“BEYOND DANGER!”
A Management Review of the
Mississippi Department of Human Services
Division of Family and Children’s Services
(MDHS/DFCS)

Cathy R. Crabtree

February 2006
## TABLE OF CONTENTS

**EXECUTIVE SUMMARY**  
1

I. **INTRODUCTION**  
4

   A. Reviewer Qualifications and Methodology  
5
   
   B. Agency Overview  
6
   
   C. Historical Background  
7

II. **MDHS IS DANGEROUSLY UNDERSTAFFED AND STAFF ARE POORLY TRAINED**  
12

   A. "BEYOND DANGER!" Caseloads Put Children's Safety At Risk  
12
   
   B. MDHS Maintains High Staff Turnover And An Ineffective Hiring Process  
14
   
   C. MDHS Fails to Adequately Train and Supervise Its Staff  
16

   (i) Training  
   (ii) Supervision

III. **MDHS LACKS STRONG AND STABLE LEADERSHIP TO ENSURE EFFECTIVE SERVICES FOR CHILDREN**  
20

   A. MDHS Leadership Has Been Inconsistent And Ineffective  
20

   (i) The Governor  
   (ii) MDHS Executive Director  
   (iii) DFCS Division Director  
   (iv) A Doomed Program Improvement Plan

   B. MDHS Fails To Provide Staff Adequate Resources  
24

   (i) Failure To Develop Adequate Placements  
   (ii) Failure to Develop an Adequate Service Array  
   (iii) MACWIS  
   (iv) Lack of Modern Technology

   C. The MDHS Management Structure Is Inefficient And Creates Gaps In Lines Of Responsibility For Children's Safety And Well-Being  
32

   D. MDHS Lacks A System Of Accountability For Agency Responsibilities  
36
(i) Lack of Administrative Accountability  
(ii) Failure to Develop an Adequate Quality Assurance System  

IV. MDHS DENIES CHILDREN ADEQUATE SERVICES AND FAILS TO PROTECT THEM FROM HARM  

A. MDHS Denies Children Safe and Appropriate Placements  

(i) Children Are Arbitrarily Placed  
(ii) Children Are Over-Institutionalized  
(iii) Children Are Placed in Inappropriate Emergency Shelter Placements  
(iv) Children Are Denied Needed Therapeutic Placements  
(v) Children Are Placed in Overcrowded Homes and Facilities  
(vi) Children Are Placed in Unlicensed Homes and Facilities  
(vii) Children Are Placed in Inadequately Screened Relative Placements  
(viii) Children in MDHS Custody Are Routinely Separated from Their Siblings  
(ix) Children Are Placed Far Away From Family  
(x) Children Are Subjected to Multiple Moves  
(xi) MDHS Fails to Supervise and Screen Children’s Placements  
(xii) Children Are Maltreated in Foster and Adoptive Placements  

B. MDHS Fails To Provide Children With Health Care And Other Needed Services  

(i) Failure to Assess Children’s Needs  
(ii) Failure to Provide Regular Medical and Dental Health Care  
(iii) Failure to Provide Mental Health Services  
(iv) Failure to Provide Educational Services  

C. MDHS Fails to Plan For Children  

(i) Poor Permanency Planning Services  
(ii) Missed Case Plan Reviews and Judicial Permanency Hearings  
(iii) Adoption Delays  

V. CONCLUSIONS AND RECOMMENDATIONS  

A. Recommendations  

(i) Staffing and Training  
(ii) Administration  
(iii) Resources  

Appendix A. Curriculum Vitae for Cathy R. Crabtree
EXECUTIVE SUMMARY

In the federal lawsuit *Olivia Y. v. Barbour*, the state of Mississippi child welfare agency is charged with failing to meet the state’s constitutional obligation to keep children in state custody free from harm. The author of this report has extensive experience in social service agency management, including eight years as Assistant Commissioner of the Tennessee Department of Children’s Services, and is currently retained to serve as interim Director of Quality Assurance for Alabama’s child welfare agency. I was asked to undertake an expert review of the Mississippi Department of Human Services (MDHS) Division of Family and Children’s Services (DFCS) to assess whether its operational management allows it to meet the minimum professional standards required to accomplish its mandate of protecting children in state custody. My assessment is based on a review of the extensive documentation that has been made available in this lawsuit.

My conclusion is that MDHS is mismanaged, insufficiently staffed, and lacking in qualified and skilled leadership. As a result, Mississippi’s foster care system fails to meet almost every professional standard designed to protect the children in its custody. This failing child welfare system places children at substantial risk of harm on a daily basis. In this report I offer recommendations for reform, but in my expert opinion, reform of MDHS cannot be achieved absent significant oversight and ongoing technical assistance.

Key Report Findings:

> **MDHS is dangerously understaffed.**

- While national standards for foster care caseloads are set at 12 to 15 children per social worker, MDHS averages 48 cases per worker, with individual social workers carrying caseloads as high as 286.

- MDHS itself has categorized caseloads of 31 or more as “DANGER!” and caseloads of 40 or above as “BEYOND DANGER!” for the children relying on the agency for care and protection. As of August 2005, 80.5% of counties had caseworkers carrying caseloads at or above the Danger level; more than half the counties had caseloads at the Beyond Danger level.
By DFCS’s own calculations, an additional 554 caseworkers are needed to bring caseloads down to the national professional standard. Yet, in its most recent Budget Request Package, DFCS requested only that 38 vacant positions be filled and that 59 previously abolished positions be re-established.

- MDHS deploys untrained and unqualified staff to work with abused and neglected children.
  - New social workers are routinely put on the job and made to carry caseloads for one month to a year before they receive any training.
  - MDHS relies on unqualified and untrained aides, homemakers, and clerical staff to perform social work tasks such as required face-to-face contacts with foster children.

- MDHS lacks knowledgeable and stable leadership to run the agency and protect children.
  - DFCS is led by a Director with no child welfare or social services experience.
  - DFCS State Office administrators do not provide adequate leadership, because they are uninformed and out of touch with what is happening in the field to children in the State’s custody.
  - DFCS has failed to put into place any system to ensure that all staff is held accountable for ensuring the safety and well-being of foster children. The agency’s electronic case record system (MACWIS) fails to provide reliable information concerning the children in MDHS custody that is necessary to monitor both individual cases and system-wide case practices.

- As a result of agency-wide deficiencies, MDHS fails to protect children from harm and denies them adequate services.
  - MDHS denies children safe and appropriate placements. MDHS’s own foster care case reviews document that 3.2% of children in custody were maltreated in their placements during the first nine months of 2005.
  - DFCS practices an “any port in a storm” approach to placement decisions, in which foster children are placed in any home or institution that can accommodate them, without regard to their individual needs or circumstances. This arbitrary approach to placement decisions results in children experiencing multiple temporary placements.
  - MDHS fails to provide children with basic medical, mental health, and educational assessments and services.
• The agency fails to provide the planning or services required to ensure that children do not spend years in foster care.

A lack of competency was found at nearly all MDHS staffing levels, with key managers demonstrating little knowledge of basic social work and child welfare concepts.

The case example that follows, derived from MDHS documents and formal discovery responses, is just one illustration of the risk of harm to which Mississippi foster children are subjected.

<table>
<thead>
<tr>
<th>Case Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>In April 2002 MDHS investigated an allegation that a Jones County foster mother was physically abusing two foster children, 11-year-old Amy and 10-year-old Sally, and determined that no abuse had occurred. In January 2003, MDHS received another maltreatment report concerning the same foster family. Following an investigation, MDHS determined that the foster mother had, in fact, physically and emotionally abused Amy, Sally, and another foster child in the home. MDHS further concluded that the foster mother had emotionally neglected all three children, as well as a fourth foster child who was residing in the home. In spite of those findings, MDHS did not revoke the foster home license or remove all of the children from the abusive foster mother's care. In April 2003, MDHS investigated another report that Amy was being harmed in the same foster home and concluded that she had been sexually abused by the foster mother's son. MDHS still failed to take licensing action that would have prevented foster care placements in this home. In February 2004, following another investigation, MDHS concluded that a different 10-year-old girl had been sexually abused in this same foster home. Again, MDHS took no licensing action. As of November 5, 2005, following a total of three confirmed reports that children were being seriously abused in the foster home, the home remains licensed with at least one female foster child placed there; Amy and Sally are no longer in the home, as both were residing in psychiatric treatment facilities. (Defendants' Responses to Plaintiffs' Second Set of Interrogatories, at 5-6, 11-12; Calendar Year 2004 MDHS Foster Home Investigations at DHS 053505; MDHS Listing of Children Currently in Custody as of 11/05/05, at DHS 086630).</td>
</tr>
</tbody>
</table>

As set forth in detail in this report, it is clear that MDHS lacks the ability to manage the day-to-day affairs of the agency, which results in the inability of MDHS to meet its basic obligation to provide for the safety and well-being of the children in its custody. Although there is certainly no “quick fix” for this agency, as long as this situation is allowed to continue, children in MDHS custody remain in danger.
I. INTRODUCTION

I was asked to undertake a review of the functioning of Mississippi’s child welfare system and assess whether its operational management allows it to meet the minimum professional standards required to accomplish its mandated mission of ensuring the safety, permanency, and well-being of children in State custody. My conclusion is that the Mississippi Department of Human Services (MDHS) Division of Family and Children’s Services (DFCS) suffers from such poor staffing, leadership, and management, that it fails to meet most every known legal and professional standard designed to protect the foster children for whom MDHS currently serves as legal custodian.

A functional child welfare agency must meet at least four criteria:

- The agency must employ enough staff to perform the agency’s work.
- These employees must be sufficiently trained and supervised.
- Employees must be provided with the resources necessary to do their jobs.
- The agency must have a strong and stable leadership in place to support the staff by setting official policy, monitoring the services delivered by frontline staff, and maximizing the effectiveness of available resources.

When an agency fails to meet even one of these criteria, it can experience symptoms ranging from minor disruptions in services to complete failure. MDHS fails to meet any of these four criteria. The systemic deficiencies that characterize MDHS and lead to poor outcomes for the State’s foster children include:

- MDHS maintains dangerously high caseloads.
- MDHS caseworkers are poorly trained and inadequately supervised.
- MDHS has failed to develop adequate resources for staff and the children the agency serves.
- MDHS lacks the strong leadership and accountability necessary to effectively monitor the delivery of services and to manage existing resources.
As a result of MDHS’s failure to meet any of the criteria necessary for a functional child welfare agency, children in state custody are routinely harmed. These harms include the denial of safe and appropriate placements, adequate supervision, necessary medical and mental health care, and permanent homes for children in State custody.

This report describes how MDHS has knowingly maintained a child welfare system that fails to meet even minimum professional standards and continues to put children at risk of harm. It begins in Section I by providing the reviewer’s qualifications and methodology, an overview of MDHS structure and responsibilities, and a brief history of longstanding agency failure. Section II looks at MDHS staffing, training and supervision of caseworkers, concluding that deficiencies in these areas doom the agency to continued failure absent dramatic changes in support of a fully staffed professional agency workforce. Section III provides a review of MDHS’s leadership, communication and accountability structures, and related infrastructural issues, finding a pronounced lack of knowledgeable or involved managers, a denial of basic resources for staff at all levels, and a general failure to encourage communication and accountability. Section IV highlights findings regarding the many ways in which MDHS’s systemic failures harm children, including such harms as (i) being subjected to multiple temporary placements and exposed to additional abuse and neglect; (ii) missing out on basic health services, like regular physicals and immunizations; and (iii) being left to languish in State custody without hope of finding a permanent family. Finally, Section V offers recommendations for badly needed reform, though with the caution that given the capacity of MDHS’s current leadership, the agency will undoubtedly require significant oversight and ongoing technical assistance in order to fix its many entrenched deficiencies.

A. Reviewer Qualifications and Methodology

The author, Cathy Crabtree, has more than 28 years of professional experience working with and advocating on behalf of children and families. Ms. Crabtree is currently a
private consultant in the field of child welfare, and in February 2006 was retained as the interim Director of Quality Assurance for Alabama’s child welfare agency. She has served as a child welfare expert in two previous federal litigations. Ms. Crabtree has worked as a direct service provider as well as in management and administrative positions in the fields of child welfare and mental health. She held the position of Assistant Commissioner of the Tennessee Department of Children’s Services for eight years and has extensive experience in the areas of children’s services, social service agency management and compliance with minimum practice standards. A current copy of Ms. Crabtree’s curriculum vitae is attached to this report as Appendix A.

In order to assess the overall organization and operation of MDHS as the State agency charged with the safety, permanency, and well-being of Mississippi’s children, the reviewer utilized many sources, including:

- MDHS policy and training manuals.
- MDHS organizational charts.
- MDHS planning documents and correspondence.
- MDHS state and county data reports.
- MDHS case review and audit data.
- MDHS and State budget documents.
- Federal review results and correspondence.
- Transcripts of MDHS staff deposition testimony in the Olivia Y. v. Barbour case.
- Results of Plaintiffs’ expert case record review of a representative statewide sample of 286 individual cases, conducted by Dr. Peg Hess.

All of this information was reviewed in light of professionally accepted standards, including applicable federal and state laws and policies, and the professional experience and expertise of the author.

B. Agency Overview

Governor Barbour is the chief executive officer of the State of Mississippi and has ultimate responsibility for the functioning of the State’s child welfare system. MDHS is the State agency charged by statute with the responsibility for the safety and welfare of
Mississippi’s children. The agency is led by an Executive Director appointed by the Governor, who is responsible for the approximately 4000 employees of MDHS. The Executive Director has oversight and administrative responsibility for state and federal programs for children and families in all 82 counties of the state, including adult services, child support enforcement, the federal welfare program known as Temporary Assistance to Needy Families (TANF), Food Stamp programs, Medicaid, and services for delinquent youth.

DFCS – the Division of Family and Children’s Services of MDHS – is the state government entity charged with protecting abused and neglected children in the State. The Division is charged with ensuring child safety, permanency, and well-being (i.e., child welfare services) and is led by a Division Director. The Division Director is responsible for the operations and administration of DFCS. DFCS has split the State into nine regions, led by nine Regional Directors, from which responsibility descends to 84 county or local offices. The county offices are the work locations for the DFCS Social Workers, Area Social Work Supervisors (ASWS), and non-social work staff responsible for the day-to-day child welfare work of the agency. The DFCS State Office is responsible for administrative and operations oversight and is organized around three program areas – Prevention, Protection, and Placement – with a separate area for Administration.

C. Historical Background

The State of Mississippi – which ranks 50th in the nation in overall child well-being scores, including infant mortality and child death rate – has been aware of serious deficiencies in its child welfare agency for over a decade. A number of federal, state and third-party reviews, reports and supposed reform initiatives from the past 15 years have
documented largely the same serious failings in the State’s child welfare system. Among them:

1992

- In its 1992 review, the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) finds that the Department of Human Services’ effectiveness in protecting children and vulnerable adults is “seriously compromised by the absence of well-trained professionals at all levels and the lack of quality assurance system capable of identifying and correcting weaknesses in service delivery.”

- The Child Welfare League of America (CWLA) undertakes a joint study with MDHS to review agency functioning. In that review CWLA warns that children are in danger of abuse or death due to excessive caseloads and inadequate staffing.

1995

- A federal review of Mississippi’s child welfare agency documents a failing system with unmanageable and excessive caseloads. Among the problems cited are a lack of preventive services, the failure to provide sound case assessments and case planning, the failure to address the medical, mental health and educational needs of children, lengthy stays in foster care with multiple moves, and a lack of placements and foster parent training and support.

- DFCS puts together a written Strategic Plan to address the agency’s failings, as identified in the federal audit, but the agency’s financial and staffing setbacks interrupt and impede any progress.

1999

- The PEER Committee, in its Follow-up Review of the DFCS finds “serious” MDHS case practice deficiencies, including failure to substantiate or investigate cases marked “high risk,” untimely investigation of reports, and investigations “not thoroughly completed according to policy.” “Many of the problems identified in PEER’s 1992 review persist.”

- MDHS Executive Director Donald R. Taylor’s response to the PEER Follow-up Review concedes that “the Division has been dangerously under funded and under staffed for many years,” and that “our employees [have] been struggling to stay on top of their mandated responsibilities . . . . In addition, there is a lack of appropriate placement alternatives for children in need of specialized care . . . . These children are needlessly moved from placement to placement, further damaging them and guaranteeing an unstable future.”
2001

- DFCS Division Director Sue Perry, in a memo to the MDHS Executive Director, writes: “In prior memorandums, I have stated our state and federal mandate to protect children; I have also mentioned the 6,200 plus cases left unattended; I have relayed the fact that children will most assuredly die, and finally, that 23 million federal dollars are at stake should the situation continue.”

- In another memo to the MDHS Director, Sue Perry writes: “there will be a death which could have been prevented, if staff [were] available to investigate, assess and work with the family. We are on the brink of a lawsuit. I have warned of this for months.”

- Mississippi Attorney General Mike Moore writes to the MDHS Executive Director concerning the effect DFCS staffing shortages are having on the State’s ability to protect its children, and how failure to protect those children is making the State vulnerable to a class action lawsuit.

2002

- In a letter to Governor Ronnie Musgrove, DFCS Director Sue Perry tenders her resignation on the ground that she can no longer fulfill her responsibility to protect children “when there are inadequate resources provided for their protection by the State.” She documents how a child might needlessly die because of the impossibly high caseloads, and that she was "sorry to inform you that this has already happened in DeSoto County."

- The Mississippi Council of Youth Court Judges adopts a resolution stating that the shortage of DHS staff creates such a crisis for children at risk as to constitute “an endangerment to the citizens and the children of Mississippi.”

2003

- MDHS’s own Self-Assessment—required as part of a federal review process conducted in all 50 states by the Children’s Bureau of the Administration on Children, Youth and Families, Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services to gauge child welfare program effectiveness—acknowledges its inadequate staffing, undocumented child protection investigations, and lack of services for children.

2004

- Governor Haley Barbour acknowledges to reporters that MDHS “has collapsed, for lack of management and a lack of leadership…. DHS has been the most poorly run, ineffective agency in the state of Mississippi for years now.”

- ACF conducts a Child and Family Services Review (CFSR) of Mississippi’s performance against federal minimum requirements for protecting and providing for
foster children. The CFSR Final Report finds that the State of Mississippi did not achieve substantial conformity with any of the seven child welfare outcomes assessed for child safety, permanency, and well-being, nor with the systemic factors of the Statewide Information System, Case Review System, Quality Assurance System, Training, and Service Array, related to the State’s capacity to achieve positive outcomes for children and families. Specific findings include:

- In 40% of the cases reviewed, it was determined that MDHS had not made concerted efforts to ensure placement stability for children in foster care.

- In 36% of the cases reviewed, an appropriate permanency goal had not been established in a timely manner.

- In 44% of the cases reviewed, reviewers determined that social worker visits with children were not of sufficient frequency and/or quality to ensure children’s safety and attainment of case goals.

- In 24% of the applicable cases, reviewers determined that MDHS had not made diligent efforts to meet children’s educational needs.

- In 26% of the applicable cases, reviewers determined that MDHS had not adequately addressed the health needs of children in either foster care or in-home services cases.

- In 50% of the applicable cases, reviewers determined that MDHS had not made a concerted effort to meet the mental health needs of children.

- The June DFCS Budget Request Package submitted to MDHS indicates that many caseloads across the state are above the “Danger!” level (31+). Of that, there are three “counties with caseloads but do not have workers. These caseloads are covered by staff from other counties. The children placed in these counties are in eminent [sic] risk of falling through the cracks.” “There is grave concern for these counties — children in these counties are placed at risk. Their lives depend on our ability to provide staff resources to investigate and access dangerous situations. Our staff are [sic] totally overwhelmed and we are losing more staff every day! There must be a way to fortify these counties of great need and possibly encourage the remaining staff to stay in the fight with us.”

2005

- As a result of failing the CFSR, MDHS was required in 2004 to submit a Program Improvement Plan (PIP) to ACF addressing all the identified deficiencies. Three PIPs were rejected by ACF, however, as inadequate before Mississippi’s March 2005 PIP was finally approved.
• MDHS’s March 2005 PIP concedes that “[t]he CFSR conducted in 2004 clearly highlights the fact that . . . the State is still addressing many of the same systemic and practice issues that were identified in the original pilot review [in 1995].”

• MDHS’s PIP concedes that while some progress toward improving outcomes for families and children had been made from 1995-2000, “after 2000, the Division of Family and Children’s Services began a struggle to maintain the progress and improvements” due to “changes in the agency and division leadership, budget cuts, loss of staff positions, and staff turnover.”

• Inexplicably, there are no provisions in MDHS’s PIP that directly address critical agency staffing shortages, acknowledged by all as one of the major impediments to improving the agency’s performance. Moreover, MDHS has already failed to complete over 50% of the initial PIP tasks according to recent federal review.

• The June 2005 DFCS Budget Request Package submitted to MDHS indicates that even though recommended caseloads are 15 to 20 cases per social worker, “[s]taff currently carry caseloads up to 286.”

These and numerous other formal and informal assessments of MDHS’ functioning tell the story of an agency in a state of ongoing crisis that is putting Mississippi’s children at risk even today. Yet State and agency leadership have failed to take necessary remedial actions. Without a significant and long-term commitment to reform, Mississippi children will continue to be victims of the very agency charged with protecting and caring for them.
II. MDHS Is Dangerously Understaffed and Staff Are Poorly Trained

A. "BEYOND DANGER!" Caseloads Put Children’s Safety At Risk

National standards promulgated by the CWLA set maximum caseloads as follows: (i) 12 to 15 individual children for workers responsible for children already in foster care; (ii) 12 families for child protective services workers doing investigations of alleged abuse or neglect of children; (iii) 10 to 12 children for adoption workers; and (iv) 17 families for workers responsible for children not in foster care but with on-going “in-home” cases (also known as “preventive” and “protective” services cases). In Mississippi, DFCS social workers generally carry mixed caseloads that include children in foster care, children and families receiving prevention services, and children alleged to have been maltreated who are receiving protection services. Child welfare caseloads as reported by MDHS are based on the number of “primary clients” served by a given worker, with that term including children in out-of-home care, children under court-ordered protective supervision, and families (who may have more than one child) receiving prevention, reunification or other services.

