

The background image shows a rural landscape with rolling hills under a clear sky. A paved road curves through the middle ground. In the foreground, a wooden fence with several posts and a strand of barbed wire is visible. The fields are a mix of green and golden-brown, suggesting a late summer or autumn setting.

Oklahoma Department of Human Services Performance Audit

Prepared for the
Oklahoma House of Representatives
by Hornby Zeller Associates, Inc.

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Hornby Zeller Associates, Inc.

Principal Authors:
Dennis E. Zeller, Ph.D., M.S.S.W.
Helaine Hornby, M.A.
Edward Cotton, B.S.

48 Fourth St. Suite 300
Troy, NY 12180
518.273.1614
ny@hornbyzeller.com

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Helaine Hornby, M.A.
Dennis E. Zeller, Ph.D., M.S.S.W.

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Executive Summary

When the Oklahoma House of Representatives requested proposals for a performance audit of the Department of Human Services (DHS) in the late spring of 2008, its focus was on child welfare but its request was broader. One of the primary concerns was the absence of a formal organizational connection between the program and policy staff in some divisions and the caseworkers and supervisors in the field. A second major area of concern related to personnel. Like many human service agencies across the country, DHS was exhibiting high rates of turnover, meaning that many positions were vacant, many positions were filled by staff still in their pre-service training (and therefore not working with a caseload) and much of the cost to hire and train new staff was wasted because so many of the staff left shortly after starting the job. Finally, the House was responding to myriad complaints from constituents, many of them foster parents, who felt themselves ill-treated by DHS.

These concerns could not be addressed adequately without gaining a full understanding of how well the agency serves families, the results it achieves, and how its policies and programs are structured. Therefore, Hornby Zeller Associates, Inc. (HZA) has structured its study and this report around five large topics:

- the results DHS achieves for its clients;
- policy and program implementation;
- the supply, training and retention of foster care providers;
- its organizational structure, management and controls; and
- personnel and training, including retention and turnover.

Results DHS Achieves for Its Clients

Oklahoma had its most recent federal Child and Family Services Review (CFSR) in 2007 and did not pass any of the seven outcomes which measure whether children brought to the attention of the child welfare system are kept safe, whether they attain permanent homes and whether they achieve reasonable physical, mental, emotional and educational functioning. While the judgment depended in large part on the review of only 65 cases, a deeper understanding of the state's performance can be gleaned from six statewide indicators which are also part of the federal review. Two of these measure safety and four measure permanency. These indicators focus on the *entire population of children in state custody* and the standards are not 95 percent achievement as with the 65 cases but rather with a standard set at the 75th percentile among all states, i.e., to meet the national standard a state must be among the top 12 or 13 states in the country.

On none of the six indicators did Oklahoma meet the national standard, and on two of them, those related to the frequency of moves of children while in foster care and to reunification it fell into the bottom half of all states.

The frequency of moves is a significant problem because children need some sense of predictability in their lives and for that they need, at a minimum, a stable home even if not their own. In measuring each state's performance in achieving placement stability, the federal government calculates the percentage of children who have experienced two or fewer placement settings and does so for three groups of children: those in care less than one year, those in care one to two years and those in care over two years. For every group, Oklahoma falls far into the bottom half of all states. In fact, in no age group, not even those under two years of age, is DHS able to provide as stable a living arrangement in the *first three months* of state custody as half of the states provide in the *first year*.

Once children are removed from home it takes too long from them to be reunified or adopted compared to other states. On the most straight forward of the federal measures related to the time to reunification, Oklahoma shows its worst results. Among children entering care for the first time, *in Oklahoma fewer than one-third return home within one year, compared to 40 percent or more in half of the states and to a national standard of 48 percent.*

Even for adoption, which DHS considers one of the state's strongest programs, among five different ways of measuring success, again encompassing all children in DHS custody, Oklahoma met the 75th percentile on only one.

While the CFSSR can rightly be criticized on a number of grounds, it provides the only means of comparing performance on a wide variety of factors across states. Moreover, the worst features of CFSSR measurement have been addressed and at least partially corrected during the second round of reviews. While no state reaches substantial conformity or the national standard on every single measure, Oklahoma does not do so on any of the seven outcomes.

There is one metric the federal government does not address, and perhaps it is the most important: a state's effort and ability to keep children safe with their own families in the first place, or, stated in the opposite direction, the placement rate or proportion of the state's children who wind up in foster care. Even here, Oklahoma does not fare well. Among the 50 states, only Nebraska has a higher proportion of its children in foster and group care. In Oklahoma 13.4 children out of every 1000, more than one percent of the

entire child population, are in DHS custody and out of their homes on any given day.¹ The national average is 6.9 per 1000, Oklahoma has nearly twice the placement rate of the entire nation.

These data suggest that the concerns heard by the House of Representatives relating to child welfare do in fact translate into poor outcomes for children in all the other areas.

Policy and Program Implementation

Legal Issues

In Oklahoma law enforcement is charged with the physical removal of children from their homes in child protection cases. Moreover, under “standing orders” in Tulsa and Oklahoma Counties, which are explicitly allowed in statute, including the proposed revision of Title 10, police can remove children without prior case specific judicial approval and *without DHS participation* of any kind, yet put them under the jurisdiction of the Department by placing them in the state-operated shelters. While law enforcement is permitted to remove children in most states, Oklahoma is nearly unique both in prohibiting DHS from doing so, and in not requiring its involvement in assuming custody. The result is that social work decisions about child safety are being made by law enforcement, not by the social workers. In addition, DHS cannot overturn those decisions without court approval.

The situation is similar with district attorneys in Oklahoma. The American Bar Association’s **Standards of Practice for Lawyers Representing Child Welfare Agencies** describe two models used throughout the United States: the Agency Representation Model and the Prosecutorial Model. The ABA recommends use of the Agency Representation Model; Oklahoma uses the Prosecutorial Model. In this model the district attorney represents “the state” rather than DHS in deprived children’s proceedings, and DHS is not even a party to the case. The prosecutorial model gives the district attorney the power to make decisions regarding the safety of children. In theory they are making decisions only about the sufficiency of the evidence; in practice they are making decisions about safety since the result in most instances is keeping children out of their homes.

¹ The number of children in foster care is based on 2005 data, the latest available for the whole nation. Oklahoma’s foster care population increased from 11,393 in 2005 to a high of 12,222 between 2005 and 2007 and has now dropped to about 10,297. If all the other states stayed the same, Oklahoma’s placement rate would now be 12.1 per thousand, placing it behind only Nebraska and Oregon.

Policy and Practice Issues

Intake

There are three separate hotlines operating in Oklahoma at this time, and there is no consistency in how they function or even in what their staff believe their roles to be. In addition, each county office accepts its own calls during the day, bypassing the statewide hotline altogether.

Among the three hotlines, there is no taping or monitoring of calls and no training for hotline staff which is specific to that function, as found in other states. The standards for determining what is to be investigated, what is to be assessed and what is to be turned away, differs from place to place, with Tulsa County showing far more assessments than Oklahoma County. Moreover, when calls are taken by individual county offices, instead of by the hotlines, in many instances the call takers are clerical staff not trained in interviewing. It seems fair to say that the function of taking referrals of abuse and neglect is inconsistent throughout the state and does not meet some basic standards that should be present in the first line of contact to an agency responsible for protecting children and vulnerable adults.

Priority Assignment

Abuse and neglect referrals receive “priority” assignments so staff know how quickly to respond. In Oklahoma’s priority system Priority One reports indicate that the child is in imminent danger of serious physical injury. The situation is responded to on the day the report is received. Priority Two reports indicate there is no imminent danger of severe injury but that without intervention and safety measures it is likely the child will not be safe. Priority Two investigations or assessments are initiated within two to 15 calendar days from the date the report is accepted for investigation or assessment.

While there may be other states which allow up to 15 days for initiating an investigation, HZA is not aware of any. This is an extraordinarily long time period and it is unclear what conditions would suggest that intervention into the family is necessary but can wait for that length of time.

Removal Criteria

For many years, child protection agencies struggled with the fact that a significant number of children who had been the subject of a child abuse or neglect investigation were being abused or neglected again within a relatively short time period after the first incident. After a few research projects in the late 1970s and early 1980’s, a risk assessment matrix was developed in several states, including New York and Illinois. These were short, somewhat generalized documents that focused on specific factors

that indicated a child was likely to be re-abused. These matrices led to enough improvement that additional research was conducted to attempt to further enhance them.

By the early 1990s it became clear that the risk assessments were adequate for identifying elements that might lead to some future abuse or neglect, but not in determining whether a child was in immediate danger. That led the field to make a distinction between risk and safety in terms of child maltreatment, to define and test criteria for each, to develop separate protocols.

Risk was defined as being the likelihood that there would be a subsequent incident of child abuse and neglect. Risk assessment protocols were understood to be used as structured decision making instruments that helped focus the case plan on what issues needed to be resolved in a family so that the children could live at home without being subject to maltreatment. They did not, however, address immediate safety issues and were therefore not useful in assessing the imminent dangers to a child which should drive the removal decision.

Safety was defined as the threat of serious harm by child abuse and neglect in the very near future. Child endangerment or safety assessments, were designed to identify those factors present in a family situation that must be ameliorated if the child is not to be removed. Harm is seen as imminent and could occur in the immediate future. Rather than identifying factors that must be *resolved* (as is done by risk assessments), these assessments identify factors that must be *controlled* until longer term services can be provided. If a safety factor is identified, a safety plan must be put in place to control that factor, or the child must be taken into protective custody.

DHS requires the use of both a safety assessment and a risk assessment protocol. However, the case record reviews performed by HZA found only a small number of risk assessment documents and even fewer safety assessments. During interviews with staff, workers often expressed confusion about the difference between the two. There was no strong feeling that either of these practices was important to their work.

For either of the safety or the risk protocols to be successful, it is critical that structured decision making processes be ingrained in all DHS child welfare staff and private agency workers who have contact with the children. These caseworkers, supervisors, and managers must be able to demonstrate proficiency at identifying both risk and safety, and must be held accountable for their decisions. It is also critical that assessing safety should occur throughout the time a case is opened to the child protection agency or with any of the agency contractors.

The lack of a safety culture is likely to have two impacts. On the one hand, it is almost certainly a major contributor to the state's high placement rate. If there is not a special focus on safety, safety cannot be the criterion for removal. On the other hand, not

focusing on safety is likely to leave some children in danger. Even though the agency uses broader criteria for removals, some situations in which a child is in imminent danger are likely to fall outside whatever criteria are being employed. Until safety becomes the criterion for removal and reunification, children are likely to lose in both directions, some by being in care unnecessarily and some by not being in care when they need to be.

Use of Shelters

For over half the children removed from their homes in Oklahoma, the first stop is a shelter. Some are fairly large and institutional, most notably the publicly run shelters in Tulsa and Oklahoma counties. There are also other types including contracted shelters, private shelters, host homes and tribal shelters.

Shelters are impersonal and potentially frightening for young children (who constitute most of DHS's population) and almost certainly damaging to newborns. Children who are exposed at very young ages to environments that are not supportive and stable, or do not feature a positive, nurturing relationship with a consistent adult, often have a disrupted development, which can cause lasting consequences. Lack of physical contact or interaction with a mother can change an infant's body chemistry, resulting in lower growth hormones necessary for brain and heart development.

Even if the children do not stay long (although the policy limits are frequently violated), shelters guarantee an extra placement move (unless the child goes home quickly, in which case one wonders how the placement could have been avoided in the first place). Placement moves have been shown to result in worse outcomes for children and they are one reason Oklahoma fails on one of the federal measures.

In addition, the shelters are costly. In state fiscal year 2008 the shelters operated by the state in only the two largest counties cost over \$8.3 million. Because the shelters are publicly run and have capacities of more than 25 children, their use is not reimbursable under Title IV-E of the Social Security Act. Currently, DHS pays for the shelters with federal Temporary Assistance for Needy Families (TANF) funds, but as noted elsewhere in this report, those very flexible funds are becoming less available.

Services

If more children are to remain safely at home in Oklahoma, the system will need to have a strong set of services to provide to the families of those children. DHS has devised a fairly unusual system with its Oklahoma Children's Services whereby families are referred for services without keeping the case open. When that system works, it is highly commendable because it reduces DHS involvement and coercion yet provides help to families. When it doesn't work, however, is when the agency feels as if it needs more oversight of the family than a preventive services case would allow, forcing it to turn to the placement of children to achieve that goal. The high placement rate suggests

that the middle ground of providing services to families in the home *while DHS or even court supervision is maintained* should be used more often in lieu of removal.

Supply, Training and Retention of Foster Care Providers

As with other parts of the system, there is great variation among regions and even counties in the supply of licensed homes relative to the need, as reflected by the population in foster care. Statewide an additional 2626 beds in non-relative family foster homes are needed. This number would provide caseworkers choices, when a friend or relative cannot be found, as is currently the case for over 6000 children, in selecting a family that is suitable to the child.

Recruitment and retention efforts also need to take into account how long a given family will stay with DHS. HZA performed a “survival analysis,” tracking families for five years at three different starting points, 2000, 2001 and 2002 (we used these historical dates to allow five years to elapse).

By one year after licensure, 22.6 percent of the foster families have left; by two years, 41.9 percent of that original group has left; by three years 56.1 percent have left; by four years, 65.9 percent have left and by five years, 73.6 percent have left. These data suggest that the largest proportion who leave – over 22 percent – leave within the first year. While the decline lessens, it is steady and averages about 15 percent per year for any given group. And when assessing all groups together, there is a 46 percent turnover per year in foster homes.

One issue affecting both the recruitment and retention of foster parents is the level of reimbursement. Oklahoma set its current standard for reimbursing foster parents in 1982 based on data provided by the US Department of Agriculture on the Cost of Raising a Child in the Urban South. This was standard practice at that time. While increments have been made to the rate since then, the basic methodology has been abandoned because raises have not kept up with the cost of raising a child. There are three rates, based on the age of the child: \$365 per month, birth to five; \$430 per month, six to twelve; and \$498 per month, 13 and over.

Three national organizations published **Hitting the M.A.R.C.²: Establishing Foster Care Minimum Adequate Rates for Children** which sets a basic foster care rate and adjusts it for each state. The rate was calculated by analyzing consumer expenditure data reflecting the costs of caring for a child; identifying and accounting for additional costs particular to children in foster care; and applying a geographic cost-of-living adjustment, in order to develop specific rates for each of the 50 states. The Foster Care M.A.R.C. includes adequate funds to meet a child’s basic physical needs and cover the

² M.A.R.C. = Minimum Adequate Rates for Children

costs of “normalizing” childhood activities, such as after-school sports and arts programs, which are particularly important for children who have been traumatized or isolated by their experiences of abuse and neglect. Assuming the validity of the M.A.R.C., Oklahoma’s current foster care rates would be increased by up to 53 percent, depending on the age of the child, to cover the real costs of providing care for children. In its current budget request DHS has asked for over \$21 million in rate increases to reach the M.A.R.C. as well as for corresponding increases in adoption subsidy funding.

Two other areas posed the largest financial concerns to foster families: clothing allowances and transportation costs. DHS allows \$150 clothing allowance for the first placement. However, children sometimes arrive at foster homes after the first placement with little or nothing, both in terms of clothing or supplies such as diapers, formula and baby food. While some families are reimbursed up to \$75 for these items, they have to attain them regardless. The second is transportation. Many children require a lot of transportation to regularly scheduled appointments, therapy, visits, court hearings, and parental visits. Sometime DHS uses aides or workers to supply the transportation but generally it is up to the foster parents who may have to travel 40 to 50 miles one way without reimbursement.

Beyond reimbursement, other issues impacting the agency’s ability to recruit and retain foster parents are the supports they receive and the way they are treated by the agency. Caseworkers do make their required monthly visits to the home by and large. However, most do not visit with the foster child privately, which is considered a best practice in the field. Private visits help to guarantee the safety of the child in care and promote the idea that the caseworker is listening to the child, one of the major concerns of foster families. Infants and toddlers should be privately observed.

One of the concerns heard repeatedly from foster parents is that they are afraid of reprisals from DHS staff should they disagree with a stance taken by a caseworker and, to a lesser degree, that children are moved without obvious good cause or reason. When the entire foster family population was asked about these matters in a survey conducted for this review, HZA learned that a fairly large proportion, almost a third of all the families, are indeed often or sometimes afraid of DHS reprisals. This is a larger negative response than on most other questions. Among those planning to leave, 40 percent fear reprisals while 26 percent think that DHS removes children without good reason. A significantly smaller percent of the families who plan to stay with the agency share these fears.

Another concern is the information foster parents receive about the children they are asked to care for. While DHS may have limited information about some children, at least at initial placement, there are ways other states are trying to systematize what parents receive through “Passport Programs.” Such programs include a basic format of the kinds of physical health, behavioral health and education information the passport will contain; working with partners such as Medicaid providers to gain access to the

information; modifying KIDS if necessary to store the information; and making a commitment to keeping it up. A Passport Program is one way to show respect to the foster family and the child while also adding a dimension of safety to the foster placement experience, even if applied to a limited group of children. In the state of Washington, for example, it is used when children have been in care for at least 90 days. DHS should further develop its partnership with the Oklahoma Health Care Authority to put the Medicaid claims data in a usable format and to add to it from other data sources such as education to provide a more comprehensive picture of history and needs to foster families.

The support foster parents most want from DHS is something that is within DHS's capacity to deliver, at no additional expense and that is communication and respect. Foster parents have better education and higher income than the average Oklahoma household. While many have high praise for caseworkers, other families feel belittled or ignored. Foster parents want to know what is "going on" in a case; they want to feel like players in the team and to feel that their opinions are being heard. The second is financial support to meet the actual costs of raising the child (children outgrow their clothes quickly, they noted, and transporting children can be extensive), and the third most frequent answer is comparable to the first, that is respect from the agency, caseworkers who care, and honesty.

Organizational Structure, Management and Controls

DHS is a large, complex organization with an atypical structure. Its various program areas, e.g., child care, family support, are organized within two very different structures. The larger of the two is called Human Services Centers, while the smaller is referred to as Vertically Integrated Services. The Human Services Centers include the Family Support Services Division, the Children and Family Services Division, the Field Operations Division, the Office of Faith-based and Community Initiatives and Substance Abuse Services. Vertically Integrated Services include the Aging Services Division, Oklahoma Child Care Services, the Child Support Enforcement Division and the Developmental Disabilities Services Division.

The essential difference between the two is that the central office program staff supervise the field staff in the Vertically Integrated Services programs and they do not do so in the Human Services Centers programs. In the latter programs, the field staff in all programs, with one notable exception, all report to the Field Operations Division.

Understanding how the linkage is made between the program divisions and the Field Operations Division requires understanding the structure of the latter. That structure includes a central office with overall administrative responsibilities, six Area offices responsible for both the administrative and programmatic functions of often large

geographic areas and “county” offices, most of which cover a single county but some of which cover more than one county and some of which, in Oklahoma and Tulsa counties, cover less than a county. Within the Area offices are staff positions, the field liaisons, explicitly intended as points of linkage between the central office program divisions and the county offices. The most basic responsibilities of the field liaisons are to disseminate policy to the county offices and to advise on difficult cases. They are neither supervisors nor managers.

There are at least three other anomalies in the organization of field work in DHS, all of them within child welfare. The first is that the workers who are responsible for working with adoptive families towards finalization report to the central office rather than to the Area or County Directors. This is basically a vertically integrated component of the operations within the Human Services Centers. The second unusual piece involves independent living. The work of ensuring that older youth are prepared to live independently is conducted by workers located in the field but in the employ of the University of Oklahoma’s National Resource Center for Youth Services (NRCYS). These are not employees of DHS at all, but the contracted program as a whole is supervised by the Child and Family Services Division, operating out of central office. As with the adoption unit, primary responsibility for casework with the youth remains with the county offices, while the NRCYS workers focus specifically on ensuring that eligible youth receive the independent living services they are required to receive under federal law.

The last component of the structure which is unusual, at least in some parts of the state, involves the foster care units, which are responsible for recruiting and approving foster homes. Unlike the adoption and independent living workers, staff in these units are located organizationally within the Field Operations Division, but in the more rural Areas, they are responsible for recruiting homes in multiple counties while they often report to a single County Director. Other County Directors are dependent on them for an adequate supply of placement resources, but they have no line responsibility over them.

These organizational features reveal a tacit but important feature of DHS’ view of its structure. Area offices are viewed as largely administrative in nature. Where they do have staff expected to be knowledgeable about program issues, i.e., the field liaisons, those staff have no line authority. The highest person organizationally in each program (the person with content knowledge and line authority) is at the frontline supervisory level, not at a more senior management level. When the agency has seen a need to increase the focus on a specific program activity above the county level, as with adoption and independent living, it bypasses the Area offices and assigns responsibility to the central program divisions.

As one examines DHS’ operations further, one sees other ways in which the agency tends to view field staff in both the Areas and the counties as responsible only for completing the most routine aspects of the work. Although their jobs necessarily involve,

at least in adult protective services and child welfare, decisions which are significant in the lives of families, children and vulnerable adults, when a set of decisions is viewed by the administration as requiring extra care, attention or money (e.g., payment for higher levels of foster care), those decisions are taken out of the field. Even Area and County Directors are not asked sufficiently often to address the issues the administration sees as most important.

This theme is repeated in two especially notable features of DHS' contracting practices. The first is that contracts are administered out of the central office program divisions; not out of the local offices or even out of the central Field Operations Division. The second is that, with one important exception, Oklahoma Children's Services (OCS) the agency is not proactive in defining the needs for services and then in pursuing a strategy for meeting those needs.

The same theme appears with DHS' accountability mechanisms. DHS' primary monitoring activities center on "key indicators." For each program the administration has defined a set of measures. Some of these are workload numbers and have no goals associated with them. For instance, in developmental disabilities, the measures include the number of individuals who are Medicaid eligible and the number of individuals receiving state funded sheltered workshop services. No target is set for either. Other measures equate customer satisfaction and client outcomes, the implication being that if the customer is satisfied, the program goals have been met.

A third type of measure is process- rather than outcome-oriented. These are found in the three programs of greatest concern to this audit: adult protective services, family support and child welfare although TANF also includes outcome measures related to self-sufficiency and child welfare includes measures of re-abuse and adoption.

Managers from supervisors through Area Directors review the results periodically (daily, weekly or monthly, depending on the office and the position), meet with the subordinates responsible for achieving the targets and require corrective actions when the targets are not achieved. Virtually every person recounting this process described the standard personnel disciplinary procedures which would be implemented for persistent failure. However, in the face of poor performance, for instance, in neither SFY 07 nor SFY 08 did any Area office achieve the target of having 86.7 percent of the children who had been in care less than 12 months experience fewer than three placement settings, nothing seems to happen. These appear not to be the measures for which staff are held accountable. Instead, they are held accountable for the most concrete items, primarily meeting timelines. While client outcomes are measured, they do not appear to be taken with the same seriousness that meeting timelines are, because the latter can be monitored on a weekly or even daily basis, while client outcomes take time to develop and are, in any event, difficult to measure reliably on a caseworker specific basis.

In addition to the key indicators, DHS does have one other internal accountability effort in place which is worth noting and probably worth expanding. This relates only to child welfare, but it could be useful in other areas, as well. Each year DHS' Continuous Quality Improvement (CQI) unit within the Child and Family Services Division conducts a review of each county. The review is based on the federal review done of all states and its results, as does the federal review, in a program improvement plan if the county is found to be deficient in some way. While similar processes have been initiated across the country, what makes DHS' unique is that it is tied to bonuses for staff if the county does well. If a county achieves 100 percent on its review, all workers in the county who have been there at least one year and who have completed their annual ongoing training requirement receive a bonus. However, county directors who choose to ignore the findings do so with impunity.

Complementing the internal mechanisms, there is an external oversight body which reviews some of what DHS does, at least in the child welfare area. This is the Commission on Children and Youth. The Commission operates the Post Adjudication Review Boards (PARBs) which conduct six-month reviews of children in foster care. The Commission also makes routine unannounced visits to DHS facilities such as shelters and group homes and responds to complaints about those facilities. The Commission has, however, no enforcement authority. As a result, many of the same violations appear repeatedly in the Commission's reports, and many of the agency's responses to those violations say that either the agency is unable to do anything about the problems or that someone else in the agency (outside the facility) is responsible. In the end there is no accountability for DHS' own facilities because DHS is regulating itself.

One of the themes of the recommendations made in this report is that the Department will operate more efficiently and effectively if both authority and responsibility are spread throughout the agency. This means giving Area and County Directors more authority and responsibility but also holding them more accountable in the real sense of providing both positive and negative consequences to their performance. In addition, external oversight groups such as the Commission should be more than advisory.

Personnel and Training

In Oklahoma, all child welfare staff are required to attend a pre-service training that introduces the workers to the basic processes of the agency. The program consists of a five-week CORE program, two weeks in the classroom, one week in the field, and then another two weeks in the classroom. Then workers have to complete Level I training within the first year, some of the modules are specific to the job function. During the on-the-job training, specific activities are assigned to the new workers to complete.

Each new child welfare worker is enrolled in CORE and is expected to start within six weeks of the hire date although that is not always the case. During their time in the office, before the training starts, new child welfare workers are supposed to complete pre-CORE activities such as shadowing an experienced child welfare worker and accompanying a worker to court. The new worker is provided selected reading as well.

HZA requested and received the child welfare pre-service training curriculum DHS uses, the CORE. These materials do not constitute a “curriculum” but an amalgam of handouts, articles, exercises and Powerpoint slide handouts loosely organized into topics, with a heavy dose of excerpts from administrative code or policy. The most critical of the issues related to training has to do with safety planning. This topic is discussed without any notations regarding the safety assessment or how to complete it. The training materials contain an article written by *Action for Children* near the front of the book that stresses that it is critical that staff understand the difference between safety and risk, but in the subsequent sections of the manual these terms are used interchangeably. In fact, the terms are often combined in “safety risks.”

The impact of this gap in the training appeared in the case records reviewed for this audit, where the safety and risk protocols were often not found. It seems to be unclear to staff whether these are only for investigators of abuse and neglect or are to be used throughout the life of the case. In addition, the interviews indicated that staff are unclear on safety assessment requirements, i.e., on which children must be interviewed privately, on which collateral contacts are mandated, on the use of the non-abusing parent as a protector and on how to monitor safety plans. In the statewide survey of staff, 57 percent were either neutral or disagreed with the statement, the pre-service training helped to prepare me for the job.

Training gaps are exacerbated by staff turnover, without any doubt the largest issue facing DHS from a personnel perspective. DHS has been proactive in trying to combat the high levels of turnover. One of those efforts involves the Continuous Service Incentive Program (CSIP), which provides bonuses to new staff at various points during their first two years of service. DHS had conducted an analysis and determined that if workers stay more than two years, they are likely to remain much longer. The CSIP is an effort to get workers to that two-year point. However, CSIP has yielded widespread resentment among longer-term staff who have not been rewarded for staying.

To understand the problem DHS faces, HZA focused specifically on the frontline workers and measured turnover as the percentage of entry-level staff who left the agency entirely within 12 months of being hired. With data from DHS’ personnel tracking system, all frontline staff hired during state fiscal years 2003 through 2007, i.e., from July of 2003 through June of 2007, were followed to identify those who left the agency within one year. Measured in this way, the highest rate of turnover was not in child welfare, although that is the program where the greatest concern is often expressed. As DHS

administrators know, the highest turnover occurs among child support staff, which is one of the vertically integrated services.

Turnover at DHS is not a single problem. Both the program and the location of the jobs have some influence on how long workers stay. DHS programs are of very different types. Child welfare, adult protective services and child support are all involuntary programs. Clients do not come forward to be served by these programs; rather, the state intervenes in the family's life whether that intervention is desired or not. Moreover, workers in two of these groups, child welfare and adult protective services, report far more overtime and on-call duties than do workers in the other groups. In the survey of staff conducted for this audit, nearly 70 percent of adult protective workers and half of child welfare workers disagreed with the statement that they were rarely on-call. The corresponding figures for family support, child support, developmental disabilities and child care workers were two percent, four percent, 16 percent and 18 percent, respectively.

Similar differences are seen in relation to overtime. When presented with the statement that they rarely have to work overtime, half of the child welfare workers and 37 percent of the adult protective workers disagreed. Family support workers disagreed only 10 percent of the time, compared to 13 percent for child support staff, 21 percent for developmental disability staff and 25 percent for child care workers.

Overtime and on-call requirements are two of the factors identified in the professional literature as contributing to turnover. In DHS the situation is exacerbated by high caseloads in some of the programs and by the compensation rules. In general, DHS staff are not paid for overtime. Instead, they are told to take compensatory time, "comp" time or "work week adjust."

One of the more curious facts about staff retention at DHS has to do with the adult protective services staff and, perhaps to a lesser extent, with the developmental disabilities staff. These two groups are the least likely to leave the agency within one year of being hired. Yet, the adult protective staff report more on-call duties than any other group and face many of the same issues as child welfare and child support staff. What the two groups have in common is that far fewer of their new frontline staff are in their twenties than is the case with the other programs and fewer are also under 40. Nearly one-half of all new frontline staff in adult protective services were 40 years old or older when they were hired.

The notion that younger workers are less likely to stay with the agency for extended periods of time fits with some of the perspectives HZA heard when interviewing staff across the agency. Some workers reported, for instance, that having to be on-call is difficult for parents of small children, particularly if they are single parents. Moreover, the costs of the benefit package increase when the employee starts a family and the stagnation of the salaries makes it difficult to keep up with the rising costs of raising

children. A salary that is adequate for a young single person or someone married to another professional may be far less adequate when child care and the other costs of raising a family become a factor.

While it is not certain that age is a major factor in retention, the issues discussed above plus the fact that many young workers do not have sufficient life experience to be ready to deal with some of the situations faced at DHS suggest that hiring more experienced adults might prove more successful. Perhaps, DHS should be not a first career for some people but rather a second. DHS could try recruiting retired military personnel, people whose children are mostly grown and who already have a pension which will supplement what the state provides. Former military personnel are likely to possess qualities DHS is looking for such as diligence, ability to both lead and follow directives, a respect for policy and a chain of command, and the experience of working with all different people in less than favorable conditions. Some of those staff are already employees in DHS and HZA's general impression was that their perspectives were somewhat different than those of the staff who are hired at a young age.

Oklahoma is home to five military bases (two Army and three Air Force), including Altus AFB (Headrick, OK), Fort Sill (Fort Sill, OK), Tinker AFB (Oklahoma City, OK), McAlester Army Ammo Plant (McAlester, OK), and Vance AFB (Enid, OK). The US Census Bureau reported in 2000 14.8 percent of the total population of Oklahoma (18 years and older) held veteran status. Several private firms help retired military personnel find and secure employment, most notably Bradley-Morris, Inc., Soar Consulting, Inc., Military Officers Association of America (MOAAA), State Job Link Center, Military Job Zone/Military Veteran Job Placement, MC2- Recruiting Military Candidates. The Human Resources Management Division held a recruitment fair with Tinker Air Force Base (AFB) and established a coordination relationship with the Transition Officer at the Altus Air Force Base. More efforts are needed with a focus on recruiting for the divisions with highest turnover.

Other career fields, such as public school education, have developed initiatives to attract military personnel before they retire by assembling detailed job packets presented in advance of retirement. DHS should experiment with different kinds of targeted recruiting whether or not it gets the step increases recommended in this audit.

In both the responses to the staff survey and the interviews, the most negative reactions from staff came in regard to compensation. In the interviews staff tended to report that the pay was "pitiful" or "ludicrous" for the level of responsibility they were expected to assume. The staff survey was more nuanced. While a majority of staff in every program disagreed that their compensation was appropriate, the overall percentage expressing that view was only 58 percent. On the other hand, when asked whether raises were timely and, separately, whether raises were adequate, 75 percent responded negatively. This is an important distinction. While staff generally believe that their compensation is

too low, they are less disturbed by that than by the fact that they do not receive raises on any regular basis.

Recommendations

- Recommendation 1:** The Legislature should review the proposed Title 10 revisions to ensure that the sole criterion for removal of a child from his or her home is an imminent safety threat. (Chapter 3)
- Recommendation 2:** The Legislature should modify Title 10 so that DHS is involved with the police in all removals of children from their homes and so that the authority for “standing orders” is eliminated. (Chapter 3)
- Recommendation 3:** DHS should contract with District Attorneys (DAs) to represent DHS in deprivation proceedings. (Chapter 3)
- Recommendation 4:** DHS should establish one centralized hotline number for all reports of the abuse and neglect of children within the Child and Family Services Division and strongly consider whether vulnerable adults can be included as well. (Chapter 4)
- Recommendation 5:** DHS should simplify and clarify the definitions of Priorities One and Two and the criteria for investigations versus assessments; modify response times; and modify the daily contact rule. (Chapter 4)
- Recommendation 6:** DHS should phase out the two large publicly funded shelters, Laura Dester and Pauline E. Mayer, and replace them with emergency foster homes when alternative placements such as neighbors and relatives cannot be found. (Chapter 4)
- Recommendation 7:** DHS should focus on creating a safety culture that is ingrained into all staff and impacts all decisions made

by a) adopting one safety assessment protocol and providing comprehensive training on its use and application to all staff, and b) making better use of the risk assessment protocol. (Chapter 4)

Recommendation 8: DHS should increase the use of court-supervised in-home placements for children who otherwise would have been removed but the safety issues have been resolved. (Chapter 4)

Recommendation 9: DHS should shift funding from out-of-home care to in-home services to support the families where children are not in imminent danger. DHS should increase the numbers and kinds of in-home services available based on an Area-level needs assessment (see Recommendation 18) and the use of evidence-based practices. (Chapter 4)

Recommendation 10: DHS Area Directors should work with their recruitment staff to develop a resource recruitment plan based on the number of children in non-relative care and the projected foster family turnover, which meets the standard of two available beds per child. (Chapter 5)

Recommendation 11: DHS should streamline its licensing processes. At a minimum it should develop a single process for resource families or Bridge homes which includes all foster and adoptive families. At a more ambitious level, it should look at consolidating the requirements if not the staff for all home-based licensing within the agency, across the divisions of child care, developmental disabilities and child and family services. In addition, families who are licensed to provide one service such as child care should not be excluded from providing another such as foster care, although limits should be maintained on the number of children a family can care for at a time. (Chapter 5)

- Recommendation 12:** DHS should develop a Passport Program for foster children similar to those developed in Texas and Washington. (Chapter 5)
- Recommendation 13:** The legislature should provide foster families with an increase both in the daily rate and in their ability to be reimbursed for clothing when a child newly comes to the home, even if the initial \$150 has already been spent elsewhere on the same child in another placement. Additionally, there should be some provisions for transportation reimbursement based on the requirements of the service plan, unless the family is receiving a difficulty of care payment. (Chapter 5)
- Recommendation 14:** Caseworkers should be required to visit with children privately at least every few months, and preferably at every visit. (Chapter 5)
- Recommendation 15:** Within Oklahoma and Tulsa Counties only, DHS should replace the positions of County Director and field liaison with programmatic directors for each of the programs within the Human Services Centers. (Chapter 6)
- Recommendation 16:** DHS should move the SWIFT Adoption workers to the Field Operations Division and integrate them into the agency's local offices. (Chapter 6)
- Recommendation 17:** Area offices should assume direct responsibility for functions which cross county lines. (Chapter 6)
- Recommendation 18:** The central office program divisions should conduct a periodic statewide services needs assessment and allocate funding to each Area office for contracted services, and the Area offices should assume responsibility for deciding which contracts to fund within their boundaries. (Chapter 6)

- Recommendation 19:** DHS administrators should act with greater speed to correct personnel performance problems, especially among Area and County Directors whose positions are unclassified. (Chapter 6)
- Recommendation 20:** The Continuous Quality Improvement unit within CFSD should review its instrument and procedures to ensure a focus on the quality of casework, including the soundness of assessments and decision-making, and DHS should develop a clear structure of accountability based on the results of those reviews, including both positive and negative sanctions. (Chapter 6)
- Recommendation 21:** The Commission on Children and Youth should assume responsibility for licensing all congregate out-of-home care facilities operated directly by DHS. (Chapter 6)
- Recommendation 22:** DHS should revise its training materials to create a formal curriculum which provides information in a logical order and helps workers gain the competencies they need to perform their jobs at a high level. (Chapter 7)
- Recommendation 23:** DHS should ensure that every worker receives job-specific training as soon after starting a position as possible. (Chapter 7)
- Recommendation 24:** The Legislature and the Governor should provide a consistent means of funding salary increases for DHS staff based on performance. (Chapter 7)
- Recommendation 25:** DHS should experiment with recruiting staff with different demographic characteristics to determine which groups are more likely to stay with the agency longer periods of time. (Chapter 7)

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When the Oklahoma House of Representatives requested proposals for a performance audit of the Department of Human Services (DHS) in the late spring of 2008, its focus was on child welfare but its request was broader. One of the primary concerns was the absence of a formal organizational connection between the program and policy staff in some divisions and the caseworkers and supervisors in the field. Child welfare was one of the programs where this connection was lacking, but it was not the only one.

A second major area of concern related to personnel. Like many human service agencies across the country, DHS was exhibiting high rates of turnover, meaning that many positions were vacant, many positions were filled by staff still in their pre-service training (and therefore not working with a caseload) and much of the cost to hire and train new staff was wasted because so many of the staff left shortly after starting the job. Again, child welfare was one of the programs afflicted by high turnover, but it was neither the only one nor the one with the worst rate of retention.

Finally, the House was responding to myriad complaints from constituents, many of them foster parents who felt themselves ill-treated by DHS. While House members also hear from families who believe that DHS has wrongly intervened into their lives, foster parent complaints came from a very different source. These were families who had volunteered to help the agency care for children maltreated by their own families and to do so for stipends well below the costs they would incur. If the agency was not treating these volunteers well, that should also raise serious questions about how it treated its client families.

These concerns could not be addressed adequately without gaining a full understanding of how well the agency serves families, the results it achieves, and how its policies and programs are structured. Therefore, Hornby Zeller Associates, Inc. (HZA) has structured its study and this report around five large topics:

- the results DHS achieves for its clients;
- policy and program implementation;
- the supply, training and retention of foster care providers;
- its organizational structure, management and controls; and
- personnel and training including retention and turnover.

Throughout the report child welfare holds center stage. For most of the topics adult protective services and family support services also receive significant attention; and

when the discussion turns to organizational structure and personnel issues every program is scrutinized.

Organizing the discussion into these five relatively discrete topics may hide some of the essential differences among the programs as well as some of the common themes which will appear across topics. The rest of this introduction is devoted, therefore, to setting the stage, first through a discussion of the nature of DHS' programs and then through an overview of the themes which connect the analyses and recommendations throughout.

DHS Programs

Like most of its counterparts in other states, DHS is an extraordinarily complex agency. Even from the broadest perspective, there are at least three separate functions for which the Department is responsible.

The first is to provide *concrete assistance* to families and individuals who are not fully financially independent. That assistance takes a variety of forms including direct cash payments, vouchers or other subsidies for food or child care or other services, medical care eligibility and assistance in preparing for and finding employment. All of these services are voluntary, meaning that people have to apply to the agency to receive them, and DHS' first task is to determine their eligibility under the prevailing rules.



The second function is *regulatory*, carried out largely by the child care staff who are responsible for licensing both residential and non-residential, i.e., "day care" providers. The regulatory function is designed to ensure public safety. While providers may come forward requesting to be licensed, most will do so because it is required. As a matter of ensuring that families, whether subsidized by DHS or paying for their child care out of their own resources, can have confidence that their children are safe when being cared for by others, the state requires that anyone providing this service submit him- or herself to a review by DHS and to the rules governing how care is to be provided.

The third function is *protective*. This involves direct intervention into a family's or individual's life, regardless of whether the family or individual believes that intervention is necessary. While through the regulatory function DHS works to *prevent* harm from occurring by imposing minimum safety standards, with the protective function the Department intervenes *after* something

harmful or threatening has happened. In that sense it is related to a police function, but the expectations are greater, both because the Department is expected to keep specific children and vulnerable adults from further harm and because it is expected to help families become able to protect their own children or elders without further intervention. In these programs DHS has to combine the roles of law enforcement and social work, which has never been a comfortable pairing. Most of the protective function is carried out by child welfare and adult protective staff, but the work of the child support staff can also be viewed in this way.

To the public DHS often appears to be a monolith, a giant agency using huge amounts of resources and exercising wide ranging powers over ordinary citizens. The truth is, most of the agency's use of resources relates to its assistance function, while its "power" relates to the other two. The agency's disparate functions generate dissimilar expectations on staff, on community partners and on the organization itself. The conflicts inherent in doing child or adult protective work are unlike (and generally greater) than those involved in imposing minimum safety standards on a provider and even more different than those involved in determining whether a family is eligible for assistance and for how much. Thus, if staff turnover is a problem, both the reasons for it and the solutions to it may not be the same in different parts of the agency. Similarly, an organizational structure that is appropriate for one type of function may or may not be appropriate for the others.

In selecting child welfare as the focus for this audit, the House of Representatives put the spotlight on the most sensitive, most volatile and most complex of all the programs. It is the most sensitive because nearly everyone believes that he or she knows how best to care for children and can therefore sit in judgment of the agency. It is the most volatile because every decision, whether to leave a child at home or to remove the child, has the potential to harm the child the agency is trying to protect. And it is the most complex because DHS is dependent on many other parties to do this work, including courts, district attorneys, and private providers and foster parents.

In situations as complex as this, those conducting the audit need to exercise caution. It is all too easy to listen only to the complaints about the agency and to find fault with everything. Equally, it is sometimes tempting to hear only the agency's side and to excuse all its failures because of conditions "beyond its control." From its work in more than 30 states, HZA is well aware of these pitfalls and has attempted to balance the perspectives. And while 60 to 80 percent of our contacts, be they attorneys, judges, caseworkers or foster parents, had some good thing to say about DHS, we could not deny the level and consistency of the vitriol that surrounds the agency. It begged for explanation and drew us to two observations. First, DHS lacks both the full scope of legal authority granted to protective agencies in other states and some of the basic resources it needs to carry out the responsibilities for which professionals, the general public and even the agency itself hold it accountable. Second, perhaps in response to this situation and perhaps because of its unique history and legal independence, the

DHS administration attempts to control the course of events so tightly that it presents an overbearing and even disrespectful face to its own workers, its community partners and its clients.

The remainder of this introduction summarizes these and related themes, while the rest of the report provides the details which have led to these conclusions as well as recommendations for addressing them.

DHS Directions, Present and Future

If there is a single conclusion to be drawn about DHS' internal operations, and particularly about its child welfare services, it is that the system works to reduce the professionalism of the frontline worker. From a legal perspective, DHS child welfare and adult protective workers have far less power and authority than their counterparts in similar agencies in almost any other state, although they are publicly held responsible for more than their authority allows. Within their organizational structures, workers in child welfare, adult protective services and family support services have little or no contact with any programmatic expert other than their own immediate supervisors, and those supervisors' own bosses are rarely experts in the program. Although the major function of a child welfare worker should be to make decisions, the training they are given is more focused on providing them information than on building the skills they need to assess safety and risk and to make reasonable judgments. Correspondingly, the accountability system is aimed at concrete, easily measurable items, largely without regard to the quality of the casework. Finally, a salary level which is inadequate for raising a family and the absence of a system for rewarding good or even outstanding performance ensure high turnover and reduce the experience level of the staff who work with children, families and vulnerable adults.

The first step in disempowering DHS workers appears outside of the agency, in the statutes which define their role. It is highly unusual for child protective workers not to have the authority to remove children from their homes, even with a court order. But that is the case in Oklahoma, except in a couple of unusual situations. Moreover, statutes make clear that although workers are expected to be familiar with court procedures and competent in writing reports for the court and testifying during trials, DHS is not a party to child welfare or adult protective cases, and the district attorney represents the "state," but not DHS. While child welfare professionals across the country have reached a consensus that children should be removed from their homes only when the child's safety is immediately threatened, not just when there is a risk of subsequent maltreatment, Oklahoma statute gives the authority to make the removal decision to law enforcement and district attorneys, neither of whom is trained to make these kinds of safety decisions or even to recognize the difference between safety and risk. What should be a social work decision has become a prosecutorial decision.

The organizational issues are more complex because DHS has two different forms of organization, but for the largest programs, family support and child welfare, as well as for adult protective services, frontline staff are organizationally separated from the central office program and policy staff. While this report will suggest that there is not an alternative which is better in all respects and in all communities, one impact is to spawn a generic brand of management designed primarily to ensure that critical tasks get done on time. Less emphasis is placed on the substance of what caseworkers do. When the first level supervisor is the highest person with expertise in a worker's line of authority, and when that supervisor is himself or herself often inexperienced, the caseworker frequently does not obtain the level of mentoring and professional development necessary to make solid casework decisions. This perpetuates mistrust and the notion that others should be in charge.

Good casework requires a high level of skill in assessing situations and taking proper action. When one examines the training provided to caseworkers, however, one sees more focus on providing information than on building skills. In the initial training workers reported that they are not even taught how to interview, and the child welfare training materials so confuse the concepts of safety and risk that workers cannot be adequately prepared for making decisions about how to keep children safe and whether or not it is appropriate to remove them from the home. They make those decisions, but the nature of the training and the data we have gathered leave open the question of how appropriate the decisions can be.

