Co-Neutral Tenth Commentary
Issued August 2018

Compromise and Settlement Agreement

(D.G. vs. Yarborough, Case No. 08-CV-074)

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I. Introduction

This is the 10th Commentary issued by the Co-Neutrals to review progress made by the Oklahoma Department of Human Services ("DHS") to improve its child welfare system. Under the Compromise and Settlement Agreement (CSA), DHS originally planned to exit the agreement in December 2016, but was unable to do so. Over the course of the reform, important advancements have been made by DHS, but they are not yet fully rooted, particularly with respect to manageable caseloads and an adequate array of placements for children. In some areas, most critically safety for children in the care and custody of DHS, the department's efforts have been inadequate. In order to improve performance for children toward the Target Outcomes identified at the outset of this reform effort, DHS must make good faith efforts to achieve substantial and sustained progress in each of the measured areas described in this Commentary.

While DHS is grateful for the Co-Neutrals' willingness to address some of the Department's concerns with this document, significant disagreements remain with the Co-Neutrals' assessments of DHS's good faith efforts. The Department's on-going efforts have not only continued apace, but even more new efforts are being put forth to improve the system. This sudden course shift by the Co-Neutrals to re-craft the narrative about the good faith efforts of DHS is misleading and concerning. It seems the Co-Neutrals have embraced a skewed perspective of DHS's efforts by selecting data and anecdotal evidence that fails to fully take into account what DHS has accomplished, not only over the past year but over the span of the Pinnacle Plan. This Commentary is replete with anecdotal examples offered by the Co-Neutrals that are lacking in contextual detail. As referenced above, it appears to DHS the Co-Neutrals are using this Commentary to now craft a narrative that is at odds with the actual efforts of the Department and, at times, directly conflicts with their previous good faith findings.

Background

On January 4, 2012, DHS and Plaintiffs reached agreement in a long-standing federal class action lawsuit against the state of Oklahoma on behalf of children in the custody of DHS due to abuse and neglect by a parent or resource caregiver. That matter, *D.G. vs. Yarborough*, Case No. 08-CV-074, resulted in the Compromise and Settlement Agreement (CSA), which was approved by the United States District Court for the Northern District of Oklahoma on February 29, 2012. The CSA requires (Section 2.10 (a)) that DHS develop a plan setting forth "specific strategies to improve the child welfare system." Under the CSA, the parties identified and the court approved Eileen Crummy, Kathleen Noonan, and Kevin Ryan as "Co-Neutrals," and charged them to evaluate and render judgment about the ongoing performance of DHS to strengthen its child welfare system to better meet the needs of vulnerable children, youth, and families. The CSA states specifically (Section 2.10 (i)) that, "Twice annually, the Co-Neutrals shall provide commentary regarding the Department's overall progress as

reflected by the [data] reports and shall provide commentary as to whether the Department is making good faith efforts pursuant to Section 2.15 of the Settlement Agreement."

DHS, with the assistance of state leaders, advocates, and other stakeholders, developed the Pinnacle Plan, which contains significant commitments to be implemented beginning in State Fiscal Year (SFY) 2013. The Co-Neutrals approved the Pinnacle Plan on July 25, 2012.

The CSA charged DHS with identifying baselines and Target Outcomes to measure and report the state's progress in core performance areas, which are grouped in the following seven performance categories:

- Maltreatment (abuse and neglect) of children in the state's legal custody (MIC);
- Development of foster homes and therapeutic foster homes (TFC);
- Regular and consistent visitation of caseworkers with children in the state's legal custody;
- Reduction in the number of children in shelters;
- Placement stability, reducing the number of moves a child experiences while in the state's legal custody;
- Child permanency, through reunification, adoption or guardianship; and,
- Manageable caseloads for child welfare staff.

As required by the CSA, the Co-Neutrals and DHS established the Metrics, Baselines, and Targets Plan (the "Metrics Plan") on March 7, 2013. For each of the seven performance categories, the Metrics Plan establishes: the methodology for the performance metrics and measuring progress; parameters for setting baselines; interim and final performance targets and outcomes; and the frequency by which DHS must report data and information to the Co- Neutrals and the public. Appendix A provides a summary chart of the metrics for the seven performance areas, with corresponding baselines and targets, established by DHS and the Co- Neutrals, and updated through September 2015.[1]

The CSA further requires the Co-Neutrals to provide commentary and issue a determination as to whether DHS' data submissions provide sufficient information to measure accurately the department's progress. The Co-Neutrals have previously found data sufficiency for all the CSA performance areas and data metrics. Pursuant to the CSA, the Co-Neutrals may revise any determination of data sufficiency based on subsequent or ongoing data submissions as deemed appropriate. It is important to highlight that DHS' data management team has made significant progress during this reform, particularly in strengthening its ability and practice to manage and evaluate its data to support data-driven management decisions and case practice improvements.

Under Section 2.15 of the CSA, the parties established that the Co-Neutrals would issue a Final Report on December 15, 2016 that determines whether DHS has made, for a continuous period of at least two years prior to December 15, 2016, good faith efforts to achieve substantial and sustained progress towards the Target Outcomes. On September 2, 2016, DHS and the Plaintiffs jointly agreed by amendment to the CSA to suspend the Co-Neutrals' issuance of the Final Report. The amendment gives DHS the opportunity to request the Final Report from the Co-Neutrals at any time and maintains the requirement that the Co-Neutrals determine as part

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[1] Under Section 2.10(f) of the CSA, the Co-Neutrals shall issue Baseline and Target Outcomes, which shall not be subject to further review by either party but may at the discretion of the Co-Neutrals, after providing the parties an opportunity to comment, be revised by the Co-Neutrals.

of that report whether DHS has, for a period of at least two years, made good faith efforts to achieve substantial and sustained progress toward each Target Outcome.

This document serves as the Co-Neutrals' Tenth Commentary under the CSA and reflects DHS' performance, data, and information available through December 31, 2017. In numerous instances, as described in this report, data and information are only available through September 30, 2017 (due to reporting lags or intervals agreed upon previously by the Co- Neutrals and DHS). In addition, in some instances, the Co-Neutrals report on more recent decisions or activities by DHS to reflect, when possible, the most current view of the reform.

Good Faith Efforts to Achieve Substantial and Sustained Progress

The CSA requires the Co-Neutrals to determine whether DHS has "made good faith efforts to achieve substantial and sustained progress" toward a Target Outcome. This standard requires more than an assessment of DHS' intentions but necessarily requires a conclusion by the Co- Neutrals that is based on an analysis of the activities undertaken and decisions made by DHS or, as the Co-Neutrals have stated, the inactions or failures to make decisions, and the impact of those decisions and activities on achieving substantial and sustained progress toward a Target Outcome. For example, the Co-Neutrals have focused their review and assessment of DHS' timeliness and thoroughness to implement, evaluate and, when needed, adjust core strategies to inform their judgment of whether the department has made good faith efforts to achieve substantial and sustained progress toward the Target Outcomes.

The CSA requires the Co-Neutrals to report on those Target Outcomes that DHS has met, those for which the department has achieved sustained, positive trending toward the Target Outcomes, and those Target Outcomes for which DHS has not achieved sustained, positive trending. The following Table summarizes the Co-Neutrals' findings of DHS' progress toward the Target Outcomes and, separately, the Co-Neutrals' assessment of DHS' efforts for each of the performance metrics assessed during this report period.

Table 1: Summary of Target Outcomes

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
1.A: Of all children in foster care during the reporting period, what percent were not victims of substantiated or indicated maltreatment by a foster parent or facility staff member in a 12 month period.	No	No	No
1.B: Of all children in legal custody of DHS during the reporting period, what number and percent were not victims of substantiated or indicated maltreatment by a parent and what number were victims.	No	No	No
2.A: Number of new foster homes (non-therapeutic, non-kinship) approved for the reporting period.	Target due June 30, 2018	No	Yes
Net gain/loss in foster homes (non-therapeutic, non-kinship) for the reporting period.	Target due June 30, 2018	No	No
2.B: Number of new therapeutic foster homes (TFC) reported by DHS as approved for the reporting period.	Target due June 30, 2018	No	No

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
Net gain/loss in TFC homes for the reporting period.	Target due June 30, 2018	No	No
3.1: The percentage of the total minimum number of required monthly face-to-face contacts that took place during the reporting period between caseworkers and children in foster care for at least one calendar month during the reporting period.	Yes	Yes	Yes
3.2: The percentage of the total minimum number of required monthly face-to-face contacts that took place during the reporting period between primary caseworkers and children in foster care for at least one calendar month during the reporting period.	Yes	Yes	Yes

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
3.3b: The percentage of children in care for at least six consecutive months during the reporting period who were visited by the same primary caseworker in each of the most recent six months, or for those children discharged from DHS legal custody during the reporting period, the six months prior to discharge.	No	Yes	Yes
4.1a: Percent of children in legal custody of DHS that experience two or fewer placement settings: Of all children served in foster care during the year who were in care for at least 8 days but less than 12 months, the percentage that had two or fewer placement settings.	No	Yes	Yes

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
4.1b: Percent of children in legal custody of DHS that experience two or fewer placement settings: Of all children served in foster care during the year who were in care for at least 12 months but less than 24 months, the percentage that had two or fewer placements.	No	Yes	Yes
4.1c: Percent of children in legal custody of DHS that experience two or fewer placement settings: Of all children served in foster care during the year who were in care for at least 24 months, the percentage that had two or fewer placement settings.	No	No	Yes
4.2: Of those children served in foster care for more than 12 months, the percent of children who experienced two or fewer placement settings *after* their first 12 months in care.	No	No	Yes

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
5.1: The number of child-nights during the past six months involving children under age 2 years.	Yes	Yes	Yes
5.2: The number of child-nights during the past six months involving children age 2 years to 5 years.	No	No	Yes
5.3: The number of child-nights during the past six months involving children age 6 years to 12 years.	No	No	No
5.4: The number of child-nights during the past six months involving children ages 13 years or older.	No	No	No
1.17: Percent of children 13 and older in a shelter who stayed less than 30 days and no more than one time in a 12- month period.	No	No	No
6.1: Of all children who were legally free but not living in an adoptive placement as of January 10, 2014, the number of children who have achieved permanency.	No	Yes – for children ages 12 and under	Yes – for children ages 12 and under
		Yes – for children ages 13 and older	Yes – for children ages 13 and older

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
6.2a: The number and percent of children who entered foster care 12-18 months prior to the end of the reporting period who reach permanency within one year of removal, by type of permanency.	No	No	No
6.2b: The number and percent of children who entered their 12th month in foster care between 12-18 months prior to the end of the reporting period who reach permanency within two years of removal, by type of permanency.	No	Yes	Yes
6.2c: The number and percent of children who entered their 24th month in foster care between 12-18 months prior to end of reporting period who reach permanency within three years of removal, by type of permanency.	No	Yes	Yes

6.2d: The number and percent of children who entered their 36th month in foster care between 12-18 months, prior to the end of the reporting period who reach permanency within four years of removal.	No	Yes	Yes

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
6.3: Of all children discharged from foster care in the 12 month period prior to the reporting period, the percentage of children who re- enter foster care during the 12 months following discharge.	Yes	Yes	Yes
6.4: Among legally free foster youth who turned 16 in the period 24 to 36 months prior to the report date, the percent that exited to permanency by age 18; stayed in foster care after age 18, and exited without permanency by age 18.	No	Yes	Yes
6.5: Of all children who became legally free for adoption in the 12 month period prior to the year of the reporting period, the percentage who were discharged from foster care to a finalized adoption in less than 12 months from the date of becoming legally free.	No	Yes	Yes

Metric	Has Met Target Outcome	Has Achieved Sustained, Positive Trending Toward the Target Outcome	Has Made Good Faith Efforts to Achieve Substantial and Sustained Progress Toward the Target Outcome
6.6: The percent of adoptions that did not disrupt over a 12 month period, of all trial adoptive placements during the previous 12 month period.	No	No	Yes
6.7: The percent of children whose adoption was finalized over a 24 month period who did not experience dissolution within 24 months of finalization.	Yes	Yes	Yes
Caseworkers	No	No	Yes
Supervisors	No	Yes	Yes

For this period, the Co-Neutrals conclude that DHS has made good faith efforts to achieve substantial and sustained progress toward the Target Outcomes in 22 of the 31 distinct performance areas. In nine performance areas, the Co-Neutrals find that DHS did not make good faith efforts to achieve substantial and sustained progress toward the Target Outcomes for this report period.