MDHS acknowledges in its own caseload tracking documents and in deposition testimony that caseloads of 25 cases per social worker are “MARGINAL,” caseloads of 31 are in the “DANGER!” zone, and that caseloads of 40 and above are at “BEYOND DANGER!” As of August 2005, the DFCS statewide caseload average was 48 cases per social worker. Some counties averaged twice the “Beyond Danger!” caseload level or more, including Lamar (130), Wayne (106), Neshoba (94), DeSoto (85), Harrison (83), and Madison (82). Named Plaintiff Cody B.’s Forrest County social worker acknowledged at deposition carrying 120 cases, including 62 children in foster care and 19 investigations of child maltreatment.
Meanwhile, the Regional Director with authority over Forrest County testified that she does not consider a caseload of 75 to be understaffed because caseloads there have been higher. According to the FY 2007 budget request submitted by DFCS, individual social workers are responsible for as many as 256 cases, and some have to temporarily cover additional caseloads in counties without any caseworkers. Such numbers also undercount the number of children for whom individual Social Workers are responsible at any point in time, because staff on leave, whose cases must be covered (in fact, if not on paper) by other Social Workers, are left in the count.

Explaining MDHS’s categorizations of “DANGER!” and “BEYOND DANGER!,” then-DFCS Director Mangold stated at his deposition: “The danger is that some child will be missed, some child will not be provided the services they should be provided.” In an elaboration of that point, then-Director Mangold’s June 2004 budget submission stated:

The danger/risk level to our children increases dramatically as the caseloads continue to increase and our staffing level stays the same or decreases due to resignations, retirements, reduction of PINs, etc. We are mandated by State and Federal Statutes to provide safety, permanency, and well-being for our children and I strongly believe that we are also morally obligated to do so. Anything less is unacceptable.

Indeed, it is quite simply impossible for a caseworker to function adequately carrying such egregiously high caseloads. Caseworkers cannot get their day-to-day work done. As Director Mangold testified, staff do not have time to work on their cases or to document the information they do learn because of the staff shortage. As MDHS acknowledged in its March 2005 PIP, critical ongoing tasks such as assessing children’s needs, identifying suitable placements for children, making regular face-to-face contacts with children and their caretakers, providing for children’s educational, medical and mental health needs, planning for permanent homes for children, and documenting each child’s progress while in foster care go unattended by Social Workers who are simply overwhelmed.
In its FY 2007 Budget Request Package, DFCS pleads for sufficient additional funding to fund “38 vacant positions that have not been filled due to lack of general fund dollars,” and to “reestablish and fund 59 positions abolished in SFY2006.”39 After years of cuts (109 positions in SFY2005 and 96 positions in SFY2004), no attempt is even made to secure full staffing for DFCS. According to DFCS’s own calculations, this would entail adding 554 social workers.40

B. MDHS Maintains High Staff Turnover And An Ineffective Hiring Process

MDHS routinely fails to retain the employees it hires and replace the employees it loses. In the past two years, Social Worker and supervisor attrition has far outstripped hiring. During 2004 and 2005, a total of 104 Social Workers and 17 supervisors resigned. During the same two-year period, MDHS was only able to hire 68 Social Workers and 1 supervisor.41

The Hess Case Record Review documents that 58.3% of children in MDHS custody had at least two social workers during the 24-month period prior to June 1, 2005, with 21.4% having had three or more social workers responsible for their case during that period.42 In Yazoo County over half the children in custody (52.2%) had four or more social workers during that same two-year period.43 MDHS noted in its Self-Assessment that turnover among Social Workers is highest in areas of the state that have the highest vacancy rates,44 yet MDHS had done nothing to get at the root of attrition. The only “concrete actions” to fight attrition cited by one Regional Director were giving workers “recognition,” “a shirt,” “pizza,” and “certificates.”45

The consequences for children of high staff turnover are severe. High staff turnover increases the risk of harm to children who, at a minimum, lose continuity in the management of their cases with each worker hand-off. Every time a social worker resigns, critical data on
children is lost because no one has the time to either record it or, if recorded, to subsequently review the record and become aware of it. If a worker goes on leave, all work on his or her assigned cases are suspended until the worker returns.\textsuperscript{46} On a systemic level, high turnover is a major contributor to the failures of the entire agency. The March 2005 PIP concedes that “changes in the agency and division leadership, budget cuts, loss of staff positions, and staff turnover” have impeded MDHS’s ability to maintain progress and improvements.\textsuperscript{47}

The consequences of MDHS’s chronically high levels of staff turnover are compounded by its failure to fill vacant staff positions. Since the end of 2004, MDHS Executive Director Don Taylor has imposed an informal hiring freeze for all positions except Social Worker. This freeze includes senior management vacancies, so DFCS has been without anyone directing the State Office Prevention Unit or the Placement Unit.\textsuperscript{48} Even when MDHS is authorized to hire, Regional Directors frequently find themselves unable to fill openings because the high caseloads discourage potential applicants.\textsuperscript{49}

Other unnecessary bureaucratic hurdles create long delays from when a position becomes vacant until the time a replacement is found (if indeed one is ever found). For instance, all hiring requests must be funneled through the State Office, causing unjustifiable delays. Regional Director Martha McDaniel testified that she had yet to begin interviewing applicants for a supervisory position that had been vacant for more than a year because she was still waiting for the State Office to give her the names of the applicants.\textsuperscript{50}

Meanwhile, Regional Directors do not have the ability to move allocated staff positions (known as “PINS”) among their counties to accommodate staffing needs. They must instead send temporary help from one county to another to cover heightened needs, and the Social Workers dispatched to struggling counties remain responsible for the children to whom they are assigned in their own counties (which may or may not be contiguous with the counties to which they are temporarily sent).\textsuperscript{51}
C. MDHS Fails to Adequately Train and Supervise Its Staff

Adequate worker training and supervision are absolutely critical to the operation of a safe, well-functioning child welfare system. MDHS Social Workers are required to make daily decisions regarding the safety, well-being and permanency of children in state custody, in accordance with established professional standards as embodied in federal and state law and agency policy. MDHS’s routine placement of inexperienced, untrained and inadequately supervised workers on the “front lines” places the children ostensibly in these workers’ care at significant ongoing risk of abuse, neglect and even death.

(i) Training

A well-designed child welfare training program is built around the social work practice model used by the child welfare agency and includes all the varying agency responsibilities related to the day-to-day work. Training links policy and procedure to practice in a way that helps the work to flow seamlessly and invisibly for the child and family. Ideally, families should experience one well-trained caseworker during their involvement with the agency. Effective training should include, at a minimum, the following components:

- a comprehensive and easily understood curriculum;
- an evaluation component both for the trainee and the trainer;
- resource materials for reference;
- an on-the-job training (OJT) period;
- ongoing, formal in-service training;
- a performance feedback mechanism for measuring the quality of the training; and
- a process that facilitates the regular review, update, and revision of the training in order for it remain abreast of changes in statute, policy, and practice.

MDHS is well aware, however, that its training program does not begin to meet these minimal requirements. In 2005, MDHS admitted to needing additional training for workers
and supervisors on (i) case planning with clear goals and tasks that support the permanency plan; (ii) purposeful narrative recording related to assessment, case planning, movement towards the permanency plan, and safety and well-being; and (iii) using MACWIS, MDHS’s management information system. MDHS has further conceded that new Social Workers must wait for their training until there is a critical mass of new hires. As a result, the majority of (in some regions, all) new MDHS Social Workers are put on the job carrying a full caseload without the benefit of any formal training, a state of affairs that can last from between one month to a year or more. A review of the training MDHS provided to new workers in 2002 showed the extent to which the agency neglects initial training for workers. At best, only 13 new Social Workers completed the MDHS training that year. Moreover, that training was interrupted and delayed for six months due to travel and budget shortages.

By MDHS’s own admission, new worker training “covers very important material” “relevant to [Social Workers’] daily job duties” and is “necessary to teach [Social Workers] how to assess children’s needs and match them with services.” At the end of the training course, there is a test on absorption of the material, but passing it is optional. One Regional Director testified that she does not even look to see whether the Social Workers under her supervision passed the test.

In addition, no formalized training is available for supervisors. MDHS’s March 2005 PIP concedes that although an intensive supervisory curriculum was developed in 2001, “supervisory intensive training was not implemented on an on-going basis.” As for ongoing training for social workers and supervisors, MDHS does not require it and concedes that it is a random offering without any core curriculum. Staff generally do not attend such training due to high caseloads. Kathy Triplett, Director of the State Office Protection Unit under which DFCS’s Training Unit is housed, testified that “[t]he opinion [of DFCS] was
that we needed to provide more ongoing training” and that “it’s been a goal for as long as I’ve been involved with the training program,” which is “more than five years.”

MDHS also fails to maintain an adequate training staff to properly train its workforce. “During 2004, the Training Program experienced a reduction in staff from nine to four staff members.” Moreover, this reduced staff is being deployed to assist with social work tasks: “Giving assistance to counties where there are staffing issues: The training staff is completing home studies, investigations, home visits, ICPC requests, cases plans and work in MACWIS to assist in closing out old cases.”

A critical “lack of funding and staff for on-going training” was also noted by the State Level Citizens Review Board, an agency charged with reviewing and making recommendations regarding the MDHS Five-Year Plan. In its May 2004 Report, the Board concluded that these deficiencies would have to be overcome for MDHS to be in a position to carry out the agency’s mission.

(ii) Supervision

Strong ongoing supervision is necessary to make sure decision-making is appropriate, consistent and timely. CWLA standards provide that supervisors be responsible for no more than five front line case workers at any one time. This is especially needed in Mississippi where MDHS concedes that the current policy manual is “cumbersome” and “difficult for staff to access and reference,” and “has created confusion.” And yet there is no supervisory training, as described above, and little evidence of regular supervisory review of casework.

Regional Directors also have supervisors perform Social Workers' job duties due to severe staffing shortages. This makes it less likely that a supervisor will be able to monitor Social Workers’ work with children.

The Hess Case Record Review found that supervisors allow basic casework functions and documentation to go un-reviewed. For example, within 30 days of when children first
enter custody, federal law and MDHS policy require the preparation of a child-specific Individual Service Plan (ISP) that includes a discussion of the safety and appropriateness of the child’s placement and of the services needed and provided.\textsuperscript{70} A review of initial ISPs for all children who entered custody on or after June 1, 2003, however, found that 40% of children did not even have this basic planning document within 90 days of entry into custody. Of those who had them, many were incomplete.\textsuperscript{71} An MDHS Foster Care Reviewer even reported in May 2005 that two Walthall County foster children's “most recent ISPs are blank but have been approved by the supervisor.”\textsuperscript{72} The county provided no response to explain how or why a supervisor would approve ISPs that contain no information.\textsuperscript{73}

The case record review shows that poor management practices infect the system all the way up the MDHS/DFCS chain of command. In deposition testimony, Regional Directors, who bear ultimate supervisory responsibility for case practice, admitted to failing to verify that local staff were taking critical actions to achieve the outcomes by which the federal government measures a child welfare system’s performance. For example, Regional Director Zadie Rogers testified that when children’s primary permanency goal is reunification, she does nothing to check that they have an alternate goal, although both Mississippi law and MDHS policy require such concurrent planning for all children in that position.\textsuperscript{74} Rogers further admitted that even when judges ordered MDHS to prepare a petition for termination of parental rights (TPR), she does nothing to ensure that the county offices under her supervision comply.\textsuperscript{75}
III. MDHS Lacks Strong And Stable Leadership To Ensure Effective Services For Children

A. MDHS Leadership Has Been Inconsistent And Ineffective

(i) The Governor

Based on the limited involvement of anyone in the Governor's Office with the issues facing the State's child welfare system, it would seem that the Governor's attention to the "Beyond Danger!" crisis at MDHS has been limited to a few sentences in his 2006 State of the State address. Formal responses to discovery requests in this case confirm that the Governor's Office does not have any briefings, meeting minutes, memos, complaints, letters, e-mail and other communications concerning MDHS's and DFCS's ability to meet its mandated functions and protect children during 2004 and 2005.

(ii) MDHS Executive Director

Over the last four years, MDHS has been under the leadership of four different Executive Directors: In January 2000, Dr. Bettye Ward Fletcher was appointed to the position. She served until Janice Broome Brooks was appointed Executive Director in November 2000. Ms. Brooks was succeeded by Thelma W. Brittain, who served until the current Governor appointed Donald Taylor the current Executive Director, in January 2004. The current MDHS Executive Director was mentioned only rarely in the many pages of documents reviewed in the preparation of this report. Approval of the release of a Request for Proposals and approvals or denials of requests to fill vacant positions accounted for most such references. For the most part, however, the Executive Director appears to have been largely uninvolved in the operation and funding of Mississippi's child welfare system, notwithstanding the many deficiencies identified in this and many other prior reports. Advocating for the Governor to request, and the state legislature to grant, the resources needed to adequately serve children and families in Mississippi's annual budget process
should be one of the Executive Director’s most important responsibilities. The record indicates that the Executive Director has failed MDHS in this respect.

(iii) DFCS Division Director

The DFCS Division Director position demands an individual with a thorough knowledge of the agency as well as strong administrative skills to advocate for the agency to get what it needs, develop and implement policy, and oversee on a macro level the quality of social work practice. Instead, the position has turned over frequently for reasons unrelated to child welfare expertise and administrative skill and this has forced the staff to constantly adjust to a revolving door of personnel at the top. Additionally, the Division Director’s position remained vacant from May 31, 2002, until January 2004, when Billy Mangold was appointed to the position, a fact recognized as problematic in the December 2003 Statewide Self Assessment.

The DFCS Division Director, as the chief administrator, should have the most thorough working knowledge of his agency and all its operations. This is not the case at DFCS. The Director in May 2005 did not know how many vacant positions remained unfilled, vacancies that had led to what DFCS referred to as the “danger” level in caseloads. Nor did he know whether MDHS conducts an internal review of children’s permanency plans when they have been in custody for 15 or more consecutive months, as required by the federal Adoption and Safe Families Act. Former Director Mangold admitted that he had been aware that MDHS/DFCS was out of compliance with Title IV-E eligibility criteria, with the result that MDHS/DFCS is unable to collect federal reimbursements. However, he could not describe what process was in place to ensure that Title IV-E criteria are met, nor how many staff were assigned to monitoring the Title IV-E penetration rate for federal reimbursements, nor what, if anything, the PIP demanded in terms of improving Title IV-E compliance. Protection Unit Director Triplett testified that she had been aware, through
reviews of Foster Care Review Board aggregate data, that there is a recurring problem with the wording of Youth Court orders, with the result that children were ineligible for Title IV-E funds, but that no specific action had been taken by the State Office to rectify that problem since Ms. Sue Perry served as Division Director in 2002. Mr. Mangold, who at least had approximately 25 years of experience in child welfare, has been replaced as DFCS Director, without explanation, by Rickie Felder. Director Felder has no child welfare or social services experience.

The problems created by the short tenures of DFCS’s various Directors have been compounded by instability at the State Office itself. The May 2004 CFSR Final Report finds that “staff turnover at the State level inhibited the collaboration process” between MDHS and stakeholders, and that “systemic barriers to achieving greater coordination of services” included “turnover in the State office, limited personnel, limited funding, and the lack of a statewide strategy to address service coordination.” It also reports a concern about “the limited working relationships between the agency and key child-serving institutions (e.g. the school system, the Youth Court, and youth service agencies), and . . . that there is a lack of shared information, resources, and case coordination.”

Lack of effective leadership has also resulted in management’s failure to prioritize MDHS’s core mission of protecting children. For example, a July 11, 2005 Memorandum from a Regional Director to Director Rickie Felder complains about the known child abuse Hotline practice of not transferring after-hours reports to the County for investigation until the next business day. Thus, a child abuse and neglect report that came in on a Friday evening whose nature “indicated the need for immediate response” was not entered in MACWIS for investigation by the County until the following Monday, 62 hours later. The investigation was not initiated until late Monday afternoon, well beyond the 24-hour response requirement. The concern articulated in the memorandum, however, is not for the children
left unprotected by the delayed response, but only for the workers who cannot show 100% compliance with policy, as “it is not fair to hold the workers accountable for something that is beyond their control.” The Regional Director even suggests that MDHS could “begin counting the timeliness when the Hotline enters and transfers the report to the county – not when the Hotline receives it.” This elevation of compliance documentation, and a perceived inequity in how untimely reports are counted, over ensuring a timely response to a suspected child maltreatment victim illustrates a misguided management culture that is unable to prioritize the agency’s primary mission of protecting children.

(iv) A Doomed Program Improvement Plan

MDHS is an agency heavy on paper plans with no follow through. For example, in 1995, MDHS developed a Strategic Plan to institute reforms, but never implemented it. A Quality Assurance system was scrapped after only a few months. The March 2005 Program Improvement Plan (PIP), which MDHS was required by the federal government to prepare for having failed the CFSR, cannot reasonably be expected to correct the agency’s collapse. This is a paper tiger of a plan that provides nothing in the way of a measurable benefit in the life of a child in foster care. It is also unclear how the agency expects to complete the PIP plan on a bare shoestring budget and with very few staff. MDHS expects the regions to shoulder much of the PIP work with a staff that is already unbelievably overloaded just trying to see the children and families on their heavy caseloads. Nothing in the PIP indicates how the staff in the field is supposed to balance or prioritize responsibilities under the PIP with the responsibilities of their day-to-day work. The only response to the prioritization of such an overwhelming burden by the state administrators was that they intended to “work smarter.”
MDHS has, in fact, failed to meet most of the initial deadlines it set for itself.\textsuperscript{92} In November/December 2005, ACF reviewed Mississippi's second quarterly PIP progress report for July-September 2005 and found that of a total 230 action steps that were due during the first and second quarter of PIP implementation, 49\% (or 114) "are overdue or postponed." In addition, of 21 performance measure baselines that the State was to establish during the first two quarters of PIP implementation, 15 (or 70\%) had not yet been established.\textsuperscript{93} MDHS requested a one-year waiver in implementing its March 2005 PIP in November 2005. In response, ACF stated that it was "willing to work with [MDHS] to provide the additional time [it] requested." The formal renegotiation of the PIP was due to occur January 31 – February 2, 2006.\textsuperscript{94}

Quite simply, MDHS/DFCS has not had the stable, effective leadership needed to chart and keep a course for the agency. And the PIP is but one more example of a reform plan that MDHS has failed to put into practice.

B. MDHS Fails To Provide Staff Adequate Resources

(i) Failure to Develop Adequate Placements

MDHS has failed to develop "a sufficient array of services in place to address the needs of children and families."\textsuperscript{95} MDHS knows it lacks "foster homes, therapeutic foster homes, and group homes for children of all ages;" "residential treatment services;" "services for medically fragile children;" "substance abuse services for adolescents;" "mental health services for children . . . including counseling, specialized therapy, day treatment, and child psychiatrists/psychologists;" and "services to prevent placement disruption," including "support and respite services for foster parents."\textsuperscript{96}

"There are not enough therapeutic placements for foster children needing such services," as there are currently only contracts for 250 therapeutic placements (defined
broadly to encompass therapeutic group homes, therapeutic foster homes, and intensive in-home services) statewide. Accordingly, children must wait in line for therapeutic placements to be granted by the Placement Unit in the State Office; MDHS does not have a process for keeping track of how long children are kept waiting for such services.\textsuperscript{97} A large number of children are placed outside their home communities because their own counties lack resources.\textsuperscript{98}

Compounding the State's placement resource problems, the State has cut and failed to restore funding for Licensing Specialists, who serve as recruiters for foster and adoptive applicants and determine if foster homes and facilities are maintaining compliance with the established standards. The Self Assessment indicates that DFCS had only 15 Licensing Specialist positions statewide designated to the foster home licensure program, and that due to insufficient staff, 

\textit{"[a]pplications and inquiries cannot be processed in a timely manner."} As a result, \textit{"[r]esources are lost due to the length of time for follow-up and the actual process."} Moreover, \textit{"due to budget constraints, two of these [Licensing Specialist] positions were abolished effective July 2002."}\textsuperscript{99} A request for five additional positions, which would allow DFCS to provide two licensing specialists dedicated to foster homes in each of the nine Regions, was made for the FY05 Budget but was denied.\textsuperscript{100} The Self-Assessment also noted that staff responsible for actually placing children in foster homes and other placements had been cut: \textit{"The number of State Level program staff to support placement has also been reduced and does not keep up with the increasing need for more therapeutic resources."}\textsuperscript{101}

Further reducing the potential placement resource pool, the board rates MDHS pays to families and facilities in order to reimburse them for the cost of providing for foster children do not come close to meeting the actual cost of raising a child in the rural or urban Southeast (as calculated by the U.S.D.A.), and have not been adjusted upward since at least 1999.\textsuperscript{102}
The March 2005 PIP states that “[t]o achieve placement stability, it will be necessary to have a pool of available and qualified foster family homes. Foster families must receive training and support to insure placement stability. With an increased pool of foster homes, the agency will rely less on emergency shelters and be able to make placement decisions based on the child’s needs and the skills and capacity of the foster parents.” And yet, though the DFCS State Office administrator in charge of the Placement Office concedes that children are placed wherever a bed is available and “we need more of all types of resources,” the March 2005 PIP makes no provisions for the addition of staff or resources to recruit, train and support additional foster and adoptive homes. Without addressing the lack of available placement resources, the PIP, even if implemented, will have little impact on DFCS’s poor placement practices.