The way workers are held accountable follows the same patterns seen in the organizational structure and the training. There is less emphasis on whether children and vulnerable adults are kept safe from subsequent maltreatment or on whether they are maintained in their homes whenever possible than on whether caseworkers make their initial and ongoing contacts with the clients on time. These are important factors, because without the contacts there is little chance of intervening appropriately, but making timely contacts is only a necessary condition for professional casework, not a sufficient one. The accountability system treats the staff more like assembly line workers charged with completing a set number of tasks within a specified timeframe than like professional social workers whose decisions affect the lives of the children and adults they serve.

Finally, the salary levels of caseworkers and, more importantly, the lack of a system for rewarding good or outstanding work, sends a clear message that workers are not valued. In general, the worker on the job ten years receives the same pay as the newly hired worker, and lack of growth in income implies that no value is placed on growth in the job. As a result, while DHS has little trouble hiring workers, it has a great deal of trouble keeping them, meaning that many of the frontline staff making significant decisions about people's lives have little experience to guide them.

Some of these factors are under DHS' control and some are not. In the end it is the system as a whole which tends towards the deprofessionalization of the casework function. But DHS' reaction to its external environment is also important. Perhaps in response to its limited legal authority, to its inability to provide pay raises and retain staff and simultaneously to being held responsible for decisions beyond the reach of its literal authority, the agency has structured itself in a strongly hierarchical way, tending to try to control most decisions from the top down. When new policy is created, the field staff are given little if any opportunity to comment on it. The decisions as to which resources should be available through private providers in each service Area are made at the central office, as are the decisions as to which providers will be selected to provide the services. When a particular function is not working as well as expected, it is centralized, as in the case of adoption.

DHS administration does not court partnerships within its ranks. County staff are not treated as partners, nor are the other element of the child welfare frontline, namely, foster parents. Even in deciding which services to make available, the agency rarely seeks out new providers proactively or offers significant incentives for providers to come forward.

DHS' independence has a long history and one not of its own making. Its establishment by the state's constitution, the fact that the Director reports to a board which is as independent of the Governor as the Federal Reserve is of the President and the now repealed earmarking of half of the sales tax for the agency's programs have all contributed to the agency's current stance towards its outside environment. While the earmarked sales tax is no longer in place and the agency is subject to legislative appropriations, DHS' administrators have found new tools with which to assert its independence, with no individual or group, including the DHS Commission, both willing and able to address the negative impacts.

Temporary Assistance for Needy Families (TANF)

This federal assistance program succeeded Aid to Families with Dependent Children (AFDC) in 1997. Prior to this time, eligibility for aid was governed by federal rules. Now, states are responsible for establishing the eligibility rules as well as for the administration of the funds provided through a block grant.

One of these is confidentiality. While no one disputes the need for confidentiality for the clients of the sensitive services DHS provides, HZA has encountered a wide range of interpretations of that mandate across the country. During this review, however, we heard reports from a wide variety of parties outside the agency about the agency's narrow interpretations of its authority to share information. Some of these reports indicated that even courts are sometimes denied information on the grounds of confidentiality.

Another recent mechanism DHS has used to foster its independence is the so-called "TANF reserve." Like most other states, for the first few

years after the introduction of TANF, Oklahoma received more funds than it needed from this federal source. State agencies were permitted to keep those funds and to use them very flexibly for as long as they lasted. And as is occurring in most other states, Oklahoma's reserve is dwindling. If DHS continues to need to dip into the reserve at the same rate as it did in the past year, the entire reserve will be gone in two years, leaving only the basic annual allocation.

The likelihood of this occurring seems high at the present time, especially since another important source of federal funding, Medicaid's Targeted Case Management (TCM), is scheduled to become far more restrictive as of April 1, 2009. DHS has already included in its budget for state fiscal year 2010 request sufficient general revenue funds to compensate for the potential loss of one quarter's worth of the current year's TCM funds and for the potential loss of all of next year's TCM funds.

Elimination of the reserve does not mean that there will be no more TANF funds available, but it does mean less flexibility. Moreover, some of the uses to which TANF funds are now put, particularly the support of DHS-operated shelters, underline the importance of that flexibility to the agency. Shelter costs in most states are reimbursable through federal Title IV-E funds, but because Oklahoma has chosen to operate the shelters through the public agency, rather than through contract, and because those shelters have more than 25 beds, DHS' shelters are not eligible for that kind of federal reimbursement. The only alternative means of funding the shelters, other than TANF, is state general revenue.

Less financial flexibility will mean less independence for the agency, and that in turn will mean a need for better working relationships with community partners. Even central office administrators report that the agency needs to reach out to the community more. Yet the solution goes beyond that point. DHS needs to see itself as one component in a larger system, and it needs to work with the other components as partners rather than as factions to win over or as obstacles to overcome. Too many of DHS' relationships reveal a lack of respect for those other parties, with foster parents treated as dispensable, judges treated with disrespect by not providing workers with the proper training to appear in court and parents' attorneys and Court Appointed Special Advocates (CASA) not getting straight answers. When the time comes, the agency cannot possibly obtain the help it needs to do its job without a major change in direction.



In the end DHS needs to lead, not to command. That theme will reverberate throughout this report, and it will have a direct impact on the recommendations we make. While we find that it is highly unusual for child welfare workers not to be allowed to remove children from their homes, we do not recommend giving them that authority, but rather removing the unilateral authority from law enforcement and requiring law enforcement and child welfare to work together on those decisions. While we find the current relationship between the Department and the district attorneys to be counter-productive, we do not propose that the Department have its own attorneys, but rather that the relationship be structured in a different way. While we think that workers are treated less professionally than they deserve, we also recommend that this change only when the expectations made of them increase to a professional level. And while we commend DHS for instituting initiatives such as the Bridge and the Practice Model we cannot see these taking hold until the policies involving investigation priorities, risk and safety can be straightened out.

Chapter Two

Results DHS Achieves for Its Clients

A performance audit of a human services agency has to begin with an examination of the outcomes achieved for the clients the agency serves, because those outcomes represent the fundamental purpose and mission of the agency. If children, families and vulnerable adults are overwhelmingly better off after having been served, it is difficult to fault the agency for not conforming to commonly accepted standards related to organizational structure and behavior. Similarly, if the agency is clearly not meeting the needs of its clients, state-of-the-art organizational structures and processes do not mean very much. In the end, the effectiveness of a human service agency is wholly dependent on how well it meets the needs of its clients.

For an agency as large and complex as DHS, a variety of standards have to be used to determine the extent to which the agency is achieving appropriate client outcomes. For purposes of this audit, the focus will be on three sets of programs: family support, including TANF, food stamps and Medicaid eligibility; adult protective services; and child welfare. For all three of these, DHS has developed and regularly utilizes a set of performance measures it calls “key indicators.” At one level, then, measuring performance is a simple matter of comparing the agency’s goals on these indicators with its actual performance.

A more comprehensive view, however, is possible for child welfare, and one that does not depend on the agency’s own definition of appropriate performance measures. The following pages begin the examination of client outcomes by focusing on child welfare and specifically on three sets of measures: the federal standards utilized in the Child and Family Services Reviews (CFSR), results from DHS’ key indicators and HZA’s own analyses of both DHS’ data and data from other states. Following that analysis, the key indicator results for adult protective services and family support services will be examined, along with an assessment of the extent to which these are the best indicators to be examining.

Child Welfare Outcomes

Across the country child welfare professionals have come to a consensus that the goals their system must achieve for each child are safety from abuse and neglect, a permanent home with a family and the more elusive “well-being.” The federal Administration for Children and Families (ACF) has articulated these broad concepts into

seven outcome statements, each tied to a series of specific items used to measure their achievement. The seven outcomes are:

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes whenever possible and appropriate.
- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for children.
- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

The first two of these measure safety, the third and fourth permanency, and the last three well-being. Each has multiple items designed to provide an accurate and valid measurement of the outcome. For instance, the extent to which children are protected from abuse and neglect is measured by two indicators: the timeliness of initiating investigations of abuse and neglect and the percentage of cases experiencing subsequent maltreatment within six months of the first report. Similarly, whether children have permanency and stability in their living situations is measured by six items, including, among others: the percentage of re-entries into foster care, the stability of foster care placement and the appropriateness of the permanency goal. To achieve acceptable performance on the outcome, the state has to achieve 95 percent acceptable performance on the items under that outcome.

Fact sheets and additional information about child welfare monitoring and the Child and Family Services Review (CFSR) process may be found at the Administration for Children & Families website:

<http://www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm>

While the CFSR can rightly be criticized on a number of grounds, it provides the only means of comparing performance on a wide variety of factors across states. Moreover, the worst features of CFSR measurement have been addressed and at least partially corrected during the second round of reviews. While individual measures are less than perfect in some cases, the overall package provides a reasonably robust measure of the effectiveness of a child welfare system.

Oklahoma had its second round CFSR in 2007 and while no state reaches substantial conformity on every component of the review, Oklahoma did not do so on any of the seven outcomes. These outcomes measure whether children brought to the attention of the child welfare system are kept safe, whether they attain permanent homes and

whether they achieve reasonable physical, mental, emotional and educational functioning.

That result depended in large part on the examination of a sample of 65 cases which were reviewed on-site. A deeper understanding of the findings can be found by examining six statewide indicators which are also used during the review. Two of these have to do with safety and four with permanency. Unlike the results of the rest of the case specific portion of the CFSR these indicators focus on the entire population, and the standards are not 95 percent achievement but rather whatever level represents the 75th percentile among all states, i.e., to meet the national standard a state must be among the top 12 or 13 states in the country. On none of the six did Oklahoma meet the national standard, and on two of them, those related to reunification and to the frequency of moves of children while in care, it fell into the bottom half of all states. Even for adoption, which DHS considers one of the state's strongest programs, among five different ways of measuring success, Oklahoma met the 75th percentile on only one of them.

Some of the reasons the federal reviewers found for the failures were especially interesting because they will be encountered again in later parts of this audit report. For instance, one of the reasons cited as a cause for the failure to protect children from abuse and neglect was that the assessments DHS does of families are *incident-based*, not *risk-based*. In other words, the federal reviewers found more focus on the police function of determining whether an event occurred than on the social work function of determining whether the child was at risk in the future. Similarly, the failure to keep children safely in their own homes whenever possible was cited as due, among other things, to safety plans that were insufficient to reduce the threat of harm, inadequate ongoing risk assessments in the foster homes and the placement of children into care with no prior efforts to prevent those removals.

The child welfare system is often pictured as one torn between two competing goals: keeping children safe from maltreatment and preserving families. The assumption behind that view is that the surest way to protect a child is to remove him or her from the family because the state is a better protector of children than is the family. With Oklahoma failing the CFSR on both the safety and the permanency outcomes, the results of the federal review charge the state with neither keeping children safe nor preserving their families and implicitly refute the claim that the state protects children better than do their families.

The CFSR is, however, not the only source of information which suggests that fundamental change is needed in the child welfare program. Although the federal review purports to measure whether children are maintained in their own homes whenever possible, it does not examine what would seem to be the most basic measure of that goal, i.e., the placement rate or proportion of the state's children who live in out-of-home care. Oklahoma's failure to preserve families can be seen by comparing the placement

rates of all states. Among the 50 states, only Nebraska has a higher proportion of its children in out-of-home care.³ In Oklahoma 13.4 children out of every 1000, more than one percent of the child population, are in DHS custody and out of their homes on any given day. The national average is 6.9 per 1000, just over half this state's figure. The contrast continues when one examines surrounding states. The rate is:

- 8.4 in Kansas,
- 8.3 in Missouri,
- 7.0 in Colorado,
- 4.8 in Arkansas, and
- 4.6 in Texas.

Since these measurements were taken, Oklahoma first increased the number of children it had in care and then decreased the foster care population from a high of 12,222 in the middle of 2007 to about 10,297. Unfortunately, cross-state data are not available to determine whether the same trends appeared in other states. What can be said, however, is that the 2007 figure represents a placement rate of about 14.2 children per thousand, even higher than the 13.4 used to compare Oklahoma to the surrounding states, while the current figure represents a rate of 12.1 children per thousand. Even that lower rate would, if all other states have stayed constant, be higher than the rates in any states in the nation other than Nebraska and Oregon.



The likelihood that Oklahoma is simply removing far too many children from their homes appears in other ways, as well. For calendar years 2006 and 2007, respectively, 19 percent and 21 percent of the children removed from their homes show no court hearing prior to discharge. Even if that is the result of faulty reporting to KIDS, DHS' tracking system for child welfare, both the data DHS supplies to ACF and HZA's own analyses show that about 20 percent of the children are returned home within one week of removal. That suggests the state is very quick to disrupt families and remove children from their homes, either because threats to safety are too often seen where there are none, or because safety is not the criterion used in making removal decisions.

Beyond the question of whether Oklahoma removes too many children from their families is what happens to these children once they enter the system. If the state is to

³ The data are drawn from the Child Welfare League of America's State 2008 fact sheets and reflect data from 2005 (<http://www.cwla.org/advocacy/statefactsheets/statefactsheets08.htm>). The District of Columbia actually shows a higher rate than any state, but it is clearly an anomaly. More than 22 out of every 1000 children in DC are in foster care, compared to 14.4 in Nebraska, the state with the highest rate.

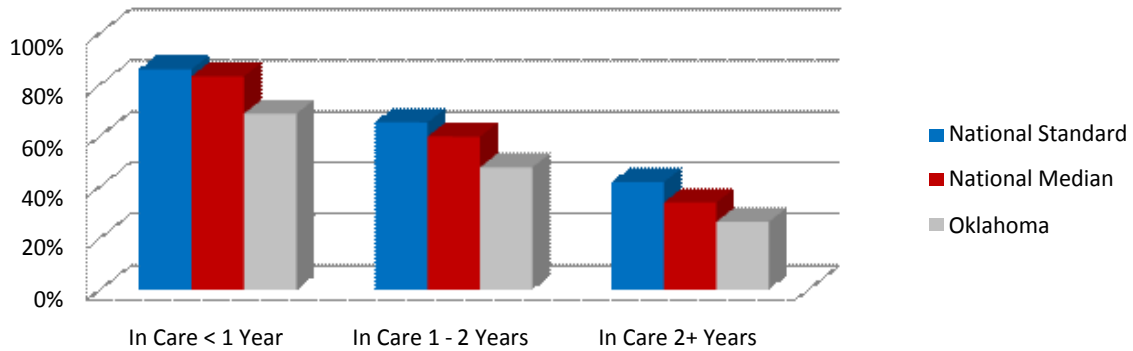
intervene into a family's life, it has the obligation to provide the child both the safety the child was lacking and the other benefits a family is supposed to provide. The federal government measures the degree to which states keep foster children safe by calculating the incidence of confirmed abuse and neglect by substitute caregivers. While Oklahoma shows that fewer than two percent of children in out-of-home care are abused or neglected, its rate of out-of-home maltreatment is more than three times the national standard. Consistently over the two and one-half years measured by ACF during the CFSR, Oklahoma showed about 1.2 percent of the children in care being abused or neglected, while the national standard was 0.32 percent.⁴

Safety is, however, only the most basic guarantee the state owes to a child who is removed from his or her home. Children also need some sense of predictability in their lives and for that they need, at a minimum, not to be moved from home to home. In measuring each state's performance in achieving placement stability, ACF calculates the percentage of children who have experienced two or fewer placement settings and does so for three groups of children: those in care less than one year, those in care one to two years and those in care over two years. For every group, Oklahoma falls far into the bottom half of all states. For instance, for those children in care one to two years, in half of the states, 60 percent or more have had no more than two out-of-home placement settings, but in Oklahoma the figure is below 50 percent. For those in care less than one year, including those in care only a few weeks, 83 percent or more of the children in half the states have experienced only one or two settings, while in Oklahoma the figure is under 70 percent. The following graph shows how the State fares in relation both to the national standard and the national median.⁵

⁴ This result needs to be noted because of its relationship to the fundamental mission of the agency. HZA will, however, not explore it in depth for two reasons. First, the rate of maltreatment while children are in care is very low compared to that for children in the agency's overall caseload. Second, and just as importantly, the way in which the federal government measures this result is seriously flawed as a measure of safety in foster care. While the denominator includes only children in DHS custody, the numerator includes all children who are maltreated while in any out-of-home care setting, not just those in the child welfare system. This means that youth in OJA who are abused or neglected are also counted against the state on this measure. While the same flaw is found in the measurement for all states and probably means that children in Oklahoma's foster care system are less safe than those in other foster care systems, the data leave some doubt about the issue.

⁵ What is shown here as the national standard is actually the 75th percentile. ACF uses the 75th percentile to set its standards, but it sets standards only for an abstract compilation of the three measures shown here, not for the measures themselves. To understand how the state fares on the individual measures it is useful to consider the 75th percentile as the standard for the individual measures.

Percent of Children Achieving Placement Setting Standard



The lack of stability in children’s placements is actually even more serious than these figures suggest. Unlike many other states, Oklahoma has not confused its child welfare system by including large numbers of older children who are in care due to their own behavior rather than to their parents’ actions. Over half of the children removed from their homes are under six years of age and they are there for their protection, not for the community’s protection. Placement instability in these other states is generally higher among the older children placed for behavior reasons than it is among younger children because foster parents and group home staff experience the same difficulties the youths’ parents did. Because, to its credit, Oklahoma has largely kept this population out of the child welfare system, its placement stability figures should be much better than those of these other states.

In fact, the age of the child in Oklahoma does not make much difference in relation to placement stability, as shown by HZA’s analysis of DHS’ KIDS data. Among children removed from their homes in the first quarter of calendar year 2008, the percentages with two or fewer placements in the *first three months after removal* were as shown in Table 1.

Age at Removal	Total Children Removed	Number with 2 or Fewer Placements	Percent with 2 or Fewer Placements
Age 0-1	489	369	75.5%
Age 2-5	405	298	73.6%
Age 6-9	309	250	80.9%
Age 10-13	220	176	80.0%
Age 14-17	202	158	78.2%

What the table shows is that for no age group, not even those under two years of age, is DHS able to provide as stable a living arrangement in the *first three months* as half of the states provide in the *first year*.

The final large question about how children fare in out-of-home care has to do with the length of time they spend in care. Here, too, Oklahoma's federal review showed that, compared to other states, Oklahoma takes too long both to return children home and to get them adopted when they cannot go home. Moreover, on the most valid of the federal measures related to the time to reunification, Oklahoma shows its worst results. Among children entering care for the first time, *in Oklahoma fewer than one-third return home within one year, compared to 40 percent or more in half of the states and to a national standard of 48 percent.*

That finding brings the discussion full circle, back to the issue of too many children in care. Unnecessary removals of children from their homes is only one reason Oklahoma has too many children in care. The other reason is that children stay in care too long. Both factors contribute to the extraordinarily high placement rate and restoring some balance to the system will ultimately require addressing both issues.

The careful reader will have noted that none of the above discussion talks specifically about DHS' performance. As will be described in detail throughout the rest of this report, there are many parties which are partially responsible for these results, in some instances even more so than DHS itself. This is an important point, because only by correctly identifying the sources of these results can this audit arrive at recommendations which will change them. Some of those recommendations will be directed at DHS but some will be directed elsewhere.

As noted above, DHS does have measures of its own performance, call "key indicators." For child welfare those indicators include the following:⁶

- Timeliness of Priority 1 Investigation/Assessment Initiation
- Timeliness of Priority 1 Investigation/Assessment Completion
- Timeliness of Priority 2 Investigation/Assessment Initiation
- Timeliness of Priority 2 Investigation/Assessment Completion
- Families Receiving Prevention Services with No Confirmed Reports within 12 Months of Closure
- Children in Out-of-home Care Less than 12 Months with Fewer than Three Placement Settings
- Children in Out-of-home Care Remaining in the Same Placement for Six Months or More
- Children in Out-of-home Care Who Achieved Permanence within 12 Months

⁶ Only those indicators with goals attached to them are shown here. The remaining indicators provide information to administrators but are not evaluative in nature.

- Children Remaining in Out-of-home Care Longer than 12 Months
- Permanency Cases with No Confirmed Reports within 12 Months of Closure
- Youth Eligible for Independent Living Services Who Receive Life Skills Assessment
- Children Receiving Face to Face Contact in the Home of the Provider during the Month
- Children with a Goal of Adoption Who Are in Trial Adoption
- Children in Trial Adoption Who Achieve a Finalized Adoption

The first thing to note about these indicators is that they are a mixture of process and outcome measures. Those relating, for instance, to cases where there is no additional confirmed report of abuse or neglect within 12 months of case closure measure safety in as direct a way as possible. On the other hand, measuring the timeliness of investigations or whether independent living youth receive the appropriate assessments are process measures. The assumption behind the process measures is that completing the right processes and doing so in a timely fashion will lead to positive outcomes, and the process is often measured because of the difficulty of measuring the outcome itself. It would, for instance, be difficult to measure with any accuracy how well youth discharged to independent living actually have the skills to live on their own.

Assuming that the presumption is correct that high performance on the key indicators will result in good outcomes for clients, it is useful to see where the agency stands on its own criteria. Table 2 shows the measures, the goals or targets and the actual performance for state fiscal years 2007 and 2008.

Table 2 DHS Performance Child Welfare Key Indicators SFY 2007 and 2008			
Indicator	Target	SFY 2007	SFY 2008
Timeliness of Priority 1 Investigation/Assessment Initiation	>=98%	96%	97%
Timeliness of Priority 1 Investigation/Assessment Completion	>=90%	81%	80%
Timeliness of Priority 2 Investigation/Assessment Initiation	>=95%	94%	95%
Timeliness of Priority 2 Investigation/Assessment Completion	>=90%	76%	81%
Families Receiving Prevention Services with No Confirmed Reports within 12 Months of Closure	>=90%	82%	85%

Table 2
DHS Performance
Child Welfare Key Indicators
SFY 2007 and 2008

Indicator	Target	SFY 2007	SFY 2008
Children in Out-of-home Care Less than 12 Months with Fewer than Three Placement Settings	>=86.7%	68%	66%
Children in Out-of-home Care Remaining in the Same Placement for Six Months or More	>=65%	71%	70%
Children in Out-of-home Care Who Achieved Permanence within 12 Months	>=35%	27%	30%
Children Remaining in Out-of-home Care Longer than 12 Months	<=50%	57%	59%
Permanency Cases with No Confirmed Reports within 12 Months of Closure	>=90%	94%	94%
Youth Eligible for Independent Living Services Who Receive Life Skills Assessment	>=80%	67%	62%
Children Receiving Face to Face Contact in the Home of the Provider during the Month	>=95%	96%	97%
Children with a Goal of Adoption Who Are in Trial Adoption	>=50%	38%	38%
Children in Trial Adoption Who Achieve a Finalized Adoption	>=50%	63%	68%

There are four measures in which the agency met or exceeded its target both years: children remaining in the same placement for at least six months, permanency cases with no confirmed reports within 12 months following closure, face to face contacts and adoptions among children in trial adoption settings. In addition, the agency is close to or at its target in both years for initiating investigations and assessments, whether Priority One or Priority Two.

Together these results do not add up to a promising picture. Three of the six measures where the agency does relatively well are simple timeliness issues, getting the work done in the prescribed time. Even two of these relate only to the beginning of the process and the results for completion of the investigations and assessments are much less positive. The results on the measure relating to children remaining in one placement for six months or more has to be compared to the results on placement stability discussed above which suggest that the results in other states would be far better than those shown here. And the relative absence of confirmed reports on children discharged from care is less impressive when one notes that few children return home

within a reasonable amount of time. All of this suggests that substantial improvements are needed in Oklahoma's child welfare system.

Adult Protective Outcomes

DHS uses only two key indicators for adult protective services: the timeliness of the initiation of the investigation and the timeliness of the completion of investigations in long-term care facilities. The goal for each of these measures is 95 percent. As with several of the child welfare key indicators, these are both process measures, but unlike



child welfare there are no nationally established and universally recognized outcome measures which would show the extent to which the agency is successful in protecting vulnerable adults. Various groups, including the National Center on Elder Abuse, the National Association of State units on Aging, the National Committee for the Prevention of Elder Abuse and the National Association of Adult Protective Services Administrators, promote standardization of the APS program, data and performance measures but to date there are neither federal standards nor a consensus on how to measure the performance of the program.

The first DHS measure for APS, timeliness of the initiation of the investigation, probably is related to safety and is similar to one of the federal child welfare indicators used to measure safety. On that one, the agency met the goal in SFY 2007 but has no figures available for SFY 2008. For the second measure, performance fell short of the target in both years, showing 73 percent in SFY 2007 and 78 percent in SFY 2008. Moreover, it is difficult to draw a direct correlation between completion of the investigation on time and the safety of the vulnerable adult. Without more evidence, the tentative conclusion would appear to be, as it is in child welfare, that DHS is better at providing an initial response than it is at following up with later actions. However, the extent to which that impacts safety is not currently known.

Family Support Outcomes⁷

This third area in which this audit reviews performance is, as indicated in the introduction, entirely different in nature from either child welfare or adult protective

⁷ While adult protective services is placed organizationally within the Family Support Services Division, it is clearly different than the rest of the programs within that division. Therefore, for purposes of examining performance indicators, the term "Family Support Services" will refer only to TANF, food stamps, child care eligibility and health related medical services.

services. While the latter two programs represent involuntary services, the services covered here, including TANF, food stamps, Medicaid eligibility and similar services, are entirely voluntary. Clients are never compelled to accept these services, and this makes DHS' role substantially different.

The goal in this instance is twofold. The first goal is simply to ensure that the eligibility processes are carried out accurately and within the prescribed timeframes. In other words, the first goal is process oriented and the degree to which clients who exhibit need as defined by the eligibility rules actually received assistance is dependent on DHS performing the processes appropriately.

The second goal for some of the family support services is to assist the client to become self-sufficient. This is not always the case, however, because some clients will be receiving food stamps or medical benefits precisely because a disability or age prevents them from working and earning an adequate income. TANF is therefore the only program for which DHS uses a self-sufficiency measure.

For state fiscal years 2007 and 2008, there are 13 key indicators. Table 3 (next page) shows the indicators, the goals and the actual performance.

Aside from the measures related to whether errors in food stamp eligibility are related to agency error or client error, which appear not to have been measured in 2008, the only measure on which family support falls substantially short of its goal relates to the processing time for long-term health care benefits. While some of the measures show results which fall short of their targets, they are not very far off. Moreover, on the two self-sufficiency related measures, TANF participation rate and TANF cases remaining closed for at least three months, the agency shows itself meeting the targets in SFY 2008.

Summary

While the performance indicators available for both adult protective services and the various family support programs are neither as extensive as those for child welfare nor as directly related to positive client outcomes, the available data suggest that DHS is performing closer to expectations in each of those program areas than it is in child welfare. At one level this is understandable, because child welfare simply involves far more complexity, far more sustained effort and far greater risks than do either of the other areas. Even despite the similarities between adult protective services and child welfare, child welfare workers are required to handle their cases much longer and to go beyond questions of immediate safety to ensure that children have permanent homes, that they have stability in their lives and that they are growing and developing

appropriately. Some of those issues surface with some adult protective cases, but in general the issues are limited to protection.

While the expectations on child welfare workers are greater than those on other workers, ultimately the agency has to meet those expectations, and it is not doing so at the present time. Too many families are disrupted through removals of their children; those children may not be as safe as they should be once they are removed; they are not provided with any reasonable level of stability while they are in care; and they stay in care too long. The remainder of this report is devoted to understanding why this is the case and to recommending changes in the system that should lead to substantial improvements, including changes that will impact other programs and changes that should occur both within and outside of DHS.

**Table 3
DHS Performance
Family Support Key Indicators
SFY 2007**

Indicator	Target	SFY 2007	SFY 2008
TANF recipients meeting participation rate (in a work activity 30 hours or more a week)	>50%	46%	52%
TANF cases closed for reason of employment which have remained closed for 3 months	>75%	85%	87%
Food Stamp program cases processed within the required time	>95%	97%	97%
Food Stamp program quality control error rate	<6%	6%	4%
Food Stamp program case errors caused by agency	<25%	47%	NA
Food Stamp program case errors caused by recipients	>75%	53%	NA
Child Care program certifications processed within required time frame	>95%	93%	92%
Average processing time for Child Care certifications	<2 days	1 day	1 day
Percent of Child Care program denials processed within required time frame	>95%	98%	98%
Health benefits processed timely (more than 20 days)	>95%	96%	96%
Short-term health benefits processed timely (20 days or less)	>95%	95%	95%
Long-term health benefits processed timely	>95%	82%	83%
Title XIX applications processed timely	>95%	95%	95%

Chapter Three

The Problem with High Placement Rates: The Contribution of Legal Definitions and Standards

Scope

The previous chapter shows that DHS removes too many children from home, keeps them in placement longer than other states, moves them more times than elsewhere, and achieves lower rates of reunification.

Oklahoma's placement rate (the proportion of children per 1,000 who are placed in foster care) is nearly twice the national average. This fact has driven HZA's analysis of the laws, policies and practices of DHS's child welfare agency. This chapter and the next deconstruct those issues with the objective of determining the reasons a high placement rate is problematic, the potential reasons for that rate and possible statutory and changes for establishing better criteria for removals of children from their homes.

Findings and Analysis

Why is a High Placement Rate a Problem?

A high placement rate is both a *problem in and of itself* and a *symptom* of other problems. There are at least three major reasons a high placement rate is a problem in and of itself. Foster care placement produces worse outcomes for children, particularly children placed as infants or at a very young age; foster care is expensive; placement uses inordinate amounts of agency and non-agency resources.

- *Foster care placement produces worse outcomes for children.*

Placement in foster care is almost always worse for children, except in really dangerous situations, than strengthening the family. We know through research that children do better with their own families, that they generally seek out their own families after they turn 18 even if they have been in foster care for years or get adopted, and that foster

care leads to poor consequences such as juvenile infractions, homelessness, lower educational achievement and higher teenage pregnancy rates.⁸

- *Foster care is expensive.*

In addition to the monthly rate given to the placement provider, DHS must pay for clothing, medical care, and other benefits. Last year DHS spent over \$50 million on foster family care alone, over \$14 million on therapeutic foster care and over \$9 million on shelters and group homes. These costs do *not* include staff. A July 2008 meta-analysis of evidence based practices in child welfare concluded that “reductions in child abuse and neglect and in out-of-home placements lead to reductions in public spending for the child welfare system and in reduced medical, mental health and other costs for victims.”⁹ In other words, it is not merely the level of maltreatment which drives system costs; it is also the way that the system deals with cases of maltreatment, and out-of-home placement is the most expensive way to deal with them.

- *Placement uses inordinate amounts of both agency and non-agency resources.*

These include caseworker time, foster parent recruiters, district attorneys’ time, judges’ time, and parent and child attorney expenses. It would be healthier both for children and families and for the system to expend the resources strengthening families and providing the specific tangible supports they may need such as job training, substance abuse treatment and housing, than putting their children into foster care, often with little net benefit either to the child or the family.

Why then does Oklahoma have a high placement rate? It is potentially a symptom of any or all of the following:

1. that Oklahoma has greater social issues such as poverty and drug abuse than the rest of the country;
2. that Oklahoma as a state and DHS as an agency harbor a philosophy of protecting children *from* their families rather than strengthening the families to be the protectors of their children;
3. that the decision making about which reports should be investigated, which investigations should result in substantiations of maltreatment and/or when children need to be removed from their homes are too broad or poorly defined;

⁸ Barth, R.P., National Survey of Child and Adolescent Well-Being: How are the Children Faring and Did Mental Health Services Help? Presented at the University of Washington School of Social Work, 2005.

⁹ Washington State Institute for Public Policy, “Evidence-based Programs to Prevent Children from Entering and Remaining in the Child Welfare System: Benefits and Costs for Washington,; Olympia, Washington, July 2008.

4. that Oklahoma lacks the preventive or more intensive services needed to keep children safely at home which other states may employ;
5. that other institutions outside of DHS which touch the child welfare system are contributing to this high placement rate.

The following pages examine each of these potential reasons.

- *That Oklahoma has greater social issues such as poverty and drug abuse than the rest of the country.*



Oklahoma's child poverty rate at 20.7 percent is in fact one of the higher ones in the country; Oklahoma is at about the 20th percentile for child poverty. However, the safety net for Oklahoma's children should be playing itself out in the *family support* services system, not in the child welfare system. Moreover, on some key issues other than poverty, Oklahoma's numbers do not suggest conditions which are worse than those in other parts of the country. For instance, the rates of both heavy drinking and binge drinking, as reported in the Center for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) is low compared to other states and to the national average (3.5 percent heavy in Oklahoma, 5.2 percent in the United States; 12.5 percent binge drinking in Oklahoma, 15.8 percent in the United States). The National Survey on Drug Use and Health looks at the use of other substances but mirrors the BRFSS findings for Oklahoma for alcohol. Oklahoma is below national averages for past-year marijuana use (8.2 percent Oklahoma, 10 percent United States, 11 percent Western United States), but higher for nonmedical use of pain relievers in the past year (6.4 percent Oklahoma, 5 percent United States, 5 percent Western United States). The only exceptions that could be found for Oklahoma relate to treatment data (as opposed to use surveys). Oklahoma does show a far higher treatment rate for methamphetamines than elsewhere and higher methamphetamine use generally tends to be concentrated in western states. While it is an extremely serious drug, its overall prevalence is far lower than those of alcohol and other drugs.

- *That Oklahoma as a state and DHS as an agency harbor a philosophy of protecting children from their families rather than strengthening the families to be the protectors of their children.*

Several of the laws, policies and practices governing or impacting child welfare in Oklahoma contain provisions which serve to punish families for their ills rather than finding ways to strengthen them. For example, if a baby is born to a family where another child has been removed, the case is automatically assigned for investigation and the infant is routinely removed, as well. The "Practice Model" introduced by DHS a

couple of years ago is an attempt to change the attitude of workers toward families, but is also an acknowledgement of past attitudes and practices. The major problem with the Practice Model, in addition to the fact that few frontline staff appear to be aware of it, is that the policies themselves have not changed to reflect concepts such as “we continually examine our use (misuse) of power...” or “we respect and honor the families we serve.” Taking a newborn from its family primarily because another child is already involved in the system does not honor the families served.

- *That the decision making about which reports should be investigated, which investigations should result in substantiations of maltreatment and/or when children need to be removed from their homes are too broad or poorly defined.*

DHS has a decentralized approach to accepting and screening child abuse reports, as well as three abuse hotlines. Consistency is difficult with this structure, and it is not made easier by the absence of any training specifically for those taking the calls and of statewide management reporting regarding the screening of calls. Without consistent criteria, it is probable that many calls which should result in investigations do not and that some of those which do should not.

More importantly, DHS has connected substantiations of maltreatment too closely to the decision to remove. Agency administrators have attributed the high placement rate at least partially to a broad definition in state law as to what counts as abuse and neglect, but over the past ten to fifteen years, child welfare professionals have come to a consensus that removals should occur not because abuse or neglect has been substantiated but because the child’s safety is imminently threatened. The agency says that it is moving to a risk and safety assessment approach, as opposed to an incident-based system, but its definitions of risk and safety fail to distinguish those two concepts adequately.

- *That Oklahoma lacks the services needed to keep children safely at home which other states may employ.*

DHS has paid attention to this issue by investing in Oklahoma Children’s Services, the name for a series of contracts covering all parts of the state which provide both placement prevention services for families who have been investigated but whose children remain in the home, and reunification services to ensure the safety of children when they do return home. DHS’ high placement rate calls into question either the sufficiency and availability of these services, their effectiveness, or the need for a broader palette of responses.

- *That other institutions outside of DHS which touch the child welfare system are contributing to this high placement rate.*

The other major actors in the child welfare system are law enforcement, the District Attorneys and the courts, and each is addressed later in this report. The most notable non-DHS structure contributing to the placement rate is the authority of law enforcement to remove children from their homes without DHS' prior involvement and, through the use of judicial standing orders in Tulsa and Oklahoma Counties, to place them in DHS custody,. This means that even if the agency moves to a narrower criterion for removal for itself, one based on imminent threats to the child's safety, there may not be much impact if it does not apply to law enforcement. Moreover, the agency's use of emergency shelters in effect facilitates these removals by providing a ready placement for police to use.

In sum, there is much more evidence that Oklahoma's high placement rate is a function of how the system operates than it is of significant differences between this state and the rest of the nation. The contributors lie both within the agency and outside of it, and fixing the problem will require changes in both places.

Statutory Issues

The Oklahoma Children and Juvenile Law Reform Committee is in the process of examining the entire legal basis for child welfare programs in Oklahoma, as represented in Title 10 of Oklahoma's Annotated Statutes and has made recommendations for code revisions. This expansive effort has been long and time consuming and the results will be addressed here only in relation to issues related directly to removal of a child from his or her home. This includes three issues: the criteria for removal, who carries out the removal and the role of the district attorney.

Criteria for Removal

The Reform Committee has proposed adding language to Title 10 emphasizing the preservation of families and has added the concept of safety to early sections of the chapter. Specifically, part of Article 1 is proposed to say the following.

It is the intent of the legislature for the Children's Code to provide the foundation and process for state intervention into the parent-child relationship whenever the circumstances of a family threaten a child's safety and to properly balance the triumvirate of interests heretofore stated. To this end, it is the purpose of the laws relating to children alleged or found to be deprived to:

1. Intervene in the family only when necessary to protect a child from harm or threatened harm.

2. Provide expeditious and timely judicial and agency procedures for the protection of the child.
3. Preserve, unify and strengthen the child's family ties whenever possible when in the best interests of the child to do so.
4. Recognize that the right to family integrity, preservation or reunification is limited by the right of the child to be protected from abuse and neglect.
5. Make reasonable efforts to prevent or eliminate the need for the removal of a child from the home and make reasonable efforts to reunite the child with in the home unless otherwise prescribed by the Oklahoma Children's Code.
6. Recognize that permanency is in the best interests of the child.
7. Ensure that when family rehabilitation and reunification are not possible, that the child will be placed in an adoptive home or other permanent living arrangement in a timely fashion.
8. Secure for each child, the permanency, care, education and guidance as will best serve the spiritual, emotional, mental and physical health, safety and welfare of the child.

The most important feature of this passage, for purposes of the present analysis, is the first numbered item. The intent is undoubtedly to minimize intrusions into family life, although the language does not provide a great deal of guidance. In fact, in the previous section where the "triumvirate of interests" is mentioned, the language suggests two very different standards. In the first, the language reads as follows.

...it is presumed that a child's best interests are ordinarily served by leaving the child in the custody of the parents...Nevertheless, this presumption may be rebutted where there is evidence of abuse and neglect or threat of harm.

The second standard appears in the following text.

...where family circumstances threaten a child's safety, the state's interest in the child's welfare takes precedence over the natural right and authority of the parent...

The proposed definition of "harm or threatened harm to a child's health or safety" is also relevant here. That term is proposed to mean:

...any real or threatened physical, mental or emotional injury or damage to the body or mind that is not accidental including, but not limited to sexual abuse, sexual exploitation, neglect or dependency.

If one uses the term “safety” in the way it has come to be used by child welfare professionals over the past couple of decades, the first statement and the definition suggest a much broader standard for court intervention than does the second. It is, however, probably not appropriate to demand of a statement of legislative intent or even of a statutory definition that it conform to current professional usage.¹⁰

The legislative intent and definitions provide, in any event, only a basis for court intervention, not for removal of the child. The criteria for the latter appear in Part 2 of the proposed changes and include the following two alternative conditions.

- a. the child is in need of immediate protection due to abuse or neglect,
or
- b. that the circumstances or surroundings of the child are such that continuation in the child’s home or in the care or custody of the parent, legal guardian or custodian would present an imminent danger to the child.

The second of these conditions represents approximately what child welfare professionals refer to as safety and is therefore a good statement of the consensus view of when removal is appropriate. The first statement can, on the other hand, be read in either of two ways. It may be read as assuming that when a child has been abused or neglected he or she is automatically in need of immediate protection, or it may be read as saying that removal is permitted only when a child’s need for immediate protection is due to abuse or neglect, as opposed to other causes. Neither of these readings would seem to be entirely satisfactory. Not every child who has been abused or neglected is in need of immediate protection and when there is such a need the court should be able to intervene, even if the cause is not abuse or neglect. Because the connection between the two statements is an “or,” there is no need for the first, a., if it has the second meaning. If it has the first meaning, it offers an extraordinarily wide scope for justifying removals.

The existing language of Title 10 also has one place where this issue is addressed. Assuming, as HZA does, that the criteria for returning a child to the parents are the reverse side of the coin to the criteria for removal a child in the first place, the current

¹⁰ HZA would suggest, however, that the proposed term “Safety Assessment and Analysis” be changed because of its potential for creating serious confusion. In the proposed legislative definition this term refers to “a written response to a report of alleged child abuse or neglect” similar to an investigation. In the professional parlance, however, a safety assessment simply examines safety and should occur at a variety of times in the life of a case even when no allegations are currently being made.

Section 7003-6.2(C)(2) and (C)(5) are also relevant. In the first, an objection to the release of a child from custody can be filed with the court “on the grounds that the order of the court releasing the child from state custody creates a serious risk of danger to the health or safety of the child.” In the second, a finding by the court that such a serious risk of danger is not present require the court to lift a previously granted stay of the order to release the child. The current language, if applied to the initial removal as well as to the release of the child, provides probably the clearest statement of when the child is better off in state custody than in parental custody.

Who Removes the Child

In Oklahoma, law enforcement is charged with the physical removal of children from their homes. Moreover, under “standing orders” in Tulsa and Oklahoma Counties, which are explicitly allowed in statute, including the proposed version of Title 10, police can remove children from their homes without prior case specific judicial approval and put them under the jurisdiction of the Department by placing them in the state-operated shelters.

While law enforcement is permitted to remove children in most states, Oklahoma is nearly unique in prohibiting DHS from doing so, except in some unusual situations. One of the few, if not the only other state with this provision is Nebraska, the only state with a higher placement rate than Oklahoma’s. On its face it might appear that limiting the range of officials who are permitted to remove children would also limit the number of removals. That view, however, ignores both the criteria used for removal and the ability, at least in Oklahoma and Tulsa Counties, for law enforcement to turn the child over to the Department.

In its 2007 study of the Oklahoma County Juvenile Courts, the American Bar Association found that law enforcement officers execute the majority of emergency removals. However, “there is presently no protocol or set of standards by which decisions to remove are guided. Furthermore there is no requirement that law enforcement contact DHS for assistance in assessing the nature of the situation and whether removal is warranted.” Moreover, in Oklahoma County alone there are eight different law enforcement agencies and “the manner in which each agency handles a removal or the circumstances under which each agency makes removal decisions vary widely.”¹¹

Law enforcement personnel are not, as a rule, trained in conducting safety assessments, nor are they trained to explore options other than placement. Yet, by making the child the Department’s responsibility, the police also initiate the court’s jurisdiction over the child. The Department is not permitted to end its custody, even with an appropriate safety plan for the child, without the court’s approval. Thus, while DHS is trying to

11 American Bar Association Center on Children and the Law, “Oklahoma County Juvenile Court Child Abuse and Neglect Case Handling Assessment,” May 18, 2007.

change its practice to emphasize risk and safety and to give parents more respect and a larger role in their own destinies, the structure of the legal system for child welfare works against this approach.

As suggested above in the discussion of the criteria to be used in removals and as will be discussed more extensively in the next chapter, it is critical that children are removed from their homes only when there is a safety threat. That also implies the possibility of alternatives to placement, and DHS staff are the ones who should have the responsibility both for determining whether the child is safe and for ensuring his or her safety.

Role of the District Attorney

The American Bar Association's **Standards of Practice for Lawyers Representing Child Welfare Agencies** describe two models used throughout the United States: the Agency Representation Model and the Prosecutorial Model. The ABA recommends use of the Agency Representation Model; Oklahoma uses the Prosecutorial Model. In this model the district attorney represents "the state" rather than DHS in deprived proceedings, and DHS is not even a party to the case. Its official role is merely to be a witness in court, but, of course, it is also charged with carrying out the orders the court makes as to the disposition of the case. In practice the district attorneys in Oklahoma generally represent DHS's position, but they are not required to do so and are sometimes at odds with it. When the DAs oppose DHS's position it can be "confusing to the court and frustrating to DHS," according to the ABA's findings.



Some of the relevant standards of practice for lawyers representing child welfare developed by the American Bar Association with input from judges and attorneys around the country are:

- to promote timely hearings and reduce continuances,
- to protect and promote DHS's credibility,
- to cooperate and communicate regularly with all parties and
- to counsel DHS on all legal matters and policy issues.

The prosecutorial model makes it much more difficult for the assistant district attorneys to uphold several of the ABA standards represented above. For example, they are not required to protect and promote DHS's credibility. Often they do not have the time to counsel DHS about all legal matters.

