare agencies must have an established process for monitoring performance and enhancing policy and practice. The CQI process should allow the agency to first, ensure that policy, procedures and practice guidelines are consistently implemented; and second, improve performance and practice by applying the results of evaluations and reviews. The results should be used to hold the agency and its staff accountable, to identify what support is needed to improve performance, and to define consequences for the failure to meet standards.

Casey Family Programs and the National Child Welfare Resource Center for Organizational Improvement developed a CQI process that is commonly used in public child welfare.¹⁷⁷ As their framework emphasizes, CQI “transforms organizations that are compliance-focused into true learning organizations that rely on their mission, vision and values to constantly improve their practices.”¹⁷⁸ The framework includes the following six components:

- An organizational culture that supports and actively promotes CQI;
- Adoption of outcomes, indicators and standards;
- Training of agency leaders, staff, children, youth, families, and stakeholders;
- Collection of data and information;
- Review, analysis, and interpretation of the data; and
- Application of learning.

According to this framework, a functioning CQI process requires information systems that are user-friendly and reliable, dedicated staff that lead and facilitate both qualitative and quantitative

usually limited to a particular topic (Clour Dep. 2/4/11 at 21, 40). Judging by DHS's ongoing poor performance in areas like abuse in care, insufficient placement resources, placement instability, worker turnover and length of time in custody, it does not appear that these case reviews are helping to solve the serious systemic problems that plague DHS.

¹⁷⁷ “Using Continuous Quality Improvement To Improve Child Welfare Practice: A Framework for Implementation,” Casey Family Programs & National Child Welfare Resource Center for Organizational Improvement; “A Framework for Quality Assurance in Child Welfare,” National Child Welfare Resource Center for Organization and Improvement; “Managing Care for Children and Families,” National Child Welfare Resource Center for Organizational Improvement; “Information packet: Quality Assurance Systems in Child Welfare,” Teija Sudol, National Resource Center for Family-Centered Practice and Permanency Planning.

¹⁷⁸ “Using Continuous Quality Improvement To Improve Child Welfare Practice: A Framework for Implementation,” Casey Family Programs & National Child Welfare Resource Center for Organizational Improvement, at 5-7.

data collection, and analyses and application of the data and information to support systemic improvements in the agency.¹⁷⁹

At DHS, the CQI Unit conducts state CFSRs annually in each county that attempt to replicate the federal CFSR.¹⁸⁰ A small number of cases from each county are randomly selected and, according to DHS policy, are supposed to be reviewed by a team made up of (i) a CQI Unit staff member (who serves as the team leader), (ii) a child welfare worker or supervisor not affiliated with the site under review, (iii) a third party identified by the area director, and (iv) at least one stakeholder, not employed by DHS.¹⁸¹ DHS, however, has chosen not to follow its own policy and does not utilize a third party chosen by the area director because “it really slows the process down.”¹⁸²

The reviews consist of an analysis of the paper file, the electronic file, and interviews of key people involved with the case.¹⁸³ The results of these reviews include a scoring summary for the county’s performance in the safety, permanency, and well-being outcomes that are utilized in the federal CFSR.¹⁸⁴ These results are relayed to the county director whose office is being reviewed, and sometimes members of their field staff, through a report and an exit meeting.¹⁸⁵ The CQI Unit leaves it up to the county directors to decide who to include in the exit meeting and how widely to distribute the report with the results.¹⁸⁶ On an annual basis, the CQI Unit provides a report to senior administrators at DHS.¹⁸⁷ There is no other periodic, aggregate reporting to area or county directors.¹⁸⁸ It is problematic that county directors, and not the CQI Unit, dictate who receives the results of the reports; these results should be widely disseminated to all child welfare workers in the county reviewed and all managers who are responsible for their work. The infrequency of the aggregate reporting is also totally inadequate.

Both the brief nature of the results and the disproportionate emphasis on strengths preclude a meaningful evaluation of child welfare practice. For example, one region in Oklahoma County scored 100% on the permanency item “proximity of substitute care

¹⁷⁹ Ibid.

¹⁸⁰ OAC 340:75-18-10; Continuous Quality Improvement: Child & Family Svcs. Review Section (<http://www.okdhs.org/divisionsoffices/hsc/cfsd/cqi/cfsr/default.htm>); Franklin Dep. 7/9/09 at 47. In addition to its CQI function, the CQI Unit also conducts contract performance reviews as part of the monitoring process for contracted private agencies (Continuous Quality Improvement: Contract Performance Review Section (<http://www.okdhs.org/divisionsoffices/hsc/cfsd/cqi/cp/default.htm>)).

¹⁸¹ OAC 340:75-18-10.

¹⁸² Franklin Dep. 7/9/09 at 55-59.

¹⁸³ Ibid. at 49-51.

¹⁸⁴ The results of these reviews consist of two parts. The first is a very short summary document that varies somewhat but often includes the following: the sites reviewed, the people who participated, the number and types of cases reviewed, some outcomes on which each site “substantially achieved 95% or greater,” and a short description of some “[s]trengths” (e.g., State-CFSR-2010-00738-41). The second part is a two-page “Site Scoring Summary” which lists each of the seven outcomes (two safety, two permanency and three well-being) and 23 items (four safety, twelve permanency and seven well-being) utilized on the federal CFSR. Each outcome is scored by the number and percentage of cases that substantially achieved, partially achieved or did not achieve that outcome. Each item is scored by the number and percentage of cases for which it is a strength or area needing improvement.

¹⁸⁵ Franklin Dep. 7/9/09 at 39-41, 51-53; Thompson Dep. 2/2/11 at 88; State-CFSR-2010-00738-41.

¹⁸⁶ Franklin Dep. 7/9/09 at 51-53.

¹⁸⁷ Ibid. at 62.

¹⁸⁸ Ibid. at 61-62.

placement,” even though over 80% of the children in that county office were placed outside of the county.¹⁸⁹ Presented with such a glowing score, neither the county nor area director is given much reason to improve the county’s harmful practice of placing children far from their homes. It is always commendable to discuss strengths in a program audit, but it is just as important to address challenges. Although the scoring summary indicates the percentage of cases that did not achieve outcomes, or needed improvement on items, the report contains no substantive discussion of the counties’ major challenges, goals to be attained by the next review, or corrective steps that should follow.

The results of these reports also seem unrealistically positive. Below are a few examples:

- According to the statewide scoring summary for calendar year 2009, 75% of cases were rated as strength on permanency item “[s]tability of substitute care placement.”¹⁹⁰ In stark contrast, Dr. Milner’s Case Record Review revealed extreme placement instability for foster children in Oklahoma. It found that only 8% of children had been in a single, stable placement during their most recent entry into DHS custody, and 55% of children experienced four or more placement settings.¹⁹¹ Many children moved from one short-term placement to another.
- According to the statewide scoring summary for calendar year 2009, 98% of cases were rated as strength on permanency item “[p]roximity of substitute care placement.”¹⁹² However, according to DHS’s own reports, as of June 2010, only 36% of children were placed in the county where their juvenile court proceeding was pending (excluding trial home reunification and trial adoption placements).¹⁹³
- According to the statewide scoring summary for calendar year 2009, high scores were achieved on placement with siblings (96%) and preserving family connections (83%), and middling scores were achieved on visiting with parents and siblings (62%).¹⁹⁴ This is inconsistent with Dr. Milner’s report, which found that 13% of the children were not placed with their siblings without adequate justifications, and that 22% of eligible children had *no* visits with their siblings in separate foster care placements over a 12-month time period.¹⁹⁵ It is also inconsistent with DHS’s own reports, which show extremely low rates of visits between workers and parents (40% in calendar year 2009) and children and their parents (12% in calendar year 2009).¹⁹⁶

It is hard to reconcile the results of the CQI process with the picture that emerges from Dr. Milner’s Case Record Review and from DHS’s own internal reports.

¹⁸⁹ Thompson Dep. 2/2/11 at 91-94; Dep. Ex. 366 (State-CFSR-2010-00744), Dep. Ex. 367 (YI617A-00057-58).

¹⁹⁰ CQI 2009 Annual Rpt-00001.

¹⁹¹ Milner Report at 5-6.

¹⁹² CQI 2009 Annual Rpt-00002.

¹⁹³ YI617A-00330.

¹⁹⁴ CQI 2009 Annual Rpt-00002.

¹⁹⁵ Milner Report at 77-79.

¹⁹⁶ YI624-00744.

Similarly, following the meetings between the CQI Unit and the field staff that take place after the reviews, there is no follow-up by the CQI Unit to ensure that corrective actions have been implemented.¹⁹⁷ Former Program Administrator of the CQI Unit H.C. Franklin admitted that the CQI Unit “cannot issue any kind of corrective action plan” and does not have authority over the county offices to require them to implement such a plan.¹⁹⁸ Mr. Franklin stated that the CQI Unit looks at data and “tr[ies]” to get that information to the field but “we don’t have further control.”¹⁹⁹ County Director Nancy Thompson echoed these statements, explaining: “[i]t’s left to us to take action.”²⁰⁰

DHS area and county directors do not appear to have assumed this responsibility. When questioned about her area’s score on the safety item related to risk assessment and safety management, which indicated that improvement was needed on 41% of the cases reviewed, Area Director Debra Clour testified that she was concerned with this poor showing, but did not remember whether specific steps were taken in response because “[t]he county director takes charge of that. I didn’t do anything with that.”²⁰¹

Nancy Thompson, one of the county directors who reports to Ms. Clour, was equally unresponsive when asked what specific corrective steps were taken in response to certain poor results in her county. Ms. Thompson was asked whether she took any steps to improve the relationship of foster children with their parents, when the state CFSR indicated that 58% of the cases in her county needed improvement in this area. She responded that she did not discuss any actions to address the challenge, beyond the general, “[w]e’re always working on getting the parents more visits.”²⁰² Ms. Thompson also made it clear that she never discussed the results of the state CFSR with her supervisor, Ms. Clour.²⁰³ One of the major problems with DHS’s CQI process is that area and county directors apparently experience no consequence for failing to respond to the issues identified in the CQI review.²⁰⁴

There is also a serious organization issue that will affect DHS’s CQI process going forward. As mentioned above, the CQI Unit was recently folded under the authority of Amy White, who is already in charge of the Permanency and Independent Living Unit of CFSD.²⁰⁵ The combination of CQI with this other program unit, under the authority of a single person, is simply not appropriate. By virtue of her responsibility for permanency, Ms. White should be developing close relationships with the field, including with senior managers in FOD. But now she is also being asked to evaluate the performance of those managers in connection with the CQI process. CQI should operate with as much autonomy, impartiality, and independence as possible in order to fulfill its function. It should be a standalone unit, reporting to the highest level of agency leadership.

¹⁹⁷ Thompson Dep. 2/2/11 at 89-90.

¹⁹⁸ Franklin Dep. 7/9/09 at 40, 42, 53-54.

¹⁹⁹ Ibid. at 39-40.

²⁰⁰ Thompson Dep. 2/2/11 at 89. Ms. Clour testified that there is no formal process for following up on the results of the CQI review, and that is left up to the area to follow up on any issues identified (Clour Dep. 2/4/11 at 26-27).

²⁰¹ Clour Dep. 2/4/11 at 30-32.

²⁰² Thompson Dep. 2/2/11 at 91.

²⁰³ Ibid. at 88.

²⁰⁴ Clour Dep. 2/4/11 at 26-27.

²⁰⁵ Litsch Dep. at 26-27; Thompson Dep. 2/2/11 at 89.

The absence of a functioning CQI process seriously limits the agency's ability to monitor and improve its effectiveness in delivering services to children and families.

D. The Reports and Data Used by DHS Workers, Supervisors, and Managers Lack Integrity

High-quality services to children and families require data-based decision making. A comprehensive statewide information system is necessary to support casework, strategic planning, and needs assessment. The system must be able to capture individual data that is useful to workers as well as aggregate data that supports policy and practice improvements. Well-designed reports allow an agency to not only see where it needs to go, but to measure its performance and hold people accountable for achieving the goals set. Without defensible data regarding case practice and outcomes, it is virtually impossible to drive good casework. Thus, it is crucial that DHS maintain data that is accessible, easy to use, and – most importantly – accurate. Unfortunately, it appears that much of the data provided to DHS staff is totally unreliable.

According to Dr. Zoran Obradovic, an expert retained by Plaintiffs to review DHS's computer data system, the lack of change control and quality control over the KIDS System creates a high risk that many – if not all – of DHS's child welfare reports contain inaccurate, unreliable, or out-of-date information.²⁰⁶

As explained in more detail in Dr. Obradovic's Report, change control is fundamental because the software code underlying the KIDS System is constantly changing, and the programs that extract information from the KIDS System in order to create child welfare reports must be updated accordingly. However, DHS does not have any formal process in place to ensure that changes made to KIDS are implemented in the programs that underlie the child welfare reports. Instead, DHS relies on informal communication from members of the Technology and Governance Unit of CFSD, who have no computer programming background or experience, to ensure that the programmers responsible for the reports are kept abreast of all relevant changes. According to Dr. Obradovic, this creates a serious risk that the child welfare reports are unreliable and out-of-date.²⁰⁷

Another serious problem is the almost total lack of quality control over the child welfare reports. "Quality control" refers to various types of testing, which ensure that software code meets the needs of users and is built as intended. Careful testing is necessary to ensure that the child welfare reports are correct, both before they are put into use and on a regular basis thereafter. However, as Dr. Obradovic explains, there is no rigorous testing of whether the software used to create the reports is functioning correctly or meets the end users' needs, nor do the reports themselves undergo any standardized testing protocol.²⁰⁸ Instead, it appears that DHS's only form of quality control is an informal assessment of whether the reports look like

²⁰⁶ Obradovic Report at 2.

²⁰⁷ Ibid. at 9-13.

²⁰⁸ Ibid. at 13-15.

they will work, and a search for problems that “stick out like a sore thumb.”²⁰⁹ As a result, there can be no guarantee that any of the reports are accurate.

As Dr. Obradovic reports, these problems are caused in part by organizational and management dysfunctions within DHS. Ultimate responsibility for the quality of the reports rests with the Technology and Governance Unit,²¹⁰ despite their lack of training in computer science or computer programming.²¹¹ The Technology and Governance Unit is supported by a small number of programmers from the Data Services Division, whose supervisor does not have any background or experience in the computer programming languages used to create the child welfare reports.²¹² DHS’s failure to put in place a properly qualified management team over the crucial area of reporting is unacceptable.

While Dr. Obradovic opined that there is a high risk that every child welfare report is inaccurate, DHS itself has also admitted that there are serious problems with one of the two major categories of child welfare reports in use at the agency, the so-called Access reports (which consist of YI 678, YI 684 and YI 701 reports).²¹³ As early as June 2010, DHS Data Services Division Programmer John Gelona discovered problems with the YI 684 Access reports.²¹⁴ In two June 28, 2010 emails, he provided Technology and Governance Unit Programs Administrator Mary Grissom with several examples of incorrect, incomplete, and/or inconsistent queries.²¹⁵ Mr. Gelona continued to email with Ms. Grissom about these issues in early July 2010, describing a number of YI 684 queries as “massively wrong,”²¹⁶ and stating that “they are just flat out giving the wrong results, especially the ones dealing with contacts.”²¹⁷ Mr. Gelona subsequently testified that between 50% and 70% of the YI 684 queries he reviewed were affected by the problems he discovered, and that they provide inconsistent and incorrect information.²¹⁸ Ms. Grissom has acknowledged that DHS has insufficient quality control to ensure that the queries used to create the Access reports were accurate, and that she is not certain that any of the reports produced are correct.²¹⁹ Furthermore, she testified that it is “[c]ertainly possible” that the same problems identified with the YI 684 reports will also be found with the YI 678 and YI 701 reports.²²⁰

²⁰⁹ Ibid. at 15-16; Roberts Dep. 11/9/10 at 50-51.

²¹⁰ Roberts Dep. 11/9/10, at 61; Jew Dep. 11/9/10 at 80; Gelona Dep. 9/23/10 at 62.

²¹¹ The Programs Administrator of the Technology and Governance Unit, Mary Grissom, stated that she is “not a technical person” and does not “know anything about programming and best practice.” She has had no computer science education or programming experience, and neither she nor anyone in her group is able to read or understand computer programming code (Grissom Dep. 9/7/10 at 28, 17-18, 27, 108). See also Roberts Dep. 11/9/10 at 15-18, 46-47; Grissom Dep. 9/7/10 at 44-45; Jew Dep. 11/9/10 at 40-42.

²¹² Obradovic Report at 7; Nair Dep. 12/1/10 at 102, 121.

²¹³ Grissom Dep. 8/5/10 at 48; Grissom Dep. 9/7/10 at 62; Gelona Dep. 9/23/10 at 146, 151.

²¹⁴ Grissom Dep. 9/7/10 at 58-59; Issuesw-AccessComm-00003; Issuesw-AccessComm-00004; Gelona Dep. 9/23/10 at 149-150.

²¹⁵ Issuesw-AccessComm-00004.

²¹⁶ Issuesw-AccessComm-00094.

²¹⁷ Issuesw-AccessComm-00003.

²¹⁸ Gelona Dep. 9/23/10 at 151-153, 146.

²¹⁹ Grissom Dep. 9/7/10 at 67-68.

²²⁰ Ibid. at 95.

Nevertheless, DHS has taken only the most limited steps to deal with these problems,²²¹ and apparently no one has analyzed the full extent of, or undertaken to fix, the underlying problems.²²² In fact, seven months after these critical issues were discovered, key senior managers at DHS were still unaware of any potential problems with the reports.²²³ DHS should have taken immediate steps to identify the full extent of these problems, informed all child welfare staff, and curtailed the usage of all potentially erroneous reports.

What is most concerning is that the Access reports are still actively used at the agency. For example, Mr. Johnson uses the Access reports and the data contained in those reports on a regular basis and expects those who report to him to review some of them as well.²²⁴ Just one example of the many ways Mr. Johnson relies on this data is his use of the Combined Workload Report, which incorporates data from the Access databases,²²⁵ and is the primary report that Mr. Johnson uses to monitor caseloads and staffing decisions.²²⁶ He testified that he monitors this report “[d]aily[,] [s]ometimes hourly”²²⁷ and expects his area directors and assistant area directors to review them as well.²²⁸ As of February 15, 2011, however, he was unaware of the problems DHS had discovered with the Access reports, and was never told not to use them.²²⁹ Evidence indicates that use of these reports is widespread in the agency, and thus use of inaccurate and unreliable information is also widespread.²³⁰

Reliable data and reports are essential to an agency’s ability to make informed decisions and provide good outcomes for children and families. Not only is DHS unable to generate reliable reports because of the flawed systems and organizational problems identified by Dr. Obradovic, but the agency and its leaders continue to use reports that are incorrect. Given the significant impact such information, if used appropriately, can have on decisions that affect the welfare of the children DHS serves, the continued reliance on reports that DHS knows are inaccurate is incomprehensible.

III. DHS HAS AN INADEQUATE SYSTEM FOR DEVELOPING, DEPLOYING, AND SUPPORTING ITS CHILD WELFARE WORKFORCE

The single most critical asset to a high-performing child welfare agency is a workforce that is appropriately qualified and trained, and has reasonable and equitable caseloads. In addition, the front-line workers must have, in equal measure, support and accountability if children and families are to receive the services they need. Without these qualities, the agency

²²¹ Ms. Grissom limited the creation of new Access queries. Grissom Dep. 9/7/10 at 46-47.

²²² Grissom Dep., 9/7/10, at 51, 71, 73, 94, 97, 203; Gelona Dep. 9/23/10 at 211.

²²³ Johnson Dep. 2/15/11 at 145-146; Clour Dep. 2/4/11 at 98-101; Howell Dep. 2/15/11 at 70; Jew Dep. 11/9/10 at 95-96.

²²⁴ Johnson Dep. 2/15/11 at 145-146, 52, 55, 73, 75, 87-88, 101, 103-104.

²²⁵ Ibid. at 84.

²²⁶ Ibid. at 87, 73, 75.

²²⁷ Ibid. at 101.

²²⁸ Ibid. at 48.

²²⁹ Ibid. at 145-146.