### Case Example

On April 29, 2005, an MDHS supervisor sent her Regional Director a shelter extension request for a 10-week old baby girl. The baby had been placed in an emergency placement in an adjoining County after her mother voluntarily placed her in foster care at 3 weeks old, “as no regular foster home placement was available in the immediate area.” Since then, MDHS has had no contact with the mother, the putative father is presumed to be incarcerated, and the supervisor acknowledged that she was unsure if a home evaluation had been requested for a maternal aunt who had contacted MDHS about custody of the infant. "The only foster home available in the area is a single, black male, who works full time and then has numerous part time jobs." The Regional Director approved an additional 45 days of shelter care, noting: "Foster homes (regular) need to be sought for this child." (Memorandum, Barnes to McDaniel, April 29, 2005, DHS 066324-25)

(ii) Failure to Develop an Adequate Service Array

In order for a child welfare system to ensure that quality services are delivered consistently it is necessary for the agency to first know the make up of the families it serves. Required information includes:

- the demographics of the agency’s child population;
• the educational, behavioral and medical services available; and

• historical tracking of trends in services

Such information is fundamental to gauge service gaps and plan effectively from year to year. A thorough needs assessment based on data and practice, not on hearsay or popular myth, is a must. From there, an agency can efficiently budget and plan year to year for changing service needs of families.

The May 2004 CFSR Final Report finds that “Mississippi did not achieve substantial conformity with the systemic factor of Service Array.” The State “does not have in place a sufficient array of services to assess the strengths and needs of children . . . [,] determine other service needs, . . . and help children in foster and adoptive placements achieve permanency.” “Critical gaps in the service array are foster homes for children of all ages, substance abuse services for adolescents . . . and mental health services for children and families.” “In addition, services are not accessible to families and children in all political jurisdictions . . . [and] county staff have a limited ability to individualize services for all children and families served by the agency.” “[L]ack of transportation, staffing shortfalls, and inadequate funding sources result in an insufficient service menu to meet the needs of families and children served by the agency.”106

DFCS has no apparent method or planned approach for obtaining needed resources to serve children in foster care. In the documents and depositions reviewed, DFCS administrators admit the inadequacy of the State’s service array107 but maintain that there is no money available to access needed services.108 There is no acknowledgment of the facts that the State continues to pay back money to the federal government due to improper documentation of eligible children’s services, and that correcting documentation practices
would significantly increase the availability of federal funding, which could be used for service development among other critical needs.\textsuperscript{109}

When resources have been added, DFCS has relied on a “dart board” approach to issuing standard Requests for Proposals (RFP). Insofar as there is any process, DFCS relies on staff in the local county offices to call attention to the need for services and pass that along to the Regional Director and State Office. The Executive Director may then approve or not approve the issuance of an RFP to cover the service need identified and decide how much money will be made available for any particular service.\textsuperscript{110} With no basis in any statewide needs assessment, MDHS’s service development is haphazard and inefficient and the services developed are not tailored to the needs of the children in MDHS custody. Thus, MDHS is out of compliance with the federal requirement that the agency meet children’s individual needs as identified in their individual service plans.\textsuperscript{111}

(iii) MACWIS

The child welfare SACWIS systems that have been developed across the country are intended to be social work practice systems for caseworkers and the official repository of case records for children. SACWIS systems are designed and jointly funded with state and federal funds.

Mississippi’s SACWIS system – MACWIS – has been designated the primary case record for all children in DHS custody since its statewide implementation in 2001, and, according to former DFCS Director Mangold, is the primary vehicle by which MDHS monitors its provision of services to children.\textsuperscript{112} However, MACWIS is not in substantial conformity with federal requirements. As was determined in the State’s 2004 CFSR review, MACWIS is unable to consistently identify, among other things, the status, demographic characteristics, location, and goals for the placement of each child in foster care because the system’s “data quality is compromised due to poor data entry.” Case information is often
incomplete, with "high worker caseloads, time constraints, lack of remote access, and inadequate clerical support," all cited as barriers to timely data entry.\textsuperscript{113}

As of March 1999, total expenditures for MACWIS had already reached more than $35 million dollars.\textsuperscript{114} Six years later, in March of 2005, ACF’s Division of State Systems (DSS) conducted a site visit at MDHS for the purposes of assisting Mississippi “in preparing for the [federal] SACWIS Assessment Review (SAR).”\textsuperscript{115} Though the project had originally been scheduled for completion in 2001, at the time of the PEER Report, in March 2005, following the expenditure of millions of additional dollars, there remained (and remain today) alarming areas of serious deficiency that negatively impact the functioning of the entire agency. Some of the deficiencies documented by the federal site visit directly put children at risk:

- Social workers currently receive no MACWIS notification if a child is placed with a resource provider whose license has expired, has been revoked, or is under investigation.\textsuperscript{116}

- Although it is agency practice to group related intakes in a single investigation, MACWIS does not link intake reports in the system by alerting the investigator that an additional related report has come in. This puts children at risk by preventing a complete picture of a particular child’s alleged maltreatment.\textsuperscript{117}

- Services through a particular provider listed in MACWIS, including placements, can show as “not available” but the meaning of this is unclear and easily misinterpreted by the Social Worker. As stated from the federal site visit, MACWIS defines this “as meaning the service is not available in that county. However, the service could still be available in an adjacent county and accessible to the client. A worker could easily conclude that a ‘No’ means the service is not available at all” thereby keeping the child or family from receiving a needed service.\textsuperscript{118}

The Hess Case Record Review revealed other significant MACWIS deficiencies, including a systemic programming error that electronically over-writes historical information in children’s ISPs and County Conference reports. Historical information, including placements and health information, is automatically replaced with current information as of
the date the report is printed out from MACWIS. Unless documents are routinely printed out and hard copies are filed in the child’s paper record, Social Workers, ASWS’s, foster care reviewers, judicial decision makers, and others are prevented from using these legally required documents to identify change and evaluate progress over time.\textsuperscript{119} MACWIS also does not enable a user to hit “print” once and print out a child’s electronic case file; instead, a worker must manually bring up each screen and print the screens separately.\textsuperscript{120}

With regard to medical, dental, psychological, and educational services, the aggregate reports generated from MACWIS have not been able to accurately reflect the information in children’s case files “[b]ecause the program was not pulling the data correctly.” Despite devoting resources to this report for a full year since discovering that problem, MDHS has yet to correct the data pulling function. One MDHS deposition witness testified that she personally compared the information in children’s case files with information in certain MACWIS aggregate reports and noted discrepancies sufficient to cause her to lose confidence in the accuracy of those reports in their entirety. Responsible for MACWIS reporting, she discovered this problem over a year before her May 2005 deposition but had not had enough technical support available to resolve it.\textsuperscript{121}

Mr. Mangold, the DFCS Division Director at the time, testified that he knew of no problems with the capacity of MACWIS to generate aggregate data on medical, dental, psychological and educational services.\textsuperscript{122} According to him, these MACWIS reports are what MDHS is going to use to measure compliance with the PIP.\textsuperscript{123} The PIP as a whole presupposes a marked increase in aggregate data collection and dissemination to MDHS managers, and assumes in turn that MDHS managers will use MACWIS as their primary tool to measure improved outcomes, if any, for children. However, as noted, MACWIS is still unable to generate critical management tracking reports.
Moreover, what MACWIS aggregate reports are presently available continue to be of limited usefulness because staff are unable to keep up with entering accurate data.\textsuperscript{124} The PIP acknowledges, for example, that even after a data clean up project targeting missing placement data in MACWIS, approximately 150 children still were missing current placement information.\textsuperscript{125} As Mr. Mangold testified to at his deposition, the timely entry of information into MACWIS is critical if the system is to perform its intended functions as a monitoring tool and as a repository of information, functions that are particularly necessary when the staff directly responsible for children turn-over frequently.\textsuperscript{126}

MDHS acknowledges in its Statewide Self Assessment that “[t]he ability to develop and integrate MACWIS and move it smoothly into case work practice was significantly under-funded and under-staffed, given the impact it has had on practice.”

[T]he effect of adding an automated system to overburdened workers [was] significantly underestimated in many ways, including: the learning curve for more seasoned workers to translate the paper processes into MACWIS, the need for more training for supervisors to help them make the transition in reviewing an electronic case file, the time and effort required to enter investigations, document cases, use reports to manage for outcomes, and the necessity of remaining in the office to document narratives that had previously been portable (taken home, completed waiting for doctor visits, etc.). Much more time than originally anticipated was needed to develop the system, adequately train users, document the usage of the system, integrate the system into policy and practice, and correct users’ errors.”
And yet, “[i]nitial estimates on the amount of training needed were reduced due to budget constrictions, and additional budget cuts ended a contract for resources identified for developing supportive materials to help supervisors review cases on MACWIS.”

**Case Example**

A foster care reviewer observed and reported in April 2005 that not only was a Forrest County sibling group separated, but that MACWIS also had completely wrong placement information for each of the siblings. “The placement information for all three children is incorrect in MACWIS. [Child 1] is listed in MACWIS as being placed in the K[] foster home but the Reviewer reports that she is actually on active runaway status. [Child 2] is listed in MACWIS as being in the K[] foster home but the Reviewer reports that she is actually placed in the E[] foster home. [Child 3] is listed in MACWIS as being placed at the P[group home] but the Reviewer reports that she is actually placed with a relative.” Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review) for April 2005, at DHS 047644).

(iv) Lack of Modern Technology

MDHS does not provide its front line staff with the resources needed for them to communicate effectively. Employees of the regional and local DFCS offices do not have access to electronic mail. In some counties, they do not have cell phones, which a Regional Director testified are unnecessary.

C. The MDHS Management Structure Is Inefficient And Creates Gaps In Lines Of Responsibility For Children’s Safety And Well-Being

MDHS is a state administered system. Policy and procedure are developed at the

**Case Example**

Foster Care Reviewer reports in February 17, 2004 Periodic Administrative Determination in Harrison County that reviewed child’s sibling “is in DHS custody per court order dated 10-2-03, but apparently has not been entered into the Macwis system. There is no ISP for [this sibling], and verbal information was obtained from the Social Worker regarding the current permanent plans for [him], and the expected date of achievement. There is no placement information in the Macwis system for the children.” The reviewer notes that the children have been placed out-of-state with their grandmother in Louisiana, but that there is no evidence of an approved home study on the relative placement. (Periodic Administrative Determination on Children in State’s Custody, February 2004, DHS 010422-010423)
state level. Financing of programs and personnel staffing are also done at the state level. Counties carry out the delivery of services based on what is directed by policy and procedure and provided by the State office. While this might on the surface seem to make sense, within DFCS, communication is so poor that there are long delays in the transfer of information from the State Office to the counties (and in some cases no effective communication at all), including on key issues involving staffing and service needs.\textsuperscript{130}

There are pronounced disconnects within DFCS between the State Office and the Regional Directors, and also in the field between the DFCS Regional Directors and the county staff. The documentation and information reviewed indicates that true bi-lateral communication between the State office and the Regional Directors rarely occurs. More typically, Regional Directors pass on requests for assistance to the State Office and then wait for an answer. The wait may be never-ending, yet there is little or no follow-up on requests or more aggressive advocacy for getting needs met.\textsuperscript{131} As a corollary to this, there is a historical pattern of non-responsiveness on the part of the State Office. Even inside the State Office itself, requests to fill staff positions are sent repeatedly with no response.\textsuperscript{132} The lines of communication are simply broken in both directions: Although the State Office generates some limited aggregate data reporting from MACWIS intended to identify performance deficiencies in the regions, Regional Directors are generally unable to interpret such reports.\textsuperscript{133} There is a lack of awareness on the part of key administrators within DFCS of the scope and seriousness of problems within the agency.\textsuperscript{134}

MDHS has a structure that by design isolates and limits communication within the State Office. The office is fragmented into program-based divisions, a structure that inhibits communication across child welfare program areas that are intertwined in practice.\textsuperscript{135} In another case of parallel universes, the State Office designs policy without information from staff in the local offices, who are in the best position to know which social work practices are
or are not yielding the sought-after outcomes in children's lives. This lack of coordination and transparency is replicated up the chain of command. For example, budgets are submitted by the DFCS Division Director, but he never sees the actual budget that goes to the legislature, and has no way of knowing if the Budget Division included his request with the greater MDHS budget.\textsuperscript{136} It was impossible to ascertain any back and forth dialog within the MDHS agency as a part of the budget planning process. This exacerbates an inability to forecast expenditures and plan for the use of already scarce state resources.

MDHS administrators also show a "not my job" attitude. The Director of the Protection Unit reported that she does not know who, if anyone, reviews the quality of investigations into allegations of abuse and neglect, noting only that "[t]hat's not something that would be a routine part of my responsibility."\textsuperscript{137} In another example, while MDHS policy provides that an protective services investigation's finding – whether abuse was or was not evidenced – and recommendations – what to do about any evidenced abuse or neglect – are incomplete until the ASWS reviews and approves them, the Director of the Child Protection Unit did not know when, pursuant to her own policy, such approval is supposed to occur.\textsuperscript{138} Her Unit does not track how many children die while under the supervision of MDHS, and she does not know if anyone else in the agency does. Similarly, neither the Protection Unit nor anyone else within MDHS, to her knowledge, keeps track of "Special Investigations" into alleged abuse or neglect by MDHS employees.\textsuperscript{139}
Regrettably, the Director of the Protection Unit is not alone in viewing her responsibilities extremely narrowly. The Director of the Placement Unit, which has jurisdiction over the medical services for children in MDHS custody, testified that she had no idea whether children receive physicals, and that she does not review data on that. She testified that she “really can’t address what [Social Workers’] problems are because I don’t work out there in the field.” Asked whether Social Workers’ caseloads impaired their ability to document the provision of services to children, she stated, “I really don’t know because I don’t see that. I think the regional directors get reports of their caseloads.”

When, by MDHS’s own admission, caseloads have been the driving force creating danger for children in state custody, such ignorance from high-level managers strains credulity.

This “not my job” attitude is especially problematic for foster children caught between jurisdictions. When children enter foster care, the DFCS county office in the child’s home county becomes what is called the “county of responsibility (COR)” in regard to his or her DFCS case. Children placed in out of home care outside their home county also have a “county of service (COS)” which splits responsibility for them. Confusion of roles between COS and COR staff means that there are children in MDHS custody for whom no staff member considers him or herself directly responsible. “Hinds County sees over 200 custody children, along with over 200 County of Service Cases from other counties. These children are placed in various facilities and foster homes. This is a tremendous task given limited staff.”

---

**Case Example**

A foster care reviewer observed and reported in June 2005 that there is no documentation that three Hancock County children placed together in a foster home licensed through Sunnybrook Children’s Home have ever been seen face-to-face by a Social Worker since they entered MDHS custody on August 18, 2004. “It appears that Hancock County has not made a county of service request to the county these children are placed in.” Foster Care Review Monthly Case Status Report [Issues Observed During Foster Care Review]. July 7, 2005. at DHS 047724.
D. MDHS Lacks A System Of Accountability For Agency Responsibilities

For a child welfare agency to be effective there must be supervision and leadership at all administrative levels. The supervisory and administrative personnel of the agency are the people who, as stated at the beginning of this report, chart the course for the agency. These are the individuals who have the responsibility of measuring the success of the services provided and the work performed by the staff. These are the individuals who make the course changes necessary to improve performance and institute new and best practice to improve services. The performance of the agency's supervisors and administrators sets the tone for the entire organization.

(i) Lack of Administrative Accountability

Little in the way of administrative accountability for agency responsiveness was found among the many documents reviewed. Even DFCS State Office administrators exhibit a general lack of knowledge about their own child welfare agency and child welfare work in general. The person responsible for the State Office Protection Unit of DFCS (a fifteen-year employee) views her role as a policy writer rather than a chief administrator necessary to guide DFCS child protection work. This same administrator conceded there was no adequate method for caseworkers to check the child abuse registry when they begin an investigation of an alleged perpetrator. Checking a child abuse registry is a common professional practice basic to a child abuse investigation at the beginning of the work.
This reviewer could find no indication of a standardized method for ensuring that supervisory directives are implemented, including directives issued by State Office to the Regional Directors, by Regional Directors to their administrative staff and supervisors, or by supervisors to caseworkers. One Regional Director reported “requiring” caseworkers to send an explanation to her concerning unmade visits to children then in the same sentence in her deposition reported she would, however, accept simply having a “sit-down” meeting with the caseworker instead.146 Such inconsistency of approach discourages the written documentation necessary to measure outcomes for foster children.

Regional Directors have no consistent method by which they gauge work performance in the counties they administer. For example, although she admitted that her region needs more foster homes, Regional Director McDaniel testified that she is not aware of the extent of that need, which may be because Regional Directors do not keep track of how many placement resources are available in their regions.147 Although the federal CFSR had called MDHS’ attention to the lack of foster homes openings for adolescents, Regional Director McDaniel did not know if the number of such homes had increased or decreased since that finding in December 2004.148 Regional Director Rogers testified that she does nothing to enforce the policy limit of no more than six children in a foster home.149 Regional Directors seem to rely on the ASWS to convey important information to them, but there is no documentation of regular supervisory meetings or a formalized feedback structure.150

The MDHS Policy Manual has not been updated since 1999. Policy changes about matters as important as deadlines are assumed to be “understood” without being disseminated to staff in writing.151 Policy is duplicative in the case of the MACWIS system. One of the conditions of accepting federal funds is that each state’s SACWIS system is expected to operate in an unduplicated fashion to automate child case records.152 But in Mississippi, DFCS continues to operate using both a paper case file and a computer case file. The DFCS
policy manual lists paper case record and MACWIS case record policies side-by-side, directing caseworkers to enter work in both the paper and computer files. In at least one case, the two side-by-side policies are contradictory with no explanation given.\textsuperscript{153} This is at best confusing and at worst misleading for caseworkers who must determine how to act on behalf of children facing multiple threats to safety and well-being.

In addition, there is no way to gauge what work has actually taken place with a child and family. Records reviewed indicated that missing documentation is found in everything from Individual Service Plans and recordings of filings for Termination of Parental Rights to entry of children's out of home placements. Although admitting that it is important for information about a child to be documented in the case file because "[t]hat's all we have to go on,"\textsuperscript{154} DFCS administrators did not express concern about a lack of documentation. Instead, Regional Directors make an assumption that work has been done, just not entered.\textsuperscript{155} This begs the question, how do they know? With no viable quality assurance system (as discussed below) and only a random look at cases themselves, the answer has to be that they do not know what is happening with the children for whom they are responsible. They don't know if children have service plans or are getting services needed. Of great concern is that in many cases they simply do not know where the children are. In a report about children in custody by placement type from May 2005, 97 children had a placement location left blank in the case record.\textsuperscript{156}

(ii) **Failure to Develop an Adequate Quality Assurance System**

Child welfare agencies must be able to monitor performance and correct course as needed to prevent the entrenchment of systemic problems. Aggregated data with trends analyzed over time educates the staff about systemic problems and provides a yardstick for measuring progress. In addition, a complete feedback loop that includes expected outcomes, actual performance, corrective action plans, and, most importantly, close monitoring of
compliance with the corrective action plans ensures that an organization has a reliable basis from which to remedy problems that arise.

The December 2003 Statewide Self Assessment acknowledges that:

efforts of the Quality Improvement Unit are limited to the reviewing of DFCS case records due to the extreme shortage of staff. Additional quality assurance processes need to be incorporated in other areas of the Division to review all aspects of service delivery, including direct services (foster care provision) and supportive services (therapy and counseling, and other contracted services). The Quality Assurance program cannot be enhanced without additional resources.\textsuperscript{157}

Additional Quality assurance deficiencies acknowledged by the Self Assessment include:

- “Quality Assurance processes that include supervisory practice, regional administrative practice and review of State Office procedures are needed. Current Quality Improvement staff are social workers advanced positions and additional expertise is needed to review other State level functions.”\textsuperscript{158}

- “There is currently no assessment process to determine whether [foster parent] training is effective, or offered at a level that is consistent in all service areas. Current staffing resources in the licensing areas and in Quality Improvement/Assurance cannot assess this information.”\textsuperscript{159}

- “Quality Improvement/Assurance reviews are needed for foster resources to ensure that they are properly trained, and properly supported when issues arise.” “Licensing workers have the responsibility for ensuring quality [placement] resources, however there is currently no link to a statewide quality assurance component.” “Currently, there are not enough positions to allow for a Quality Improvement focus for this effort.”\textsuperscript{160}

- “There is no statewide evaluation for the effectiveness of [foster and adoptive home] recruitment and retention plan/activities or the degree of effectiveness demonstrated.”\textsuperscript{161}

- “The ability to support permanency placements through statewide assessment and monitoring of these [permanency] programs is limited” due to staffing.\textsuperscript{162}

The May 2004 CFSR Final Report finds that Mississippi is not in substantial conformity with the systemic factor requiring a quality assurance system. “The State’s Quality Improvement system is not fully operational . . . and is limited to the review of case records for newly opened in-home cases.” “[F]oster care cases are monitored through the Foster Care Review . . . [but] counties do not consistently prepare the required Action Plans to
address identified concerns.\textsuperscript{163} This lack of a functioning Quality Assurance process means that no one in the state knows whether policies are, in fact, followed in practice.

Reasonable child welfare professional standards would require an internal case review system as part of an overall quality assurance program. The data generated by a randomly selected sample of case records provides first, a baseline, and later, performance outcomes to strive for in improving the work. The case review process is one of DFCS’s weakest areas.\textsuperscript{164} In the past, Foster Care Review Boards were utilized as a type of quality check for casework with children and families. Originally the Foster Care Review Boards were comprised of community stakeholders who reviewed children’s records and progress every six months. Recommendations of the Foster Care Review Boards were reported to the courts and were to be followed by DFCS if approved by the courts. While the policy and procedure regarding the Foster Care Review Board process continues to remain in the DFCS policy manual,\textsuperscript{165} the Boards were discontinued in 1999-2000.\textsuperscript{166} Again, what is put on paper by DFCS does not match reality.