Methodology

The Co-Neutrals conducted a series of verification activities to evaluate DHS' progress and implementation of its commitments. These activities included meetings with DHS leadership and scores of staff across the state, private agency leadership, and child welfare stakeholders. The Co-Neutrals also reviewed and analyzed a wide range of aggregate and detailed data produced by DHS, and thousands of child and foster home records, policies, memos, and other internal information relevant to DHS' work during the period.

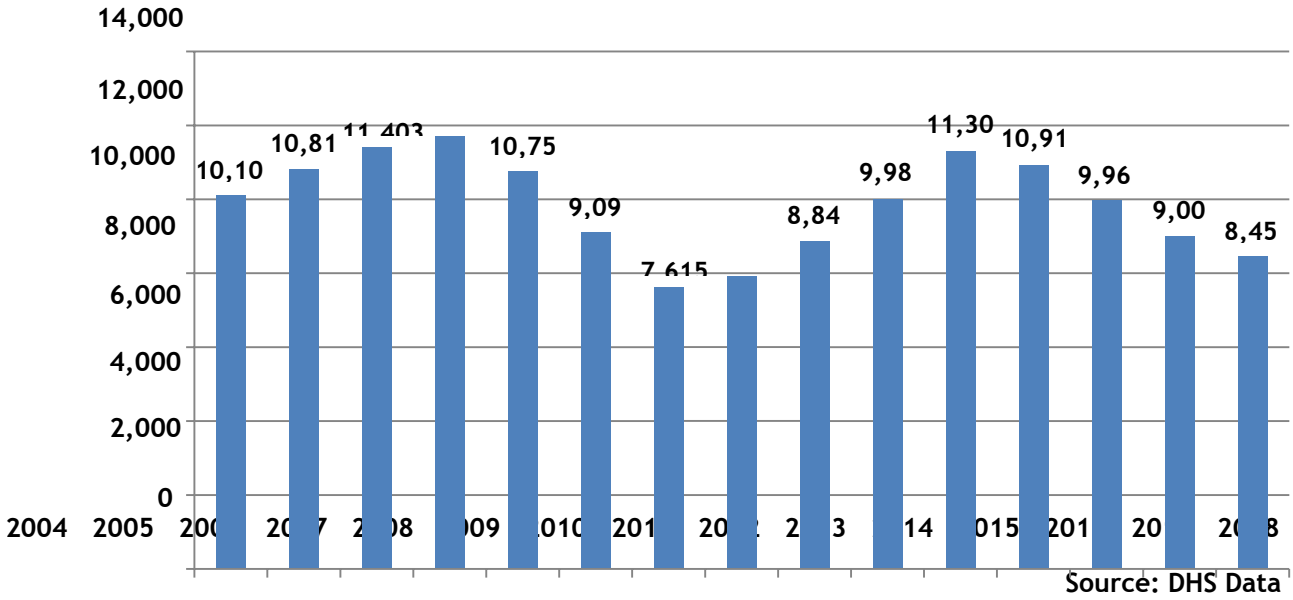
The remainder of this report includes:

- Context Data of Children in DHS Custody (Section III);
- Seven Performance Categories: Assessment of Progress and Good Faith Efforts (Section IV);
- Appendices; and,
- Glossary of Acronyms.

III. Context Data of Children in DHS Custody

DHS has experienced a steady decline in the number of children in care over the last three years. At its highest number of children in care since 2007, there were 11,301 children in DHS custody on June 30, 2014. Four years later, on June 30, 2018, there were 8,455 children in care, a 25 percent drop. The decline in the population of children in care is the result of more children exiting care than entering care each year.

Figure 1: Number of Children in DHS Custody at the End of SFY - 2004 to 2018

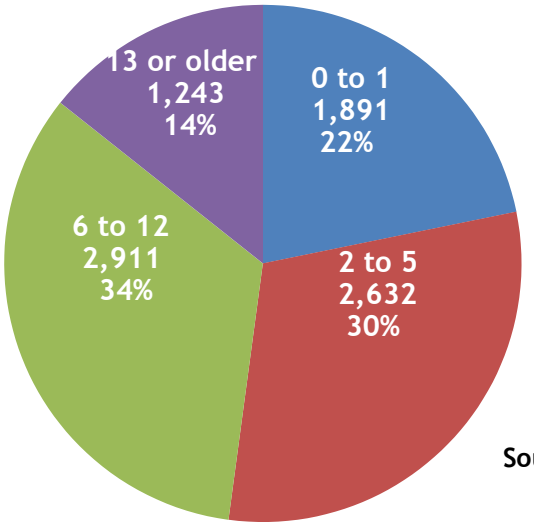


Demographics

DHS data show that there were 8,677 children in custody on December 31, 2017, while there were 8,997 children in custody on July 1, 2017.[2] During the reporting period from July 1, 2017 to December 31, 2017, 2,328 children entered care and 2,648 children exited care.

Young children aged zero to five years make up the largest portion (4,523 or 52 percent) of children in care. Children aged 6 to 12 years comprise 34 percent (2,911) of the population in care and fourteen percent (1,243) are 13 years or older, as detailed in the following chart:

Figure 2: Children in Care on December 31, 2017 by Age Group (Total = 8,677)



Source: DHS Data

With regard to gender, the population is split almost equally — 52 percent male and 48 percent female. With regard to race, the population of children is 37 percent White, nine percent African-American, and seven percent Native American. In addition, 19 percent of children identified with Hispanic ethnicity (and can be of any race). Twenty-eight percent identified with multiple race and ethnicity categories, of which 72 percent identified as Native American.[3]

As presented in Figure 3 below, DHS' data shows that of the children in care on December 31, 2017, 48 percent (4,187) were in care for less than one year; 29 percent (2,516) between one

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[2] In the prior commentary, DHS reported 9,001 children in care on June 30, 2017. Due to data entry lag and merged identifying numbers, OKDHS data now indicate 8,997 children in care on July 1, 2017. These types of adjustments are common in child welfare administrative data.

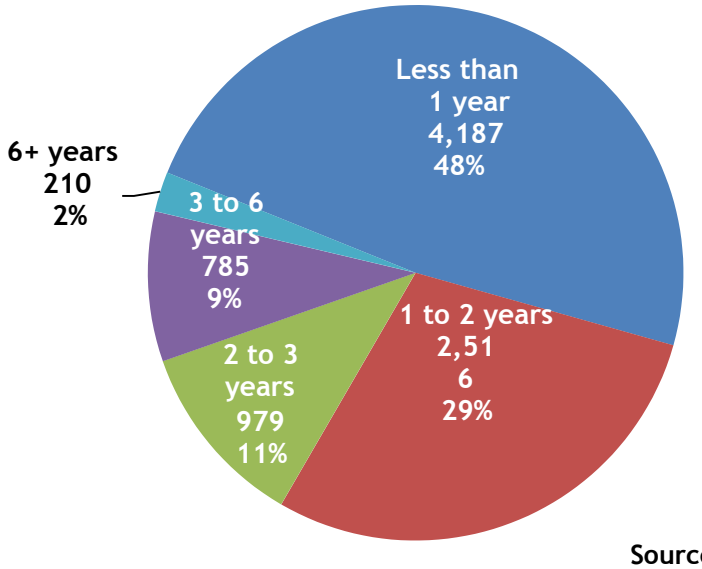
[3] Overall, 33 percent of children identified as Native American including those children who identified with more

than one race and ethnicity category and those who identified as Hispanic.

and two years; 11 percent (979) between two and three years; 9 percent (785) between three and six years; and 2 percent (210) for more than six years.

Figure 3: Children in Care on December 31, 2017 by Length of Stay (Total = 8,677)

Percentages in this paragraph may not add up to totals due to

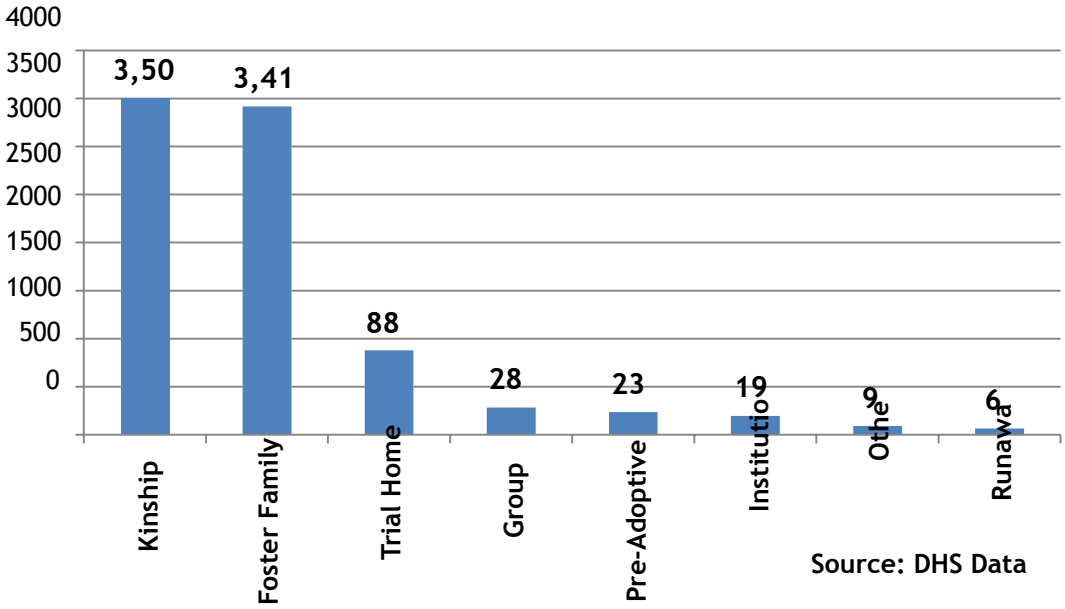


Source: DHS Data

As the following chart demonstrates, 93 percent of children (8,034) in DHS custody on December 31, 2017 live in family settings, including in relative and non-relative kinship homes (40 percent), with foster families (39 percent), with their own parents (ten percent), and in homes that intend to adopt (three percent). Of children in custody, 481 (six percent) live in institutional settings, including shelters, residential treatment and other congregate care facilities. The remaining two percent reside in unidentified placements (listed as "other" in the table below) or are AWOL (listed as "runaway" in the Table below).[4]

[4] Percentages in this paragraph may not add up to totals due to

Figure 4 : Children in Care on December 31, 2017 by Placement Type



Of the 8,034 children living in family settings, 1,868 (23 percent) are less than two years old, 2,607 (32 percent) are two to five years old, 2,731 (34 percent) are six to 12 years old, and 828 (10 percent) are 13 years or older. Of the 481 children living in institutional settings, seven (two percent) are less than two years old, six (one percent) are 2 to 5 years old, 149 (31 percent) are 6 to 12 years old, and 319 (66 percent) are 13 years or older.[5]

A. Foster Care

Foster Care Target Outcomes: New Foster Homes and Net Foster Home Gains

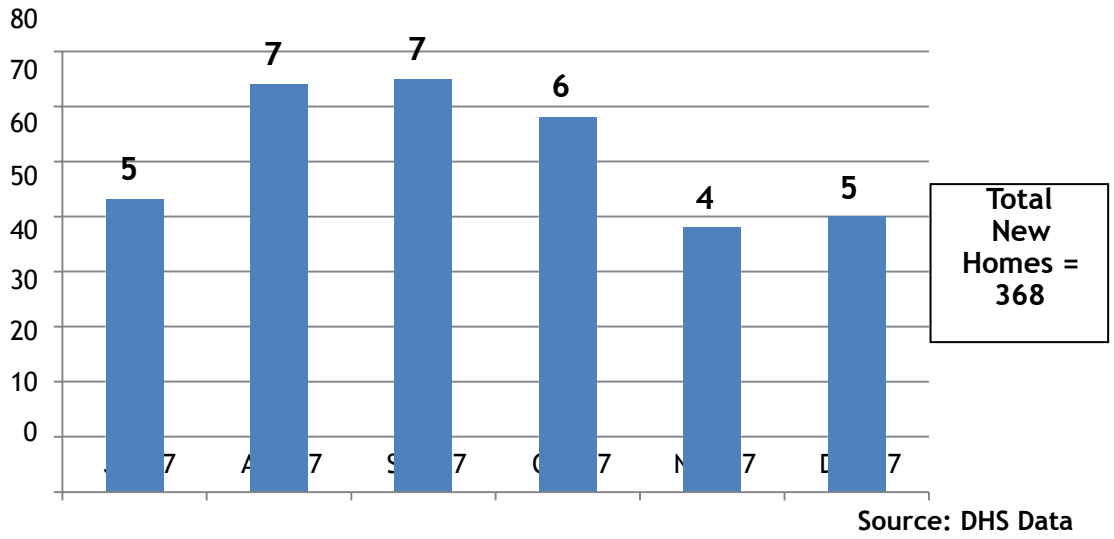
For SFY18, DHS committed to develop 1,075 new traditional, non-kinship foster homes. During this six-month report period (which represents the first half of SFY18), DHS, along with its private agency partners, approved 368 new traditional foster homes. For this report period, for the reasons described below, the Co-Neutrals find that DHS made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for new foster home development.