Like law enforcement, district attorneys in Oklahoma play a very large role in child welfare cases. When law enforcement has not already initiated the court's jurisdiction by

turning a child over to DHS, the district attorney decides what goes to court for judicial oversight and what does not. One of the potential conflicts in this situation is that DHS may find the child needs to be removed because there is a safety threat, but if the district attorney does not agree, no petition is filed and the child is not removed. In essence, the prosecutorial model gives the district attorney the power to make decisions regarding the safety of children. In theory they are only making decisions about the sufficiency of the evidence; in practice they are making decisions about safety.

Recommendations

Recommendation 1: The Legislature should review the proposed Title 10 revisions to ensure that the sole criterion for removal of a child from his or her home is an imminent safety threat.

Not a lot of detail needs to be in statute. DHS policy can provide the specific factors which need to be taken into account and the processes which need to be conducted prior to a removal. It is important, however, that the Legislature make clear its intent that the system is not to disrupt families except when there is a clear danger to the children.

In some places the language appears to open a path for children to be removed from their homes in circumstances other than imminent danger. For instance, the following appears (§10-7003-2.1):

- B. The court shall not enter an emergency custody order removing a child from the child's home unless the court makes a determination:
1. That continuation in the child's home is contrary to the welfare of the child or that immediate placement is in the best interests of the child; and
 2. Whether reasonable efforts have been made to prevent the removal of the child from the child's home, or
 3. An absence of efforts to prevent the removal of the child from the child's home is reasonable because the removal is due to an emergency and is for the purpose of providing for the welfare of the child.

The first part of (B)(1) is language presumably designed to conform to federal requirements for Title IV-E, but the second part allows removals when continuation in the child's home is **not** contrary to the welfare of the child but "immediate placement is in the best interests of the child." "Best interests" is a much looser standard than "imminent danger" and, because the two statements in this clause are connected with an "or," it is presumably intended also to be looser than the federal requirement of "contrary to the welfare," making the children removed on that basis ineligible for federal reimbursement.

Similarly, in the proposed §7003-5.5(A)(2) dealing with dispositions, placement with the Department is listed as one of several potential dispositions and it is only implied that the condition for making this disposition is that the other alternatives are not available or appropriate. No standard is clearly articulated for when that might be the case.

These are but examples of where the language is similarly either unclear as to the standards for removal or more expansive than a strict safety standard would be.

Recommendation 2: The Legislature should modify Title 10 so that DHS is involved with the police in all removals of children from their homes and so that the authority for “standing orders” is eliminated.

Despite the uniqueness of Oklahoma’s prohibition on DHS removals of children, HZA is not recommending changing that prohibition. Rather, it is recommending that the police no longer have unilateral authority to remove children and give custody to DHS without DHS involvement.

If the police are considering removal of a child for any reason, DHS should be required to conduct a safety assessment and develop a safety plan. Removal is only one means of assuring safety, and it should be DHS’ responsibility to attempt to prevent the placement through other safety measures, including finding a fit and willing relative or neighbor if necessary to take the child, particularly when the situation does not involve an abuse and neglect allegation. The most important strategy for reducing the placement rate in Oklahoma is to assure that placements are made only for safety reasons and that reasonable efforts are made to prevent removals. This is impossible if DHS is not part of the removal decision. Removal of the authority for standing orders will be an essential component of the effort to prevent inappropriate removals.

Recommendation 3: DHS should contract with District Attorneys to represent DHS in deprivation proceedings.

DHS should be the district attorney’s client and DHS should be a party to every deprivation case. The funds that pay for DAs work on deprivation cases would simply be channeled to DHS who would contract for the services of the DAs. In addition to moving to the ABA’s recommended “Agency Representation” model (as opposed to the Prosecutorial Model) the new relationship would allow DHS to recover federal Title IV-E funds as an administrative cost for children in foster care.

Scope

The second chapter of this report showed that Oklahoma removes too many children from home, keeps them in placement longer than other states, moves them more often and achieves lower rates of reunification. The previous chapter begins by discussing why a high placement rate is problematic and which components of the system, in broad terms, contribute to that rate. That chapter then focuses on the statutory factors affecting the placement rate and makes suggestions for changes in Title 10. This chapter takes the analysis further, focusing on the policies, practices and programs that govern child welfare. Specifically, this chapter addresses:

- how abuse and neglect referrals are handled,
- how assessments and investigations are performed,
- casework decision-making,
- the use of shelters and
- the services available to serve children and families.

Findings and Analysis

How Abuse and Neglect Referrals are Handled

Standards

When the protective agency receives reports of abuse and neglect on children and vulnerable adults, the public and professionals making those reports should have an assurance that the report will be handled in the same way, regardless of where or from whom the call originated. That assurance can only be guaranteed when the agency has consistent intake policies, trained staff answering the calls and consistent monitoring of performance. While it may not be literally impossible to ensure consistency within a system where reports are taken in more than 70 locations, it is much more difficult to do so than it is in a system where reports are taken in a single place.

There are at least six advantages to a centralized abuse reporting hotline. The first has to do with efficiency and consistency. In a centralized system, there are fewer staff taking calls, and with fewer people to train, hotline managers can more easily ensure

that staff are making accurate case determinations that are consistent with Department policy. Monitoring work, handling “gray area” situations, and implementing changes to existing intake policies are also easier. When this task is rotated among workers throughout the state, it is much more difficult to ensure that each worker is using current policy, especially when many, if not most of those workers are doing the intake function only part-time.

The second advantage is closely related. When the staff answering and assessing the calls are the same staff who do the investigations, objectivity is difficult to maintain. A worker who knows that all protective investigators in the county already have a high number of pending investigations may be more likely to screen out a call. In other words, local variations in workload, among other factors, can make a difference in how calls are handled. A call which requires investigation in the northern part of a state should also require investigation in the eastern, western and southern parts of the state.

Third, reporting abuse and neglect is often the first contact many people have with the agency. With a limited number of people answering the incoming calls, in-depth customer service training becomes manageable. The agency presents a more professional face.

Fourth, when case carrying field staff do not have to spend part of their time waiting for calls, they can devote more time to the families assigned to them. Child welfare agencies achieve better outcomes when workers spend the maximum amount of time possible with face-to-face contact with children, families and foster families. Likewise, adult protective service workers need to devote their time investigating maltreatment and setting up services, not answering new calls. Relieving them of this diversion leads to better casework and more comprehensive investigations.

Finally, monitoring the agency’s performance in conducting intakes is simpler when the process is centralized. In addition to the number of calls requiring new investigations, the agency needs to know which calls are screened out so it can ensure that the decision making is accurate and that those calls are handled appropriately. A significant number of calls come from the public attempting to report abuse and neglect which are not accepted by the agency. Some states have a secondary category of referrals that do not meet the criteria for an investigation, but contain indicators that some type of intervention or assessment is necessary. There may also be a group of callers that are simply requesting information while many calls are screened for a wide variety of reasons that should be accounted for. Of equal importance is identifying the number of callers who attempt to contact the human services agency to report abuse and neglect but hang up before someone answers. These calls are generally called “abandonments” and are a major concern in a well-functioning agency. The automation required to track such calls in a highly decentralized system is simply not feasible.

Practice in Oklahoma

There are three separate hotlines operating in Oklahoma at this time, and there is no consistency in how they function or even in what their staff believe their roles to be. In addition, each county office accepts its own calls during the day, bypassing the statewide hotline. It is useful to analyze each of these methods.

The statewide hotline is located in Oklahoma City. It is open 24 hours a day, 365 days a year, with occasional down times when there are staff meetings or trainings (during that time, callers are referred to the Oklahoma County hotline). Although its function is to accept calls for the entire state, the hotline staff report to a County Director for Oklahoma County, not to the central office or even to the Area Director. Despite the fact that the hotline workers have the same job classification as the investigators and permanency workers, that is, they are generally experienced workers, they do not make any case-related decisions. The decision to accept the call for investigation or assessment is made by supervisors among the field staff.

There are several issues related to the current operation of this hotline. First, workers at this hotline do not assess any of the calls, making its value questionable. The information provided by the callers is merely taken down and sent to the appropriate county for a determination of whether or not an investigation is warranted, an assessment is needed, or no action occurs. This means that the caller is not informed when no report was accepted and may be under the impression that protective action is occurring when the report was simply filed. This job is basically a high-level clerical function, requiring customer service and interviewing skills, but not social work knowledge or experience.

Even at the statewide hotline, the calls are not taped, nor is there any way for the supervisor to listen in on the call. Therefore, there is no assurance that the hotline worker has accurately documented the information or treated the caller in a respectful, professional manner. Supervisors rely on the experience of the workers and walking around, hearing one side of the conversation to judge the accuracy of the written reports.

Third, there is no bilingual worker except for a case aid who works after 4:00 pm. While DHS has access to a multi-lingual service telephonically, supervisory staff did not mention that when asked how they handle such calls. Instead, they said that Spanish speaking callers are told to call back after 4:00 pm. Similarly, the hotline does not have a TDD to receive reports from hearing-impaired reporters and when asked staff did not mention that an alternative, the Tulsa Source for Hearing Loss, is available. Either staff do not know about these alternatives (a training need) or the resources are not practical to use for some reason.

The abandonment rate (callers hanging up before someone answers) is extremely high – over 18 percent. The agency has no established goal for this rate, and no plan to

address the problem. The usual goal is five percent in other states such as Florida, Illinois and New York. Moreover, current management reports are not helpful in addressing this issue, because they provide abandonment information only by a 24-hour day, not by shift or hour. Thus, managers cannot determine during what times of day they are unable to answer calls at an acceptable level.

The fifth issue is related. Although management staff believe that all calls to the hotline are documented and sent to the appropriate county, management reports for FY08 show that almost 19,000 calls (44 percent) did not become referrals to the local office. No report is available to account for those calls.

Sixth, workers at the hotline do not conduct background checks on new report subjects, leaving that to local office staff. That only makes sense in the context that the hotline workers do not decide which calls will be investigated or assessed, because previous reports of abuse and neglect are generally considered to be one of the best indicators of current risk. It thus reinforces the clerical nature of the position, but it also prevents the call taker from identifying some Priority One (24-hour response) calls and alerting the county office in a timely fashion.

Although the hotline accepts calls regarding the abuse, neglect, or exploitation of vulnerable adults, once these reports are transmitted, hotline supervisors can no longer view them. If they get questions about the information, they cannot review the intake.

Staff from counties other than Oklahoma or Tulsa are not allowed to refer callers to the statewide hotline during the day. Therefore, they must spend time waiting for and processing calls, even though they have caseloads to attend to.

The hotline is reportedly seen by some in the agency as a “dumping ground” for workers that management doesn’t want working in the field. Even though they have no authority, they are Child Welfare Specialist II positions. Moreover, there is no training specific to hotline work as found in other states. Texas, for example, has a seven-week training program, while Florida provides eight weeks of training for hotline staff before they start working on the hotline, six weeks of classroom and two weeks of practicum. In both systems the hotline workers have far more responsibility than they do in Oklahoma, but the ability to collect and record information accurately, to know how to handle both professional and lay reporters, and to have a customer-service orientation are critical functions.

Finally, the hotline phone system is antiquated. Although there are as many as 13 workers taking calls at a given time, there are only five available lines. This means that, if five workers are on calls, no other call can get through, even if eight other workers are available to take a call. In most systems it is the inability to get through in a reasonable time that is the largest contributor to the abandonment rate.

The Oklahoma County hotline is operational only from 8:00 am to 5:00 pm, Monday through Friday. Work is handled quite differently at this hotline than at the statewide hotline. Hotline workers document a referral, and then it is electronically transmitted to a “searcher” unit at the hotline. The searcher (a clerical position) conducts background searches in KIDS, TANF, and Juvenile Offenders, but not in adult criminal systems. When the searcher completes this work, the report goes to the hotline supervisor, who then determines what the disposition should be, choosing from: investigation; assessment; and screen out. If the information is accepted for investigation, the supervisor determines whether it is a Priority One or a Priority Two report (Priority One reports must be initiated within 24 hours, while Priority Two reports require an initiation within 2-15 days). The search unit also gets reports from the statewide hotline that come in overnight or on weekends.



Several of the issues with the Oklahoma County hotline are similar to those with the statewide hotline. Calls are not taped or monitored and there is no training specifically for hotline staff in how to perform this role, including customer service.

There are also some differences. Perhaps the oddest contrast is in the reporting line. While the statewide hotline reports to a county director, the Oklahoma County hotline supervisors report to an Assistant in the Area Office, i.e., a higher level of the organization.

More importantly, the standards for determining whether the information provided in a call should lead to an investigation or an assessment are sufficiently different from those used elsewhere that very few calls are considered assessments in Oklahoma County. Finally, the county hotline does not accept calls on vulnerable adults, which confuses callers since the statewide hotline does.

The Tulsa County hotline also operates from 8:00 am to 5:00 pm, Monday through Friday. Although its processes are similar to the Oklahoma County hotline, there are some differences.

Each morning, the Tulsa hotline gets all the referrals that were received the previous evening by the statewide hotline. Since the statewide hotline staff do not perform searches for prior history, the Tulsa hotline supervisor and her assistant complete those checks. Because the statewide hotline does not screen or make case determinations, the Tulsa hotline supervisor must read each one to determine which of the following

actions should occur: investigation, assessment, or screen out. The Tulsa supervisor also determines whether the investigations should be Priority One or Two. The hotline supervisor assigns the new reports to one of five investigation teams in rotation. There is another specialized unit that handles sexual abuse, deaths, serious physical injuries, day care reports, foster home reports, substance exposed infants and high profile cases. The supervisor of this unit reports to one of the Tulsa County Directors.

As with the other hotlines, there is no taping or monitoring of calls and no training for hotline staff that is specific to their function. Moreover, the standards for determining what is to be investigated and what is to be assessed differs from place to place, with Tulsa showing about one-third of its referrals being investigations, one-third being assessments and one-third screened out.

Like the Oklahoma County hotline and unlike the statewide hotline, the Tulsa County hotline staff do searches on the alleged victims' and perpetrators' prior history with the agency. Like the state hotline, the Tulsa County hotline has only one bilingual worker. In this instance, it is the lead worker, but she is often called upon to provide interpretative services for child protection investigators and permanency workers, because most Tulsa units do not have bilingual staff.

When vacancies occur, the hotline supervisor is not involved in the interviewing process and has no say in who gets hired. New staff have reportedly included those who "gotten in trouble" in the field and those with medical issues. Tulsa was also the one site where the hotline's physical condition was problematic. It is located next to the lobby in a noisy area with many people coming and going.

The above description applies only to the largest intake points in DHS' abuse reporting system. In addition, each county office also accepts reports. In many instances calls are taken by clerical staff when all the caseworkers are unavailable. In sum, it seems fair to say that the function of taking referrals of abuse and neglect has been given low priority by the agency.

How Assessments and Investigations are Performed

There are two major decisions which have to be made regarding reports accepted for action. One relates to the priority, i.e., how quickly a response needs to be made. The other relates to whether the action should be an investigation or an assessment.

In Oklahoma's priority system Priority One reports indicate that the child is in imminent danger of serious physical injury. The situation is responded to on the day the report is received. Priority Two reports indicate there is no imminent danger of severe injury but that without intervention and safety measures it is likely the child will not be safe. Priority Two investigations or assessments are initiated within two to 15 calendar days from the date the report is accepted for investigation or assessment.

While there may be other states which allow up to 15 days for initiating an investigation, HZA is not aware of any. This is an extraordinarily long time period and it is unclear what conditions would suggest that intervention into the family is necessary but can wait for that length of time.

A new requirement included in administrative code changes effective in June of this past year mandates that two “good faith” attempts are made to have face-to-face contact with the alleged child victim on the assigned day of initiation of either a Priority One or Two investigation or assessment. Moreover, continued good faith attempts must be made each working day thereafter until contact is made or it is determined that the child cannot be located.

Since this new requirement appears to apply to both Priority One and Two reports (there is no distinction in the new instructions to staff 340:75-3-7.1), it strangely requires intensive work even on cases in which no action is initially required for the first 15-days. That would seem to represent a work burden on staff, raised by several people in the interview process, which is inconsistent with the more general requirements around Priority Two cases.

The new guidance also attempts to clarify what is an assessment versus an investigation. An infant born exposed to drugs is an investigation by rule. An assessment can be done for either priority but only when the allegations in the referral do not indicate a serious and immediate threat to the child’s health or safety; for example when the concerns in the report indicate “inadequate parenting or life management rather than very serious, dangerous actions and parenting practices.” Examples include minor injuries suggesting inattention to a child’s safety, untreated minor physical injuries, illnesses or impairments where the child is not in danger of significant harm in a short time period. That last part, “not in danger of significant harm in a short period of time,” would appear to suggest that an assessment referral cannot be a Priority One referral, but that is not the case. That situation almost certainly leads to confusion about what should and should not be an assessment.

Other situations which are said to be appropriate for assessment include unexplained absences from school, a child placed in shelter either by law enforcement or voluntary placement where the circumstances that resulted in the shelter placement fit the criteria for an assessment, and corporal punishment by a foster or trial adoptive parent involving a child four to five years of age, that is, physical discipline that did not result in injuries of any kind and did not involve unreasonable force.

Despite the attempt to make it clearer to staff when they should conduct an investigation and when an assessment, the guidance also notes that, “As in any decision-making process, the risk factors are considered first rather than strictly following the guidelines.” That kind of directive assumes that staff are clear on issues of risk. As the chapter on personnel issues will suggest, that does not appear to be the case.

Casework Decision-making

The critical decisions that are made in the life of a case include:

- Whether a referral should be investigated, assessed, referred to another agency, or receive no follow-up;
- Whether the allegations in an investigation should be substantiated;
- Whether the family should be provided voluntary services;
- Whether the family should receive court-ordered services;
- Whether the child should be removed from home;
- Whether the child should be returned home;
- Whether the case should be closed.

Much of this chapter up to now as well as the last has related to the first two critical decisions. This section focuses on the decisions to keep a child in the home with or without services, the decision to remove and the decision to return home.

Standards

For many years, child protection agencies struggled with the fact that a significant number of children who had been the subject of a child abuse or neglect investigation were being abused or neglected again within a relatively short time period after the first incident. Often the second reported incident was more serious than the original maltreatment. Child advocates were concerned about the inability of child protection workers to identify children who were in immediate danger or were at risk of serious harm in the near future. After a few research projects in the late 1970s and early 1980's, a risk assessment matrix was developed in several states, including New York and Illinois. These were short, somewhat generalized documents that focused on specific factors that indicated a child was likely to be re-abused. These matrices led to enough

improvement that additional research was conducted to attempt to further enhance them.



By the early 1990s it became clear that the risk assessments were adequate for identifying elements that might lead to some future abuse or neglect, but that determining whether a child was in immediate danger was not served by these protocols. That led to the defining of a distinction between risk and safety,

in terms of child maltreatment, and led to the creation of separate protocols for each.

Risk was defined as being the likelihood that there would be a subsequent incident of child abuse and neglect. Risk assessment protocols were understood to be used as structured decision making instruments that helped focus the case plan on what issues needed to be resolved in a family so that the children could live at home without being subject to maltreatment. Although many variations were created, the factors were often focused on four areas: child issues, caregiver/perpetrator issues, environmental issues, and family dynamics. The future maltreatment was not defined by severity or a specific time frame. These protocols were successful at helping caseworkers center their attention on issues that created or sustained risk. They did not, however, address immediate safety issues and were therefore not useful in assessing the imminent dangers to a child which should drive the removal decision.

Safety was defined as the threat of serious harm by child abuse and neglect in the very near future. Child endangerment or safety assessments, were designed to identify those factors that are present in a family situation that must be ameliorated if the child was not to be removed. Harm is seen as imminent and could occur in the immediate future. Rather than identifying factors that must be *resolved* (as is done by risk assessments), these assessments identify factors that must be *controlled* until longer term services can be provided. If a safety factor is identified, a safety plan must be put in place to control that factor, or the child must be taken into protective custody.



Research studying the effects of implementing strong safety assessments into child protection systems has shown very positive results in several states. In Illinois, for example, the number of children who were subjects of a subsequent abuse and neglect report within 60 days after a prior report decreased by 17 percent in the first year, and continued to decrease incrementally after that.

Risk-assessment protocols have also been demonstrated through research to be effective. Case plans that are focused on the identified risk factors lead to shorter time periods for open cases and clearer, individualized objectives for the parents to work on.

One of the areas in which it seems clear that safety is not being used as the criterion for removal involves cases of parental substance abuse, including those involving drug-exposed infants. Most drug-exposed newborns (with the exception of some with marijuana exposure) go directly from the hospital to a shelter and then to a foster or kinship home, with occasional stays in an emergency foster home after the shelter. The process was presented in several interviews as so automatic that safety standards do not appear to be applied. Table 4 shows that the result of the policy for the past eight

quarters. The number of drug exposed children in the removal column often exceeds the number of drug-exposed victims in the referral column. This suggests that more children of that age are removed than are even formally referred.

Period	REFERRALS			REMOVALS		
	All Referrals with at Least One Victim <2 Years of Age	Drug-exposed Child		All Removals of Children <2 Years of Age	Drug-exposed Child	
		No.	%		No.	%
3/31/08	2,640	18	0.68%	489	36	7.36%
12/31/07	2,352	14	0.60%	407	24	5.90%
9/30/07	3,033	12	0.40%	548	18	3.28%
6/30/07	2,883	9	0.31%	555	13	2.34%
3/31/07	2,636	14	0.53%	498	23	4.62%
12/31/06	2,538	14	0.55%	514	19	3.70%
9/30/06	2,761	28	1.01%	467	25	5.35%
6/30/06	2,638	24	0.91%	492	26	5.28%
3/31/06	2,534	18	0.71%	522	18	3.45%

In Oklahoma County there are special units to handle cases of drug affected infants, both at intake and permanency. For example, the Infant Parenting Program gets assigned all the cases where a baby has been exposed to drugs. This is a large unit. It is usually assigned the case a month after the baby is born, and often there have not been any parental visits prior to that. If one can imagine the damage that drug or alcohol exposure *may* cause, one can be absolutely confident of the harm wreaked on an infant by being separated from its mother at birth and being placed in an institution, then shifting to one or two other places in the first month of life, before even visiting with the mother.

While suggesting that some of these children should not be removed from their mothers may appear to be an outrageous idea to some, the fact is that most the cases assigned to the Oklahoma County unit result in reunification after a few months, with court approval. By that time, however, the requirement of every helping profession to “do no harm” has already been violated. If instead of assuming that drug cases require placement, DHS used safety assessment and planning, it could find a better way of meeting the needs of this population. If necessary, it could send a case aide or volunteer home with the mother and infant to assure the baby’s safety while other provisions are put in place. A more extreme solution, but still preferable alternative would be to move the mother and infant together into a protective environment or treatment setting.

For either of the safety or the risk protocols to be successful, it is critical that structured decision making processes are ingrained in all DHS child welfare staff and private agency workers who have contact with the children. These caseworkers, supervisors, and managers must be able to demonstrate proficiency at identifying both risk and safety, and must be held accountable for their decisions. It is also critical that assessing safety should occur through the time a case is opened to the child protection agency or with any of the agency contractors. The most common milestones for safety assessment to be conducted are:



- after the first contact with the victim,
- anytime any change occurs with the family, including new household members or new allegations of maltreatment,
- whenever the case is transferred from one worker to another,
- prior to any unsupervised parental visits for a child in placement,
- prior to returning a child home and
- prior to closing a case.

There are a variety of methods used for assessment, including actuarial models that direct workers to assign a numerical indicator of the level of safety or risk, and clinical (sometimes called consensus) models that do not employ numbers but rather snapshots of issues in each area. Each method has its proponents and either method can be successful as long as the staff are well trained at applying it, are held accountable for correctly implementing it and are supported by supervisory and management staff.

Current Practice in Oklahoma

DHS requires the use of both a safety assessment and a risk assessment protocol. However, the case reviews by HZA found only a small number of risk assessment documents and even fewer safety assessments. During interviews with staff workers often expressed confusion about the difference between the two. There was no strong feeling that either of these practices was important to their work. There was also much concern that, when a safety or risk assessment was in the file, it had been completed at the end of the worker's involvement with a family (investigation or permanency) and only because it was a DHS policy. This negates the whole purpose of these assessments which is to help workers to structure their decision making process.

Although the training manual references one safety assessment form, HZA staff were provided two different forms. One was simply titled “Safety Assessment” and the other was titled “Ongoing Safety Assessment.” Three child protective staff interviewed were not sure which form they were supposed to use or which one they had used on their most recent interaction with an abused child. The forms are basically the same, although the “Ongoing” form has a much more detailed summary area and directions for a safety plan. However, only the first, more limited form is included in the training curriculum.

There is no documented training as to how these factors should impact a worker’s safety decision. Two examples are school problems and high levels of parental stress. The inclusion of school problems among the list of factors does not mean that every child with school problems is in imminent danger of serious child abuse. But the workers are left to try to figure out when it does rise to that level. The same is true of parental stress levels. Many parents have high levels of stress, but each worker apparently decides individually when this sets off a red flag necessitating a safety plan. These two examples indicate the confusing crossover between risk and safety that make it difficult for workers to identify children who need immediate intervention.

Unlike most other states, Oklahoma law does not allow child protection investigators to take protective custody of a child. In fact, they are told in training that, if a child is found to be home alone, they are to leave (even a toddler) and call the police. During interviews, caseworkers noted that sometimes it takes the police two hours to respond. During that interval, the child could drown in the tub, fall out a window or have any number of other things happen to him. In terms of safety assessment, this impedes them from having a “safety first” attitude when conducting child abuse and neglect investigations or assessments. A “safety culture” has not developed within the child welfare agency.

The lack of a safety culture is likely to have two impacts. On the one hand, it is almost certainly a major contributor to the state’s high placement rate. If there is not a special focus on safety, safety cannot be the criterion for removal. Every other criterion is, however, broader and will result in more children being removed from their homes.

On the other hand, not focusing on safety is likely to leave some children in danger. Even though the agency uses broader criteria for removals, some situations in which a child is in imminent danger are likely to fall outside whatever criteria are being employed. Until safety becomes the criterion for removal, children are likely to lose in both directions, some by being removed unnecessarily and some by not being removed when they need to be.

Use of Shelters

Standards

Since 1980 federal law has established the basic standards for placement settings for children in out-of-home care. Those settings, while meeting the service needs of the child, should be close enough to the child's home to allow the child to maintain the continuity of his or her relationships with family and friends and they should be the least restrictive, most family-like setting compatible with meeting the child's service needs.

Practice in Oklahoma

For over half the children removed from their homes in Oklahoma, the first stop is a shelter. Some are fairly large and institutional, most notably the publicly run shelters in Tulsa and Oklahoma counties. There are also other types including contracted shelters, private shelters, host homes and tribal shelters.

Table 5 shows how often these shelters are used and how long children remain in them. Over 50 percent of all children statewide are placed initially into a shelter setting. About one in five of those stay for less than two days. About two in five of that initial group stay between two days and one week. About 30 percent stay for one week to a month, which is technically the limit, and about eight percent exceed the limit. Most casework practices vary considerably across the state and the use of shelters is no exception. One county reports that it will not use shelters under any circumstances because it does not like the concept.

Period	All Removals	Initially Shelter		Shelter for <48 hours		Shelter for 48h-1 week		Shelter for 1w-1 month		Shelter for >1 month	
		#	%	#	%	#	%	#	%	#	%
3/31/08	1,626	913	56.2%	193	21.1%	363	39.8%	275	30.1%	82	9.0%
12/31/07	1,471	813	55.3%	165	20.3%	318	39.1%	261	32.1%	69	8.5%
9/30/07	1,775	933	52.6%	196	21.0%	396	42.4%	278	29.8%	63	6.8%
6/30/07	1,899	1,049	55.2%	228	21.7%	437	41.7%	304	29.0%	80	7.6%
3/31/07	1,755	916	52.2%	183	20.0%	373	40.7%	308	33.6%	52	5.7%
12/31/06	1,707	872	51.1%	195	22.4%	336	38.5%	282	32.3%	59	6.8%

Table 6 shows the number and percent of children placed in shelters at their initial placement by DHS service Areas for the past four quarters.

The use runs from a low of about 10 percent (average over four quarters) in Area 5 to a high of 83 percent in Area 6, with Area 3 being a little lower than Area 6 at 77 percent. Needless to say, the variation is huge.

Table 6													
Use of Shelters at Initial Placement by Area													
Period	All Removals	Area 1		Area 2		Area 3		Area 4		Area 5		Area 6	
		#	%	#	%	#	%	#	%	#	%	#	%
3/31/08	1,626	127	23.6%	135	55.8%	448	77.8%	49	25.4%	11	5.6%	240	82.3%
12/31/07	1,471	131	22.9%	98	47.3%	370	79.9%	30	17.4%	21	11.1%	264	85.4%
9/30/07	1,775	167	21.6%	121	44.5%	450	74.1%	65	30.4%	23	9.8%	238	85.0%
6/30/07	1,899	176	34.1%	106	41.9%	491	75.2%	42	24.3%	35	14.3%	325	78.9%

Shelters are used for two basic reasons. The first is that police can remove children without DHS involvement and they need some place to take them. As discussed in the previous chapter, the standing orders in Oklahoma and Tulsa Counties allow the police to give DHS responsibility for the child simply by placing them in the shelter. The second reason for the use of shelters is that they are convenient, even for DHS. They are open all the time; the agency does not have to recruit a family to take a child in the middle of the night; and the shelter can and must take anyone under the age of 18.

That the shelters do not conform to the federally established standards on placement settings goes without saying. In the 2007 federal Child and Family Services Review, one of the federal criticisms was, “the use of emergency shelter care for placement of children, including infants and toddlers, as opposed to locating a placement that matches the needs of the child.”

Shelters are impersonal and potentially frightening for young children (who constitute most of DHS’s population) and almost certainly damaging to newborns. Children who are exposed at very young ages to environments that are not supportive and stable, or do not feature a positive, nurturing relationship often have a disrupted development, which can cause lasting consequences. Lack of physical contact or interaction with a mother can change an infant’s body chemistry, resulting in lower growth hormones

necessary for brain and heart development.¹² DHS has authorized a pilot project in Tulsa and Oklahoma counties to send children five years of age and younger to emergency shelter homes instead of facilities,

Even if the children do not stay long, shelters guarantee an extra placement move (unless the child goes home quickly, in which case one wonders how the placement could have been avoided in the first place). Placement moves have been shown to result in worse outcomes for children and they are one reason Oklahoma fails on one of the federal measures.

In addition, the shelters are costly. In state fiscal year 2008 the shelters operated by the state in only the two largest counties cost over \$8.3 million. Because the shelters are publicly run and have capacities of more than 25 children, their use is not reimbursable under Title IV-E of the Social Security Act. Currently, DHS pays for the shelters with TANF funds, but as noted elsewhere in this report, those very flexible funds are becoming less available.

The final issue with the shelters is that they repeatedly violate the standards set for them. The Oklahoma Commission on Children and Youth conducts oversight visits of shelters, some announced and some unannounced. HZA reviewed the findings of the last five visits conducted at the Laura Dester Shelter in Tulsa, which has a licensed capacity of fifty. These visits spanned from November 14, 2006 to July 13, 2008. Not one of these visits was free from a compliance violation. Violations included overcrowding (i.e., censuses beyond the 50 licensed slots, with the high being 66); children over five years of age staying more than 60 days; children under five years of age staying more than 24 hours; numerous personnel violations such as incomplete training requirements including training on behavioral interventions, incomplete immunizations and incomplete references.

HZA also reviewed five reports on the Pauline E. Mayer Shelter in Oklahoma City dating from October 5, 2006 to February 27, 2008. This shelter is licensed for 42 youth in the main shelter and 16 in the annex. While the first report in 2006 did not report overcrowding, the rest did. The director's written response was, "We desperately need more emergency foster homes." In fact, shelters cannot refuse to take children who are dropped off there. One violation was a Fire Marshall's inspection being overdue; others included the same types of issues found at the Laura Dester Shelter: children staying too long, lack of service plans in the records and personnel violations.

DHS has contracts with Sunbeam and Baer to recruit emergency foster homes. A review of one of these contracts shows that of the \$44 per day received by the contractor, which includes recruitment, training and support functions, the foster families

¹² Institute of Medicine, "From Neurons to Neighborhoods: The Science of Early Child Development," <http://www.nap.edu/books/0309069882/html>, accessed June 2007.

themselves receive \$15 a day for 0 to 5 year olds, \$17 a day for 6 to 12 year olds and \$19 a day for 13+. If these contracts are not producing sufficient numbers of homes, DHS should consider raising the amount that the foster families receive.

Services to Strengthen Families and Heal Children

Standards

The basic standards for services are found in the federal Child and Family Services Review guidelines. One of the systemic factors examined in those reviews is “service array.” This looks at 1) whether the state has an array of services to meet the needs of children and families; 2) whether the services are accessible to children and families throughout the state; and 3) where they are individualized to meet the unique needs of the children and families served.

Practice in Oklahoma

If more children are to remain safely at home in Oklahoma, the system will need to have a strong set of services to provide to the families of those children. In Oklahoma child welfare services are generally provided under contract, from another division within DHS such as Family Support Services or through Medicaid billing of third party providers. An analysis of DHS’ child welfare contracts shows that, with the exception of Oklahoma Children’s Services, nearly all the contracts are either for the provision of foster care or residential services or for children in foster care, specifically the Independent Living program. Like the rest of the child welfare program, the majority of the resources is going toward placement services and related costs.

Table 8 shows expenditures on contracted services relating to child welfare in 2008. It is divided into out-of-home and in-home services and includes the cost of foster care services itself, as designated in DHS’ budget.

DHS’s budget has a broad category called Miscellaneous Social Services which includes services to children in the home, children out-of-home and other services, such as training contracts and provider background checks. Of the \$18.6 million in the Miscellaneous Social Services category \$2,114,574 can be classified as services to families in the home, \$8,734,766 as services related to placement, \$5,078,090 as training, and \$2,669,484 as either which was allocated evenly to out-of-home and in-home in the table above. Training costs in the miscellaneous category are omitted from the table. Of the \$99,596,321 spent on contracted services, 12 percent go to children and families in the home.

Table 8			
Summary of CFSD Contracts, In home and Out of Home			
Out-of-Home		In-Home	
Group Homes and Shelters	\$ 9,266,070	Oklahoma Children's Services	\$ 7,016,995 ¹³
Foster Care	\$ 50,745,192	MH behavior outpatient (state share)	\$ 1,532,857
Medical	\$ 400,036	Miscellaneous Social Services	\$ 3,449,316
Therapeutic Foster Care	\$ 12,659,677		
Intensive Treatment Services	\$ 4,456,670		
Miscellaneous Social Services	\$ 10,069,508		
Total	\$ 87,597,153		\$ 11,999,168

In the 2007 federal review the reviewers found:

- that children are placed in foster care without providing services to children or families to prevent removal from the home,
- a lack of ongoing assessment of the families' needs to address safety issues while the child is in the home,
- workload issues that result in staff not taking the time needed to refer families for voluntary services and
- a lack of consistency in providing sufficient services to children and families to address risk of harm issues.

In the 2007 federal review, Oklahoma was not in substantial conformity on the "service array" factor. It is interesting to note that, after the first CFSR in 2002, the steps that were taken to improve the service array focused primarily on out of home care services. The agency sought to increase foster and adoptive homes, identify resource development specialists, participate in a Casey Foundation recruitment demonstration and implement contractual incentives for therapeutic foster care. Of the nine improvement strategies, very few could be applied to services to families in their homes (e.g., review and refine the Individual Service Plan; develop a resource directory detailing all licensed health, mental health and dental providers available online).

While the federal review found both that there were not adequate services and that children were being placed without adequate service efforts to prevent it, some large service providers with whom DHS has contracts for these services report that they are not receiving sufficient numbers of referrals from DHS even to meet their contracted capacities. In addition, they report that the referral process is burdensome, perhaps accounting for why workers do not make all of the referrals they should.

¹³ Additional funds for this contract are allocated to Miscellaneous Social Services.

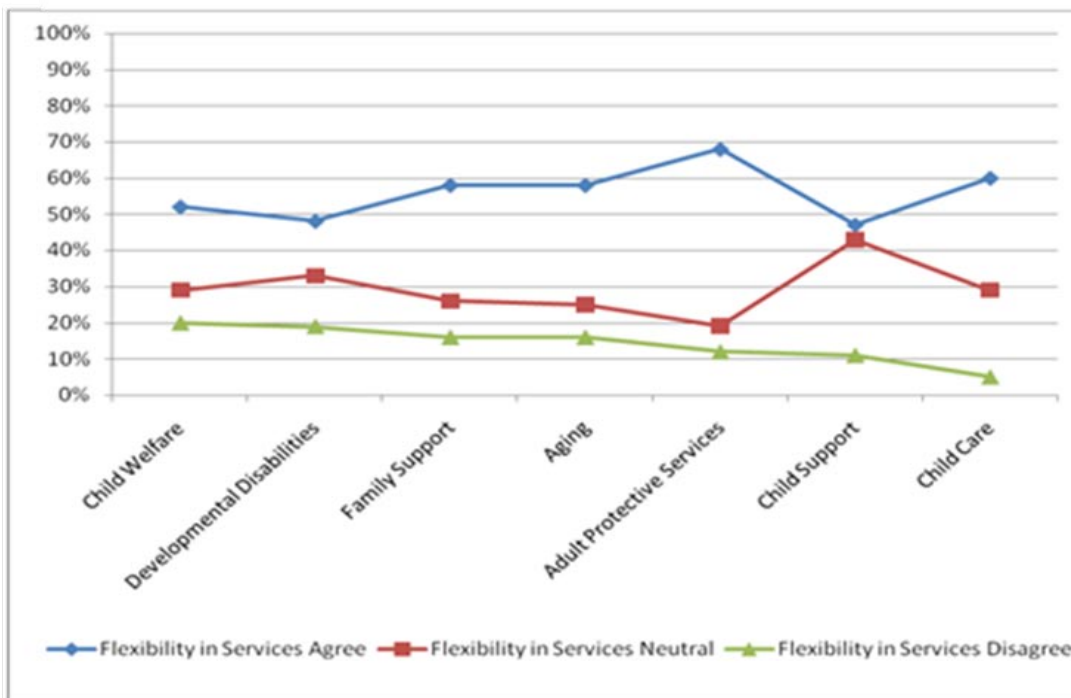


DHS has devised a fairly unusual system with its Oklahoma Children's Services whereby some families who have been investigated or assessed are subsequently referred for services and DHS does not keep the case open. When that system works, it is highly commendable because it reduces DHS involvement with the family (both a workload and coercion issue) yet DHS is paying for and providing help through a contracted service. However, the current system does not give DHS sufficient options: it is either refer the case and close or remove the child. The high placement rate suggests that a middle ground of providing services to families in the home while DHS or even court supervision is maintained should be used more often in more difficult cases where placement can

nonetheless be prevented.

In the statewide survey conducted for this audit, staff were asked about the availability and adequacy of services. Considering all programs within DHS, on a statewide basis, 53 percent of the staff agree with the statement, "I have flexibility in the services I can access for my clients." The other 47 percent are either neutral or disagree. However, among all the programs, more staff in child welfare disagree (green line) than in other programs, as shown in the figure below. Adult protective services were the most likely to agree.

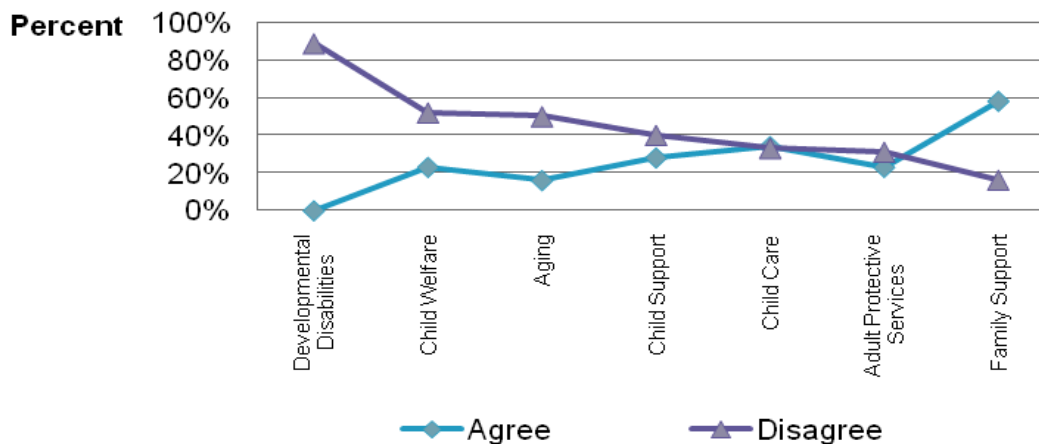
"I Have Flexibility in the Services I Can Offer," by Program



Overall, one-fifth of the staff are not pleased with the variety of services available, and over 30 percent say that there is a waiting list for services.

The issue of waiting lists varies considerably by area and by program. The next figure shows staff who agree or disagree with the statement, “there is rarely a waiting list for services” by program. (Staff with neutral responses are not shown.) More staff in the Developmental Disabilities program were concerned with waiting lists than all others, followed by child welfare. Family support services staff had the fewest concerns.

"There is Rarely a Waiting Lists for Services," by Program



Staff in Areas 3 and 4 are less likely to encounter waiting lists for their clients, while more staff in Area 4 say there are waiting lists than anywhere else in the state.

In an open-ended question, staff in all DHS programs were asked to identify the greatest service needs in their communities. A general comment throughout was that more services in rural areas and more preventive services are needed. The following list reflects the most frequent specific responses; where there were strong Area differences they are noted.

- Mental health
- Affordable housing
- Transportation
- Drug treatment
- Medical/dental/vision
- Counseling
- Shelter
- Food pantry
- Child care (after hours, overnight, special needs)
- In-home providers (CHBS has long waiting list, particularly Area III)
- Life skills classes for parents (e.g., how to budget, pay bills)
- Sexual abuse counseling and treatment for victims and perpetrators (particularly Area 4)
- Education (GED) and vocational services for parents
- Services in rural communities in general including providers that accept Medicaid (Areas 2, 4, 5)
- Spanish/bi-lingual services (Area 3)



As the agency shifts to providing services in the home rather than having placement be the major service, it will need to develop more services to support families at home. Elsewhere HZA recommends that a service needs assessment be conducted in each Area and that Area Directors be given the service contract dollars to apportion according to the needs identified. The list above suggests what some of those services will no doubt be.

Birth parent says ...
[CHBS] really helped me with my little girl. They taught me what to do when she was acting out. I couldn't have made it without them.

DHS participates in Systems of Care which is targeted at children with emotional and behavioral problems and operated by the Department of Mental Health and Substance Abuse Services; it is available to children in 39 counties. Systems of Care embraces the family-focused principles that are consistent with DHS's new direction. DHS contributes a modest amount, just shy of \$222 thousand toward it. Such a service should be expanded to other communities and focused on keeping children with serious mental health issues who are also involved with the child welfare system in their own homes. In addition to Comprehensive Home Based Services (CHBS), which is the principal

component of Oklahoma Children's Services, DHS should consider introducing other evidence-based programs and services that have been shown to be effective specifically with child abuse and neglect populations.

The Washington State Institute for Public Policy just published in July 2008 a meta-analysis of evidence-based practices¹⁴ whose specific target is preventing children from entering and remaining in the child welfare system. The table below, excerpted from the Institute's report, summarizes the findings.

Drawing from the Institute's results, for families with problems relating to infants, Oklahoma should consider Nurse Family Partnership for Low Income Families and/or other Home Visiting Programs for At-Risk Mothers and Children or Triple P Positive Parenting Partnership. If programs such as these are already offered by other agencies in Oklahoma, DHS should partner with them. Note that Parent Child Interaction Therapy used in Oklahoma is effective in reducing child abuse and neglect and is listed on the table. This is a short-term, specialized behavior management program designed for young children (ages 2-7) experiencing behavioral and/or emotional difficulties. PCIT works with the child and care-giver together to improve overall behavior, reduce parenting stress and enhance the parent-child bond and is offered at least by North Care Center, one of the Oklahoma Children's Services providers.

Oklahoma should add Intensive Family Preservation Services (specifically using the Homebuilder's Model) which has also proven effective, for use with more difficult cases. The estimated cost is \$3,484 per participant and could be started in Tulsa and Oklahoma Counties. Intensive case management should be considered for youth in foster care who are emotionally disturbed. It should be noted that structured decision making, discussed earlier in this chapter, is one of the Administrative Policies in the illustration below. Flexible funding should be a component of every Area Director's services budget (note that safety assessments and some flexible funding are already requirements of the CHBS contractors). At the other end of the service spectrum when children cannot return home safely and termination of parental rights is neither attainable nor desirable, subsidized guardianship is an important permanency option that should be made available broadly. With the October 2008 passage by Congress of the Fostering Connections to Success and Increasing Adoption Act, subsidized guardianship will soon be eligible for federal Title IV-E reimbursement. This tool can help states like Oklahoma which is one of 34 to have a subsidized guardianship program make greater use of it to reduce the foster care roles as well as to benefit children in foster care and their relatives.

¹⁴Washington State Institute for Public Policy, "Evidence-based Programs to Prevent Children from Entering and Remaining in the Child Welfare System: Benefits and Costs for Washington, Olympia, Washington, July 2008.