²³⁰ Ibid. at 7, 30, 46-47, 49, 50, 89, 52, 53-58, 69, 70-73, 75, 84, 87-88, 91, 96, 101, 103-104, 126, 133; Clour Dep. 2/4/11 at 36, 86, 49-50, 76-77, 86, 92-93, 101, 68-70; Thompson Dep. 2/2/11 at 47-48, 59-61, 65, 70, 95, 97-98, 104, 115-116; Howell Dep. 2/15/11 at 68-69, 70, 77, 85, 87, 88, 122, 134, 98-99, 112, 122-123, 134; Litsch Dep. 2/4/11 at 55, 58, 76, 107; Grissom Dep. 9/7/10 at 54-58, 76, 78-79, 87, 89-91; Gelona Dep. 9/23/10 at 117, 142; Roberts Dep. 11/9/10 at 25, 28, 97-100, 105-106, 111-112; APSR-2010-6.30.09-00044.

cannot ensure that its direct service workforce has the time, ability, and supervision needed to perform its functions in accordance with policy and proper practice and in the best interest of children and families.

A. DHS’s Fractured Case Assignment Practice Is Ineffective and Has a Detrimental Impact on Children and Their Families

In order to mitigate the trauma that necessarily exists after a child is removed from his or her home, child welfare agencies have a responsibility to provide as much consistency and stability for that child as possible. In Oklahoma, children in custody and their families often have not one, but *several* different workers assigned to their case at any one time. Even on its face, the DHS model for case assignment does not reflect good practice. In the field, it is ineffective and has a detrimental impact on children, who experience a revolving door of DHS workers coming in and out of their lives during their time in custody, which is further exacerbated by the high levels of staff turnover at DHS (see Section III.E below).

Every child in DHS custody is assigned a “primary” caseworker, who is located in the county where the child’s juvenile court proceeding is pending (*i.e.*, the county of court jurisdiction).²³¹ Every time a child is placed outside the county of court jurisdiction, he or she is also assigned a “secondary” caseworker in the county of placement.²³² While the primary worker’s supervisor is based in the county of court jurisdiction, the secondary worker’s supervisor is based in the county of placement. This fragmented two worker/two supervisor model is extremely common practice at DHS given that approximately 65% of foster children were placed out of the county of court jurisdiction.²³³ One must also keep in mind that if a child is moved from one out-of-county placement to another, he or she is assigned a *new* secondary worker with a *new* supervisor in the county of placement. The assignment of multiple secondary workers to a child during his or her stay in DHS custody happens frequently, given the extreme placement instability that children in DHS are subjected to while in custody (see Section IV.C.1 below). In fact, Dr. Milner’s Case Record Review found that 81% of children had at least one secondary worker and 38% had *five or more*.²³⁴

When primary and secondary workers are assigned to a child’s case, they have “equal responsibility” for the care and oversight of the child, and are required to make collaborative decisions regarding case planning and service delivery.²³⁵ However, in practice, their day-to-day responsibilities are fractured. The primary worker has ultimate responsibility for keeping the court apprised of the child’s status – completing court reports and attending court hearings – while the secondary worker is responsible for visiting the child and “mak[ing] sure that all the

²³¹ White Dep. 8/6/09 at 48-49, 60-61; OAC 340:75-1-29, Instructions to Staff 2.

²³² White Dep. 8/6/09 at 72:19-22; OAC 340:75-6-48 Instructions to Staff 5(a)(1)(B); Overstreet Dep. 11/10/10 at 18:5-14.

²³³ YI617A-00330.

²³⁴ Milner Report at 82-83.

²³⁵ White Dep. 8/6/09 at 40, 72; White Dep. 12/18/09 at 78; Johnson Dep. 2/15/11 at 117:6-118:3; Overstreet Dep. 11/10/10 at 20:3-21:2; OAC 340:75-1-29, Instructions to Staff, 2(2); OAC 340:75-6-48, Instructions to Staff, 5(a)(1)(B).

child's needs are being met."²³⁶ When questioned about the responsibilities of primary and secondary workers, Larry Johnson, Director of FOD testified:

That responsibility somewhat is split between the secondary worker and the primary worker. The secondary worker that has visitation responsibility doesn't have any responsibility for preparing all the court reports, dealing with the district attorney, all of the court information; but at the same time, the primary worker doesn't have a need to have really much – any contact with that child on a regular basis. That's someone else's responsibility.²³⁷

The DHS model of case assignment becomes even more complicated when one considers the realities of many families who have children in state custody. In situations where a foster child's siblings and parents are located in counties other than the county of court jurisdiction, a single family working towards reunification can be assigned multiple workers (as well as their different supervisors) at any one time. As Amy White, Programs Administrator for the CFSD Permanency and Independent Living Unit, testified:

The worker in the county of jurisdiction is always the worker in – the worker where the court case resides. All of the other workers are dependent on the parents' residence and the current placement where the child resides. You could have a scenario where you have a county of jurisdiction worker whose only responsibility is as being the county of jurisdiction worker, and they gather the information to provide the information to the court, but the parent may reside in another county, another child may reside in another county and another parent could reside in another county. There are many circumstances where they don't all reside within the same county.²³⁸

There is no doubt that this disjointed case assignment model is ineffective and contributes to DHS's poor performance on reunifying children with their families in a timely manner (see Section IV.C.2 below).

Moreover, in addition to primary and secondary workers, children are often assigned other workers, including independent living workers, adoption workers, adoption transition workers, and permanency expeditors, during their time in custody. This deeply fragmented structure deprives children of a consistent person at DHS they can rely on at a time when they need it the most. According to Vera Fahlberg, "[c]hildren entering, moving through, and exiting from the interim care system are faced with repeated separations and losses. . . . One of the most serious challenges of child welfare work is helping children cope with these traumatic separations."²³⁹ Stability in the child's caseworker provides some level of constancy in the child's life. Unfortunately, DHS does not provide children in its custody with that constancy.

DHS's process for worker assignment is one more indication of the disjointed nature of the organization and the lack of focus on good outcomes for children and families. This model

²³⁶ Overstreet Dep. 11/10/10 at 17-19; White Dep. 8/6/09 at 48-49, 60-61, 72.

²³⁷ Johnson Dep. 2/15/11 at 116:16-25.

²³⁸ White Dep. 8/6/09 at 48-49.

²³⁹ Vera I. Fahlberg, *A Child's Journey Through Placement*, at 141 (1991).

has a negative impact not only on the children for whom DHS is responsible, but on the workers who want to be effective in their job and make a difference in the lives of children and their families. In order to remedy this problem, DHS must focus on both placing children closer to their home communities and providing some level of stability in case assignment. As long as DHS continues its awful track record of not placing children close to home, it will be difficult to stabilize caseworkers. Therefore, a coordinated approach will be necessary, and must include significantly improving the recruitment and retention of foster homes. If DHS hopes to improve the outcomes for the families and children it serves, this work will be essential.

B. DHS Has No Reliable System for Monitoring Its Child Welfare Workers' Total Caseloads

It is imperative to a well-functioning child welfare agency that its caseworkers have manageable caseloads; the safety and well-being of children depend on this. High caseloads significantly reduce the capacity of both caseworkers and their supervisors to perform the essential activities of good child welfare practice. As Joani Webster, Programs Administrator of the CFSR Resource Unit, stated: “children and families suffer” because of excessively high caseloads; for overburdened caseworkers “it is very difficult to spend the time you need individually with that child, with that family to help them.”²⁴⁰

The nationally accepted caseload standards promulgated by the Child Welfare League of America (CWLA), the country’s oldest child advocacy organization, comprised of public child welfare administrators and workers throughout the country, set a maximum of 12 to 15 individual foster children per worker.²⁴¹ It is important to note that any time a case beyond these accepted standards is added to a worker’s caseload, it has a significant impact on the caseworker’s capacity to perform high-quality casework. The difference, for example, between managing 15 and 18 cases is far greater than the number “three” suggests. Given the time it takes to complete even the *minimal* amount of work necessary to ensure foster children’s safety, permanency, and well-being – which includes completing thorough and ongoing safety and needs assessments; making sure that children are in appropriate placements; providing consistent, quality visitation; arranging necessary services; and performing adequate case documentation – adding even three cases can make the difference between good and bad outcomes for children.

Numerous reports in the past several years – most completed by DHS itself – have identified high caseloads as a serious, ongoing problem:

- DHS’s 2007 CFSR Statewide Assessment repeatedly tied the agency’s failure to adequately protect the children in its care to excessive caseloads,²⁴² reporting that 187 additional child welfare workers were necessary to meet DHS’s workload standard.²⁴³

²⁴⁰ Webster Dep. 1/6/10 at 51.

²⁴¹ CWLA Standards of Excellence for Family Foster Care Services § 3.48.

²⁴² Dep. Ex. 161 (OKDHS Child and Family Services Review Statewide Assessment, May 2007) at 29, 31, 41, 45, 50-52, 60, 62, 86.

²⁴³ Ibid. at 3.

- In 2008, the Oklahoma Child Death Review Board reported that DHS’s child welfare workers and supervisors were carrying active caseloads that were two to three times higher than the national standards recommended by CWLA,²⁴⁴ and found that caseloads needed to be in compliance with those standards “[i]n order to reduce the number of deaths due to child abuse and/or neglect.”²⁴⁵
- Oklahoma’s February 2009 Draft Second Round CFSR Program Improvement Plan (PIP) listed high caseloads as an area of key concern.²⁴⁶ It stated: “Oklahoma feels strongly that the ability of child welfare staff to achieve desired safety, permanency and well being outcomes for children and families is dependent upon having and maintaining an adequate workforce. . . . Permanency Planning workers on average have primary assignment of 23-24 children which is significantly higher than Child Welfare League of America (CWLA) standards of 12-15 children per worker. Workers also carry secondary case assignments on numerous additional cases due to children being placed out of county, one parent residing out of county, etc.”²⁴⁷
- DHS’s July 2009 application for technical assistance, “Raising the Bar: System Change through an Enhanced Model of Child Welfare Supervision,” repeatedly referred to problems with excessive caseloads as impeding high-quality case practice.²⁴⁸
- DHS’s June 2010 Child and Family Services Plan reported that 58% of caseworkers who responded to a worker satisfaction survey stated their caseload has not decreased in the last six months, and 48% stated they were unable to spend enough quality time with children and families to assess their needs.²⁴⁹

Although DHS leadership claims that the caseloads of its child welfare staff have recently improved due to the reduction in the number of children in foster care custody,²⁵⁰ given the agency’s long history of having an overburdened child welfare workforce, I do not see how current caseloads could possibly be within the nationally recognized standards recommended by CWLA. In fact, DHS has not adopted these standards to guide its case practice or set a specific caseload target for child welfare workers that is within the maximum recommended under the standards.²⁵¹

Equally disturbing, it is impossible to accurately assess how far caseloads continue to remain above nationally recognized standards because DHS does not have a reliable system for monitoring its workers’ total caseloads. Despite the existence of a SACWIS-approved electronic case management system,²⁵² the reports upon which DHS leadership rely to assess child welfare caseloads are incomplete and inaccurate. In my opinion, this failure is one of the

²⁴⁴ Dep. Ex. 159 at 3 (OCDRB Recs 5.08-00003).

²⁴⁵ OCDRB-2008 AnnRpt-00010.

²⁴⁶ PLAINTIFFS 07596.

²⁴⁷ PLAINTIFFS 07587-88.

²⁴⁸ Raising the Bar (WhiteA-007612) at 3, 38.

²⁴⁹ APSR-2010-6.30.09-00138, 00146.

²⁵⁰ Dkt. 475 at 18-19; Dkt. 436 at 5.

²⁵¹ Johnson Dep. 6/17/09 at 84-85.

²⁵² SACWIS stands for Statewide Automated Child Welfare Information System.

most serious deficiencies in the administration of Oklahoma’s child welfare agency. Without this capability, it is not possible for DHS to thoughtfully or effectively manage workloads.

Based on my review of DHS’s various caseload reports, none of them provides reliable information about the *actual* number of children assigned to child welfare staff. Mr. Johnson, who has ultimate responsibility for monitoring child welfare workloads, primarily relies on the Combined Workload Report to track caseloads.²⁵³ This report calculates average caseloads based on the larger of two different counts: (1) the number of children whom an individual worker is required to visit;²⁵⁴ and (2) the number of children assigned to workers on a primary basis.²⁵⁵ However, as Mr. Johnson himself has confirmed, both of these counts *systematically understate* workers’ true caseloads.²⁵⁶ The first count excludes children assigned to workers on a primary basis where those children have been moved outside the county of court jurisdiction. This is problematic because, in such cases, although the primary worker is not required to visit the child, according to DHS policy and practice, the primary worker is still responsible for the care and oversight of the child.²⁵⁷ Likewise, the second count excludes children assigned to workers on a secondary basis. This is problematic because almost two-thirds of children in foster care placements are placed out of the county of jurisdiction, and are therefore assigned secondary workers.²⁵⁸ Thus, both of the counts which comprise the Combined Workload Report do not account for some part of workers’ caseloads.

Another serious issue with the Combined Workload Report is that it only provides *average* caseload information, broken down by county and area, with no information on individual caseloads. This ignores the significant variance in caseloads among workers within the same county. Mr. Johnson is – or at least should be – aware that this variance is extreme.²⁵⁹ Based on my experience, it is impossible to effectively manage child welfare caseloads without data regarding individual worker caseloads. For all of these reasons, it is extremely concerning that DHS leadership continues to rely on the Combined Workload Report to manage child welfare caseloads.

Recently, DHS management has also started using a new DHS report to monitor caseloads. This report was created in mid-2010 because of “internal and external questions about . . . excessive workloads,” including questions raised by Plaintiffs in this lawsuit and complaints by DHS county directors that actual caseloads did not match up to DHS’s existing workload reports.²⁶⁰ Entitled “Count of Children by Worker,” this new report purports to track both primary and secondary assignments for child welfare staff. As Mr. Johnson admitted, before this report was created, the agency did not have any process in place that permitted management to track the total caseloads of individual child welfare workers.²⁶¹ However, significant inconsistencies and errors have been identified in this report – including vast

²⁵³ As discussed in Section II.D above, the data underlying this report is not sufficiently reliable.

²⁵⁴ Johnson Dep. 6/17/09 at 86-87.

²⁵⁵ YI624-00006; YI617A-00001-02; Johnson Dep. 2/15/11 at 112.

²⁵⁶ Johnson Dep. 2/15/11 at 112-114.

²⁵⁷ Johnson Dep. 6/17/09 at 92-93; Johnson Dep. 2/15/11 at 117-118.

²⁵⁸ YI617A-00330; Johnson Dep. 2/15/11 at 112.

²⁵⁹ YI743 Caseload Report, Count of Children by Worker

²⁶⁰ Johnson Dep. 2/15/11 at 82.

²⁶¹ Ibid. at 81-82, 91.

inequities in caseload size among workers within the same county, inexplicably low caseloads for certain workers, and the assignment of children to workers who do not even work in permanency planning.²⁶² These inconsistencies indicate that this report does not accurately track caseloads, something which DHS management itself has acknowledged.²⁶³ Thus, this report, like the Combined Workload Report, provides an unreliable basis for effective caseload management.

Because DHS does not systematically track true worker caseloads, manual hand-counts are currently the only way to accurately assess this information. However, hand-counts are time-consuming, labor-intensive, prone to error, rarely conducted, and a poor substitute for an electronic caseload tracking system. It is entirely unacceptable that a child welfare agency with a functioning SACWIS-approved system does not adequately monitor such a critical aspect of case management. Even more concerning is the fact that DHS management does not appear to have any immediate plan to remedy this serious deficiency.

There is currently no centralized system of accountability for ensuring that caseloads are being accurately tracked and distributed equitably. For example, Mr. Johnson testified that he was not concerned with the uneven distribution of workloads and other anomalies reflected in the “Count of Children by Worker” report because he only uses this report “to look for potentially excessive caseloads,” which he considers to be caseloads that exceed 25 individual children (well above the CWLA recommended maximum).²⁶⁴ Mr. Johnson was unaware of many of the errors in this report and stated, “that’s not what my focus is and that’s not what the purpose of the report’s for.”²⁶⁵ Aside from this, he expects area and county directors to balance worker caseloads and ensure that workload and staffing information is accurate.²⁶⁶ But given the uneven distribution of workloads in every area of the state, it is clear that this is not being done.

Equally as concerning, if not more so, is the fact that Mr. Johnson only reviews the average number of new cases assigned to CPS workers; he does not monitor individual CPS worker assignments or their total caseloads.²⁶⁷ Kelli Litsch, CFSD Programs Administrator for CPS, does not either,²⁶⁸ nor did Esther Rider-Salem when she was the CPS Programs Manager at CFSD.²⁶⁹ DHS Area Director Debra Clour testified that she relies on her county directors to monitor new cases assigned to individual CPS workers.²⁷⁰ DHS’s system of “passing the buck” on an issue as important as caseload management displays extremely poor practice. Too much discretion is left to the supervisor level in individual counties to address caseload issues, with little centralized monitoring, which can result in inconsistent and unsafe case practice.

In order to efficiently monitor child welfare caseloads, DHS management must also develop up-to-date workload standards. A workload study based on the actual day-to-day tasks that must be performed by child welfare workers to meet policy and reasonable practice is a commonly accepted tool for evaluating reasonable caseload levels. Although DHS completed a

²⁶² Ibid. at 94-99.

²⁶³ Ibid. at 94-99; Thompson Dep. 2/2/11 at 113; Clour Dep. 2/4/11 at 93, 95.

²⁶⁴ Johnson Dep. 2/15/11 at 97-99, 94, 100.

²⁶⁵ Ibid. at 95.

²⁶⁶ Ibid. at 99-100.

²⁶⁷ Ibid. at 87-88; Johnson Dep. 6/17/09 at 113-114.

²⁶⁸ Litsch Dep. 2/4/11 at 55.

²⁶⁹ Rider-Salem Dep. 9/16/09 at 97-98.

²⁷⁰ Clour Dep. 2/4/11 at 101-102.

Child Welfare Services Workload Study in July 1999, it has not been updated since then.²⁷¹ DHS management has confirmed that this study is invalid and outdated because it does not reflect current casework requirements and practices, and is no longer used for staffing purposes or caseload management.²⁷² Although there has been some discussion at DHS of updating this analysis, there are currently no plans to do so.²⁷³

In my opinion, DHS's grossly insufficient workload management practices, which do not adequately ensure that child welfare staff caseloads are reasonable or equitably distributed, are placing all children in DHS custody at grave risk of harm. This issue is indicative of widespread disregard by the agency of the importance of caseload management.

C. DHS's Child Welfare Training Lacks Focus on High-Quality Casework and Is Inadequately Monitored

After reviewing DHS's process and structure for the professional development of its child welfare workforce, it is clear that the agency needs to improve both the pre-service and in-service child welfare training curriculum, more consistently and effectively incorporate its Practice Model into day-to-day practice, and develop a system to monitor staff training. All of this will be necessary to improve outcomes for the children and families that DHS serves.

1. The Substance and Structure of DHS Child Welfare Training Should Be Enhanced

A well-trained workforce is essential to the operation of a safe, well-functioning child welfare system. According to the standards recommended by the CWLA, "[f]or agencies to provide quality services and to reach the desired outcomes . . . they must have [] a skilled, committed, stable work force."²⁷⁴ Effective training – which includes pre-service and ongoing training, as well as continuous on-the-job training through supervisory consultation and support – enables workers and supervisors to make sound decisions regarding children's safety, well-being, and permanency, in accordance with established professional standards, federal and state law, and agency policy.

CWLA standards recommend that the agency require and offer a strong pre-service training program for all newly-hired staff, which covers a variety of areas, including the purpose, goals, philosophy, and organizational structure of the state foster care program; the laws, regulations, policies, and values that guide that program; and the knowledge and practice skills required for family foster care work.²⁷⁵ A functional child welfare agency establishes and enforces skills through in-service training, to ensure that staff have the specialized skills and knowledge necessary to provide quality services, and that they maintain up-to-date knowledge about changes in policy or law and advances in social work theory and practice. This training

²⁷¹ Johnson Dep. 6/17/09 at 126-127.

²⁷² Johnson Dep. 2/15/11 at 77-80.

²⁷³ Litsch Dep. 2/4/11 at 61-62.

²⁷⁴ CWLA Standards of Excellence for Adoption Services § 1.23.

²⁷⁵ CWLA Standards of Excellence for Management and Governance §§ 3.17- 3.19.