For SFY 18, DHS committed to achieve a net gain of 206 foster homes. For this six-month report period, DHS reported a net loss of foster homes with 64 fewer homes open at the end of the

[5] Percentages in this paragraph may not add up to totals due to

period compared to the number of homes open at the beginning of the report period. Further, during this report period DHS did not take adequate steps to gain an understanding of the reasons for the high rate of foster home closures and did not implement expanded efforts to support and retain existing foster families. For this period, the Co-Neutrals do not find that DHS made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for a net gain in the state's pool of foster homes.

Figure 5: New Foster Care Homes Developed by Month, July 2017-December 2017

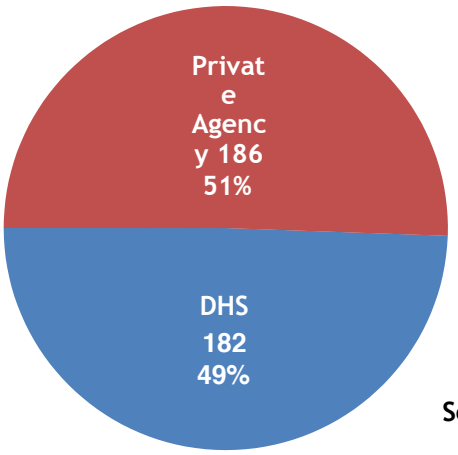


Source: DHS Data

Of the 368 new foster homes approved during this six-month report period, DHS developed 49 percent of the homes (182) and its partner agencies developed 51 percent (186).[6]

[6] As of July 2017, DHS had 15 private agency partners recruiting traditional foster homes.

Figure 6: New Foster Homes Developed by Agency, July 2017-December 2017 (N=368)

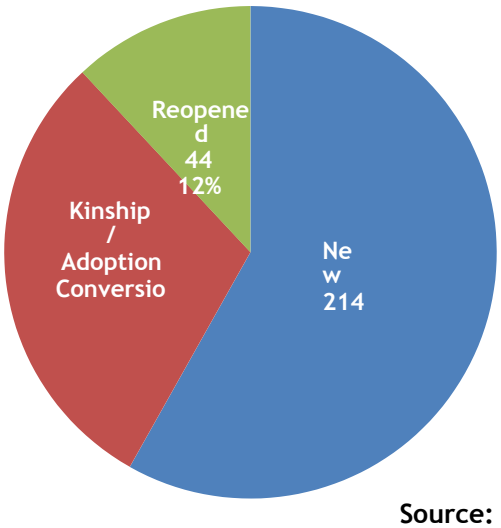


Source: DHS Data

Of the 368 foster homes approved during the first six months of SFY18, 214 families (58 percent) were newly recruited by DHS and the private agencies, 110 homes (30 percent) were already approved by DHS as adoption homes or kinship homes that were then converted to traditional foster homes to serve non-kin children, and 44 (12 percent) were DHS resource homes[7] that were closed for more than a year and reopened during this report period.

[7] DHS resource homes that are reopened could have been previously approved as a number of different types of DHS resources, including traditional, kinship, emergency foster care, TFC, and DDS homes.

Figure 7: New Foster Homes by Type, July 2017-December 2017 (N=368)



Source: DHS Data

Efforts to Recruit New Foster Homes

During this report period, DHS maintained its internal team of regional foster home recruiters and continued to collaborate with its private agency partners to develop new homes and move toward the SFY18 recruitment goals. The statewide Oklahoma Fosters campaign continued to support DHS' efforts to recruit additional foster homes and held several recruitment events throughout Oklahoma during the period. Due to DHS' substantial loss of foster homes over the last eighteen months, these recruitment efforts continue to be crucial to ensure DHS is able to build and maintain a robust pool of foster homes to serve children in DHS custody.

DHS made initial efforts to develop specialized, family-based placements for children with developmental disabilities. DHS established a team of five DHS recruiters to coordinate with DHS' Developmental Disabilities Services (DDS) to develop new DDS Specialized Foster Care and Agency Companion homes, as well as identify any open, experienced foster homes willing and able to meet the specialized and therapeutic needs of children with developmental disabilities.[8] This is a new recruitment team and DHS was still in the process of filling staff positions during the period. As of February 2018, DHS reported that three of the five recruiters had been hired and were completing cross-training with foster care and DDS and that the other two positions had been posted to fill.

[8] Specialized Foster Care and Agency Companion homes are managed out of DHS' DDS program office and children placed with these families, who receive specialized training, must meet specific disability diagnosis criteria to obtain the required Medicaid waiver for placement.

Some children with developmental disabilities meet the criteria for a Medicaid waiver, which allows them to be placed in specialized family-based homes that are managed by DDS. However, some children who present on a spectrum of high to low disability needs do not qualify for the waiver but still require additional services for them and/ or their foster parents to meet their needs and advance their permanency, stability and well-being. In coordination with the Oklahoma Fosters team, DHS began conducting targeted outreach to build its foster home capacity for children with varying levels of disabilities and reviewing the different supports that can be offered to foster families willing to complete additional training and care for children with disabilities.

DHS has long faced the challenge of having a substantial waitlist for specialized DDS homes to care for all Oklahoma children needing a DDS home placement, not only for children in DHS custody with a developmental disability. As discussed further below, DHS, over the last two years, increasingly used the Laura Dester Children's Center (Laura Dester), a state-run shelter in Tulsa, to place children in DHS custody who are dually or multi-diagnosed with complex behavioral, medical and developmental challenges.

DHS has found it most challenging to secure family-based placements for sibling groups, adolescents and children who present with some behavioral challenges but do not qualify for TFC or higher-level placement. DHS reports that it continues to update and implement new home recruitment plans targeted to these populations of children. However at this time, as discussed below, DHS' data shows there are too few available foster home placements for children removed from their families. This limits DHS in its ability to ensure that best placement matches are made into foster homes capable of meeting a child's needs.

Net Gain Target and Performance

DHS' net gain target for the full 12 months of SFY18 was set at 206 foster homes. While DHS made progress with the development of 368 new foster homes during this report period, DHS closed more homes than it developed. DHS began the period with a starting baseline of 2,139 open foster homes and by the end of the six-month period, DHS reported 2,075 open homes, a net loss of 64 foster homes. Of the 2,139 foster homes open at the beginning of the period, 460 were no longer open at the period's end, a high closure rate of 22 percent. Of these foster homes, 263 (57 percent) were DHS managed homes and 197 (43 percent) were foster homes managed by DHS' private agency partners. Of the 368 new foster homes approved during this report period, 12 closed by January 1, 2018.

Oklahoma's net loss of foster homes has been an ongoing problem that did not begin during this report period. Over the last three periods, from July 1, 2016 to December 31, 2017, DHS

closed 1,465 foster homes, resulting in a net loss of 271 foster homes. Despite the steady decline in the number of children in DHS' custody over the last four years, DHS continues to experience a shortage of foster homes due to these net losses. At the beginning of April 2018, DHS staff reported to the Co-Neutrals during a field office visit in Oklahoma City that there were only five foster homes in the county that were available for a new placement. To verify and further assess this reported foster home shortage, the Co-Neutrals reviewed in early May 2018 DHS' real time foster home vacancy data that caseworkers rely on daily to identify available family-based placements. The report contains the list of all traditional foster homes (managed by both DHS and the private agencies) that have at least one vacant bed. The Co-Neutrals determined there were only eight foster homes in Oklahoma County with a vacancy, none of which indicated the foster parents were willing to care for a child over the age of 10. The data also showed that Oklahoma County had 18 foster homes with more children placed with the families than the number of children foster parents reported as their preferred number of placements.[9] At the same time, DHS' placement data showed that during the same month (May 2018), DHS removed 41 children whose county of jurisdiction is Oklahoma County and 17 of these 41 newly removed children were placed in traditional foster homes; however, only nine of these 17 children were placed in Oklahoma County.

In Tulsa County, there were only 13 traditional foster homes at the beginning of May 2018 with a vacancy and of these only five foster homes were vacant with no child placements. New removal placement data for May 2018 showed that DHS removed 58 children whose county of jurisdiction is Tulsa with 26 of these children entering a traditional foster home as their first placement; however, only eight of these 26 children were placed in a Tulsa-based foster home.

Statewide, DHS' data showed just 170 traditional foster homes had at least one vacant placement at the beginning of May 2018, with only 19 of 170 homes willing to accept placement of a child older than 12 years. Only 91 homes statewide were vacant with no current placements. During the month of May 2018, DHS removed 353 children statewide with
153 children entering traditional foster homes for their first placement: 99 of these 153 children were placed in foster homes outside of their county of jurisdiction. During this six- month report period, DHS' data showed that statewide the department removed an average of 390 children each month and that an average of 446 children exited care each month. Even taking into account that DHS' data shows that the number of child exits from custody exceeded the number of children entering care during the period and that nearly half of all newly

[9] A foster home can be licensed to accept the placement of more children than the preferred number of placements identified by the foster parents. As such, this data showing placements above a foster family's preferred number of placements does not necessarily mean these homes are overfilled.

removed children are placed in kinship homes, DHS will have to maintain a larger pool of available traditional foster homes to sufficiently meet the family-based placement needs of children entering DHS custody.

The Co-Neutrals have raised concerns in prior Commentary reports about the high percentage of foster homes that remained vacant for extensive periods of time, many of which were listed as unavailable for placements. DHS has worked over the past 18 months to assess whether these homes should remain open and has taken action to close the homes of families unwilling to accept placements. The Co-Neutrals support DHS' efforts to close foster homes that will not accept placements so that DHS knows with certainty its viable foster home capacity. Despite the closure of vacant and unavailable foster homes contributing to foster home net losses, families who did not accept placements were not viable resources and DHS' past practice of maintaining those families on the roster of open foster homes masked the need for the development of additional foster homes. With the closure of such homes, DHS now has a better picture of the actual number of foster homes available and willing to accept child placements. DHS worked diligently to close homes that were not viable; however at the end of this process, DHS had not gained a full understanding of the reasons these foster families decided to close their homes.

The Co-Neutrals previously urged DHS to establish a process to enable the agency to gain an understanding of the reasons for Oklahoma's high foster home closure rate. Acknowledging over one year ago that the department needed "to assess the ongoing trend of high closure rates of resource families," DHS in April 2017 issued guidance to staff to document in DHS' KIDS database system the most accurate reason for each home closure as a first step in this assessment. In July 2017, DHS foster care caseworkers and supervisors were provided instructions on the use of an updated and expanded menu of closure reasons that the department added to the KIDS database system. By the middle of this report period, DHS shared that the information gathered from staff's recorded home closures did not indicate any specific trend or issue was leading to the high closure rate.