Source: Washington State Institute for Public Policy, July 2008

<i>Up and down arrows indicate a statistically significant effect on the indicated child welfare outcome. Orange arrows indicate effects in the desired direction; blue arrows indicate effects in the undesired direction. The international symbol for zero indicates no statistically significant effect.</i>	Child Abuse and Neglect Outcome	Out-of-Home Placement Outcome	Placement Permanency Outcome	Placement Stability Outcome
PREVENTION PROGRAMS (For families not involved in the child welfare system)				
Chicago Child Parent Centers:	↓	↓	Not measured	Not measured
Early Hospital Discharge and Intensive In-Home Follow-Up for Low Birthweight Infants (Pennsylvania):	⊘	⊘	Not measured	Not measured
Healthy Families America:	↓	Not measured	Not measured	Not measured
Iowa Family Development and Self Sufficiency Program:	⊘	Not measured	Not measured	Not measured
LEARN (Local Efforts to Address and Reduce Neglect):	⊘	Not measured	Not measured	Not measured
Nurse Family Partnership for Low-Income Families:	↓	Not measured	Not measured	Not measured
Other Home Visiting Programs for At-Risk Mothers and Children:	↓	⊘	Not measured	Not measured
Parents as Teachers:	⊘	Not measured	Not measured	Not measured
Triple-P Positive Parenting Partnership (South Carolina):	↓	↓	Not measured	Not measured
INTERVENTION PROGRAMS (For families already involved in the child welfare system)				
Abuse-Focused Cognitive Behavioral Therapy (AF-CBT):	⊘	Not measured	Not measured	Not measured
Dependency (Family Treatment) Drug Court (California, Arizona, New York):	↑	↓	↑	Not measured
The Family Connections Study (Canada):	⊘	Not measured	Not measured	Not measured
Family to Family (New Mexico):	Not measured	⊘	Not measured	Not measured
Family Group Conferences:	↑	Not measured	Not measured	Not measured
Family Group Decision Making (California):	⊘	Not measured	Not measured	⊘
Family Therapy:	⊘	Not measured	Not measured	Not measured
Intensive Case Management for Emotionally Disturbed Youth:	Not measured	⊘	↑	↑
Intensive Family Preservation Service Programs (All Homebuilders® model):	↓	↓	Not measured	Not measured
Intensive Family Preservation Services for Out of Home Placement Prevention (Homebuilders® model):	⊘	↓	Not measured	Not measured
Intensive Family Preservation Services for Increased Reunification (Homebuilders® model):	⊘	↓	Not measured	Not measured
Other Family Preservation Services (non-Homebuilders®):	⊘	↑	Not measured	Not measured
Parent-Child Interaction Therapy (Oklahoma):	↓	Not measured	Not measured	Not measured
Project KEEP (San Diego):	Not measured	Not measured	↑	Not measured
ADMINISTRATIVE POLICIES				
Family Assessment Response (Minnesota):	⊘	↓	Not measured	Not measured
Flexible Funding (Title IV-E Waivers in North Carolina and Oregon):	Not measured	↓	Not measured	Not measured
Structured Decision Making (Michigan):	↓	Not measured	↑	Not measured
Subsidized Guardianship (Illinois):	Not measured	Not measured	↑	⊘

WSIPP, 2008

Recommendations

Recommendation 4: DHS should establish one centralized hotline number for all reports of the abuse and neglect of children within the Child and Family Services Division and strongly consider whether vulnerable adults can be included as well.

This number should be well-publicized through public service announcements, billboards, and outreach programs to schools and other community agencies. Each DHS office should inform callers, through a recording or in-person, that if they are calling to report abuse and neglect, they should call that number. Investigations and assessments should occur only when the referrals come from the hotline. This hotline should be organizationally housed in the Children and Family Services Division. However, DHS should strongly consider whether vulnerable adults (APS clients) can be included in the same hotline, as is done in Florida.

- a. This hotline should be staffed 24 hours per day, 365 days per year. It should include at least one Spanish-speaking person on each shift, a Telephone Device for the Deaf (TDD), and access to a language bank for callers speaking other languages.
- b. Hotline workers should be required to have at least two years of field experience and a degree in social work or a related field.
- c. Hotline-specific training should be developed; it should include interviewing skills, customer service, narrative writing, computer skills, making case determinations, and identifying Priority One situations.
- d. There needs to be one standardized set of management reports that hotline supervisors are required to use. They should include: hourly call volume and abandonment rate; individual performance data including number of calls answered, investigations and assessments accepted, average talk time, and data entry time; and categories to specify the reason for screening any call.
- e. After an initial period of on-the-job training, hotline workers should make the determination as to whether information received justifies an investigation, an assessment, or should be screened; they should also determine the priority response. This will free up the supervisors to attend to supervisory duties rather than replicating the work of the hotline call floor staff. There will still be some borderline cases requiring supervisory input.
- f. Calls accepted by the hotline as investigations should not be subject to screening out later by field staff. Complaints can be made for future

reference, but too much time is wasted debating whether something should, or should not, be an investigation. Policy should be developed to allow field staff to “unsubstantiate” some borderline reports with limited investigation activities (for example, just seeing the victim). This requires the hotline staff to be well-trained experts on the criteria for investigation or assessment acceptance, as well as selection of the appropriate response priority.

- g. Hotline calls should be taped, and there should be a monitoring capacity added so that supervisors can listen to calls without the workers' knowledge. The taping will allow supervisors to listen to more calls in a shorter time frame than doing it live, and will provide good documentation when members of the public make inaccurate statements about their calls. It will also provide documentation to support disciplinary action when necessary. Monitoring will allow immediate feedback or even intervention if needed. Management should establish a standard for the number of calls that supervisors must monitor for each worker. *NOTE:* HZA identified a hotline taping system installed three years ago that could tape 125 stations at once for \$55,000. This is far more stations than Oklahoma needs, and technology has probably driven down this cost.
- h. Unit statistics should be prepared by the supervisor for each month. Staff who are handling far less work than the unit average must be subject to a stringent work review.
- i. A competent phone system capable of distributing all the calls that come to the hotline should be installed that includes easy supervisor monitoring and thorough management reports. *NOTE:* A 40-station call center was just installed in another state for \$100,000. Oklahoma probably doesn't need that many stations, and there are so many phone technology companies now that a bidding process would probably find a less costly alternative.

Recommendation 5: DHS should simplify and clarify the definitions of Priorities One and Two and the criteria for investigations versus assessments; modify response times; and modify the daily contact rule.

HZA recommends that Priority One cases have an immediate (three-hour) response, and that a second attempt be made the same day if the first does not succeed, with daily efforts made thereafter, as the new policy suggests. Priority Two cases should be initiated within two to five days and follow-up requirements should be limited.

Recommendation 6: DHS should phase out the two large publicly funded shelters, Laura Dester and Pauline E. Mayer, and replace them with emergency foster homes when alternative placements such as neighbors and relatives cannot be found.

OAC limits the amount of time children can stay in shelters, which is consistently violated, and says they should move to emergency foster homes after that if no better alternative can be found. Once the recommendation that DHS be involved in all removals is implemented, the need for a convenient place for police to drop off children will no longer be present. DHS should replace the number of slots currently licensed for shelters with emergency foster homes. Not only will these homelike settings be less frightening for children, they will save the state significant revenue. DHS is currently spending \$8.3 million per year on the two shelters. DHS's rate for contracted emergency foster homes is \$44 per day. With a current licensed capacity in the two shelters of 110 children, although HZA's analysis showed that as many as 118 children were in these facilities on a given day. Assuming that 120 children need emergency foster homes each and every day, the cost to DHS would be \$1.9 million. Given the current cost of over \$8.3 million that would be a savings of \$6.4 million, all of which would be reimbursable either through TANF or through Title IV-E.¹⁵

Recommendation 7: DHS should focus on creating a safety culture that is ingrained into all staff and impacts all decisions made by a) adopting one safety assessment protocol and providing comprehensive training on its use and application to all staff, and b) making better use of the risk assessment protocol.

For DHS staff to be able to take on the responsibility of conducting safety assessments for every report and for all cases throughout the life of the case, staff will need to be better trained and the tools at their disposal will need to become more structured. The safety assessment documentation form itself should be reviewed and only the factors that impact immediate safety should remain. Otherwise, the protocol is too broad and will not produce the attitude or results desired. Any factor that remains should include specific training as to when that factor rises to the level of creating danger for a child. For example, the parental factor of "diagnosed mental illness" should contain a training module provided by child mental health professionals that is descriptive of when this factor should lead to removal or a safety plan. The same is true for the presence of substance use in the home or the presence of domestic violence. In each instance, professionals in that field should be involved in providing the training.

¹⁵ Please see the final chapter for a more detailed cost savings analysis.

Investigators must be trained to understand that the safety assessment is the driving tool for determining whether a child can be left with the parent and/or alleged perpetrator. Permanency staff must be trained to use the safety assessment appropriately when the identified milestones are reached in cases where children do get removed. All staff must comprehend the notion that these assessments are used to drive decisions, not simply to document what was already decided. A proficiency test and/or certification by each person's supervisor should be mandated.

Training must provide the understanding that properly completing a safety assessment leads to worker protection. Despite all research and good practice, there will still be some situations that have bad outcomes. A solid safety assessment makes it clear that the worker did all that was possible to keep each child safe.

Case reviews must focus on each safety assessment, with attention to the following questions.

- Did the worker gather sufficient information to conduct an accurate safety assessment?
- Was the assessment done in a timely manner?
- Was supervisor approval obtained?
- Was the safety decision correct?
- If a safety plan was necessary, is it adequate to ensure the immediate safety of the child?
- Was the safety plan implemented?
- Is there a monitoring component and was it implemented?

One common theme in HZA interviews with court personnel and other "outside" parties was that almost all of the service plans are "cookie cutter." The feeling was that, if the family's name was cut off the top, any other name could be put there because they all say basically the same thing. If DHS is going to provide maximum assistance to families and keep children from being abused in the process, action is needed.

- Ensure that the training on risk assessment distinguishes it from safety assessment.
- Provide all workers with in-depth training on what services are at their disposal in working with families on their caseloads.
- Train workers to use the risk assessment protocol to direct the construction of a service plan that is focused on the specific issues prevalent in each family.
- Provide flexibility and funding to Area directors (as stated elsewhere in this report) to obtain the needed services.
- Train supervisors to monitor cases for appropriate use of risk assessments.

Recommendation 8: DHS should increase the use of court-supervised in-home placements for children who otherwise would have been removed but the safety issues have been resolved.

When the agency is concerned about risk and the families will not accept services voluntarily, DHS should move for a court-supervised in-home placement which is already permitted by state statute (Sec. 7003-5.5(C) in the current statute and Sec. 7003-5.5(A) in the re-written Title 10). This recommendation is not intended to increase the overall number of children in state supervision, but to increase the options available to protect children when safety issues have been resolved and risk can be mitigated by devoting increased resources and flexibility (see next recommendation) to in-home services.

Recommendation 9: DHS should shift funding from out-of-home care to in-home services to support the families where children are not in imminent danger. DHS should increase the numbers and kinds of in-home services available based on an Area-level needs assessment and the use of evidence-based practices.

Service funding should be used to develop a broader array of evidence based practices such as Nurse Family Partnership for Low Income Families and/or other Home Visiting Programs for At-Risk Mothers and Children or Triple P Positive Parenting Partnership, Parent Child Interaction Therapy in other communities, Intensive Family Preservation Services (Homebuilder's Model), Systems of Care (expanded and used for children in their home) and administrative practices such as Structured Decision-making, including safety and risk protocols and subsidized guardianship. Flexible funding should be a component of every Area Director's services budget to help families with tangible supports including housing repairs and job training.

HZA has projected the cost savings from shifting from an out-of-home to an in-home system. The savings can be used to fund this recommendation as well as others in this plan, including an increase in rates for foster families. Here are the assumptions, based on actual expenditures and data from State Fiscal Year 2008.

Out-of-home Care Expenditures¹⁶

Foster Care:	\$50.7 M
Therapeutic Foster Care:	\$12.7 M
Group Homes/Shelters:	\$9.3 M

¹⁶ Source: DHS Department of Finance Division, SFY 2008

Average Daily Population¹⁷

Foster Care:	8645
Therapeutic Foster Care:	1015
Group Homes/Shelters:	456

Average Cost per Child per Year

Foster Care:	\$5865
Therapeutic Foster Care:	\$12,512
Group Homes/Shelters:	\$20,305

Oklahoma Children's Services

Expenditures	\$9.8 M
Average Cost per Child per Year¹⁸	\$3614

Savings Assumptions:

1. DHS reduces its placement rate to that equal to the highest rate in an adjacent state (Kansas, 8.4 per 1000).
2. The agency serves all of the families of the children who would otherwise have been placed through CHBS or an alternative array of services averaging the same cost as CHBS.
3. Families with two children in foster care would receive two times the in-home allocation in services, i.e., \$7228.

Reduction Percentage:	37%
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Number of Children *Kept out of Care*

Foster Care:	3199
Therapeutic Foster Care:	376
Group Homes/Shelters:	169

¹⁷ The Average Daily Population represents the averages of the figures shown in the monthly statistical reports for January through June of 2008 which can be accessed on the DHS website. Figures before that are not comparable, apparently because they did not count all children in out-of-home care. Because there were more children in care during the first half of the fiscal year, this estimate may actually over-estimate the costs per child for foster care. Children in psychiatric facilities and children on trial reunification are excluded. It is not clear that the budget category for foster care is the same as the population category, but it does look very close.

¹⁸ This is based on the RFP for SFY 2009 only for CHBS, and excluding Parent Aide Services, using the funding and minimum expectations figures. PAS is excluded because some clients presumably receive both.

Savings per Child

Foster Care:	\$2215
Therapeutic Foster Care:	\$8898
Group Homes/Shelters:	\$16,691

Total Savings

Foster Care:	\$7.1 M
Therapeutic Foster Care:	\$3.3 M
Group Homes/Shelters:	\$2.8 M
Total:	\$13.2 M

With 3 Year Phase-in, Savings Available (after providing for in-home services at a cost of \$3614 per child for every diverted child)

First Year:	\$4.3 M ¹⁹
Second Year:	\$8.7 M

¹⁹ Please see Chapter 8 for a more complete analysis of costs and savings.

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Chapter Five

Most Favored Volunteers: Supply, Training and Retention of Foster Homes

Scope

Foster families are volunteers. In every state they are asked to serve 24 hours a day, seven days a week, working with children who are often emotionally upset if not yet disturbed, and care for those with various disabilities. During the course of this study we met families who were motivated by a power that was stronger than themselves, be it a spiritual calling, the love of children, or the desire to give more than they themselves ever had. We met people who were inspiring, some who were a little off-beat, and those who were angry. For many, their evolution as foster families was similar to that of children growing up: they started out young and enthusiastic, were engaged in a learning curve both through training and direct experience, received some jolts along the way, and determined either that the human rewards were equal to the demands received some jolts along the way, and determined either that the human rewards were equal to the demands and decided to keep at it, or concluded that they were not and decided to quit.

This section addresses the following key issues, drawn both from the literature on foster family recruitment and retention and from the findings that emerged in the performance audit itself:

- Supply of homes
- Recruitment and licensing practices
- Training of foster parents
- Placement practices
- Reimbursement practices
- Roles and responsibilities of foster families
- Relations with DHS staff
- Support services for foster parents and children

As well as the national literature, much of the data in this chapter came both from interviews with foster parents and from a statewide survey of foster parents which was mailed to 3,541 open and licensed foster family homes as well as to 2,407 homes which had been closed in the past 24 months, meaning they were no longer licensed to accept children. The response rate was 27 percent for open homes and 11 percent for closed homes.

Standards

Supply of Homes

There is no national standard on the number of beds or homes that should be available for each child in care to assure a proper match. HZA has developed the standard, in its work elsewhere, of two available beds to every child in care. Because kinship homes by definition cannot be recruited in advance, the number of children in kinship care is not considered in the calculations in this section about how many homes are needed throughout Oklahoma compared to the current supply.

Recruitment and Licensing Practices

The following recruitment and licensing practices have been found in the literature to be effective and are considered in assessing Oklahoma's practices:

- Dual licensure of foster and adoptive families streamlines paperwork and reduces the time it takes for a resource family to legally evolve into an adoptive family.²⁰
- Kinship care is given priority and ruled out before placement with non relatives is considered.²¹
- Kinship care placements are licensed with minimum standards met allowing immediate placement and other licensing issues are dealt with promptly.²²
- Caseworkers carry kits (smoke alarms, safety covers for electrical outlets) with them when inspecting kinship care homes to help kin foster parents meet standards.²³
- Kinship foster parents receive the same reimbursement rate as non-kin foster parents.²⁴
- Foster families participate in recruitment and are used as facilitators during pre-service foster parent training classes.²⁵

²⁰ CFP 2001.

²¹ National Family Preservation Network (NFPN). *An Effective Child Welfare System & Evidence-Based Practice for the Child Welfare System*.

²² National Family Preservation Network (NFPN). *An Effective Child Welfare System & Evidence-Based Practice for the Child Welfare System*.

²³ National Family Preservation Network (NFPN). *An Effective Child Welfare System & Evidence-Based Practice for the Child Welfare System*.

²⁴ Geen, Rob. (2004). The Evolution of Kinship Care Policy and Practice. *The Future of Children*, 14(1), 131-149

²⁵ Lawton & Rhea Chiles Center (2000). *Florida Foster Care Recruitment and Retention Perspectives of Stakeholders on the Critical Factors Affecting Recruitment and Retention of Foster Parents*. Phase 1 Study Report; Breakthrough Series Collaborative. (2005). *Recruitment and Retention of Resource Families Promising Practices and Lessons Learned*. Series number 001

- Faith community groups participate in recruitment.²⁶
- Recruitment materials and activities cover racial, ethnic and tribal groups.²⁷
- The certification process is timely as long waits from first inquiry to licensing/approval result in loss of families.²⁸

Training of Foster Parents

The following training practices are recommended in the literature:

- Training is offered at sites and during times that are convenient to resource families.²⁹
- Information shared with prospective foster and/or adoptive families is honest in regard to the certification process and realities of foster/adoptive parenting.³⁰

Placement Practice Standards

The following standards accompany good placement practices:

- Children should be placed within their own communities and neighborhoods or with relatives.
- Children should be placed with siblings.
- Children should be placed in the least restrictive, most home-like setting available.
- Children should be placed in homes of the same race or ethnicity when that can be done without delaying the placement.
- Children should be placed in homes which may potentially adopt them when their goal is adoption.
- Children should be exposed to emergency placements on a strictly limited basis, no more than 30 days and no more than once per removal episode.

²⁶ Department of Health and Human Services Office of Inspector General (2002). *Recruiting Foster Parents*.

²⁷ Lawton & Rhea Chiles Center (2000). *Florida Foster Care Recruitment and Retention Perspectives of Stakeholders on the Critical Factors Affecting Recruitment and Retention of Foster Parents*. Phase 1 Study Report; Breakthrough Series Collaborative. (2005); Department of Health and Human Services Office of Inspector General (2002). *Recruiting Foster Parents*.

²⁸ McKenzie & McKenzie (n.d). *Answering the Call Recruitment and Work Plan Guide for Adoption and Foster Care Managers*. The Collaboration to Adopt US Kids; Department of Health and Human Services Office of Inspector General (2002). *Recruiting Foster Parents*.

²⁹ (LRCC 2000, CFP, 2001)

³⁰ (LRCC 2000)

Reimbursement Practices

The following standards have been established for reimbursing foster families:

- Basic foster care rates must be equal to the cost of raising a child in that community.
- Foster families should be reimbursed for necessary costs that exceed basic needs when special circumstances arise.
- Children with needs that are so intense that they require extra time of the foster parents beyond what can be expected of children of that age should have higher rates.³¹

Relations with DHS Staff

The following is considered good practice:

- Caseworkers must respond to potential resource families as customers and respond to their requests for information/communication promptly. Multiple transitions from one staff member to another should be minimized, as multiple “hand offs” result in loss of families.
- Caseworkers are responsive to the needs of resource families.³²
- Resource families and foster children are screened to ensure the match offers a stable placement.³³
- Resource families are provided with a family history and behavioral, health and educational assessment of the child.³⁴
- Resource families are respected as partners with the agency.³⁵
- Resource families are notified of all court hearings, name of judge and/or hearing officer, location of hearing and court docket number of case and are kept informed of decisions made by the court and/or state agency concerning the child.³⁶

³¹ Children’s Rights, National Foster Parent Association, University of Maryland School of Social Work released *Hitting the M.A.R.C.: Establishing Foster Care Minimum Adequate Rates for Children*, 2007.

³² OK stat. tit. 10 §7206.1, BSC 2005, CFP 2001

³³ BSC 2005, CFP 2001)

³⁴ Christian, 2002, OK stat.tit. 10 §7206.1, LRCC 2000, BSC 2005, CFP 2001

³⁵ Christian, 2002, OK stat.tit. 10 §7206.1, LRCC 2000, BSC 2005, CFP 2001

³⁶ Christian, 2002, OK stat.tit. 10 §7206.1

Support Services for Foster Parents and Children

The following are considered best practice supports for foster families:

- Caseworker turnover is minimal.³⁷
- Respite care is available and included in case planning.³⁸
- Communication with other foster parents who have cared for child is facilitated.³⁹
- Resource families are provided family counseling, transportation, health insurance, liability insurance and recreational activities for foster children.⁴⁰

Findings and Analysis

Supply of Homes

As with other parts of the system, there is a great variation among regions and even counties in the supply of licensed homes relative to the need, as reflected by the population in foster care.

The supply of homes cannot be thought about monolithically. That is, the need for homes, and particularly excess beds so that caseworkers can choose an appropriate home, not just an available one, depends on how broadly kinship or relative care is used in an Area.

In Oklahoma the term “relative” is used loosely when it comes to finding a home known to the child. That is a good thing. Caseworkers look not only at blood relatives but also people who are family friends and significant people to the child in question. Since, by definition these relatives cannot be recruited in advance of an abuse incident, one would not expect to have a much higher supply of licensed relative beds than of children in relative foster care. (Each relative and non-relative home can be licensed for up to five children and we refer to the maximum number as the bed capacity.) The other key placement resources (other than shelters which are discussed in the Policies and Programs chapter) are group homes and institutions. At any given time between 33 and 40 percent of the children are living with relatives.

Table 9 shows the number of licensed beds in each area of the state for the four major categories: relative care, non-relative care (standard foster family homes), group care and institutions such as residential treatment. For each category the table shows the

³⁷ Christian 2002

³⁸ Christian 2002

³⁹ Christian 2002, OK stat. tit. 10 §7206.1

⁴⁰ Christian 2002

statewide total and then the breakdown by area. Table 9 shows that on a statewide basis there are an adequate number of relative care foster beds; although in Area 3 there are more children in relative care than there are licensed beds by 150. Either some of these children are placed in other areas, or some of the homes are beyond their capacity.

Table 9 Licensed Beds in Foster Homes, Group Homes and Institutions								
Geographic Area	Relative		Non-relative		Group Home		Institution	
	Beds	In Care	Beds	In Care	Beds	In Care	Beds	In Care
Statewide	4,774	4120	8,649	6023	722	910	492	302
Area I	335	316	818	512	174	65	9	33
Area II	771	520	1,658	962	133	153	144	46
Area III	1,813	1975	1,692	2029	122	357	60	123
Area IV	543	403	1,406	682	4	62	62	14
Area V	498	400	1,832	812	102	70	105	28
Area VI	531	506	1,210	967	186	201	94	58

From the next part of the table, Non-relative, we determine that an additional 3397 beds are needed ($6023 \times 2 - 8649$). At a rate of four beds per home (the maximum licensed capacity is five, but it depends on the family circumstances), 850 foster homes are needed statewide; at a rate of three beds per home, 1132 homes are needed statewide. This number would provide caseworkers choices, when a friend or relative cannot be found, as is currently the case for over 6000 children, in selecting a family that is suitable to the child.

Table 10 Number of Approved Beds per Foster Family Home		
Approved beds	Number of Homes	Total Beds
1	2006	2006
2	1,694	3388
3	991	2973
4	449	1796
5	268	1340
6+ ⁴¹	30	180
Total	5438	11683

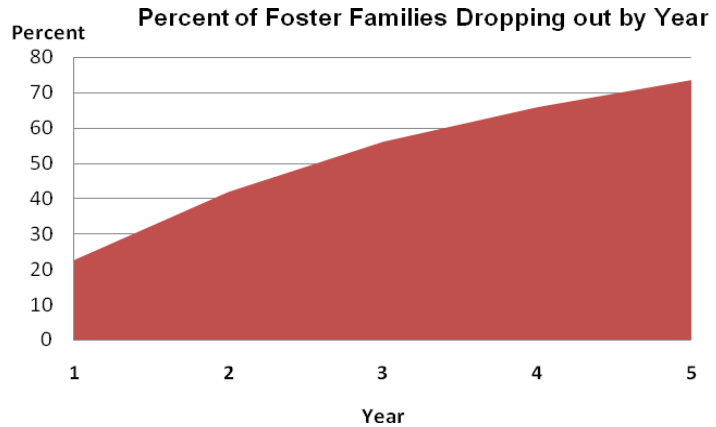
Many homes are licensed for one child only, although five are permitted. Table 10 shows the distribution of licensed beds for the 5,438 homes (relative and non-relative) in services on March 31, 2008 and for whom the licensed capacity is known (that is, recorded in KIDS). The average number of beds is 2.2, while the median is two in this pool of both relative and non-relative homes.

As noted above, HZA has established a standard, used for a consent decree analysis in another state whose subject

⁴¹ May include data errors since some exceed the maximum by a considerable amount.

was inadequate placement resources, of two beds available to one needed for every child in non-relative foster care. Since homes are licensed for more than one bed, this is not an overly generous target; that is, not two homes for every child but two available beds for every child who needs to be placed, excluding children in relative foster homes.

Of course not all areas are equal in terms of recruitment needs. The graph below shows the proportion of beds to children by area. Areas 4 and 5 do not have to recruit additional homes at this time; they just have to maintain what they have. Area 3 has the largest recruitment need, followed by Area 6.

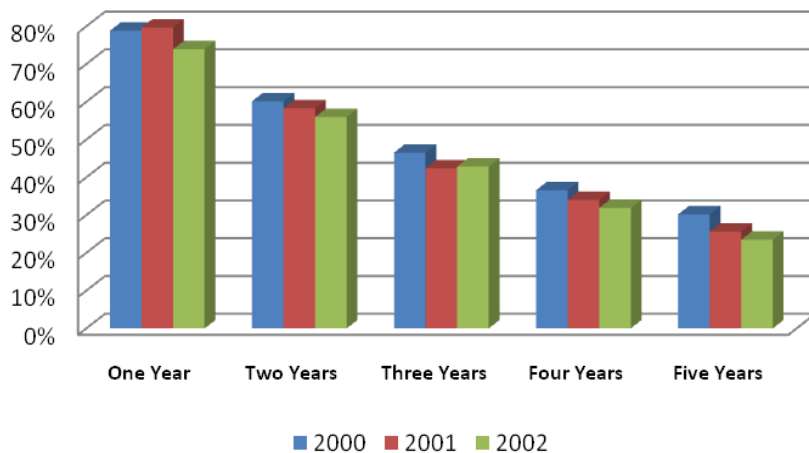


Recruitment and retention

efforts also need to take into account how long a given family will stay with DHS. HZA performed a “survival analysis,” tracking families for five years at three different starting points, 2000, 2001 and 2002 (we used these historical dates to allow five years to elapse).

The analysis, displayed in the graph at right shows the non-relative homes since they are the ones for which DHS can devise recruitment plans. Slightly over 1000 homes are represented in each time period at the beginning. By one year after licensure, 22.6 percent of the

Statewide "Survival" of Non-kinship Foster Families

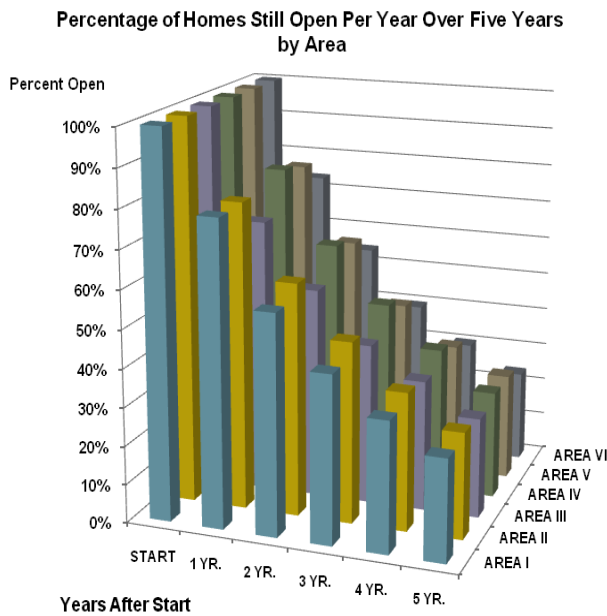


foster families have left; by two years, 41.9 percent of that original group has left; by three years 56.1 percent have left; by four years, 65.9 percent have left and by five years, 73.6 percent have left. These data suggest that the largest proportion who leave – over 22 percent – leave within the first year. While the decline lessens, it is steady and averages about 15 percent per year for any given group. (This is not a turnover rate for

all families, since different ones will have started at different years.) The graph shows that the people who started later, in 2002, declined at a slightly quicker pace than those who started in 2000. As with staff turnover, the first year followed by the second year, the foster families are most vulnerable to turnover.

The next graph averages the data from the three cohort groups (those who started in 2000, 2001 and 2002) to illustrate the drop-out curve over five years.

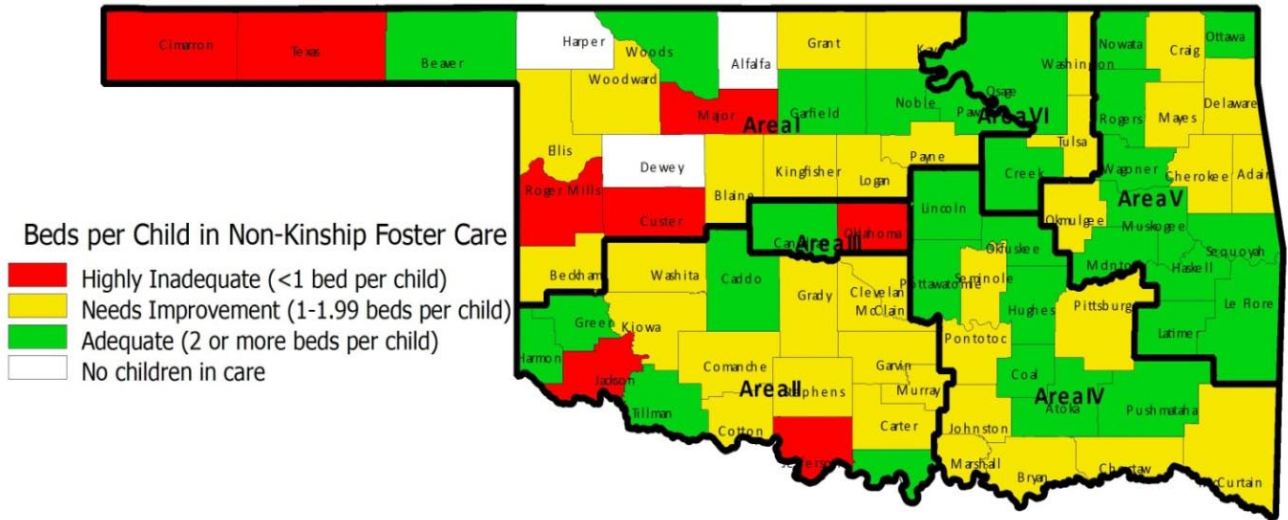
The annual turnover rate for all foster families was 46 percent in 2007. There were 7,209 active homes at the beginning of the year while 3,349 ended during the year. DHS recruited 3,111 new families during the year, ending with 6,977 at the end. According to the foster family survey, about seven percent of those who leave do so because they adopted a child.



The final graph in this analysis depicts foster family retention by Area. It shows that Areas 3 and 6 have comparable losses while Area 4 has the highest retention. By the third year Area 6 has fewer than two out of five homes it started with and ends the five years with the lowest retention among all the areas. The other areas are comparable to one another by the fifth year mark.

The map below displays the need for homes by county. The map uses four colors: red for counties where there is a highly inadequate number of homes, based on the two bed to one child standard; yellow for counties where there is at least one but less than two beds per child, and therefore needs improvement; and green for counties which meet the standard. The fourth color, white, was used for counties which had no children in care at the time this analysis was done.

Adequacy of Supply of Foster Home Beds by County



In Chapter 6, addressing management, we recommend that certain activities, including foster home recruitment, be managed at the Area level for all counties in that Area. Each Area should develop a recruitment plan which targets both the numbers and kinds of homes that are needed. The plan should be driven by the characteristics of the children in care in that area, including age, sibling groups and special needs. In that way the homes that are needed for the population will be targeted for recruitment.

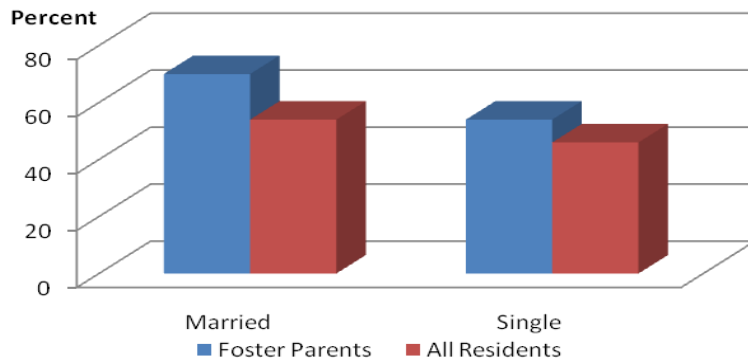
These figures can be refined by analyzing the numbers of siblings, teenagers and special needs children in each area and allocating the need to these groups as they appear proportionally in the population. In addition, according to the Multi-ethnic Placement Act (MEPA), the racial composition of the children should be represented in the racial and ethnic composition of the provider pool. DHS may have plans to do this type of analysis in conjunction with a five-year grant it received from the US Department of Health and Human Services for \$400 thousand per year. DHS plans to develop a Foster Parent Resource Center, a comprehensive recruitment plan, innovative approaches to recruitment of resource families, a rapid response resource center, technology to be used in training, and support and mentoring to resource families. Its objectives are to increase the number of resource homes that mirror racial and ethnic distribution of children and youth in care; to increase the percentage of resource families who will provide concurrent placement; to reduce the number of months in state custody for children; to increase the number of children leaving foster care; and to reduce the timeframes for parents to be approved for foster or adoptive placement.

Recruitment and Licensing Practices

Who does Oklahoma attract to be foster families? Their characteristics, as gleaned from their survey responses, are presented below and compared, when possible to other families in Oklahoma.

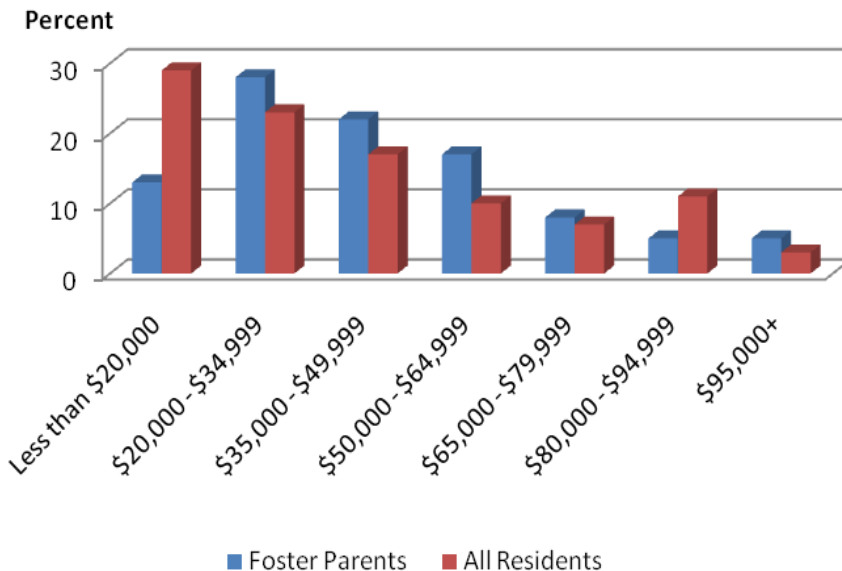
Among the current foster families, 70 percent are married, whereas the rest are single or partnering. Compared to the households throughout Oklahoma, more foster parents are married than the rest of the adult population.

Comparison of Marital Status of Oklahoma Foster Parents and All Oklahoma Residents



Household income is shown below. Half the foster family population earn between \$20,000 and \$50,000, while nearly 36 percent earn more than \$50,000 and about ten percent earn less than \$20,000; these figures are exclusive of foster care reimbursements. Foster families are better off than the general household population in Oklahoma, where over a quarter earn less than \$20,000. While a larger proportion of households in the state, about 10 percent, earn \$80,000 to \$90,000 than is the case with foster parents, in general foster families are more solidly middle class; that is, there are fewer very poor families and fewer very wealthy ones.

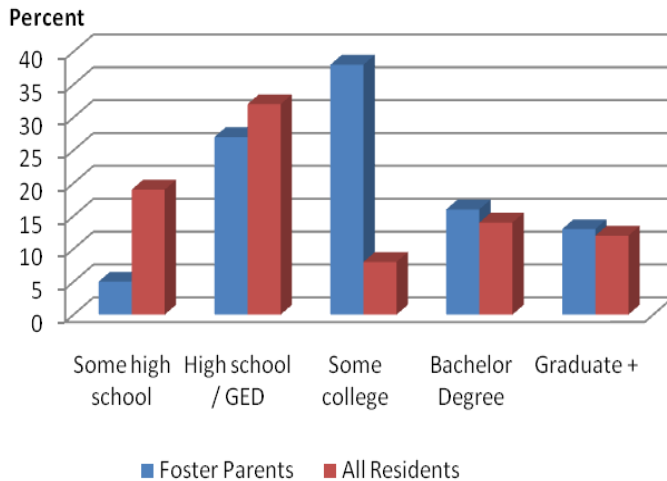
Comparison of Household Income of Oklahoma Foster Parents and All Oklahoma Households



Sixty-eight percent of the foster families have education beyond high school, whereas five percent have not completed high school and 27 percent have either a high school diploma or GED. As the graph below indicates, a far larger percentage of foster families have a member with some college than households in the population as a whole

in Oklahoma. In addition, larger shares of these families have a member with a bachelor or even a graduate degree.

Comparison of Highest Level of Education Obtained of Oklahoma Foster Parents and All Oklahoma Residents



Some people have the perception that foster families are relatively poor and uneducated. These data challenge those perceptions. In fact, as a group, they are more likely to be married, more likely to have a middle class income, and more highly educated than the typical Oklahoma household.

When they first looked into being foster families, 60 percent were thinking about being only foster families; 10 percent wanted only to adopt; and about 30 percent wanted to be both foster and adoptive families. By the time they completed the survey a higher proportion wanted only to be adoptive families and fewer wanted to be foster families only but that included people who were no longer certified and did not want to be involved or had already achieved adoption.

It makes sense for recruitment efforts to target the motivations of people for becoming foster or adoptive families. In Oklahoma these were primarily, and in order of frequency:

- 1) they were a relative of a specific child (24.9 percent);
- 2) they want to have more children (24.9 percent);
- 3) they knew other families who had fostered (22.4 percent); and
- 4) they were interested in a specific child (21.4 percent).

In an open ended question many said they became foster families because they want to help children in general. It is interesting to note that only 3.1 percent were motivated through church recruitment, 5.1 percent through a public service announcement, and 0.6 percent from community leader recruitment.

In a national study of foster families in the early 1990s, before kinship care was broadly used, about 36 percent first heard about the need for foster parents through other foster parents, 28 percent through mass media (television, radio, poster, or other advertisement), nine percent through a civic or community organization, four percent through a church or other religious organization, and 24 percent through other sources

such as adoption agencies. More respondents in the national survey heard about foster parenting through church than in Oklahoma, even though Oklahoma does have a One Church One Child contract which does faith-based recruiting.



The study found that those who were recruited through church served as foster parents longer than those recruited through public media; in addition, previous research has shown that many foster parents are religious⁴² and report attending worship services⁴³. Le Porn (1993) found that one motive for fostering is to fulfill religious beliefs by helping a child,

and Kraus (1975) suggests that people who belong to a place of worship may be more altruistic in their motives and less centered on their own needs. Cox (2000) found that foster families who belong to a place of worship were more willing to foster children who have been deprived or abused than families who did not belong to a place of worship. The authors suggest that churches provide a social network that can support foster families. Indeed, from the numbers church recruitment seems to be a relatively untapped but promising resource in Oklahoma.

In Oklahoma, the reasons people become foster families are varied, with no one reason capturing more than a quarter of the population. Wanting to help a specific child or relative and knowing other families who have fostered are the most prevalent reasons given by foster parents in Oklahoma. What seems surprising is that very few foster parents report being motivated or recruited by someone at church. The literature suggests that agencies use a variety of recruitment strategies and it would seem wise to include church recruitment more prevalently in Oklahoma's plans.

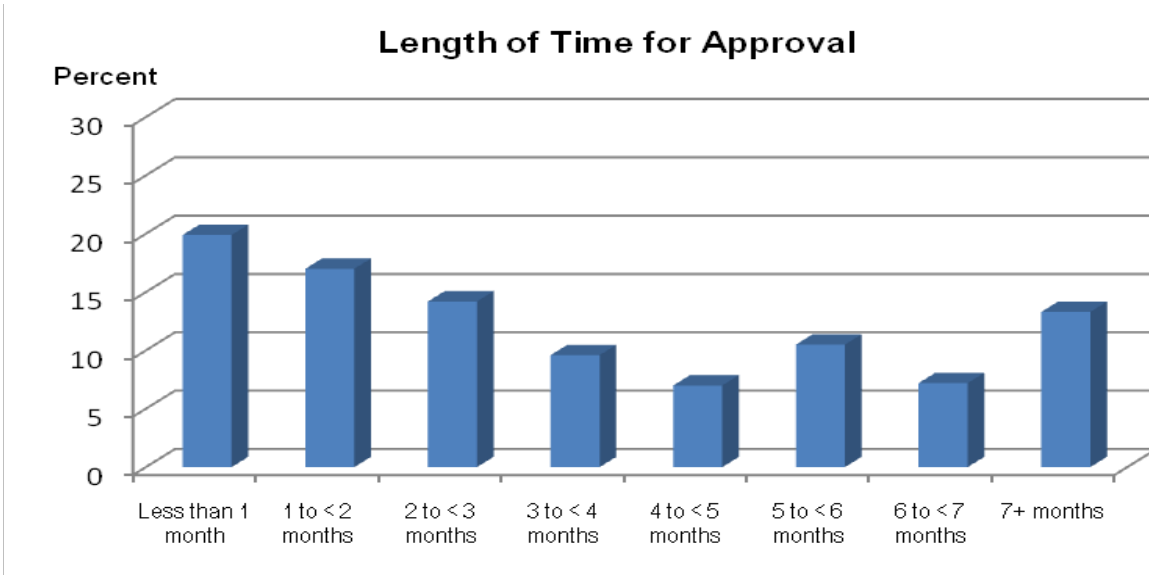
Nearly half the foster parents received a response to their inquiry to be a foster home within a week, whereas for a quarter of the families it took more than a month to hear back. There is a regulation, however, that contact be made within a week. There is no consistent pattern to how long the approval process takes, according to foster parent survey responses. Slightly more than half take three months or less while 18 percent take five months or more. While DHS expects approvals to occur within 90 days, over half exceed that standard.

Over 80 percent of the foster parents were satisfied with how long the process took to complete while over a quarter were not. There was a statistically different response in

⁴² Abbey, 1974; Buehler, Cox, & Cuddeback, 2001; Fine and Pape, 1991; Le Prohn, 1993

⁴³ Abbey, 1974; Kirby, 1997

this area among foster parents who started the process because they were interested in or were contacted about a specific child; 35 percent of these kinship families were not satisfied with how long the process took. Over 80 percent of the families were also satisfied with the way they were treated during the approval process, while eight percent were dissatisfied and the rest were neutral.



However, there were several areas where kinship families or those recruited for a specific child were less satisfied with the approval process than other families. Each of these was statistically different between the two groups:

- the process was explained fully and fairly
- the training was timely
- DHS matches children and families

The last one is odd since presumably the match was assumed. Perhaps they agreed to serve without thinking they were a good match or they were reflecting on other children they were asked to take.

In the national foster family survey 72 percent reported an intention to continue fostering; in Oklahoma the percent is 74 among those still fostering, strikingly similar and certainly no worse.



Oklahoma meets some of the best practice standards that were found in the literature on the subject of recruitment and licensing practices. As indicated earlier, DHS has put a big emphasis on kinship placement, broadly defined, and between a third and 40 percent of the children in care reside in such placements. There are provisions for kinship families to have a placement and receive \$375 training stipend and a \$375 start-up stipend before they complete the traditional assessment and training processes. Kinship placement is dependent on completion of an initial kinship placement agreement, a criminal background check, a child welfare records search, a physical house assessment, and contact with three personal references. While the accommodation acknowledges the need for a speedy placement, there are sometimes glitches or perceived lack of fairness on the

part of the kinship families about what portion of the month they were paid for, or when payments begin and end. Kinship families receive the same reimbursement as other foster families if they are licensed. There are other provisions in the law (10-22.1) for kin to accept children as a diversion from foster care, at which time they are eligible for TANF.