“should help personnel maintain and expand the knowledge and skills they need to fulfill their individual responsibilities.”²⁷⁶

DHS child welfare training is provided through the University of Oklahoma Health Services Center.²⁷⁷ All new child welfare workers must complete general CORE training, which consists of four weeks of classroom training and one week of on-the-job training.²⁷⁸ Although DHS policy requires new workers to begin CORE training no more than six weeks after their hiring date (prior to which they engage in pre-CORE activities that include shadowing workers and reading assigned materials),²⁷⁹ the HZA Audit reported that pre-service training was often not scheduled for several months after a worker’s start date, resulting in lost time since workers are not permitted to carry caseloads until this training is complete.²⁸⁰ New workers assume full caseloads 60 days after the completion of CORE training.²⁸¹ However, child welfare workers are not expected to complete their first level of specialized training specific to their job responsibilities until 12 months after the completion of CORE training,²⁸² meaning that workers are not trained on all aspects of their job before carrying full caseloads and functioning independently. As Tricia Howell, Programs Manager of the Permanency Planning Unit of CFSD, stated in an October 2009 email:

I think that [new workers] are turned to [sic] loose to work independently way more than anyone plans, with hope that they will ask questions as needed. The bad thing is, if they don’t have really good judgment and life experience, they probably don’t know which things they should be bringing to someone’s attention.²⁸³

Effective training must link policy and procedure to day-to-day practice. However, the CORE training materials focus largely on policy and process rather than high-quality casework. There seems to be little, if any, discussion of the competencies workers are expected to develop, or the desired outcomes for children and families. As noted in DHS’s own Supervisor and Mentor Guide regarding CORE training: “Despite our best efforts to ‘keep it simple’ we often find the new workers drowning in a sea of information which makes no sense to them.”²⁸⁴ The HZA Audit found several areas where the pre-service training provided to child welfare staff was lacking or inadequate. After reviewing the child welfare pre-service training curriculum provided by DHS, it concluded: “These materials do not constitute a ‘curriculum’ but an amalgam of handouts, articles, exercises and PowerPoint slide handouts loosely organized into topics, with a heavy dose of excerpts from administrative code or policy.”²⁸⁵ Moreover, the on-the-job training conducted by supervisors in the field is unstructured.²⁸⁶ It comes as no surprise,

²⁷⁶ Ibid. § 3.20.

²⁷⁷ Child Welfare Training Program – OUHSC & OKDHS (<http://www.ou.edu/cwtraining/index.htm>); Bogard Dep. 10/10/08 at 16-17.

²⁷⁸ OAC 340:75-1-231; Overview, CORE Training (www.ou.edu/cwtraining/core.htm).

²⁷⁹ Ibid.

²⁸⁰ Dep. Ex. 173 (HZA Audit) at 134.

²⁸¹ OAC 340:75-1-231, Instructions to Staff 1(4)

²⁸² OAC 340:75-1-232.

²⁸³ Dep. Ex. 409.

²⁸⁴ Supervisor and Mentor Guide FY2011 at 1.

²⁸⁵ Dep. Ex. 173 (HZA Audit) at xiii, 134-35.

²⁸⁶ Ibid. at 137.

then, that the Audit reported 58% of child welfare staff interviewed did not find that pre-service training helped prepare them for the job.²⁸⁷ Regarding DHS pre-service training, the HZA Audit found:

[I]t is not evident that [child welfare workers] are taught to make sound, reasoned judgments. Knowing the facts about the laws and regulations governing casework is not sufficient. The basic job of caseworkers, especially in child welfare . . . is to make judgments. For those judgments to improve in Oklahoma, the training will have to change to focus on skill and competency rather than simply on knowledge.²⁸⁸

Following pre-service training, DHS child welfare workers are required to complete a minimum of 40 hours of in-service professional development training per year.²⁸⁹ As with pre-service training, the content and process of ongoing training provided to DHS child welfare workers is inadequate if the ultimate goal is keeping children safe and becoming a family-focused agency. The existing in-service training consists of a disparate list of courses, some mandated and some selected.²⁹⁰ Although staff meetings and “non-child welfare comprehensive training program workshops” conducted in the county offices are counted towards annual in-service training hours, the CFSD Training Unit is not responsible for these aspects of training, does not receive the agendas or outlines that are used, and does not keep track of these hours.²⁹¹ Rebecca Bogard, Programs Manager for the Child Welfare Training Unit of CFSD, testified that there is no specific policy to guide these county office trainings; the only requirement is that they be “training related.”²⁹² This is far too vague and open-ended. In addition, training on new or amended DHS policies is predominantly done by child welfare field liaisons and CFSD staff, either via email, or during quarterly training sessions for supervisors, who are then ultimately responsible for disseminating the new information on to their staff, and ensuring that policy is properly implemented.²⁹³ This informal, ad hoc ongoing training structure where supervisors are not even required to meet with their workers to provide necessary training does not adequately ensure that policy is being consistently applied throughout all of the regions, or that child welfare staff are receiving the necessary professional development.

2. The DHS Practice Model Is Not Being Effectively Incorporated Into Training or Consistently Implemented

A well-designed child welfare training program is built around the social work practice model used by the child welfare agency. A practice model establishes the standards of best practice that the agency will embrace; details the underlying philosophy that will drive the agency’s work; sets goals, objectives, and outcomes; and identifies the specific action steps to complete the work with families and children. In an attempt to address the numerous

²⁸⁷ Ibid.

²⁸⁸ Ibid. at 139.

²⁸⁹ OAC 340:75-1-232.

²⁹⁰ Child Welfare Training Program – OUHSC & OKDHS (<http://www.ou.edu/cwtraining/allworkshops.htm>); Bogard Dep. 10/10/08 at 52, 84, 100.

²⁹¹ Bogard Dep. 10/10/08 at 53-55; OAC 340:75-1-232, Instructions to Staff 2(6).

²⁹² Bogard Dep. 10/10/08 at 54-55.

²⁹³ Howell Dep. 2/15/2011 at 49-51; Clour Dep. 2/4/2011 at 80; Thompson Dep. 2/2/11 at 76-77; Dep. Ex. 173 (HZA Audit) at 139.

deficiencies that had been identified in the federal CFSR and to improve case practice particularly around placement instability and the maltreatment of children in out-of home care, DHS developed and began to implement its new Practice Model in 2008.²⁹⁴ The Practice Model was implemented statewide in 2010.²⁹⁵

A major failing of the Practice Model is that although it moves from a child-centered to a family-centered practice – a major shift in the culture of child welfare practice that agencies across the county are embracing – it does not provide strong guidance on how such a fundamental change in practice will be consistently implemented. For example, the Practice Model adopts Family Team Meetings, which are the core of engaging families and improving outcomes, but concludes: “After considerable discussion, OKDHS made a decision not to adopt any specific model but to allow the areas of the state to decide how they will approach the Family Team Meeting process.”²⁹⁶ This indicates very limited understanding of the realities on the ground, where often multiple workers in different counties are responsible for one family.

In fact, in July 2009, DHS applied for technical assistance to alleviate the problems it was encountering in implementing the Practice Model, and to yield better outcomes for children, with a specific focus on improving the quality of child welfare supervision.²⁹⁷ It admitted that “OKDHS still struggles to have the [Practice Model] become fully engrained in the practice of the agency,” resulting in “inconsistent practice.”²⁹⁸ Based on the findings of Dr. Milner’s Case Record Review discussed extensively throughout this report, which covers the time period through June 1, 2010, it is clear that the Practice Model is still not being effectively implemented. DHS must focus on improving its child welfare training to better incorporate this model into day-to-day practice if it wants to see better outcomes for children.

3. DHS Fails To Systematically Monitor Child Welfare Staff Training

DHS fails to systemically monitor whether its child welfare caseworkers and supervisors have completed all mandatory training within the required timeframes. Training hours are tracked in several different locations, so there is no one record for DHS management to review on a regular basis to ensure that the annual hours required by policy have in fact been completed by child welfare staff. When asked how DHS supervisors determine if their caseworkers are meeting training requirements, Mary Grissom, former Programs Administrator for the Technology and Governance Unit at CFSO, confirmed that although some training records are maintained on the KIDS System, other training information is stored elsewhere. She testified:

We’ve made some efforts to try to coalesce those [training hours] together [on the KIDS System] and haven’t been very successful with that. But [supervisors] would probably need to go look at learning management system for some of the

²⁹⁴ Webster Dep. 1/6/10 at 20, 28-30, 36-45; Raising the Bar (WhiteA-007612) at 1.

²⁹⁵ Howell Dep. 2/15/11 at 115.

²⁹⁶ Child Welfare Practice Model Guide at 35.

²⁹⁷ Raising the Bar (WhiteA-007612).

²⁹⁸ Ibid. at 1.

training. Would also need to look at the [human resources management division] section for training for that.²⁹⁹

Moreover, there is no consistent practice at DHS for holding workers and supervisors accountable if they fall short of their required annual hours. Discretion is left to individual county directors to handle these situations, but there is no DHS policy to guide this process.³⁰⁰ While Ms. Bogard explained that staff training should be reviewed by the county directors during performance evaluations,³⁰¹ there is no process in place to systematically track whether this is in fact occurring, and the HZA Audit found no indication of any repercussions for workers who do not timely complete the required specialized training.³⁰² Ms. Bogard testified that she had “no idea” how many total workers or supervisors fail to complete their annual training because “that’s a county director thing.”³⁰³ The fact that the head of the CFSD Training Unit does not consistently keep track of workers or supervisors who are deficient in their training requirements demonstrates remarkably poor management by DHS.

DHS should give serious attention to a comprehensive review of its staff training and procedures. In order to become a high-performing agency, DHS must improve its pre-service and ongoing training curriculum and process and develop a rigorous system for assuring that training requirements are being met by the child welfare workforce on a timely basis. If, in fact, the agency is attempting to implement a family-teaming, strengths-based model as the new Practice Model indicates, there will need to be a fundamental change in how workers are trained, coached, mentored, and evaluated. If workers are expected to understand and embrace this change, they must have access to an adequate pre-service and in-service training program that is based on a shared belief in what constitutes good outcomes and best practice, and they must be effectively monitored.

D. DHS Child Welfare Caseworkers Are Inadequately Supervised

It is important to remember that, unfortunately, in child welfare, often the least experienced workers are on the front line. Therefore, strong supervision is critical to make sure that decision-making is appropriate, consistent, and timely, and that the agency is achieving good outcomes for children and families. It is imperative that competent supervisory support is available to workers for clinical consultation and guidance, as well as to assure that policies are properly implemented. According to the standards recommended by the CWLA, supervisors should work with their staff to develop quantifiable outcome-focused objectives, and supervisor review of the achievement of those objectives should be an ongoing process that analyzes both the quality and quantity of the work performed by caseworkers.³⁰⁴

Given that comprehensive supervision enables child welfare caseworkers to achieve the highest quality of practice, and supervisors are key in providing continuous training for caseworkers, the preparation and training that DHS provides to new supervisors is woefully

²⁹⁹ Grissom Dep. 10/10/08 at 87-88.

³⁰⁰ Bogard Dep. 10/10/08 at 59.

³⁰¹ Ibid. at 60.

³⁰² Dep. Ex. 173 (HZA Audit) at 139.

³⁰³ Bogard Dep. 10/10/08 at 60, 62-63.

³⁰⁴ CWLA Standards for Management and Governance § 3.26.

inadequate. Although there is a DHS training academy for new supervisors, the training is not program-specific, so supervisors for all DHS programs (e.g., child welfare, adult protective services, and child support enforcement) attend the same sessions.³⁰⁵ Beyond that, no mandatory, formal training is required for child welfare supervisors.³⁰⁶ As Ms. Bogard testified, preparing someone to become a child welfare supervisor is “really done in the county office.”³⁰⁷ In my opinion, a training structure with limited focus on child welfare and heavy reliance on ad hoc training by the counties cannot lead to high-quality supervision.

In addition, DHS child welfare caseworkers receive inadequate supervision to ensure that case management and the provision of services to children and families are consistent with the exercise of professional judgment. Although agency policy requires supervisors to have weekly conferences with new workers,³⁰⁸ DHS does not systematically document or track these conferences. Nancy Thompson, a County Director in Oklahoma County, who bears ultimate supervisory responsibility for case practice in part of a large metropolitan county, testified that she does not do anything specific to ensure that child welfare supervisors follow DHS policy requiring enhanced supervision of new workers.³⁰⁹ Moreover, she confirmed that there is no consistent, monitored approach for regular supervisory review of casework. As she explained, “supervisors meet with their staff once a month, once every two months, to staff cases and go over things” but these monthly meetings do not consistently take place because “there were times when it was too chaotic, it was too busy.”³¹⁰ In Ms. Thompson’s county, caseworkers are not required to provide their supervisors with any regular, written reports; nor are supervisors required to provide their superiors with such reports, or keep supervisor notebooks.³¹¹ In fact, the only report from the KIDS System that Ms. Thompson requires her supervisors to review is the YI 684 visitation report.³¹² In addition, DHS’s fragmented case assignment system, as discussed in Section III.A above, means that often several different supervisors are responsible for the same family’s case, further weakening accountability and making it even more difficult to ensure that high-quality casework is being practiced. This unstructured and unmonitored approach to supervision falls far short of the standards recommended by CWLA and does not allow front-line child welfare workers to receive the support they need to consistently make good decisions for children and families.

Oklahoma’s July 2009 request for technical assistance – “Raising the Bar: System Change through an Enhanced Model of Child Welfare Supervision” – was specifically aimed at “improv[ing the] competency of child welfare supervisors.”³¹³ This request correctly identifies serious concerns with DHS’s supervisory practices. DHS admitted that “[t]he current training and mentoring programs may not be adequate to meet the needs of [child welfare] supervisors under th[e] new [Practice Model].”³¹⁴ It reported that supervisor training was “very policy or

³⁰⁵ Dep. Ex. 173 (HZA Audit) at 137.

³⁰⁶ Bogard Dep. 10/10/08 at 101-104.

³⁰⁷ Ibid. at 101-102.

³⁰⁸ OAC 340:75-1-231, Instructions to Staff 1(4)(C)(iv).

³⁰⁹ Thompson Dep. 2/2/11 at 67.

³¹⁰ Ibid. at 57-58, 64-65.

³¹¹ Ibid. at 63-65.

³¹² Ibid. at 65-66.

³¹³ Raising the Bar (WhiteA-007612) at i.

³¹⁴ Ibid. at 1.

agency focused,” and supervisors needed to be “more prepared to train staff and improve fieldwork consistency.”³¹⁵ Furthermore, approximately 60% of supervisors were not accompanying new employees into the field at all, “which means that often employees do not receive regular mentoring on field-based observational and analytical techniques, appropriate methods of documentation, demonstrations of effective interviewing techniques to utilize while in the field, or on-the-spot-field-based feedback.”³¹⁶

The inadequate structure and quality of supervision of child welfare workers remains an ongoing problem for the agency, as is reflected in the findings of Dr. Milner’s Case Record Review. Although the review as a whole is an indictment of DHS’s case practices, several findings specifically indicate deficient supervision because supervisors should have ensured their workers had completed these basic case practice requirements, including:

- Adequate safety assessments were conducted prior to a trial reunification in only 46% of the cases in which the child was in a trial reunification placement at some time during the child’s most recent entry into DHS custody.³¹⁷
- In 31% of the cases, the child’s caseworker or supervisor did not visit the child at least monthly while the child was in custody during the review period of June 2009 to May 2010, despite DHS policy requiring monthly visits. For 41% of the months during which a caseworker or supervisor did not visit the child, there was no indication in the case file that there was an attempt to arrange a visit.³¹⁸
- One out of every five eligible children had no visits with their siblings in separate foster care placements during the 12 months prior to June 1, 2010.³¹⁹
- The appropriateness of the child’s permanency plan and steps taken to achieve the goal for the child were documented in less than two-thirds of the case plans, despite federal and DHS requirements to include them in the case plans of all children in foster care.³²⁰
- Almost one-half of the cases did not identify the services to be provided to the child in the case planning documents, despite DHS policy requiring this information to be included in the official case plan.³²¹
- The child’s health record was not included in 71% of children’s case plans, despite federal requirements to include it in all case plans for children in foster care.³²²
- Only 25% of the youth in the case review sample who were eligible for independent living services had an plan in their file.³²³

³¹⁵ Ibid. at 6.

³¹⁶ Ibid. at 3.

³¹⁷ Milner Report at 5.

³¹⁸ Ibid. at 8.

³¹⁹ Ibid. at 9.

³²⁰ Ibid. at 8.

³²¹ Ibid. at 8.

³²² Ibid. at 8.

- The case files demonstrated poor case file management, documentation and organization, including incomplete contact notes, missing court hearing reports, inadequate documentation of foster parent contacts, and lack of detail regarding children’s placement changes.³²⁴

I have tremendous respect for the individuals doing the extremely difficult and complex work of keeping children safe, helping them move to a forever family, and attending to their health and educational needs. These front-line workers and supervisors are too often overloaded and under-compensated and cannot be expected to produce high-quality work unless they are trained sufficiently, have reasonable caseloads, have excellent supervision and support, and are held accountable for the specific outcomes of their children and families. This is simply not happening for DHS caseworkers. DHS must significantly improve its quality of supervision if it intends to become a functioning agency and improve outcomes for children and families.

E. DHS Child Welfare Staff Turnover Is Excessive and Harmful to Children

Stability in a child welfare agency’s workforce is essential. The consequences to children in custody as a result of high staff turnover are severe, and an agency’s inadequate retention of child welfare workers increases the risk of harm to children. According to DHS’s own documents, “improv[ing] retention rates of [child welfare] workers . . . will improve the safety, permanency, and well-being outcomes of the children they serve. . . . Research has shown that reductions in [child welfare] worker turn over also reduces the length of time a child is in care.”³²⁵ High turnover rates also result in a workforce with a diminished level of experience.

The importance of constancy and stability in the life of foster children has been discussed widely in the literature. These children have, by the very fact that they have been removed from their homes because of abuse or neglect, experienced grief, pain and loss in their lives. With high staff turnover, children, at a minimum, lose any trust that may have been established with their caseworkers, as well as continuity in the management of their cases. As Ms. White admitted, DHS’s ability to evaluate a child’s needs is diminished if there is high worker turnover for that child.³²⁶ Every time a caseworker leaves, his or her cases must be reassigned to a new worker who often has to start from scratch in learning about the case. Thus, changes in caseworkers increase the likelihood that critical case management information will be lost. Given the poor state of DHS’s case file management, documentation and organization, as found by Dr. Milner’s Case Record Review,³²⁷ high turnover is an issue of particular concern for the agency.

Child welfare staff turnover at DHS is a chronic challenge. According to the HZA Audit, “[w]ithout any doubt the largest issue facing DHS from a personnel perspective is turnover.”³²⁸ At the time of the audit, 30% of child welfare workers hired had left the agency within the first year of employment.³²⁹ Indeed, DHS’s July 2009 request for technical assistance

³²³ Ibid. at 8.

³²⁴ Ibid. at 10.

³²⁵ Raising the Bar (WhiteA-007612) at 3, 18.

³²⁶ White Dep. 12/18/09 at 81-82.

³²⁷ Milner Report at 10.

³²⁸ Dep. Ex. 173 (HZA Audit) at 140.

³²⁹ Ibid. at 142.

to improve the quality of child welfare supervision was specifically aimed at combating “high staff turnover.”³³⁰ Recent DHS data demonstrates that turnover has not improved. As of July 2010, the overall instability rate of DHS child welfare workers was 40%³³¹ and, as of December 2010, 35% of child welfare workers had less than two years of experience.³³² Based on my experience, this incredibly high level of staff turnover poses serious risks of harm to children in DHS custody.

Dr. Milner’s Case Record Review also raises significant concerns related to DHS turnover. It reported that 60% of children had three or more primary caseworkers during their time in custody, and 29% had five or more.³³³ Perhaps an even more pressing issue identified by Dr. Milner’s review is the relationship of worker turnover to the quality of casework practice. Dr. Milner found that multiple changes in primary caseworkers were associated with multiple permanency goal changes for children, suggesting that when new workers are assigned to cases, they are inclined to establish new permanency goals based on their perception of what is most appropriate for the child.³³⁴ The review also found a significant relationship between the number of primary caseworkers assigned to a child’s case and the time it took for the child to become free for adoption.³³⁵ In general, longer times prior to being free for adoption were associated with higher numbers of primary caseworkers being assigned to the child’s case, suggesting that new workers are re-evaluating case goals and the status of the child before moving forward with the case.³³⁶ These results clearly demonstrate how the turnover in DHS child welfare workers has negatively affected children.