DHS leadership reported that the expanded menu of closure reasons is limited in terms of providing a qualitative assessment of how practice and supports should be improved to better retain foster parents. However, the expanded closure menu in KIDS provided DHS with data regarding closure reasons that can serve as a starting point for a qualitative assessment of why families leave the system. The breakdown of reasons for closures are outlined in the chart below. Of the 512 foster homes that closed during this report period, twenty six percent (132)

of the families had adopted a child, which resulted in closure due to permanency.[10] However, 159 families (30 percent), closed their homes due to: the family having no desire to foster or adopt; dissatisfaction with the foster home process; the family's placement preferences not being met; and the family not being able to meet a child's needs. The remaining 221 homes were closed due to administrative agency decisions, changes in family circumstances, and requests by families to provide only respite care for children and a small number of other unknown reasons.

Figure 8: Traditional Home Closure Reasons, July - December 2017

Resource Closures July to December 2017	# Resources	% Resources
ADOPTION SERVICES COMPLETED	132	26%
AGENCY DECISION-CONTRACT VIOLATIONS	7	1%
AGENCY DECISION-FAILURE TO COOPERATE	10	2%
AGENCY DECISION-LEGAL ISSUES	2	0.4%
AGENCY DECISION-REFERRAL/ INVESTIGATION	21	4%
RESOURCE REQUEST-DISPLEASED WITH PROCESS	16	3%
RESOURCE REQUEST-FAMILY DYNAMIC CHANGED	68	13%
RESOURCE REQUEST-MEDICAL/ILLNESS	26	5%
RESOURCE REQUEST-MOVING	31	6%
RESOURCE REQUEST-NO DESIRE TO FOST/ ADOPT	133	26%
RESOURCE REQUEST-PLCMT PREFER NOT MET	3	1%
RESOURCE REQUEST-UNABLE TO MT CHILD NEED	7	1%
RESPITE ONLY	43	8%
OTHER	11	2%
AGENCY TRANSFER	2	0.4%
TOTAL CLOSURES	**512**	**100%**
Data Source: Net Gain and YI035		

In order to engage with foster parents to gain an understanding of the reason for

foster home closures, DHS committed to utilize its monthly customer service survey calls to contact foster parents who requested to close their homes and whose foster homes were closed during the

[10] As noted above, 460 of the 512 homes closed during this period were calculated in the overall home closure rate, because these homes were open on the first day of the SFY. Additionally, 12 homes closed that were part of the 368 new homes opened during the year and count toward the new home target. Lastly, 40 homes closed during the year that were new homes opened during the year that, for various reasons, do not count toward the new home target.

prior month.[11] DHS and the Co-Neutrals agreed in September 2017 that DHS would undertake this qualitative assessment with the exit survey calls starting in November 2017, allowing time for DHS to develop a brief closure reason survey of six questions and a process to record and track survey responses. Questions in the survey include: tell us about what led you to the decision to no longer be a foster parent; and, is there anything you would recommend DHS (or applicable agency) consider doing differently that might enhance the experience of foster parents. DHS planned to select families from the pool of traditional foster homes that closed in October 2017 and then continue the survey process in each subsequent month.

For the 110 foster homes DHS contacted in November and December 2017, DHS found that approximately 40 of the homes should not have been part of the survey sample as some were still open and others were kinship homes, which were not designated to be part of the survey. DHS reported that based on the sample of homes that were correctly called, no obvious trends were identified. However, DHS did find "there may have been some instances in which communication between the assigned resource worker and family was not clear as to the home's closure. In some cases, the families pointed out they were requesting time to take a break, but were encouraged by their worker to close their resource home." Based on these communication concerns, DHS reported in February 2018 it is now requiring that for any traditional foster home requesting to close, the assigned supervisor or field manager must contact the family to inquire about their experience, resolve any issues when possible and ensure there has been clear communication between the family and their assigned caseworker.

It was not until well after the close of this report period that DHS began to glean some preliminary information on some underlying reasons foster families requested home closure. Specifically, in June 2018, DHS reported to the Co-Neutrals that the home closure exit surveys completed with 52 families that closed their homes between January and March 2018 were beginning to provide some initial insights on the reasons these foster homes closed. The Co- Neutrals support DHS' efforts to gather this feedback from foster parents and encourage the department to use these surveys to obtain as much qualitative information it can to best inform what actions DHS should take to support and retain foster families. The Co-Neutrals will report on DHS' findings in the next Commentary.

[11] As highlighted in a prior Commentaries, DHS still maintains the practice that foster care workers must contact their assigned foster homes at least one time per month and visit the families in their homes once every three months.

Supporting Foster Parents

More than a year ago, DHS began to survey foster parents each month on the challenges they experienced fostering Oklahoma's children. Through the survey, foster parents identified additional training opportunities as an important and unmet need. (See Appendix B) Specifically, foster parents requested training regarding effective care for teens, including how to manage their behaviors and guide them appropriately toward adulthood. Foster parents also identified training needs regarding: how to respond therapeutically to the behavioral health challenges and needs of foster children; the child welfare and court processes from removal to reunification; and, working with and understanding the perspective of biological families. Foster parents also requested more training availability in local and rural areas.

In their last Commentary, the Co-Neutrals highlighted some of these foster parent training requests and encouraged DHS to ensure that foster families are aware of the numerous topics available in the in-service training program and to assess where additional training should be developed or updated for foster families. DHS reported that its foster care and adoption staff were sent in June 2017 a listing of all foster parent in-service trainings available online, as staff previously were not aware of the courses available to foster parents. However, DHS, as of April 2018, had not yet shared directly with foster parents the full list of online trainings that are available.

DHS has decided only foster families approved and managed by DHS are ensured full, free access to all online training. Foster families managed by private agencies have free access to pre-service training and a limited number of in-service trainings. DHS expects that the private agencies will work with the National Resource Center for Youth Services (NRCYS), the purveyor of the largest menu of foster parent trainings in Oklahoma, to establish a payment agreement to allow the more than 1,000 private agency foster homes access to in-service training resources. DHS should ensure that both its own foster parents and private agency foster parents have access to all available trainings that will help to strengthen their capacity to safely and effectively care for children and youth in DHS' custody. DHS reports the department has begun to address the need for greater access to foster parent training, including working with the state's Foster Care and Adoption Association in each region of the state to meet some of the needs identified through the Foster Parent Support Workgroup.

Just over two years ago, DHS established its Foster Parent Support Workgroup to identify services or supports foster parents need, develop solutions to any trending concerns impacting foster families and proactively explore opportunities for service enhancements. The workgroup was developed as a core strategy to help retain foster parents. At the mid-point in this period,

DHS reported that this workgroup had completed its assigned tasks, was on hiatus and had not met since April 2017. (The exception was a subgroup that continued to meet to focus on and address training issues.) DHS later clarified that the workgroup had reconvened in mid-February 2018. The group includes DHS child welfare staff and representatives of tribes, foster care private agencies and other community partners, foster parents and foster parent advocates. The Co-Neutrals do not presume that this one workgroup could have reversed the trend of high foster home closure rates over the last three periods; however, it is of concern that DHS placed the workgroup on hiatus during the time it was experiencing net losses in foster homes. The Co-Neutrals urge DHS to make focused efforts to utilize the workgroup and all available means to communicate with foster parents in order to identify their needs and, in collaboration with foster parents and private agency partners, build supports to strengthen and retain the foster homes Oklahoma has worked to develop.

Foster Home Board Rate

As previously reported, the monthly board rate payment provided to foster and adoptive families was reduced by five percent effective July 1, 2017, which is approximately one dollar per day for each child they foster or have adopted. DHS had announced that statewide revenue failures led to the department's decision to reduce the rates but also highlighted that the daily rate for foster and adoptive parents would remain approximately four dollars per child above the rate provided prior to 2012 when the reform effort began. In a positive reversal, the Oklahoma Legislature and Governor Mary Fallin restored at the beginning of the SFY17 the five percent reduction and provided an additional five percent increase, which will go into effect July 1, 2018.

The need for DHS to develop, support and retain foster parents capable of providing homes for children in the state's custody has reached a critical point. Moving ahead DHS must sustain the efforts it began after the close of this report period to understand the reasons more foster parents are leaving the system than entering. DHS must then provide services and support to retain foster families in order to ensure Oklahoma can provide available and safe foster homes for children in need of family-based placements.

B. Therapeutic Foster Care

Children who are eligible to be placed in therapeutic foster care (TFC) homes have been assessed to have emotional and behavioral health needs and can live in the community with specially trained foster parents and therapeutic services. DHS has established TFC homes as a key component of Oklahoma's continuum of care resources. TFCs are intended to ensure that appropriate services are provided for children in need of behavioral health treatment to avoid

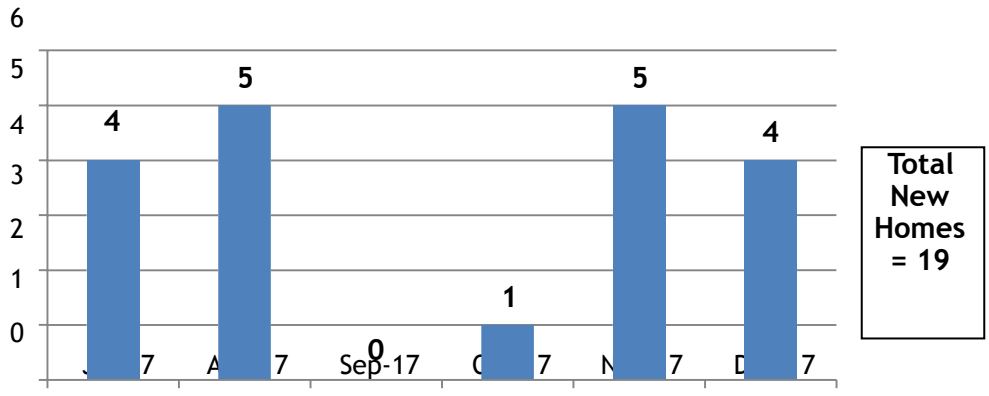
placing children in higher-levels of congregate care, offer family-based placements for those children ready to step-down from higher-levels of care and support more stable placements.

Since the beginning of the reform, DHS has faced several challenges within the TFC program, which the Co-Neutrals have documented in previous reports. One of the primary challenges is the continuing net loss of TFC homes over the past five consecutive report periods. For the sixth consecutive period, DHS reported having fewer TFC homes to serve children in DHS custody at the end of the report period compared to the beginning of the period. The continuous net loss of TFC homes is a result of inadequate focus and efforts to develop new TFC homes, which DHS has consistently reported below the established, annual Target Outcome.

TFC New Home Development and Net Gain/Loss

DHS contracts with eight private agencies to recruit, manage and support TFC homes; unlike traditional foster homes, DHS does not recruit and manage its own TFC homes. [12] The Co- Neutrals accepted DHS' proposed Target Outcome for new TFC home development for SFY18, which is set at 138. During the first half of SFY17, DHS reported that its private agency partners developed only 19 new TFC homes that met the established criteria for counting new TFC homes.

Figure 9: New Therapeutic Foster Homes by Month, July 2017-December 2017



Source: DHS Data

[12] At the beginning of the report writing, DHS had contracts with ten TFC private agencies and subsequently reported that TFC contracts with two agencies were ended. For this report period, only seven of the ten agencies with contracts at the start of the period developed at least one new TFC resource home.

Of the new TFC homes, nine were brand-new homes, three were adoption/kinship home conversions, and seven were reopened homes.

TFC Net Gain/Loss

On July 1, 2017, DHS began the fiscal year with a starting baseline of 280 TFC homes and ended the six month period with 225 open TFC homes on January 1, 2018, representing a net loss of 55 TFC homes. The SFY18 net gain target was established at 20 TFC homes. Of the 280 TFC homes open on July 1, 2017, 84 were no longer open on January 1, 2018, resulting in a TFC home closure rate of 30 percent within the first half of the fiscal year. Of the 19 new TFC homes DHS' partner agencies developed from July 1, 2017 to December 31, 2017, two homes closed by January 1, 2018.

During the period, the number of children placed in a TFC home also declined substantially (24 percent) from 307 children on June 30, 2017 to 232 children on December 31, 2017. The decline is even starker (44 percent) when reviewed over a one-year period, as there were 413 children in a TFC placement on December 31, 2016. The fundamental result of DHS' diminished pool of available TFC homes is that fewer children with behavioral challenges are cared for in specialized family-based placements with increased therapeutic supports.