Foster family assessments and adoptive family assessments are described separately in the policy manual. However, the Bridge program integrates foster and adoptive family licensing processes for new applicants to either program. Once approved, resource family homes can provide foster or adoptive care. Ongoing collaboration with therapeutic foster care agencies should eventually lead to inclusion of these families in the streamlined approval process. How long this will take or what role the SwiftAdopt workers would play in the new process is not known.

One of the concerns expressed by several foster families was the state's either unwillingness or prohibition of allowing families to be licensed for more than one function, for example, to be a developmental disabilities home provider and a traditional foster family provider, or to be a licensed child care provider and a foster family provider. DHS says there is no prohibition against a child care provider being a foster care parent.

Now that historic barriers not just in Oklahoma but in all states to being both foster and adoptive families have been broken, DHS should consider the requirements for being a child care provider, a foster family provider, a provider of care for developmentally disabled children, a therapeutic foster care provider, an emergency foster care provider,

and potentially other areas and develop a hierarchy of requirements. Certainly there are some requirements that are common to all, such as background checks or household income. If DHS created a licensing hierarchy or menu of requirements, then any person who reaches a certain level or fulfills certain requirements should be able to care for children at that level or below. Combining the licensing functions could reduce staff from the various agencies and make it more worthwhile for families to undergo the process. DHS would have to monitor how many children are being served in the various categories (e.g., child care provider, foster family provider) so no family is over capacity in total, but with available information technology that should not be overly difficult.

Training of Foster Parents

All foster parent applicants and adult household members, according to policy, have to complete prescribed foster parent training that addresses the values and competencies essential to caring for a child who is a victim of maltreatment. The training consists of approximately 27 hours of instruction addressing required competencies, including, but not limited to: protecting and nurturing children who have been abused, emotionally maltreated, or neglected; meeting the medical and developmental needs of these children; supporting relationships between children and their parents, siblings, and kin, as specified by DHS; connecting children to safe, nurturing relationships; and collaborating with DHS as a team member.

Foster families may ask for waivers of some training requirements based on past service in Oklahoma or another state but the request must go all the way up to CFSD's Foster Care Section program manager for approval who has 30 days to decide. This person may also approve a self-study curriculum addressing the required competencies if the prospective foster family's work schedule precludes the completion of training. It is even possible for a family member to receive a permanent training waiver if he or she has a significant disability that precludes completion of classroom or self-study curricula. However, that person cannot be the primary care provider.

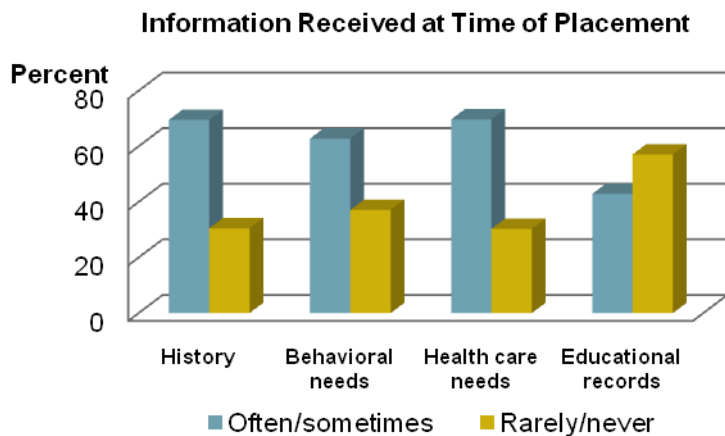
All foster parents complete 12 hours of continuing in-service training per calendar year on subjects that promote their skills and interests as providers. This may take the form of training, conferences, video and taped instruction, internet instruction, and literature. The resource specialist approves programs for which training hours will be claimed. Pre-service training is delivered by the National Resource Center (NRC) at the University of Oklahoma under contract with DHS since 1997. The University, as a state agency, does not bid competitively for the contract. A standard curriculum called PRIDE is used. Training is made up of nine three-hour sessions totaling twenty seven hours of training and covers the following areas: teamwork, attachment, loss, strengthening family relations, and discipline. In the last session, the trainers bring in a panel of teens, foster parents and maybe even a birth parent to talk to the foster families. There is also some behavioral management training. While couples are supposed to attend together,

one or more can make up a class by attending another session (as in another community) or completing the material at home.

There are 160 different sessions scheduled in a year. The NRC works with DHS to coordinate and set up the schedule. The NRC strives for at least eight people in each class but it depends upon the area. Families have options for their training schedules. They can attend training two evenings a week over a five week period, or once a week over a nine week period. NRC also offers an accelerated weekend program, where families can attend two sessions (six hours) on Saturdays for five weeks. NRC works to get kinship families into the accelerated sessions whenever possible because they are usually the families that do not have any advance planning to become foster parents and their payments are contingent upon certification.

One of the concerns expressed by foster families is that some have to drive 40 miles or more each way to attend training. The NRC cannot reimburse for mileage because it is not in its contract although training staff note that this is a persistent issue. Many foster families expressed problems with the travel and the timing of the programs in the interviews.

Foster parent trainers undergo an application process. They may not be current DHS employees, but they can work in a related field such as mental health; they may also be former DHS workers or experienced foster parents. The curriculum was completely modified in July 2007 and now includes information on the Bridge program, such as the benefits of foster families working with birth families, as well as some of the challenges that this practice presents. This is a new and evolving part of the curriculum.



Four-fifths of the foster parents surveyed believe that training is initiated in a timely manner while about three-quarters think the training is provided at a convenient place and time. Somewhat fewer, 64 percent, believe the training teaches families about the reality of being a foster family. There

was less agreement that the training prepares families to meet the children’s behavioral needs, while there was most disagreement with the statement, training provides adequate information about the way DHS operates and what to expect.

Families who were interested in a specific child were significantly less likely to think the

process was explained fully or that the training was initiated in a timely manner. The families who are willing to continue fostering are more satisfied with all five dimensions measured at a statistically significant level. This suggests that these are important and distinguishing factors which should be addressed.

Placement Practices

While some foster families are used over and over again, others do not get any placements or very few placements, spaced far apart. According to those interviewed, one of the reasons for this is that caseworkers are reluctant to place children outside of their own counties, even if the next county is closer than the home the child winds up going to. While there is a Resource Family module in KIDS, it is not clear that it is used by caseworkers to locate a foster family for a child, particularly one who may reside in a neighboring county.

Another issue with placement practices is the amount of information provided to the foster family at or near the time of placement. We recognize that very often DHS does not have a lot of information about the child, especially when he or she was removed by the police; nonetheless it is incumbent upon them to follow up as quickly as possible to obtain all available information. The graph shows foster parents report that information on a child's health care needs is more readily available to the foster family than information on the child's educational or behavioral needs.

When DHS places a child during normal working hours the caseworker is supposed to print a placement form from KIDS which contains the child's background information if available. Caseworkers report that they gather the child's medical history, medications, allergies, immunizations, doctor's contact information, school attending and grade.



Some foster parents report hair-raising stories about not having the proper medical information, which can have immediate consequences. One example is an asthmatic child arriving without his nebulizer and having a serious attack. Another is a child with sickle cell anemia having been placed with a family after being in a shelter for three months but the foster family was not told about the condition and four weeks later took the child to the hospital due to a deteriorating condition. Another is a foster parent not being given proper instruction on how to feed an infant released to her from the hospital with a feeding tube. Another family had to wait a long time for a medical card which required it to pay for or delay the child's treatment while another took a foster child to the emergency room for a life-saving treatment but when DHS did not approve the payment it went on the foster family's credit card and ruined their credit.

Some states are making efforts to gather and record a child's history in one place online and to keep it available wherever he or she goes. The state Health and Human Services Commission (HHSC) in Texas rolled out the online Health Passport last year. Today more than 20,000 foster children have electronic records that update most information automatically and follow children when they move to a new home. From insurance claims to food allergies, a foster child's medical data is housed by an array of companies, state agencies and practitioners. The Texas Health Passport draws these data sources together and presents them side by side.

Through a Web-based interface, each child's guardian, doctors and "medical consentor" (a legal designation often, but not necessarily, awarded to the foster parent) can access the passport, review the child's medical history and make necessary updates. Meanwhile, insurance claims, lab results and most other medical data update automatically. The result is a more complete and accurate snapshot of the child's medical history. To make such a program optimally effective, DHS would have to partner with the Oklahoma Health Care Authority which runs the state's Children Health Insurance Program (CHIP) as well as Medicaid. This agency would likely already have information on many of the children in foster care.⁴⁴



Another example can be found in the state of Washington which has established the Foster Care Passport Program. The program compiles the health history of children in foster care into an abbreviated health record called a Passport. The Passport includes information about medical and dental exams, diagnoses, hospitalizations or surgeries, immunizations, allergies and medications, the information needed by caseworkers, foster parents, parents, and health care providers to manage the child's health care needs appropriately.

Washington found that children in foster care have disproportionately high rates of physical, developmental, and mental health problems, and may arrive at their foster homes with unmet medical and mental health needs (American Academy of Pediatrics [AAP] Policy Statement, Nov. 2000). In addition, foster children move a lot. The Passport Program was established for children who have been in care for at least 90 days and therefore does not address the initial placement issue, but is intended to have longer term benefit.

⁴⁴ In Texas the Health Passport was mandated in legislation. Superior Health Plan, a St. Louis-based Centene Corp. developed the system called Star Health; the vendor was already managing parts of Texas' Medicaid and CHIP programs. Contact person: Yvonne Sanchez, senior health policy analyst, HHSC. Other states with foster care passports include Indiana, Michigan, New Hampshire and counties in California.

Due to budget constraints Washington gave children with identified health concerns priority in developing the Passport. A public health nurse and health program assistant work together to compile a child's records from numerous places, including health care providers, hospitals, clinics and dentists. These records are searched for any relevant health care history. This information is entered into the computer and a Passport is created. The nurse recommends preventive health care and follow-up care for identified health concerns. These recommendations accompany the Passport and a copy is sent to the foster parent and the social worker. The foster parent is encouraged to take the Passport to all the child's health care appointments.

DHS itself has a partnership with the Oklahoma Health Care Authority whereby children who come into foster care and who have received Medicaid services can have their medical records electronically produced from historic Medicaid paid claims data. These data can help the family understand a child's medical history including medication regimes. However, there is nothing in our review that shows awareness of this program in the field. It is something to be built upon.

Reimbursement Practices

Oklahoma set its current standard for reimbursing foster parents in 1982 based on data provided by the US Department of Agriculture on the Cost of Raising a Child in the Urban South. This was standard practice at that time. While increments have been made to the rate since then, the basic methodology has been abandoned because raises have not kept up with the cost of raising a child. There are three rates, based on the age of the child: \$365 per month, birth to five; \$430 per month, six to twelve; and \$498 per month, 13 and over.

In Oklahoma, the basic payment rate includes room, board, clothing and incidentals such as school supplies, education/vocational expenses, personal allowances, and recreation activities. The foster care policy states clearly that the basic reimbursement also covers: fees for special activities, school pictures, athletic and band instrument fees, cap and gown rental and prom clothing; and birthday and holiday gifts. Liability insurance, physical, and dental health care are paid by DHS. Child Care is paid for foster parents employed 20 hours a week or more.



In addition to the monthly rate, DHS also provides a one-time clothing allowance when a child is initially placed in foster care in the amount of \$100 (ages 0-5), \$150 (ages 6-12), or \$200 (13+ years). If a child is placed in a non-paid kinship home, a family may also receive an "emergency clothing authorization" of \$75 up to four times a year. Some regular foster families have reported receiving the \$75 voucher to reimburse clothing purchases when a child first moved in.

Foster parents may also receive a “difficulty of care” rate based on the schedule in Table 11. This is a supplement to the basic rate for more difficult children; the criteria are laid out in DHS policy. In the foster parent survey 55.8 percent of the families said they have never received a difficulty of care rate, 13.4 percent rarely, 20.4 percent sometimes and 10.5 percent often.

	Daily rate	Monthly rate
Level I	\$ 1.67	\$ 50
Level II	\$ 3.33	\$100
Level III	\$ 5.00	\$150
Level IV	\$ 7.50	\$225
Level V	\$13.33	\$400

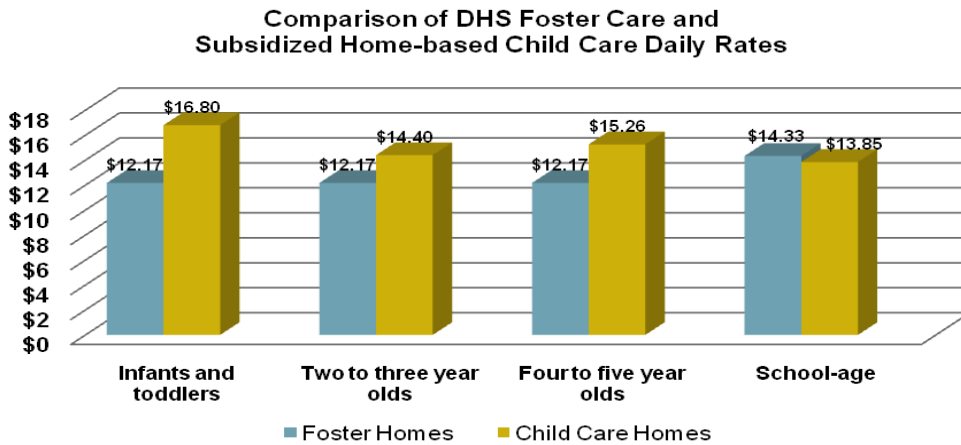
It is not a simple matter to compare rates with other states because some include items such as clothing allowance and transportation in the daily rate while others do not. However, Table 12 provides some comparisons, but the footnotes provide a more complete picture. Neighboring states were selected since the rates should be based on regional cost differentials. Compared to its five neighboring states, Oklahoma provides the second-lowest rate for birth to five year olds and six to twelve year olds, and the third lowest for teens. However, the lowest state, Missouri, provides additional funds for “career foster parents” who receive extra training and take children who require more individualized care and for respite care.

	Birth – 5 years		6 – 12 years		13 + years			
	Daily	Monthly	Daily	Monthly	Daily	Monthly		
Oklahoma⁴⁵	\$12.17	\$365	\$14.33	\$430	\$16.61	\$498		
Kansas	\$20.10	\$603	\$20.10	\$603	\$20.10	\$603		
Louisiana	13.57	\$407	\$14.97	\$449	\$16.70	\$501		
Missouri⁴⁶	\$9.40	\$282	\$11.17	\$335	\$12.40	\$372		
Texas⁴⁷	\$21.44	\$643.20	\$21.44	\$643.20	\$21.44	\$643.20		
	Birth – 5 years		6 – 11 years		12 – 14 years		15 + years	
	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly
Arkansas	\$13.33	\$400.00	\$14.16	\$425.00	\$15.00	\$450.00	\$15.83	\$475.00

⁴⁵Ongoing monthly clothing allowances of the following amounts are included in the basic monthly rate: \$20.00 (ages 0-5), \$25.00 (ages 6-12), \$33.33 (13+ years). Therapeutic Foster Care (TFC) rates: \$70.51 total per day which includes \$16.63 for room/board and \$53.88 for clinical treatment services. Emergency Foster Care (EFC) rates: \$15.00 per day (ages 0-5), \$17.00 per day (ages 6-12), \$19.00 per day (ages 13+).

Another useful comparison is what DHS pays for subsidized child care versus foster family care. DHS uses market rate surveys to determine the rates for child care and tries to hit the 75th percentile, meaning the subsidies DHS pays would be accepted by 75 percent of the homes without compromising their rates, giving families the ability to choose among providers. DHS child care rates are also based on the qualities and qualifications of the child care provider, the age of the children in care, and whether the provider comes from a metro county or non-metro county. DHS has established a star rating criteria and the subsidy for which a family is eligible depends on the number of stars it has.

The following graph shows the actual average daily amount DHS paid for child care subsidy to homes, not centers (centers are paid more) in 2007, taking into account the number at each rate in each county based on published data, for children at different ages, and compares it to what foster parents receive for the same age children. Note that for each age group, except school age, where presumably the home would spend fewer hours with the child in most instances, the Child Care Division pays its providers more than CFSD for far fewer hours of care.



While there is no real private market for foster care, therefore obviating CFSD's ability to do a market rate survey, and foster parents are volunteers, it is difficult to comprehend

(footnote 45 cont'd) Adoption assistance payment rates: \$0-\$310.50 (ages 0-5), \$0-\$364.50 (ages 6-12), \$0-\$418.5 (ages 13+).

⁴⁶ Rates are effective July 16, 2008

Additional infant allowance: \$50.00 (ages 0-2).

Annual clothing allowances: \$150.00 (ages 0-5), \$200.00 (ages 6-12), \$250.00 (ages 13+).

Career foster care rate: \$48.00 per day (all ages).

Career foster parent respite care rate: \$40.00 per day (all ages).

Career foster parent availability/transitional services rate: \$21.00 per day for up to 90 days (all ages).

Professional parenting payment rate: \$100.00 per month (all ages).

⁴⁷ Rates for higher levels of care: Moderate foster care rate: \$37.52 per day, Specialized foster care rate: \$48.24 per day, Intense foster care rate: \$85.76 per day.

why a foster care provider with 24-hour responsibility for infants and toddlers would receive less than the subsidy portion of the child care provider’s pay.

Three national organizations⁴⁸ published Hitting the M.A.R.C.: Establishing Foster Care Minimum Adequate Rates for Children (M.A.R.C.) which sets a basic foster care rate and adjusts it for each state. The rate was calculated by analyzing consumer expenditure data reflecting the costs of caring for a child; identifying and accounting for additional costs particular to children in foster care; and applying a geographic cost-of-living adjustment, in order to develop specific rates for each of the 50 states. The Foster Care M.A.R.C. includes adequate funds to meet a child’s basic physical needs and cover the costs of “normalizing” childhood activities, such as after-school sports and arts programs, which are particularly important for children who have been traumatized or isolated by their experiences of abuse and neglect and placement in foster care. The rates do not include the cost of transporting a child to visit with his or her biological family or the cost of full-time child care for working foster parents. They do include:

- Food
- Shelter
- School Supplies
- Daily Supervision
- Clothing
- Personal Incidentals
- Liability Insurance

Assuming the validity of the M.A.R.C., Oklahoma’s current foster care rates would be increased by up to 53 percent, depending on the age of the child, to cover the real costs of providing care for children. The current rates and the projected rates are shown in Table 13.

Oklahoma’s Current Monthly Foster Care Rate	Foster Care MARC for Oklahoma	Increase Needed to Hit the MARC:
Age 2: \$365	\$557 + travel and childcare expenses	53%
Age 9: \$430	\$639 + travel and childcare expenses	49%
Age 16: \$498	\$700 + travel and childcare expenses	41%

⁴⁸ Children’s Rights, National Foster Parent Association, University of Maryland School of Social Work, October, 2007

In its current budget request DHS has asked for over \$21 million in rate increases to reach the M.A.R.C. as well as for corresponding increases in adoption subsidy funding. If DHS were to maintain its practice of aligning foster and adoptive family subsidies, then the amounts provided to newly adopted children would need to increase as well.

In the foster parent survey, the parents were asked whether reimbursement was adequate to meet their children's needs. Nearly 44 percent replied rarely or never, whereas about a quarter thought the reimbursement was often adequate and 32 percent said sometimes. An even larger group, 83 percent, said they rarely or never get reimbursement for the purchase of extras when needed. Some of the real problems and frustrations expressed relating to reimbursement had to do with two primary areas:

When a child newly arrives in the home with little or no belongings, even if the child had already been in foster care and the initial \$150 was expended, the parents had to spend considerable amounts for clothing and supplies (e.g., diapers, formula, baby food) with no reimbursement or perhaps a \$75 voucher.

Many children require a lot of transportation to regularly scheduled appointments, therapy, visits, court hearings, and so forth. Sometime DHS uses aides or workers to supply the transportation but generally it is up to the foster parents who may have to travel 40 to 50 miles one way; they are rarely reimbursed for extensive transportation costs.⁴⁹

Roles and Responsibilities of Foster Families

We started this chapter by saying that foster families are volunteers. Having looked at their rates of reimbursement and what they have to cover with the funds, that point now should be underscored for the reader. However, when one reads their explicit responsibilities which are laid out in code and thinks about the emotional component of caring for a child, one becomes awestruck at both the enormity of the task and the size of the hearts of the people who do this work. Foster parents are responsible both for integrating the child into the family as the "foster parent's own child" and for providing mentoring to the child's parents and coordinating visits to facilitate timely reunification.

They must work as a multidisciplinary team member with the child welfare worker and the child's parent(s) toward family reunification or other permanency plan; help the child understand why he or she is in foster care and deal with the grief caused by the separation; cooperate and assist in sibling contact or visitation, including phone and mail

⁴⁹ DHS has reportedly begun to address the issue by paying 3 trips per month per child if over 25 miles, but the issue deserves continued attention to determine both the cost, effectiveness and prevalence of the new procedure.

contact, when siblings are separated; help the child maintain a connection to the child's kin, culture and community; and cooperate with and assist the caseworker in the placement of siblings together.

They must help the child develop a positive identity and self-esteem by feeling lovable, capable, worthwhile, and competent; help the child learn appropriate behavior without using physical punishment; use appropriate behavior management, parent-child conflict resolution, and stress management techniques in a manner appropriate to the age and development of the child in foster care.

They must also enroll the child in an accredited school, if applicable, and ensure the child attends regularly; advocate for the child to obtain appropriate educational testing and placement in a timely manner; attend school conferences and Individualized Education Plan (IEP) meetings; ensure the child participates in extracurricular and other recreational activities as appropriate; ensure the child's necessary medical, dental, and counseling needs are met by: (i) making appointments; (ii) providing transportation to appointments and sibling and parent visits; and (iii) obtaining prescription medications or over-the-counter medications as necessary and administering the medication as directed; maintain records of all medical, dental, and counseling appointments and notify



the caseworker of the time and place of the appointments, all medications prescribed for the child, and over-the-counter medications given to the child; and notify the caseworker of all medical and educational problems and progress.

They must ensure the child's opportunity to participate in the religious practices of the child's family's choice, including the provision of transportation to worship services other than those of the foster parent, if necessary, and ensure a child in foster care is not made to attend religious services against the child's wishes; provide transportation for the child to meet with legal counsel upon reasonable request, attend court hearings as desired or required, submit to the court written reports or present testimony concerning the strengths, needs, behavior, important experiences, and relationships of the child, in addition to other information the court requests; and provide from the foster care reimbursement all of the items discussed in the section on reimbursement above.

They must provide federally mandated independent living services to youth who are at least 16 years of age and assist other children in learning basic life skills that allow the opportunity to improve self-concept and strengthen identity in preparation for life after foster care; allow the child access to mail from family members and the child's attorney; and allow the child overnight stays with friends of the child whom the foster parent knows and approves while ensuring the safety of the child.

In addition, the foster parent has myriad responsibilities associated with the development and support of an appropriate permanency plan for each child such as participating in meetings and case staffings, completing all required training hours each calendar year, including policy training when offered; and maintaining current medical and education records for each child in foster care as well as a Life Book to support the child's sense of family continuity.

We list these responsibilities here because we expect this report to have an intensely interested if not wide audience, and we doubt people have stopped to think much about what we as a society are expecting of these volunteers. It is an awesome responsibility, and many unusual and highly-motivated people have accepted it throughout the state. It is no wonder, then, that when a relatively small but significant number of these people feel as if they have been used, abused or mismanaged by DHS, or that the children in their care have been neglected by the system or worse, placed in harm's way, they become incensed. For every foster family that has gone to the newspaper or called a state legislator, we received scores of letters and phone calls from those who quietly wanted to tell their stories. Here is some (a fraction) of what we heard with identifying information modified to protect anonymity:

Our boy had 3 different case workers in less than two years. I worked well with the first two because they genuinely seemed to care for the boy and valued my input. The third worker, however, was a very different story. She was assigned to M. for months but never came to see him; we live a mile out of the county these workers worked in...his primary case worker continued to make life changing decisions without meeting him...The system has to place enough value on the kids to have the person making life altering decisions get to know the kids personally. The children's sense of security and trust must have some weight in the system.

We did not apply in the beginning to be a foster parent. After getting involved we saw the urgent need for good homes for these wonderful children and consequently remained as foster parents. The children's behavioral needs are ordinarily down played by DHS staff in order to get you to agree to take the placement.

The support I receive is very good. I enjoy what I am doing.

The monthly reimbursement is always gone two weeks into the month requiring that we use our personal funds to provide for the needs of the children. With all the appointments required by DHS, gasoline is an incredible expense.

It is extremely difficult to get some of the DHS staff, particularly the supervisors, to place a younger child in counseling. We had one young child who would smear his face with feces, pinch himself until he bruised, kick and bite his siblings, and I was told by a supervisor that he was displaying normal 3-year old behavior.

The caseworkers provide inaccurate information to judges to show that the families are improving, not using drugs, just to make it look like they are fixing broken families.

A wonderful experience is being able to help children. DHS has been great to work with.

DHS absolutely does not respect the input of foster families, nor do they want any, making that apparent by the way they treat you. They treat you as if you are illiterate when you offer input based on your knowledge of the bond that exists between all of us.

It is unfortunate that their power is so abused as to use the children in their custody as pawns in a chess game yet they are not as of yet held accountable.

DHS workers are reimbursed for mileage but foster parents are not.

I have serious concerns about the culture of DHS. Though I have dealt with struggling organizations before, I can honestly say I've never dealt with a more dysfunctional group. The caseworkers are for the most part well-intentioned but ill-equipped to do their jobs. The rules appear to change weekly, they have very little accurate information about resources or procedures and they appear to have little support from their supervisors.

Foster families need, above all, respect from DHS staff which is for the most part lacking. They automatically dismiss any suggestion we may have because their idea is different.

I pray for all our sakes someone will have enough gumption to say, enough! Our children deserve so much better than we have given them. I know this letter will do absolutely no good, but I want to at least try.

It is an overall perception that DHS is required to return a percentage of children in their custody to their homes within a certain timeframe regardless of the condition of the parents or the home, disregarding the safety of the children solely to meet the requirements.

Our frustration was the way our case was handled at the end. They removed S. to his aunt and that was the end of our DHS experience. A short time later we received an official notification of the closing of our foster home and that was it. No one ever contacted us to ask if we would be interested in fostering again. No one ever said thank you. No one ever contacted us about our experience until now. We felt that DHS used us and then just threw us away. We may have been interested in working with another child but DHS made no attempt to recruit us.

Relations with DHS Staff

One of the concerns heard repeatedly is that foster parents are afraid of reprisals from DHS staff, should they disagree with a stance taken by a caseworker and, to a lesser degree, that children are moved without obvious good cause or reason. When the entire population was asked about these matters in the survey we learned that a fairly large proportion, almost a third of all the families, is indeed often or sometimes afraid of DHS reprisals. This is a larger negative response than on most other questions. Among those planning to leave, 40 percent fear reprisals. Of those planning to continue fostering, 15 percent think DHS removes children from their home without good reason compared to 26 percent who plan to leave.

Over half the foster parents say they have seen the treatment plan and over three-quarters of them report that they are notified of court hearings, while a slightly smaller group says that they attend sometimes or often.

Earlier we discussed the Bridge, whereby foster parents are supposed to work with birth families both in the visitation process but also to help them develop their parenting skills

Foster parent says ...

We recently sent a baby home who we had for six months. Her mother allows us to come visit her when we want. She is also attending church with us and includes us in her daughter's life.

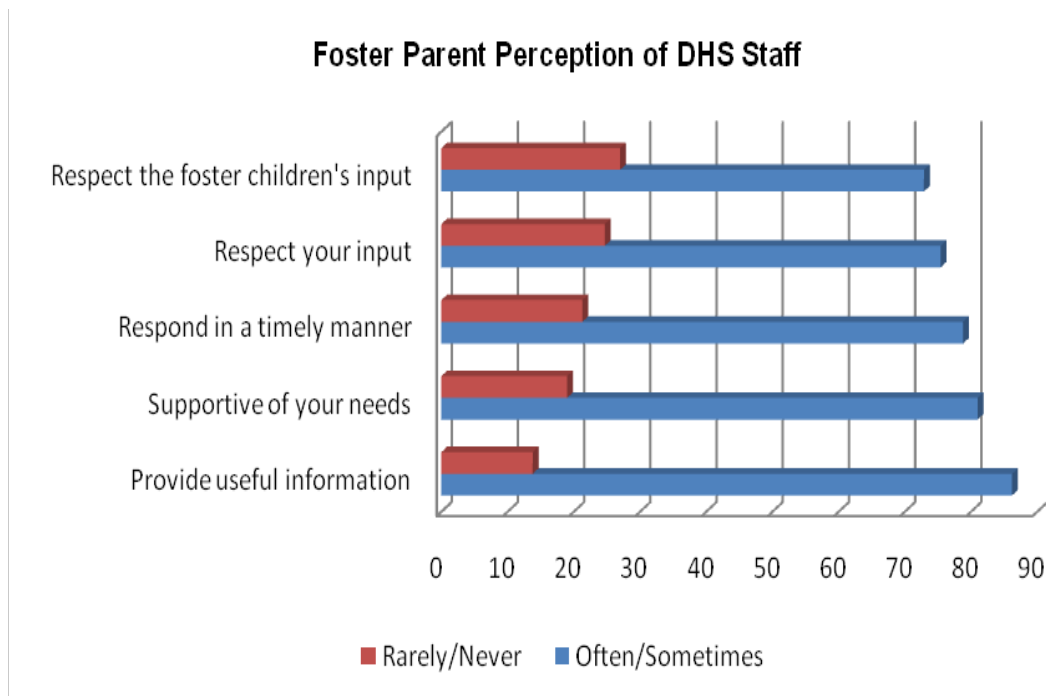
It is a blessing to serve these children!

where appropriate. This program has elicited both positive and negative response from the foster families, as one might expect. It is a huge departure for DHS to even engage in an initiative such as this given for example, its stance several years ago that the identity of foster families should be a secret presumably because birth families might come after their children. And in conducting the survey of foster families, DHS did not want to permit the auditors to mail the surveys because the identity of the foster families was confidential (even though we signed confidentiality agreements). So the Bridge is a leap, and one in the right direction.

Seventy-eight percent of the foster families said that they often or sometimes are asked to work with birth families; we see above that “mentoring” the birth families is one of the responsibilities of foster families. A few foster families reported how proud they were in helping the birth families; some even invited them to their churches. Others were resentful at situations where they transported the child for a visit, sometimes a long way, and the birth family did not show up, or the foster parent was asked at the last minute to perform this job because something had come up for the caseworker.

A number of foster families clearly see family rehabilitation as beyond their responsibility. Some did not have time for that and others did not want to work with families who had the kinds of problems that brought the children into care in the first place. Some reported that the DHS attitude is: if you don’t want to we will find someone who does. Some foster families suggested their services to birth families should be voluntary, and foster parents should be asked if they wish to participate in this practice, not told that it is expected of them. Others suggested they receive a stipend for this function. While we do not have a specific recommendation on this matter, we think the issue should be visited (or revisited) by DHS with something beyond, if you don’t want to we will find someone who does; again, these people are volunteers.

The following graph displays foster parent responses on a number of dimensions regarding their relationships with DHS staff. The largest proportion agreed that DHS staff often or sometimes provides useful information to them. Consistent with other findings throughout this report, the area that was problematic for more families than others was “respect the input of the foster child” and “respect the input of the foster parent.” Among the foster parents who say they are not willing to continue fostering,



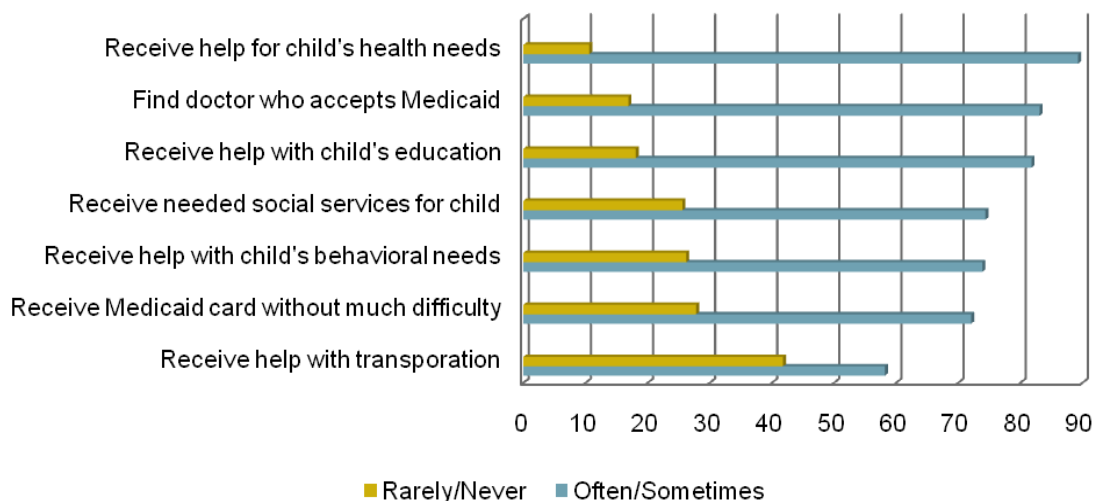
there was a statistically significant response on each and every one of those dimensions. For example, 35 percent said that DHS rarely or never respects their input and 41 percent said the agency does not respect the child's input. These factors may not be all that distinguish between those who are and are not willing to stay but they are nonetheless important distinguishing factors.

Support Services for Foster Parents and Children

The families and children receive two major types of support: directly through their relationships with DHS staff and indirectly through the services and supports provided by DHS. The majority of foster families initiate calls monthly to DHS while a third contact the agency at least weekly and eight percent never initiate contact. The vast majority, over 90 percent, receive a visit monthly from a DHS worker, while 5.6 percent say they never receive visits. The survey data on visits is consistent with a US Department of Health and Human Services Office of Inspector General Report which found that Oklahoma was one of only six states in the nation that could document that at least 90 percent of the children in foster care are visited each month. About half say that the caseworker visits the child privately during the visit, while over 43 percent say the caseworker *never* visits with the child privately. This is considered a best practice and should be instituted.

Foster families have to help children attain the various services that they need including health care, social services and educational support. The graph below shows the degree to which foster parents believe they get the help they need from DHS in fulfilling this role, in the order of satisfaction. That is, over 89 percent of the foster families believe they sometimes or often get the help they need to meet the child's health care needs. The area of most concern to foster families among the items listed is transportation, followed by difficulty receiving a Medicaid card. As with the factors above, there is a statistically significant different response among families who do not plan to continue fostering on most of these items. That is far more of them do not feel supported. The areas of largest discrepancy between those who will continue and those who will not are: help with behavioral problems, health care needs, educational needs and transportation. When considering how to boost retention, DHS needs to take these areas into account.

Foster Parent Perception of Support



The foster parent survey included three open-ended questions about the help foster parents would most like to receive that is currently lacking, the services foster families need to help them do their jobs and the services children in their care need.

The help they most want is something that is within DHS's capacity to deliver, at no additional expense (but time and attention) and that is communication. Foster parents want to know what is "going on" in a case; they want to feel like players in the team and to feel that their opinions are being heard. The second is financial support to meet the actual costs of raising the child (children outgrow their clothes quickly, they noted), and the third most frequent answer is comparable to the first, that is respect from the agency, caseworkers who care, and honesty. The next set of responses related to respite care, training and transportation. Training was requested specifically in the areas of: working with different age groups, understanding the various types of maltreatment and their effects on children, cultural sensitivity, DHS processes, and how to work effectively with birth families. The services foster families need are pretty much the same as responses to the first question: consistent, timely, two-way communication with caseworkers including requests for case updates and prompt return of phone calls; more respectful caseworkers and better communication with them; and additional clothing vouchers and financial assistance for school supplies and home repairs; better information about the child including case history, educational history and identification of special needs.

Regarding the children's needs, the item that appeared twice as frequently as the next highest was mental health and behavioral treatment. The next two were comparable in frequency: medical, dental and developmental services such as speech therapy and educational assistance, and more placement stability and timeliness to permanency. The latter includes involving the children in selecting placements.

HZA started the audit by conducting a literature review about the factors that have been shown to make a difference in foster parent retention, among other topics. The survey of foster parents bears out what has been seen elsewhere. It is not that all the families intend to leave fostering. The survival analysis shows that over 20 percent leave the first year, and 10 to 15 percent leave each year thereafter of the initial group that started together.



Discounting the responding parents who have already left the system, but taking into account the current families who intend to leave, that is, upwards of 38 percent, more of them were dissatisfied with the factors that have been shown to make a difference in foster parent retention. These include, most notably:

- the way they were treated during the recruitment process and how long the process took,
- information provided about the way DHS operates,
- training convenience and content,
- information received about the child,
- help provided by DHS to meet the child's needs,
- supportiveness of workers and
- respect for child and family input.

Recommendations

Recommendation 10: **DHS Area Directors should work with their recruitment staff to develop a resource recruitment plan based on the number of children in non-relative care and the projected foster family turnover, which meets the standard of two available beds per child.**

In the chapter on management we recommend that certain activities, including foster home recruitment, be managed at the area level for all counties in that area. Each area should develop a recruitment plan which targets both the numbers and kinds of homes that are needed. The plan should be driven by the characteristics of the children in care in that area including age, sibling groups and special needs. In that way the homes that are needed for the population will be targeted for recruitment. The recruitment plan should include not only the numbers of homes needed but the methods of finding them. The research has shown that two particular methods, using faith-based recruitment as well as other foster families, are effective when recruiting people other than relatives and should be emphasized in the recruitment plans.

Recommendation 11: **DHS should streamline its licensing processes. At a minimum it should develop a single process for resource families or Bridge homes which includes all foster and adoptive families. At a more ambitious level, it should look at consolidating the requirements if not the staff for all home-based licensing within the agency, across the divisions of child care, developmental disabilities and child and family services. In addition, families who are licensed to provide one service such as child care should not be excluded from providing another such as foster care, although limits should be maintained on the number of children a family can care for at a time.**

For a long time state human service agencies resisted the idea that the standards for foster families were comparable or the same as those of adoptive families. Those barriers are beginning to break down elsewhere. The agency can use all of the materials collected for the foster home licensing and add a few more items for the adoption component. More fundamentally, DHS should look into permitting families licensed for one function to be able to perform another function of equal or lesser difficulty, even simultaneously, while maintaining limits on the total number of children in care.

In addition, DHS should consider consolidating licensing and home study functions across the agency (for all home-based services); develop a menu of requirements, for example criminal background checks, DHS KIDS background checks, household income, numbers and types of references, and education and training requirements, and then apply the more specialized requirement to those who want specialized licenses. For example, to be a therapeutic foster care provider or a developmental disabilities provider will necessitate education, training and/or experience beyond more basic licenses. The Child Care Division's star system should be reviewed as a potential model that can be used by other divisions or across divisions to recognize families who have gone beyond basic requirements.

Recommendation 12: DHS should develop a Passport Program for foster children similar to those developed in Texas and Washington.

Such a program includes a basic format of the kinds of physical health, behavioral health and education information the passport will contain; working with partners to gain access of the information; modifying KIDS if necessary to store the information; and making a commitment to keeping it up. A Passport Program is one way to show respect to the foster family and the child while also adding a dimension of safety to the foster placement experience, even if applied to a limited group, like in Washington, of children who have been in care for at least 90 days. DHS should further develop its partnership with the Oklahoma Health Care Authority to put the Medicaid claims data in a usable format and to add to it from other data sources such as education to provide a more comprehensive picture of history and needs to foster families.

Recommendation 13: The Legislature should provide foster families with an increase both in the daily rate and in their ability to be reimbursed for clothing when a child newly comes to the home, even if the initial \$150 has already been spent elsewhere on the same child in another placement. Additionally, there should be some provisions for transportation reimbursement based on the requirements of the service plan, unless the family is receiving a difficulty of care payment.

It should be standard practice for DHS to offer the foster family an initial stipend of \$100 to start a child off in a new home, rather than only at the first placement for that child. In addition to generally being needed, it sends a message of support to the foster family.

It is not realistic to expect the full M.A.R.C. to be achieved in one year, which would constitute over 50 percent in rate increases; however, we recommend that the increase be phased in over three years. The cost would be about a \$7 million per year increase

under current figures, but could be cut by one-third to one-half with the projected reductions of children in foster care. To maintain parity, adoption subsidies in the future should be increased as well.

In addition, if a child's treatment or visiting plan (including family and sibling visits) calls for consistent transportation of more than once a week to specified appointments farther than ten miles from home, the agency should reimburse foster families for transportation, as agreed upon in advance by the caseworker. Again, it shows the agency's commitment to the plan as well as respect for the foster family's time and effort. To control costs, DHS should allocate a budget to each Area Director for transportation and clothing allowances. These costs can receive Title IV-E reimbursement as part of the maintenance provisions of the act.

Recommendation 14: Caseworkers should be required to visit with children privately at least every few months, and preferably at every visit.

Private visits help to guarantee the safety of the child in care and promote the idea that the caseworker is listening to the child, one of the major concerns of foster families. Infants and toddlers should be privately observed.

A Closer Look at Management and the Organization

Scope

One of the primary motivations for this audit was a concern that the organizational structure of DHS was not conducive to effective and efficient operations. Of particular concern was the fact that the program experts at the central office did not have line authority over the workers in the field. The basic question to be answered was whether, given the present structure, the directions set by the program staff were or even could reasonably be expected to be implemented at the local office level.

The answer to that question involves an examination of more than just the structure of the organization. Indeed, the frequency with which public agencies reorganize themselves suggests that no one has ever found the organizational structure perfectly designed to ensure effective and efficient operations. The real question is not whether the structure is the right one but rather whether the combination of the structure and the roles defined for each component of the structure are sufficient to ensure proper functioning. Specifically, the issues which have to be addressed include:

- the roles assigned to each component of the structure,
- policy making,
- communication of the expectations laid out in policy,
- support and resources to facilitate implementation of the policy and
- accountability or the consequences following the results of the monitoring.

The second of these topics was covered in the previous chapter, so the discussion here will focus on the first and the last three. As will be seen, the structure plays a role in the effectiveness of these functions, but it is only one component.

Standards



The standards regarding administration utilized by the Council on Accreditation (COA) will be used as reference points for the discussion in this section. These standards are sufficiently broad to apply to any public human services agency and they are especially applicable in Oklahoma, since DHS previously sought and gained COA accreditation for its child welfare operations and state statute requires COA accreditation for DHS facilities, where appropriate. Focusing on the standards which relate to the four topics to be considered here, this chapter will use the COA standards as a general guide to the examination of the administration of the agency.

Agency leadership establishes expectations for clear communication throughout the agency and with service providers, service recipients, and payers, as applicable, through a system that:

- a) provides all parties with timely information needed to operate effectively; and
- b) spells out mutual expectations for all parties.

The scope of services offered:

- a) is defined in writing;
- b) is adaptable and can respond to changes in the service environment, identified needs, and desired outcomes of service recipients;
- c) is secured through written agreement with qualified service providers, community partners, individual practitioners, and consultants; and
- d) considers allocation of resources together with available evidence of effective practice.

Ready access to services is achieved through clearly articulated service utilization goals and access guidelines responsive to the service population.

The agency's performance goals, and outcomes appropriate for clients and programs, are clearly articulated.

Oversight entities:

- a) reflect the demographics of the communities served;
- b) represent the interests of the communities served;
- c) link the agency and the public or community; and
- d) ensure that the agency's policies and performance uphold the public trust.

One or more agency oversight entities review agency performance and outcome reports, within a mutually agreed to, useful timeframe or as mandates require to support continual improvement and timely correction.

The agency establishes and maintains a stakeholder advisory group that serves as a bridge between the agency and the community and it:

- a) includes representatives of relevant community groups, consumers, parents, service providers, advocates, and others with an interest in the success of the agency at achieving its mission or purpose;
- b) provides information and feedback to the agency about services, outcomes, the perception of the agency within the community, and other information that would help the agency better serve its covered population and the community; and
- c) serves in an advisory capacity only and does not assume governing body or management responsibilities.

The administrative team establishes in writing:

- a) responsibilities;
- b) a process for assessing and implementing responsibilities, such as establishing task forces/committees; and
- c) under what conditions and to whom interim authority can be delegated.

Resource Management and development responsibilities include:

- a) setting resource development targets and goals, as reflected in federal, state, and county budgets and/or consolidated plans;
- b) using available resources efficiently;
- c) ensuring the full use of resources available to support the agency's programs and services; and
- d) ensuring the most flexible possible use of resources to support effective programs and services.

It is noteworthy that COA standards contain nothing about organizational structure.