There are a number of factors that contribute to turnover in a child welfare agency. In my experience, these factors include workers’ feelings of lack of empowerment and respect; inadequate salary and benefits; lack of overtime pay, job stress, and a poor work environment; and dissatisfaction with training and support. According to the standards recommended by the CWLA, effective staff retention is founded on “the assignment of appropriate workloads and the provision of quality training, preparation, and supervision; adequate financial compensation; access to resources for clients; . . . [and] clear performance expectations.”³³⁷

DHS has not implemented effective statewide retention strategies to combat the causes of staff departures. Instead, the employee furloughs recommended by Commissioner Hendrick due to the state’s recent budget crisis would only further impede DHS management from stabilizing its child welfare workforce.³³⁸ When asked what was being done to deal with worker turnover,

³³⁰ Raising the Bar (WhiteA-007612) at i, 2, 8-9.

³³¹ Combined Workload Report, July 1, 2010. FOD Director Larry Johnson testified that instability is a more accurate measure than turnover because, while the latter only includes workers that leave the agency, instability tells the “true story” by including workers who move within the agency, such as when they are transferred from one unit to another or demoted (Johnson Dep. 2/15/11 at 106-107).

³³² CFSR-SFO-2.1-00032.

³³³ Milner Report at 82.

³³⁴ Ibid. at 64-65.

³³⁵ Ibid. at 84.

³³⁶ Ibid. at 84.

³³⁷ CWLA Standards of Excellence for the Management and Governance of Child Welfare Organizations § 3.4.

³³⁸ Randy Ellis, “Oklahoma DHS employees learn of plan to reduce pay,” *NewsOK*, (April 8, 2010).

Ms. Thompson mentioned several morale-building activities, such as employee recognition, office luncheons and parties.³³⁹ These steps are clearly inadequate.

Low compensation rates are directly tied to staff turnover. Therefore, DHS leadership must do all it can to ensure that staff compensation is adequate despite Oklahoma's budget issues. The starting salary for a DHS front-line child welfare worker is just over \$28,000 which, based on my experience, is on the very low-end of the salary scale for this position.³⁴⁰ The HZA Audit found that state workers are paid, in general, 12% less than their colleagues in comparable positions in the private sector.³⁴¹ It is very problematic when state child welfare cannot compete with the private sector in attracting the most qualified applicants. In addition, while DHS staff interviewed for the HZA Audit generally believed their compensation was too low, they were more concerned with the lack of incremental salary increases.³⁴² Not only is this situation demoralizing to workers, but it actually results in progressive pay cuts as the cost of benefit packages increase.

A deeply concerning issue related to compensation is the very limited access to overtime compensation. Instead, workers are required to take compensatory time. In child welfare, particularly CPS, this situation is dangerous because it can seriously compromise workers' ability to do their job. As the HZA Audit observed, "[u]sing the comp time meant that they fell further behind on some of their cases, which then required that they work more overtime, which then required them to take more comp time, in an endless cycle."³⁴³ In order to keep up with their cases, the HZA Audit noted that some staff worked "off the clock."³⁴⁴ This compensation structure for DHS child welfare staff does not support recruitment and retention.

DHS leadership can only address the serious issues related to child welfare staff turnover by performing a careful analysis of who is being hired; the hiring process; the conditions of employment, including an in-depth compensation analysis; and what factors are driving instability. Once those issues are evaluated, DHS will need to develop and implement a well thought-out and effective plan to stabilize its workforce.

IV. DHS FAILS TO ENSURE THE SAFETY, PERMANENCY, AND WELL-BEING OF CHILDREN

A. Children in DHS Custody Are Being Abused and Neglected at an Alarming Rate

There is universal agreement that the singular most important role of a public child welfare agency is to protect children from harm. Based on my review, it is clear that DHS is not meeting even the most minimum requirements to reasonably protect children from further maltreatment while in state custody.

³³⁹ Thompson Dep. 2/2/11 at 49-50.

³⁴⁰ State Payroll, Tulsa World (<http://www.tulsaworld.com/webextra/itemsofinterest/statepayroll/statepayroll.aspx>); Org P&P-2-00002.

³⁴¹ Dep. Ex. 173 (HZA Audit) at 147.

³⁴² Ibid. at 146.

³⁴³ Ibid. at 144.

³⁴⁴ Ibid. at 144.

In my opinion, the clearest indication that the administration and management of Oklahoma's child welfare agency is deficient is the incredibly high rate at which children in state custody are suffering from abuse and neglect, as demonstrated by Dr. Milner's Case Record Review. He found that:

- 35% of children had at least one formal report alleging that they were the victim of maltreatment while in DHS custody;³⁴⁵
- 21% of children were the subject of a maltreatment allegation while in DHS custody that was substantiated or where there was sufficient concern to recommend services;³⁴⁶ and
- 12% of children were the subject of a maltreatment allegation while in DHS custody that was substantiated.³⁴⁷

These findings are alarming, and are evidence of an agency that has failed at the most basic level. Based on my experience, such high rates of abuse in care are indicative not only of a child welfare agency that lacks an adequate system of accountability, but also of a mismanaged, poorly-trained, and overburdened workforce, and an agency with unsafe and inadequate placement and visitation practices for the children and families in its care.

Equally as concerning is the fact that DHS is not adequately responding to referrals of abuse or neglect of children in its care. This serious failure was found by both Dr. Milner's Case Record Review and Mr. Goad's Review. Mr. Goad's Review demonstrates that DHS's entire system for responding to maltreatment reports of children in custody is deficient, including extremely poor quality investigation practices, and places children at further risk of harm, in some instances, even leading to their death. Most importantly, he found:

- The deaths of *five* out of the nine children whose case files he reviewed – all of whom died as a result of abuse or neglect while in DHS custody since January 1, 2007 – could have been prevented if DHS had exercised reasonable steps in protecting those children from potential harm.³⁴⁸
- Investigations of allegations that foster children who are placed in foster and kinship care homes have been abused or neglected by their foster parents are untimely, incomplete, display extremely poor-quality decision-making, and fail to include appropriate action to protect children from further maltreatment. Mr. Goad found that as many as 46% of all these investigations conducted in 2009 resulted in flawed findings, placing the agency outside of any reasonable child welfare standard.³⁴⁹ He also noted DHS's disturbing practice of continuing to use foster and kinship parents as caregivers for children in custody even *after* they had been found to abuse and neglect foster children in their homes.

³⁴⁵ Milner Report at 26.

³⁴⁶ Ibid. at 26-27.

³⁴⁷ Ibid. at 27.

³⁴⁸ Goad Report, Executive Summary.

³⁴⁹ Ibid.

- Investigations into abuse and/or neglect allegations concerning children in the agency's custody who are placed in shelters, group homes, and residential treatment centers are delayed for shocking periods of time, are routinely superficial, display extremely poor-quality decision-making, and fail to include appropriate action to protect children from further maltreatment. Mr. Goad found that as many as 38% of all alleged victims in these investigations conducted in 2009 were affected by flawed findings, placing the agency far outside any reasonable standard.³⁵⁰
- Far too many referrals alleging that children in custody have been abused or neglected by the caregivers with whom the agency has placed them are screened out and not investigated. DHS's failure to identify child abuse and neglect subjects the children about whom the referrals have been made, as well as the other children placed in the same homes or facilities in the future, to danger. Mr. Goad found that as many as 32% of alleged victims in referrals screened out in 2009 were affected by flawed findings, placing the agency far below any reasonable standard of child protection practice.³⁵¹

In sum, Mr. Goad concluded that “[b]ecause of OKDHS’s many failures to protect its child wards, foster care in Oklahoma is a dangerous place to be.”³⁵²

While Dr. Milner’s Case Record Review did not focus on assessing DHS’s response to indications of abuse or neglect of children in custody, it found serious concerns with DHS’s practice in this area, including:

- In a large percentage of cases where maltreatment reports were investigated, DHS did not take any action either during or after the investigation in response to the report, such as removing the child from the home, closing the foster home permanently or temporarily, or terminating the child’s trial reunification placement.³⁵³ Specifically, in 25% of the cases involving maltreatment reports that were investigated, no action was taken by DHS either during the investigation or after the investigation other than to investigate the report; in 39% of the cases no action was taken during the investigation; and in 45% of the cases no action was taken after the investigation.³⁵⁴
- 50% of cases involving maltreatment reports involving children in state custody were referred to the child’s caseworker for action rather than conducting a formal investigation, in violation of DHS’s own policy.³⁵⁵

³⁵⁰ Ibid.

³⁵¹ Ibid.

³⁵² Ibid.

³⁵³ Milner Report at 30-31.

³⁵⁴ Ibid.

³⁵⁵ Ibid. at 28. OAC 340:75-3-8.1, Instructions to Staff, No. 2(2) requires that for children in foster or trial adoptive homes, an investigation be conducted on all reported allegations that meet the definition of abuse or neglect, including all non-accidental physical or mental injuries to children of any age; neglect; sexual abuse; and any practices by the foster or trial adoptive parent that involve hitting or striking a child three years of age or younger, even when there is no report or observation of injury.

- 12 children in the sample had information in their case file indicating that possible abuse or neglect had occurred while the child was in DHS custody, but it was not formally reported by DHS, and therefore never addressed.³⁵⁶

Testimony from DHS management only further confirms the agency’s inadequate and dangerous practices for responding to abuse and/or neglect reports of children for whom it is responsible:

- Tricia Howell, Programs Manager for the Permanency Planning Unit of CFSD, testified that in October 2009, she told Amy White, then-Programs Administrator of CFSD’s Permanency, Adoptions, and Independent Living Unit: “I am amazed at how many of our staff think they have no power when they have concerns of care in a foster home. Unless it is blatant abuse, they think the foster parent can do whatever they want. I have seen this with supervisors as well.”³⁵⁷
- Office of Client Advocacy (OCA) Director Mark Jones, who reports to the Commissioner of DHS, testified that OCA investigates reports of abuse and neglect of all children who are placed in facilities “above” the therapeutic foster care (TFC) level, including shelters, group homes, residential treatment centers and psychiatric hospitals.³⁵⁸ His deposition testimony makes it clear that the focus of OCA investigations is on the perpetrator rather than the victim and that the findings of OCA investigations are primarily for the purpose of allowing the district attorney to consider possible prosecution.³⁵⁹ When asked if OCA sends notices to the alleged victim’s caseworker when an investigation is pending, he responded, “we don’t know who their caseworker is. And, frankly, we don’t care.”³⁶⁰ When asked about the definition of “serious risk to the victim” that would require an immediate response under OCA policy, Mr. Jones was unable to provide the parameters his unit uses to assess such risk, stating, “I don’t know if it is specifically defined in our rules or in the guide.”³⁶¹
- OCA has a process called “caretaker conduct reviews” that allows certain maltreatment referrals – including those involving “minor physical injur[ies]” or “serious physical injur[ies]” that are “unlikely” to be the result of abuse or neglect – to be referred back to the facility to be dealt with internally.³⁶² Ms. Litsch, Programs Manager for CFSD’s unit responsible for CPS, testified that she has never seen any report tracking the number of referrals that OCA refers back to facilities for caretaker conduct reviews, nor was she aware of any measures taken to ensure that caretaker conduct reviews are being conducted under the appropriate circumstances.³⁶³ In fact, from January 1, 2007 to July

³⁵⁶ Milner Report at 27.

³⁵⁷ Dep. Ex. 409; Howell Dep. 2/15/11 at 137, 149.

³⁵⁸ Jones Dep. 8/5/09 at 29-35.

³⁵⁹ Ibid. at 127, 148, 179, 194-195.

³⁶⁰ Ibid. at 117-118.

³⁶¹ Ibid. at 150.

³⁶² OAC 340:2-3-37; Jones Dep. 8/5/09 at 148-149.

³⁶³ Litsch Dep. 2/4/11 at 53.

30, 2009, OCA referred over 1,000 referrals back to facilities for handling as caretaker conduct reviews.³⁶⁴

- Mary Grissom, former Programs Administrator of CFSD’s Technology and Governance Unit, testified that if an allegation of abuse or neglect involving a child placed in a foster home is determined to be a “policy violation,” it is not formally investigated by DHS, and is instead “addressed in the resource record.”³⁶⁵ When asked whether allegations of corporal punishment of foster children are investigated or considered policy violations by DHS, Ms. Grissom stated that it depended on the age of the child and the circumstances surrounding the incident: “[S]ome of those would be investigated as abuse and neglect allegations, [if they involved] a very small child or an injury was alleged. If it was an older child with no injury alleged, that would . . . [be] dealt with as a policy violation.”³⁶⁶ However, she admitted that “our field is struggling with understanding the difference between those at this point.”³⁶⁷ Oklahoma’s 2010-2014 Child and Family Services Plan further acknowledged “there has been some confusion among Child Welfare workers regarding the difference between alleged policy violations and alleged abuse or neglect in out of home care.”³⁶⁸ There is no policy that allows DHS to treat any maltreatment allegations involving children in foster homes as “policy violations.”³⁶⁹

In addition, the failure of DHS to have a comprehensive and adequate system to collect and track instances of abuse in care is one of the most egregious failures of DHS management that I found in this review. The data that DHS maintains and reports to the federal government on confirmed instances of abuse or neglect does *not* include foster children who were maltreated in group homes, residential treatment facilities, institutions, or shelters, since this data is maintained separately by the OCA division and has not been integrated into a single database on DHS’s KIDS System.³⁷⁰ Nor does this data include foster children who are abused by their biological parents during visits or trial home reunifications.³⁷¹ Therefore, the maltreatment data that DHS maintains does not provide an accurate assessment of the extent to which children in DHS custody are being subjected to abuse or neglect, and Oklahoma is underreporting this extremely important data element to the federal government. In my opinion, a more complete and reliable assessment of the number of children who have been abused or neglected while in DHS custody is provided in the findings of Dr. Milner’s review, which is based on a statistically significant sample and sound methodology.

³⁶⁴ Final OCA with CW Custody

³⁶⁵ Grissom Dep. 10/1/08 at 120-121.

³⁶⁶ Ibid. at 121-122.

³⁶⁷ Ibid. at 122.

³⁶⁸ CFSP-2010 to 2014-10.22.09-00007; CFSR-PIP-2008-Rev 10.12.09-00014.

³⁶⁹ However, OAC 340:75-3-8.1 Instructions to Staff, 2(2) requires investigations of all non-accidental physical injuries to children of any age in a foster or trial adoptive home, and of “any practices by foster or trial adoptive parents that involve hitting or striking a child three years of age or younger.”

³⁷⁰ Grissom Dep. 10/1/08 at 53-54, Franklin Dep. 7/9/09 at 141-143; Roberts Dep. 11/9/10 at 80; Dkt. 475 at 14 n.6. Ms. Litsch’s testimony with regard to DHS’s maltreatment data is indicative of an agency that clearly does not place the required emphasis on child safety. Although she is responsible for child protection services for children in DHS custody, she did not know whether DHS includes maltreatment of children in residential facilities, institutions, or shelters in the maltreatment data DHS reports to the federal government (Litsch Dep. 2/4/11 at 53-54).

³⁷¹ Grissom Dep. 10/1/08 at 54.

All of this evidence confirms that DHS is not taking the necessary precautions to ensure that foster children are safe. DHS has not operationalized a consistent or coordinated approach for responding to allegations of maltreatment, nor does it comprehensively track the children in its care who are being abused and neglected. These dangerous practices are placing all children in DHS custody at severe risk of harm. If DHS wants to improve the alarmingly high rate at which foster children are being harmed, it must first begin to treat this issue with the urgency that is called for. Until then, the children in its care will continue to live in danger.

B. DHS's Current Practices in Implementing Its Dual-Track Child Protective Services System, Combined with the Precipitous Decline in the Number of Children in Custody, Raise Serious Concerns About Children's Safety

There has been a significant decline in the number of children in DHS custody in a short time period. In only the last few years, the number of children in out-of-home care has dropped from 12,000 to under 8,000.³⁷² DHS's 2010 Annual Report stated that 35% fewer children were in out-of-home care compared to three years prior.³⁷³ This decline has coincided with the agency's shift to a dual-track system, under which abuse or neglect referrals of children who are not in custody that are not screened out are assigned either an investigation or an assessment track.³⁷⁴ Although the agency's shift to this dual-track system is understandable in theory, given Oklahoma's history of bringing a high percentage of children into care when in-home services might have served those children better, the agency's current practices in implementing this system are extremely concerning.

Given the seriousness with which allegations that a child has been abused or neglected must be treated, any CPS system must be based on the philosophy: "if in doubt, investigate." This is clearly not the approach Oklahoma has taken. In early 2009, DHS's CPS workers were specifically instructed to assign the majority of referrals as assessments.³⁷⁵ As a result, the percentage of screened-in referrals that were accepted for investigation has declined dramatically from 78% in state fiscal year (FY) 2008 to 42% in state FY 2010, while the percentage of screened-in referrals that were accepted for assessment increased from 22% in state FY 2008 to 58% in state FY 2010.³⁷⁶

My concerns are further heightened by the fact that the percentage of screened-in referrals that resulted in confirmed findings of maltreatment has declined from 19% in state FY 2008 – already below the national average of 22% – to only 15% in state FY 2010,³⁷⁷ and, during the same time period, the percentage of referrals that were screened out has increased from 46%

³⁷² Dkt. 436 at 5; Howell Dep. 2/15/11 at 70.

³⁷³ OKDHS 2010 Annual Report at 6.

³⁷⁴ OAC 340:75-3-7(a). Under DHS policy, investigations are required to be performed when the allegations in the referral indicate there is "a serious and immediate threat to the safety of a child." (OAC 340:75-3-7.3(b)). Assessments, on the other hand, are conducted when a referral of abuse or neglect "does not constitute a serious and immediate safety threat" to the child. (OAC 340:75-3-7.3(a)). Unlike investigations, assessments rarely result in children being brought into state custody because when an assessment is conducted, the DHS worker is not required to determine whether the referral is substantiated or whether court intervention is appropriate (Child Maltreatment 2009 at 189).

³⁷⁵ CWFL-MN-1.21.09-00004.

³⁷⁶ YI624-004464; YI624-009760.

³⁷⁷ YI624-04464; YI624-09760; Child Maltreatment 2009 at 13.

in state FY 2008 – already well above the national average of 38% – to 56% in state FY 2010.³⁷⁸ In my opinion, these overall trends in DHS’s treatment of abuse and neglect referrals, combined with the precipitous drop in the number of children in DHS custody over a short time period, indicate that children in Oklahoma are facing serious risk of harm both before and after they enter state custody.

After conducting their respective reviews of DHS practice, both Dr. Milner and Mr. Goad shared my concerns. Dr. Milner found that many children and their families in his sample had extensive histories with DHS before their latest entry into custody:

- 92% of families had at least one prior maltreatment report before the report that resulted in the child’s most recent entry into DHS custody. One-fourth of the families had *ten or more* such prior reports;³⁷⁹ and
- 65% of children had been identified in at least one prior maltreatment report with a disposition of services or court involvement recommended; 24% were identified in four or more such prior reports.³⁸⁰

Likewise, Mr. Goad noted that the recent upward trend in the proportion of abuse and neglect referrals that are being screened out by DHS strongly suggests that the agency has withdrawn the protection of CPS investigations from many children.

In addition, several other aspects of DHS’s current practices in responding to abuse and neglect referrals under its dual-track system are grave cause for concern. For example, the agency’s current policies setting forth its decision-making process for responding to reports of maltreatment do not meet CWLA standards, which emphasize that the process “should be guided by straightforward agency policies and protocols.”³⁸¹ Under current DHS policy, both investigations and assessments are assigned Priority I or II status depending on the severity and immediacy of the alleged harm to the child. Referrals are to be assigned as Priority I when they indicate that the child is in imminent danger of serious physical injury, and as Priority II when they indicate that there is no imminent danger of severe injury, but without intervention, it is likely the child will not be safe.³⁸² However, this priority assignment system makes no sense when applied to DHS’s current investigation and assessment assignment system. Pursuant to DHS policy, an investigation must be performed when a referral constitutes “a serious and immediate threat to the safety of a child,”³⁸³ but referrals for investigations are to be treated as Priority II investigations when there is *no* imminent risk to the child.³⁸⁴ When asked about this contradiction, Ms. Litsch, CFSD Programs Administrator for CPS, could not explain it.³⁸⁵ Similarly, although DHS policy dictates that a referral is to be assigned as an assessment when it “does not constitute a serious and immediate safety threat” to a child,³⁸⁶ referrals for assessments

³⁷⁸ YI624-04464; YI624-09760; Child Maltreatment 2009 at 11.

³⁷⁹ Milner Report at 33.

³⁸⁰ *Ibid.* at 34.

³⁸¹ CWLA Best Practice Guidelines for Child Maltreatment in Foster Care at 32.