TFC Waitlist and Home Vacancies

Despite the continuing decline in the number of open TFC homes in Oklahoma, the waitlist of children who need a TFC placement also has fallen significantly. In May 2018, DHS' TFC waitlist showed a total of 41 children, representing a marked, steady decline from 120 children on the waitlist in March 2016 and 62 children on the waitlist in March 2017.

In numerous prior reports, the Co-Neutrals highlighted that DHS' data showed an incongruity between a TFC waitlist of over 100 children and a significant number of TFC homes appearing as vacant, often for extended periods of time.

DHS, during the second half of calendar year 2016, undertook a comprehensive evaluation of its TFC program, which included a review of longstanding vacant homes, the TFC child waitlist, the challenges with effectively matching children with TFC families and the quality of therapeutic services and care in TFC homes. DHS found that a substantial number of open, vacant TFC homes needed to be closed for a variety of reasons, including families no longer wanting to care for children with higher-level needs and homes being interested only in providing temporary respite care and not full time therapeutic foster care for a child with behavioral needs. DHS has committed to make it a standing practice to maintain a more accurate account of the pool of open and available TFC homes and to work with its TFC partner agencies to routinely review

TFC homes with extended vacancies to determine which homes that should remain open for TFC placement and which should be closed.

Of the 225 TFC homes open on January 1, 2018, 62 homes (28 percent) had no TFC placement and 17 (eight percent) had been vacant for more than 90 days. Forty-four TFC homes were vacant of any placements, 129 had only TFC child placements; 18 had non-TFC placements only; and the remaining 34 had a combination (with a total of 69 non-TFC kids).[13]

With respect to the TFC waitlist, DHS reported that its TFC program assessment determined there were children placed on the TFC waitlist who should not have been included or maintained on the list. DHS had previously reported that all children on the waitlist had received initial approval for TFC placement by the Oklahoma Health Care Authority (OHCA), the authorizing state agency. However, DHS leadership subsequently came to understand that individuals, including DHS caseworkers and supervisors, outside of the TFC program office were adding children to the waitlist, sometimes without an authorization request ever being submitted to OHCA.[14] As a result, there were children on the waitlist who had not received initial authorization from OHCA, and who, based on their diagnosis, were not eligible to receive authorization to be placed in a TFC home. DHS also found children on the waitlist who had been stabilized in non-TFC placements (family-based and higher-level settings) that more appropriately met their needs and therefore no longer required a TFC home.

Improved Child Placement Process

DHS developed a new management tool called the Application for Therapeutic Foster Care ("Application"), which it began using in May 2017 to aid the child placement process. The Application, which DHS updated during this report period, is a form that includes information about a child that is supplied by a child's caseworker to DHS' TFC program staff when the decision is made to request authorization for a TFC placement. The Application replaced a one- page worksheet, which most caseworkers previously completed to request a TFC placement. OHCA reviews the completed Application for each child to make an initial decision to authorize TFC level care. Only after initial OHCA authorization is received will DHS' TFC program staff add a child to its TFC waitlist, assuming a TFC placement is not available immediately upon request. DHS now distributes a child's Application to the TFC agencies only after a child has received an

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[13] Of those homes with a combined number of TFC and non-TFC children placed together, five was the maximum total number of children placed (three TFC and two non-TFC children), which occurred in just one TFC home. This was followed by a maximum of four children placed (two TFC and two non-TFC children), which occurred in four TFC homes. The most frequent combination of TFC and non-TFC child placements together appeared in 17 TFC homes that had one TFC child and one non-TFC child.

[14] Upon the request of DHS' TFC program office, OHCA determines if a child in DHS custody meets the state of

Oklahoma's established criteria and is authorized to be placed in a TFC home.

initial authorization from OHCA for TFC level of care. To help ensure that the TFC waitlist is accurately maintained, DHS has established that only TFC program staff can place a child on the waitlist.

By gathering more comprehensive information through the new Application about each child's needs, diagnosis to date and placement and behavioral histories, DHS is in a better position to communicate and match the needs of a child to available homes managed by the TFC agencies. DHS reports the new Application has helped to reduce the amount of time a child remains on the waitlist prior to being placed in a TFC home. To support more timely placements, DHS also continued through this review period to host weekly calls with the TFC agencies to review children waiting for a TFC placement and discuss available and possible TFC home matches. DHS has reported that it is reassessing the best structure and schedule for these child specific placement reviews as program staff believe they can be managed more efficiently and effectively for DHS and the participating agencies.

DHS reported that since May 2017, when the department began to use the Application, there has been a steady decrease in the number of children for whom DHS submits an Application to OHCA for TFC approval. DHS also reported that it cannot pinpoint one reason why the number of Applications and requests for TFC placements has declined from 133 in May 2017, to 78 in July 2017 and 48 in September 2017. DHS ended the year with 62 Applications submitted in December 2017. However, DHS reported that child welfare staff and TFC staff alike have become more familiar with the information gathered for the Application, particularly regarding a child's treatment history and diagnoses, and will identify upfront which requests OHCA will deny. This expanded awareness can lead DHS to pre-emptively end the Application process and not submit the request to OHCA. However, given the significant decrease in the number of TFC placement authorization requests submitted to OHCA, DHS needs to ensure that children who need and could be authorized for TFC services are supported through the full TFC Application and placement process.

DHS noted the primary reasons OHCA denies TFC authorization requests include a child having a developmental level or disability that does not meet the TFC authorization criteria, and a child having behavioral challenges and needs that are too acute to be met in a family-based setting, including a TFC home.[15] That said, DHS still needs more TFC homes to best care for children who do meet the TFC placement criteria. In addition, the department also needs therapeutic placements (family-based and higher-level) that can meet the behavioral and developmental needs of children who are not approved for TFC homes.

[15] Children who are diagnosed with a developmental disability are not eligible for a TFC placement.

Quality of Therapeutic Services and Care in TFC Homes

Through its qualitative review of therapeutic diagnoses, treatment plans and services for 65 TFC placed children, which DHS completed over one year ago, DHS found various deficiencies in the quality and individualized nature of the services these children received. To address the identified concerns regarding the quality and effectiveness of TFC treatment services, DHS committed through its January 2017 enhanced core strategies to establish a multi-disciplinary staffing team for each child, which would include a mental health consultant for children entering or already placed in a TFC home, as well as the child's permanency caseworker.

To meet this commitment, DHS sought to leverage the OHCA requirement that each TFC child's individual treatment plan and clinical progress be assessed every 90 days. Specifically, DHS committed that its TFC liaisons would coordinate efforts between TFC providers and DHS caseworkers and field staff to prepare for each child's 90-day assessment and treatment team meeting. Although the 90-day assessment has been a long-standing requirement, DHS and private agency representatives reported that the assigned permanency caseworkers, although provided a standing invitation to these reviews, generally do not participate in these 90-day assessments. Clearly there is value in a child's permanency caseworker participating in these regularly scheduled sessions, including to ensure everyone has a shared understanding of a child's permanency and treatment goals, objectives and progress. At the same time, DHS recognizes that caseworkers do not always have the clinical expertise to assess a child's treatment needs and progress and, as a result, committed to supporting caseworkers and these discussions with DHS' in-house mental health consultants.

As previously reported by the Co-Neutrals, a lack of staff resources and organizational capacity in the TFC program resulted in DHS not initiating this commitment during the last period. Instead, DHS reported in October 2017 that it shifted to establish a pilot group, focused on one TFC agency, to implement a "standardized process for these reviews that allows for more focus on the quality of care the children are receiving than tracking down staff for paperwork completion." DHS further reported in October 2017 that its goal was to implement a similar process with several other TFC agencies during the following few months.

After the period ended, in March 2018, DHS reported that the one participating agency in the pilot group reported that "scheduling and maintaining vigilant contact with the [permanency caseworker] assigned has increased their participation in the 90-day reviews." The Co-Neutrals are concerned this is the only progress DHS has reported with respect to assessing whether children receive quality therapeutic care in the TFC program. While DHS has reported that it is encouraging all TFC agencies to take a similar approach and be more vigilant in coordinating with assigned caseworkers, the department has not specified what, if any, agency-wide plans or

communications it developed to offer guidance or stress the importance to its caseworkers to participate in these treatment review sessions if a child assigned to them is placed in a TFC.

As of March 2018, the department had still not gathered any particular findings regarding the therapeutic diagnoses, treatment plans and quality of services for the reviewed children despite DHS reporting the goal of its single agency pilot was to focus on the quality of care children receive, rather than tracking down caseworkers.

DHS reported, after the end of the period, that a Master of Social Work practicum student was beginning to work with DHS' mental health consultants to focus on 20 children and conduct "a new type of review to better focus on the quality of care and actual treatment the children are receiving while placed at the TFC agencies." For this review, DHS selected 20 children who have been in a TFC placement for over three years in order to "better understand the lack of clinical progress, specifically with these children, and through review opportunities better understand what is needed for the child to be successful." The Co-Neutrals will report on DHS' efforts and any available findings from this review in their next Commentary.

DHS and the Co-Neutrals have discussed concerns about the quality of TFC services and the preparedness and willingness of TFC families to meet the higher-level needs of children placed in TFC-approved homes. Although DHS identified concerns with the quality of TFC treatment services through its 2016 child case review, the department's focus to address these concerns has been modest, at best. As a result, DHS has not reported any meaningful improvements to the quality of the treatment and therapeutic services children in these homes receive.

TFC Program Improvement Efforts: Maltreatment in Care, Placement Stability and Training

DHS made efforts to address the disproportionate rate of maltreatment experienced by children in TFC homes when compared to other family-based placements for the period of October 2015 through September 2016. Through new provisions included in the department's SFY18 contracts with the TFC agencies, DHS required several specific remedial actions to address confirmed incidents of maltreatment or potential safety risks identified through a maltreatment investigation or referral. DHS' most recent maltreatment data for this period showed a reduction in the number of child maltreatment substantiations in TFC homes.

With respect to placement stability, DHS sought, also through new contract provisions, to reduce placement disruptions in TFC homes through monetary sanctions against the TFC agencies. DHS established that an agency would be sanctioned $250 per placement disruption when the numbers of placement disruptions exceeded the number of successful placement transitions (i.e., moving to a kinship home or trial reunification) an agency makes during each month of SFY18. DHS reported that it issued a total of 16 monetary sanctions during the six- month period of July through

December 2017.

Regarding the specialized pre-service training that TFC foster parents receive to advance their skill set and abilities to safely meet the therapeutic needs of children with behavioral and emotional challenges, DHS identified the need to establish a different training program for TFC homes. Through its analysis of the TFC program in 2016, DHS found that some TFC resource families had not acquired the ability to meet the higher acuity needs of children who DHS places in TFC homes. This identified lack of skill and preparation has contributed to placement instability and maltreatment in TFC homes. DHS found that the supplemental training (Behavior Crisis Management Training), which all TFC families must complete in addition to the 27-hour training (Guiding Principles) that all other foster parents must complete, was outdated and endorses the use of physical therapeutic holds, which can escalate physical encounters between children and their TFC caregivers. After partnering with its consultants to review and evaluate several other training modules used across the country, DHS selected a new pre- service training model (Pressley Ridge TFC) for all TFC families starting in July 2018. Further, starting in August 2018, all new families certified as a TFC home will complete only this training and not have to complete the Guiding Principles training required of all traditional and kinship foster homes.[16]

DHS TFC Program Staff and Capacity

The Co-Neutrals have stressed to DHS that additional efforts are needed to expand the state's pool and continuum of therapeutic, family-based placements as the TFC program has continued to shrink every report period, as represented by: the number of open, available homes; the number of partner agencies recruiting and managing TFC homes in Oklahoma; the number of DHS staff managing the state's TFC program; the number of children placed in TFC homes and the number of children authorized for TFC level services.

Throughout this report period and since the beginning of this reform effort, DHS' TFC program office has operated with an inadequate number of staff, which has impacted the strength of this program and impaired DHS' implementation of its core strategies, particularly with respect to the department's commitment to conduct regular, structured reviews to ensure children are receiving quality and effective therapeutic services. DHS reports the department began to hire more staff for the TFC unit beginning in late 2017.