In another now abandoned effort, MDHS once had what was called a Quarterly Regional Comparison Report, which was drawn from a sampling of five cases per region per month and compiled quarterly. The report was summarily discontinued. A State Office manager described the Quarterly Regional Comparison Report as “one of those well-meaning things that didn’t quite pan out.”\textsuperscript{167}

DFCS uses its own staff as foster care reviewers now, but only eleven reviewers have been allocated to cover the entire state of Mississippi.\textsuperscript{168} These foster care reviewers facilitate what is called a county conference in which they look over the ISP and the case record and make recommendations that have no force of authority. The county conference is nothing more than an exercise in paperwork.\textsuperscript{169} In theory, reviewers’ concerns are sent up the chain of command and back out to the Regional Directors for follow-up explanation and
response. In fact, however, at least three of the nine Regional Directors have failed to acknowledge ongoing problems brought to light through the case review process. In the words of the head of the MDHS Foster Care Review Unit, “the reviewers have no case control. You know, they don’t tell the workers or the supervisors how to work their cases. They just make suggestions, recommendations.” \(^{170}\) At present the Foster Care Reviewers generate a monthly randomly sampled case review of cases per regions whose purpose is to compare performance across regions against a small set of indicators. These indicators are duplicative, fail to capture qualitative information, and do not align with the federal CFSR measures. \(^{171}\)

The March 2005 PIP proposes to further dilute the statistical power of the Foster Care Case Review process. Because “[t]hese revisions have increased the number of items and added to the length of time it would take to review a case,” the number of cases reviewed in the FCR’s monthly random sample case review will be reduced from 5 cases per region per month to 3 cases per region per month, for a total of 324 cases a year (down from 540 cases). \(^{172}\)
IV. MDHS Denies Children Adequate Services And Fails To Protect Them From Harm

Tragically, the Agency’s operational and fiscal mismanagement creates a grave risk of harm to children in State custody that is both foreseeable and avoidable.

Federal and State law and professional standards require that children in custody have services available to meet their needs.\textsuperscript{173} Children who are removed from their homes for safety reasons must be placed in the least restrictive, most family-like setting possible in close proximity to their homes and have their needs assessed.\textsuperscript{174} Child welfare agencies must also provide regular medical and dental care, and necessary mental health services to foster children.\textsuperscript{175} Reunification and adoption services are also required to meet the permanency needs of the custodial child.\textsuperscript{176}

A. MDHS Denies Children Safe and Appropriate Placements

MDHS policy ranks placement settings from the least to the most restrictive – from foster homes to emergency shelters and other institutional facilities – and, consistent with federal law and professional standards, requires children to be matched to the least restrictive placement appropriate to their needs and in close proximity to their home.\textsuperscript{177} The goal is to keep children in the most home-like setting possible and geographically located such that they are better able to maintain family ties, especially when the permanency plan is family reunification. Children in State custody must also be protected from further abuse and neglect. Their placements should be adequately screened, and the children should be seen face-to-face by their caseworker at least monthly.\textsuperscript{178}

(i) Children Are Arbitrarily Placed

Children are being inappropriately placed by MDHS using an “any port in a storm” approach. The May 2004 CFSR Final Report finds that “[o]ne of the areas of greatest concern is the State’s performance on Permanency Outcome 1,” finding that MDHS does not engage in adequate matching of children with foster care placements to ensure stability. Placement stability is also undermined by the lack of foster homes and agency support to foster
parents and relative caregivers. Furthermore, ... [DFCS] relies extensively on the use of emergency shelter facilities for the initial placement (even for very young children) or when placements disrupt (often due to children’s behavior and foster parents’ inability to manage behavior).179

Though the MACWIS system, at least in theory, tracks the most basic information on placements, such that a Social Worker may search for homes which have the capacity to take additional children, the system does not provide the Social Worker with such essential facts as which homes can meet a child’s medical needs, are in a child’s school district, or are willing to accept siblings.180 In most counties, a Social Worker is responsible knowing those details about a placement for a child by relying solely on his or her memory.181 There is no comprehensive written list of placement resources; MDHS once tried to maintain such a list, but abandoned that effort because “it was just going to be too much work.”182 Though there is a list of placements with substantiated or pending allegations of abuse or neglect, the list is kept in the State Office and Social Workers, who are based in the county offices, do not routinely check whether particular placements are on the list before placing children in them.183 The impact of such a disorganized placement process is devastating: children already traumatized by abuse and neglect are forced to travel miles away from familiar family, friends, and schools to live among strangers; family members must travel great distances to visit with children with whom they may soon be reuniting; and, most troubling, MDHS is putting children into the hands of caregivers whom MDHS knows, or should know, are alleged to have, or have been shown to have, maltreated children.

Case Example

In response to a February 2005 foster care review report finding that a foster child’s placement information in MACWIS is incorrect, Forrest County states: the child "does not have a placement. He is with a sitter." (Foster Care Review Monthly Case Status Report [Issues Observed During Foster Care Review] for February 2005, at DHS 047569)
(ii) **Children Are Over-Institutionalized**

MDHS places children who would be better served in families in overly restrictive institutional placements because it does not have enough regular foster homes.\(^{184}\) The Hess Case Record Review found that 20.8% of children in MDHS custody were in congregate care facilities.\(^{185}\) Of 2958 children whose placements are reported, there are 609 in group homes and “institutions” (20.59%), and 30 are on runaway status (1.01%).\(^{186}\) The December 2003 Statewide Self Assessment acknowledges that the 1995 federal review of Mississippi’s child welfare system had already noted that Mississippi was “overly dependent on institutional facilities for children.”\(^{187}\) Of particular concern is data even more recent than the Care Record Review indicating a significant increase in the State’s institutionalization rate. Mississippi’s Child and Family Services Review Data Profile, dated December 8, 2005, found that for Federal FY 2005 (ending September 30, 2005), 24.8% of children in custody were placed in group homes or institutions.\(^{188}\)

(iii) **Children Are Placed in Inappropriate Emergency Shelter Placements**

The Hess Case Record Review found that 63.8% of children in custody have been placed at least once in an emergency shelter facility or emergency foster home during their current foster care stay, spending an average of three months in such placements. The total time spent by children in emergency placements ranged from one day to one year and 15 weeks, and 45% of the children faced multiple emergency placements. 26% of these children were between zero and five years old and they spent an average of two months in emergency placements.\(^{189}\)

MDHS concedes in its March 2005 PIP, that it continues to over-utilize shelter placements for very young children, and children remain in shelters for extended periods of time.\(^{190}\) In some counties, MDHS has admitted that “standard practice” is to “use the shelter as the first placement for children.”\(^{191}\) In Harrison County, according to Regional Director Rogers, it is unwritten “protocol” that children who have been the victim of sexual abuse are automatically placed in a shelter rather
than with a foster family. The May 2004 CFSR Final Report likewise found that in 40% of the foster care cases reviewed shelter facilities were used as placements because of the lack of available foster homes, including in the case of a one-year-old child. Regional Director Rogers admitted that children were still being stuck in shelters even though they would be better served in a foster home because the shortage of foster homes continued as of her deposition on August 9, 2005. (It is worth noting that the shelters in Rogers’ region are lockdown facilities in which children are limited to on-campus schools.)

MDHS’s “Weekly Shelter Care Report” from December 10, 2005 to December 16, 2005 shows that there were 40 children in shelters across the state during that week, including a child who had been in a shelter for 128 days, one who had been in a shelter for 129 days, and one who had been in a shelter for 142 days. The statewide average length of stay in a shelter was 53 days; the statewide average for cumulative days stayed in a shelter was 64 days. It is noted that the Weekly Shelter Care Report for August 6-12, 2005 included three children with 800 “days in shelter,” as well as other children listed with 359, 269, 263, 247, and 220 “days in shelter.” And MACWIS shelter data from May 2005 indicates that of all children placed in emergency shelters statewide, 42 (or 18%) were less than four years of age.

It is difficult to imagine a professionally acceptable circumstance that would require a baby or very small child to be placed in an emergency shelter rather than a home setting. In this reviewer’s experience, it is the rare foster parent that will turn down very young children such as these, and in fact, it is commonly known that young children are much

---

**Case Example**

An August 2005 Foster Care Review notes that Veronica, age sixteen and her six-month old daughter, spent 144 days in emergency shelter placements before Veronica finally ran away with her infant child. As noted by the Foster Care Reviewer, “shelters are considered short-term interim placement resources and thus not appropriate for long-term placements." The reviewer recommended that, if found, the children be placed in a "more family-like placement." Periodic Administrative Determination, August 5, 2005, DHS 070172

---

45
easier to place with foster families than older children and teens.

In November/December 2005, ACF reviewed Mississippi’s second quarterly PIP progress report for July-September 2005 and found that DFCS had not yet completed any of the action steps related to clarifying regional procedures and criteria related to Regional Director review and approval for extensions of shelter placements beyond 45 days.199

(iv) Children Are Denied Needed Therapeutic Placements

MDHS fails to place children with special needs in therapeutic settings corresponding to the level of care they require. The Hess Case Record Review found that as of June 1, 2005, 83.4% of the children with diagnosed mental illness or developmental disorders who were placed with foster families were placed in non-therapeutic foster homes. One in four of these children (25.7%) were placed with unlicensed relatives.200

The “Therapeutic Foster Care Placement Log/Pending Placements” lists manually maintained by the State Office Placement Unit show that of the 265 foster children referred for a therapeutic placement during the second half of 2005, 133 (50%) had not been placed in such a placement as of January 12, 2006. Of those, 55 had been waitlisted for at least three months, despite their multiple diagnoses such as “major depressive D/O, recurrent with psychotic features R/O bipolar; PTSD; polysubstance abuse,” and “PTSD; ODD; Psychosis NOS.”201

(v) Children Are Placed In Overcrowded Homes and Facilities

DFCS routinely places children in overcrowded foster homes and facilities. As of January 12, 2005 MACWIS data, 18 foster homes

---

Case Example

A June 2004 Foster Care Review reports that ten-month-old Jarod is placed in a foster home that is “licensed for four children and housing eleven children,” “two reportedly babies,” and recently under investigation for abuse. The Foster Care Reviewer notes that she is unable to assess the safety and appropriateness of the placement given her “questions about the appropriateness of the placement.” As of the date of the review, Jarod had not been visited at the home in more than three months. Periodic Administrative Determination. June 10, 2004. DHS

---
had more children placed in them than the number for which they were licensed. One congregate care facility licensed for 10 children was housing 22 children.\textsuperscript{202} The May 2004 CFSR Final Report specifically reports that “maltreatment in foster care may be a result of too many children in a foster home.”\textsuperscript{203}

(vi) **Children Are Placed In Unlicensed Homes and Facilities**

DFCS places children in unlicensed homes and facilities, putting those children at great risk.\textsuperscript{204} In a policy bulletin dated February 26, 2003 to DFCS staff, Wanda Gillom states that provisional licenses for foster homes are no longer permitted: “It was recently brought to our attention during the Federal Title IV-E Audit, that Title IV-E funds cannot be claimed for children placed in foster homes with a provisional license.” She also states: “In addition, we will no longer be able to maintain children in a foster home whose license has expired.”\textsuperscript{205} According to a January 12, 2005 MACWIS report, however, at least four foster homes had children placed with them even though their licenses were expired.\textsuperscript{206}

The May 2004 CFSR Final Report finds that the State may also place children in “unlicensed group facilities that are exempt from licensing because they are religious organizations.”\textsuperscript{207} As of January 12, 2005, 18 foster homes had more children placed than the number for which they were licensed. One congregate care facility licensed for 10 children was housing 22 children. 4 foster homes had children placed with them even though their licenses had expired.\textsuperscript{208} Some children are placed in medical or psychiatric facilities because no other placement has been identified. The agency has no ability to license and monitor these services effectively. This occurs even though DFCS policy

---

**Case Example**

According to a September 2005 Foster Care Review, siblings Cindy and Hannah, ages six and eight, are placed in an "unlicensed, non-relative placement." The Foster Care Reviewer explains that there are "serious concerns" regarding safety of this placement and evidence "indicat[ing] that the father molested Cindy in the home of the current placement." Despite these concerns, the reviewer notes that she is unable to assess the safety and appropriateness of the placement as there is "only one in-placement face-to-face contact" documented in the last six months. Periodic Administrative Determination, September 21, 2005, DHS 070490, 011669.
requires immediate agency legal intervention with the court should such an unlicensed placement be ordered.\textsuperscript{209}

(vii) **Children Are Placed In Inadequately Screened Relative Placements**

DFCS has also placed children with relatives without required criminal background checks on those relatives or adequate screening of their homes. Named Plaintiff Olivia Y., for example, was placed in a relative’s home before a background check revealed that a convicted sex offender also lived in the home.\textsuperscript{210} Most (83\%) of the substantiated abuse and neglect in care incidents acknowledged by MDHS in its Self-Assessment involved relative placements.\textsuperscript{211} The State Office Protection Unit does not keep track of allegations of abuse or neglect of children in MDHS custody if those children are in unlicensed placements or if they are on a visit or trial reunification with their biological parents.\textsuperscript{212}

\begin{center}
\textbf{Case Example}
\end{center}

A July 2005 Foster Care Review notes that four-year old Samantha is placed in the home of her paternal grandfather. While there, Samantha’s mother has “allowed [Samantha] to be in potentially threatening situations,” exposing her to sexual abuse by the babysitter’s son, and “allowing [Samantha] to go away from her with various men.” The reviewer notes that Samantha has been a victim of prior sex abuse and characterizes Samantha’s placement as “neither safe nor appropriate.” Samantha’s individualized service plan has not been updated in ten months, and no investigation is documented. Periodic Administrative Determination, July 13, 2005, DHS 069798.
A foster care reviewer observed and reported in June 2005 that a seven-year-old foster child’s “6-22-05 narrative in MACWIS reads as follows: ‘Anonymous caller stated that [mother] has been in jail twice in the last few months for various things. Concerns are with the children being with her and she is being picked up by police and the kids are with her when this happens. [Foster child is the only one right now in jeopardy with Mom.] She may also have other warrants in Florida, Louisiana, and Stone county area.’” [emphasis in original] “The child is supposedly placed with his grandmother. There is no documentation that this allegation has been followed up on.”[1] Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review), July 7, 2005, at DHS 047723).

(viii) Children in MDHS Custody Are Routinely Separated from Their Siblings

DFCS unnecessarily separates children from siblings and otherwise isolates them from family. Accepted professional standards stress the importance of maintaining family ties by keeping siblings together and ensuring visitation with family as a key to successful outcomes. The May 2004 CFSR Final Report finds that in 23% of applicable foster care cases reviewed “there was no valid reason for the separation of the siblings.”[2] Likewise, the Hess Case Record Review found that for the 44.7% of children who were placed separately from one or more of their siblings, 28.1% had no documented justification for the separation and 72.3% had no case documentation of any MDHS efforts to identify a placement for the sibling group.[3]

Moreover, in 45% of applicable foster care cases reviewed by ACF, MDHS “had not made concerted efforts to ensure that visitation between parents and children and among siblings was of sufficient frequency to meet the needs of the child.”[4] The Hess Case Record Review found that the majority of the children with the goal of reunification had not been provided any parent-child visits with their mothers (51%) or their fathers (85%) during the 12-month period prior to June 1, 2005.[5] Likewise, none of the children placed separately from other siblings in MDHS custody were
provided with sibling visits twice a month as required by Agency policy, and 60.1% were denied even one sibling visit during the entire 12-month period prior to June 1, 2005.\textsuperscript{218}

The March 2005 PIP acknowledges that “MDHS was not consistent in its efforts to (1) place siblings together; (2) establish frequent visitation between children in foster care and their parents and siblings; (3) preserve connections for children in foster care; (4) seek relatives as potential placement resources; and (5) promote or maintain a strong, emotionally-supportive relationship between children in foster care and their parents.”\textsuperscript{219} In addition, according to the PIP, MDHS’s Foster Care Program 4\textsuperscript{th} Quarter 2004 Annual Report documents that siblings were placed together in only 59.9% of the 167 applicable cases reviewed during 2004.\textsuperscript{220} The Foster Care Review Program found it to be “of concern” that during the first quarter of Fiscal Year 2006, three quarters of the children reviewed had “infrequent contact (less than monthly or none at all) with either parent or their siblings who are placed separately in state’s custody.”\textsuperscript{221} In the fourth quarter of Fiscal Year 2005, 55.6% of children reviewed did not have frequent visits with their siblings, and 70.3% did not have frequent visits with their parents.\textsuperscript{222} DFCS Foster Care Review Program’s quarterly report for the third quarter of fiscal year 2005, reports that 47.7% of the sample children did not have MACWIS documentation of frequent visitation with siblings, and 63.7% did not have documentation of frequent visitation with parents.\textsuperscript{223} Although county office staff are required (by federal and state law) to conduct “diligent searches” for relatives\textsuperscript{224} and make “reasonable efforts” to place children with relatives within two months of the child’s entry into custody\textsuperscript{225}, the Regional Directors do nothing to ensure that such searches take place.\textsuperscript{226}

The March 2005 PIP aims to increase the statewide percentage of siblings placed together to 61.9% by March 2007 (with a benchmark interim goal of 60.9% by March 2006), an increase of only 2% from its 2004 baseline of 59.9%.\textsuperscript{227} In its second quarter PIP progress report, for July-September 2005, DFCS admits that for July-September 2005, 57% of children in custody
were placed with siblings, a decline from 66% in the preceding quarter and even below the state’s baseline for this performance measure.\textsuperscript{228}

(ix) Children Are Placed Far Away From Family

MDHS concedes that “[t]he availability of appropriate placement options for children within counties varies greatly, impacting the ability to comply with policy” requiring children to be placed in their home county in close proximity (within a 50 mile radius) of their original home.\textsuperscript{229} In the fourth quarter of FY 2005, the Foster Care Review Program determined that 16.2% of children it reviewed had not been placed within close proximity of their homes.\textsuperscript{230} By the first quarter of FY 2006, over one third of all children reviewed (36%) had been placed more than 50 miles from their original homes.\textsuperscript{231} The March 2005 PIP acknowledges the 2004 CFSR’s finding that “MDHS did not make concerted efforts to ensure that children in foster care are placed, when appropriate, in close proximity to their parents and communities of origin,” and additionally concedes that the Foster Care Program 4\textsuperscript{th} Quarter 2004 Annual Report found that in 16% of the 376 applicable cases reviewed the child was not placed within 50 miles of his/her original home.\textsuperscript{232} Likewise, the May 2004 CFSR found that in 16% of applicable foster care cases reviewed “the child was in a placement outside of his or her community of origin because of a lack of adequate placement resources.”\textsuperscript{233} Even children MDHS is supposed to be making diligent efforts to reunify with their parents are placed out-of-state (including in Tennessee, Texas, and Florida) because Mississippi lacks appropriate placement options.\textsuperscript{234}

The CFSR noted that Mississippi had not developed enough regular foster homes willing to accept adolescents.\textsuperscript{235} In deposition, Regional Director McDaniel testified that one of her counties had zero foster homes able to accept sibling groups.\textsuperscript{236} But despite MDHS’s repeated acknowledgment that it does not have enough foster homes of all types, MDHS has failed to enact the most basic, common-sense fixes. A full year and a half after it admitted in its Self-Assessment to
a pattern of losing potential foster families through failure to process foster parent applications in a timely manner due to insufficient recruitment staff, it had failed to add, or even seek, more recruitment staff, or to keep track of how long applications lie dormant.

In its second quarter PIP progress report, for July-September 2005, DFCS admits that “[t]he State has failed to meet or exceed the established baseline [for proximity of foster care placement] for two consecutive quarters.” For July-September 2005, 64% of children in custody were placed in close proximity of their original homes, a dramatic 20% drop in performance from the preceding April-June 2005 quarter, where 83.8% of children in custody were placed in close proximity to their original homes.

(x) Children are Subjected to Multiple Moves

Children are also subjected to multiple moves preventing them from achieving any sense of stability and permanency. As acknowledged in the MDHS Policy Manual, a “foster child who moves many times, or who constantly fears that he/she may have to move, can suffer devastating effects on his/her emotional health.” As reported in the May 2004 CFSR Final Report, however, in 40% of the foster care cases reviewed “[t]he child experienced placement changes that were not for the purpose of meeting the child’s needs or attaining the child’s goals.”

The Hess Case Record Review found that 82.7% of children in custody have been moved between one and 57 times during their most recent stay in custody. For these children, the average number of moves was 5.8. When examined by length of stay in custody, more than a third of these children averaged three or more moves per year. Some of the youngest children were subjected to the highest average number of moves per year of any age group: infants less than one year of age (4.1 moves per year) and three year olds (4.3 moves per year). Similarly, the Self Assessment acknowledges that many of the children in MDHS custody are subjected to a large number of placement moves, with over 200 children in care experiencing nine or more placements.
MACWIS data from November 2005, indicates that children in MDHS custody have undergone an average of 3.4 placement moves during their time in care. 236 of the children out of the 3,277 reported have had 9 or more placement moves, 54 have had 8 placement moves, 82 have had 7 placement moves, 128 have had 6 placement moves, and 212 have had 5 placement moves.\textsuperscript{244}

**Number of placements for children in MDHS custody**

Most recently, the Foster Care Review Program found that in the first quarter of SFY 2006 (July – September 2005), 43% of children reviewed changed placement, 57% of whom experienced two or more placement moves in just those three months.\textsuperscript{245}

Many of these damaging placement moves could have been avoided. The Hess Case Record Review found that over 90% of the time DFCS failed to make efforts to offer or provide supportive services to either the child or the caregiver to maintain the placement and prevent a move.\textsuperscript{246} MDHS concedes in the Self Assessment that support and training for foster parents to help them address the needs of foster children – a deficiency noted in the 1995 federal review\textsuperscript{247} – continues to be a problem.\textsuperscript{248} The May 2004 CFSR Final Report likewise determined that there is “no formal support system in place for foster parents,” and that in 25% of the applicable foster care cases reviewed
"needed services were not provided to foster parents." It notes with concern that in cases of multiple placement disruptions due to the child’s behavior “there was no evidence that the agency provided support to foster parents to help maintain the placement when there was a threat of disruption due to behavioral acting out." MDHS does not even have any system for respite care, whereby another licensed caretaker may watch a foster child on a short-term basis. The CFSR further found that, insofar as “most of these children should be in therapeutic foster care or other therapeutic settings[,] these types of placement are not available.” In this same vein, the Hess Case Record Review finds that 45.7% of placement moves were related to the child’s mental health or behavioral needs or difficulties, or the unmet need for a different level of care.