³⁸² OAC 340:75-3-7.1

³⁸³ OAC 340:75-3-7.3(b); Litsch Dep. 2/4/11 at 30.

³⁸⁴ OAC 340:75-3-7.1; Litsch Dep. 2/4/11 at 31.

³⁸⁵ Litsch Dep. 2/4/11 at 35.

³⁸⁶ OAC 340:75-3-7.3(a); Litsch Dep. 2/4/11 at 30.

are to be treated as Priority I when a child is at imminent risk of harm.³⁸⁷ When asked under what circumstances there could be a Priority I assessment, Ms. Litsch responded, “[t]his is a part of policy that I’ve recently found does not match. . . . [U]nder that policy all priority Is should have to be investigations.”³⁸⁸ These contradictory policies cannot be effectively, consistently, and safely applied by DHS workers in the field. Moreover, the fact that the CFSD Programs Administrator with responsibility for CPS has only recently discovered these policy issues – and only some of them – indicates extremely poor management practices.

Furthermore, data demonstrates that DHS is not timely responding to abuse and neglect referrals – most significantly, referrals that are assigned as Priority I investigations. These are often referred to in the field as “drop your pencil and run” situations, and it is imperative that they are initiated immediately and completed timely. DHS practice requires such investigations to be completed within 30 days.³⁸⁹ Ms. Litsch testified that extensions of up to an additional 30 days are routinely granted to complete the necessary paperwork for reasons such as “excessive caseload, staff turnover, worker vacancies.”³⁹⁰ In my opinion, these “reasons” reflect serious systemic deficiencies that must be dealt with by DHS management, and are not appropriate excuses for untimely investigations. According to DHS data, in state FY 2010, 45% of Priority I investigations did not have all of the necessary interviews completed within 30 days³⁹¹ and 21% of Priority I investigations were not completed within even 60 days.³⁹² Larry Johnson, Director of FOD, admitted that DHS’s performance in completing both Priority I and II investigations within 60 days has been declining recently.³⁹³ Moreover, several DHS workers and supervisors were terminated in late 2010,³⁹⁴ resulting in “a dramatic drop in the number of staff” and leaving the agency with “an inadequate number of staff to complete the work in a timely fashion.”³⁹⁵ DHS Area Director Debra Clour confirmed that, in October 2010, there was a more than 45% increase in the number of overdue abuse and neglect investigations in Oklahoma compared to the previous month.³⁹⁶ These delays in DHS’s response to the most serious abuse and neglect referrals threaten the safety of children, and demonstrate dangerous and irresponsible practice by DHS management.

In addition, DHS’s process of implementing purely voluntary “safety plans” in an effort to protect children who are the subject of assessments is concerning.³⁹⁷ While there are circumstances in which voluntary in-home safety plans, if carefully monitored, are appropriate, court oversight can be critically important to ensure that the requirement of these plans are being carried out, or that no-contact orders are put in place as circumstances demand. Based on my experience, the agency’s exclusive use of voluntary safety plans does not allow adequate monitoring of whether children are remaining safe in their homes, and increases the risk of harm to children.

³⁸⁷ Litsch Dep. 2/4/11 at 31.

³⁸⁸ Ibid. at 37-38.

³⁸⁹ Ibid. at 43.

³⁹⁰ Ibid. at 43.

³⁹¹ Ibid. at 83; Dep. Ex. 396 at 1 (YI624-09776).

³⁹² Litsch Dep. 2/4/11 at 80-81; Dep. Ex. 396 at 1 (YI624-09776).

³⁹³ Johnson Dep. 2/15/11 at 132-137; Dep. Ex. 385 at 1 (YI624-07864); Dep. Ex. 386 at 1 (YI624-10096).

³⁹⁴ Johnson Dep. 2/15/11 at 137-138.

³⁹⁵ Ibid. at 139.

³⁹⁶ Clour Dep. 2/4/11 at 44-46; Dep. Ex. 383 at 1.

³⁹⁷ Litsch Dep. 2/4/11 at 45-48.

After considering all of these findings, it is my opinion that DHS's current implementation of its dual-track system for handling abuse and neglect referrals has dangerous consequences for children. The agency's dramatic shift towards performing assessments rather than investigations, combined with the significant decline in the number of children in custody over a short time period; inconsistent DHS policy and practice in this core area; untimely response to abuse and neglect referrals; and the exclusive use of safety plans that lack court oversight, all raise extremely serious concerns about children's safety.

C. DHS's Poor Permanency Practices Are Harmful to Children

Foster care is intended to be a temporary measure. Children need enduring, stable relationships to grow emotionally and should be moved as expeditiously as possible to a safe and nurturing "forever" home. Therefore, child welfare agencies must devote significant attention to establishing permanent homes for children as soon as they are brought into custody. As I like to say, permanency planning must begin with "the first knock on the door." Ensuring child safety – while of utmost importance – is simply not enough.

1. DHS Subjects Children to Extreme Placement Instability

Multiple moves within foster care – which occur when a child is moved from one placement to another – result in a lack of stability for children and are damaging to children's development and well-being. DHS acknowledges that multiple moves "traumatize children, damage their sense of trust, safety, predictability and compromise their ability to attach and form healthy relationships,"³⁹⁸ as well as decrease children's chances of achieving permanency.³⁹⁹ Therefore, it is critical that DHS limit the number of times that children are moved from place to place.

In her seminal work, *A Child's Journey Through Placement* (1991), Vera I. Fahlberg details the devastating effects on child development that result when foster children are moved frequently from place to place, and deprived of the opportunity to form attachments with their primary caregivers, especially at a young age. Among her findings are that:

- children with multiple moves during the first three years of life are particularly vulnerable to severe problems in the development of social emotions, carrying long-term implications for interpersonal relationships, conscience development, and self-esteem;⁴⁰⁰
- every placement move adds psychological trauma and interrupts child development, and moves should be therefore limited to all but the most unavoidable situations;⁴⁰¹
- because children need primary attachment objects who respond to the child's needs and who initiate positive activities with the child, it is crucial that all children removed from

³⁹⁸ CFSR-PIP-2009TO2011-QR-00053.

³⁹⁹ CFSR-PIP-2009TO2011-QR-00054; Webster Dep. 1/6/10 at 38-39.

⁴⁰⁰ Vera I. Fahlberg, *A Child's Journey Through Placement*, at 146 (1991).

⁴⁰¹ *Ibid.* at 176.

their homes and placed in foster care be given the opportunity to develop attachments with their primary caregivers.⁴⁰²

Placement instability (*i.e.*, frequent moves in custody) has long been recognized by DHS management as a serious problem facing foster children in Oklahoma.⁴⁰³ However, recent DHS data indicates that the situation has only gotten worse, and children are experiencing an unacceptably high number of moves while in custody. Between October 2009 and September 2010, 28% of children in out-of-home care for less than 12 months had three or more placements – compared to 26% the year before.⁴⁰⁴ This performance falls far below the federal standard.

The findings of Dr. Milner’s Case Record Review with regard to placement instability paint an even bleaker picture for foster children in Oklahoma. Indeed, one of the most alarming findings of his review was the extreme placement instability that foster children routinely experience during their time in state custody. The review’s key findings with regard to placement stability include that:

- 55% of children experienced four or more placement settings during their most recent entry into DHS custody, and 14% experienced *ten or more*,⁴⁰⁵ and
- 43% of children in custody for less than 12 months had three or more placement settings.⁴⁰⁶

Dr. Milner’s findings on placement instability for young children are of particular concern since these children need continuous, stable, and nurturing family relationships in order to grow emotionally and establish positive human relationships. His findings in this area include:

- 49% of children who were younger than age three on June 1, 2010 had already been in three or more placements during their time in state custody, and 10% of those children had already been in *six or more* placements;⁴⁰⁷ and
- 59% of children younger than age five on June 1, 2010 had already been in three or more placements, and 15% had already been in six or more placements.⁴⁰⁸

Importantly, Dr. Milner also reported that many children were moved from one short-term placement to another, indicating that DHS is not carefully matching children with appropriate placements that are able to meet their needs.⁴⁰⁹ Almost 75% of children with at least

⁴⁰² Ibid. at 21, 23.

⁴⁰³ *E.g.*, H_Hendrick-Docs-2008-00272; Webster Dep. 1/6/10 at 30, 38.

⁴⁰⁴ Dep. Ex. 407 (CFSR-PO-P1.2-00043); Dep. Ex. 406 (CFSR-PO-P1.2-00027); Howell Dep. 2/15/11 at 131-132; Johnson Dep. 2/15/11 at 143-144.

⁴⁰⁵ Milner Report at 35.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. at 41.

⁴⁰⁸ Ibid.

⁴⁰⁹ Ibid. at 43.

two placements spent less than one month in their first placement,⁴¹⁰ and almost 50% of children with at least three placements spent less than one month in their second placement.⁴¹¹

In addition, one of the significant findings related to placement stability in Dr. Milner's review concerns the high disruption rate of foster children who are placed in relative homes. Although kinship placements are generally associated with increased placement stability, Dr. Milner found that 54% of relative placements disrupted, suggesting that DHS is not adequately ensuring that children are placed in safe and appropriate kinship homes.

Based on my experience, the extreme number of moves which children of all ages in DHS custody are experiencing is indicative of seriously deficient placement practices. Of equal concern is the lack of effort by DHS management to mitigate the harm caused by these moves. For example, DHS management admitted in October 2009 that "many placements [that] disrupt . . . could have been salvaged with added supports from staff and other support systems."⁴¹² Dr. Milner found that DHS did not offer *any* services to foster caretakers to prevent placement changes in 76% of the cases where services would have been appropriate.⁴¹³

Until DHS management places more emphasis on reducing placement disruptions, children will continue to be harmed. In order to effectively combat placement instability, DHS must revise its placement process and practice, limit the use of emergency shelters, focus on recruiting and retaining foster homes, and provide necessary services to caregivers.

2. DHS Subjects Children to Unacceptably Long Stays in Custody Without Timely Moving Them Towards Permanent Homes

Long periods of time spent in foster care keep children from finding permanent, loving families and have negative consequences for children's development and well-being. Research indicates that the longer a child stays in custody, the less likely that child is to exit to a permanent family.⁴¹⁴ Foster children in Oklahoma have been, and continue to be, subjected to unacceptably long stays in the system, contrary to all acceptable practice standards. This indicates that DHS is doing an inadequate job of finding permanent homes for the children in its care.

Dr. Milner's report found that the median length of stay for children in DHS custody as of June 1, 2010 was approximately 23 months, with 49% of children having been in DHS custody for two years or longer.⁴¹⁵ This median far exceeds the national median of 15.4 months.⁴¹⁶ He further reported that, as of June 1, 2010, 31% of children had been in DHS custody for three years or longer, and 20% for *four years or longer*.⁴¹⁷ Significantly, Dr. Milner's review also found that the older the child was on June 1, 2010, the more likely the child was to have

⁴¹⁰ Ibid.

⁴¹¹ Ibid. at 44.

⁴¹² Dep. Ex. 409.

⁴¹³ Milner Report at 35.

⁴¹⁴ Ibid. at 57.

⁴¹⁵ Ibid. at 59.

⁴¹⁶ The AFCARS Report: Preliminary Estimates for FY 2009 as of July 2010 at 1.

⁴¹⁷ Milner Report at 59.

been in DHS custody for a longer period of time, suggesting that many of the older children in his sample aged while in DHS custody, rather than entering custody at older ages.⁴¹⁸

In addition to subjecting children to unacceptably long stays in foster care, DHS is struggling to find them permanent homes. When children cannot remain safely in their homes and must enter foster care, the state must find permanent homes for those children in a timely manner. The length of time it takes to achieve permanency for children, either through reunification or adoption, is critical so that they do not languish in the foster care system for years. Ideally, children who are removed from their homes should be reunited with their parents as soon as possible. But efforts at reunification cannot go on endlessly. Therefore, if reunification is not a possibility, the state must expeditiously move children towards an alternative permanent family arrangement.

For these reasons, federal law requires that a permanency plan be developed for each foster child, and establishes mandatory timeframes within which reunification with parents, termination of parental rights (TPR) to free the child for adoption, or finalization of an alternative permanent placement must take place.⁴¹⁹ Each child must receive a permanency hearing after 12 months in care, to determine if and when the child will be returned to their parents, or if an alternative permanent home needs to be established.⁴²⁰ Furthermore, TPR *must* be initiated once a child has been in care for 15 of the most recent 22 months, unless it can be clearly demonstrated that this is not in the best interests of the child.⁴²¹

Unfortunately, DHS has failed to live up to these federal standards. Dr. Milner's Case Record Review reveals that many children remain in custody for far too long before parental rights are terminated. A shocking 41% of children did not become free for adoption until at least *two years* after entering DHS custody, and 34% were in custody for over two years before the goal of adoption was even established.⁴²²

DHS's failure to pursue timely TPR petitions may be exacerbated by the fact that the agency does not have in-house attorneys that can fulfill this responsibility. Instead, child welfare workers are responsible for recommending a TPR to the district attorney's office, and DHS is reliant on the district attorney or the child's personal attorney to pursue the motion.⁴²³ Regardless, such long periods of time before children are available for adoption increase the likelihood that these children will age out of state custody without ever finding a permanent home.

In addition, those children who eventually achieve reunification remain in state custody for far too long before the reunification is finalized, and the agency's poor performance in this area has not improved. Between October 2008 and September 2009, only 48% of children statewide who exited to reunification did so in less than 12 months, far below the federal

⁴¹⁸ Ibid. at 7.

⁴¹⁹ 42 U.S.C. § 675.

⁴²⁰ Ibid. § 675(5)(C).

⁴²¹ 42 U.S.C. § 675(5)(E).

⁴²² Milner Report at 66.

⁴²³ OAC 340:75-1-23. Ms. Howell suggested that one systemic factor affecting the length of time for termination of parental rights was that "the district attorney wasn't filing [the motion]" (Howell Dep. 2/15/11).

standard of 76.1%.⁴²⁴ The following year, from October 2009 to September 2010, the percent of children who exited to reunification in less than 12 months remained virtually unchanged, at 47%.⁴²⁵ DHS managers' total lack of accountability and responsibility for this problem is troubling. For example, Ms. Howell acknowledged that she is concerned by DHS's reports showing how long it takes for children to be reunified with their parents, but could not remember whether she discussed the issue with anyone at DHS.⁴²⁶ Likewise, Ms. Clour testified that she has faced no consequences for leading the area with the highest length of time to reunification in the state.⁴²⁷

Even more concerning is evidence that when children are reunified with their parents, their safety and well-being may still be at risk. Dr. Milner's Case Record Review suggests that DHS is not properly assessing the safety of these homes. According to his findings, adequate safety assessments were conducted prior to trial reunification in only 46% of the cases.⁴²⁸

Given this poor performance, DHS's ongoing failure to provide for regular parent-child visitation, further hindering children's chances of reunification, clearly indicates that the agency is not treating this serious failing with the attention that is due. Under DHS policy and under any reasonable standard, children in custody have a right to visitation with their parents.⁴²⁹ If a child's permanency goal is reunification, unless extraordinary circumstances exist, DHS is required to arrange for visitation between the child and his or her parents more than once per month.⁴³⁰ However, Ms. Howell testified that she has "known for a long time that [parent-child] visitation . . . is an area that we need to improve on," and she "realize[s] we're not where we need to be."⁴³¹ According to a DHS report, only 14% of the parent-child visits that were required to occur between July 2009 and June 2010 actually took place.⁴³² Likewise, the agency fails to ensure that siblings who have been separated in custody are seeing each other on a regular basis. As Dr. Milner found in his Case Record Review, one out of every five children with siblings in separate foster care placements who were eligible for visitation had *no* visits with those siblings during the 12 months prior to June 1, 2010.⁴³³ Moreover, in 76% of cases, a sibling visitation plan was not included in the child's Individualized Service Plan, or did not specify the frequency of visitation.⁴³⁴ This is a clear violation of DHS policy.⁴³⁵

DHS's failure to provide reunification in a timely way is mirrored by its failure to provide for timely adoptions. According to Dr. Milner's Case Record Review, 31% of children not available for adoption had been in custody for longer than two years, and 23% had been in

⁴²⁴ Dep. Ex. 401 (WF-Time-Reunif-Exit-00080).

⁴²⁵ Dep. Ex. 402 (WF-Time-Reunif-Exit-00099).

⁴²⁶ Howell Dep. 2/15/11 at 90-91.

⁴²⁷ Clour Dep. 2/4/11 at 126.

⁴²⁸ Milner Report at 33.

⁴²⁹ OAC 340:75-6-30(a).

⁴³⁰ OAC 340:75-6-30(b).

⁴³¹ Howell Dep. 2/15/11 at 98, 100.

⁴³² YI624-09767.

⁴³³ Milner Report at 80.

⁴³⁴ Ibid.

⁴³⁵ OAC 340:75-6-40.4.

custody for longer than three years.⁴³⁶ This is far too long for children to wait for the permanent homes they desperately need.

The state's dismal performance with regard to both reunification and adoption is unacceptable. DHS has fallen far short of what should be its top priority as a child welfare agency – timely securing a forever family for the children in its custody. Instead, all too often, it is allowing children to languish in custody, moving from one temporary placement to another.

D. DHS's Poor Practices Are Harming the Well-Being of Children

Federal law requires that a child's social, emotional, educational, and physical needs are met while in state foster care custody. To do this, the state must provide the services that foster children need to promote healthy growth and development.

Unfortunately, Dr. Milner's Case Record Review reveals that DHS is failing in this crucial area. Among other things, he found that:

- in 45% of the cases he reviewed, DHS did not even identify the services to be provided to the child in the child's case planning documents, in violation of DHS's own policy;⁴³⁷ and
- the children's case plans did not include health records in 71% of the reviewed cases, in violation of federal law.⁴³⁸

In its Second Round CFSR Program Improvement Plan (PIP), DHS itself acknowledged serious problems in the area of service delivery. The PIP shows that, in only 59% of the reviewed cases, DHS met the criteria for adequately assessing the needs of children, parents, and foster parents, and providing the services necessary to meet those needs.⁴³⁹ Service delivery problems were also noted in the HZA Audit, which found that county offices with responsibility for ensuring that families receive needed services have little ability to make sure those services are actually available.⁴⁴⁰

While the state is required to provide its foster children with educational services, DHS's handling of this important matter is especially problematic. The ability of Oklahoma's foster children to obtain adequate schooling is seriously compromised by the extraordinarily high percentage of children who are placed outside their home counties and by the frequent moves that foster children are forced to experience. Both of these factors operate to disrupt the child's education, leaving foster children significantly behind their peers. Education monitoring is also a big problem at DHS. Dr. Milner found that of the 242 children in his sample who were at least five years old at the start of the September 2009 school year, almost 20% did not have information regarding school performance in their case file in violation of federal law.⁴⁴¹

⁴³⁶ Milner Report at 65.

⁴³⁷ Ibid. at 68; OAC 340:75-6-40.1 (2).

⁴³⁸ Milner Report at 68; 42 U.S.C. §§ 671(a)(16), 675(1).

⁴³⁹ CFSR-PIP-2008-Rev 10.12.09-00071.

⁴⁴⁰ Dep. Ex. 173 (HZA Audit) at 110-111.

⁴⁴¹ Milner Report at 68; 42 U.S.C. §§ 671(a)(16), 675(1).

Federal law also requires the state to provide independent living (IL) services to older teenagers in order to prepare them for living on their own after they age out of foster care. The CWLA standards mandate that “[t]he child welfare agency, as the legal custodian and decision[]maker regarding the services to foster youth, is responsible for ensuring that the opportunities necessary for acquiring [transition, IL and self-sufficiency] are made available to young people in their care.”⁴⁴² These services are vital, given the “[u]nique challenges [that] exist for young people who will leave foster care on their own, without the support of a family.”⁴⁴³ Foster children in particular “need supplemental supports and services that enable them to learn life[] skills, facilitate social and community connections, learn about resources they can access once on their own, and build vocational competency.”⁴⁴⁴

Oklahoma statutory law and DHS policy provide further content to the IL services that the state must provide. Under the Oklahoma Independent Living Act, foster children are entitled to receive services that will allow them to become self-reliant and productive citizens, including transitional planning, housing, medical coverage, and education.⁴⁴⁵ Foster children are eligible to receive these services from the age of 16 until the age of 18 while in DHS custody, and those services may continue to the age of 21 under certain circumstances.⁴⁴⁶ Federal law, state statute, and DHS policy further require that such youths are provided with an IL assessment, which is a comprehensive evaluation of the youth’s readiness for independent living and identification of the services and supports required for the youth to achieve “a maximum level of self-sufficiency;” an IL plan, which describes the services, supports, and activities that are identified as necessary for the youth to transition to independence; and, of course, the IL services themselves.⁴⁴⁷ DHS policy requires the agency to initiate the IL plan with every child in state custody and in out-of-home placement when the child turns 16 years old.⁴⁴⁸

Sadly, Oklahoma’s foster children are not receiving the IL services they need to support a safe journey to adulthood. Notably, Dr. Milner found that only 25% of the children in his case sample who were eligible for IL services as of March 1, 2010 had an IL plan in their file. Of those youths, only six out of ten ever received the IL services that were specified in their plans.⁴⁴⁹ DHS’s own reports show a somewhat better performance, but still far below any professional standards. One in three youths in custody aged 16 and 17 did not receive an IL assessment in the first quarter of state FY 2010, a result that was repeated in the second quarter of state FY 2010.⁴⁵⁰ Clearly, the state’s foster children are being harmed by DHS’s pervasive failure to provide IL services, as required by law.