Findings and Analysis

Organizational Roles

As might be expected from a large organization with a diverse set of programs, DHS' structure is complex, defining many different roles and functions. This discussion will present a somewhat simplified explanation because the only functions of genuine concern are the program functions. Support functions, such as budget, information technology and human resources, are largely centralized and lie primarily outside the program areas. That is neither an unusual structure nor one that is particularly problematic.

What is more unusual is that within the program areas DHS is organized into two units which are organized in very different ways. The larger of the two is called Human Services Centers, while the smaller is referred to as Vertically Integrated Services. Vertically Integrated Services include the Aging Services Division, Oklahoma Child Care Services, the Child Support Enforcement Division and the Developmental Disabilities Services Division. The Human Services Centers include the Family Support Services Division, the Children and Family Services Division, the Field Operations Division, the Office of Faith-based and Community Initiatives and Substance Abuse Services.

The essential difference between the two is that the central office program staff supervise the field staff in the Vertically Integrated Services programs and they do not do so in the Human Services Centers programs. In the latter programs, the field staff in all programs, with one notable exception, all report to the Field Operations Division.

A couple of examples will illustrate the differences. Oklahoma Child Care Services, which is one of the Vertically Integrated Services, is responsible for licensing child care facilities across the state. Its staff are distributed in local offices, often with the staff from other programs. However, even when the staff are located in an office managed by a County Director, they report not to the County Director but rather to the central office staff in the Oklahoma Child Care Services Division.

Post Adjudication Review Board member says ...

He [County Director] is great. There is a lot of respect for him within the office and the community. He is like Roosevelt's 'walk softly and carry a big stick.'

The situation is entirely different with staff in local offices among Human Services Centers programs. While child welfare program and policy directions are set by the Child and Family Services Division, child welfare staff in the local offices report to the

County Directors, whose reporting line is within the Field Operations Division. In many rural counties, the County Director is the face of the agency, and sets the tone for how it is perceived. Similarly, adult protective services workers and family support services workers report to the County Directors, despite the fact that the policies governing those programs are established by the Family Support Services Division. Moreover, Field Operations does not report to either the Family Support Services Division or the Child and Family Services Division; they are all equal in stature.

While this description may make the Human Services Center structure appear odd, it is hardly unique. Before the Texas human services agency split several years ago into multiple agencies, it had an almost identical structure. And in the 11 states which are county administered and state supervised, this type of structure is built into the definition of the system, because the state agency only supervises the counties as a whole, not program by program.

The alternative structure is found in neighboring Arkansas. Within the Department of Human Services there, each program directly supervises the workers in that program. The local offices are administered by the Division of County Operations, which is programmatically responsible for eligibility functions, equivalent to those in Oklahoma's Family Support Services Division. County Operations is basically the landlord for the other program divisions, and the latter are dependent on County Operations for the resources needed to operate, e.g., office space, phones, copiers, etc. This is the same relationship that exists in Oklahoma between the Field Operations Division and Oklahoma Child Care Services in those offices where they are co-located.

Understanding how the linkage is made between the program divisions and the Field Operations Division requires understanding the structure of the latter. That structure includes a central office with overall administrative responsibilities, six Area offices responsible for both the administrative and programmatic functions of often large geographic areas and "county" offices, most of which cover a single county but some of which cover more than one county and some of which, in Oklahoma and Tulsa counties, cover less than a county. Within the Area offices are positions explicitly intended as points of linkage between the central office program divisions and the county offices.

These are the field liaisons. These are persons who are knowledgeable about individual program areas and, while they are located organizationally in the Field Operations Division, the intent is that they serve as the link between the central office program staff and the line staff in the county offices. Each Area office has field liaisons for adult protective services, child welfare services and family support services. Field liaisons have no line authority over the county offices, but in general they are responsible for ensuring that county program staff know what the policies are and know how to apply them.

The most basic responsibilities of the field liaisons are to disseminate policy to the county offices and to advise on difficult cases. As indicated in the previous chapter, this is not the only means of communicating policy, because e-mail messages are also used as a means of ensuring that staff know about policy changes. Most of the staff interviews addressing this issue, however, indicated that field liaisons hold quarterly meetings with supervisory staff in the counties to inform them of policy and procedure

Supervisor says ...

In past years, policy information sharing has been a large issue. It is getting better.

changes, and the supervisors are then charged with instructing their own staff about those same changes. A few of those interviewed indicated that, at least in some Areas, this is about to change and that field liaisons will soon train all staff on the new policies.

The field liaisons also appear to act in a more *ad hoc* fashion to help staff know how to apply the policies. When a worker has a “difficult” case, which seems to be defined as one in which he or she does not know how to apply a policy, the worker takes the case to the supervisor. If the supervisor is also unsure, he or she turns to the field liaison to assist in making a decision. Thus, the liaisons not only provide formal training on the policies but also help staff in knowing how to implement the policy in individual cases.

Within this general framework there are obviously variations. Reportedly, some Area Directors use their field liaisons as their semi-official representatives on individual case decision-making, meaning that at least informally the liaison has sufficient authority to impose a decision, even if the county staff disagree. While most of the staff expressed either positive or neutral views of field liaisons, some found them of little use. Part of this reaction seemed to come from difficulties in getting access to and responses from the field liaisons (a charge frequently laid against caseworkers and supervisors by those outside the agency), but more of it appeared to come from other roles the field liaisons have been assigned.

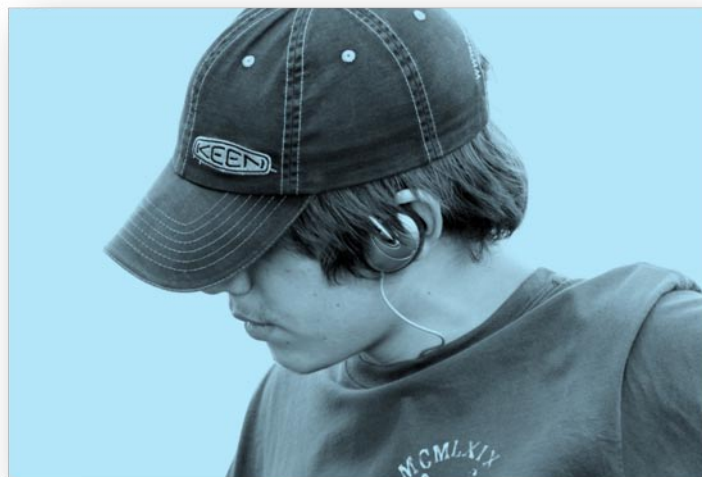
While these positions were originally created basically for communication purposes and therefore needed no line authority, additional liaison positions have been created which are more control oriented. This seems to appear most frequently in child welfare where there are permanency field liaisons, liaisons who funnel referrals to private agencies and sometimes other specialized liaison positions. Moreover, at least in some of the Areas, the field liaisons are given authority to approve or disapprove specific actions on individual cases which either require higher than normal expenditures or some exception to the standard policies.

One of the impacts of this expansion of the field liaison role is that it narrows the range of things both caseworkers and supervisors have to know and be responsible for. More particularly, it narrows the range of the judgments they must make. As will be suggested several times in this report, this approach to solving organizational issues is a fairly pervasive feature of DHS’ administration and contributes to the de-professionalizing of

the frontline staff. When an issue becomes important, either a special unit or position is created to handle it, or it is centralized.

Aside from the field liaison positions, there are at least three other anomalies in the organization of field work in DHS, all of them within child welfare. The first is that the workers who are responsible for the recruitment of adoptive homes report to the central office rather than to the Area or County Directors. This is basically a vertically integrated component of the operations within the Human Services Centers. This part of the structure was created nearly ten years ago in hopes of increasing the speed with which adoptions occur, and the unit is called the SWIFT Adoption unit. The adoption workers are secondary workers on a case, rarely meeting with the child but working to ensure that homes are recruited, trained and approved so that children waiting for adoption have resources potentially willing to take them. Most of the work appears to involve broad-based recruitment efforts, but some child-specific work occurs, as well.

The second unusual piece of the picture involves independent living. The work of ensuring that older youth are prepared to live independently is conducted by workers located in the field but in the employ of the University of Oklahoma's National Resource Center for Youth Services (NRCYS). These are not employees of DHS at all, but the contracted program as a whole is supervised by the Child and Family Services



Division. As with the adoption unit, primary responsibility for casework with the youth remains with the county offices, while the NRCYS workers focus specifically on ensuring that eligible youth receive the independent living services they are required to receive.

The last component of the structure which is unusual, at least in some parts of the state, involves the foster care units, which are responsible for recruiting and approving foster homes. Unlike the adoption and independent living workers, staff in these units are located organizationally within the Field Operations Division, but in the more rural Areas, they are responsible for recruiting homes in multiple counties while they often report to a single County Director. Other County Directors are dependent on them for an adequate supply of placement resources, but they have no line responsibility over them.

This reveals a tacit but important feature of DHS' view of its structure. Area offices are viewed as largely administrative in nature. Where they do have staff expected to be

knowledgeable about program issues, those staff have no line authority. Virtually all program work occurs at the county level, which is presumably why the foster care units report to County Directors, not Area Directors. The highest person organizationally in each program is at the frontline supervisory level, not at a more senior management level. When the agency has seen a need to increase the focus on a specific program activity above the county level, as with adoption and independent living, it bypasses the Area offices and assigns responsibility to the central program divisions.

It should be noted that focus on the county level is even characteristic of the organizations in Oklahoma and Tulsa Counties, where there are multiple “county” offices. Some of those offices are very narrow in their scope, while others cover wide ranges of functions. A single county office in Tulsa, for instance, is responsible for the child abuse hotline, the court liaison unit, the Child Advocacy Center and the diligent search unit for all of the county offices in Tulsa County, while also carrying out the normal range of county child welfare operations. Others have only two units of child welfare workers, one for intake and one for permanency. Those units are dependent on the other county office for a portion of their resources.

There is a theme which emerges here as one examines DHS’ operations. As seen in the chapter on program and policy, the agency tends to view field staff in both the Areas and the counties as responsible only for completing the most routine aspects of the work. Although their jobs necessarily involve, at least in adult protective services and child welfare, decisions which are quite significant in the lives of families, children and vulnerable adults, when a set of decisions is viewed by the administration as requiring extra care and attention, those decisions are taken out of the field. Staff in the field, including Area and County Directors, are not asked sufficiently often to address the issues the administration sees as most important. As will be seen below, workers tend to view themselves as without decision-making power, as well. Their concerns are with completing specific tasks within prescribed time frames, with little attention given to the judgments they are asked to make. This situation has a direct impact on both the operation and the image of the agency.

Communication

One area in which DHS tends to fall short of the COA standards on communication has to do with ensuring mutuality in communication, which in turn is part of providing “all parties with timely information.” A strong sense of hierarchy defines the communication mechanisms throughout the agency. For instance, the vast majority of frontline workers in all programs indicated that they had little or no contact with the field liaisons. All of that contact goes through the supervisors, whether the communication involves the formal training on policy and procedure or the ad hoc consultation on individual cases. As indicated, that may be changing in some Areas, at least in relation to the formal training, but there was no suggestion that it would change in relation to case consultation.

Hierarchy clearly appears to be a mechanism DHS uses to ensure both communication and control. Every job within Field Operations has a description of its functions, authority and expectations, and staff at all levels reported that they were quite clear about what they were supposed to do. Communication from the top down appears to work fairly well. It does not appear to work as well in the



other direction. Numerous staff across programs reported that they generally did not think that either central office (more frequently) or field liaisons (less frequently) understood the conditions in the field sufficiently to be of much help. As discussed elsewhere, field staff at various levels also reported that they have little or no voice in relation to the policies developed or the contract resources made available. Those decisions are made centrally and largely without opportunities for field input.

Even in relation to the communications from the top of the agency down, part of the success in communicating messages appears to come from narrowing the message. As indicated in the previous chapter, the policies say a lot about specific processes and timelines, but they are far less clear about how to make reasonable judgments. That creates something of a vicious cycle in which workers are not asked to make judgments in ambiguous situations, so they cannot be trusted to make those judgments, so decisions on the most important issues have to be centralized in some way and that further narrows the judgments the workers are expected to make. In sum, workers do receive and understand the communications DHS administrators want to convey, but at a genuinely fundamental level they are not asked to be part of the team that ensures the effective and efficient operation of the agency.

This situation is perhaps best illustrated by some of the interview responses HZA received. When asked what the service philosophy of the agency was, several Area Directors and County Directors and only a few supervisors mentioned the Practice Model being put in place for child welfare and the related Field Operations Standards of Excellence. These initiatives represent a change of philosophy and orientation for the agency which has been underway for some time. However, virtually no workers mentioned either set of standards. The change in philosophy has not penetrated down to the worker level in large part because there are no concrete mechanisms which make the new philosophy a part of everyday practice. Until the communication of the basic philosophy of the agency reaches the line staff, it is unlikely to have much impact.

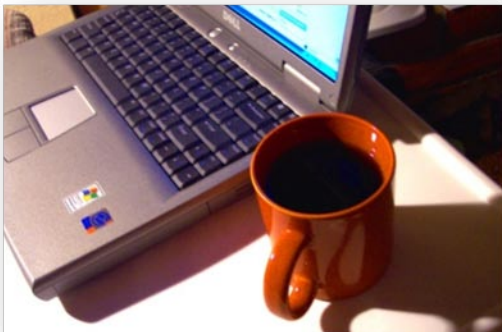
One COA standard relates to advisory bodies and is aimed at ensuring that agencies have regular input from the community outside itself. While DHS is involved in a number

of state level commissions and groups, one of the areas in which several administrative interviewees thought the agency needed to do a better job was in “reaching out to the community.” The potential for success in such efforts was evidenced by responses from those in the field where multi-disciplinary teams (MDT) are in operation in child welfare. With few exceptions, interviewees noted that active MDTs fostered better communications among all the agencies participating, and that even relationships with the courts were often better when there was an MDT. Similar reactions came in regard to the Systems of Care initiative in which the agency participates. Those addressing the impacts of these efforts affirmed the value of mutual communications and collaborative relationships.

Both of these examples highlight a more general image of the agency as often isolated from the rest of the community. Part of that isolation appears to come from the legal structure of child welfare and adult protective services in which DHS is formally just the recipient of the decisions of the district attorneys and the courts. Instead of having a role as a legal party to those decisions, the agency is required simply to carry out the decisions and it is the only agency in that position. Part of its reaction to that situation seems to have been to control as much of what it can control as possible and that necessarily means acting without drawing others into its decision-making. That makes the agency both act and appear as more monolithic and powerful than it is.

Support and Resources

Support and resources include many things. On one side are the basic tools to do the work, such as office space and computers. Also included are structures or processes which make the work possible, such as appropriate supervisory guidance and a person to go to for help with difficult questions. Support includes Employee Assistance Programs (EAP) and other programs designed to relieve stress, especially in intensely stressful jobs such as child welfare and adult protective services. In the human services



arena support and resources must also mean access to the resources needed to achieve positive outcomes for clients, i.e., the services provided by community partners. The issues of communication were discussed above and issues of supervision and training will be covered in the next chapter. Here the focus will be on space and equipment, EAP and related programs, and community services.

Space and Equipment

If one begins with the most concrete supports, i.e., space and equipment, the judgment must be that DHS has done an outstanding job in some respects. Most notable and most often mentioned by the staff is the provision of both cell phones and tablets (laptop computers) to line workers. The tablets in particular represent a step far beyond what most human service agencies across the country have done. While many states continue to struggle simply with having adequate computer systems, DHS has provided its workers with laptop computers which connect to the Department's systems, allowing workers to get work done almost regardless of where they are. For instance, for intake workers who are on-call after hours, it is important to know whether the person on whom a report of adult or child protection is being made is already known to the agency, and this is possible with the technology the Department has given to each worker. While some staff complained that they work in areas where connectivity is not always reliable, that has to do with the broad band infrastructure in Oklahoma's rural areas, and DHS cannot do much, if anything, about that.

The physical space in which human service agencies operate is often difficult. Few states are willing to purchase Class A space for field offices. The standard against which the environments provided by DHS have to be measured reduce, therefore, to whether the space is adequate, whether it allows the kind of privacy needed for the sensitive work caseworkers have to do and whether it is customer friendly.

On those standards, DHS generally has done well. Obviously, with offices in every county of the state, the physical conditions vary, but in general, the physical environment does not hinder the work that needs to be done.

There may, however, be a couple of exceptions. Both from HZA's own observations and from staff complaints, at least one of the buildings in Tulsa is overcrowded, subjects workers to significant background noise when they are talking on the phone to clients and providers and, upon initial entry, presents a confused and decrepit impression. This was the only place where interviews produced complaints of the cubicle office plan and it is to be assumed that the other offices where this type of layout is used are simply less crowded.

In Oklahoma City a somewhat different situation was encountered. In at least one office there, when the building got too crowded the agency simply created a unit in which the workers worked from their homes. No staff were complaining about that situation, but, especially in an agency where so much seems to be so tightly controlled, the question has to be asked whether that was a better solution than finding additional space. Indeed, it was only possible because the unit does child welfare intake and spends much of its time going to the clients' homes rather than meeting them in an office.

Employee Assistance

Like most public agencies, DHS has a formal Employee Assistance Program designed to assist staff with handling stress, both personal and professional. All employees seem to know that it exists, although few reported using it. Those who did mostly reported that the stresses for which they sought help were personal, not professional, and most reported that the service was of benefit to them.

More notable is the emphasis the agency has recently been placing on “compassion fatigue.” Recognizing that constantly helping other people who have problems serious enough to be known to this agency and frequently dealing with significant levels of conflict are prime contributors to burn-out, the agency has held training sessions on how to deal with this type of stress. This effort is also addressed in the child welfare Practice Standards with one of the guiding principles being that workers have to be healthy themselves in order to help others become healthy. Most of the interview discussions of compassion fatigue came from administrators, probably because the agency’s motivation in beginning these efforts has been to reduce turnover among line staff. Workers mentioned it less often, but those who did were generally appreciative of the efforts.

Community Services

For the services needed to help families become more self-sufficient, whether in relation to their finances or in relation to issues of protecting children and adults, the services on which DHS relies are generally not provided by the agency itself. Mental health services, substance abuse treatment, job training and the other supports families need to become fully self-sufficient are generally provided by community agencies, either public or private.

Some of these are provided without reimbursement from DHS, and the agency has done an unusually good job at entering into contracts with agencies who are willing to provide services without reimbursement, other than for concrete expenses such as clothing and children’s allowances. Such arrangements are much less frequent in other states, but have been used here, at least in part, to engage the faith community without breaching the wall between church and state.

Clearly, though, DHS will have better access for its clients if it is paying for the service through a reimbursable contract spelling out what the agency can expect to receive. The focus of this discussion is, therefore, on the contractual arrangements DHS makes to ensure that it is an adequate quantity of high quality services.

There are two especially notable features of DHS’ contracting practices. The first is that contracts are administered out of the central office program divisions; not out of the local

offices or even out of the central Field Operations Division. The second is that, with one important exception to be discussed at the end of this section, the agency is not proactive in defining the needs for services and then in pursuing a strategy for meeting those needs.

One of the COA's standards for an appropriate administration is that its services can be adapted to changing needs. DHS does not have, however, any systematic needs assessment effort which would identify changing needs as they occur. Moreover, in every interview at every level of the agency where the question was asked, DHS managers reported that the availability of services is dependent on provider capacity. While there is no doubt that provider capacity cannot be expanded indefinitely to cover all parts of the state with all the needed services, the agency appears to have ceded the responsibility for identifying the services needed to the providers and their ability to identify opportunities for approaching DHS about expansions of services, either to new modalities or to new geographic areas.

This is perhaps the area in which the disjunction between the program experts and field operations is most serious. The program divisions naturally tend to view the state as a single entity, while Area Directors and County Directors are just as naturally concerned primarily with their own spheres of responsibility. Yet, across the state local managers reported that they had little impact on which service providers received contracts or on which services were available. Nor is there in any program an allocation of funds to the Areas, which might ensure some equity in the distribution of services across the state and alert managers in each Area that the funds are available to expand the availability of services so that they could identify providers or entice providers to move into the Area. Because the availability of services is left dependent on provider capacity, the geographic distribution of services is also left essentially beyond the control of DHS.

There are two ways in which local managers reported that they had some impact on contracts. The first is that when an Area or County Director identifies a service provider and can work out a viable model, he or she can approach the central office for financial support and will often receive that support. A number of contracts appear to have been developed in this way in cooperation with both local school districts and tribal agencies.

The second way in which some local managers reported they have a say in relation to the contracted services has to do with monitoring. Some of the County Directors reported that they are asked each year to provide input to an evaluation of the contracts. Few if any of them, however, believed that this had much impact. At least one manager reported that utilization is taken as an indicator of quality, but that when there is only one provider for a given service, utilization is necessarily high, regardless of quality.

In sum, the DHS offices which have the responsibility of identifying which services individual families need and of ensuring that those families obtain those services have little say over which services are available, and the program divisions which decide

which services will be available have largely taken a reactive position towards contracting. They are responsive to local providers who come forward offering to work with DHS and to managers who take the initiative beyond what is expected of them, but they have generally not developed a positive agenda which would ensure that families have adequate access to services.

The impact of this approach is additional cost to DHS and the state treasury. The areas most affected by gaps in services appear to be child welfare, developmental disabilities and adult protective services. In the staff survey, fewer than half the responding child welfare staff across all levels were satisfied with either the quality or the variety of services, and barely a quarter agreed that “there is rarely a waiting list.” In interviews workers talked about waiting lists of one to two months even in urban areas. Because many of those served are families with children in foster care, a one month waiting list is virtually guaranteed to extend the time a child remains in foster care, because his or her parents cannot get the services required in the treatment plan. For those whose cases have been closed but who have been referred to contracted services, such as CHBS or parent aide, the delay in services means that whatever level of protection the referral was supposed to provide the children in the family is not being provided.

A majority of the staff in developmental disabilities (which is a vertically integrated service) reported satisfaction with the quality and variety of services, but only ten percent agreed that there is rarely a waiting list. Workers in the adult protective program were concerned about both the variety of the services and the waiting lists. For all three of these populations, gaps in community services can mean more frequent or more extended use of out-of-home services, and these are nearly always more expensive than the alternatives.

The one exception to DHS’ normal contracting practices is Oklahoma Children’s Services (OCS), which is a contracted program consisting of Comprehensive Home Based Services (CHBS) and Parent Aide Services (PAS). While the contracts are operated out of the Children and Family Services Division, the program is provided on a statewide basis and funding is specifically allocated for each Area office. Moreover, renewal of the contract after the initial evaluation is dependent, at least in part, on the satisfaction of the County Directors in whose counties the services are provided.

OCS was initiated in 1991 and at that time there were almost certainly not sufficient providers ready, willing and able to provide these services across the state. The fact that there is now statewide coverage (albeit with waiting lists that are reported to be sometimes quite long, even in the largest urban areas) suggests what could be done with a wider variety of services, if the same approach were taken. It is a matter of building on something DHS has already shown itself capable of doing.

Accountability

Accountability encompasses two separate but related components: monitoring and acting on the results. Some agencies produce reports or have other means of monitoring their activities and results but have no standard way of correcting their practices when the results indicate deficiencies. DHS has implemented methods for both components.

One of the questions asked of all those interviewed inside and of several outside the agency was whether people are held accountable within the agency. Answers varied somewhat from those outside the agency, but far less so from those inside. Moreover, the processes described were virtually identical across all levels of staff and across all programs.

Caseworker says...

DHS has seen a big shift and is striving for accountability.

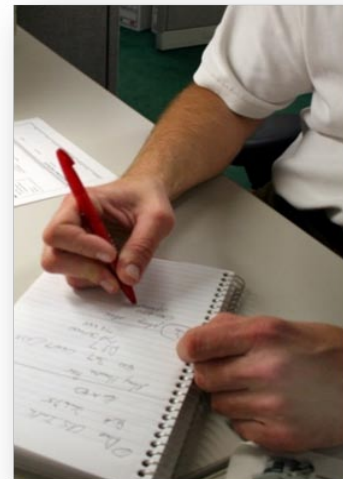
Monitoring

As suggested in the analysis of client outcomes, DHS' primary monitoring activities center on the "key indicators." For each program the administration has defined a set of measures. Some of these are simply workload numbers and have no goals associated with them. For instance, in developmental disabilities, the measures include the number of individuals who are Medicaid eligible and the number of individuals receiving state funded sheltered workshop services. No target is set for either figure.

In terms of accountability, the more important figures are clearly those for which there is a target. Staying with developmental disabilities, those indicators include:

- percent of consumer surveys indicating satisfaction with case management services,
- percent of survey factors rated good or exceptional,
- percent of service recipients participating in supported employment,
- percent of recipients in supported employment – individual placements, and
- percent of service recipients in sheltered placements.

These measures are of two different types. The first two are customer satisfaction measures, while the last three, given an assumption that most of the developmentally disabled served by the Department cannot be fully independent, can be viewed as client



outcome measures. Customer satisfaction is often also viewed as a measure of client outcomes, the implication being that if the customer is satisfied, the program goals for that customer have been met.

A third type of measure is found when one examines the measures for the three programs of greatest concern to this audit: adult protective services, family support and child welfare. Many of these are process measures. For adult protective services there are only two measures with targets or goals. Investigations are expected to be initiated within the prescribed time frames in 95 percent of the cases and 95 percent of the investigations of long-term care facility referrals are to be completed within 60 days. Neither measure addresses either client outcomes or customer satisfaction. While initiating an investigation on time is probably a necessary condition for ensuring the safety of vulnerable adults, it is not sufficient, so the measures do not reveal whether the adults are safer because of DHS' intervention.

The measures for family support services are similar. For child care and health related medical services, all of the measures with targets have to do with the timeliness of the eligibility determinations. For food stamps there is one measure related to timeliness and three measures of accuracy: the overall error rate, the percentage of case errors caused by the agency and the percentage of errors caused by the client. (The last two are basically the same measure because it is impossible to achieve one without achieving the other.) Although it is not directly a measure of client outcome, accuracy is important in assuring both that clients in need receive the benefits for which they are eligible and that public dollars do not go to those who are ineligible. It may appear curious, however, that despite dozens of staff reporting in their interviews that the service philosophy of the agency is to help families and individuals become self-sufficient, there is no measure of self-sufficiency among the food stamp measures.

The measures for TANF are more outcome oriented and focus on self-sufficiency. There are only two measures with goals or targets attached to them and both relate to self-sufficiency. One is the percent of TANF recipients meeting the participation rate (in a work activity 30 hours or more a week) and the other is the percent of TANF cases closed for reason of employment which have remained closed for three months. The lack of timeline or accuracy measures is probably a function of the fact that the rules governing timelines and the eligibility criteria are determined by the state and not by the federal government. That is not the case for food stamps or for health related medical services.

The federal impetus is also seen in child welfare. Here, the federal government has established a series of outcome indicators which are applied to all states. Most involve relatively direct measures of safety and permanency, with only one safety related measure focused on a process deadline. While DHS has not directly adopted most of the federal indicators, their influence is clear in the indicators the agency uses.

Unlike the other program areas, child welfare has targets or goals for every indicator but one, the number of children in out-of-home care. That is to say, there is only one workload measure here; the rest are performance measures. There are, however, both process and outcome measures. The process measures include the percent of investigations initiated on time, the percent completed on time, the percent of youth eligible for independent living services who have received a Life Skills Assessment and the percent of children receiving a face to face contact in the home of the placement provider during the month. Outcome measures include, among others, the percent of families receiving prevention services with no additional confirmed reports within 12 months of case closure, the percent of children in out-of-home care less than 12 months with fewer than three placement settings, the percent of children in out-of-home care who achieve permanency within 12 months and the percent of children with a goal of adoption who are in a trial adoptive home.

While one could argue that different measures should be used, the DHS indicators do cover important aspects of child welfare work and they are relatively comprehensive in that they cover the major concerns of the program. There is one omission which became obvious to HZA in part because one of the Area offices includes it in its own monitoring. This is the frequency of caseworker contacts with the birth families of children in foster care. The frequency of contacts with children is monitored presumably because of relatively new federal requirements on that subject, but if the agency is to be effective in its permanency efforts, more work has to be done with the parents than with the children in care. The omission is all the more notable because the one Area which monitors this factor falls well short of the goal established for the frequency of parent contacts.

Actions Taken

During the interviews conducted for this review, staff at all levels and in all programs provided consistent reports of how the results of DHS' key indicators are used. Managers from supervisors through Area Directors review the results periodically (daily, weekly or monthly, depending on the office and the position), meet with the subordinates responsible for achieving the targets and require corrective actions when the targets are not achieved. Virtually every person recounting this process then described the standard personnel disciplinary procedures which would be implemented for persistent failure.

Given this description and the results on some of the key indicators as discussed in the chapter on client outcomes, one would expect widespread disciplinary actions across the agency. For instance, in neither SFY 07 nor SFY 08 did any Area office achieve the target of having 86.7 percent of the children who had been in care less than 12 months experience fewer than three placement settings. Similarly, in no Area were fewer than 50 percent of the children in out-of-home care there less than 12 months. While Area

specific figures are not available for programs other than child welfare,⁵⁰ on a statewide basis the percent of child care program certifications processed within the required time frames was below the 95 percent in both SFY 07 and SFY 08, including in every quarter of SFY 08, and the same is true for the percent of long-term care facility referrals adult protective services investigates within 60 days.

The reason for the dissonance between the reported process for taking action on key indicators and the absence of large scale disciplinary action appears to lie, at least partially, in the emphasis given to some of the indicators at the expense of the others. Staff were virtually unanimous, again across all levels and programs, that timelines were the essential measures for which they were responsible. One of the more disaffected family support workers described the social worker's job as processing the paperwork within the federally prescribed timelines, never even referencing accuracy issues, much less impacts on clients. Thus, it would appear that workers may be held accountable for the frequency of contacts with the children in their foster homes (where most Area offices and the agency as a whole meet the target) and for initiating investigations within the required time frames (where performance is nearly at the target), but not for ensuring that children experience stability while they are in care or achieve permanency in a reasonable time frame.

At one level this is reasonable. If, for instance, there are not enough foster homes available for children to be well matched to their foster families, one would expect more placements to disrupt and the individual worker will be able to have little if any effect on this. The failure is a failure of the system, not of the individual, although it is the responsibility of some individuals at administrative levels to fix the problem. Something similar may be at work on the permanency side. If families cannot immediately access the services in their treatment plan because of long waiting lists, children are likely to stay in foster care longer, and it is not the individual worker's fault that the services are not available in sufficient quantity. Again, however, someone is responsible.

While one can acknowledge that workers should not be held accountable for things they cannot control, focusing as much attention on the timelines as DHS appears to do seems like a version of "measuring what is measurable." It is easy to measure whether an activity was completed on time; it is far more difficult to determine whether workers are using appropriate judgment in their safety and permanency decisions. While client outcomes are measured, they do not appear to be taken with the same seriousness that meeting timelines are, because the latter can be monitored on a weekly or even daily basis, while client outcomes take time to develop and are, in any event, difficult to measure reliably on a caseworker specific basis. One way to understand what is amiss in the accountability structures within DHS is to say that there is too much focus on controlling the most discrete actions and not sufficient focus on the broader picture.

⁵⁰ DHS produced the Area specific child welfare figures at HZA's request. They are not routinely generated, although numerous reports can be generated at the local level which presumably provide that information.

Even with that understanding, however, there remains the question of why wide-scale disciplinary actions are not taken when many of the timelines are routinely not met. In adult protective services, for instance, 95 percent of the investigations of long-term care facilities are supposed to be completed within 60 days. In SFY 07 only 73 percent were completed within that time frame and in SFY 08 that figure rose only to 78 percent. A similar situation is found in child welfare relative to priority two investigations. Here, 90 percent are supposed to be completed within 60 days but in both SFY 07 and SFY 08 only 77 percent were completed within that time frame.

HZA cannot say why the disciplinary process does not work as reported. There is, however, one plausible reason. If it is true, as was widely recounted in interviews both inside and outside the agency, that caseloads are too high, one cannot expect workers to complete all their tasks on time, much less with consistent accuracy or good judgment. If that is DHS' rationale, what the agency has done is to get workers and supervisors and managers to focus on a couple of the most important (to the administration) of the indicators and to ensure compliance with those. That would explain why adult protective and priority one child protective investigations are initiated on time, foster children are seen in their foster homes regularly, and the food stamp error rate is kept low. The necessary side effect is that many of the other expectations are allowed to fall by the wayside.

There is an alternative approach if the issue is workload, and the workload problem is not immediately soluble, to adjust the targets for the measures that DHS considers to be less critical. If the ideal is for 90 percent compliance on a measure when workers have 15 cases per month, but in fact they have 20 per month, it is likely either that they will only achieve 60 percent.

As the example above relating to foster homes suggests, the accountability measures seem to weigh far more heavily on the individual workers than they do on the managers. The Field Operations Division does have a set of expectations for each level of staff, including managers, and at least some of the managers' standards relate more to outcomes than to discrete processes. Some of them, however, are not captured in the standard key indicators. For instance, there is an expectation that County Directors will close two percent of their TANF caseloads each month due to earnings. That measure simply does not appear in the standard table of key indicators (it may be in the system somewhere and available for internal use, but it was not provided to HZA), and one has to assume that means it is taken less seriously than that, for instance, all programs achieve 95 percent timely processing.

DHS does have one other accountability effort in place which is worth noting and probably worth expanding. This only relates to child welfare, but it could be useful in other areas, as well. Each year DHS' Continuous Quality Improvement (CQI) unit within the Child and Family Services Division conducts a review of each county. The review is

based on the federal review done of all states and its results, as does the federal review, in a program improvement plan if the county is found to be deficient in some way. While similar processes have been initiated across the country, what makes DHS' unique is that it is tied to bonuses for staff if the county does well. If a county achieves 100 percent on its review, all workers in the county who have been there at least one year and who have completed their annual ongoing training requirement receive a bonus.

Some of the parameters of this system should probably be changed. It is, for instance, difficult to imagine that in a review which mimics the federal review in a genuinely substantive way any county could get 100 percent, although it has reportedly happened with these reviews. If the review is genuinely as substantive as the federal review, more reasonable goals would be in the 80 to 90 percent range. While it is difficult to know merely from examining the instrument how substantive the review is, even the notion of a 100 percent score suggests that many of the items are easily quantifiable.

What makes the CQI reviews interesting, however, is the fact that the bonus requires a group effort. Everyone has to have done well on their cases for anyone to gain. That makes this effort nearly the polar opposite of the key indicator process which focuses on the actions of individual workers and even then on the most easily measurable of those actions.

Two final points should be made about DHS' accountability efforts. The first is that while there is some process for evaluating contracted providers' performance, the contracts themselves are sufficiently vague in their provisions that a rigorous evaluation seems unlikely. From both inside and outside the agency, interviewees registered numerous complaints about the quality of the providers, but, as noted above, few believed that even when these views were expressed formally to the agency that they had any impact. Given the passive stance DHS has taken to most of its contracting, allowing existing provider capacity and willingness to dictate the location and quantity of services, it is not surprising that it seems to have done the same in relation to quality.

The second point is that there is an external oversight body which reviews some of what DHS does, at least in the child welfare area. This is the Commission on Children and Youth. The Commission operates the Post Adjudication Review Boards (PARBs) which conducts six-month reviews of children in foster care. The Commission also makes both routine unannounced visits to DHS facilities and responds to complaints about those facilities. The Commission has, however, no enforcement authority. As a result, many of the same violations appear repeatedly in the Commission's reports, and many of the agency's responses to those violations say that either the agency is unable to do anything about the problems or that someone else in the agency (outside the facility) is responsible. In the end there is no accountability for DHS' own facilities because DHS is regulating itself.

Recommendations

There are seven large recommendations HZA makes in regard to DHS' organization, management and accountability, but they all derive from a single vision of what the agency should look like and how it should operate, some of which is articulated in other chapters of this report. To repeat what is said many times here, authority and resources have to be commensurate with perceived responsibility, and once that balance has been achieved (but only then), there must be concrete accountability mechanisms for ensuring that the responsibility is carried out. This applies to the agency as a whole and to each component of the agency, down to the individual caseworker.

Those recommendations are the following.

Recommendation 15: Within Oklahoma and Tulsa Counties only, DHS should replace the positions of County Director and field liaison with programmatic directors for each of the programs within the Human Services Centers.

As noted above, the structures within Areas 3 and 6 are confused at best. In both Oklahoma and Tulsa Counties, there are multiple county offices, but they do not operate at equal levels. Some have a wide range of functions; others have very narrow functions; and still others have functions on which all county offices in the Area rely. An attempt several years ago to decentralize services foundered on budget cuts, leaving a truncated system in which in Tulsa there is sometimes more than one "county office" in the same building. The organization reflects the results of a history of ad hoc decisions and needs to be rationalized. The following pages provide conceptual drawings of the current organizational structures in Areas III and VI as well as the proposed structures.

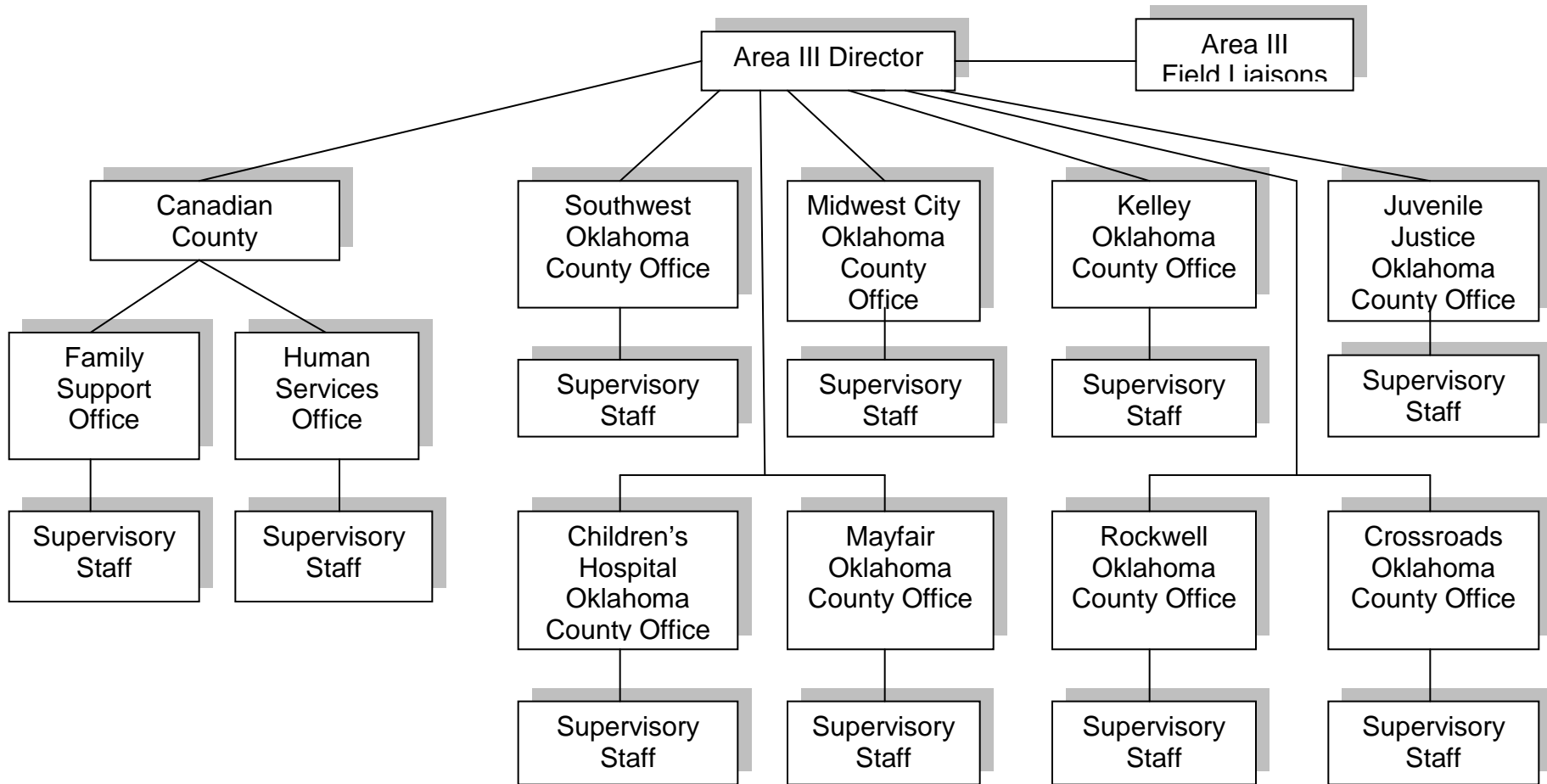
This proposal would recognize that Oklahoma and Tulsa Counties are different than the rest of the state, that their structures ought to be designed specifically for them and that the rest of the state should not have structures imposed on it that are appropriate for the larger urban areas. In the rest of the state, the economies of scale are not sufficient to create the kind of structure proposed here for Oklahoma and Tulsa Counties, and the local communities need a single face representing DHS. The County Directors, by and large, fulfill that function well at the present time.

The first step in this process would be to strip away from Areas III and VI those counties outside of Oklahoma and Tulsa. Canadian County would presumably move to either Area 1 or Area 2, while Creek, Osage and Washington Counties would each move to one of the Areas to which it is adjacent.

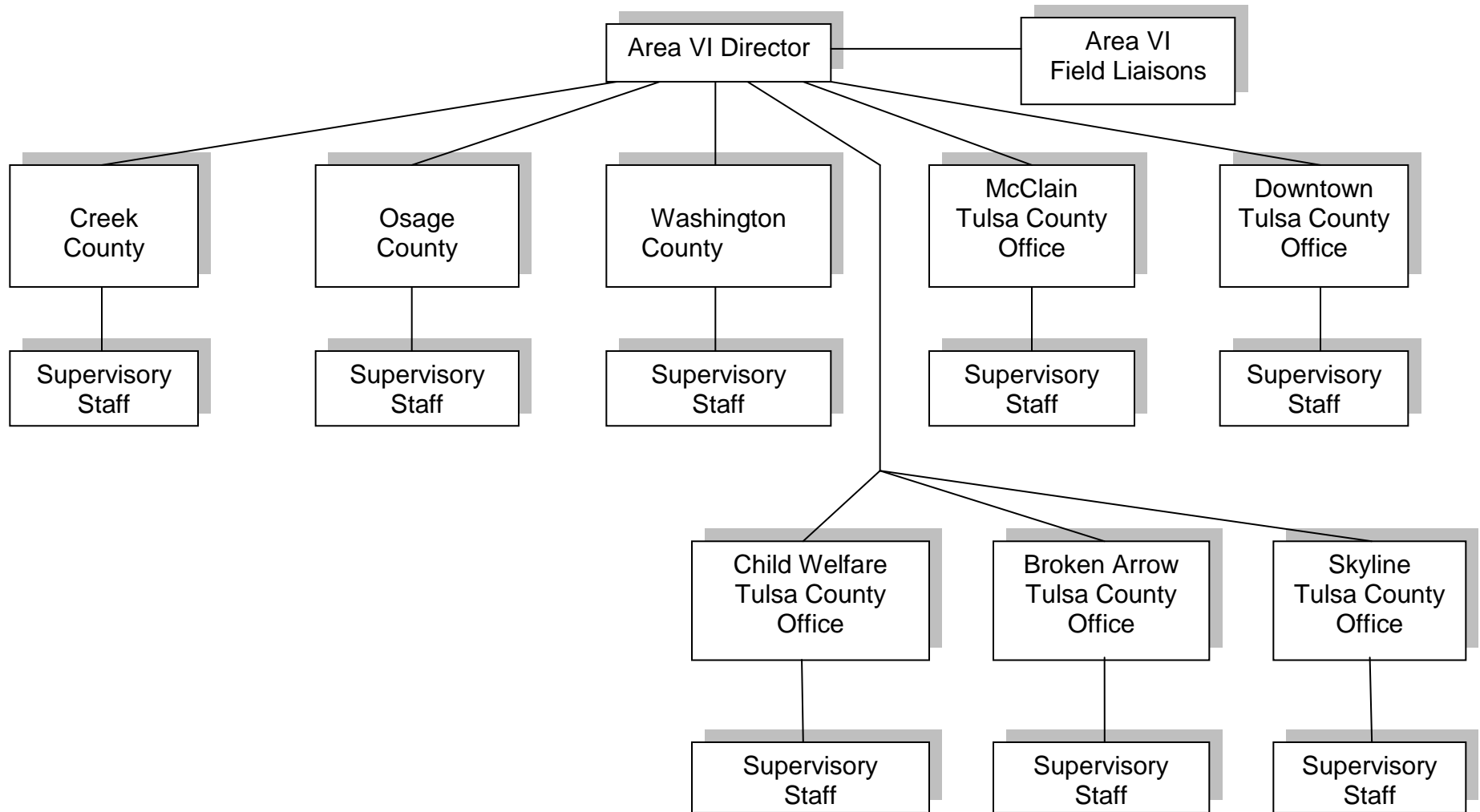
The second step would be to re-define the positions now held by the County Directors and field liaisons so that each position became programmatically discrete, which should

result in fewer managers than the current number of County Directors and field liaisons. Below each Area Director in those two counties there would be an adult protective services program director, a child welfare program director and a family support services program director. For child welfare and perhaps for family support, there would be a layer of managers below that, assuming that the programs were large enough to support four to five units. For example, for child welfare there would be an intake manager responsible for assigning assessments and investigations to caseworkers as they come in from the hotline; an ongoing manager responsible for both preventive, in-home and out-of-home cases; a permanency manager responsible for children on the path to adoption; and a resource manager responsible for recruiting, approving and supporting foster and adoptive homes. Supervisors and their units would report to these managers.