Over the last several years, DHS acknowledged it had exhausted options to adequately meet the needs of children requiring family-based therapeutic services by relying solely on Oklahoma's existing TFC program. DHS leadership shared that the department needed to

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[16] DHS reports that the exception will be for TFC families who may later decide to adopt a child in DHS custody: these families also will have to complete the Guiding Principles training required of traditional, kinship and adoptive families.

explore a different approach to build its continuum of therapeutic, family-based placements for children in DHS custody who present with varying levels of behavioral, emotional, development and medical diagnoses and needs. In the meantime, DHS continued to work with its contracted TFC agencies to restructure the processes, as discussed above, used within the current TFC program and focus its efforts to expand foster homes with therapeutic services by supporting its TFC agency partners with recruitment training offered by the department's national consultants.

In this report period, the Co-Neutrals raised concerns with DHS regarding the low number of new TFC homes that had been developed, with only nine new TFC homes developed by September 31, 2017 and zero new TFC home approvals recorded for the month of September. The Co-Neutrals met with DHS leadership to urge the department to explore additional family- based therapeutic models that can support the stability, permanency and well-being of children in DHS custody whose caregivers may require additional, specialized supports and services to meet a child's behavioral and emotional needs.

The Co-Neutrals suggested that DHS revisit a review of the state's Systems of Care (SOC) services that are coordinated through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) to assess if the SOC services provided to children in DHS custody and their family-based caregivers represented a form of therapeutic foster care that DHS could maximize through expanded access for children in out of home care.[17, 18]

Although the Co-Neutrals previously understood from DHS that access to SOC services statewide was limited, DHS and ODMHSAS reported in October 2017 that the SOC program was serving 6,500 children (mostly children not in DHS custody) across the state, in 77 counties with two to three providers per county and three to five SOC teams per provider. DHS' liaison to the SOC program reported that DHS had underutilized SOC and that the service providers under the SOC umbrella had as much training, if not more, than those providing services through the TFC program.

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[17] In SFY16, DHS had identified expanded statewide access to SOC services for child in custody as a core strategy to improve placement stability outcomes, starting with embedding SOC coordinators in DHS' Region 4 offices. DHS later reported that the availability of SOC services was limited statewide, which led to DHS and the Co-Neutrals agreeing that SOC services would not remain a part of the department's strategy to advance placement stability.

[18] Oklahoma policy states that its System of Care is a framework that offers a comprehensive array of behavioral health and other support services organized into a coordinated network to meet the multiple and changing needs of children with serious emotional disturbances and their families. SOC offers services that are individualized to each child, family, and community, and includes services that are strengths-based and grounded in partnerships with families that include case management, collaboration with all child-serving agencies and a philosophy of wraparound services.

The Co-Neutrals offered to work with DHS to conduct a case record review of children in DHS custody who receive SOC services to assess if the SOC and TFC programs provide commensurate therapeutic supports and if a child in the SOC program, while placed in a regular kinship or traditional foster home, could "count" toward DHS' Target Outcome for therapeutic foster care. Unfortunately, an initial assessment of the 240 children in DHS custody who were reported as receiving SOC treatment services found that only 14 of these children (six percent) received 12 or more hours of services per month, the minimum service hours that ODMHSAS established for the SOC program. In fact, the data showed that the majority of children received well below the established service standard for the program.

At this point, the Co-Neutrals and DHS agree that the billing data and case information reviewed for the SOC program and services do not indicate that SOC services can be considered equivalent to TFC services, which requires a therapist to provide two hours of service each week (one hour with the child alone and one hour with the child and their TFC caregiver(s)) and that the trained TFC parents conduct therapeutic work with the child for 1.5 hours every day. Although the SOC-serviced homes will not be counted in the state's pool of therapeutic foster homes at this time, the Co-Neutrals encourage DHS to continue discussions and qualitative reviews with ODMHSAS to evaluate how the SOC statewide network of service providers can best support outcomes for children in DHS custody and assess where the state can expand on any successes that the SOC program can report for children in care. As discussed further below in the placement stability section of this Commentary, DHS has since revisited use of SOC as a strategy to help prevent placement disruptions and support stability in foster homes that can safely meet the needs of children who present with behavioral challenges.

At the end of this report period and prior to completing the review of the SOC claims data and selected records for children in custody, DHS included as one of three revised core strategies the hopeful anticipation (of both DHS and the Co-Neutrals) that SOC-serviced homes could help supplement the state's reported pool of therapeutic foster homes toward the Target Outcome for TFCs. Another strategy included in DHS' December 2017 revised TFC core strategies is a plan to convert traditional foster homes to new TFC homes that would count toward the Target Outcome. As a first step in this strategy, DHS committed to develop for the Co-Neutrals' review and approval a proposed protocol to convert these homes.[19]

The remaining strategy that DHS proposed to support its contracted TFC agencies to recruit more TFC homes was assigning one DHS traditional foster home recruiter to partner with one TFC agency and "work events and other recruitment activities together to bring in families

[19] Currently, the criteria for counting new TFC homes do not allow DHS to count homes that are already open as a traditional foster home.

specifically for the TFC program." Through a shared exchange of resources, DHS proposed that the TFC agencies would train the DHS recruiters on the various particulars and information relevant for recruiting TFC homes and DHS would develop new TFC home recruitment materials. As this strategy was proposed at the end of the report period, the Co-Neutrals will provide an update on this effort in their next Commentary.

New Staff Assigned to DHS' TFC Program

In December 2017, DHS further committed to develop a new staff position in the TFC program to serve as the "recruitment navigator/coordinator" for new families coming through the recruitment pipeline and manage the process to convert existing resource families to TFC homes. DHS reported in May 2018 that the new position was approved and was posted for applicants in April 2018, with the selected individual expected to be hired and in the position no later than July 1, 2018.

In addition, DHS announced after the end of the period that it had decided to add to the TFC program office a special unit focused on the statewide recruitment of homes for children with developmental disabilities (e.g. agency companion homes). DHS is moving this unit of recruiters (one supervisor and five child welfare specialists) from DHS' Developmental Disabilities Services (DDS) program office to the TFC program where these specialists will conduct recruitment activities for both TFC and DDS homes to expand the capacity to care for children with higher- level needs in family-like settings. DHS further reported after the end of the period that it planned to hire one additional child welfare specialist (III) to support the daily programmatic operations of the TFC unit.

In DHS' most recent statewide core strategy update to the Co-Neutrals in May 2018, the department reported that it was "going to focus on thinking through alternative options to the current TFC model since the recruitment and retention activities by the private TFC providers is not a long-term sustainable plan for any of them to continue engaging in this work." DHS and the Co-Neutrals have agreed on this for several years now. This does not mean that DHS' current TFC agency partners and TFC homes do not continue to be a valuable component of Oklahoma's continuum of care. However, DHS must now take aggressive and focused actions to bridge the state's placement gap of family-based therapeutic care for children with various levels of specialized needs and fully engage in this alternate planning.

The Co-Neutrals also encourage DHS to actively support the current TFC agencies on ways to implement effectively the recruitment training its TFC partners received over the last year. During a meeting of DHS and the TFC agencies in early November 2017, the Co-Neutrals observed that there was minimal discussion and strategizing on how to expand recruitment of

new TFCs, as well as no coordinated discussion of how to apply the approaches and skills transferred to the agencies through their new training.

The outcome of only 19 new TFC homes developed over six months reflects inadequate efforts to achieve progress toward the Target Outcome. While DHS presented several new strategies at the end of this report period, as well as some resources to help expand the state's family-based therapeutic resources, DHS' efforts to grow its pool of TFC resources were unfocused, untimely and under-resourced during this report period. As a result, DHS reported a net loss of 55 TFC resources over the six months ending in December 2017. The Co-Neutrals do not find that DHS made good faith efforts to achieve substantial and sustained progress toward the new home development and net gain Target Outcomes for TFC resources for this report period.

A strong collaborative effort continues between DHS's Child Welfare Services and Developmental Disabilities Services. A significant push continues to use existing DD resources and develop additional ones to serve dually diagnosed children.

The focus of these efforts is to target placement and support of children at risk of being placed in an emergency placement and/or who are intellectually disabled requiring extra supports for their specific needs. A well-designed strategy is continuing to be developed to build the necessary infrastructure for current service system. Some of the efforts are listed below:

- *Collaborative staffings by CWS/DDS staff to develop and identify placement and supports of children with intellectual disabilities and behavioral challenges.*
- *Development of a model waiver for crisis intervention and community-homes designed for 3 residents with 1:1 staffing's.*
- *ICF/IID treatment center at the Laura Dester Children's Center*
- *Supplemental Support Authorizations Contracts for OJA shelters to provide 1:1 staffing cost reimbursements. This allows for 1:1 staffing when needed at emergency placements.*
- *5 OJA shelters have agreed to take (upon review) emergency placements of higher needs placements.*
- *Expedited Shelter staffings to review placements and permanency goals.*
- *JD McCarty partnership to expedite review of children in need of placement to review if admission is appropriate.*
- *DDS – CWS use of Specialized Foster Care & Agency Companion Homes. All current providers of these services have been contacted and are continuously involved in placement efforts.*
- *Development of radio and TV PSAs by U.S. Senator James Lankford calling for families for*

special needs placements.

- *Expansion of Oklahoma Fosters field recruiters focusing only on to the development of special needs placements.*
- *CWS and DDS have been immediately responding to any request from Group Home providers for support and training of program staff.*
- *Immediate review of referrals and program documentation for providers that have special needs placements.*
- *Further contracting with Liberty Corporation for training and outreach to foster families and group homes to increase stabilization.*
- *Nursing Care and expansion for targeting placements of higher-needs children.*
- *Continual outreach to all current Specialized Foster Care & Agency Companion homes to match children in need of placements.*

There are additional children within TFC placements, both tribal and CFC, that are not calculated in the TFC data. DHS is having to compete for bed space with other resources, i.e., approximately 60 kids in CFC. DHS has begun efforts to assess the feasibility of continued placement of CFC youth in TFC homes. CFC resources serve dually diagnosed children when there are no other placement options through DDS or Child Welfare.

C. Caseworker Caseloads and Supervisor Workloads

Establishing and maintaining manageable caseloads for child welfare caseworkers is essential to child safety, well-being and permanency. DHS committed to achieve the following caseload standards for child welfare workers and workload standard for supervisors:

Table 2: Pinnacle Plan Caseload and Workload Standard Commitments

Role	Standards	Weight Per Case
CPS	12 Open Investigations or Assessments	0.0833
OCA	12 Open Investigations	0.0833
Family Centered	8 Families	0.125
Permanency Planning	15 Children	0.0667
Resource Family	22 Families	0.0455

Adoption	16 Children	0.0625
Supervisors	1 Supervisor Dedicated to 5 Workers	0.2 per worker

During this report period, DHS maintained caseload performance substantially better than its baseline at the outset of this effort. That said, during the period DHS continued to experience a dramatic increase in the number of referrals accepted for investigation, specifically during the summer and early fall of 2017. This contributed to a sharp rise in the number of overdue maltreatment investigations. As of November 2017, the backlog of overdue child maltreatment investigations had reached more than 800 cases. The increase in investigations contributed to a decline in caseload compliance, which was further evidenced during the reporting period by a divergence in two critical data points: total workload (all cases assigned and managed) and the workload capacity DHS caseworkers are eligible to carry under the caseload standards. By the

end of September 2017, DHS' data showed that for the first time since the summer of 2016 total workload exceeded total workload capacity.

As a result, DHS did not make gains in the number of caseworkers meeting caseload standards, and in fact, reported a decline in caseload performance by the end of the period (December 31, 2017) as compared to the end of the previous period (June 30, 2017). As investigations surged during the period, and the CPS backlog grew, DHS proactively developed and implemented a Workload Improvement Plan (WIP) to hire more workers, maximize existing workforce capacity by temporarily increasing the number of cases a new caseworker can carry under the department's graduated caseload program and launching an overtime plan.[20] DHS' data shows that while the number of caseworkers meeting caseload standards declined this period compared to the previous reporting period, DHS was able by the end of the period to improve its performance from its lowest ebb during the period. The department also reduced the number of CPS cases overdue for resolution, which totaled 618 on December 31, 2017, and reduced the number of workers carrying a caseload over 200 percent of the caseload standard. DHS responded with focus to the workload challenges encountered this period and made good faith efforts to protect the substantial and sustained progress it has made toward the Target Outcomes in prior periods.