In order to ensure that foster children’s safety, permanency, and well-being needs are being met, and that children do not continue to be harmed and placed at risk of harm every day, DHS must reform its practices.

⁴⁴² CWLA Standards of Excellence for Transition, Independent Living, and Self-Sufficiency Services at 15.

⁴⁴³ *Ibid.* at 9.

⁴⁴⁴ *Ibid.* at 8.

⁴⁴⁵ 10A Okla. Stat. 1-9-107(B)(1).

⁴⁴⁶ 10A Okla. Stat. 1-9-107(C), (D).

⁴⁴⁷ OAC 340:75-6-110(d)(1), (2), (4).

⁴⁴⁸ OAC 340:75-6-40.4(d).

⁴⁴⁹ Milner Report at 68.

⁴⁵⁰ Dep. Ex. 341 at 2 (Key Indicators-New-Report-00002).

V. DHS’S OVERUSE OF EMERGENCY PLACEMENTS, INCLUDING SHELTERS, IS HARMFUL TO CHILDREN AND INCREASES PLACEMENT INSTABILITY

As discussed above (see Section IV.C.1), frequent moves in foster care are devastating to foster children and can cause long-lasting psychological damages. However, Oklahoma allows a foster care system in which thousands of children are placed in temporary settings, including shelters and emergency foster homes, immediately after being separated from their parents. DHS’s widespread use of temporary placements harms children by jeopardizing their ability to form the emotional attachments that are crucial for their development.

A. DHS’s Overuse of Shelters Is Harmful to Children

Far too many children in Oklahoma foster care are placed into shelters upon entry into custody. Remarkably, Dr. Milner’s Case Record Review found that 59% of the children were placed in shelters after being removed from their homes.⁴⁵¹ When an action occurs almost 60% of the time, it is no longer an “emergency,” but a conscious choice being made by the agency. Dr. Milner also found that 36% of the children in his sample who were infants (*i.e.*, younger than one year old) at the time of their entry into DHS custody were placed in a shelter.⁴⁵²

To make matters worse, children in shelter care are kept there for far too long. Under DHS policy, children aged five years old or younger are not supposed to be in a shelter for more than five days, and children six or older are not supposed to remain in shelter care for more than 30 days, with a maximum of 60 days if an extended shelter stay is required.⁴⁵³ Dr. Milner found that 43% of the infants and 19% of children aged five to ten who were placed in shelters upon entry into state custody remained there longer than permitted under DHS’s own policy.⁴⁵⁴

These abysmal practices are borne out by DHS’s own reports, which show that during the 2009 calendar year, 3,673 children were placed in private and DHS-run shelters.⁴⁵⁵ Over 40% (or 1,576) of these children were five years old or younger, and their average shelter stay was 12 days – more than twice the length of time permitted under DHS policy.⁴⁵⁶ The situation was even worse for the 473 children aged five and under who had the misfortune of being placed in youth services shelters (which are private); their average shelter length of stay was 16 days – more than three times the duration that DHS policy allows.⁴⁵⁷

DHS’s wholesale use of shelters has continued into state FY 2010 (July 1, 2009 to June 30, 2010), during which 4,279 children were placed in shelter care.⁴⁵⁸ Of these, 1,593 were under six years old.⁴⁵⁹ It is difficult to reconcile DHS’s shelter practice with the DHS policy that authorizes the placement of children in residential settings “only after all other less restrictive

⁴⁵¹ Milner Report at 36.

⁴⁵² *Ibid.*

⁴⁵³ OAC 340:75-10-9(b)(1), (2).

⁴⁵⁴ Milner Report at 36.

⁴⁵⁵ YI613-00001.

⁴⁵⁶ *Ibid.*; OAC 340:75-10-9 (b)(1).

⁴⁵⁷ YI613-00011.

⁴⁵⁸ YI624-09938.

⁴⁵⁹ *Ibid.*

settings have been attempted or considered.”⁴⁶⁰ The wide gulf between policy and practice shows that DHS voices one belief and consistently practices another.

B. DHS’s Use of Emergency Foster Homes Needlessly Increases Placement Instability

In addition to its heavy reliance on shelters, DHS also uses another type of temporary placement – emergency foster homes. All this does is substitute one form of short-term care with another. Like children placed in shelters, children placed in emergency foster homes are still subject to an additional placement move, since emergency foster homes, by definition, are short-term placements. DHS data confirms that the average length of stay for children exiting emergency foster care during state FY 2010 was a mere 20 days.⁴⁶¹

DHS’s use of emergency foster care represents a short-term fix to a long-term problem. Why not ask the same private providers who offer emergency homes to partner with DHS to do the desperately needed work of expanding the agency’s non-relative foster home network throughout the state? It simply makes no sense for Oklahoma to pay three times as much for emergency foster home care than it pays to foster families who provide more stable, longer-term care for foster children.⁴⁶² There is no benefit to Oklahoma’s foster children in this approach. If DHS builds an adequate network of foster homes, pays the actual cost of foster care and supports foster parents, foster families will be willing to take children at any time of night or day, just like emergency foster parents.

The real challenge that DHS faces is its lack of a suitable number and array of foster homes to allow placement decisions to be made under a “first placement best placement” model of service. As long as the agency fails to address this very serious problem, caseworkers will continue to place children in short-term placements like shelters and emergency foster homes. When a caseworker is sitting in his or her office with a traumatized child and no place to clean them, feed them or put them to bed, that worker will take whatever placement is available.

VI. DHS’S EXISTING PLACEMENT PROCESS UNDERMINES GOOD OUTCOMES FOR CHILDREN AND FAMILIES

Determining where to place a child who has just entered state foster care custody is one of the most important decisions a child welfare worker can make. Once a child has been removed from his or her parents, it is vitally important that the caseworker find a substitute home as soon as possible that is capable of meeting the child’s needs. In Oklahoma, a number of factors conspire to undermine the placement process, including the agency’s poor placement practices and its inadequate oversight of private placement providers. The result is poor outcomes for children and families.

⁴⁶⁰ OAC 340:75-6-1.

⁴⁶¹ YI624-09765.

⁴⁶² The State pays \$44 per day for emergency foster care, compared to daily rates from \$12.17 to \$16.61 for traditional foster care depending on the child’s age (Appendix C-20-00001, 00003).

A. DHS's Poor Placement Practices Harm Children

Caseworkers cannot possibly match foster children with suitable homes given the enormous gap between the number of children in DHS custody and the number of available foster homes in the state. According to a DHS report, the statewide ratio of children to foster home beds as of December 31, 2009 was 0.52 – meaning there is half a bed for every child in custody who needs a foster home.⁴⁶³ As of May 2009, the ratio of approved foster care homes to children was 0.30 – 9,887 children in custody to 2,978 approved homes.⁴⁶⁴ In light of this enormous disparity, DHS, in its own words, winds up making placements “based on available space rather than the individual needs of the child, skills of the foster parents, or both.”⁴⁶⁵

Further evidence of the lack of sufficient placements is the lengthy waiting lists maintained by DHS for placement in above-therapeutic foster care (TFC) placements⁴⁶⁶ and emergency foster homes.⁴⁶⁷ As Joani Webster, Programs Administrator of the Resource Unit of CFSD, testified: “[U]nfortunately there’s not enough emergency beds to say, ‘Okay, we’ve picked between these three homes; and this one’s the best’ . . . [T]hat’s just not the way it is . . . if there’s a bed available and there’s a child in the shelter that needs the bed . . . they’re going to this bed.”⁴⁶⁸

The lack of available foster homes in Oklahoma leads workers to place an enormously high number of foster children outside of the county where they live. The grief and trauma that children experience when they are removed from their homes is exacerbated when they are taken away from everything that is familiar to them and moved to locations far from their home communities. Incredibly, as of June 2010, only 36% of foster children in state custody (excluding children placed in trial home reunification and trial adoption placements) were placed in the county where they are from.⁴⁶⁹ This placement practice demonstrates not only a stunning disregard for the importance of keeping foster children close to home in order to minimize the emotional trauma of removal and facilitate reunification, but also undermines the caseworkers’ ability to effectively and efficiently manage children’s care while they are in state custody.

The fact that DHS has no comprehensive data bank of available placement resources that can be consulted when a child is in need of a foster home is extremely problematic.⁴⁷⁰ In the metropolitan counties, including Oklahoma County and Tulsa County, each DHS “resource specialist” has knowledge of only a small portion of the available foster homes in that county – those to which he or she has been specifically assigned.⁴⁷¹ Thus, when a caseworker asks a resource specialist in those counties to recommend a foster home for a child, the resource specialist’s response will be based on incomplete information. The resource specialist will not know whether more suitable homes exist that have been assigned to one of the other resource

⁴⁶³ #68&69-BR-Grant-1-00002-03.

⁴⁶⁴ BR-Grant-00070.

⁴⁶⁵ OKB-Prog Nar-7.1.09-00018.

⁴⁶⁶ Reeder Monthly Rpts-00003-Apr 2010; Reeder Monthly Rpts-00012-Feb 2010; Reeder Monthly Rpts-00017-Jan.2010; Reeder Monthly Rpts-00022-June 2010; Reeder Monthly Rpts-00025-Mar 2010; Reeder Monthly Rpts-00030-May 2010.

⁴⁶⁷ Webster Dep. 2/4/10 at 163-164.

⁴⁶⁸ Ibid. at 198.

⁴⁶⁹ YI617A-00330.

⁴⁷⁰ Poplin Dep. 10/18/08 at 106; Burleigh Dep. 2/3/11 at 82.

⁴⁷¹ Webster Dep. 2/4/10 at 34-35.

specialists for that county. Moreover, a private contractor named APS, not DHS, has final approval to place foster children in TFC homes.⁴⁷² APS makes this determination based on a paper review without even seeing the child.⁴⁷³

In addition, for children removed from their birth parents, often the only family connection that can be maintained is with siblings. DHS acknowledges, however, that there is a lack of resources available for sibling groups, which “frequently results in the separation of at least one sibling from the others, particularly in large metropolitan areas that operate OKDHS shelters.”⁴⁷⁴ Likewise, Dr. Milner found that 13% of the children in his sample who had siblings in DHS custody were not placed with all of their siblings, and DHS either provided no justification for those placements or its only justification was that it could not find a home that would take the siblings.⁴⁷⁵ As Dr. Milner correctly notes, federal law *requires* that siblings be placed in the same foster home unless the state documents that placing them together would be contrary to their safety or well-being.⁴⁷⁶ Moreover, when large sibling groups are kept together in DHS custody, it appears that they are often placed in group homes rather than in family settings.⁴⁷⁷

B. DHS Fails To Adequately Monitor Private Placement Providers

DHS does not apply performance-based measures aimed at tracking whether the placements provided by private contractors (including emergency, TFC, and group homes) are leading to permanent homes for children. Private providers should not be viewed as a place to “house” foster children, but rather as partners with the state agency working to move children to permanency as soon as possible. Certain performance-based measures can be used to track whether private placement providers are meeting this objective. For example, a state can track how many children are exiting the private provider’s care to a “forever family;” how many children are exiting to a less restrictive environment (*i.e.*, making a step toward permanency); the average length of stay of children placed with private providers; and how many children re-enter state custody after exiting custody from a private placement. Several jurisdictions, including New York City and Tennessee, have implemented performance-based contracting using these types of principles. My understanding is that Oklahoma does not track such measures, and therefore does not know which private providers are doing good work in effectuating permanency for children in state custody.

Instead of applying performance-based measures, DHS’s monitoring of private placement providers consists of a system of uncoordinated activities that result in little meaningful oversight at all. To start, all private placement providers, including TFC agencies, group homes and other child placing agencies (CPAs), are licensed by a division of DHS called Oklahoma Child Care Services (OCCS). These licenses never expire,⁴⁷⁸ and DHS has not revoked the

⁴⁷² Ibid. at 47.

⁴⁷³ Ibid. at 53.

⁴⁷⁴ OKB-Prog Nar-7.1.09-00015.

⁴⁷⁵ Milner Report at 77.

⁴⁷⁶ 42 U.S.C. § 671(a)(31)(A)

⁴⁷⁷ Webster Dep. 1/6/10 at 157-158.

⁴⁷⁸ Case Dep. 11/13/09 at 31.

license of a single CPA in the last ten years.⁴⁷⁹ OCCS receives serious incident reports from private placement providers, but it does nothing with them.⁴⁸⁰ None of the licensing records created by OCCS are kept on the KIDS System, and thus are not readily accessible to most child welfare personnel.⁴⁸¹

Under DHS policy, the program managers in the Resource Unit at CFSD also have limited oversight responsibility for private placement providers. One of their main responsibilities is to conduct annual contract compliance reviews of each private placement contractor falling within their area of responsibility (*i.e.*, the programs manager for TFC is supposed to conduct the annual contract compliance review of all TFC contractors, and the programs manager for community-based residential placements is supposed to conduct the contract compliance reviews of all group homes).⁴⁸² Joani Webster, the Program Administrator of the Resource Unit, described those reviews as “just a visit to [the provider agency’s] office,”⁴⁸³ but Annette Burleigh, the CFSD Program Manager for TFC, does not even take that minimal step, nor does she keep any files pertaining to the annual reviews.⁴⁸⁴ In fact, she does not conduct independent contract compliance reviews at all.⁴⁸⁵

Moreover, according to Ms. Burleigh, when there has been a report of suspected abuse or neglect involving a child at a TFC home, it is up to the TFC agency itself to determine what the corrective action plan should be, and those plans are not routinely provided to DHS.⁴⁸⁶ Nor is there any requirement at DHS that Area Resource Coordinators (ARCs), who keep lists of children waiting for TFC homes, be notified when a TFC home is the subject of an abuse or neglect report.⁴⁸⁷ As a result, there is a serious risk that the ARC will recommend that other children be placed at the same potentially dangerous home in the future. And while the ARCs are supposed to send monthly reports to Ms. Burleigh regarding children referred for and denied TFC, not all of them do so.⁴⁸⁸

The continuous quality improvement (CQI) unit at CFSD is also supposed to conduct annual “contract performance reviews” of CPAs, but it does not visit TFC homes as part of those reviews, nor does it keep a file of all serious incident reports involving CPAs.⁴⁸⁹ Even when CQI identifies a performance issue during the course of one of its reviews, it has no authority to require the contracting party to implement corrective measures. Instead, CQI merely forwards its report to the Resource Unit at CFSD.⁴⁹⁰ At that point, as discussed above, corrective action plans are prepared by the contractors themselves and, in the case of TFC providers, are not always provided to DHS.

⁴⁷⁹ Ibid. at 170.

⁴⁸⁰ Ibid. at 161-162.

⁴⁸¹ Grissom Dep. 10/1/08 at 118.

⁴⁸² OAC 340:75-8-4(b); OAC 340:75-11-234(b); Webster Dep. 1/6/10 at 69.

⁴⁸³ Webster Dep. 1/6/10 at 112.

⁴⁸⁴ Burleigh Dep. 2/3/11 at 48-52, 57.

⁴⁸⁵ Ibid. at 48-51.

⁴⁸⁶ Ibid. at 35-37.

⁴⁸⁷ Ibid. at 74-75; Webster Dep. 2/4/10 at 66.

⁴⁸⁸ Burleigh Dep. 2/3/11 at 71-73.

⁴⁸⁹ Franklin Dep. 7/9/09 at 126, 123-124.

⁴⁹⁰ Ibid. at 70-71.

It is my conclusion that the fractured, uncoordinated system of oversight provided by DHS subjects all children placed by private placement contractors to a serious risk of harm.

VII. DHS LACKS A WORKABLE APPROACH FOR DETERMINING ITS PLACEMENT RESOURCE NEEDS

There are several serious impediments that are preventing DHS from providing appropriate placements to the children in its care. Perhaps most importantly, as discussed above, the agency lacks a sufficient pool of foster homes to meet the needs of Oklahoma's foster children. DHS is well aware of this shortage. Joani Webster, Programs Administrator of the Resource Unit at CFSD, testified at her deposition that "[t]here are not enough traditional foster homes for every child . . . that needs to be served" by them, and "there is a shortage of foster homes for . . . children with different needs."⁴⁹¹ Annette Burleigh, the Therapeutic Foster Care (TFC) Program Manager at CFSD, testified that for as long as she has held her position, there have not been enough TFC homes to meet the needs of the children in Oklahoma referred for TFC.⁴⁹²

A. DHS Needs To Conduct a Resource Needs Assessment

As a first order of business, DHS needs to conduct a comprehensive needs assessment so that it can determine the appropriate number, type and location of placement resources to meet the needs of Oklahoma's foster children. A high-performing agency has continual access to data concerning the number, characteristics, and needs of children coming into state custody. These data need to be analyzed over time so that the agency can direct its internal resource development staff and its private providers to develop the required number and types of placements in the locations where they are needed. Once DHS has developed a sufficient pool of resources for the children in its care, the agency will no longer have to put them in emergency shelters or emergency foster homes.

Private providers are businesses that sell a service. Businesses will deliver what the customer – in this case, the child welfare agency – is purchasing. As long as DHS continues to purchase shelter, group home, and emergency foster care services, those are the services that the private providers will develop and deliver. If DHS ceases to use emergency and congregate placements, the private providers will re-focus their efforts and start making available the resources that DHS wants and needs to improve outcomes for children and families.

Foster home recruitment and retention must be addressed at DHS from the top down. Without a statewide, executive leadership initiative that includes specific strategies and goals, it will be difficult to hold county directors accountable for results at the county level. Each county will need to evaluate the resources that they have and need, and then develop specific action steps to meet established goals and to continuously evaluate the effectiveness of the process. Several types of recruiting must occur, as needed: generic recruitment so that new homes are available to replace those closed by adoption; targeted recruitment for specific types of families (*e.g.*, families for teens or large sibling groups); and child-specific recruitment to find homes for specific children.

⁴⁹¹ Webster Dep. 2/4/10 at 212-214.

⁴⁹² Burleigh Dep. 2/3/11 at 82-83.

B. DHS's Fiscal Practices Undermine DHS's Resource Development

At the root of DHS's inability to move away from its reliance on emergency shelters and emergency foster homes and toward a strong network of family placements for children is the drastic underfunding of resource families. DHS cannot rely on "charity" to build this network, but that is what it is doing. It is actually costing foster families real dollars from their family budgets to care for children in state custody. Based on the USDA's method for calculating child care costs, the current foster care reimbursement rates in Oklahoma are close to \$10.00 per day (or \$3,650 per year) *lower* than the actual cost of caring for a child.⁴⁹³

The M.A.R.C. (Minimum Adequate Rates for Children) estimated that Oklahoma would need to adjust its foster care reimbursement rate by up to 53% to cover the real cost of providing for the state's foster children.⁴⁹⁴ Current rates start at \$365.00 per month, or \$12.17 per day, and have not changed since 2006.⁴⁹⁵ TFC rates of \$16.63 per day are also significantly below an adequate level.⁴⁹⁶

While DHS has not received funding for its prior requests to increase foster care reimbursement rates, it is unacceptable for the agency to do nothing while waiting for the legislature to appropriate more dollars. States, like families, put their dollars where their hearts are. Things that are valued are funded, and things that are not valued are not funded. In an agency as large and diverse as DHS, there are always opportunities to adjust priorities.