Since the CSFR noted that MDHS does an inadequate job of matching children with placements, which sets the stage for those placements to disrupt, MDHS has made no changes to its matching process. In November/December 2005, ACF reviewed Mississippi’s second quarterly PIP progress report for July-September 2005, and found that DFCS had not yet completed any of the action steps due in the first two quarters of PIP implementation related to enhancing and expanding foster and adoptive parent support groups and services.

This expert foresees that placements will remain unstable without radical reform of the State’s placement procedures, a dramatic increase in the pool of placement resources available to MDHS, and the development of adequate supportive services and training programs for foster parents.

(xii) MDHS Fails to Supervise and Screen Children’s Placements

The harm to children caused by MDHS’s placement of them in inappropriate and/or distant placements is compounded by MDHS’s inability to consistently monitor their welfare. MDHS policy and national practice standards require monthly supervision of children in their placements, including face-to-face contact with children. Former Director Mangold confirmed that the Social
Worker to whom a foster child is assigned is responsible for monitoring the child’s ongoing safety in the placement, including in situations in which the child is placed in a private placement.\textsuperscript{257} The Director of the State Office Placement Unit testified, however, that while it would be “best practice” for Social Workers to visit foster children in their placements and make observations about whether that setting is safe and meets children’s health needs, her understanding of MHDS policy did not require that visits be in person or that Social Workers lay eyes on the homes where the children on their caseload are being held in state custody.\textsuperscript{258} In further contradiction of MDHS policy and accepted professional standards, Regional Director McDaniel testified that MDHS is relieved of its obligation to make face-to-face contact with children in its custody when it places them out of state, even if the state in which MDHS has placed the children has refused to visit them.\textsuperscript{259}

The Hess Case Record Review finds that 87.6% of children in custody failed to receive at least one face-to-face contact per month by their caseworker or supervisor during the one-year period prior to June 1, 2005, and that 13.5% were deprived of any such contact during the entire year. Social workers/supervisors only made an average of less than half of the required monthly visits to children.

\begin{boxeditemize}
  \item \textbf{Case Example}
  
  Siblings Lashana, James, Thomas and Kaleb came into foster care in December 2000, at the ages of 1, 5, 7 and 14. A February 2005 Foster Care Review notes that these children “have not been seen by a social worker since their placement in their maternal grandparents home” in 2000, and that there was “insufficient documentation” to assess the safety of the children’s placement. The Foster Care Reviewer also reports that the children’s individualized service plans lack any medical, dental, psychological or immunization records. Periodic Administrative Determination, February 22, 2005, DHS 064088.
\end{boxeditemize}

Due to a lack of staff, MDHS has resorted to using social work aides, homemakers, and clerical staff “to do much of the same duties” as Social Workers, even though “[f]ormalized training is not available for case aides and homemakers.”\textsuperscript{260} For example, the agency has waived the requirement that a child’s assigned Social Worker maintain face-to-face contact with children in custody, allowing unqualified and
untrained MDHS homemakers and case aides to make these critical visits. Of course this defeats the purpose of hiring trained Social Workers, a reform that was instituted in 1994 in direct response to prior agency failures. In any event, even counting face-to-face contacts made by unqualified and untrained MDHS staff, including clerks, children in MDHS custody still averaged only 9.9 contacts for the year, and 8.4% of children failed to receive any MDHS contact for the entire year prior to June 1, 2005. Moreover, none of the children’s foster parents were seen face-to-face in their homes by a Social Worker or supervisor on a monthly basis for the entire year prior to June 1, 2005, and for 32.6% of the children, MDHS staff did not visit the caretakers in their home even once during that year.

The Foster Care Review Program similarly found that in the first quarter of FY 2006, 20% of the children reviewed had been visited by a caseworker “or other responsible party” either less than monthly or not at all. And though the March 2005 PIP acknowledges “the importance and the impact that caseworker visitation [with children] can have on improved outcomes for families and children,” MDHS admits in it that staffing and caseloads issues are impacting DFCS’ ability to make monthly visits. MDHS itself reports that from July to December 2004, an average of only 67.1% of children statewide had monthly face-to-face contacts with their Social Worker. And recent MDHS aggregate reporting indicates that as of November 2005, of the 3423 children reported in custody, 880 (25.71%) had not had contact with their Social Worker in at least 30 days. It is significant that this level of failure to regularly lay eyes on children in custody is despite the statewide waiver of agency policy allowing the required face-to-face contacts “to be made by agency Homemakers and Social Work Aides as well as Social Workers.”

---

**Case Example**

Siblings Michele and Sam, ages nineteen months and four years old, have been in care since August 2004. In the children’s January 2005 Foster Care Review, the reviewer reports that she is unable to assess the safety or appropriateness of the children’s placement because: “**There is no placement information**” and no documentation of face to face contact with these children in either the placement home or the office. Periodic Administrative Determination, January 10, 2005, DHS 063837.
Every month that a MDHS Social Worker fails to see the children on their caseload is a lost opportunity to assess the child’s safety, well-being and progress towards permanency and prevent further maltreatment. Although the March 2005 PIP acknowledges “the importance and the impact that caseworker visitation [with children] can have on improved outcomes for families and children,” MDHS characterizes its plan to increase the percentage of minimum monthly face-to-face worker contacts with children in custody by only 6% over two years as “ambitious due to the staffing and caseloads issues impacting casework.”269 Regional Director Zadie Rogers testified that throughout her five years in that position, her staff had never succeeded in making the required visits to all children in care.270 As another Regional Director testified when asked about the impact that repeated denials of her requests for more staff had had on her staff’s ability to make required visits, “I regret that we cannot do that because we really need it, we really need it. But if we can’t, we can’t.”271
Brian is three years old and has been in custody for almost half his life. A December 2005 Foster Care Review notes that evidence seems to "indicate that this is a child with some special needs who may require more frequent contact." However, Brian’s individualized service plan had not been updated in five months and the reviewer notes that "there is no documentation that agency staff persons have had face to face contact with [Brian] since [October 12, 2005]." In addition, despite the fact that "[court orders filed in the case record show the court ordered on [September 28, 2005] that the agency pursue termination of parental rights and then adoption for this child," a TPR petition had not been filed. Periodic Administrative Determination, December 19, 2005. DHS 090291.

The Licensure Unit of DFCS is responsible for the licensing of foster homes, child placing agencies, and residential child caring facilities. As of January 12, 2005, MDHS active placement resources included 859 homes and 33 facilities with MDHS child placements.272 At one time the Unit had fifteen Foster Home Licensure Specialists, but in the FY 2006 Budget Request it was noted that the number had been reduced to eleven to cover the entire state.273 The May 2004 CFSR Final Report finds that while “[p]olicy requires licensing staff to visit each foster home one time per month[, t]his standard is not met due to the high caseloads of staff.”274

MDHS’s Self Assessment acknowledges, furthermore, that private child caring agencies have limited access to Central Registry background check information on past abuse and neglect incidents involving childcare staff and foster parent applicants. Instituting “a policy to require annual criminal background checks and child abuse checks on foster parents and adoptive parents” is recommended,275 but MDHS has yet to issue such a policy. The Self Assessment also acknowledges that “due to significant staff turnover and several reorganizations,” a planned revision of the 1986-88 standards for child placing agencies and residential child caring facilities has yet to be completed and issued.276 The May 2004 CFSR Final Report cited “staffing issues in the licensing unit” for the continued failure to issue these new standards as planned.277
A foster care reviewer observed and reported in June 2005 that a one-year-old medically fragile child with a severe heart defect who came into care June 18, 2004 has been placed in a foster home in Arkansas. There is no documentation that any Arkansas social service staff has had face-to-face contact with the child since she has been placed there, and the last face-to-face contact with a Mississippi social worker was six months prior to the review, in January 2005. Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review), July 7, 2005, at DHS 047704

An April 2005 foster care review notes that “[t]he DFCS Jackson County ASWS stated to the Reviewer [] that Jackson County DFCS staff can no longer visit Mississippi foster children placed in Alabama except for children placed at Wilmer Hall in Mobile.” As a result, two young Mississippi foster children (ages 3 and 2) placed with their grandmother in Alabama had not been seen by a Mississippi or Alabama social worker in at least eight months. (Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review) for April 2005, at DHS 047653).

(xii) Children Are Maltreated In Foster And Adoptive Placements

Keeping children safe is a primary responsibility of MDHS. State policy requires child abuse and neglect referrals to be classified and, if accepted, responded to within 24 hours. Case investigation must be complete within 30 days of the referral. In practice, however, MDHS does not respond in a timely fashion to protect children, nor does it appear to have operationalized or even formulated a consistent or coordinated response to allegations of maltreatment of children already in foster care.* Of most significant concern to this reviewer is the fact that an unacceptably high percentage of children in MDHS custody are being exposed to maltreatment and corporal punishment in their placements.

During the first nine months of 2005, the average maltreatment rate of children in MDHS custody was 3.2%, according to MDHS’s own case reviews of 342 children in custody. This is more than five times the allowable federal standard of 0.57% on this critical child safety measure. During

* Many of the maltreatment reports on foster children recorded by the Protection Unit were not evidenced. The validity of those findings cannot be assessed at this time as MDHS did not produce the investigation reports until several days ago.
January to March 2005, four out of the 135 children reviewed (3.0%) experienced abuse or neglect in MDHS custody. During April to June 2005, four of 126 children reviewed (3.2%) experienced abuse or neglect in their MDHS placements. During July to September 2005, three children out of 81 reviewed (3.7%) experienced abuse or neglect in State custody.

The State Office Protection Unit, which only keeps a manual log of those cases it is notified of, is oblivious to how many children are really being maltreated in care. The Unit’s manual log documents only six substantiated cases of abuse or neglect of foster children in the whole State for all of 2005. By contrast, during only the first nine months of 2005 Foster Care Reviewers tallied 11 cases of substantiated abuse out of a sample of only 342 foster children. Applying the actual rate of maltreatment in care recorded by the Foster Care Reviewers to the average number of children in care for the first nine months of 2005 (3323), approximately 106 foster children would have been the victims of substantiated abuse in care during that same period.

The Director of the Protection Unit concedes that the Unit may not get notified of all reports and investigations of abuse and neglect of children in MDHS custody, and that their manual log purporting to list all allegations of abuse of children in custody is incomplete. The Unit relies on manual notification as there is no automated reporting system. Nonetheless, the Protection Unit
Director has never directed anyone in this State Office Unit to conduct an electronic search of MACWIS for maltreatment reports on children in custody that the Protection Unit was never notified of. Thus, only the county office Social Work staff who are supposed to enter each investigation into the computer are likely to know of allegations of abuse or neglect of foster children. Even a Regional Director, charged with supervising investigations and signing off on ultimate findings, testified that she does not keep track of how many children in her region are abused while in MDHS custody. Another Regional Director testified that although she had learned almost a year and a half before her deposition that 6.7% of foster children in her region had been abused or neglected while in MDHS custody, she had done nothing about it.

---

**Case Example**

The first week in August 2005, Ronald H. Shiyou was arrested on four counts of sexual molestation involving two foster girls, six and eight years old, in his Hancock County home. A Sun Herald article the following week recounted these facts and stated that the "state Department of Human Services is working with Hancock investigators to determine how many children have lived with Shiyou since 2002, when the alleged sex crimes began." ("Abuse charges go up to four," Sun Herald, August 11, 2005) As of December 2005, however, the State Office Protection Unit had yet to determine who the sexually abused foster children were and whether an MDHS investigation was conducted. Where the "Allegations," "Investigative Report," and "Findings" are supposed to be noted, the 2005 MDHS Foster Home Investigations log only notes "E-mail stated possibly [Smith] children. No specific foster children named at this point and nothing in MACWIS". (DHS 091929)

The Hess Case Record Review confirms that maltreatment of foster children is rampant in Mississippi’s child welfare system. The review found that nearly one in four children in MDHS custody (24%) had indications in their records that they themselves, or another foster child placed in their home or facility, had been the subject of maltreatment while in custody. One in ten children in custody (11.8%) were placed in homes or facilities where maltreatment was substantiated and/or the conduct complained of was serious enough to result in a placement move. One in twenty children in custody (4.9%) were the victims of substantiated maltreatment. As alarming, for 5.6% of children,
suspected maltreatment in their placements was documented but never formally reported or investigated.\textsuperscript{287}

According to Ms. Triplett, the Director of the Protection Unit, MDHS does not treat or investigate allegations of corporal punishment as child abuse, although MDHS policy expressly forbids the use of corporal punishment on foster children (who are often prior victims of physical and sexual abuse).\textsuperscript{288} In reviewing an allegation that a man hit a foster child with a belt, Ms. Triplett – the MDHS administrator responsible for MDHS policy on child maltreatment and protection – stated that she “did not see a report that meets the criteria for abuse and neglect” and determined that “this would not require an investigation.”\textsuperscript{289} She went on to testify that MDHS would “not necessarily” investigate whether sexual abuse had occurred if “a little girl” contracted a sexually transmitted disease while in a foster home.\textsuperscript{290} The Director of Protection’s understanding of maltreatment diverges so far from professionally acceptable standards – including the legal presumption that sex with a child below the age of consent is by definition abuse – as to shock the conscience.

Even when reports of maltreatment of foster children rise to the level necessary to trigger investigation by MDHS, the agency fails to treat those reports with urgency and protection of children may be subordinated to staffing concerns. MDHS’s Self Assessment notes that in 2003 the agency had a backlog of over 2,800 incomplete abuse and neglect investigations open more than 30 days “due to insufficient staffing numbers.” It also identifies a troubling connection between MDHS’s staffing crisis and investigations:

\begin{quote}
The areas of the state with chronic understaffing have a lower rate of substantiated reports per capita. In reviewing data, areas with fewer staff appear more likely to ‘screen-out calls’ and have fewer substantiated investigations. If the number of investigations exceeds the number that can reasonably be done by available staff, the result may be less thorough investigations.\textsuperscript{291}
\end{quote}

Recent aggregate MACWIS data indicates that as of November 15, 2005, there were 2754 investigations statewide open more than 30 days.\textsuperscript{292} A September 2005 “Child Investigation
Timeliness Report – Statewide Summary” (dated 10/10/05) shows that only 75.4% of 1030 investigations were initiated within 24 hours as of October 10, 2005.293

The May 2004 CFISR Final Report finds that in 25% of applicable cases reviewed (both foster care and in-home cases), including the case of a maltreatment report of abuse in a treatment facility, MDHS “had not established face-to-face contact with the child subject of a maltreatment report in accordance with the State’s required timeframes.” It is also reported that “‘follow-up’ on investigations after the initial contact with the child is made often do not occur in a timely manner,” and that “a large percentage of maltreatment reports . . . are not substantiated even when there is evidence to warrant substantiation.”294 In 13% of applicable foster care cases reviewed, DFCS had not made “diligent efforts to reduce the risk of harm to the children involved in each case.” In one case it was specifically found that “[t]here was insufficient assessment of risk of harm to children in their foster homes and risk issues were not addressed.” It is also reported that “maltreatment in foster care may be a result of too many children in a foster home.”295 MDHS’s March 2005 PIP confirms that from July-December 2004 an average of only 67.99% of intake investigations were initiated within 24 hours, as required by Mississippi policy.296

**Case Example**

GARY entered foster care in February 2001, at the age of five. According to a July 2004 Foster Care Review. Gary was subjected to “nineteen placements” in his first two years in care. Seven of the placements were “emergency” or “temporary” facilities. Although the “Reasons for Removal” indicate that Gary was sexually molested in at least two different placements and was suffering from encopresis and sexual acting out, there is no indication that such maltreatment was ever formally reported or investigated. Gary was freed for adoption on February 13, 2003, at the age of seven, but it was no cause for celebration as he spent the next two nights in a “Holiday Inn Express” with a “sitter” because MDHS had no other placement for him. After another fifteen months in custody Gary was still not adopted. His individualized service plan was more than twenty months out-of-date and “lack[ed] physical, dental, psychological, immunization record and the correct placement.” The Foster Care Reviewer had to reconstruct his placement history as only one placement was showing in his primary MDHS case file. Periodic Administrative Determination. July 29, 2004, p. 2, DHS 012178 (See below)
<table>
<thead>
<tr>
<th>Date</th>
<th>Placement</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/13/01</td>
<td>Foster Home (Peach River County)</td>
<td>Family moved from place to place, financial problems</td>
</tr>
<tr>
<td>2/21/02</td>
<td>Foster Home</td>
<td>Had endless screaming fits when told &quot;no&quot;</td>
</tr>
<tr>
<td>2/25/03</td>
<td>Foster Home</td>
<td>Temper tantrums, kicked a hole in wall</td>
</tr>
<tr>
<td>3/15/03</td>
<td>Foster Home</td>
<td>&quot;Pooping&quot; in his pants three and four times a day, at this home, began saying his cousin (see first placement) &quot;touched&quot; him.</td>
</tr>
<tr>
<td>6/13/03</td>
<td>Foster Home</td>
<td>He would argue constantly, not a &quot;fun&quot; child to be around, began having to take off all the time, for behavior at school or to take him to the doctor.</td>
</tr>
<tr>
<td>7/26/03</td>
<td>Shelter</td>
<td>Temporary</td>
</tr>
<tr>
<td>8/2/01</td>
<td>Adoptive Home (Clark County)</td>
<td>Was defiant and uncontrollable</td>
</tr>
<tr>
<td>1/22/03</td>
<td>Pine Grove</td>
<td>Temporary facility, requisite for the</td>
</tr>
<tr>
<td>1/31/03</td>
<td>Adoptive Home (Clark County)</td>
<td>Behavior uncontrollable, they didn't think he fit into their home</td>
</tr>
<tr>
<td>2/8/03</td>
<td>Pine Grove</td>
<td>Facility</td>
</tr>
<tr>
<td>2/7/03</td>
<td>Foster Home</td>
<td>Put a pillow over another child with intentions of smothering him, tried to touch the granddaughter sexually</td>
</tr>
<tr>
<td>2/13/03</td>
<td>Holiday Inn Express</td>
<td>Family &amp; Children's Services tried to get into Memorial Behavior but they could not accept him. Had a sitter for him at Holiday Inn.</td>
</tr>
<tr>
<td>2/15/03</td>
<td>Pine Grove</td>
<td>Temporary facility</td>
</tr>
<tr>
<td>2/19/03</td>
<td>Foster Home</td>
<td>Temporary</td>
</tr>
<tr>
<td>2/27/03</td>
<td>Emergency Foster Home</td>
<td>Temporary</td>
</tr>
<tr>
<td>7/7/03</td>
<td>Foster Home</td>
<td>Another child in the home touching sexually</td>
</tr>
<tr>
<td>7/11/03</td>
<td>Emergency Foster Home</td>
<td>Did well in this home, had medication changed, Adoption Unit found him an Adoptive Home</td>
</tr>
<tr>
<td>12/23/03</td>
<td>Adoptive Home</td>
<td>They want to finalize</td>
</tr>
</tbody>
</table>
Matthew, a six-year-old child in DHS custody, was placed out of state in a Louisiana nursing home because Matthew requires around-the-clock special medical care. In February 2004, when Matthew was four years old, a MDHS Foster Care Reviewer concluded that Matthew's county of supervision "is aware that Louisiana DHS does not supervise placements in nursing homes, and it appears the county is neglecting to ensure [the child's] safety."¹ The Southdown Care Center where DHS left Matthew completely unsupervised for almost 10 months was the site of a deadly viral outbreak in 1996 that killed 10 child residents. A federal Center for Disease Control investigation found that Southdown's management failed to take basic steps to contain the virus and care for the medically needy children, who continued to get sick and die over a period of two and a half months. The facility has been cited and fined three times since 1996 for violations that endangered its residents, and found liable in 2000 for two of the deaths by a jury in a $1.2 million verdict. As of August 2005, Matthew was still placed at Southdown "Tragedy in the Children's Ward," New Orleans Times-Picayune, April 18, 2005.

B. MDHS Fails To Provide Children With Health Care And Other Needed Services

Children in the State’s custody are required by federal law and professional standards to have their educational, medical, and mental health needs met,²⁹⁷ and MDHS policy requires the Social Worker to whom each child is assigned to ensure that treatment is in fact delivered on an ongoing basis.²⁹⁸ The trauma of being removed from their homes makes the importance of stable and ongoing connections with family, friends, and school even more important for these children. Children in out-of-home care are at a higher risk for emotional and behavioral problems than are children in their biological homes.²⁹⁹ Without having their needs adequately assessed and met, foster children suffer continuing harm at the hands of those charged with their care.