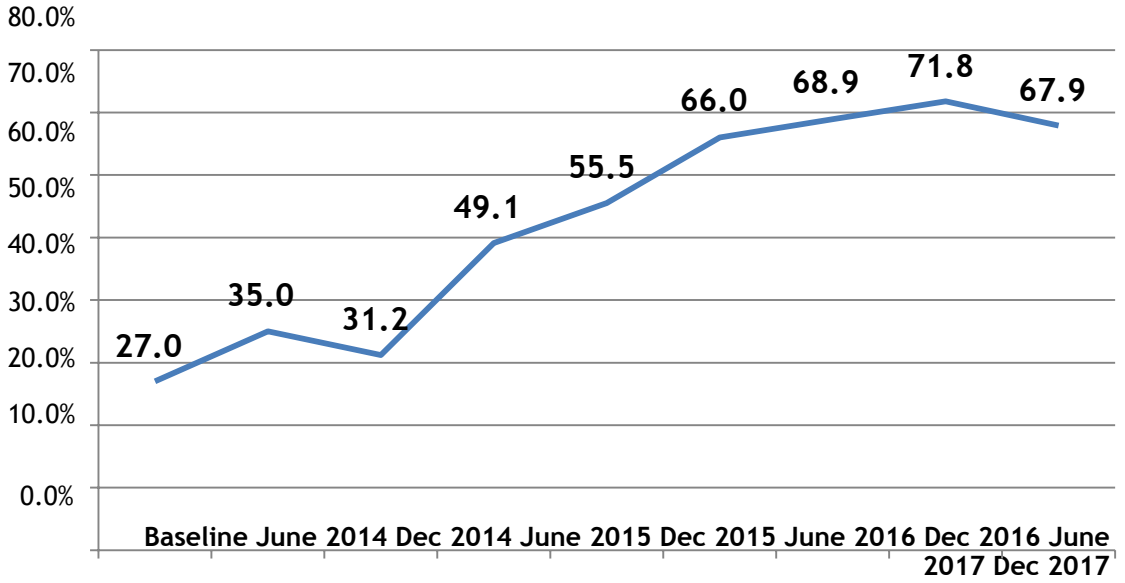
To achieve its caseload Target Outcomes in 2018, DHS developed a Workload and Hiring Plan that commits the department to hire 547 caseworkers by December 31, 2018 and includes district-specific plans to support hiring and retention goals. The Co-Neutrals will continue to monitor DHS' implementation of its Workload and Hiring Plan to assess whether the department continues to make good faith efforts to achieve substantial and sustained progress toward the Target Outcomes.

Performance – Target Outcomes
Quarterly Caseload Data (October-December 2017)

DHS reports that 67.9 percent of all caseworkers met the established caseload standard for the last three months of the period (October 1, 2017 – December 31, 2017). Since last period, DHS' quarterly caseload performance declined from 71.8 percent of caseworkers meeting the caseload standard.

[20] In February 2018, DHS made permanent the modified graduated caseload assignments, which is discussed in greater detail in this section.

Figure 10: Worker Caseloads: Percent of Workers Meeting Caseload Standards



Source: DHS Data

DHS' quarterly performance for the first three months of this report period (July 1, 2017 – September 30, 2017) showed a slight improvement in performance compared to caseloads in the preceding quarter (April 1, 2017 – June 30, 2017) of the last period. For the first three months of the current period, DHS reports that 72 percent of caseworkers met the caseload standard. The decline in caseload performance from the first to second quarter (72 percent to
67.9 percent) of this report period was largely due to the steadily increasing number of investigations assigned to caseworkers. The spike in assigned cases peaked in mid-October 2017, which corresponded to DHS' lowest caseload performance during the six-month period.

Point in Time Caseload Data

According to the point in time (PIT) data from the end of this report period, DHS reports that 70.5 percent of all caseworkers met the established standard on December 31, 2017. When compared to the PIT data at the end of the last report period, DHS' compliance decreased by
6. percent from 80.1 percent.

On December 31, 2017, caseload compliance by worker type varied, as detailed in Table 3 below. Recruitment workers maintained the highest caseload compliance (94.7 percent), while ATU workers maintained the lowest (42.7 percent).

Table 3: Caseload Compliance by Worker Type – December 31, 2017

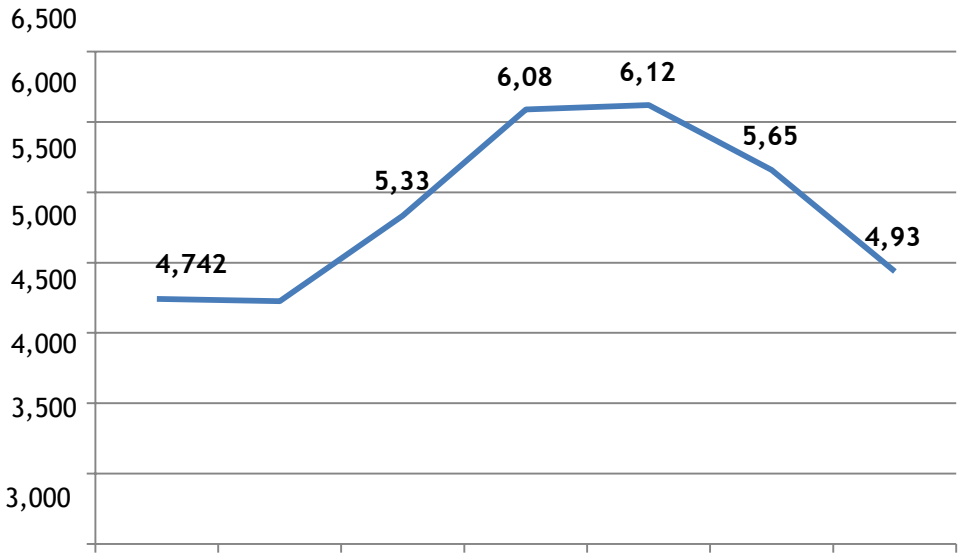
WORKER TYPE	MET	TOTAL	% MEETING
INVESTIGATION	259	411	63.0%
PERMANENCY PLANNING	514	725	70.9%
PREVENTIVE / VOLUNTARY	56	83	67.5%
FOSTER CARE / ADOPTION	216	260	83.1%
ATU	16	38	42.1%
RECRUITMENT	36	38	94.7%
TOTAL	**1097**	**1555**	**70.5%**

Causes of Decline in Caseload Compliance this Period

Rise in Investigative Cases

During this period, DHS' data showed a marked increase in the number of accepted investigations compared to last period. In October 2017, caseworkers were responsible for 1,379 more investigations than at the end of June 2017. This reflects a nearly 30 percent increase in CPS cases in just over three months. This substantial increase in investigative cases placed tremendous pressure on caseworkers who were assigned many more cases to investigate. For example, caseworkers in Oklahoma City were responsible for 484 more investigations in October than in June, and Tulsa caseworkers had 237 more investigations added to their caseloads.

Figure 11 : Investigative Cases, June 2017 to December 2017



June 2017 July 2017
Aug 2017 Sept 2017
Oct 2017 Nov 2017
Dec 2017

Source: DHS Data

The increase in investigations resulted in a drop in caseload compliance. In October 2017, only 65 percent of caseworkers met the caseload standard, a drop of 15 percentage points from June 2017. Some workers and districts experienced the rise in workload even more acutely. For example, caseload compliance for investigators fell from 72 percent compliance in June 2017 to just over half (51 percent) of investigators meeting the standard on October 17, 2017. By the end of the reporting period, DHS' efforts through the implementation of its WIP reversed these troubling trends and positioned the agency to make gains again.

At the end of the report period, DHS reported having onboard 1,695 case carrying staff, including 1,555 who were managing at least one case. Of the remaining 140 caseworkers not carrying a case, 105 were still early in their training and not yet eligible to receive case assignments. This is the largest reported increase of caseworkers on board, but not yet eligible to carry cases, since March 30, 2016, when there were 135 new caseworkers in this status. The increase in the number of new staff between periods demonstrates that DHS continued to hire and move new caseworkers through the pre-service training program.

DHS reported that despite its hiring to backfill positions, the department experienced a net loss of staff due to turnover. Since June 28, 2017, the total number of caseworkers statewide decreased by 43 from 1,738 to 1,695 caseworkers as of December 31, 2017. Further, the number of case-carrying staff decreased by 66, from 1,621 last period to 1,555 this period. The result of DHS' staff attrition was a loss in the total case carrying capacity of all caseworkers on board for the period.

Workload Performance Improvement Plan

DHS developed and implemented its WIP, effective October 31, 2017, to respond to the increase in the investigative caseload and the simultaneous net decrease in the number of caseload carrying staff. (See Appendix C) In its plan, DHS articulated:

> *"An increase in the number of overdue investigations and assessments combined with an increase in the overall number of pending, is an indication that if we do not make adjustments quickly, we will lose the workforce stability we've diligently worked to achieve. Therefore, in addition to expediting recruitment, hiring and onboarding efforts to ensure the right number of staff are in place, immediate adjustments in workload distribution are required to stabilize the workforce."*

The plan consists of the following three primary strategies to increase workload capacity:

1. *Adjustment to graduated workload standard.* DHS implemented graduated caseloads in 2015 as a central strategy to increase retention of new workers. The original commitment was to assign new caseworkers, after finishing CORE

training, 25 percent of

a caseload for the first three months on the job. Subsequently, at six months, a worker is assigned a 50 percent workload and at nine months, a full caseload of 100 percent. DHS effectively implemented graduated caseloads and protected most of its new workers from being assigned a full caseload prior to nine months on the job. For example, last period, 91 percent of caseworkers eligible for graduated caseloads met their 25 or 50 percent caseload standard.

To increase workload capacity, DHS modified the graduated workload standards from 25 to 50 percent of a workload for the first three months, and at six months, from 50 to 75 percent of a workload. DHS reported by increasing graduated caseload assignments, the department would have greater workload capacity. DHS instructed supervisors to give careful consideration to new workers' individual skill level and development when making graduated caseload assignments as some new caseworkers may need to start with a lighter workload.

DHS leadership and the Co-Neutrals separately received extensive feedback from workers in the field that the original 25 percent graduated caseload for new workers was often not demanding enough, while the subsequent jump from 50 to 100 percent of a caseload at nine months was too much of an increase for some new workers to manage effectively. On December 31, 2017, using the new graduated caseload assignments, DHS reported that 97 percent of staff eligible to carry a graduated caseload met the standard. Effective February 16, 2018, DHS made permanent the modified graduated caseload methodology.

2. *Adjustment to workload standard.* For the 11 districts that did not have the workforce capacity to meet their total assigned workload as of October 30, 2017, DHS temporarily revised their workload target and allowed supervisors to increase the number of cases both investigators and permanency workers could carry to distribute the burgeoning workload more evenly. DHS leadership temporarily allowed for permanency workers to be assigned an additional three children (18 children total) and CPS investigators to be assigned an additional two cases (14 cases total).[21]

3. *Overtime plans.* For those districts with the highest number of investigations and assessments in backlog status, DHS utilized overtime plans to increase workforce capacity.

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[21] The revised workload standard is used only by DHS as an internal management strategy for those districts that do not have a sufficient workforce to meet their total workload. DHS continues to report caseload compliance to the Co-Neutrals using the original caseload standards, which have not changed.

Initial Progress after WIP Implementation

Following the implementation of the WIP in late October 2017, DHS' data at the end of the period indicates improvement in these areas:

1. *Increased number of caseworkers meeting the caseload standard*. At the end of June 2017, 80.1 percent of caseworkers met the caseload standard. By the middle of the current period, only 65 percent of workers met the standard. During November and December 2017, the percent of caseworkers meeting the caseload standard steadily increased. The average caseload compliance for November 2017 was 68.6 percent and for December 2017 was 69.3 percent. By the end of December 2017, 63 additional workers were meeting the caseload standard when compared to October 1, 2017.