For example, by reducing its reliance on emergency foster homes, which are reimbursed by the federal government at a rate three times higher than regular foster care,⁴⁹⁷ and by reducing its reliance on group homes and shelters (upon which DHS spent \$10.2 million in state FY 2010),⁴⁹⁸ DHS can make more funds available for traditional foster homes. Doing so would be both fiscally sound and beneficial to the state's foster children. State funds currently being used to support shelter care could be re-allocated to expand the much-needed foster care network, while at the same time being eligible for federal match. Temporary Assistance to Needy Families funds could be used to expand the amount and quality of in-home services available to support birth parents and relatives in order to prevent disruptions and to keep children safe in permanent homes.

Finally, DHS's staffing breeds inefficiencies. DHS is a huge agency with a great number of mid-level managers who have limited spheres of responsibility. There are six area offices that are largely administrative in function.⁴⁹⁹ The agency has fiscal, human resources, technology, and contracting personnel, all of which are duplicated within CFSD. As chief executive officer for two different state agencies, one similar in size to DHS, I found annual "right-sizing" to be a

⁴⁹³ USDA Expenditures on Children by Families, 2009, at 26.

⁴⁹⁴ Hitting the M.A.R.C. at 5 (PLAINTIFFS 00969).

⁴⁹⁵ Appendix C-20-00001.

⁴⁹⁶ Appendix C-20-00002.

⁴⁹⁷ Appendix C-20-00001, 00003

⁴⁹⁸ Table 1, OKDHS Expenditures

(www.okdhs.org/library/rpts/ar/2010/docs/018_s10027_okdhsannualreport_tables.htm). Group homes, like emergency foster homes, are also more expensive for the State than traditional foster homes, ranging from \$24.55 per day for Level B group homes to \$154.00 per day for Level E group homes (Appendix C-20-00002-03).

⁴⁹⁹ Johnson Dep. 6/17/09 at 57.

valuable tool in resource allocation. By reducing and re-allocating its administrative positions, DHS could expand its direct service staff, which would help to ameliorate the constant turnover of child welfare workers, and children and families would be better served.

CONCLUSIONS AND RECOMMENDATIONS

DHS is organizationally and programatically disjointed. The child welfare system lacks the leadership necessary to become a high-performing agency that can effectively serve vulnerable children and their families. The system is plagued by a lack of communication and engagement at all levels. One of the most troubling findings in this report is the absence of a performance quality assurance system. There is no process to assure data integrity. There is a lack of accountability at all levels both within the agency and with contracted providers.

DHS has multiple and segmented layers of administration that lead to a culture of blame and lack of responsibility. The direct services workforce is neither supported nor held accountable. There is an indefensible system for controlling and managing the safety of children. The agency's response to any crises is to put initiatives into effect that are not integrated into a comprehensive plan for service delivery driven by a clear vision of good outcomes for children and families.

For example, when criticized for the number of children in care, the agency developed and deployed a dual-track CPS system without clarity and adequate staff development and training. This action resulted in a dangerous shift from over-commitment of children to a precipitous drop in custody numbers over a very short time period without an understanding of the potential risk to children. Similarly, when criticized for overcrowding emergency shelters, the agency allocated resources for additional emergency foster homes. Now children go to the emergency shelters, perhaps for a shorter period of time, before being transferred to an emergency foster home, thus simply adding an additional placement move for the traumatized children DHS serves.

The agency has trapped itself in a vicious cycle of poor placement decisions and permanency work. They are at the mercy of and have a shocking overreliance on emergency placements. The resources used to support these placements are precluding investment in building a strong placement and services infrastructure capable of ensuring the safety, permanency, and well-being of children and families.

In my opinion, until systemic reform of DHS is accomplished, foster children in Oklahoma will remain in danger on a daily basis. As mentioned at the beginning of this report, there are certain elements that are essential for any high-performing child welfare agency. With those elements in mind, I recommend that Oklahoma implement the following measures in order to achieve an adequate foster care system.

Recommendations

1. Administration

- Oklahoma should initiate a comprehensive business process analysis and redesign of the child welfare system with the ultimate “product” being the safety, permanency, and well-being of children. Restructuring without systemic culture change is no more than logistics. In contrast, a product-based business process analysis will be founded on a thoughtful outcomes-based approach to service delivery.
- DHS should develop a dynamic leadership team to drive the child welfare change initiative over the coming years. The systemic reform needed will require strong leadership with a clear vision of work that is child-centered, family-focused, strengths-based, and culturally responsive.
- DHS should implement a child welfare Performance Quality Assurance (PQA) office answering directly to top child welfare leadership. This office must have as much independence from bureaucratic interference as possible. The PQA should include the use of a standardized quality services review process for measuring the casework and outcomes of individual custody children. This office should also provide leadership for the implementation of a continuous quality improvement process that involves all staff across the agency as well as stakeholders outside the agency, including providers, community partners, service recipients, and foster parents.
- DHS should implement a high-quality data management system. This system must be staffed with the expertise necessary to ensure data integrity, and must allow the use of data reporting and analysis to inform decision-making and evaluate agency effectiveness on measurable outcomes.

2. Staffing

- DHS should abandon its antiquated workload analysis and develop a sustainable approach to workload management. This approach must not only include adherence to acceptable caseload standards, but it must also establish a mechanism for ensuring equity in assignment. Use of aggregate data and averages to determine caseload compliance must cease. Caseloads can only be managed at the individual staff level.
- DHS should initiate a “right sizing” initiative and seize the opportunity to reallocate staffing to child welfare as necessary.
- DHS should develop well-defined responsibilities and accountability for every position in the child welfare system, and set clear goals and objections for its child welfare staff.
- DHS should ensure the presence of a sufficient number of caseworkers and supervisors at all times by developing strategies to mitigate vacancies and turnover.

3. Professional Development and Workforce Competency

- DHS should develop an enhanced professional development program that is integrated and monitored; based on accepted principles of adult learning, including coaching and mentoring; and focused on outcomes for children and families.
- DHS should develop a more integrated approach to professional development in cooperation with the state's university system.
- DHS should develop specific curricula for both pre-service and in-service training for the child welfare workforce.
- DHS should continue to enhance its child welfare supervision training curriculum, including a performance competency evaluation.
- New worker training should require successful completion of a performance competency evaluation prior to caseload assignment.
- DHS should ensure that private provider caseworkers meet the same professional development standards as the public system staff.

4. Quality Assurance and Child Safety, Permanency, and Well-Being

- DHS should develop an integrated, comprehensive system of reporting, tracking, and monitoring outcomes, in particular the abuse and neglect of all children in care.
- CPS should begin joint investigations with the Office of Client Advocacy for all abuse and neglect reports involving custody children in congregate care. The findings of these investigations should be included in KIDS and reported to the federal government.
- DHS should implement a Quality Services Review (QSR) for evaluating cases of children in custody, which should include external reviewers along with DHS staff.
- DHS should implement a process to ensure that QSR recommendations are followed and action steps implemented.
- DHS should carefully monitor and refine the implementation of its dual-track CPS system in accordance with best practice standards.

5. Resources

- DHS should immediately develop and implement a plan to eliminate the use of emergency placements (particularly shelters), and reallocate those resources to develop an adequately funded, supported, and monitored placement system.
- DHS should develop and implement a dual certification program for foster and adoptive families to support a network of family-based placement services that are most likely to result in permanency, and to minimize placement instability.
- DHS should implement a continuous state, county, and community-based resource home needs assessment, including generic, targeted, and child-specific goals and strategies.
- DHS should develop, implement and monitor a plan for recruitment and retention of resource homes based on goals established from the needs assessment and should engage current resource families in this work.
- DHS should establish and monitor performance outcome measures for both public and private service providers and hold both accountable for those outcomes.

6. Contract Monitoring and Licensure

- DHS should implement performance based contracting.
- DHS should ensure that all private agency monitoring and licensure information is integrated and used to inform contract decision-making.
- PQA should become the repository for all contracts and provider monitoring information. It should regularly review all information available on each provider to determine the safety and well-being of children, and should make recommendations in writing regarding the continuation of contracting based on the information reviewed.


Viola P. Miller, Ed.D.

March 15, 2011

Appendix A



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Richard D. Emery

Lawrence J. Fox

Daniel H. Galpern

Mark Lopez

Howard M. Maisel

Jordan Seaman

James Stanton

February 18, 2011

Dr. Viola Miller
1614 Fifth Ave. North
Nashville, TN 37208

RE: Expert Service Retainer Agreement – Management Review

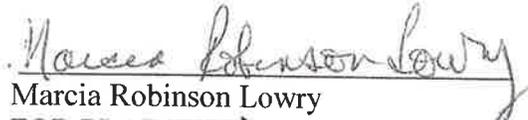
Dear Dr. Miller:

This letter agreement confirms your retention by Plaintiffs as a testifying expert in the *D.G. v. Henry* litigation as of January 14, 2011. By signing and dating this letter, we all indicate our agreement with its terms.

The scope of your work concerns an analysis of the quality and adequacy of the organizational and programmatic decision-making by the Oklahoma Department of Human Services' management in its administration of the State's child welfare system. In addition to completing a written report of your findings, you also agree to be available to testify at deposition and at trial in this case, if necessary. You will be paid an hourly rate of \$160 for all of your time spent in this matter, including any time preparing for and testifying at deposition and trial.

You agree to submit a full preliminary draft of your expert report to Plaintiffs' counsel by no later than March 4, 2011, and a final expert report to Plaintiffs' counsel by no later than March 10, 2011.

If these terms are acceptable, kindly return one of the signed copies of this letter and retain the second copy for your records.


Marcia Robinson Lowry
FOR PLAINTIFFS


Dr. Viola Miller
Date 02/25/11

Appendix B

RESUME

Viola P. Miller

**1614 5th Avenue North
Nashville, TN 37208
615-251-1657
(Cell) 270-293-8268**

PROFESSIONAL EXPERIENCE – CHILD WELFARE

Commissioner, Department of Children’s Services, Tennessee – appointed by Governor Phil Bredesen, December 2003 – January 2011

Responsibilities: One of twenty-one Cabinet Members of the Executive Branch of Tennessee State Government. Responsible for approximately 5,000 employees and a budget of six-hundred and forty million dollars. Program areas include Child Protective Services, Foster Care and Adoption, Child Permanency, Juvenile Justice and Independent Living.

Additional Assignments: Governor’s Children’s Cabinet; Connect Tennessee; Council on Children’s Mental Health; Governor’s Task Force on Criminal Justice

Major Accomplishments: National accreditation by the Council on Accreditation; Performance Based Contracting; Quality Services Review; Path to Excellence; Road to Reform; FOCUS, Permanency for Hard to Place Youth; Leadership Academy

Secretary, Cabinet for Families and Children, Commonwealth of Kentucky - appointed by Governor Paul E. Patton, December 1995 – December 2003

Responsibilities: One of twelve Cabinets in the Executive Branch of Kentucky State Government. Responsible for approximately 10,000 employees and a budget of nine hundred and fifty million dollars. Program areas include Temporary Assistance for Needy Families (TANF), Child Support, Child and Adult Protective Services, Foster Care and Adoption, Guardianship, Family Resources and Youth Services Centers, Food Stamps and Medicaid Eligibility, Disabilities Determination.

Additional Assignments: Child Abuse and Exploitation Board; Child Care Policy Council; Child Support Enforcement Council; Council on Domestic Violence; Human Service Collaboration Commission; Task Force on Children in Placement; Task Force on Early Childhood; Early Childhood Development Authority; Governor’s Council on Domestic Violence and Sexual Assault; State

Advisory Panel for Exceptional Children; Substance Abuse Policy Board;
Advisory Council for Exceptional Children

Major Accomplishments: National accreditation by the Council on Accreditation;
Vision 2000 – Child Welfare Reform; Comprehensive Family Services; Pre-
Service Child Welfare Certification Program; Human Services Leadership
Institute

PUBLICATIONS

Fox, S. and Miller, V., Barby, A. (2003). Finding and keeping child welfare workers: Effective training and professional development. Journal of Human Behavior in the Social Environment. Vol. 7 No. ½.

Miller, V. (2003). Congress should use welfare to target the true enemy: poverty. Stateline: State Policy and Politics – Pew Center on the States. December, 02.

Huebner, R., and Miller, V., Hommrich, B., Hiemstra, H. (2002). The Kentucky foster care census: profiles in permanency. Child Welfare League of American.
www.cwla.org/programs/trieschman/2003

Huebner, R. and Jones, B., Miller, V., Custer, M, Crutchfield, B. (2002). Comprehensive family services and customer satisfaction outcomes. Child Welfare. Vol. 85., No. 4.

Burnham, D. and Fox, S., Miller, V. (1999). Site pre-service certification programs garners praise in Kentucky. Partners for Child Welfare Newsletter Vol. 6., No. 2.

Burnham D. and Fox, S., Miller, V. (1997). Reengineering the child welfare training and professional development system in Kentucky. Public Child Welfare. APHSA.

PROFESSIONAL ACTIVITIES

National Association of Public Child Welfare, Executive Committee, 2007

Excellence in Child Welfare Leadership Project, American Public Human Services Association, 2001

Child Welfare Advisory Group, American Public Human Services Association, 1999

American Public Human Services Association Executive Committee, 1998-99

National Council of State Human Services Administrators, American Public Human Services Association, 1996

PROFESSIONAL HISTORY

Dean for Continuing Education; Assistant Vice-President for Academic Outreach, Murray State University, 1988-1995

Responsibilities: Supervised and managed all aspects of the University's Center for Continuing Education and Academic Outreach including extended campus activities, Distance learning, the Bachelor of Independent Studies Degree, community Education, professional conferences and workshops, special events and adult student services. Taught two courses per year for the Department of Special Education, provided clinical supervision assistance, served on graduate committees and advised students.

Chair, Department of Special Education, Murray State University, 1985 (Interim) 1986-1988

Responsibilities: Directed all aspects of departmental activity including fiscal, curricular and personnel management; student recruitment and retention; responded to university, state and national evaluative and accreditation requests; maintained appropriate departmental, academic and practicum/clinical data; 50% teaching load.

Director, Division of Communication Disorders, Department of Special Education, Murray State University, 1976-1984

Responsibilities: Directed activities of the undergraduate and graduate programs in communication disorders; taught 75% load; reported to the department chair on divisional curricular and personnel matters. Successfully lead the division to national accreditation by the American Speech, Language and Hearing Association.

PROFESSIONAL HISTORY (Overview)

Murray State University, Murray, Kentucky

Assistant Professor, Division Director of Speech and Hearing, 1976-1978

Associate Professor, Division Director of Communication Disorders, 1978

Associate Professor, Chair, Department of Special Education Consultant, Project Independence for Older Americans Consultant, Program for Early Education of Exceptional Children

Consultant, Area Health Education Service, Field Based

Communicative Disorders Program

Consultant, Headstart Screening

Consultant, Wendell Foster Center for the Physically Handicapped

Consultant, West Kentucky Diagnostic Center Consultant, Henry County Schools, Paris, Tennessee

Director, Murray State University Handicapped Infant/Toddler Intervention

Program Chair, Presidential Scholars Committee

University of Alabama, University, Alabama

Doctoral Student, 1975-76

Northern State College, Aberdeen, South Dakota

Assistant Professor, 1970-1975

Speech Correction Program Director, 1971-75

Consultant, Aberdeen Public School Program for Hearing Impaired

Consultant, Gettysburg Public School Therapy Program

Consultant, Headstart Program, Cheyenne River Indian Reservation

Consultant, Headstart Program, Sisseton, South Dakota

Consultant, St Francis Mission Indian School, Rosebud, South Dakota

Consultant, State Department of Special Education, Advisory Committee on State Plan for Special Education

Consultant, State Department of Education, Exceptional Children Advisory Board for Speech and

Hearing Therapy Consultant, Americana Nursing Homes Consultant, South Dakota

State School for the Visually Impaired

Co-Director, Multi-County Hearing Screening Services for Older Americans

Co-Director, Multi-County Communication Disorders Education Program for Older Americans

Duke University Medical Center, Durham, North Carolina

Speech Pathologist, 1968-1970

Consultant, Cleft Palate Board

Consultant, Stroke Team

Consultant, Developmental Evaluation Clinic, Duke Hospital

Consultant, Developmental Evaluation Clinic, Henderson, North Carolina

Consultant, Head Start Program, Public Health Center

Northwestern State University of Louisiana, Natchitoches, Louisiana

Instructor, Department of Special Education, 1966-68

Speech and Hearing Consultant, Northwestern State College Special

Diagnostic Evaluation Team

Caddo School for Exceptional Children, Shreveport, Louisiana

Speech Therapist, 1964-65

Tulane University, New Orleans, Louisiana

Graduate Assistant, 1964-65

Speech Pathology Consultant, U.S. Merchant Marine Hospital

Research Assistant, Birth Cry Study

PUBLICATIONS

- Miller, V. and Weaver, J. (1993). More on teachers: The new academy. Issues in Kentucky Higher Education: Essays by Kentucky Educators. The Prichard Committee for Academic Excellence.
- Miller, V. (1991). Distance learning alternative instructional strategies. Humanities and Technology Association Review. 10.
- Miller, V. and Blodgett, E. (1991). Practice power for phonology. LinguiSystems: Moline, IL.
- Blodgett, E. and Miller, V. (1989). Easy does it for phonology (2 volumes). LinguiSystems: Moline, IL.
- Miller, V. (author, scripter), Homback, M. and Blodgett, F. (1985). An overview of handicapped infant/toddler intervention [videotape]. Department of Special Education, Murray State University, Murray, Kentucky. (Funded by U.S. Department of Education, Grant Number G008401376).
- Miller, V. (author; scripter), Homback, M. and Blodgett, F. (1987). The impact of nurses on the families of young handicapped children [videotape]. Department of Special Education, Murray State University, Murray, Kentucky. (Funded by U.S. Department of Education, Grant Number G008401376).
- Miller, V. (author; scripter), Homback, M., and Blodgett, F. (1987). The impact of social workers on families of young handicapped children (videotape]. Department of Special Education, Murray State University, Murray, Kentucky. (Funded by U.S. Department of Education, Grant Number G008401376).
- Miller, V. (1983). Creative resource identification for providing services to rural handicapped students. A preservice curriculum module for preparation of qualification rural special educators. National Rural Research and Personnel Preparation Project, Murray State University, Murray, Kentucky.
- Miller, V. (1979). Book Review of Early intervention-A team approach ASHA. XXL 32.
- Condon, M., Miller, V. and Blodgett, E. (1979). Phonetic analysis: Educational training and clinical application. Proceedings of Mid-South Educational Research Association (abstract - complete text in archives of the association).
- Schillit, J. and Miller, V. (1977). Semantics and mental retardation. Research and the Retarded. 4(1).
- Miller, V., Condon, M., Schallenkamp, K. (1976). Use of computerized satellite clinics to provide hearing testing services to rural senior citizens. South Dakota Speech and Hearing Association Journal. 5(1).
- Miller, V., Condon, M., Schallenkamp, K. (1975). Hearing testing survey of 1200 geriatric patients in rural United States. Convention Abstracts International Congress on Gerontology. Jerusalem,

Israel.

Miller, V. (Task Force Author). (1975). Speech and Hearing Program Guidelines and Standards for the State of South Dakota. State Department of Education, Pierre, South Dakota.

Miller, V. (1972). Communication Aids. South Dakota Speech and Hearing Association Journal. 2 (R)

Miller, V. (1969). Language development: An analysis of difficulty and proficiency. North Carolina Medical Journal. 30.

Miller, V. (1969). [Book review of The World of Sound! Journal of Speech and Hearing Disorders. 34.

Miller, V. (1965). Speech correction facilities available in Louisiana. Louisiana Speech and Hearing Association Newsletter.

REPRESENTATIVE PROFESSIONAL ACTIVITIES

Grants Developed and Funded

Kentucky Telelinking Network. Funded 1994 (\$3.6 million for first year, \$4.0 million for second year) by the Office of Education Research and Innovation, U. S. Department of Education.

West Kentucky Interactive Telecommunications Distance Learning and Medical Link Network. Funded 1994 (\$319,376 for one year) by The Rural Electrification Administration, U. S. Department of Agriculture.

Adult Basic Education Program. Funded 1993-ongoing, by the Kentucky Cabinet for Workforce Development (\$84,739 for first year). (With Dot Newbem)

Training Resource Center. Funded (1991-95) by the Kentucky Department for Social Services (\$54,746/annually, 1991-95). (With Tamikia Dumas)

Alternative Special Education Certification Program. Funded 1987-1990 (3 years - \$95,000 annually) by the Office of Special Education and Rehabilitative Services, Department of Special Education. (With Allan Beane)

Improving Services to Minority Handicapped Children Through Pre-service Training and Minority Recruitment in Communication Disorders. Funded 1987-1990 (3 years - \$71,010 annually) by the Office of Special Education and Rehabilitative Services, Department of Education. (With E. Blodgett and C. Richardson)

Training Related Services Personnel for Professional Involvement with Handicapped Infants, Toddlers, and Families. Funded 1984-1987 (\$54,423 annually). Handicapped Personnel Preparation, U.S.