MDHS’s Self Assessment acknowledges that the federal review in 1995 had already identified as a problem that “[h]ealth records for children [were] not routinely contained in the foster child’s foster care case records, and the children’s “mental health needs [were] not [being] adequately identified, assessed or addressed.”³⁰⁰ Although the Self Assessment acknowledges that services should be available statewide, MDHS concedes that “[m]inimal services are available in most rural counties.”³⁰¹
The May 2004 CFSR Final Report likewise identifies as a key concern “a general lack of mental health services throughout the State.” A key CFSR finding with regard to [Well-Being Outcome 3] was that [DFCS] is not consistent in its efforts to meet children’s physical or mental health needs. In 52% of the foster care cases reviewed DFCS had not met the service needs of children, parents, and foster parents; had not involved children and parents in the case planning process; and/or had not established face-to-face contact with children and parents with sufficient frequency to ensure the children’s safety and well-being. Yet, in both August 2005 and November/December 2005, ACF reviewed Mississippi’s quarterly PIP progress reports for April-September 2005 and found that MDHS had failed to add steps and strategies for ensuring that “services are accessible to families and children in all political jurisdictions covered in the State’s CFSP” and that “services can be individualized to meet the unique needs of children and families served by the agency.”

(i) Failure to Assess Children’s Needs

Establishing the physical and mental health of children entering State custody is critical to the Agency’s ability to provide for their needs and prevent further harm to them. It is also imperative for the Agency’s ability to properly advocate for the best interests of the children in custodial proceedings to have documentation of the children’s baseline condition at the time of entry into custody. MDHS policy requires that children be provided a physical health exam within seven days of entry into foster care custody; a dental exam for children ages three or older within 90 days of entry into custody; and a psychological exam for those children ages four and older, also within 90 days.

All of a foster child’s medical, dental and psychological information must be maintained in the child’s case record, and the child’s complete health history, including immunization
records, must be in the child’s Initial Service Plan. Further, foster caregivers must be provided with the current health information of the foster children placed in their care.

The Hess Case Record Review found that 84.1% of children entering custody on or after June 1, 2003, were not provided the required physical exam within seven days. Wide variation was found in County practices, with Humphreys County providing all such children a physical exam within seven days, and Harrison County only providing such exams to 4% of its children entering custody on or after June 1, 2003. DHS also failed to provide 80.8% of children three and older with the required dental exam within 90 days of entry into custody on or after June 1, 2003. Moreover, for 89.4% of children entering custody on or after June 1, 2003, health records were not provided to the child’s caretaker at the time of entry into custody. MDHS also failed to maintain immunization records for 17.4% of children in custody age 0-5 years old. For 40% of the children no health or mental health information was included on the child’s initial ISP because no ISP was even completed within 90 days of entry into custody.

MDHS likewise failed to provide 57.7% of children age four and older the required psychological assessment within 90 days of entry into care on or after June 1, 2003. Over a third of children (35.5%) never received any evaluation. This included children who had identified behaviors of concern such as hurting other children, perpetrating sex abuse, damaging or destroying property, attempting suicide, carrying a weapon, masturbating in public, stealing, and having serious emotional and behavioral problems in school. Even for those who did receive an evaluation, 50% of those whose evaluation recommended further assessment were never provided with any further assessment. It is significant that 80.3% of those children in custody who were evaluated for mental illness or
developmental disorder were diagnosed with such an illness or disorder.\textsuperscript{311} This underscores how vulnerable and at risk the population of children in DHS custody truly is.

MDHS's own Foster Care Review Program found that between July and September 2005, 9\% of the foster children's physical health needs were not assessed.\textsuperscript{312} MDHS's Self Assessment concedes that "[a]lthough policy mandates a medical review within 7 days, review of files indicates that many of these cases require additional time to complete the medical assessment." In addition, only approximately half of reviewed cases "indicated documented evidence of the sharing of detailed [medical] information" with foster and adoptive caregivers.\textsuperscript{313} The Self Assessment also concedes that although all children in custody ages four and older are required to have a psychological assessment/evaluation within 90 days of custody, "for children in relative placements and in cases that have been opened less than 6 months, the psychological is missing."\textsuperscript{314}

\begin{center}
\textbf{Case Example}
\end{center}

\begin{quote}
\textit{Siblings Caleb, Thomas, Alex and Monica, ages 14, 11, 6 and 3, entered care in January 2005. A July 2005 Foster Care Review reports that the children still do not have individualized service plans and "[f]here are no written permanent plans." "The medical screens for all four children show that they have not had dentals, psychologicals and only [Monica] has been to the doctor. There is no documentation that fourteen-year-old [Caleb] has been offered Independent Living Services." The Foster Care Reviewer observed that, during the conference, Monica would "stare off into space several times before coming to herself and proceeding with her activity." The paternal grandmother reports that Monica "does that all the time and she would like for [Monica] to see a specialist or psychologist." Periodic Administrative Determination, July 7, 2005, DHS 069619.}
\end{quote}

The May 2004 CFSR Final Report likewise finds that "mental health assessments are not always completed on children entering foster care despite agency policy requiring them," and that "social workers may make assessments . . . without input from mental health professionals."\textsuperscript{315} The CFSR Final Report also notes that the quality and availability of sexual abuse examinations are "problematic."\textsuperscript{316}
MDHS is still unable to run a MACWIS report that tracks the provision of medical, dental and psychological assessments to children in MDHS custody. Moreover, the March 2005 PIP contains no plans to address the issue of medical documentation and health records being missing from children’s case records.

A foster care reviewer observed and reported in March 2005 that there was no documentation that two Jackson County foster children, who entered DFCS custody in October 2004 due to sexual abuse, ever received a medical exam. The county’s response indicates that a doctor finally saw the children in April 2005, six months later. Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review) for March 2005, at DHS 047612

(ii) Failure to Provide Regular Medical and Dental Health Care

The Hess Case Record Review found that DHS failed to provide any physical exam for 28.2% of the children in custody at least one year, during the two years prior to June 1, 2005. The youngest children in custody (0-5 yrs), those for whom multiple immunizations are required and important developmental milestones occur, were the most likely not to have received any physical exam (32.4%). DHS also failed to provide any dental exams to 42.2% of children ages three and older who had been in custody at least one year during the two year period prior to June 1, 2005.

MDHS’s own Foster Care Review Program found that between July and September 2005, one in ten of the children whose physical health assessments revealed medical needs did not receive physical health services to meet those needs. The Foster Care Review Program likewise found that between April and June 2005, 14.3% of children’s ISPs reviewed did not “indicate” that the child’s medical needs were being met with appropriate physical health services.

The December 2003 Statewide Self Assessment similarly concedes that although “Health and Safety are paramount in planning for children in foster care,” medical documentation, including immunizations and doctor visits, continues to be missing from case records. “More emphasis is [still]
Case Example

Siblings Alan, Lana, Diana, Joshua, James and Shana entered care in November 1999, when they were aged 10, 8, 7, 5, 3 and 1. According to a November 2005 Foster Care Review, adoption was not established as the permanency plan for these children until more than five years later, on January 6, 2005. The Foster Care Reviewer notes: "no TPR referral yet forwarded to State office," further delaying the possibility of achieving the plan. In the interim, "there is no documentation [that] the physical, mental health, and educational needs of all the children have been assessed." There is no psychological in the system for James or Shana: Alan's "current" medical and dental were 18 months ago; Diana's "current" medical and dental visits were in mid-2002 as was James's last dental visit; Lana's last dental was fourteen months ago and her current referral to a cardiologist does not appear in her health record in the system only in Narratives; the psychological for Diana, Joshua, Lana, and Alan were "scheduled" for May, 2001, but there is no follow-up documented under their health records beyond "see hard copy" so that actual needed services are not in the system." In addition, children's individualized service plans had not been updated in more than seven months and the reviewer notes that "it is not clear whether their grade levels are accurate" in the reviews, but "if they are, some may need tutoring or other educational services that do not appear on the ISP." There is also "no indication that the agency has attempted any sibling visits since the last one documented in June, 2005." Periodic Administrative Determination, November 10, 2005, DHS 089835.

needed to document and track the health care of children,” as “medical information is not routinely entered into MACWIS, and cannot be measured through automated means.”

State Office Program Specialist Robin Wilson confirmed at deposition that MDHS is still unable to run a MACWIS report that tracks the provision of medical and dental services to children in MDHS custody. The May 2004 CFSR Final Report finds that in 20% of the foster care cases reviewed “there was clear evidence of [children's] health-related needs that were not being addressed by the agency.” In the words of Regional Director Rogers, “[w]e have not necessarily done a really good job with making sure that medical and physical needs have been met.” Having admitted that, Rogers conceded that she does not take any action to check that foster children get physicals or immunizations. The March 2005 PIP concedes that DFCS has yet to even determine a baseline statewide percentage of children who receive health services based on identified and assessed physical health needs.
(iii) Failure to Provide Mental Health Services

The Hess Case Record Review found that of the children in custody who received a psychological evaluation, 80.3% were diagnosed with a mental illness or developmental disorder. Of these, 81% had specific treatment recommendations documented in their case records. As of June 1, 2005, however, most children were not being provided the recommended treatment by DHS, including 92.3% of those children with recommended treatment for an anxiety disorder, 69.2% of those children with recommended treatment for a psychotic disorder, 60.8% of those children with recommended treatment for an adjustment disorder, 54% of those children with recommended treatment for a developmental disability, mental retardation (MR), or borderline MR, and 51.9% of those children with recommended treatment for post-traumatic stress disorder. In 21% of the instances in which inpatient treatment – which addresses acute mental illness – was specifically recommended for a child, such treatment was not provided during the entire two-year period prior to June 1, 2005.327

MDHS's own Foster Care Review Program found that between July and September 2005, one out of every 10 child (11%) who were found to be in need of mental health services did not receive those services.328 The Foster Care Review Program likewise found that between April and June 2005, 17.8% of ISPs did not contain documentation that services had been provided to meet children's mental health needs.329 The December 2003 Statewide Self Assessment concedes that there continues to be inconsistency in the provision of mental health services, due in part to the unavailability of resources. "Services such as counseling, especially when recommended in the psychological [evaluation], are frequently absent from case recordings, even when a support service has been funded. More emphasis in documenting mental health counseling and the outcomes of this counseling are [still] needed."330

As conceded by MDHS in its Self-Assessment: "There are not enough therapeutic placements for foster children needing such services. Currently, there are only contracts for 250
therapeutic slots (Therapeutic Group Homes, Therapeutic Foster Homes, and Intensive In-Home Services).” The May 2004 CFSR Final Report confirmed that in 48% of applicable foster care cases reviewed DFCS “had not made concerted efforts to address the mental health needs of children.” In those cases “[m]ental health needs were not fully assessed, although a mental health assessment was warranted” or “[m]ental health needs were assessed but needed services were not provided.” MDHS is still unable to run a MACWIS report that tracks the provision of mental health services to children in MDHS custody. MDHS’s March 2005 PIP concedes that DFCS has yet to even determine a baseline statewide percentage of children who receive mental health services based on identified needs.

(iv) Failure to Provide Educational Services

Federal law and MDHS policy require that children in custody receive appropriate services to meet their educational needs and that the child’s educational records and information be included in their agency case record and provided to the child’s caretakers at the time of placement.

The Hess Case Record Review found that 22% of school-age children who entered custody on or after June 1, 2003, had no information in their MDHS case files about the child’s schooling. MDHS also failed to provide school records to foster caregivers for 78.8% of school-aged children who entered custody on or after June 1, 2003, even though the majority of school-age children (58.4%) did not remain in the school they attended prior to their most recent entry into custody. Of those children who changed schools, 63.6% had no information regarding their subsequent school enrollment in their MDHS files. Of those children with school enrollment information in their files, 40.4% missed more than one week of school when first placed in custody because MDHS failed to ensure that they were enrolled in school for periods from 10 to 90 days. Moreover, 61.9% of the school-age children with school enrollment information in their files had experienced at least one school change once in custody, with 9.1% changing school four times. Notably, 78.3% of the
children’s documented school changes while in custody were due to MDHS moving the child to another out-of-home placement.\textsuperscript{336}

The Hess Case Record Review also found that only 18.2\% of school-age children in custody were receiving special education services. One quarter of the children (24.1\%) who had been referred to special education were not in special education as of June 1, 2005. Likewise, 80\% of those children who had been diagnosed with mental illness or a developmental disorder were not receiving special education services. MDHS failed for 29.2\% of those children receiving special education services to even maintain a copy of their current Individualized Education Plan (IEP) in their file.\textsuperscript{337}

Although MDHS acknowledges that “educational issues and problems should be part of working with the child,” “attention to educational issues with children in custody vary by county and region,” and “workers do not consistently enter adequate data.” The Self-Assessment acknowledges that “[d]ocumentation in the automated system is lacking, and so does not provide enough information to adequately track data.” “During mock reviews, it was evident that casework addressing educational needs of the child varied considerably based on . . . the staffing resources in the DFCS county office.”\textsuperscript{338}

MDHS’s March 2005 PIP acknowledges the 2004 CFSR’s finding that children received appropriate services to meet their educational needs in only 75.9\% of applicable cases, yet concedes that DFCS has yet to determine a baseline statewide percentage of children who receive educational services based on identified educational needs.\textsuperscript{339} MDHS is still unable to run a MACWIS report that tracks the provision of educational services to children in MDHS custody.\textsuperscript{340}

C. MDHS Fails to Plan For Children

When children cannot be kept safely in their homes and must enter foster care, the primary responsibility for the state once it assumes custody becomes establishing a permanent living situation for the child. Federal law requires that the state have a permanency plan for each foster child and
prescribes time frames that must be adhered to for reunification of the child with parents, terminating parental rights to free the child for adoption, or finalizing some other permanent placement. Long years in foster care keep children from available permanent, loving families and leave them as adults without the stability of an extended family of their own.

The Hess Case Record Review found that as of June 1, 2005, the total length of time that children had been in MDHS custody ranged from less than one year to 17.9 years, with a mean length of stay of 2.8 years. Nearly thirty percent (29.8%) of the children had been in custody three or more years, and 8.8% had been in custody for more than five years. 20.9% of the children had spent at least half of their lives in MDHS custody.

MDHS MACWIS data shows that as of September 30, 2005, (736) children had been in care at least three years.

![Length of Stay in Foster Care](image)

"Unfortunately, the lack of staff may be contributing to the length of time children remain in care." As acknowledge by MDHS in its Self Assessment, "[i]t appears from the mock reviews that when a worker is able to devote more time to a case . . . the length of time a child is in care is
shortened.” “During the Mock Reviews, there was a noted concern on [sic] the amount of time
workers could devote to their families.”345 The May 2004 CFSR Final Report likewise finds that
“[o]ne of the areas of greatest concern is the State’s performance on Permanency Outcome 1,” which
measures whether children in state custody have permanency and stability in their living situations.
In 64% of the foster care cases reviewed MDHS failed to establish an appropriate permanency goal
for children in a timely manner and/or ensure their placement stability.346

(i) Poor Permanency Planning Services

MDHS uses an Individual Service Plan (ISP) as the official method by which permanency
planning for a child takes place in Mississippi.347 It is through this plan that the federal mandates of
safety, permanency, and well-being are individually addressed for each child. The initial child ISP is
required to be completed within 30 days of the child’s entry into custody, and then reviewed at least
every 6 months thereafter. Parent ISPs are also required within 30 days of the child’s entry into
custody. MDHS policy requires a family team conference within 30 days of the child’s entry into
custody and every six months thereafter to work with the family to identify other family members,
extended family, and supportive persons that the family wants to engage in the process and to bring
these members into the assessment and case planning process as early as possible and actively
engage the family throughout the life of the case in the decision-making process.348

The Hess Case Record Review found that child ISPs were not completed within 30 days for
66.7% of children entering custody on or after June 1, 2003. Non-compliance with this requirement
was particularly routine in Clarke (100%) and DeSoto (87.8%). For 40% of the children entering
custody on or after June 1, 2003, MDHS failed to provide them with an ISP within the first three
months. Even when an ISP was provided within 90 days, one out of five failed to contain a primary
permanency plan, and one out four failed to contain a concurrent permanency plan. As a result,
MDHS failed to provide 61.8% of the children entering custody on or after June 1, 2003, an initial
ISP with an identified primary permanency plan within 90 days of placement, either because no initial ISP was provided, or the ISP provided failed to contain the required permanency plan. Two thirds of children (66.1%) failed to have a concurrent permanency plan as required within 90 days.\(^{349}\)

**Case Example**

Allison, age seven, has been in care since November 2003. A May 2004 Foster Care Review reports that Allison still lacks both an individualized service plan and a valid permanency plan. Though the "permanent plan mentioned in the Conference was reunification," "there is no Parental ISP approved." In addition, it is "unknown if [Allison] is safe in her placement and whether or not it is the least restrictive or most appropriate" because "the last face-to-face with [Allison] by agency staff was on December 23, 2003," "no one from DHS has seen [Allison]" since she was placed in her maternal aunt’s home. and "[T]he placement listed in MACWIS incorrect." Periodic Administrative Determination, May 3, 2004, DHS 010986-010987.

Moreover, MDHS failed to complete an ISP for either parent within 30 days for 56.1% of the children who entered custody on or after June 1, 2003. Another 36% of the children only had an ISP completed for one of two applicable parents. MDHS also failed to convene a Family Team Conference within 30 days for 97.5% of the children who entered custody after June 1, 2003. MDHS failed to hold even one Family Team Conference for 94.5% of all children in custody during the two-year period prior to June 1, 2005.\(^{350}\)

For 95.2% of the children with a primary or concurrent goal of reunification as of June 1, 2005, MDHS social workers/supervisors failed to maintain monthly face-to-face contact with the child’s mother during the prior 12-month period (92.1% non-compliance for fathers). For 45.5% of these children, MDHS failed to meet with the child’s mother even once (58.5% for fathers). Moreover, 51% of these children were not even provided one visit with their mother, and 85.2% were not provided a single visit with their father, during the entire one-year period prior to June 1, 2005, despite their goal of reunification. MDHS failed to offer or provide services to 57% of the mothers and 83.4% of the fathers to facilitate reunification. Children with a primary permanency goal of reunification had been in MDHS custody for an average of 1.2 years, ranging from .8 years in Hinds to 3.4 years in Humphreys.\(^{351}\)
For 23.5% of all children in custody, MDHS failed to complete or update their ISP during the six months prior to June 1, 2005. For 9.6% of those children, MDHS did not provide a single ISP during the two-year period prior to June 1, 2005. Of those who had an ISP during this period, 14% of the children’s most recent ISP were missing their primary permanency goal, 46.3% were missing their concurrent permanency goal, 42% did not even have a caseworker signature, and 28.6% were missing a supervisor’s signature.\(^{352}\)

MDHS’s own Foster Care Review Program found that between July and September 2005, 38% of children did not have an ISP developed within 30 days of their entry into custody as required by MDHS policy.\(^{353}\) In the previous quarter, the Foster Care Review Program determined that 15.1% of children reviewed did not have an ISP competed within the mandated timeframe.\(^{354}\) The March 2005 PIP concedes that DFCS has yet to even determine a baseline percentage for how many children in foster care have appropriate permanency plans.\(^{355}\)

MDHS’s Self Assessment concedes that inconsistencies in assessment and case planning has been an ongoing issue. “Case plans lack specificity and are not updated or individualized.” “Notification and case planning with the parents and caretakers were noted as continuing to be problematic.” Additionally, “in only approximately 50% of the cases are all dates associated with the case plan consistent with policy.”\(^{356}\) The 2004 CFSR likewise found that in 36% of the foster care cases reviewed MDHS “had not established an appropriate [permanency] goal for the child in a timely manner.” Also, case plans are not developed jointly with the child’s parents on a consistent basis.\(^{357}\) Even when concurrent goals appear in the case plans, it is reported that “most of the social workers tend to work on the goals consecutively rather than concurrently.” The May 2004 CFSR Final Report finds that in 58% of the foster care cases reviewed with a goal of reunification, guardianship, or permanent placement with a relative “there were avoidable delays in attaining [those] goals.”\(^{358}\)
The May 2004 CFSR Final Report also finds that in 53% of the applicable foster care cases reviewed MDHS “had not made diligent efforts to support the parent-child relationships of children in foster care,” and “the frequency and/or quality of social worker visits with parents were not sufficient to . . . promote the attainment of case goals.”\footnote{359} As noted in the PIP, current policy “does not clearly address frequency of visitation with parents.”\footnote{360}

The March 2005 PIP admits that while “Mississippi has understood the importance and necessity of family centered practice since the CFSR pilot review in 1995,” the State has failed to consistently implement family centered practice in its casework. “Supports necessary to reinforce this family centered approach and practice change such as on-going training for caseworkers and supervisors was [sic] not in place.”\footnote{361} The Hess Case Record Review found that MDHS failed to convene even one conference with family members (Family Group Conference) to make plans for the child for 94.5% of the children who entered custody on or after June 1, 2003.\footnote{362}

MDHS has in fact abandoned any pretense of “trying to replicate a formal family team conferencing model with the caseworker being responsible for the workload and activities” as it is “not feasible” due to “Mississippi’s current staffing issues.”\footnote{363} Although the March 2005 PIP relies heavily on Family Centered Practice (FCP), Family Team Meetings (FTM), and County Conferences (CC) “to improve the appropriateness and timeliness” of foster children’s permanency goals, it provides for FTM to be “implemented in a way that does not create additional workload for existing staff.” Practice guidelines are to be developed \textit{not} to contain “explicit procedures and requirements,” so as not to “burden” staff.\footnote{364} It is unclear how MDHS expects that current casework practice by overwhelmed staff will improve with such studious avoidance of any measurable performance standards. Mississippi’s Child and Family Services Review Data Profile, dated December 8, 2005, found that for Federal FY 2005 (ending September 30, 2005), of all
children who exited care to reunification with their parents or caretakers, only 69% exited care less than 12 months from the latest date of removal. The national standard is 76.2% or more.\textsuperscript{365} MDHS fails to diligently search for relatives as required by policy and practice standards.\textsuperscript{366} The May 2004 CFSR Final Report finds that in 32% of the foster care cases reviewed MDHS “had not made diligent efforts to locate and assess relatives as potential placement resources.”\textsuperscript{367} The March 2005 PIP concedes that in FFY2004, only 33.5% of children statewide were placed in relative foster family homes, according to Mississippi’s CFSR Data Profile generated December 13, 2004.\textsuperscript{368} As the Self Assessment acknowledges, a plan for “permanently funded kinship care is needed” for those relatives that require financial support for a permanent family placement. “Because of a lack of State funding, Mississippi has not been able to effectively promote kinship care through durable legal custody as a viable option for permanency.”\textsuperscript{369}

\textbf{Case Example}

\textit{Siblings Andy and Carrie entered foster care in March 2003, at the ages of nine and seven. An April 2005 Foster Care Review notes that, despite the children’s young age, the permanency plan for the children is “formalized long term foster care” with a concurrent plan of “emancipation,” a plan that is “inappropriate,” and contrary to “agency policy,” given that “the more stable permanent arrangement of adoption is the goal of choice for those children when reunification or placement with relatives is not possible.” The Foster Care Reviewer also notes that an assessment of the safety and appropriateness of Andy’s current placement is not possible because there was no documented face-to-face contact with the child in the previous five months. Periodic Administrative Determination, April 21, 2005, DHS 064804.}

\begin{itemize}
  \item[(i)] \textbf{Missed Case Plan Reviews and Judicial Permanency Hearings}
  
  Children’s cases must be reviewed at least every six months, with at least one of those reviews annually being a judicial permanency hearing.\textsuperscript{370} The Hess Case Record Review found that 85.5% of the children who had been in custody at least one year as of June 1, 2005, were not provided a 12-month judicial permanency hearing in the previous 24 months. For 5% of children, MDHS failed to even provide one six-month review during the previous 24 months.\textsuperscript{371}
\end{itemize}
MDHS's own Foster Care Review Program reports document that between April-May 2005, 23.6% of foster children in need of an annual permanency hearing had no documentation in MACWIS that any such hearing was held. The Foster Care Review Program found that between July-September 2005, for 30% of the children who had not had a permanency hearing, "the primary reason appears to be that the agency did not request the hearing." MDHS's Statewide Self Assessment concedes that DFCS is often out of compliance with the required six-month case reviews. "There are currently twelve (12) foster care reviewers in the State of Mississippi to cover 82 counties and conduct reviews and County Conferences on the cases of approximately 3,150 foster children." "Currently, there are not enough Foster Care Review staff to adequately and consistently cover all areas of the state. Those areas not consistently reviewed have noted a decrease in [the quality of] documentation, and an inability to ensure that each child in custody is reviewed every 6 months." "Additional FCR staff are needed to ensure 100% compliance with review dates." "[C]ounties with a full time FCR indicated that 80% of the cases were within the time frames expected, however that number was significantly lower in the counties without a full-time review staff, dropping to less than 50%." In his deposition, Mr. Hamrick - Program Administrator Senior for the Foster Care Review Program - confirmed that no new Foster Care Reviewers have been added, although he had difficulty remembering whether he had 12 or only 11 reviewers working for him at that point.