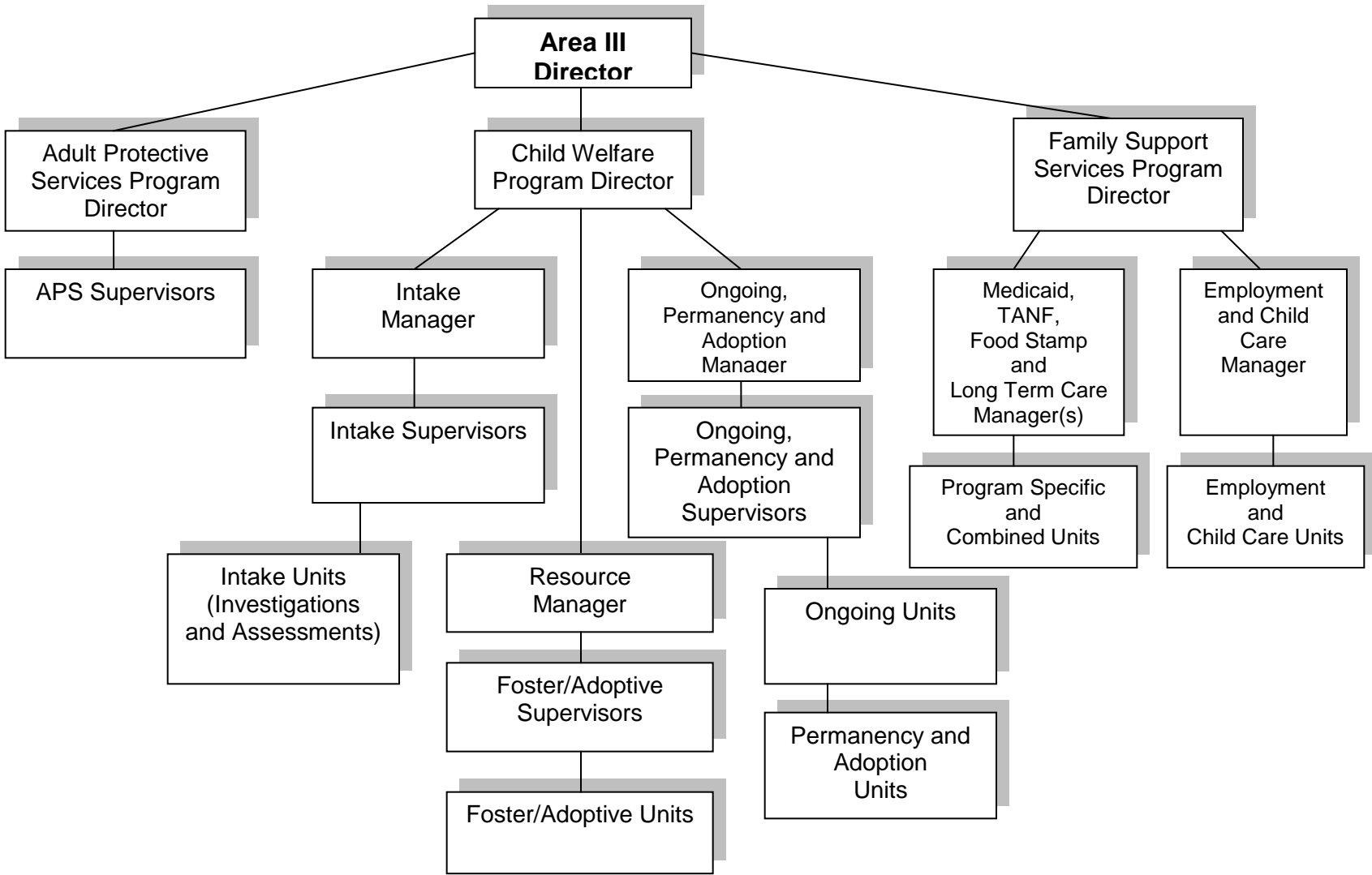
Area 3 Current Organizational Structure



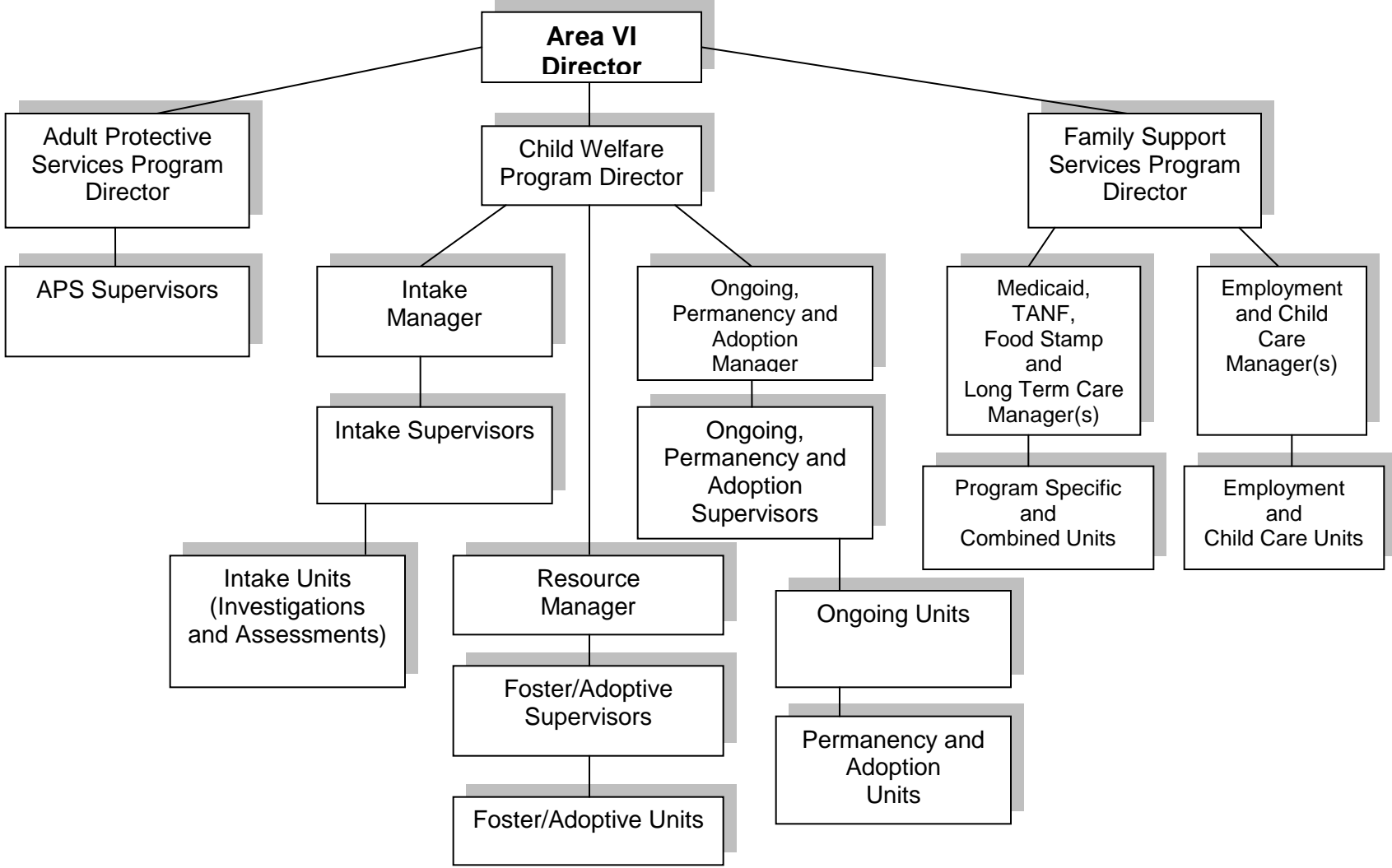
**Area 6
Current Organizational Structure**



**Area 3
Proposed Organizational Structure
(Oklahoma County Only)**



**Area 6
Proposed Organizational Structure
(Tulsa County Only)**



The intent here is to join authority and resource on one side with responsibility on the other. Many of those interviewed for this audit, including people both inside and outside the agency, voiced a concern that too many managers within DHS' field offices had no experience in child welfare. Some said the same thing about managers' experience and knowledge of family support services. Because Oklahoma and Tulsa Counties are so different from the rest of the state, the appropriate answer to that is not, as HZA sees it, to make all the local offices report to the program office but rather to put program experts with line authority into the field. The field liaisons have no line authority but they do exercise authority over many program decisions without having responsibility for the results of those decisions. Caseworkers and supervisors have the responsibility but often lack the authority and the resources to make appropriate decisions. By putting program experts into the field at levels above frontline supervisors, this recommendation tries to unite authority, program expertise and responsibility. It also gives people outside the agency, such as judges, a single point of contact (rather than a maze of county directors) for their area of interest.

The way in which this recommendation gets implemented is also important. There should not be an assumption that all the existing County Directors and field liaisons will automatically get slotted into one of the new positions. DHS needs to develop program and job-specific descriptions and then should hold an open competition for each position following Merit System rules. As an important step in building community support for the agency as a whole and for this new organization specifically, DHS should also involve representatives of the professional community, including foster parents, in the interviewing process. The final decisions on who fills which positions has to be made by the Area Director, but this opportunity for renewing community support should not be missed.

Finally, HZA anticipates that there will be fewer managers under the new structure than there are now County Directors and field liaisons. The excess positions should become worker positions in the same counties, relieving at least a bit of the current workload.

Recommendation 16: DHS should move the SWIFT Adoption workers to the Field Operations Division and integrate them into the agency's local offices.

The intent in creating the SWIFT Adoption unit and having it report centrally to the Child and Family Services Division was to speed up the process of getting children adopted. There are nearly 100 line workers in this unit, each one responsible primarily for working with adoptive families to assist them in finalizing their adoptions and achieving that result for between 11 and 15 families per year.

While state fiscal year 2008 saw a record number of adoptions finalized in Oklahoma, there do appear to be one or more bottlenecks in the system. Oklahoma appears to do well compared to other states on the speed with which terminations of parental rights occur, but after that point Oklahoma's performance compares less favorably to that of other states. Either children are not being matched to adoptive homes sufficiently quickly or those homes are not moving to finalization as quickly as they do elsewhere. The former alternative suggests more resources should be spent on recruiting and matching, while the latter suggests that the SWIFT Adoption unit is not as effective as it should be.

Even beyond these considerations, the agency's own initiatives have made the SWIFT Adoption unit outdated. The unit was created nearly ten years ago when foster and adoptive homes were treated as entirely separate kinds of resources. With the Bridge program, which seeks to find foster homes which are willing to become adoptive homes, the unit's scope is narrower than it should be.. The unit should be integrated into the foster care units in the local offices to improve both recruiting and support for foster and adoptive homes. Such a consolidation may also allow some positions to be transferred to the permanency units, thus reducing workloads there.

Recommendation 17: Area offices should assume direct responsibility for functions which cross county lines.

The most direct application of this recommendation relates directly to the integration of the SWIFT Adoption unit into the local offices. In some of the Areas foster care recruitment and approval units report organizationally to individual counties but serve multiple counties. County Directors who do not supervise these units are dependent on them for an adequate supply of foster homes.

For those Areas in which economies of scale are possible only by employing multi-county recruitment units, the Area office should assume direct responsibility for the function. Resource development is the job of management, and in these instances the job involves the entire Area. Aside from representing a more rational structure, this change also begins to get the Area offices more involved with the programs, which is addressed directly in the proposed reorganization of Areas III and VI. It is, as is intended with all of these recommendations, a mechanism for getting everyone substantively involved in pursuing the Department's mission.

There may be other instances which HZA has not discovered of similar Area-wide responsibilities being carried out by individual counties. Some of the hotlines are operated in this way, but the recommendation to centralize hotline intake would resolve those anomalies. If others exist, they, too, should be moved to the Area offices.

Recommendation 18: The central office program divisions should conduct a periodic statewide needs assessment and allocate funding to each Area office for contracted services, and the Area offices should assume responsibility for

deciding which contracts to fund within their boundaries.

At present contracting functions lie totally with the central program divisions. That structure leaves out of account the relationships built by Area and County Directors with local agencies, and it often fails to take account even of the experiences the local managers have with various providers. Moreover, because the agency has taken a relatively reactive stance towards contracts, allowing current provider capacity and willingness to dictate which services will be available, there is no systematic means of identifying the extent to which the existing contracted services are meeting the needs of the population.

DHS should conduct, probably on a biennial or triennial basis, a formal needs assessment for all service populations. The program divisions, both those controlled by the Human Services Centers and those on the vertically integrated side of the agency, should conduct that assessment. The vertically integrated divisions can use those results themselves, but the situation needs to be a bit more complex for the services controlled by the Human Services Centers.

Two results should emerge for the Human Services Centers. First, based on the results of the needs assessment, each program division should allocate a fixed amount of funds to each Area office. The allocations will not be an automatic result of the needs assessments, both because of the range of services which are likely to appear as needed and because the costs for those services will differ both by service and by Area. Many states, however, do develop formulas for such allocations and, as inexact as they may be, they represent an improvement over no allocations, at all. The only exceptions to the allocations should be for those programs, such as residential centers, which serve the entire state.

Once the allocations are made, the Area offices become responsible for using those funds to contract for services. The second result of the needs assessment, then, is that the findings are given to the Area Directors to guide their decision-making. It is assumed here that Area Directors will work closely with their County Directors and field liaisons (program managers in Oklahoma and Tulsa Counties) in making the decisions about the services for which they wish to contract.

One of the reasons given for the current structure is that contract processing is a relatively technical task involving stringent procedures to conform to state purchasing rules. That point is well taken, and it would not be efficient for Area Directors to replicate those skills in six different locales. Part of HZA's recommendation, therefore, is that there be a single central office unit responsible for the technical aspects of contracting. That unit would work with the Area Directors who would make all of the substantive decisions about which services to include and which providers to select. A single central office unit would eliminate the duplication which currently exists by having every program office

responsible for contracting. It could be located in the Field Operations Division or elsewhere in central office, perhaps most usefully in fiscal operations.

Nothing in this recommendation should prevent the program divisions from determining that there are some contracted services which should be available to all clients across the entire state. Equity in the geographic availability of services is an important principle. That decision should, however, apply only to services which are so fundamental to the program that the central office administration believes the program cannot operate at even a minimum level of equity without those services. Presumably, that excludes any contracted service which is not currently universal, meaning that probably only Oklahoma Children's Services qualifies. Even here, however, the Area Directors need the authority to decide which provider(s) will be selected to deliver the services and, as that "(s)" suggests, whether there should be more than one for different counties within the Area.

Recommendation 19: DHS administrators should act with greater speed to correct personnel performance problems, especially among Area and County Directors whose positions are unclassified.

One of the themes of the recommendations made in this report is that the Department will operate more efficiently and effectively if both authority and responsibility are spread throughout the agency. The previous recommendation in particular provides Area Directors with much greater say over the resources at their command, and it is assumed that they will exercise this authority in conjunction with their County Directors or other managers. Under the current structure, Area and County Directors have too little control over the resources available to them for them to be held responsible for much of what occurs. Some managers are better than others and find ways to have a greater impact, but the structure does not promote that. If these recommendations are implemented, however, that will not be the case, and the managers will need to be held to higher standards of achievement and subject to more serious consequences.

At the time of this review there were a few Directors who are recognized by DHS' central office to be either unable or unwilling to carry out their functions effectively. However, these few have not been called to account and, at least in some cases, have become lightning rods for dissatisfaction with DHS generally in specific local communities. By treating these staff as if they were in protected jobs rather than in at-will positions, DHS administrators have generated negative impacts for clients and for the rest of the staff in the agency.

When a particular Area or a particular County is not producing the client outcomes and not achieving the other performance goals of the agency, the Directors should be held responsible. While every human service agency will periodically experience serious reductions in performance, in part because new issues arise which could not have been foreseen, sustained failure over time to achieve reasonable expectations should not be

tolerated, and the managers responsible should be either terminated or moved to positions where they can function more effectively.

Recommendation 20: The Continuous Quality Improvement unit within CFSD should review its instrument and procedures to ensure a focus on the quality of casework, including the soundness of assessments and decision-making, and DHS should develop a clear structure of accountability based on the results of those reviews, including both positive and negative sanctions.

One of the positive elements of DHS' operations is the Continuous Quality Improvement unit within CFSD. Spurred by the federal Child and Family Services Reviews, the agency initiated annual reviews of each county's child welfare performance using a tool similar to the federal instrument. Moreover, as noted above, the system includes a mechanism for paying bonuses to staff when the county achieves 100 percent conformity on those reviews.

This structure should undoubtedly be maintained, but there are varying reports as to its actual efficacy. Some within the Department report that performance in the field has improved significantly since the introduction of these reviews; others contend that counties are free to and often do ignore the results. Moreover, there was only one instance reported in all of the interviews held with staff across the state in which county staff received a bonus, suggesting either that the standard is so high as to be largely unattainable except by chance or that the way the instruments are actually scored places emphasis on whether actions were taken and not on the quality of the casework.

Two things should happen. First, the tool and the procedures for its use need to be reviewed and, if necessary revised, so that they focus specifically on the quality of the casework. That should include a review of decisions as to whether children need to come into care, the largest gap in the CFSR. The fact that a standard can be set at 100 percent in a field such as child welfare and that an office can actually achieve it even once suggests that the review is too focused, either in the instrument itself or in its application, on concrete, measurable actions rather than on substantive casework issues.

Second, the impact of the reviews should not be primarily the development of a program improvement plan, which at the federal level appear to have had little if any impact on improving performance between the first and second rounds of the CFSR. While such plans may usefully be part of the outcome of the reviews, more concrete impacts are needed. On the positive side standards should be set in such a way that county staff can realistically achieve bonuses either for high performance or for very substantial improvements in performance. Clearly, if that turns into a system in which a majority or even close to majority of the staff receive such bonuses, it will not improve practice, but at the same time the standard needs to be attainable without a significant amount of good

luck in the pulling of the sample. On the negative side, the results of the review should be used in determining whether Area and County Directors are accomplishing what they are supposed to do. Since this only involves child welfare, it cannot be the only factor in that determination, but consistently poor results over two or three years should raise a question about those managers' effectiveness.

For child welfare the increased emphasis on the CQI reviews should either overshadow or be used in conjunction with the key indicators. If the reviews are conducted appropriately, they will focus primarily on sound decision-making and diligent efforts, precisely the things required to improve outcomes for children and families.

Any estimate of the cost of this recommendation is purely a guess. The reviews need to be revised, a new standard needs to be set and some experience needs to be gained to allow an estimate of how many staff might be affected in any given year. Perhaps the best way to begin implementation is to set aside a fixed pot of money and distribute an equal amount to each relevant staff person. The higher the standard is set, the fewer staff are likely to become eligible and the greater would be each person's share. The lower the standard, the more staff will become eligible and the smaller the shares.

In estimating the amount needed, DHS administrators should keep in mind that, at least in the first year, it is not plausible for a majority of counties to be ranked as outstanding. Something like ten percent might be a more likely number. In addition, the amount that is likely to satisfy workers may also depend on whether this report's recommendation regarding compensation is implemented. If it is, smaller bonuses may be sufficient. If it is not, a small bonus for outstanding achievement is not likely to have as much impact either in retaining good, experienced staff or in motivating staff to achieve more.

Recommendation 21: The Commission on Children and Youth should assume responsibility for licensing all congregate out-of-home care facilities operated directly by DHS.

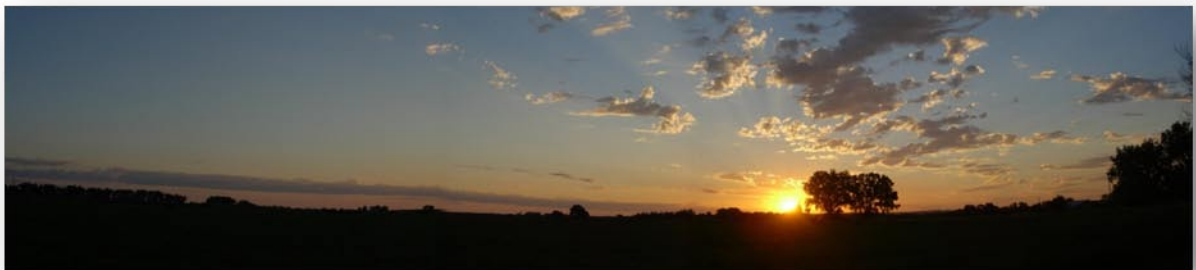
This review did not place any special emphasis on conditions in the facilities operated by DHS, nor do those facilities appear to be the primary source of most of the complaints about the agency. On the other hand, nothing particularly positive was heard about any of them and some of the information provided to HZA raised serious questions about the quality of care provided both in the shelters and in the group homes.

HZA is not making a substantive finding about the quality of care provided in those facilities, but it does find that an agency which licenses its own facilities is necessarily placed into a conflict of interest situation when serious complaints are raised about those facilities. It is for this reason that the recommendation is made that the Commission on Children and Youth be made responsible for licensing any facility operated directly by DHS, with all the same powers DHS has in its licensing of facilities. Currently, the Commission already reviews those facilities both as the result of complaints and as part

of its periodic, routine operations. Despite the fact that some of these reports indicate the same problem persists across several reviews, the Commission's only power is persuasion. Giving the Commission licensing authority over these facilities would lend it enforcement power for the first time.

While it may appear strange to include this recommendation in the section on management, it is appropriate here for two reasons. First, DHS represents only one component of the child welfare system. The courts, the district attorneys, private providers, the Commission and others are also part of the overall system, and this represents a recommendation about the management of the entire system. Second, the recommendation is intended as an enhancement of the agency's accountability. Aside even from any benefit children may experience from greater accountability for these facilities, the agency will engender greater confidence in the services it provides if someone else has given the stamp of approval.

The potential cost for this recommendation should be easy to estimate, but it was beyond the scope of this audit to explore the Commission's staffing and workload. A fair approximation can be made, however, by noting that only four facilities are involved, two shelters and two group homes, and that Commission staff already make two unannounced visits to each facility each year. These visits probably do not cover quite as extensive a range of subjects as would a licensing visit, but the resources currently spent visiting those programs and writing the subsequent reports should be used in the licensing process. Perhaps one or two additional staff may be needed, but it is difficult to see how it could be more than that.



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Scope

Both the Office of Personnel Management (OPM) and the Governor's Blue Ribbon Task Force on personnel issues articulated the goal of personnel management for the State of Oklahoma: the state as the employer of choice. If state government is to function as it is expected to do, it must attract high quality personnel, it must train them adequately and it must be able to keep them. Especially this last issue has become a matter of serious concern within DHS. The Department estimates that it costs \$12,000 to train each new employee, and that means that high levels of turnover become very expensive. When the work to be done depends, as it does in most DHS programs, on the relationship between the caseworker and the client, the issue is even more critical.

This chapter will consider all three of the tasks described above, hiring, training and retention. Because of the high turnover rate within the agency, the last of these will get the most attention, including an examination of the reasons for that turnover.

Findings and Analysis

Hiring

It should be noted upfront that DHS, in most of its offices, does not find it difficult to attract a sufficient number of employees. In interviews across the state, Area and County Directors repeatedly reported that they get sufficient applicants to fill their vacant positions. In part this is due to the fact that for much of Oklahoma, especially in the rural areas, stable jobs with decent benefits are difficult to find.

There is, however, an issue with the time it takes to hire new staff. Local office managers and supervisors generally reported that it takes at least two months to hire someone into a vacant position. Recent changes in OPM rules have extended the time competitive Merit System jobs must be posted and those rules have added several weeks to the process. DHS has, however, responded to this by obtaining an agreement with OPM to allow an expedited process for child welfare positions. As part of a two-year demonstration, DHS is allowed to advertise for entry-level child welfare positions without

requiring a test or using a ranked list of candidates. The candidates have to meet the educational and experience requirements of the job, but they are not required to take a test.

This cuts significant time off of the hiring process because, in contrast to some other states, many of those applying do not take their Merit System tests until they have applied for a job. Waiting for the candidates to get through that part of the process normally adds time to the hiring time frame. Now, for child welfare positions only, DHS simply receives the application, ensures that the candidate meets the qualifications and interviews the candidates to determine which of them it wishes to select.

The Department sought this exception to the rules for child welfare not because turnover was highest in child welfare (it is not) but rather because the consequences of empty positions were more significant than in other programs. As will be discussed below, child welfare is one of the programs where workers regularly work overtime and have to be on-call, and vacancies at the worker level therefore place additional pressure on those who are already subject to the pressures of overtime and on-call work.

Without a Merit System ranking of the candidates, DHS tends to interview all of those who apply for entry-level positions in child welfare. That could potentially increase the time and effort needed to hire new staff, but in fact it does not. While DHS generally obtains a sufficient number of candidates, there are rarely so many that the interview process delays the hiring.

The hiring process is probably the least problematic of any of DHS' personnel issues. In part that is because the agency was proactive in addressing the issue of extended hiring time when it arose; in part it is because of the stability of the jobs and the benefit packages that go with them. The degree to which hiring represents a barrier to agency performance ultimately depends, however, on how often it has to be done. If staff are trained and prepared to do their jobs when they are given their initial caseloads and if they have sufficient incentives to remain with the agency for an extended period of time, hiring occurs less often and represents less of a burden. When the opposite occurs, the effort involved in the hiring process becomes a larger issue.

Training

Training programs for human services staff should include three components: pre-service or new worker training, on-going or in-service training and new policy training.

Pre-service training must provide new staff with all the core information needed to function in the Department, such as personnel practices, pay schedules, insurance, family leave, usage of sick time, submitting work time, overtime policies, agency structure, ethics, confidentiality, employee assistance programs, and others. In addition,

this beginning training can include sessions on topics that are common to many different job titles. For those working with DHS this includes, but is not limited to: interviewing skills, customer service, case flow, writing reports, assessing safety, assessing risk, Federal requirements, and using the computer system. Finally, there must be a component that includes specialized training for each particular job role. This step should include both additional classroom work and on-the-job experiences.

On-going or in-service training should continue throughout each person's career with DHS. The focus of the topics offered in this area should be twofold. One focus must be on advancing each staff person's expertise and knowledge base for the position in which he or she is working. The goal of these training sessions is to improve the workers' performance levels, thereby enhancing the services provided to Oklahoma citizens. These trainings can also be used to address a specific problem that is occurring on a widespread basis and indicates a need for all staff to receive curative training.

The second focus of on-going training involves courses designed to provide professional growth to staff. These classes may not be directly related to their current functions, but prepare them to assume more advanced roles in the Department.

New policy training is similar to on-going training, but it is not elective. This type of training is designed to ensure that all staff are notified and have an understanding of policy changes that have occurred due to statutory changes or decisions by executive management to alter an existing practice.

Each of these areas is critical to a high functioning human services organization. In DHS workers must be held accountable for their work. However, in order to hold them accountable, management must ensure that they are properly trained in all aspects of their job. That is one component of giving staff the capacity to do those things for which they will be held responsible.

In Oklahoma, all staff are required to attend a core pre-service training that addresses many of the issues identified above as necessary for pre-service training. In SFY 2006, 342 participants attended CORE. The program consists of a five-week CORE program, two weeks in the classroom, one week in the field, and another two weeks in the classroom. Then workers have to complete Level I training within the first year, some of the modules are specific to the job function. During the on-the-job training, specific activities are assigned to the new workers to complete.

Generally two training programs are offered at once, one for 30 people and one for 20 people, although they start on a rotating basis (e.g., one will start two weeks after another, so there is overlap). The size of the classes is dictated by the size of the training rooms available.

Each new child welfare worker is enrolled in CORE and is expected to start within six weeks of the hire date although that is not always the case. During their time in the office, before the training starts, new child welfare workers are supposed to complete pre-CORE activities such as shadowing an experienced child welfare worker and accompanying a worker to court. The new worker is provided selected reading as well.

An assessment is given to the new child welfare workers on the first day of CORE. He or she must achieve a score of 65 to pass or be given another try after studying. If the worker does not succeed again the county office is notified, but it is not clear what consequences if any there are.

The classroom training includes the following modules:

- Risk Assessment and Safety Planning (focuses on the investigation, assessment and safety planning),
- SACWIS/KIDS Training (Computer),
- Children in the System (focuses on the needs of children who are in the CW System),
- Placement Orientation (Resource Family Training),
- Permanency Planning,
- Worker Safety,
- IMS (Computer),
- Legal and
- Interpersonal Skills and Practice (teaches basic interviewing techniques).

At the end of each CORE module, participants complete an evaluation on their overall satisfaction with the training. Each report is reviewed and followed up on if there are concerns. Within three weeks of the end of CORE training, a report is sent to each participant's county with information on the participants' performance during CORE, including pre and post-test scores. A professor from the University of Louisville is working with DHS on developing tests for trainees.

During interviews with HZA, many staff expressed concern that the pre-service training classes may not be scheduled for several months after a worker's start date, which results in "busy work" and lost time, because workers are not permitted to carry caseloads until they have completed the training. This means that while many offices may be fully staffed in a technical sense, some of the workers are not yet functioning in their normal roles.

HZA requested and received the child welfare pre-service training curriculum DHS uses. However, the training manuals alone provided do not form a curriculum. Instead, they simply represent information about a group of relevant topics, including extensive

excerpts from administrative code or policy. Included are articles, handouts and exercises. We do not know if this is the participants' manual or the trainers' manual (or whether there is a difference) and what is supposed to be learned from each exercise. Without an actual curriculum, it is difficult to assess how much staff are actually taught in each area, and in fact that may vary widely from trainer to trainer. It is clear that the core areas are covered at some level, although some of the sections, such as confidentiality, appear to be too generic to be useful.

The pre-service training dealing with the sections on tasks and skills that are common to workers in various job titles takes up the biggest part of the initial training. Although the training manual addresses most areas, there is concern about the order in which the information is presented, seemingly moving from topic to topic without a clear flow of information.

The most critical of the issues has to do with safety planning. This topic is discussed without any notations regarding the safety assessment or how to complete it. The training materials contain an article written by **Action for Child Protection** near the front of the book that stresses that it is critical that staff understand the difference between safety and risk, but in the subsequent sections of the manual these terms are used interchangeably. In fact, the terms are often combined in "safety risks."

The impact of this gap in the training appeared in the case records reviewed for this audit, where the safety and risk protocols were often not found. It seems to be unclear to staff whether these are only for investigators of abuse and neglect or are to be used throughout the life of the case. In addition, the interviews indicated that staff are unclear on safety assessment requirements, i.e., on which children must be interviewed privately, on which collateral contacts are mandated, on the use of the non-abusing parent as a protector and on how to monitor safety plans.



Aside from the confusions about safety and risk, which are reflected in casework practice, there are at least four additional areas in which the training provided to child welfare staff is lacking or inadequate. First, there is no job specific training for intake staff, either at the statewide or the local level. With the hotline (or intake line in county offices) being the first contact that potential reporters of maltreatment have with DHS, staff in these positions should be highly trained in interviewing techniques, in comprehensive and accurate documentation and in providing top notch customer service.

Intake workers at all three hotlines currently are expected to learn the job by sitting with veteran staff and talking with supervisors.

As noted in the section on policy and practice, DHS has no systematic way to assess the quality of hotline work and there is, therefore, the strong possibility that the work practice that is being passed on to new workers is not what administration wants it to be. In the smaller counties, there are many occasions when a clerical person with no training on what information should be gathered is answering these calls. A supervisor reviews the intake and makes case decisions, but these decisions are almost certainly based in some instances on inaccurate or inadequate information.

The second area where there are clear deficiencies involves the courts. The training regarding the courts focuses on the process and the various types of hearings that are held, along with required time frames. This information is thorough. It may be overwhelming to new staff, but it does provide them reference material for the future. What this section does not provide, however, is practical training on critical competencies workers need when preparing for and appearing in court. These include at least the following three issues.

- Some workers do not know how to testify and the training is not informative on this subject. Caseworkers have to be taught what is appropriate to say and what is not, as well as which statements will help the case and which will hurt it.
- Workers often do not separate opinion from fact. Numerous judges and district attorneys noted that workers sometimes mix the two, both in court reports and in their testimony.
- Workers need to understand what is admissible as evidence and what is not. Caseworkers have undermined some cases either by injecting inadmissible information into the court process or by neglecting to provide one or more critical facts.



Although HZA received only the child welfare training materials, interviews with staff also suggested similar issues among Adult Protective Services workers. APS staff report that they are not trained on how to interview vulnerable adult victims of maltreatment, nor do they learn techniques for interviewing alleged perpetrators. This puts them (and the district attorney) at a great disadvantage when a case goes to court. They also report getting no training on how to write legally sound

reports to be used in criminal court or litigation.

The third gap in training for child welfare workers involves the Indian Child Welfare Act (ICWA). As with the court material, this part of the training appears to involve simply imparting information; it does not build skill or competency.

Although cultural preservation has long been a major issue around the country, it is not addressed in pre-service training. In Oklahoma of all states, cultural competency, particularly in relation to Native Americans, must play a larger role.



Finally, the training contains basic information on interviewing children, including a well written summary of how children understand questions and actions differently at various ages. However, the caseworkers receive no training on forensic interviewing when a child has allegedly been abused. This is risky in two ways.

- Critical information may be missed or misinterpreted if the right questions are not asked in the right way.
- Leading or inappropriate questions can turn horrific disclosures into inadmissible evidence.

In the statewide survey, 58 percent of the child welfare staff were neutral or disagreed with the statement, the pre-service training helped to prepare me for the job. Many of the staff interviewed for this audit also reported that the pre-service training does not provide specific training for specific positions. This training is supposed to be provided within the first year after the staff member is hired, but that means that he or she is performing the work with only a general introduction to the agency, not the specific set of competencies necessary to carry out the specific job.

The structure of the pre-service training for child welfare workers makes the on-the-job training that much more important. However, this training, conducted by the supervisors in the field, is unstructured. Training staff report that within six months of the training someone is sent out to shadow the new worker for one day in the field to critique the job they are doing. However, this was not mentioned in the interviews. Nor are there any management or progress reports on this activity.

Ongoing staff training is organized by level with Level I being part of the basic training but presented in modules throughout the first year. Level I adds about ten days of training. After the CORE training, child welfare workers are assigned a track specific to their work assignment. All child welfare staff must complete Level I training within 12 months of the CORE training.

The requirement thereafter is 40 hours a year of ongoing training. The training manager sends county directors lists of people who have not complied and they decide what, if anything, to do.

All Level II training must be completed within 48 months of the Core. Level III is open to all workers who completed CORE, Level I and Level II training. About 50 Level I and Level II workshops are offered each year and about 15 Level III. At that level, training topics are different each year based on requests from the field. Workers are required to complete 40 hours of training per evaluation year.

All child welfare training is tracked through KIDS. The system tells who enrolled in what programs, what was completed and who withdrew.

It should also be noted that when workers transfer from one position to another, e.g., from permanency to intake, there is no universal training for the new job. Thus, permanency workers who transfer to intake do not receive training on how to conduct investigations, and intake workers who transfer to permanency do not receive training on how to do permanency work. Even for the field liaison position, which DHS administrators see as critical to ensuring that agency policy is implemented in the field, there is no specific training. The staff promoted to that position are expected to depend largely on their own experience in the agency.

There is, however, a training academy for new supervisors. This training is not program specific; all new supervisors from all programs (e.g., family support, adult protective services, and child support enforcement) attend the same sessions and get oriented to each program area. It gives new supervisors an opportunity to meet the programs managers in each area and to ask specific questions.

All child welfare supervisors are required to attend Clinical Consultation sessions in three out of four quarters of the year. The format of the meetings includes two hours of training and two hours of case consultation for the case management of difficult cases. There are currently 14 groups. The Clinical Consultation Program is in its eleventh year. A new initiative for lead workers implemented in 2007 offers several workshops on management techniques to develop staff for future supervisory responsibilities.

While the efforts are commendable, from the interviews most comments regarding the supervisors' training ranged from "horrible" to "boring, just having policy read to us" to "okay, but not helpful in the real job." There was a consensus that the real training for supervisors is on the job experience, and that there may not be a better way. Supervisors are not required to attend supervisory training prior to becoming a supervisor; they sometimes have done the job for months before going to training to learn the job.

In sum, the pre-service training, at least for child welfare caseworkers, shows evidence of some of the same issues discussed in the chapter on policy and practice. Workers are given information but it is not evident that they are not taught to make sound, reasoned judgments. Knowing the facts about the laws and regulations governing casework is not sufficient. The basic job of caseworkers, especially in child welfare and adult protective services, is to make judgments. For those judgments to improve in Oklahoma, the training will have to change to focus on skill and competency rather than simply on knowledge.

Ongoing training consists of a wide variety of classes, some of which are mandated and some elective. Those that are elective require supervisory approval to verify that the topic is related to the staff person's job. DHS's efforts at giving workers a wide variety of options in choosing training topics of interest is commendable, but three issues are worth noting.

- There are so many mandated classes that workers often do not have time for electives.
- Training often takes place a great distance from a worker's office, resulting in extra time away from families (both personal and case-related).
- Workers are allowed 12 months to finish the first level of training requirements. This means that they are not trained on all the elements of the job, even though they are functioning independently. Also, there is no indication of any repercussions for not completing the training during the first year.

Training on new or amended policy is generally done by the field liaisons on a quarterly basis. Policy is sent by e-mail, usually to all staff but occasionally just to supervisors. Then the liaisons provide training on the topic to the supervisors. Supervisors are then to train the staff who report to them. During the interviews staff noted at least three Issues.

- Not all staff (including supervisors) read their mail regularly, so there is no assurance that everyone is aware of policy changes. In fact, many supervisory and management staff acknowledge that policy changes have not been implemented in all offices.
- Most staff interviewed stated that they do not complete a training evaluation after the quarterly training sessions, so improvements do not occur. Those staff who reported they thought there are evaluations done were not able to produce a report.
- The training is seen by many as liaisons just reading the policy to the supervisors – again information is being disseminated but guidance on how to carry out the policy is missing.

**Caseworker
says...**

We are encouraged to read the policy online on a regular basis and we get a booklet of policy each year from the state.

However, they are encouraged that policy is easily accessible through an on-line system.

Worker Retention

Without any doubt the largest issue facing DHS from a personnel perspective is turnover. While sufficient candidates come forward whenever there is a position open, many of those staff, especially at the frontline level, leave the agency within a short period of time. As with the delays in hiring, DHS has been proactive in trying to combat the high levels of turnover. One of those efforts involves the Continuous Service Incentive Program (CSIP), which provides bonuses to new staff at various points during their first two years of service. DHS had conducted an analysis and determined that if workers stay more than two years, they are likely to remain much longer. The CSIP is an effort to get workers to that two-year point. It has been in place less than two years, so its impact is not yet known. While one may doubt that altering the reasons workers stay for two years by providing bonuses to those who do so will result in continued longevity past that point, one has to commend the agency for making the attempt.

To understand the turnover issue, it is necessary to understand the factors that impact the decision to remain with the agency or to seek employment elsewhere. The professional literature⁵¹ cites numerous factors including the following:

⁵¹ Examples of articles reviewed:

Cicero-Reese, B. & Black, P. (1998). Research findings suggest why child welfare workers stay on job. *Partnerships for Child Welfare*, 5(5).

DeLapp, L.R. (2002). *Accountability Systems: Improving Results for Young Children*. [PDF] The Finance Project. Retrieved from: <http://www.financeproject.org/Publications/accountability.pdf>

Ellett, A. J. (2000). *Human caring, self-efficacy beliefs and professional organizational culture correlates of employee retention in child welfare*. Baton Rouge, LA: Louisiana State University and Agricultural and Mechanical College.

Ellett, A. J., Ellett, C. D., & Rugutt, J. K. (2003). *A study of personal and organizational factors contributing to employee retention and turnover in child welfare in Georgia: Executive summary and final project report*. Athens, GA: University of Georgia School of Social Work.

Graef, M. & Hill, E.L. (2000). Costing child protective services turnover. *Child Welfare*, 79(5), 517-533.

Landsman, M. (2001). Commitment in public child welfare. *Social Service Review*, 386–419.

McLean, J. & Andrew, T. (2000) Commitment, satisfaction, stress and control among social services managers and social workers in the UK. *Administration in Social Work*, 23, 93-117.

National Family Preservation Network. (2006). *An Effective Child Welfare System & Evidence-Based Practice for the Child Welfare System*. [PDF]
Retrieved from: http://www.nfpn.org/images/stories/files/effective_cws.pdf

- 1) Caseloads are reasonable.
- 2) Workers are not required to be on-call in addition to their normal shifts.
- 3) There is an award system for recognizing talented staff, i.e., the agency has a career ladder that is based on performance rather than on tenure.
- 4) Workers feel respected, particularly by other professionals such as judges, attorneys, physicians and teachers.
- 5) Workers feel moderate to low stress from the external environment, i.e., the media, service providers and the community.
- 6) Workers feel a sense of personal accomplishment.
- 7) The work environment promotes open communication, flexibility and risk-taking.
- 8) Workers perceive an organizational commitment to employees.
- 9) The ratio of supervisors to workers is reasonable.
- 10) The organization provides the tools workers need to do their jobs, e.g., cell phones and up-to-date computers.
- 11) Workers have a professional commitment to children and families.
- 12) Workers report they are satisfied with their compensation, i.e., salaries are competitive.
- 13) Benefit packages are strong.
- 14) Incentive programs are in place to promote worker satisfaction.

Hopkins, K., Cohen-Callow, A., Golden, G., Barnes, G., Salliey, A., & Morton, C. (2007). *Maryland Child Welfare Workforce Recruitment, Selection and Retention Study*. University of Maryland School of Social Work. Baltimore, MD.

National Council on Crime and Delinquency. (2006). *Relationship between Staff Turnover, Child Welfare System Functioning and Recurrent Child Abuse*, Cornerstone for Kids, Houston, Texas.

Sparks, K., Faragher, B., Cooper, C.L. (2001). Well-being and occupational health in the 21st century workplace. *Journal of Occupational and Organizational Psychology*, Vol. 74, 489-509.

Sze, W.C., & Ivker, B. (1986). Stress in social workers: The impact of setting and role. *Social Casework*, 67, 141-148.

Tilbury, C. (2006). Accountability via Performance Measurement: The Case of Child Protection Services. *Australian Journal of Public Administration*, 65(3), 48-61(14). [PDF]
Retrieved through Science Commons at:
http://www98.griffith.edu.au/dspace/bitstream/10072/11223/1/tilbury_accountabilityviaPM.pdf

Weaver, D., Chang, J., & Gil de Gibaja, M. (2006). *The retention of public child welfare workers*. Berkeley: University of California at Berkeley, California Social Work Education Center.

Zlotnik, J.L., DePanfilis, D., Daining, C., & McDermott Lane, M. (2005). *IASWR Research Brief 1, Child Welfare Workforce Series: Retaining Competent Child Welfare Workers: Lessons from Research*. Washington, DC: Institute for the Advancement of Social Work Research.

As noted in the chapter dealing with the agency's management, DHS has addressed some of these issues explicitly. Workers have cell phones and laptop computers; they can avail themselves of the Employee Assistance Program to help them deal with stress, whether from personal or professional causes; and the agency explicitly addresses the stresses from "compassion fatigue." In addition to DHS efforts, the state has a benefit package which most workers describe as very good, including a defined benefit retirement package, something which is now quite rare in the private sector and does not leave workers' retirement subject to the fortunes of the stock market.

Despite these efforts, turnover at the agency remains high. Before examining the reasons for the turnover, it is necessary to quantify it. From a client family's perspective, turnover has to include those situations where the family is assigned a new caseworker because the caseworker was promoted to a supervisory position. That kind of turnover, however, cannot be counted as a problem for the agency, because the potential for promotions are a standard feature of any organization and, indeed, one of the reasons staff remain with the same organization for several years.

To understand the problem DHS faces, HZA focused specifically on the frontline workers and measured turnover as the percentage of entry-level staff who left the agency entirely within 12 months of being hired. With data from DHS' personnel tracking system, all frontline staff hired during state fiscal years 2003 through 2007, i.e., from July of 2003 through June of 2007, were followed to identify those who left the agency within one year. This included those who may have transferred during that year to another position, either laterally or as a promotion and were therefore not in their original positions when they left the agency.

Supervisor says...

I would rather be understaffed with qualified people.

Measured in this way, the highest rate of turnover was not in child welfare, although that is the program where the greatest concern is often expressed. As DHS administrators know, the highest turnover occurs among child support staff, which is one of the vertically integrated services. The percentages of new frontline staff leaving the agency within one year are as follows:

- Child Support: 39%
- Family Support: 31%
- Child Welfare: 30%
- Adult Protective: 25%
- Developmental Disability: 24%

While DHS does not experience turnover equally in all parts of the state, there are some differences. Table 14 shows the turnover rates for staff originally hired in Oklahoma and

Tulsa Counties for the three categories with the highest rates of turnover, the only ones with sufficient numbers of staff hired to make the comparisons meaningful.