Department of Education, Washington, D.C.

Environmental Communication Intervention for the Aging. Funded 1978, 1979 (\$56,000 annually)
Department of Health, Education and Welfare, Administration on Aging, Washington, D.C.

Multi-Disciplinary Career Training in Gerontology. Funded 1979-1981 (\$80,000 annually). Health,
Education and Welfare, Administration on Aging, Washington, D.C. (with M. Simpson).

Program Assistance Grant — Preservice Early Childhood Handicapped Infant Intervention Specialty Training
Subcomponent and Preservice Personnel Preparation in Severely Handicapped. Funded 1981-84 (\$67,000
annually). Bureau for Education of Handicapped, Washington, D.C.

Juried Presentations

"Reengineering the Child Welfare Training and Professional Development System in Kentucky," National
Staff Development and Training Association Annual Conference, Washington, D.C, 1997 (with S. Fox).

"The Delivery of Academic Programs to a Rural Area Via a Telecommunications Network: One
University's Experience," First International Conference on Distance Education, Moscow, Russia, July
1994 (with A. Lawson, M. Hobbs, and M. Posey).

"Taking Charge of Change in Academic Technology: A Case Study for Challenge in Planning," The
Society for College and University Planning Annual Conference, San Francisco, California, July 1994
(with A. Lawson).

"High Tech! High Touch! Training SLP's for Rural Service Delivery," American Speech-Language-
Hearing Association Annual Convention, San Antonio, Texas, November 1992 (with Ann Beth Deily,
Gary Adamson and Cheryl Prichard).

"Interactive Educational Telecommunications: The Future's Now," National University Continuing
Education Association 77th Annual Conference, San Diego, California, April 1992.

"Murray State University Interactive Telecommunications Network (TTN)," America Speech-Language-
Hearing Association Annual Conference, Atlanta, Georgia, November 1991 (with Communication
Disorders graduate students).

"Distance Learning - Alternative Instructional Strategies," Interface '90 - The Fourteenth Annual Humanities
Technology Conference, Atlanta, Georgia, October 1990.

"Establishing Extended Campus Centers: The Excellence/Access Dilemma," Adult Learning Conference,
Columbia, South Carolina, May 1990.

"Establishing Extended Campus Centers: The Excellence/Access Dilemma,"¹¹ Kentucky Deans and
Directors of Continuing Education, Bowling Green, Kentucky, May 1990.

"Phonological Awareness: A Metalinguistic Approach," American Speech-Language-Hearing Association

Annual Convention, Boston, Massachusetts, 1988 (with E. Blodgett).

"Establishing Phonological Targets: Is There Life After Processes?" Kentucky Speech-Language-Hearing Association Annual Convention, Louisville, Kentucky, 1988 (with E. Blodgett).

"A Description of Phonological Processes in Preschool Communicatively Disordered Children," Kentucky Speech-Language-Hearing Association, Louisville, Kentucky, 1986 (with E. Blodgett).

"Internationalizing the Honors Program," Southern Regional Honors Council Conference, Clemson, South Carolina, April 1986 (with Anita Lawson and Milton Grimes).

"The Effect of Imitation and Utterance Length on the Phonology of Preschool Communicatively Disordered Children," American Speech-Language-Hearing Association Annual Convention, Detroit, Michigan, 1986 (with E. Blodgett).

"A Description of Phonological Processes in Preschool Communicatively Disordered Children," American Speech-Language-Hearing Association Annual Convention, Washington, D.C., 1985 (with E. Blodgett).

"Communicative Approach to Phonological Structure," American Speech-Language-Hearing Association Annual Convention, Washington, D.C., 1985 (with E. Blodgett).

Training Communicative Interaction in Severely/Profoundly Handicapped Infants and Children, American Speech-Language-Hearing Association Annual Convention, Cincinnati, Ohio, 1983 (with E. Blodgett).

"Phonological Analysis of Spontaneous and Imitated Speech Samples," American Speech-Language-Hearing Association Annual Convention, Cincinnati, Ohio, 1983 (with E. Blodgett).

"Phonological Process Analysis: Traditional Articulation Vs. Conversational Sample," American Speech-Language-Hearing Association Annual Convention, Cincinnati, Ohio, 1983 (with R. Simmons and E. Blodgett).

"Teaching Communicative Interaction to Severely/Profoundly Handicapped Infants and Young Children," Kentucky Speech and Hearing Association Convention, Lexington, Kentucky, April 1983 (with E. Blodgett).

"New Approaches in the Diagnosis and Treatment of Articulation Disorders," Council for Exceptional Children Kentucky Federation Convention, Fort Mitchell, Kentucky, April 1982 (with E. Blodgett).

"Communicative Approach to Phonological Structure," Kentucky Speech and Hearing Convention, Lexington, Kentucky, 1982 (with E. Blodgett).

"Clinical Implications of Two Interactive Settings," American Speech-Language-Hearing Association Annual Convention, Los Angeles, California, 1981 (with E. Blodgett).

"Facilitating Communicative Interaction in the Adult-Handicapped Infant-Dyad," American Association on Mental Deficiency Convention, Detroit, Michigan, 1981 (with E. Blodgett).

"Communication Intervention in Normal and Disordered Child-Adult Dyads," Kentucky Council on Exceptional Children, Louisville, Kentucky, 1981 (with E. Blodgett).

"Facilitative Language Model," Kentucky Speech-Language-Hearing Association Annual Convention, Louisville, Kentucky, 1980.

"Facilitating Language Training and Management for Parents of Language Deficient Children," American Speech-Language-Hearing Association Annual Convention, Atlanta, Georgia, 1979 (with E. Blodgett).

"Modified Melodic Intonation Therapy with an Autistic Child," American Speech-Language-Hearing Association Annual Convention, Atlanta, Georgia, 1979 (with E. Blodgett).

"Facilitating Communicative Interaction in Normal and Disordered Infant-Mother Dyads," Association for Mental Deficiency Convention, Detroit, Michigan, 1979.

"Use of Computerization and Satellite Clinics for Providing Hearing Testing Services to the Geriatric Population in a Rural Area,"¹¹ American Speech and Hearing Association Annual Convention, Washington, D.C., 1975 (with M. Condon and K. Schallenkamp).

"Language Characteristics of Public School Hearing Impaired Children," American Speech and Hearing Association Annual Convention, New York, 1970 (with Marilyn Condon).

"Educational Planning Considerations for Hard of Hearing Children," North Carolina Speech and Hearing Association Spring Convention, 1970 (with M. Condon).

"Supportive Speech Therapy in Traumatic Injury Cases," North Carolina Speech and Hearing Association Convention, Durham, North Carolina, 1970.

"The Use of the Continuous Tone Masking Test in Diagnosing Conductive Hearing Impairments," American Speech and Hearing Association Convention, Washington, D.C., 1968.

Selected Invited Presentations/Workshops

"Changing the Way We Deliver Our Services - Access to Education-Telecommunications," Governor's Conference on Higher Education Trusteeship, Lexington, Kentucky, October 2-3, 1994 (with R. Geoghegan).

"State Networking Update (KTLN) State Backbone RFP, NTIA-NIL" KHECC Conference, Louisville, Kentucky, September 1994.

"Therapy for Young Children with Speech Sound Disorders: They Are Not Short Sixth Graders," West Virginia Speech-Language-Hearing Association, Huntington, West Virginia, April 1994 (with E. Blodgett).

"Language Intervention Models for Public School Speech-Language Pathologists," Caddo Parish School Board, Shreveport, Louisiana, October 1993.

"SACS Criteria and Continuing Education," Kentucky Continuing Education Deans and Directors, Owensboro, Kentucky, June 1992.

"Establishing and Maintaining Successful Distance Learning Programs, Part I," The Society for College and University Planning, Lexington, Kentucky, April 1992.

"Pre-school Language and Metalinguistics," South Dakota Speech-Language-Hearing Association," Rapid City, South Dakota, April, 1991.

"Facilitating Language Learning in Very Young Children: They are Not Short Fourth Graders," Kentucky Speech-Language-Hearing Association Annual Convention, Lexington, Kentucky, March 1991 (with E. Blodgett).

Talking about Talking: Metalinguistics in the Treatment of Phonological Disorders," Seventh Annual National Language Conference in Orlando, Florida, October 1990; Chicago, Illinois, October 1990; and San Francisco, California, February 1991. Sponsored by LinguSystems, Inc (with E. Blodgett).

"How Telecommunications Technology Changes the Way We Work," American Association for Higher Education Telecommunications Action Committee Meeting, AAHE National Conference on Higher Education, San Francisco, California, April 1990.

"Ethical Issues in Speech-Language Pathology," Kentucky Speech-Language-Hearing Association, Louisville, Kentucky, April 1990.

"Excellence in the Service Environment," Keynote Address National Association of Educational Buyers Fall Regional Workshop, Berkley State Resort, Kentucky, September 1989.

"Phonology Therapy for Preschool," Mississippi Bend Area Education Agency, Bettendorf, Iowa, June 1989 (with E. Blodgett).

"Phonological Disorders in Young Children-Diagnosis and Remediation," Jordanhill College, Glasgow, Scotland, 1988.

"Language Disorders in Pre-School Children," Northwest Tennessee Headstart Program, 1985.

"Communicative Approach to Phonological Structure," Kentucky Speech-Language-Hearing Fall Conference, Bowling Green, Kentucky, 1986 (with E. Blodgett).

"Communicative Approach to phonological Structure," Western Kentucky University Department of Special Education and regional speech-language pathologists, Bowling Green, Kentucky, 1988 (with E. Blodgett).

"Communicative Approach to Phonological Structure: An Articulation Therapy Approach for Public School Clinicians," Department of Communication Disorders, North Dakota State University and the North

Dakota State Board of Examiners in Audiology and Speech Pathology, Fargo, North Dakota, March, 1983
(with E. Blodgett).

The Cognitive Interactional Model of Instruction for the Severe/Profound Multihandicapped Child,"
Mucatatuck Special Education Center, Special Services Unit, North Vernon, Indiana. November 1983
(with E. Blodgett).

"Mother-Infant Interaction," Keynote Address, West Kentucky Association for Education of Young
Children, 1981.

"Melodic Intonation Therapy for an Autistic Child," Bloomsburg Conference, Terre Haute, Indiana, 1980
(with E. Blodgett).

"Suggested Practices of working with abnormal speech development in young children," Multihandicapped
Workshop for Pennyroyal Mental Health/Mental Retardation Center Early Childhood Handicapped
Personnel, Hopkinsville, Kentucky, 1977.

"Neuromuscular Disorders," Cerebral Palsy Institute, University of Alabama, University, Alabama, 1976.

"Hearing Testing Survey of 1200 Geriatric Patients in Rural United States," International Congress on
Gerontology, Jerusalem, Israel, 1975 (with M. Condon and K. Schallenkamp).

"Communication Disorders of the Aging," Nursing Home Association of South Dakota. Presented for
Americana Nursing Homes, Inc., of South Dakota and Council on Aging, Aberdeen, South Dakota, 1974.

"Language Development and Disorders of Early Childhood," Indian Child Service, Bismarck, North
Dakota, 1972.

Professional Activities

Distance Learning Advisory Committee, 1997

Strategic Committee on Postsecondary Education, 1997

State Advisory Panel for Exceptional Children, 1996

Workforce Partnership Council, 1996

Housing Policy Advisory Committee, 1996

Kentucky Commission on the Deaf and Hard of Hearing, 1996

Job Training Coordinating Council, 1996

Advisory Council for Adult Education and Literacy, 1996

USDA State Outreach Council, 1999

Site Visit Peer Reviewer, Southern Association of Colleges and Schools, 1993-1995.

Editor, Newsletter for Committee on the Status of Women in the Profession, NUCEA, 1993-1995.

Developed and implemented the Murray State University Interactive Telecommunications Network (UN), 1990.

Three Month International Faculty Exchange with Jordanhill Teachers College, Glasgow, Scotland, April-June, 1988

Teacher Education Member, Internship Supervision Teams (Certified Observer, Florida Performance Measurement System), 1986-1990

Kentucky Board of Speech-Language Pathology and Audiology Appointed by Governor Martha Layne Collins, 1986-1989; re-appointed 1989-1992 by Governor Wallace Wilkinson

Charter Executive Committee Member (representing Kentucky), Southern Rural Education Association, 1985

Executive Committee, Kentucky Speech-Language-Hearing Association, 1984-1995 Chair, Ethical Practices Committee, 1985-90 Chair, Multicultural Issues Committee

Initiated Handicapped Infant/Toddler Program, 1980

Evaluative Consultant, Excepticon-Outwood Institution, 1979

Journal Editor, South Dakota Speech and Hearing Association Newsletter, 1972-1974

Member, Third Party Evaluation Team Mountain-Plains Regional Center for Services to Deaf-Blind Children, Denver, Colorado, 1975

President Elect, South Dakota Speech and Hearing Association, 1974

Membership Chairman, Louisiana Speech and Hearing Association, 1966

PROFESSIONAL HONORS, SOCIETIES

National Governor's Association Award for Distinguished Service in State Government, 2003

Kappa Delta Pi – National Educational Honor Society – Northwestern State University

Bush Foundation Leadership Fellows Award, 1975-76
Mid-Career Recognition for Leadership

Omicron Delta Kappa National Leadership Honor Society
Elected as a faculty member at Murray State University
Faculty Secretary, 1978-80

Phi Delta Kappa Education Society

Phi Kappa Phi – National Scholastic Honor Society – Northwestern State University

Tennessee Connections, Winter 2005
Public Official of the Year

Thirty One Most Powerful Women In Tennessee – The Tennessean, 2010

EDUCATION

Ed.D. Special Education, University of Alabama, Tuscaloosa, Alabama - 1978

Speech-Language Pathology, University of Iowa, Iowa City, Iowa - 1966

Residency in Speech Pathology, Duke University Medical Center, Durham, North Carolina –
1968-69

M.S., Speech-Pathology and Audiology, Tulane University, New Orleans, Louisiana - 1966

B.A. Speech and Hearing Therapy, Northwestern State University, Natchitoches, Louisiana –
1964

Appendix C

Materials	Relevant Bates Range
Notes from Oklahoma PIP Site Visit, Jan. 8-9, 2009, attached to email from H.C. Franklin to Larry Johnson, Cindy Halbern, Marq Youngblood, et. al. re: notes from Jan 8-9, dated Jan. 23, 2009	CFSR.PIP.Franklin-00011-12
Final Report outline notes, attached to email from Dana Huckabee to H.C. Franklin, dated Dec. 18, 2008	CFSR.PIP.Franklin-00026, CFSR.PIP.Franklin-00028
Email from H.C. Franklin to Margaret DeVault, Mary Grissom, Kevin Haddock, et. al. re: Oklahoma comments, dated June 19, 2009	CFSR.PIP.Franklin-00033
Notes from Child Welfare Field Liaison meeting, Feb. 27, 2008	CWFL-MN-2.28.08-00001-13
Oklahoma Department of Human Services Performance Audit, Prepared for the Oklahoma House of Representatives by Hornby Zeller Associates, Inc., Feb. 2009	Dep. Ex. 173 (from Franklin Dep., July 7, 2009)
Children's Bureau, Executive Summary, Final Report: Oklahoma Child and Family Services Review, Mar. 2008.	OKDHS-CFSR-2008-Exec Sum 3.08-00001-23
Children's Bureau, Final Report, Oklahoma Child and Family Services Review, Mar. 2008	OKDHS-CFSR-Final Report 3.08-00001-00103
Oklahoma Department of Human Services Child Welfare Practice Model Guide, Oct. 31, 2008	CWPM-Comp-Folder-01644-01769
Oklahoma Department of Human Services, Child and Family Services Review Program Improvement Plan, Oct. 12, 2009	CFSR-PIP-2008-Rev 10.12.09-00001-78
Oklahoma Department of Human Services, FY-07 Budget Request (Detail Summary)	BR-2007-00002-41
Oklahoma Department of Human Services, FY-08 Budget Request (Detail Summary)	BR-2008-00001-42
Oklahoma Department of Human Services, FY-09 Budget Request (Detail Summary)	BR-2009-00001-40
Oklahoma Department of Human Services, FY-10 Budget Request (Detail Summary)	BR-2010-00001-54
Oklahoma Department of Human Services, FY-11 Budget Request (Detail Summary)	BR-2011-00001-10
Table with DHS Salary Information	Org P&P-2-00001-11
Training Material - Supervisor and Mentor Guide for FY 2008	Dep. Ex. 58 (from Bogard Dep., Oct. 10, 2008)
Safety Assessment	CWPM-Comp-Folder-00001-30
Oklahoma Department of Human Services Supervisor's Handbook To Implementing the Practice Standards and the Practice Model, July 2008	CWPM-Comp-Folder-02139-73
Organizational Charts	R&R-8-00217-20, R&R-8-00223-25, R&R-8-00237-38, Org P&P-4-00001
Oklahoma Child and Family Services Review Data Profile, July 23, 2009	OK07b08a-08-08b09a-DP-7.23.09-00001-16

Materials	Relevant Bates Range
Oklahoma Child and Family Services Review Data Profile, Feb. 23, 2010	OK-08-08b09a-09-DP-2.23.10-00001-16
Child and Family Services Review Program Improvement Plan Quarterly Report: Quarter 2, May 12, 2010	CFSR-PIP-2009TO2011-Q2R-00001-51
Child and Family Services Review Program Improvement Plan Quarterly Report: Quarter 1, Feb. 12, 2010	CFSR-PIP-2009TO2011-QR-00001-45
Child Protective Services Policy Excerpt and Related Forms, Apr. 2010	CPS-Excerpt-Vers-5-00001-00216
Child Protective Services Policy Excerpt and Related Forms, July 2008	CPS-Excerpt-Vers-4-00001-00241
Child Protective Services Policy Excerpt and Related Forms, May 2006	CPS-Excerpt-Vers-1-00001
Service Contract Evaluation for Oklahoma Families First	Contract_Monitor-00026-30
Service Contract Evaluation for Shadow Mountain Behavioral Health Systems	Contract_Monitor-00027
Service Contract Evaluation for J. Roy Dunning Children's Shelter	Contract_Monitor-00028
Service Contract Evaluation for Christian Services of Oklahoma	Contract_Monitor-00029
Service Contract Evaluation for The Bair Foundation	Contract_Monitor-00030
Continuous Quality Improvement Contract Performance Review for United Methodist Circle of Care	CPR-3-00001-75
Continuous Quality Improvement Contract Performance Review for Murrow Indian Children's Home	CPR-4-00001-20
Continuous Quality Improvement Contract Performance Review for Ivalene Pendergrass Specialized Community Home	CPR-8-00001-82
Oklahoma Child Care Services Monitoring Reports for Associated Centers for Therapy	OCCS-MR-15-00001-00127
Oklahoma Child Care Services Monitoring Reports for Pauline Mayer Group Home	OCCS-MR-21-00001-00105
DHS Presentations to Legislature	WhiteA-017174, WhiteA-016447
Child Family Services Review State Scoring Summary for 2008	CQI 2008 Annual Rpt-00001-02
Child Family Services Review State Scoring Summary for 2009	CQI 2009 Annual Rpt-00001-02
Children and Family Services Division Rates Schedule, Jan. 1, 2009	Appendix C-20-00001-07
Contracts between Oklahoma Health Care Authority and APS	ContractsAPS-OHCA-00001-00143
Oklahoma Department of Human Services Child and Family Services Plan, 2010-2014, 2010 Annual Progress and Services Report, June 30, 2010	APSR-2010-6.30.09-00001-00156
Bridge to the Future - Agenda	#68&69-BR-Grant-1-00023-29
Bridge to the Future - Customer Support Center	#68&69-BR-Grant-1-00148-49

Materials	Relevant Bates Range
Data Worksheets, Children No Kin/Rel & CW Foster Home Beds Only State-Area-County, Dec. 31, 2009	#68&69-BR-Grant-1-00002-21
Bridge to the Future - Evaluation	#68&69-BR-Grant-1-00152-00292
Bridge to the Future - Front Cover	#68&69-BR-Grant-1-00001
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