The December 2003 Statewide Self Assessment acknowledges that required annual judicial permanency hearings, meant "to promote and achieve a safe and permanent setting for children within time frames that are more conducive to their physical and emotional well-being, “are not being held as required, and IV-E funding is lost due to inadequate court orders.” For example, the DFCS IV-E Eligibility Unit reported that "court reviews were missed on an estimated 8% of the cases in July through September, 2002. It is estimated that as much as $200,000 dollars could be lost on those cases alone over the next year." Quality Improvement reports also indicate that
"permanency compliance orders were [only] in 54.3 percent of the case records and Permanency orders found in 38.7 percent of the cases reviewed." The Self Assessment also concedes that "[a]lthough MACWIS has the ability to track" the required annual judicial permanency reviews, "inadequate information has been entered." "Accuracy and timeliness of these hearings are not currently being measured."\textsuperscript{376}

The May 2004 CFSR Final Report likewise found that Mississippi is not in substantial conformity with the systemic factor requiring a case review system, including the following problems:

- MDHS/DFCS is "unable to consistently implement a process to ensure the periodic review of the status of each child, no less frequently than once every 6 months," either by a court or by administrative review.

- MDHS/DFCS is not consistently "ensuring that each child in foster care has a permanency hearing no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter."

- MDHS/DFCS does not "consistently provide a process for foster parents, preadoptive parents, and relative caregivers of children in foster care to be notified of, and have an opportunity to be in, any review or hearing with respect to the child."\textsuperscript{377}

The March 2005 PIP, however, concedes that DFCS has yet to determine a baseline percentage of children afforded a six-month administrative review (county conference or CC) within six months of custody and every six months thereafter, or a baseline percentage of children afforded an annual 12-month Permanency Hearing.\textsuperscript{378} Further, the March 2005 PIP plans to improve the percentage of foster children who have appropriate permanency plans, as well as increase the statewide percentage of children afforded six-month administrative reviews and annual Permanency Hearings, by "[c]ollaborat[ing] with CIP [the Court Improvement Project] and AOC [Administrative Office of Courts] to distribute monthly reports for county youth court judges that will improve the consistency of periodic review of the status of each child." The PIP plans to develop a Title IV-E Compliance Report (by June 2005) and a Periodic Review and Permanency
Hearing Report (by July 2005) “to provide to youth court judges to make them aware of Title IV-E compliance or non-compliance per county and [the] need for Permanency Hearings.” Before being released to the courts, these reports will be sent to the Regional Directors and counties for review and corrections to ensure data accuracy: the initial Compliance Reports will be ready for release by July 2005 and the initial Permanency Hearing Reports by August 2005. The DFCS Division Director and CIP Director will then meet with the Mississippi Supreme Court Chief Justice to initiate the monthly reports for the youth court judges, and a cover letter to the judges explaining the reports and expectations will be sent in July 2005. Copies of the reports will then be sent to the AOC, who will then forward them on to the youth court judges and also request responses from the judges. The AOC will then forward both the reports and the judges’ responses to the Mississippi Supreme Court Chief Justice. This process will occur monthly, beginning in July 2005 for the Compliance Reports and in August 2005 for the Permanency Hearing Reports. Finally, beginning in June 2005, periodic meetings between the DFCS Division Director, the CIP Director and the Mississippi Supreme Court Chief Justice will occur “to address identified trends or patterns based on the data,” “responses from the Youth Court Judges related to the monthly reports,” and “other court and agency issues impacting timely permanency.” A schedule of these meetings and notes will indicate that these meetings have occurred.379

ACF reviewed Mississippi’s second quarterly PIP progress report for July-September 2005 and found that MDHS had not yet completed any of the action steps due in the first two quarters of PIP implementation related to collaborating “with the [Court Improvement Project] and the [Administrative Office of the Courts] to distribute monthly reports for county youth court judges that will improve the consistency of periodic review.”380
(iii) Adoption Delays

Federal law requires that for children who have been in custody 15 of the last 22 months, a petition to terminate parental rights (TPR) be filed or an acceptable exception document. The Hess Case Record Review found that 79.7% of children in custody had been in MDHS custody for at least 17 months, yet MDHS failed to file a petition to free them for adoption or document a compelling reason for not filing a petition for the termination of parental rights (TPR). Of the children for whom a TPR petition was filed, 24.1% spent another two years or more waiting for TPR to be granted. Half of the children with a goal of adoption (51.0%) had been in MDHS custody for a total of 3 years or more; one in five (20.7%) had been in custody for a total of between 5 and 17.9 years. After being legally freed for adoption, 26.2% spent another 3 years or more in MDHS custody, up to as many as 11 years. MDHS failed to place 36.9% of the children with the goal of adoption in an adoptive home, and for 85.5% of children with this goal, MDHS made no efforts to identify an adoptive family for them in the two years covered by the review. For 34.1% of the children with the primary goal of placement or adoption with a relative, MDHS failed to identify any relative with whom the child could be placed or adopted.

Case Example

In a June 22, 2005 memorandum to a Jackson County supervisor, a foster care reviewer expressed concern at being unable to schedule nine county conferences on MACWIS for July 2005 due to part of the Youth Court Summary not being completed by the social worker. The foster care reviewer states, "We haven't had this many cases that I was unable to schedule in a long time. I think the last time I can remember was when we first went on-line." As of July 5, two weeks after the problem was brought to the attention of the county supervisor, five of those nine cases were still locked, four of which were still unable to have county conferences scheduled. Mem. from C. Dodge to M. Mathews. June 22, 2005, at DHS
MDHS's own Foster Care Review Program found that as of the first quarter of FY 2006, more than one out of every four (26%) children who had been in custody for 15 of the past 22 months and who had not been referred for TPR had no compelling reasons documented. In the previous quarter, approximately one out of every three (32%) children who had been in custody for 15 of the past 22 months and who had not been referred for TPR had no compelling reasons documented.

The Foster Care Review Program also found that as of the first quarter of FY 2006 41% of children with permanency plans of adoption did not have “steps in place” for the finalization of their adoptions within 24 months. “Agency staff was responsible for 36% of the barriers to achieving permanency through adoption within 24 months of entering states [sic] custody. These barriers include, but are not limited to, failure to complete a TPR referral, the court ordering a plan of TPR with the county completing the TPR referral in a timely manner but the referral was not processed [sic] through the agency’s state office in a timely manner, and county staff not appropriately returning petitions for TPR to the attorneys serving the agency in TPR matters.” During the previous quarter, 22.2% of children freed for adoption had no documented involvement with the Agency’s adoption unit.

Case Example

An August 2005 Foster Care Review reports that the permanency plan for fifteen-year-old Cindy "continues to be reunification although there is no evidence that the mother wants Cindy back or has attempted to secure reunification" and "the child does not want to return to her mother." According to the Foster Care Reviewer, Cindy has "on several occasions," "requested that her parents' rights be terminated soon." Though Cindy has been in care since October 2004, and her mother's parental rights have been terminated with respect to Cindy's sibling and half siblings, an adoption plan was not suggested for Cindy until August 15, 2005. The Foster Care Reviewer further reports that an assessment of the safety and appropriateness of Cindy's placement cannot be made. Cindy was returned to the foster home from which she was removed after another foster child in the home had sex with her, and "there is no documentation [at this time] that she has been seen since this move or that any other contact has been attempted with either Cindy or her foster parents to check on her adjustment," or to "verify that [the other foster child] is no longer in the home or that appropriate steps were taken to assure they would not have opportunity to be alone while he remains in the home." Periodic Administrative Determination, August 18, 2005 DHS 070023.
Mississippi’s Child and Family Services Review Data Profile, dated December 8, 2005, found that for Federal FY 2005 (ending September 30, 2005), of all children who exited care to finalized adoption, only 16.3% exited care less than 24 months from the latest date of removal. The national standard is 32% or more.\(^{387}\)

MDHS’s Self Assessment concedes that: “For those staff with a large caseload, the additional burden of TPR and adoption becomes secondary to crisis management. Additional staff and additional permanency training would help increase the number of finalized adoptions and lessen the ongoing caseloads in many areas.”\(^{388}\) The Self Assessment also notes that “many children are in foster placements that will never be adoptive resources for them. Prolonged stay in these foster resources, and the lack of adoptive resources willing to take older or more difficult to place children is increasing the length of stay for many of the children in care.” Inconsistent “social work practice and case coverage from county to county [also] has an impact on attaining permanent homes in a timely manner for children.”\(^{389}\) Inadequate assessments of the child’s background and poor matches between the child and the prospective parents also contribute to [adoption] disruptions.\(^{390}\)

The May 2004 CFSR Final Report likewise finds that in 80% of the foster care cases reviewed with a goal of adoption “the State had not made concerted efforts to achieve an adoption in a timely manner.” The lack of consistency in filing for TPR in a timely manner was attributed to “[DFCS] staff shortages, high caseloads, a failure to conduct diligent searches for absent parents early on in the case, and a lack of legal counsel.”\(^{391}\)

Aware that its TPR process is slow, MDHS still clings to a routine practice of waiting until the child is

**Case Example**

siblings Sandy and Shana have been in care since September 1998. A January 2005 Foster Care Review reports that “[w]hen adoption began as the plan, [Sandy] was 8 1/2 years old and [Shana] was 6 1/2. They are now 13 and 11," and TPR hearings have yet to be held. Periodic Administrative Determination, January 14, 2005. DHS 063809.
legally freed to assign that child an Adoption Specialist. Because only Adoption Specialists recruit potentially adoptive parents, MDHS practice piggybacks on a flawed TPR process to further compound children's wait for a permanent family. While children wait for families, approximately 50 families wait to be paired with them in the southern third of Mississippi alone. Such poor matching is the logical consequence of MDHS's decision to isolate the Social Worker responsible for foster children in every aspect except for adoption from the recruitment of adoptive parents for that child.

By 2005, MDHS had acquired unfilled vacancies in the Adoption Specialist position, bringing it below the number of 18 specialists (supporting the entire statewide program) that MDHS itself deemed inadequate in its Self Assessment.

---

Case Example

A foster care reviewer observed and reported in June 2005 that the "compelling reasons given by the social worker do not appear to be appropriate reasons to not pursue TPR for" a 12-year-old foster child in agency custody for 15 of the most recent 22 months. "The reasons given by the social worker are as follows: 'Worker has not submitted a TPR referral on [child] due to the probability that he would not be adopted if he were freed for adoption. Worker feels that [child] would not allow himself to be adopted by anyone that would not be [child's] own choosing. Worker feels [child] would make it extremely hard for himself to fit into a family if he did not choose to be adopted.'" (emphasis in original)Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review), July 7, 2005, at DHS 047712
V. CONCLUSIONS and RECOMMENDATIONS

An effectively functioning child welfare agency provides safety for children, support for families, and meets the needs of the children in foster care. This is accomplished through proper staffing and training, the development and provision of resources needed by families, and connecting the work within and across the agency so administration and communication is clear, open, and available to all employees. For the agency to remain effective in the work, performance accountability, feedback and results must be measured continuously. This review found the Mississippi child welfare agency to be dangerously under-staffed and untrained, and woefully lacking in any capacity to serve children and families. Even more frightening for children in MDHS custody is the lack of accountability or any method for effectively ensuring that children are being seen and, more importantly, kept safe.

Recommendations

This reviewer believes that in order for DFCS to become a successful child welfare agency all of the following recommendations must be completed from beginning planning stages through full implementation. In addition, an ongoing method for ensuring the maintenance of changes over time must be instituted. This reviewer does not believe that the MDHS organization is capable of meeting these recommendations without significant oversight and ongoing technical assistance.

I. Staffing and Training

There are simply not enough people to manage the work of DFCS in Mississippi. The staffing should be addressed across the board, including social work staff, support staff and supervision staff in the counties, and administrative staff in the State Office to provide leadership and gauge effectiveness of the work. Mississippi should adopt and adhere to the CWLA
recommended caseload standards for all areas of work. These standards are the maximum recommended. Specific recommendations include the following:

A. Personnel
1. Implement the CWLA caseload standards for child welfare as follows:
   Foster care cases = 12 to 15 children
   Child protective services cases = 12 families
   Adoption cases = 10 to 12 children
   Ongoing in-home cases = 17 families
2. Implement the CWLA supervisor to worker ratios at 1 to 5.
3. Increase the support staff (e.g. secretarial, case aids, transportation) necessary to properly support the direct service staff.
4. Increase the State Office administrative staff in the program areas of Foster Care, Child Protective Services, Adoption, Licensing & Monitoring, and Quality Assurance to properly guide and support the direct service staff.
5. Establish a streamlined hiring process that allows vacancies to be quickly filled.

B. Salaries
1. Increase social worker salaries to bring them up to current market rates.
2. Establish a career ladder salary range to increase the retention rate of social workers and supervisors.

C. Education
1. Maintain or establish minimum educational requirements that direct service social work staff have a Bachelor’s degree in social work and supervisory staff a Master’s degree in social work.
2. Establish and implement an educational reimbursement program for staff to pursue advanced degrees to increase the retention rate of social workers and supervisors.

D. Training
Develop and implement a family-centered practice training program that encompasses all of the following:
   • A comprehensive and easily understood curriculum;
   • An evaluation component both for the trainee and the trainer;
   • Resource materials for reference;
   • Pre-service training with an evaluation component to be completed prior to social workers assuming caseloads.
   • A supervisory training with an evaluation component to be completed within six weeks of supervisors assuming their positions;
   • An on-the-job training (OJT) period;
   • Required ongoing, formal in-service training for Social Workers and supervisors;
• Required and ongoing in-service training for foster and adoptive parents;
• A performance feedback mechanism for measuring quality of the training; and
• A regularly scheduled review, update, and revision of the training process to remain abreast of changes in statute, policy, and practice.

II. Administration

Leadership for this agency is one of the weakest links. Mississippi simply cannot continue to move the same people around on the same chess board using different fingers to plug the proverbial hole in the dike. There is a great need for competent leadership across the agency from people who are highly skilled in the field of child welfare. DFCS requires leaders who are dedicated to the strong advocacy necessary to obtain the resources needed to stabilize the agency and provide for the children and families that DFCS serves. It is recommended that Mississippi consider a national search for future top leadership candidates. Specific recommendations include the following.

A. Leadership
1. Revise the State Office organization to provide a standardized communication and feedback loop among the areas of Programs, Finance, and Personnel.
2. Revise the State Office and County Office organization to provide a standardized communication and feedback loop between the State and County offices in areas of Programs, Finance, and Personnel.
3. Organize the Program structure within the State Office around the areas of Safety, Permanency, and Well-Being.
4. Increase State Office staffing and provide administrative training for new staff in the areas of Foster Care, Adoption, Child Protective Services, Licensing & Monitoring, and Quality Assurance.

B. Quality Assurance
1. Obtain technical assistance to develop and implement an ongoing quality assurance system using a standard protocol to include case file, stakeholder, and staff reviews.
2. Establish and implement meaningful outcomes to measure progress in the areas of safety, permanency, and well-being.
3. Establish and implement a process for reviewing Quality Assurance protocols and making any necessary adjustments every three years.
III. Resources

Resources include both tangible tools to do the job as well as the funding of services for children and families. The ability to communicate quickly and process documents timely in meeting the safety, permanency, and well-being of children is an absolute necessity. The functioning of the MDHS MACWIS system is imperative so that all staff can monitor state and county staffing trends and advocate more effectively for necessary resources. To develop and access necessary resources DFCS requires funding in an amount sufficient to meet the needs of the children. Knowing what those needs are is critical to making the best use of available dollars. Specific recommendations include the following.

A. Communication Tools
1. Computer Access capability is a must for all employees. State Office and County staff must have access to E-mail and the State/Departmental Intranet. In addition, program area administrative staff should have Internet access.
2. Access to on-line reports through MACWIS and training in the use of these is necessary for State Office and County staff.
3. Glitches in the functioning and processing of information in the MACWIS system must be fixed. In particular, the inability to capture previous historical information from a family’s ISP or monitor the provision of services.
4. The duplication of work in the paper file and the MACWIS file should be eliminated.