Table 14		
Percent of Frontline Hires Leaving DHS within One Year		
	Oklahoma County	Tulsa County
Child Support	38%	52%
Family Support	33%	40%
Child Welfare	31%	34%

The Oklahoma County figures track the statewide averages fairly closely. The Tulsa figures, however, show a higher turnover in each of the four programs, with the rate for child welfare showing the least difference from the statewide figures.

There is little information in the tracking system which reveals much about the employees and that might help understand some of these trends. The one piece of information that is available, the age of the person at the time of hiring, is interesting, although somewhat difficult to interpret. New frontline hires in the three programs with the highest turnover are significantly younger than those in developmental disabilities or adult protective services. Table 5 shows the statewide percentages who are under 30 and under 40 in each program.

Table 15		
Age of Frontline Hires by Program		
	Under 30	Under 40
Child Support	32%	63%
Family Support	43%	69%
Child Welfare	51%	78%
Adult Protective	20%	51%
Developmental Disabilities	22%	60%

The most suggestive part of these data is that the two programs with the lowest turnover rate show the lowest percentages of staff hired while in their twenties. There is not, however, anything close to a perfect correlation between hiring age and turnover. In fact, staff hired in Oklahoma County are somewhat more likely to be in their twenties than are staff hired in Tulsa, but the latter shows higher turnover.

The one thing all of these figures indicate is that turnover at DHS is not a single problem. Both the program and the location of the jobs have some influence on how long workers will remain with the agency. While this study cannot identify why in both Human Services

Centers and in Vertically Integrated Services Tulsa shows a higher turnover rate than does Oklahoma County or the state as a whole, it is possible to examine the forces operating in the various programs which might contribute to variations in staff retention.

As noted in the introduction to this report, DHS programs are of three very different types. Child welfare, adult protective services and child support are all involuntary programs. Clients do not come forward to be served by these programs; rather, the state intervenes in the family's life whether that intervention is desired or not. Moreover, workers in two of these groups, child welfare and adult protective services, report far more overtime and on-call duties than do workers in the other groups. In the survey of staff conducted for this audit, nearly 70 percent of adult protective workers and half of child welfare workers disagreed with the statement that they were rarely on-call. The corresponding figures for family support, child support, developmental disabilities and child care workers were two percent, four percent, 16 percent and 18 percent, respectively.⁵²

Similar differences are seen in relation to overtime. When presented with the statement that they rarely have to work overtime, half of the child welfare workers and 37 percent of the adult protective workers disagreed. Family support workers disagreed only 10 percent of the time, compared to 13 percent for child support staff, 21 percent for developmental disability staff and 25 percent for child care workers.

As noted above, overtime and on-call requirements are two of the factors identified in the professional literature as contributing to turnover. In DHS the situation is exacerbated by high caseloads in some of the programs and by the compensation rules. In general, DHS staff are not paid for overtime. Instead, they are told to take compensatory time, "comp" time. The agency is required to pay them if they have not taken the comp time by six months after the overtime occurred, and for that reason administrators put a fair amount of pressure on staff to take the comp time. On-call time is not paid, unless the worker is actually called and then it is treated as overtime, with the same rules.

While three-quarters of the staff responding to the survey indicated that the ability to use comp time was one of the advantages to their jobs, in many of the interviews, especially with child welfare staff, workers reported that they found it difficult to take comp time because of their caseloads. Using the comp time meant that they fell further behind on some of their cases, which then required that they work more overtime, which then required them to take more comp time, in an endless cycle. A few of the workers found a way out of the conundrum by taking their laptops home and doing their case recording at home. That did not have to be approved by a supervisor and did not count as overtime.

The level of on-call work also varies, both across programs and within a single program. As noted above, adult protective services workers report being required to be on-call

⁵² The percentages for some programs would have been 100 percent if all the respondents were frontline workers. However, supervisors and County Directors also responded to the survey, and many of them do not report either overtime or on-call work.

more than do workers in any other program. Part of that is a function of size. Adult protective services has fewer workers than do other programs and in many of the rural counties there is only one APS worker. That person is generally on-call all of the time. Some of the APS workers have developed their own method of easing that situation. In at least one part of the state, APS workers from three counties have banded together to share their on-call. Each one is on-call every third week and responds to all emergencies in all three counties.

Child welfare, on the other hand, is a much larger program with many more workers and that has, in most offices, limited the frequency with which any individual must be on-call. Even here, however, there are exceptions. In Oklahoma County, for instance, each permanency worker is considered to be on-call at all times. While in other offices an assigned on-call worker responds to an emergency involving any case, in Oklahoma County each permanency worker responds to emergencies involving his or her own cases. This means that a smaller range of cases are being covered by each worker and so the probability of being called is lower, but the possibility is always there.

Some of the factors noted in the professional literature that keep people in human service jobs have to do with their dedication to families, children and vulnerable adults and their sense of making a difference. In all programs, more than 80 percent of staff reported that they felt they made a difference and more than 90 percent of the respondents to the survey said they were dedicated to the goals of the agency. Nearly 90 percent also said that they understood what was expected of them, and nearly three-quarters reported being proud to work for the agency.

Area Director says...

DHS has been a good place to work as you can tell from my longevity. I believe in what we do and that we provide a valuable service to the citizens of Oklahoma.

This last factor is notable because it contrasts with several stories heard during the interviews. There, staff often reported that they did not tell friends and acquaintances where they worked because when they had done so in the past the reaction had always been negative. In fact, the survey responses suggest that the pride DHS workers feel is often internally generated, because fewer of them believe they are respected by other professionals or even that their work was appreciated by the agency. Overall, 56 percent of the respondents said that they were respected by professionals in the community, ranging from 81 percent of adult protective workers down to 46 percent of family support workers. Only 59 percent said that they thought their work was appreciated by the agency, with child care workers most often reporting positively on that measure (73 percent) and family support workers again reporting the lowest percentage (57 percent).

The surveys were less positive about the benefit package than were staff in the interviews. Overall, 63 percent thought they had a strong benefit package, with all the programs falling within a relatively narrow range, from 70 percent among child support staff to 61 percent among child care staff. Even in the interviews, however, it was clear that the benefit package is better for staff without families. Several staff noted that the costs of the health benefits for the entire family are a significant burden. In addition, because there are no regular salary increases but benefit costs continue to climb, the value of the benefits declines each year.

In both the responses to the staff survey and the interviews, the most negative reactions from staff came in regard to compensation. In the interviews staff tended to report that the pay was “pitiful” or “ludicrous” for the level of responsibility they were expected to assume. The staff survey was more nuanced. While a majority of staff in every program disagreed that their compensation was appropriate, the overall percentage expressing that view was only 58 percent. On the other hand, when asked whether raises were timely and, separately, whether raises were adequate, 75 percent responded negatively.

APS worker says...

I love my job and don't want to leave but we need to be compensated appropriately. If high caseloads and low pay continue the turnover rate will also increase.

This is an important distinction. While staff generally believe that their compensation is too low, they are less disturbed by that than by the fact that they do not receive raises on any regular basis. Moreover, there are two aspects to this issue. First, the legislature does not routinely appropriate money for cost of living increases for all state employees. This is the source of the complaints about the rising costs of the benefit package. If health care premiums increase but the salary does not, the net effect is that the staff have experienced a reduction in pay.

Child welfare worker says...

I love the office I work in which is why I drive one hour and 15 minutes every day. The people are very supportive of what I do here. A raise would help us out and would increase worker retention.

The second aspect has to do with the relative flatness of the pay structure for any given position.

Every position is associated with a range of salaries. New employees are generally hired at the lowest level of the salary range and in general they stay there. In the past there were defined “steps” within the salary range, and through some combination of longevity and merit workers would climb the steps, getting paid more without moving out of that specific position. The step system was reportedly eliminated during a budget crisis when the alternative was furloughing staff, although an argument was constructed which justified the elimination as consistent with preferred practices in the private sector and as a mechanism for paying for results. While there are exceptions to the general pattern,

the overall effect is that caseworkers who have been in their positions for many years make the same as newly hired workers and that state workers in general are paid 12 percent less than comparable positions in the private sector, regardless of their results.

The state has attempted to ameliorate this situation with a system of longevity bonuses. Each year, after a staff person has been with the agency for at least two years, staff receive a bonus. For years two and three, the bonus is equal to \$250; for years four and five it is \$426; for years six and seven it is \$626; and it continues to climb by about \$200 each year so that after 20 years the bonus is \$2000. This does not, however, become part of the employee's base pay and it is seen only once a year.

Both the lack of steps in the salary ranges and the size of the longevity bonuses, approximately one hundred dollars a year for each year worked, has caused some of the veteran staff to see the CSIP as a statement about their own lack of value to the agency. The total amount of the CSIP is \$2000 over the course of the first two years, roughly equivalent to what a ten-year employee would receive in longevity pay over a two-year period. The Department's counter-argument is that if the CSIP works to retain employees, the rest of the workforce benefits by not having the workload of vacant positions thrust upon them.

The salary aspect of the turnover issue is one about which DHS can do very little. The agency has attempted to address the issue where it could, including in recent years providing some bonuses to child welfare workers from federal funds received by the agency and, as noted in the chapter on management, giving bonuses to county staff where the county performed exceptionally well on the annual review of cases. In the end, however, it is a problem with which the legislature has to deal and the impact would obviously reach far beyond DHS. The entire system of Oklahoma State government operates in the same way.

Summary

Although nearly three-quarters of the staff responding to the survey reported that they expect to be with the agency three years from now, past history suggests that many will change their minds during that period. Some local DHS administrators suggest that one of the reasons for the turnover is that most of the people hired into entry-level positions are relatively young and without much life experience. They are simply not prepared for the conditions with which they are faced at DHS, particularly but not solely in child welfare and adult protective services. If, however, DHS were to begin trying to recruit individuals with families, it would be likely to find that the salaries are simply not sufficient and that the benefit packages look far less appealing to families than to unattached individuals or couples with two careers. In fact, during the interviews with staff and in some of the written comments attached to the survey, several staff reported that they and/or

colleagues were eligible for and receiving either Medicaid or food stamps or both. A part of what may be happening now, therefore, is that individuals take a DHS job when they are just starting on their careers and before they have started families and leave for better prospects once their needs grow and their experience prepares them for better paying positions elsewhere.

Perhaps the most important point here is that this examination of personnel issues represents a reprise of some of the themes of the previous chapters. While the caseworkers employed by DHS are involved in jobs which require them to make decisions that affect the safety of children and adults and involve them in coercive interventions into family life, their training does not provide them with the skills to make those decisions and their compensation fails to match their level of responsibility. The system is not set up to promote professionalism, and the wonder is not that it fails so often but that it succeeds in as many cases as it does.

Recommendations

Recommendation 22: DHS should revise its training materials to create a formal curriculum which provides information in a logical order and helps workers gain the competencies they need to perform their jobs at a high level.

Training in DHS focuses more on information dissemination than on skill building. It is as if the agency believes that if someone has the right information, he or she will also know how to apply that information, even in the highly volatile situations involved in child welfare and adult protective services. Providing a quasi-academic explanation of safety and risk, for instance, without direct application to when safety and risk assessments are to be done or what information is to be gathered or from which persons or how the information is to be assessed to make judgments about safety and risk is not useful to the workers. The section on safety assessment needs to be sufficiently specific that the decision making process is consistently applied and becomes the standard for determining when immediate actions are needed.

The focus should be on determining when the presence of each safety factor rises to the level of needing action (for example, what distinguishes the situation in which a mentally ill parent poses an immediate threat to a child's safety and the situation in which that is not the case). This must include the need to assess safety throughout the life of the case. In addition, training on safety plans needs to be revised to include a monitoring component, so the worker knows whether the plan is being carried out. The part of the training dealing with risk assessment needs to be clear about when this protocol must be completed, and the training should demonstrate how the risk items drive the service plan.

Part of the competency child welfare and adult protective services workers need also relates to their expertise in preparing reports for and testifying in court. These workers need to know how to be professional, competent witnesses and how to determine what is admissible as evidence. DHS should involve some of the district attorney's offices and/or the American Bar Association in designing this training.

A similar point can be made about training on ICWA issues. DHS should work with tribal representatives to identify the issues to be addressed in the training and the competencies workers need to create collaborative working relationships with the tribes.

As a beginning step in revising the training, DHS should conduct a survey of workers who have been on the job for six to 12 months, asking them to identify areas of their job for which training did not prepare them. This information can then be used to help redesign pre-service training.

Recommendation 23: DHS should ensure that every worker receives job-specific training as soon after starting a position as possible.

Job-specific training should include training for:

- hotline and local intake workers, including training on customer service, case assessment and determination, gathering complete information, and accurate documentation;
- adult protective service workers, including investigation skills such as interviewing vulnerable adult victims, conducting forensic interviews of alleged perpetrators and more focus on the court process and on how to write reports that will stand up in court;
- foster care and adoption workers, including practices on how to make foster parents part of the service team, on providing appropriate support and on managing interactions with casework staff; and
- field liaison workers, including training to clarify their role and provide them the expertise to earn professional respect from field staff.

This training needs to be provided not only to new or newly promoted staff but also to staff moving laterally within the agency from one position to another. There is nothing a permanency worker will automatically know about how to conduct an investigation or that an intake worker will know about working with foster parents and other service providers to achieve permanency for children removed from their homes.

For the supervisory training, a first step might be to convene a group of supervisors with various amounts of supervisory experience to provide input on how to make the initial supervisory training more relevant to the actual work the supervisors need to accomplish. The same holds for field liaisons, as well.

Recommendation 24: The Legislature and the Governor should provide consistent means of funding salary increases for DHS staff based on performance.

As discussed above, DHS staff, at least, have greater concerns about the stagnation of their incomes than they do about the absolute levels of those incomes. This is one reason that hiring people into the agency is easier than keeping them there. The retention of highly qualified, professional staff will simply not be possible, if those staff see that the room for advancement is as limited as it is today, and state services will suffer as a consequence. While this study did not examine any agencies other than DHS, HZA

suspects that the same is true for all agencies. As the Governor's Task Force on State Employee Compensation wrote:

...State government has not been able to follow a strategy for employee compensation as the market changes, resulting in occasional, sporadic efforts to catch up to the market...The gap that has grown over a two year, three year, or even longer period since the last pay adjustment is so large that the gap cannot be closed in a single year. By addressing these market issues annually, the State can avoid the "feast or famine" pattern that...too often falls short of market considerations.

The proposed salary increases can take a variety of forms. It could, for instance, mean re-instating the step system but requiring that it be merit-based rather than longevity based. It could also simply be a commitment by the Legislature to set aside a fixed amount each year for salary increases, again with a proviso that the increases be distributed based on merit but permitting each agency flexibility in defining that. HZA estimates that raises amounting to five percent for about half of the DHS staff who have more than one year's tenure would cost between three and four million dollars. Both the mechanism and the amount are, however, less important than the principle, and the principle is simply that the question the Legislature and the Governor should answer each year is not *whether* to provide funding for salary increases to state staff but *how much* to provide. The wrong question is being answered today, in part because in the name of flexibility a system of "pay movement mechanisms" has been created which requires affirmative initiatives from both the Legislature and the agencies.

This recommendation will clearly have a cost attached to it. Assuming that the recommendation cannot be implemented without applying it to the entire state government means that much if not most of the cost will be incurred outside of DHS. Estimating the cost at that level is beyond the scope of this report. It is useful, however, to study one example of how salary increases could be expected to represent an investment with a calculable rate of return.

The primary purpose of this recommendation is to reduce the turnover rate. To the extent that this occurs, DHS should realize fiscal benefits from implementing the recommendation. To take child welfare as an example, DHS estimates initial training costs at \$12,000 per new worker. Since most workers are hired at the Child Welfare Specialist I level at starting salaries between \$28,573 and \$32,604, the costs of training represent an addition to salary costs of nearly 40 percent during the first year. In addition, about 30 percent of these staff leave the agency within one year, meaning that for many of them both the salary and the training costs are virtually a total loss because they do not carry any caseload until after the training and most do not carry full caseloads until some months later.

One way to look at the benefit DHS would derive from implementing the salary increase recommendation is to compare the potential savings in wasted salary and training costs to the increase caused by the recommendation's raises. The actual first year cost (not including benefits or employment taxes) for each new child welfare worker is approximately \$42,000. Thirty percent of that cost or about \$12,600 is lost because of turnover. If turnover could be reduced by ten percentage points due a reliable system of salary increases, the savings for each child welfare worker hired would be \$6,000 while the total savings for each retained worker is \$7,500. That savings would occur because DHS would hire and train fewer new staff, avoiding both the salary and the training costs for the number reduced. The amount saved represents more than four times the amount needed for a five percent salary increase. In other words, even if all the remaining new staff received increases at the end of the year, those could be paid for by the savings from not having had to hire as many staff.

This is not to say that regular salary increases will have no net cost. They will, because it will not be just the frontline workers who receive them. It is, however, to say that there is some fiscal return on the investment. The amount of that return can only be calculated with accuracy when the size and distribution of the salary increases are determined and the agency has actually experienced a reduction in turnover. There is, however, no doubt that there will also be a less tangible return reflected in the quality of the service provided to the population.

Recommendation 25: DHS should experiment with recruiting staff with different demographic characteristics to determine which groups are more likely to stay with the agency longer periods of time.

One of the more curious facts about staff retention at DHS has to do with the adult protective services staff and, perhaps to a lesser extent, with the developmental disabilities staff. These two groups are the least likely to leave the agency within one year of being hired. Yet, the adult protective staff report more on-call duties than any other group and face many of the same issues as child welfare and child support staff. What the two groups have in common is that far fewer of their new frontline staff are in their twenties than is the case with the other programs and fewer are also under 40. Nearly one-half of all new frontline staff in adult protective services were 40 years old or older when they were hired.

The notion that younger workers are less likely to stay with the agency for extended periods of time fits with some of the perspectives HZA heard when interviewing staff across the agency. Some workers reported, for instance, that having to be on-call is difficult for parents of small children, particularly if they are single parents. Moreover, the costs of the benefit package increase when the employee starts a family and the stagnation of the salaries makes it difficult to keep up with the rising costs of raising children. A salary that is adequate for a young single person or someone married to

another professional may be far less adequate when child care and the other costs of raising a family become a factor.

While it is not certain at this point that age is a major factor in retention, the view discussed above that many young workers do not have sufficient life experience to be ready to deal with some of the situations in which their work at DHS involves them does suggest that hiring more experienced adults might prove more successful. Perhaps, DHS should not be a first career for some people but rather a second career. One could extend that idea and develop, for instance, a program to recruit retired military personnel, people whose children are mostly grown and who already have a pension which will supplement what the state provides. Former military personnel are likely to possess qualities OKDHS are looking for in their applicant pool, such as diligence, ability to both lead and follow directives, a respect for policy and a chain of command, and the experience of working with all different people in often time's less than favorable



conditions. Some of those staff are already employees in DHS and HZA's general impression was that their perspectives were somewhat different than those of the staff who are hired at a young age.

Oklahoma is home to five military bases (two Army and three Air Force), including Altus AFB (Headrick, OK), Fort Sill (Fort Sill, OK), Tinker AFB (Oklahoma City, OK), McAlester Army Ammo Plant (McAlester, OK), and Vance AFB (Enid, OK). The US

Census Bureau reported in 2000 14.8 percent of the total population of Oklahoma (18 years and older) held veteran status. Several private firms help retired military personnel find and secure employment. Some of the more popular firms include: Bradley-Morris, Inc., Soar Consulting, Inc., Military Officers Association of America (MOAAA), State Job Link Center, Military Job Zone/Military Veteran Job Placement, MC2- Recruiting Military Candidates. The Human Resources Management Division held a recruitment fair with Tinker AFB and has worked with the transition officer at Altus AFB. DHS should continue targeted recruitment for the Divisions with the highest turnover.

The American Legion holds a military-to-civilian career fair in Oklahoma City where "veteran friendly" organizations are made available to retired and soon to be retired military personnel who are looking to transition into a civilian career. Other career fields, such as public school education, have developed initiatives to attract military personnel before they retire by assembling detailed packets of possible jobs once they retire or leave the military. This initiative allows for military personnel to consider their future

careers once they leave the military and gives them a checklist of credentials and qualifications they must have to be eligible.

This recommendation is put in the form of urging DHS to experiment with different kinds of targeted recruiting. Hiring older staff or retired military personnel may not be the answer, but during the experimentation DHS may identify one or more groups where turnover is less likely. What is known is that the current practices are not working, and targeting different groups when recruiting staff is something DHS can do whether or not the legislature implements the recommendation dealing with salary increases.

Chapter Eight

Summary of Recommendations and Their Cost

This section initiates an analysis of costs and savings which would result from the recommendations in this report. These are estimates and are subject to refinement. The table reflects one-time costs, ongoing costs, cost savings and net costs. Please see the scenarios at the end to gain a better understanding of the savings associated with reducing the foster care population and serving families in their homes instead.

Recommendation	One- time Cost	Ongoing Cost	Cost Savings	Net	Notes
Chapter 1: The Paradox that is DHS					
No recommendations					
Chapter 2: Results DHS Achieves for its Clients					
No recommendations					
Chapter 3: The Problem with High Placement Rates					
1.The Legislature should review the proposed Title 10 revisions to ensure that the sole criterion for removal of a child from his or her home is an imminent safety threat.					
2.The Legislature should modify Title 10 so that DHS is involved with the police in all removals from their homes and so that the authority of "standing orders" is removed.					This is part of a larger initiative to reduce placements and therefore costs.
3. DHS should contract with the District Attorneys to represent DHS in deprivation proceedings.			Savings unknown at this time: approximately 20% of ADA costs in dependency cases due to Title IV-E recovery		The cost and source of the Assistant District Attorneys would not change. However, by providing the funds to DHS which would contract for the District Attorneys, DHS could claim for Title IV-E reimbursement, yielding about a 20 percent savings on the total cost of District Attorneys in dependency cases.

Recommendation	One-time Cost	Ongoing Cost	Cost Savings	Net	Notes
Chapter 4: How Families are Served: Policies and Programs					
4. DHS should establish one centralized hotline number for all reports of the abuse and neglect of children within the Child and Family Services Division and strongly consider whether vulnerable adults can be included as well.	\$250,000	\$350,000		\$600,000	The one-time cost is for equipment and renovations of work space. The ongoing cost is for staff training and quality assurance. We assume that staffing can be steady state accounting for the three hotlines currently in operation. In addition, there will be staff savings in all counties which currently take calls directly; these staff should be now allowed to carry caseloads, thus reducing caseload size.
5. DHS should simplify and clarify the definitions of Priorities One and Two and the criteria for investigations versus assessments; modify response times; and modify the daily contact rule.					
6. DHS should phase out the two large publicly funded shelters, Laura Dester and Pauline E. Mayer, and replace them with emergency foster homes when alternative placements such as neighbors and relatives cannot be found.			\$6,456,000	(\$6,456,000)	The net savings assumes DHS continues to use TANF to fund the Emergency Foster Homes. If it were to shift to Title IV-E DHS would yield at least another 20% savings. However, since TANF is federal funding, DHS would have to shift TANF to another item in its budget which cannot be matched and use state funds for the Emergency Foster Homes. The potential savings does not include this shift. This figure does not take into account a reduction in the out of home care population. (See Scenario 1 below.)
7. DHS should focus on creating a safety culture that is ingrained into all staff and impacts all decisions made by a) adopting one safety assessment protocol and providing comprehensive training on its use and application to all staff, and b) making better use of the risk assessment protocol.	\$150,000	\$150,000		\$300,000	Development and training costs.
8. DHS should increase the use of court-supervised in-home placements for children who otherwise would have been removed but the safety issues have been resolved.					Both the cost-savings of placement and the cost expenditures of in-home services are reflected in other items below.

Recommendation	One- time Cost	Ongoing Cost	Cost Savings	Net	Notes
<p>9. DHS should shift funding from out-of-home care to in-home services to support the families where children are not in imminent danger. DHS should increase the numbers and kinds of in-home services available based on an Area-level needs assessment and the use of evidence-based practices.</p>			<p>Year 1: \$10,018,660</p> <p>Year 2: \$12,580,754</p> <p>Year 3: \$17,439,689</p>	<p>(Year 1: \$10,018,660</p> <p>Year 2: \$12,580,754</p> <p>Year 3: \$17,439,689)</p>	<p>If DHS were to close the shelters (recommended above) the total savings for both that and reductions in foster care would be:</p> <p>Year 1: \$10,018,660 Year 2: \$12,580,754 Year 3: \$17,439,689</p> <p>The savings assumes an overall shift of 37% over three years from out-of-home care to in-home services, with a 12% reduction the first year, a 24% reduction the second year and a 37% reduction the third year.</p> <p>See Scenarios 2 and 3 below.</p> <p>Note that all the new cases should be classified as placement prevention so that service costs can be claimed under Title IV-E.</p>
Chapter 5: Most Favored Volunteers: The Supply, Training and Retention of Foster Homes					
<p>10. DHS Area Directors should work with their recruitment staff to develop a resource recruitment plan based on the number of children in non-relative care and the projected foster family turnover, which meets the standard of two available beds per child.</p>					

Recommendation	One- time Cost	Ongoing Cost	Cost Savings	Net	Notes
<p>11. DHS should streamline its licensing processes. At a minimum it should develop a single process for resource families or Bridge homes which includes all foster and adoptive families. At a more ambitious level, it should look at consolidating the requirements if not the staff for all home-based licensing within the agency, across the divisions of child care, developmental disabilities and child and family services. In addition, families who are licensed to provide one service such as child care should not be excluded from providing another such as foster care, although limits should be maintained on the number of children a family can care for at a time.</p>			\$50,000	(\$50,000)	<p>We cannot estimate the savings at this time but conservatively call for one position. There may also be contracting cost implications.</p>
<p>12. DHS should develop a Passport Program for foster children similar to those developed in Texas and Washington.</p>	\$100,000	\$50,000		\$150,000	<p>Contract to develop the system. DHS is currently working with the Oklahoma Health Care Authority on the Medicaid component.</p>

Recommendation	One-time Cost	Ongoing Cost	Cost Savings	Net	Notes
<p>13. The legislature should provide foster families with an increase both in the daily rate and in their ability to be reimbursed for clothing when a child newly comes to the home, even if the initial \$150 has already been spent elsewhere on the same child in another placement. Additionally, there should be some provisions for transportation reimbursement based on the requirements of the service plan, unless the family is receiving a difficulty of care payment.</p>		<p>Daily Rate: First Year (with 12% placement reduction): \$1,500,720</p> <p>First Year (without placement reduction): \$8,619,000</p> <p>Second year (with 24% placement reduction): \$1,318,200</p> <p>Second year (without placement reduction): \$15,737,280</p> <p>Third year (with 37% placement reduction): \$2,788,500</p> <p>Third year (without placement reduction): \$24,031,800</p> <p>Clothing Voucher: \$1,500,000</p> <p>Transportation: \$300,000</p> <p>First Year Adoption Subsidy increase: \$548,377</p> <p>Second Year Adoption Subsidy increase: \$3,387,037</p>	<p>Title IV-E share of costs: at least 28% reduction from cost (56% penetration rate x 50% administrative cost)</p> <p>Adoption subsidies are reduced by 48% to account for Title IV-E recovery</p>	<p>With 12% placement rate reduction, \$1,110,533 Year 1 including Title IV-E reduction; without placement rate reduction, \$6,378,060 in Year 1 including Title IV-E reduction.⁵³</p> <p>\$1,080,000: clothing vouchers</p> <p>\$216,000: transportation</p> <p>Adoption Subsidy Year 1: \$283,511</p> <p>Adoption Subsidy Year 2: \$1,751,098</p> <p>Adoption Subsidy Year 3: \$4,168,571</p>	<p>The rate of the foster parent increase is assumed to be 50% divided evenly over 3 years. The fiscal impact depends largely on whether DHS is realizing the projected placement rate reduction at the same time.</p> <p>DHS currently spends \$825,000 on clothing vouchers. To add \$100 for each move will equal \$1,500,000. If we assume 12% reduction in placements and 28% Title IV-E match the net cost would be \$1,080,000.</p> <p>Transportation is budgeted as an Area allocation to be allocated by foster care population and assumes a 28% Title IV-E recovery.</p>
<p>⁵³ Title IV-E reduction is calculated using Oklahoma's 56% Title IV-E penetration rate and Oklahoma's 64.4% FMAP, or 36% federal share overall.</p>					

Recommendation	One-time Cost	Ongoing Cost	Cost Savings	Net	Notes
14. Caseworkers should be required to visit with children privately at least every few months, and preferably at every visit.					
Chapter 6: A Closer Look at Management and the Organization					
15. Within Oklahoma and Tulsa Counties only, DHS should replace the positions of County Director and field liaison with programmatic directors for each of the programs within the Human Services Centers.					As of 7/1/08 there were 4 county directors in Tulsa and 7 in Oklahoma and at least 15 field liaisons in Human Services Centers program. We are going to assume cost neutrality for the reorganization at this time.
16. DHS should move the SWIFT Adoption workers to the Field Operations Division and integrate them into the agency's local offices.					
17. Area offices should assume direct responsibility for functions which cross county lines.					
18. The central office program divisions should conduct a periodic statewide needs assessment and allocate funding to each Area office for contracted services, and the Area offices should assume responsibility for deciding which contracts to fund within their boundaries.					Funding for in-home services is captured in the recommendation to shift from out-of-home to in-home care. That budget assumes a cost per child of \$3614 for in-home services. We assume the needs assessment can be done with current staff.
19. DHS administrators should act with greater speed to correct personnel performance problems, especially among Area and County Directors whose positions are unclassified.					
20. The Continuous Quality Improvement unit within CFSD should review its instrument and procedures to ensure a focus on the quality of casework, including the soundness of assessments and decision-making, and DHS should develop a clear structure of accountability based on the results of those reviews, including both positive and negative sanctions.					There will be a cost to this proposal, but virtually any amount could be used. The cost will depend on how much the agency sets aside to provide bonuses to successful units.

Recommendation	One- time Cost	Ongoing Cost	Cost Savings	Net	Notes
21. The Commission on Children and Youth should assume responsibility for licensing all congregate out-of-home care facilities operated directly by DHS.		\$100,000		\$80,000	DHS should claim Title IV-E reimbursement for this contract, thus reducing state share.
Chapter 7: Without Them we are Nothing: Retaining DHS Staff					
22. DHS should revise its training materials to create a formal curriculum which provides information in a logical order and helps workers gain the competencies they need to perform their jobs at a high level.	\$200,000			\$200,000	Contract to revise curriculum.
23. DHS should ensure that every worker receives job-specific training as soon after starting a position as possible.		\$250,000		\$250,000	Revise current practice; increase as needed.
24. The Legislature and Governor should provide a consistent means of funding salary increases for DHS staff based on performance.		Year One: \$3,150,000	\$750,000	\$2,040,000	Figure assumes that 50% of child welfare staff who have been there more than one year would receive on average a 5.2% performance increase based on merit. Savings is based on 10 percentage points in reduced turnover and includes 15% Title IV-E reduction (percentage is less since not all employees can be attributed to foster care)
25. DHS should experiment with recruiting staff with different demographic characteristics to determine which groups are more likely to stay with the agency longer periods of time.					Savings in staff turnover are calculated and incorporated above.
NET COST	Implementation of these recommendations could ultimately be cost neutral if DHS closes the public shelters and reduces the foster care population by 37 percent over three years. During the first two to three years there could be additional costs of at least \$3 to \$5 million dependent upon how quickly DHS reduces the foster care population and eliminates the publicly-operated shelters.				

Scenario 1: Shift from public shelters to emergency foster homes immediately but do not alter the total number of children in out-of-home care.

IMPACT OF CLOSING THE SHELTERS IMMEDIATELY			
Setting Type	Average Cost per Child per Year	With Closing Shelters	
		Average Daily Pop.	Total Cost
Public Shelters	-	0	\$0
Other Shelters/Group Homes	\$2,723	336	\$914,823
Foster Care	\$5,865	8,645	\$50,700,000
Therapeutic Foster Care	\$12,512	1,015	\$12,700,000
Emergency Foster Care	\$16,071	120	\$1,928,520
In-Home Services	\$3,614	2,712	\$9,801,076
Total		10,116	\$76,044,419
Savings			\$6,456,657

Scenario 2: Shift population from out-of-home to in-home services over three years but maintain public shelters.

IMPACT OF REDUCING THE PLACEMENT RATE BUT MAINTAINING PUBLIC SHELTERS OVER 3 YEARS										
Setting Type	Average Cost per Child per Year	Current		With 12% reduction in placement rate		With 24% reduction in placement rate		With 37% reduction in placement rate		
		Average Daily Pop.	Total Cost	Average Daily Pop.	Total Cost	Average Daily Pop.	Total Cost	Average Daily Pop.	Total Cost	
Public Shelters	\$69,876	120	\$8,385,177	106	\$7,378,956	91	\$6,372,735	76	\$5,282,662	
Other Shelters/Group Homes	\$2,723	336	\$914,823	296	\$805,044	255	\$695,265	212	\$576,338	
Foster Care	\$5,865	8,645	\$50,700,000	7,608	\$44,616,000	6,570	\$38,532,000	5,446	\$31,941,000	
Therapeutic Foster Care	\$12,512	1,015	\$12,700,000	893	\$11,176,000	771	\$9,652,000	639	\$8,001,000	
Emergency Foster Care	\$16,071	0	\$0	0	\$0	0	\$0	0	\$0	
In-Home Services	\$3,614	2,712	\$9,801,076	3,926	\$14,188,275	5,140	\$18,575,382	6,455	\$23,328,081	
Total		12,828	\$82,501,076	12,828	\$78,164,275	12,828	\$73,827,382	12,828	\$69,129,081	
Savings					\$4,336,804	\$8,673,695	\$13,371,996			

Scenario 3: Shift population from out-of-home to in-home services over three years plus close the public shelters (totals subsume the \$6,456,657 savings from closing shelters one, Scenario 1).

IMPACT OF REDUCING THE PLACEMENT RATE AND CLOSING THE SHELTERS OVER 3 YEARS										
Setting Type	Average Cost per Child per Year	Current		With 12% reduction in placement rate		With 24% reduction in placement rate		With 37% reduction in placement rate		
		Average Daily Pop.	Total Cost	Average Daily Pop.	Total Cost	Average Daily Pop.	Total Cost	Average Daily Pop.	Total Cost	
Public Shelters	\$69,876	120	\$8,385,177	0	\$0	0	\$0	0	\$0	
Other Shelters/Group Homes	\$2,723	336	\$914,823	296	\$805,044	255	\$695,265	212	\$576,338	
Foster Care	\$5,865	8,645	\$50,700,000	7,608	\$44,616,000	6,570	\$38,532,000	5,446	\$31,941,000	
Therapeutic Foster Care	\$12,512	1,015	\$12,700,000	893	\$11,176,000	771	\$9,652,000	639	\$8,001,000	
Emergency Foster Care	\$16,071	0	\$0	106	\$1,697,098	91	\$1,465,675	76	\$1,214,968	
In-Home Services	\$3,614	2,712	\$9,801,076	3,926	\$14,188,275	5,140	\$18,575,382	6,455	\$23,328,081	
Total		12,828	\$82,501,076	12,828	\$72,482,417	12,828	\$68,920,322	12,828	\$65,061,387	
Savings					\$10,018,660	\$13,580,754	\$17,439,689			

Foster Parent Rate Increase: This table assumes an overall 50% increase in foster parent rates over three years simultaneous with a reduction in the percent of children in placement.

INCREASING THE FOSTER PARENT REIMBURSEMENT WHILE REDUCING THE PLACEMENT RATE								
	Current Ave. Daily Pop.	Current Cost	Year 1		Year 2		Year 3	
			Pop. With 12 % reduction in placement rate	Cost with 17% increase in FP rate	Pop. With 24% reduction in placement rate	Cost with 35% increase in FP rate	Pop. With 37% reduction in placement rate	Cost with 50% increase in FP rate
Foster Care	8,645	\$50,700,000	7,608	\$52,200,720	6,570	\$52,018,200	5,446	\$47,911,500
Net Increase (Decrease)				\$1,500,720		\$1,318,200		(\$2,788,500)
State Share (after Title IVE)				\$960,461		\$843,648		
Increase with No Reduction in Foster Care Population				\$8,619,000		\$15,737,280		\$24,031,800
State Share (after Title IVE)				\$5,516,160		\$10,071,859		\$15,380,352

Adoption Subsidy Rate Increase: This table assumes an overall 50% increase in adoption rates over three years for children who are newly adopted during that period.

INCREASING THE ADOPTIVE PARENT SUBSIDY FOR CHILDREN NEWLY ADOPTED, KEEPING PACE WITH INCREASED FOSTER FAMILY REIMBURSEMENT						
	Year 1		Year 2		Year 3	
	Children Newly Adopted	Cost with 17% increase in Adoption Subsidy	Children Newly Adopted	Cost with 35% increase in Adoption Subsidy	Children Newly Adopted	Cost with 50% increase in Adoption Subsidy
Adoption Subsidy (for children newly adopted)	550⁵⁴	\$3,774,127⁵⁵	1650	\$13,064,287	2750	\$24,191,750
Net Increase (Decrease) before Title IV-E is applied		\$548,377		\$3,387,037		\$8,063,000
Net Increase (Decrease) after Title IV-E is applied⁵⁶ (State Share)		\$283,511		\$1,751,098		\$4,168,571

⁵⁴ Assumes an average of 1100 adoptions per year; since they will be occurring throughout the year, the increase would apply on average to half that number over the course of the year.

⁵⁵ Assumes current cost per child equals the current average cost of all children in foster care (i.e., \$5865 per year); 17 percent is added to account for the rate increase (\$6862 per child); this assumes every adoptive parent will receive the full amount they would have received had the child stayed in foster care. While this is an overestimate the figure does not account for the higher cost of children in therapeutic care.

⁵⁶ Oklahoma has a 75% penetration rate for adoption subsidy and a 64.43% FMAP yielding a 48.3% federal share.

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Appendix: Methodology

HZA conducted this Performance Audit between August and December, 2008. The following processes were used:

- 1) analysis of published and unpublished reports,
- 2) analysis of budget and contract information,
- 3) analysis of administrative data, such as the information found in KIDS,
- 4) interviews with key stakeholders and case record review, and
- 5) surveys with DHS staff and foster families.

Analysis of Published and Unpublished Reports

HZA reviewed data and results of the Child and Family Services Review conducted in 2007, statistical information, both in the federal report on the CFSR and in various reports produced by the agency itself, such as Key Indicator reports, and in other studies of the agency dating back over a decade.

In addition, several publicly available materials were reviewed, such as the “Mission Driven Strategic Plan, Fiscal Years 2009–2014” and public reports investigating the deaths of children in DHS care, financial reports, and the June 2008 Cost Allocation Plan. HZA also obtained Internal documents, including reports from unannounced routine visits, and confidential reports on investigations within the agency.

Analysis of Budget and Contract Information

HZA examined budget information, revenues and expenditures, for five fiscal years as well as contract information. This included examples of Requests for Proposals, e.g., for Oklahoma Children’s Services and training contracts to identify their scope and to quantify the deliverables required of vendors.

Analysis of Administrative Data

Even with the wide range of data already available, as is the case with most states, there were significant gaps in the management and performance information available. HZA received a data extract of the child welfare case management system, KIDS, which permitted a more thorough examination of child welfare and foster care services. Much of the statistical data in this report, for example the tables on placements, use of shelter care, and foster parent turnover, was derived from HZA’s analysis of KIDS data.

HZA also received a data extract of DHS' personnel management system. These data served to examine turnover rates and length of service, and this extract was also used to project costs to DHS of proposed personnel changes.

Interviews with Key Stakeholders

Interviews were conducted with a variety of stakeholders, including DHS and community representatives, resource families and clients.

DHS Staff and Community Stakeholders

HZA also conducted interviews with state DHS representatives, area/county representatives and community representatives. Beginning in the latter half of August and concluding at the end of October, we conducted in-person interviews across the state at the area/county level, in each of the six areas. Counties were selected to obtain representation from large, medium and small counties, as well as counties with particular demographic influences, such as a high Native American Indian population.

Counties were selected as follows:

<u>Area</u>	<u>Counties</u>
1	Garfield, Kay, Logan, Woods
2	Caddo, Comanche, Cotton, Grady
3	Canadian, Oklahoma
4	Choctaw, Pontotoc, Pottawatomie, Pushmataha
5	Delaware, Latimer, Muskogee, Rogers
6	Tulsa, Washington

Area and county directors were instrumental in identifying community stakeholders to interview. HZA conducted interviews with judges, district attorneys, assistant district attorneys, public defenders, law enforcement officials, mental health provider agencies, CASAs, and Guardians *ad litem*.

The table below illustrates the array of staff and community partners that were interviewed during the audit process. HZA completed over 250 interviews, from which it was able to gather information about the organizational structure of DHS and how it interacts with community stakeholders. The interviews also provided information about

agency policies, as well as resource needs and support, and service availability and access.

ARRAY OF PARTICIPANTS INTERVIEWED BY AREA						
Interview Type	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
DHS Staff						
Area Director	X	X	X	X	X	X
Child Welfare Field Liaison	X		X			
Family Support Field Liaison			X			
County Director	X	X	X	X	X	X
Child Welfare Supervisor	X	X	X	X	X	X
Permanency Planning Supervisor	X		X			X
Foster Care Supervisor		X	X	X		X
Family Support Services Supervisor	X		X	X	X	
APS Supervisor		X		X	X	
Child Welfare I, II or III	X	X	X	X	X	X
Permanency Planning I, II or III			X			X
Foster Care I, II or III	X	X			X	X
Adoption I, II or III			X	X		X
Family Support Services I, II or III	X		X		X	
APS I, II or III		X	X	X	X	
Child Care Licensing					X	
Tribal worker/liaison			X	X	X	X
Court Liaison Supervisor			X			X
Community Stakeholders						
Judge	X	X	X	X	X	
District Attorney/Assistant DA	X	X	X	X	X	X
Parent Attorney		X		X		X
Child Attorney		X		X		
CASA	X	X	X	X	X	X
GAL			X	X		X
Public Provider	X					
Private Provider						
Law Enforcement						
PARB	X				X	

Resource Family Interviews

Foster care and adoptive resources are critical stakeholders in regard to children removed from the home. Using a structured, open-ended interview guide, HZA interviewed resource families in each DHS Area to learn about the recruitment and training processes, supports they receive and experiences they have encountered. DHS provided us with an Excel file which identified resource families by county and case number. In all, 28 resource families were selected for review, six in each of the metropolitan areas, i.e., Oklahoma and Tulsa, and four in each of the other four areas.

Client Interviews and Case Record Reviews

Interviews were conducted with clients in four of the six areas, specifically Areas 1, 2, 3 and 6. Cases were randomly selected for review from two Excel files received from DHS, one of which contained in-home or investigative cases, and the other which contained cases involving children removed from their homes: ten cases in Areas 3 and 6, five from each group; i.e., in-home and out-of-home; five cases in Areas 1 and 2, in Area 1, three in-home and two out-of-home cases, in Area 2, two in-home and three out-of-home cases.

During October and early November, HZA conducted the case record reviews using a structured case review tool allowing staff to gather information about the investigation process, services to children and families, and responsiveness. The case reviews were followed by interviews with the parents and DHS staff to identify the strengths of DHS and areas for process and resource improvement.

Surveys with DHS staff and foster families

Foster Family Survey

Using the materials gathered as part of the literature review, which involved identifying best practice standards for recruitment, training, ongoing support and retention, HZA developed a survey which was administered to 6000 resource families. Of that number, approximately two-thirds were currently certified resource families, while the remaining one-third were former resource families no longer providing care to Oklahoma's children.

Stamped envelopes containing the survey, a postage-paid return envelope, and a raffle entry slip to encourage participation were sent to DHS, who then affixed mailing labels and sent them out to resource families. As the responses were received, the information was populated into a database for analysis. Responses were received from 1238 families; this number represents 1048 current resource families and 190 past resource families. Resource families were also provided the opportunity to request a follow-up

telephone interview, and these were conducted with approximately 20 families who asked to be contacted.

DHS Staff Survey

Using a broadcast email message, DHS staff were asked to visit a website, hosted on HZA's server, to complete a survey. Its purpose was to help HZA to learn about the organization from the staff's perspective, as well as their role and experiences with the organization. Many of the questions asked the staff person to rate their agreement, using a five-point Likert scale, in a number of areas, including: adherence to policy, management and organization, accountability and support of peers, caseload responsibilities and expectations, training, availability and quality of services, and overall job satisfaction. The web-based survey was completed by 3,630 DHS staff in all programs.

Analysis

Every staff interview and case record review was written up following a standard protocol. Staff developed summary analyses of interview data for Area. Each open ended question on the foster parent and staff surveys were analyzed as well as the closed ended questions. HZA performed multiple analyses on the KIDS data and the personnel data base. Data from all these sources were analyzed separately and jointly. The three principal writers met with all staff who performed field work to discuss their perceptions and findings. They then met together for three days to discuss major themes and the data to support them before initiating the writing of the report.