B. Services to Children
1. A comprehensive Needs Assessment with recommendations from an outside technical resource is needed.
2. Technical assistance is needed in developing and implementing a resource development strategy for service development including a development of a standardized RFP process.
3. Licensing and monitoring of foster homes and facilities must have a standardized process developed and implemented, including an incident reporting, correction system, and penalty system.
4. Policy and procedure should be developed and implemented for criminal background checks of anyone assuming responsibility for a child’s care and in direct contact with children.
5. A recruitment plan to increase the number of foster and adoptive homes should be developed and implemented.
6. Placement of children in unlicensed homes, facilities, or institutions should be prohibited with associated penalties developed.
7. Practice improvements needed include the following:
   - Decreasing the number of adoption disruptions
   - Decreasing the use of congregate care and emergency shelter care
   - Prohibiting the placement of children under age six in emergency shelter care
   - Increasing the number of siblings placed together
   - Decreasing the number of child placement moves
   - Increasing the visitation between siblings and family members
1 Miss. Code Ann. § 43-1-51; § 43-15-5
2 MDHS website, www.mdhs.state.ms.us (last visited February 7, 2006)
4 Annie E. Casey Foundation, KIDS COUNT State Level Data Online, at 31-33, available at www.kidscount.org. KIDS COUNT is a national project of the Annie E. Casey Foundation that began in 1990 and tracks ten measures related to the status of children in the United States. The best data available is used to track children’s social, emotional, and educational well being for both the United States as well as the individual states. The goal of the data gathered by KIDS COUNT is to measure child outcomes and increase public accountability for children’s welfare. Since 1999, Mississippi has had the worst ranking of all the states in the U.S. at number 50. See also December 2003 Statewide Self-Assessment at P 001941.
5 Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER), A Follow-up Review of the Division of Family and Children’s Services of the Department of Human Services, May 11, 1999, at cover page
6 P 001935, from MS CFIS State Assessment
7 Child Welfare League of America, 11/1/92, at P 001210
8 December 2003 Statewide Self-Assessment, at P 001935
9 December 2003 Statewide Self-Assessment, at P 001936, 001945, March 2005 PIP, at DHS 038161
10 Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER), A Follow-up Review of the Division of Family and Children’s Services of the Department of Human Services, May 11, 1999, at cover page, 15-19
11 May 10, 1999 Letter, attached to Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER), A Follow-up Review of the Division of Family and Children’s Services of the Department of Human Services, May 11, 1999, at 31
12 DHS 062821
13 DHS 062903
14 August 27, 2001, P 000195.
15 May 8, 2002 letter, P 000153-55
16 October 2002, P 002144
17 Child and Family Service Review — Statewide Self-Assessment, December 2003
20 May 2004 CFIS Final Rpt., at 1, 3-4.
21 DFCS FY06 Budget Request Package, Attachment C, DHS 030742-46.
22 March 2005 PIP, at DHS 038159-038356
23 March 2005 PIP, at DHS 038162
24 March 2005 PIP, at DHS 038162
25 MS PIP, ACF Response to Second Quarterly Report, Dec. 11, 2005 at DHS 091690-691
26 DFCS FY07 Budget Request Package, DHS 053725
27 CWLA, Standards of Excellence for Foster Care Services (1995), at 113; CWLA, Standards of Excellence for Services for Abused or Neglected Children and Their Families (1999), at 137-38; CWLA, Standards of Excellence for Adoption Services (2000), at 101; CWLA, Standards for In-Home Aide Services for Children and their Families (1990), at 46.
28 P 001943, 2003 Self-Assessment
29 DHS 020088, MDHS – Division of Family and Children’s Services, Workload Information, October 6, 2004; Mangold 5/16/05 Dep. 66:16-67:9.
30 Direct Service Clients By Region, August 2005, DHS 091851-52
31 Simpson Dep. 11:4, 12:1-6
32 Henry Dep. 58:10-18, 59:3-14
33 DHS 053725, DFCS FY 2007 Budget Request Package
34 McDaniell Dep. 64:24-25
35 Mangold 5/16/05 Dep. 67:10-14.
36 FY 2006 MDHS Budget Request
32 Mangold 6/2/05 Dep. 63:7-64:1
33 March 2005 PIP, at DHS 038167; Mangold Dep. 6/2/05 Dep. 32:4-20
34 DHS 053725
35 FY2007 Budget, DHS 053725; Direct Service Clients By Region, August 2005, at DHS 091852.
36 DHS 091861
37 Hess Case Record Review Report, at Sec. IV.D
38 PIP, DHS038162
39 P 001945
40 Rogers Dep. 284:6-8; McDaniel Dep. 67:20-68:11, 68:19-69:12
41 Foster Care Review Summary Report Issues in Foster Children’s Cases, September 22, 2003,
42 DHS027224
43 PIP, DHS038162
44 Mangold 6/2/05 Dep. 14:15-15:8, 18:16-21, 19:6-17, 22:15-17
45 Rogers Dep. 285:18-23
47 McDaniel Dep. 14:19-20
48 December 2003 Statewide Self Assessment, P 001940, 001958-59, 001979; March 2005 PIP, DHS
49 038178 -79
51 December 2003 Statewide Self Assessment, P 001984-87
52 McDaniel Dep. 110:4-18; Trippett 6/1/05 Dep. 31:24-32:21; December 2003 Statewide Self
54 Trippett 6/15/05 Dep. 32:25-33:9.
55 McDaniel Dep. 116:8-11.
56 Trippett 6/15/05 Dep. 39:8-16.
57 PIP, DHS038178
58 Trippett 6/15/05 Dep. 41:14-19; March 2005 PIP, DHS 038178
59 December 2003 Statewide Self Assessment, P 001990, 92.
61 DHS 53709-53710, FY 2007 Budget Request Package
62 DHS 53711-53712, FY 2007 Budget Request Package
63 DHS 019270, State Level Citizens Review Board, May 2004
64 CWLA Standards of Excellence for Foster Care Services (1995), 113-14
65 March 2005 PIP, DHS 038177
67 McDaniel Dep. 77:6
68 42 U.S.C. § 675(1); MS Policy Manual, Revised 05-01-99, at DHS 00161-62
69 Hess Case Record Review, at Sec. VII.B
70 Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review), June 9,
71 2005, at DHS 047670
72 Foster Care Review Monthly Case Status Report (Issues Observed During Foster Care Review), June 9,
73 2005, at DHS 047670
74 Rogers Dep. 265:14-266:10; Miss. Code Ann. § 210.112(4)(3); MS Policy Manual, Revised 5-1-99, at
75 DHS 00420.
76 Rogers Dep. 243:9-14, 244:5-8
77 DHS 088835
78 Mangold 6/04 Dep. 22:11-14; DHS 088835
79 DHS 088835
80 December 2003 Statewide Self Assessment, at P 002075
81 Mangold 5/16/05 Dep. 68:11-25.
82 Mangold 5/16/05 Dep. 38:21-25
83 Mangold 6/2/05 Dep. 83:22-85:10, 85:15-21, 86:2-10
84 Trippett 6/15/05 Dep. 98:1-99:22
85 Mangold 6/04 Dep. 20:14-21; 22:18-25
Mississippi State Personnel Board, Statewide Payroll and Human Resources System (Oct. 11, 2005); Pin History of Current and Past Employees (Sept. 30, 2005).

May 2004 CFSP Final Rpt., at 78

Memorandum w/ attachments, McDaniels to Felder, July 11, 2005, DHS 066328-30 (emphasis in original)

December 2003 Statewide Self-Assessment, at P 001936, 001945, March 2005 PIP, at DHS 038161


DHS Program Improvement Plan (PIP), March 2005

C. Billy Mangold, 8/25/04 14:19-20

MS PIP, ACF Response to Second Quarterly Report, Dec. 11, 2005 at DHS 091690-691

Mississippi Program Improvement Plan, ACF Response to Second Quarterly Report, December 11, 2005, at DHS 091690-1

Letter from C. Williams to R. Felder, November 10, 2005, at DHS 091817; Email from C. Pike to R. Felder, December 13, 2005, at DHS 091837.

May 2004 CFSP Final Rpt., at ??


December 2003 Statewide Self Assessment, P 001939, 002008, 002029, 002044

December 2003 Statewide Self Assessment, P001995-96, 2033-34

December 2003 Statewide Self Assessment, P001995-96, 2033-34; Mangold 6/2/05 Dep. 32:4-20

December 2003 Statewide Self Assessment, P002000

Brister Fiscal Report, XIV

March 2005 PIP, at DHS 038171

Young 10/2/04 Dep. 76:25-77:1.

March 2005 PIP, DHS 038172

January 2004 CFSP Final Rpt., at 11, 72, 75

Young 10/20/04 Dep. 16:12-17; December 2003 Statewide Self Assessment, at P002016, P001999, P002077, P001935-36, P001940, P002079-80.

Rogers Dep. 81:13-17; 82:7-12; 281:15-16; McDaniels Dep. 79:5-8.

42 U.S.C. § 672

Mangold 8/25/04 Dep. 66:22-67:16; 68:4-18; Young 10/20/04 Dep. 79:1-6

May 2004 CFSP Final Rpt., at DHS 058975

Mangold 8/25/04 Dep. 37:13-18; March 2005 PIP, at DHS 038188

May 2004 CFSP Final Rpt., 60-61

DHS 068717, September 14, 1999 PEER Report to the Mississippi Legislature, #397, p.4

DHS 088995, Draft Mississippi March 2005 Site Visit Summary


Hess Case Record Review, Sec. VII.B

Wilson 5/16/05 Dep. 60:13-61:8


Mangold 6/2/05 Dep. 82:16-83:5

Mangold 6/2/05 Dep. 79:11-14


March 2005 PIP, at DHS 038188

Mangold 8/25/04 Dep. 98:24-99:6

December 2003 Statewide Self Assessment, at P 001952-53

Young 5/16/05 Dep. 26:4-5, 25:11-13

McDaniel Dep. 70:6-14

McDaniel Dep. 11:8-25


Hamrick Dep. 91:14-92:5

McDaniel Dep. 182:19-22

Henry Dep. 20:11-20

DFCS Organizational Charts, DHS 019809
December 2003 Statewide Self Assessment, P 002064
Rogers Dep. 191.5-10
May 2004 CFSR Final Rpt., at 30-31
Rogers Dep. 190:23-191:4
Rogers Dep. 187.9-24
Weekly Shelter Care Report, December 16, 2005, at DHS 092875-76
MDHS Item 6: Stability of Foster Care Placements / Emergency Shelter Care For the Month of May, 2005, June, 10, 2005, at DHS 044681-044735
Mississippi Program Improvement Plan, ACF Response to Second Quarterly Report, December 11, 2005, at DHS091701-DHS091702; DHS091689-091728
Hess Case Record Review, at Sec. V.C
Therapeutic Foster Care Placement Log/Pending Placements, July 2005-January 2006, DHS 091892-091917
Licensed Foster Homes, January 12, 2005, DHS 019272-019440
May 2004 CFSR Final Rpt., at 27
DHS 037277-037399 DHS Custody by Placement Type
Mem. from W. Gillom to DFCS staff, February 26, 2003, DHS 047277
Licensed Foster Homes, January 12, 2005, DHS 019272-019440
May 2004 CFSR Final Rpt., at 80
Licensed Foster Homes, January 12, 2005, at DHS019272-DHS019440
MS Policy Manual DHS 00136-137; DHS 00368.
NP 06369,06440,06423-06424
December 2003 Statewide Self Assessment, P002057
Triplette 6/14/05 Dep. 85:2-7, 14-17
CWLA FC 2.36, COAS21.2.01a, S21.10.02
May 2004 CFSR Final Rpt., at 40
Hess Case Record Review, at Sec. VII.H
May 2004 CFSR Final Rpt., at 42
Hess Case record Review, at Sec. VII.G
Hess Case Record Review, at Sec. VII.I.
March 2005 PIP, DHS038166
March 2005 PIP, at DHS 038215
Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 071000
Foster Care Review Program Quarterly Regional Comparison Report, 3rd Quarter FY 2005, DHS 047097-047098
42 U.S.C. 671§ (a)(15)
MS Code of 9172 § 43-15-13; MS Polocy Manual at DHS 00397, 00416-00417, 00467
Rogers Dep. 240.8-12
March 2005 PIP, at DHS038215.
March 2005 PIP, DHS 038214
Foster Care Review Program Quarterly Regional Comparison Report, 4th Quarter FY 2005, at DHS 063543.
Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 071001.
March 2005 PIP, DHS 038166
May 2004 CFSR Final Rpt., at 39
Young 6/15/05 Dep. 93:17-97:1
May 2004 CFSR Final Rpt., at 39
December 2003 Statewide Self Assessment, p. 104
McDaniel Dep. 140:24-141:14; Rogers Dep. 150:4-13, 150:18-22
MS Policy Manual DHS00405
May 2004 CFSR Final Rpt., at 30-31
Hess Case Record Review, at Sec. III & IV.A
December 2003 Statewide Self Assessment, P002071-72.
Number of Placements for Children in Active Custody as of 10/31/05, November 15, 2005, at DHS 086435.
Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 070992-93.
Hess Case Record Review, at Sec. IV.A
December 2003 Statewide Self Assessment, P001935-36
December 2003 Statewide Self Assessment, P001939, 2027, 2058
May 2004 CFSR Final Rpt., Ex. at 48
May 2004 CFSR Final Rpt., at 31-32
McDaniel Dep. 164:10-12
May 2004 CFSR Final Rpt., at 31-32
Hess Case Record Review, at Sec. IV.A
McDaniel Dep. 147:6-10
Mississippi Program Improvement Plan, ACF Response to Second Quarterly Report, December 11, 2005, at DHS091728
MS Policy Manual at DHS00392, DHS 00772
Mangold Dep. 5/16/05 Dep. 28:24-25:11, 30:19-22
Young 6/15/5 Dep. 73:17-74:9
McDaniel Dep. 27:18-28:1
Henry Dep. 53:24-54:6; May 2004 CFSR Final Rpt., at 70; Rogers Dep. 75:3-76:3
MDHS Bulletin No. 5692-2000
Hess Case Record Review, at Sec. IV.C
Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 071080.
March 2005 PIP, at DHS 038167, DHS 038224
Bulletin No. 5692, December 4, 2000, DHS
March 2005 PIP, DHS 038224
Rogers Dep. 67:11-14
McDaniel Dep. 81:9-11.
Licensed Foster Homes, January 12, 2005, at DHS 019272-440. Included are two “dummy homes” with addresses of “do not delete, jackson, MS.”
FY 2006 MDHS Budget Request
May 2004 CFSR Final Rpt., at 68
December 2003 Statewide Self Assessment, P002038-39
December 2003 Statewide Self Assessment, P001995, 2033
May 2004 CFSR Final Rpt., at 80
Foster Care Review Program Quarterly Regional Comparison Report, 3rd Quarter, FY 2005, at DHS 047115
327 Hess Case Record Review, Sec. V.C
328 Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 071008.
329 Foster Care Review Program Quarterly Regional Comparison Report, 4th Quarter FY 2005, at DHS 063548.
330 December 2003 Statewide Self Assessment, at P 001940, 002082
331 December 2003 Statewide Self Assessment, at P 001939
332 May 2004 CFSR Final Rpt., at 58-59
333 Wilson 5/16/05 Dep. 34:7-35:3
334 March 2005 PIP, at DHS 038230
336 Hess Case Record Review, at Secs. VI.A-D
337 Hess Case Record Review, at Sec. VI.E
338 December 2003 Statewide Self Assessment, at P 002077
339 March 2005 PIP, at DHS 038166-67, 038227
340 Wilson 5/16/05 Dep. 34:7-35:3
342 Hess Case Record Review, VIII.D
343 DHS 084966.
344 December 2003 Statewide Self Assessment, P 002067, 002074-75
345 December 2003 Statewide Self Assessment, P 002067, 002074-75
346 May 2004 CFSR Final Rpt., at 1, 30-34
347 MS POLICY MANUAL DHS 03288
348 MS Policy Manual, DHS 00395, 3297-3298, 3447-3448
349 Hess Case Record Review, at Sec. VII.B
350 Hess Case Record Review, at Sec. VII.C & D
351 Hess Case Record Review, at Secs. VII.E-G, J
352 Hess Case Record Review, at Sec. VIII.B
353 Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 071004.
354 Foster Care Review Program Quarterly Regional Comparison Report, 4th Quarter FY 2005, at DHS063546.
355 March 2005 PIP, at DHS 038206-07, 038276
356 December 2003 Statewide Self Assessment, P 001938-40, 001956
357 May 2004 CFSR Final Rpt., at 62
358 May 2004 CFSR Final Rpt., at 33-35
359 May 2004 CFSR Final Rpt., at 46, 52-53
360 March 2005 PIP, at DHS 038177
361 March 2005 PIP, at DHS 038173-038174
362 Hess Case Record Review, VII.D
363 March 2005 PIP, at DHS 038181
364 March 2005 PIP, at DHS 038181
366 MS Policy Manual 3273
367 May 2004 CFSR Final Rpt., at 45
368 March 2005 PIP, at DHS038219
369 December 2003 Statewide Self Assessment, at P 00212-13
370 MS Policy Manual, at DHS 03446
371 Hess Case Record Review, at Sec. VIII.C
372 Foster Care Review Program Quarterly Regional Comparison Report, 3rd Quarter FY 2005, DHS 047095
373 Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 071005
374 December 2003 Statewide Self Assessment, at P 001958, 001960, 001965
375 Hamrick Dep 8:20-23
December 2003 Statewide Self Assessment, at P 001963, 001967-68, 001977
May 2004 CFSR Final Rpt., 61-64, 66
March 2005 PIP, at DHS 038236
March 2005 PIP, at DHS038172-DHS038173, DHS038279-DHS038280, DHS038326-DHS038329.
Mississippi Program Improvement Plan, ACF Response to Second Quarterly Report, December 11, 2005, at DHS091702
42 U.S.C. § 675(5)(E)
(Hess Case Record Review, Section IX.)
Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 070994
Foster Care Review Program Quarterly Regional Comparison Report, 4th Quarter FY 2005, at DHS 063541.
Foster Care Review Program Quarterly Regional Comparison Report, 1st Quarter FY 2006, at DHS 070995.
Foster Care Review Program Quarterly Regional Comparison Report, 4th Quarter FY 2005, at DHS 063541.
Mississippi Child and Family Services Review Data Profile, December 8, 2005, Ex. __, at DHS091828.
December 2003 Statewide Self Assessment, at P 002068
December 2003 Statewide Self Assessment, at P 002077, 002075
May 2004 CFSR Final Rpt., at 74
May 2004 CFSR Final Rpt., at 65
Millsaps Dep. 79:15-80:1
Mangold 5/16/05 Dep. 41:15-41:25.
Mangold 5/16/06 Dep. 42:4-42:24.
Appendix A
Catherine R. Crabtree

3949 Jasmine Hill Road
Wetumpka, AL 36093

Phone: (334) 567-0665
Fax: (334) 567-0660
E-mail: thegeneralsehouse@aol.com

Experience

2003-Present
Consultant Services
Montgomery, AL

- Child welfare and juvenile justice expert court consultation.
- Organizational consulting, quality improvement, program development, evaluation and assessment, child advocacy assistance, mediation services, strategic planning, government relations, and business development.
- Consulting services to public and private agencies working with children and families.
- Retained as Interim Director of Quality Assurance, Alabama Department of Human Resources

2001-2003
Tennessee Department of Children’s Services
Nashville, TN
Assistant Commissioner, Compliance

- Responsible for implementation monitoring of child welfare practice reforms through Compliance Division of the DCS federal settlement Brian A. v. Sundquist.
- Technical resource to DCS staff, outside agencies, legislators, and the general public in interpretation of the Settlement Agreement.
- Provided ongoing monitoring of the welfare of the named children in the Settlement Agreement.
- Reviewed and approved all contracts related to the Settlement Agreement.
- Finalized needs assessment expenditures related to the Settlement Agreement.
- Provided oversight for a racial disparity study, salary compensation study, graduate stipend program development, and IV-E training revenue maximization study.

Assistant Commissioner, Program Operations

- Responsible for child welfare, juvenile justice, and prevention programs for five regions of the state.
- Oversight of program operations in five regions including budgeting, staffing, programming, training, and resource development.

**July-December 2000**

**Science Applications International Corp.**

**Oak Ridge, TN**

**Director of Government Services**

- Developed and implemented organization transitional and training initiative for government and business.
- Member of team developing cultural change initiative for organizations.
- Led planning for child advocacy center perpetrator tracking system project.
- Facilitated legislative monitoring, tracking, lobbying.

**1995-2000**

**Tennessee Department of Children’s Services**

**Nashville, TN**

**Assistant Commissioner**

- Planned, developed, and implemented new department of state government (Department of Children’s Services) merging 3000 employees and budgets totaling $370 million dollars.
- Responsible for child welfare, juvenile justice, and prevention programs for the State of Tennessee for central office and field operations.
- Oversight of staffing, budgeting, training, resource development, and administrative functioning of the twelve regions of DCS.
- Member of Governor’s legislative team writing and passing key legislation including: creation of the new Department of Children’s Services, inclusion of Adoption and Safe Families Act into Tennessee statute, the Tennessee Foster Parent Bill of Rights, and departmental improvement legislation resulting in an additional $15 million dollars to the DCS budget.
- Created regional Health Units across the state to improve health care access to children in state custody.
- Facilitator in development of state’s first managed health care networks for TennCare (Medicaid) eligible children.
- Initiated and chaired first DCS project committee on development of federal SACWIS TNKIDS Information System.
- Created an implementation review process for monitoring and auditing casework performance in the field.

**1994-1995**

**East Tennessee Community Health Agency**

**Knoxville, TN**

**Director of Children’s Services**

- Administrator of a 15 county region with 75 employees for program serving children in state custody and prevention programs for those at risk of state custody.
• Developed and chaired first Regional Utilization Group in the state responsible for development of a managed care review methodology in social services child custody arena.
• Developed policy and procedure in relation to programming for child population served by the agency.
• Developed monitoring and reporting mechanisms to improve service delivery to children and families.

1993-1994  Peninsula Lighthouse
            Knoxville, TN
Director of Mental Health Programs
• Developed a new service of Peninsula Psychiatric Hospital that provided an outpatient day treatment program for psychiatric patients.
• Responsible for budgeting, staffing, training, and administrative supervision of staff.
• Provided individual clinical counseling and group and family therapy to psychiatric outpatient population.

1991-1993  The Krisland Group
            Knoxville, TN
Vice-President
• Group communication and facilitation training using process communication therapy as basis of work with business and industry clients.
• Outplacement counseling for employees and groups in transition from job loss.

1987-1989  Peninsula Psychiatric Hospital
            Louisville, TN
Director of Admissions
• Developed the first Admissions Department for the hospital.
• Responsible for the administration of the department including budgeting, training, staffing, and liaison with surrounding area hospitals.

1982-1987  Private Practice
            Knoxville, TN
Psychological Examiner
• Conducted testing and assessment using MMPI, intelligence tests, and projective tests with children, adolescents, and adults.
• Provided court consultation and testimony, and individual and group therapy with children, adolescents, and adults.
• Developed and taught seminar on Child Behavior Management for University of Tennessee Continuing Education division.
1979-1982 Cherokee Mental Health Center
Morristown, TN

Community Liaison
- Provided pre-adjudication screening for juvenile courts in six counties for assessment and treatment needs of juvenile offenders.
- Administrator for Law Enforcement Planning Grant (LEPA) to provide consultation and education to local youth shelters, juvenile courts, and law enforcement agencies for juvenile offender mental health concerns.
- Provided group and individual therapy for children and adolescents.
- Provided classroom behavioral observation and consultation with local schools in a six-county area.

1977-1979 East Tennessee Human Resource Agency
Knoxville, TN

Program Counselor
- Provided counseling to adolescents in a specialized program for juvenile offenders “Youth Opportunities Unlimited”.
- Developed and implemented a weekend wilderness program for this same population.

EDUCATION
1977 University of Tennessee Knoxville, TN
- B.S. Education
1982 University of Tennessee Knoxville, TN
- M.S. Educational Psychology

LICENSURE and CERTIFICATION
Psychological Examiner, State of Tennessee; License #PE925 (inactive)
Civil Mediation certification

PUBLICATIONS and PAPERS


HONORS