2. *Rise in total workforce capacity.* At the end of June 2017, DHS reported a total workforce capacity of 1,525. By mid-October 2017, total workforce capacity had dropped to 1,449, representing a deficit against the 1,507 total workload assignments. During November and December 2017, total workforce capacity progressively increased and by December 31, 2017, reached 1,495.

3. *Reduction in CPS investigative cases.* During the period, DHS significantly reduced the total number of investigative cases assigned to caseworkers. At the end of the period, DHS reported 4,938 investigative cases, a nearly 20 percent drop in cases from mid- period when the total number of investigative cases exceeded 6,000. At the close of last period, DHS reported 349 cases in its backlog. During the current period, the backlog had reached over 800 overdue investigations. At the end of December 2017, DHS' data showed 618 cases in overdue, backlog status.

4. *Drop in the number of caseworkers carrying a caseload over 200 percent*. During the first half of the current period, the number of caseworkers with a caseload over 200 percent of their respective standard more than tripled from 18 caseworkers in July 2017 to 65 in October 2017. On December 31, 2017, DHS reported only 14 caseworkers with a caseload over 200 percent, a nearly 80 percent reduction from October 2017.

These improvements reversed worsening trend lines on key caseload indicators and averted a more significant downturn in DHS' caseload performance for this period.

Workload and Hiring Plan

In March 2018, DHS began implementation of a statewide Workload and Hiring Plan that establishes the roadmap for DHS to achieve its caseload Target Outcomes this year. (See

Appendix D) The plan consists of a hiring strategy to bring onboard by December 31, 2018, 547 new staff across DHS' 27 districts and foster care and adoption units. Of these 547 positions, DHS reports 276 are positions currently vacant and the remaining 271 positions will need to be backfilled due to DHS turnover estimates. To establish its hiring plan, DHS used historical workload data to project, by district, the number of staff needed not only to meet, but exceed, total workload assigned. In its plan, DHS stated, "…DHS must ensure it has adequate staff hired and able to carry cases so that the capacity is greater than the workload."

A review of DHS' data at the end of this period shows that 21 of the 29 child welfare districts in Oklahoma had the capacity to either meet or exceed their total workload, without accounting for projected attrition, while eight districts did not have sufficient caseworker staffing capacity to meet their total workload. Of the eight districts that did not have the caseworker staffing capacity to meet their total workload, three districts required three or fewer additional workers to meet their total workload. DHS' hiring plan includes hiring a sufficient number of additional staff for each of these eight districts to exceed their current total workload.

While most districts had the capacity to meet or exceed their total workload at the end of the period, DHS' data shows that the majority of districts (72 percent or 21 out of the 29 districts) did not meet 90 percent caseload compliance on December 31, 2017.[22] The disparity between these two data points (most districts have either the capacity to meet or exceed their workload and most districts' caseworkers did not meet the caseload standard) reflects the reality that while a district may have enough staff to meet its total workload, the distribution of work in a district between the types of workers and types of cases assigned often do not align. These realities support DHS' commitment to hire a sufficient number of staff to exceed a district's total workload in order for districts to be able to effectively respond to the daily fluctuations in the type, volume and special characteristics of a district's total workload.

[22] Of the 21 districts where caseworkers did not meet 90 percent caseload compliance, six districts' caseworkers had between 80 and 89 percent compliance; seven districts between 60 and 79 percent compliance; and the remaining eight districts' caseworkers had below 60 percent caseload compliance. It is important to highlight that while a district's caseworkers may not collectively meet 90 percent caseload compliance, some of that district's caseworkers may carry caseloads in compliance. For example, District 17 reported 75 percent caseload compliance on December 31, 2017. While this district did not meet the 90 percent standard, 21 of the district's 28 caseworkers' caseloads met the standard.

Figure 12 : District Capacity to Cover Workload and Caseload Compliance[23]

District	Capacity to Cover Workload	Capacity to Cover Workload	90% of Workers Meeting Std.	% of Workers Meeting Std.
1	145 %	Y	Y	100 %
2	137 %	Y	N	89%
3	119 %	Y	N	82%
4	102 %	Y	N	61%
5	121 %	Y	N	80%
6	87%	N	N	43%
7	105 %	Y	N	71%
8	86%	N	N	38%
9	135 %	Y	Y	93%
10	66%	N	N	50%
11	134 %	Y	Y	95%
12	130 %	Y	N	86%
13	110 %	Y	N	67%
14	81%	N	N	35%
15	138 %	Y	Y	93%
16	154 %	Y	Y	96%
17	122 %	Y	N	75%
18	111 %	Y	N	82%
19	110 %	Y	N	74%

20	92%	N	N	48%
21	93%	N	N	55%
22	144 %	Y	Y	100 %
23	137 %	Y	Y	92%
24	122 %	Y	Y	93%
25	98%	N	N	50%
26	91%	N	N	37%
27	109 %	Y	N	66%
Adoption	146 %	Y	N	72%
Foster Care	115 %	Y	N	83%
STATE	**109 %**	**Y**	**N**	**70. 5%**

[23] In the Figure, a district shaded yellow means that the district has the workforce capacity to meet its total workload, however, has less than 90 percent of its caseworkers meeting the caseload standard; a district shaded red means that the district does not have the workforce capacity to meet its total workload and less than 90 percent of its caseworkers are meeting the caseload standard; and a district shaded green means that the district has the capacity to meet its total workload and at least 90 percent of its caseworkers are meeting the caseload standard.

Of the 21 districts not meeting 90 percent caseload compliance at the end of the period, seven districts reported having 50 percent or fewer caseworkers meeting the caseload standard. For these districts, many of which have persistently struggled with low caseload compliance, DHS must be particularly focused in its efforts to improve caseload compliance. In its hiring plan, DHS identified most of these seven districts as requiring greater managerial attention to fill their vacant positions, which has been a challenge noted by DHS.

Included in DHS' Workload and Hiring Plan is an individual plan for each region, and its districts, to accomplish each district's specific hiring and retention goals by December 31, 2018. The plans set forth a diverse set of strategies unique to specific regional/ district needs, which include strengthening tracking, monitoring and managing of caseloads; improving the selection process to ensure the right candidates are hired; and, supporting caseworkers through improved mechanisms for staff to provide feedback. For many of the seven districts with 50 percent or fewer caseworkers meeting the caseload standard, regional plans include strategies to leverage personnel among better-staffed districts and these under-staffed districts to maximize staffing and case assignments.

The last component of DHS' Workload and Hiring Plan involves a commitment to reduce the percent of staff carrying excessively large caseloads. DHS has committed to:

- By July 1, 2018, no staff will have a caseload that exceeds 200 percent of standard;
- By October 1, 2018, no staff will have a caseload that exceeds 175 percent of standard; and,
- By December 31, 2018, no staff will have a caseload that exceeds 150 percent of standard.

As noted above, by the end of December 2017, 14 of 1,555 caseworkers carrying at least one case had a caseload that exceeded 200 percent of standard, bringing within reach DHS' first goal of eliminating its largest caseloads. The Co-Neutrals will closely monitor DHS' implementation of its Workload and Hiring Plan and continue to assess the Department's efforts to make meaningful gains in caseload compliance.

Performance Standards and Target Outcomes – Supervisor Workloads

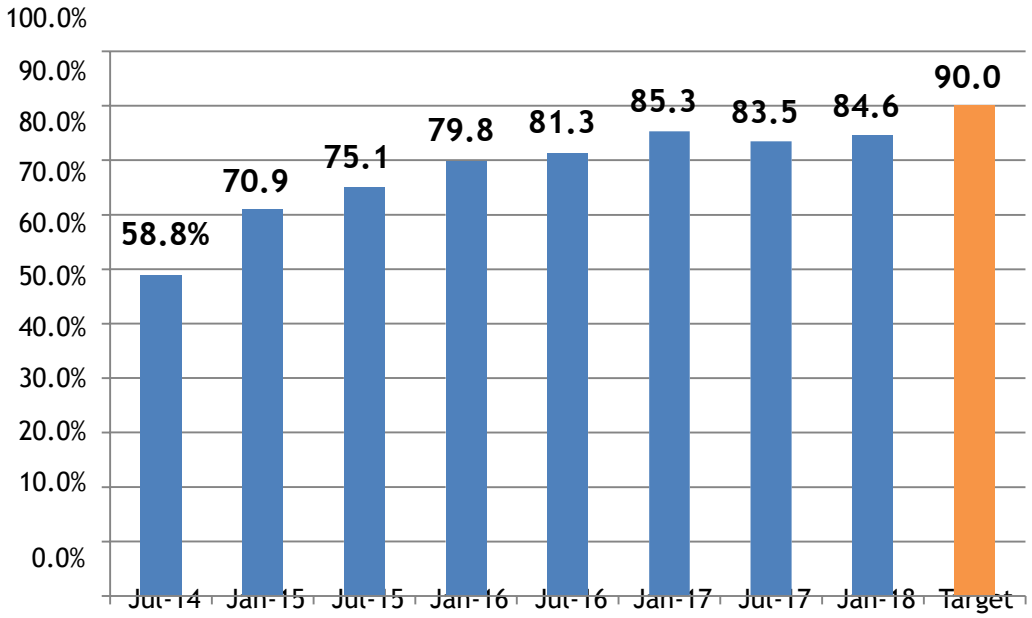
DHS understands that strong supervisory support for caseworkers, especially new caseworkers, is essential to supporting effective and consistent child welfare practice and positive outcomes for children and families. DHS committed to meet the same final Target Outcome for supervisor workloads as it did for caseloads: 90 percent of supervisors meeting the 1:5 caseworker ratio.

As of December 31, 2017, DHS' data showed that 84.6 percent of supervisors met the

1:5 workload standard, compared to 83.5 percent on June 28, 2017. As the chart below shows,

over this reform effort, DHS has made substantial and sustained progress from the baseline toward the Target Outcome.

Figure 13: Supervisor Workloads: Percent of Supervisors Meeting Workload Standards



Source: DHS Data

DHS reported a slight, positive decline in the number of supervisors who are assigned and manage their own cases. Child welfare cases managed by supervisors carry the same case weight as the cases managed by caseworkers and are calculated into each supervisor's workload ratio. As of December 31, 2017, 21 supervisors carried more than two cases, a slight worsening from the 15 supervisors who carried more than two cases on June 28, 2017.

For this report period, the Co-Neutrals again find that DHS has made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for meeting supervisor workload standards.

D. Shelter Use

In light of the systemic stressors placed on the foster care system, particularly to provide care for children with the highest of needs, DHS argues its efforts to adequately care for these children were sufficient to demonstrate good faith. Since December of 2012, it is estimated no less than 222 provider beds were lost across the spectrum of facility care. The Department made great strides to fully utilize the remaining resources at its disposal and to develop new resources to ensure the children who entered its care and the children needing to transition between placements had appropriate care and a place to sleep. These efforts, however, do not receive adequate attention from the Co-Neutrals.

DHS has made important strides toward its goal of eliminating shelter care for the youngest children in DHS custody. For the third consecutive period, no child, ages one year or younger, experienced a shelter stay, and only four children between the ages of two and five experienced a shelter stay this report period. Oklahoma has become rooted in a case practice that ensures, except in the rarest of circumstances, that the youngest children in DHS' custody are not placed in shelters. The Co-Neutrals find DHS made good faith efforts during this periodto achieve substantial and sustained progress toward the shelter Target Outcomes for Metrics
5.1 (children ages 0 to 1 years old) and 5.2 (children ages 2 to 5 years old).

DHS has not achieved this critical progress for children six years of age and older who continue to be placed too often in shelters across Oklahoma. For children in this age group, particularly those with behavioral, developmental, and/or mental health issues, shelter care is sometimes, still, the only placement option. As the Co-Neutrals have highlighted in multiple prior Commentaries, the significant lack of placement options for children with specialized needs has perpetuated DHS' ongoing reliance on shelter care.

In addition to the lack of placement options for children who experienced a shelter stay this period, DHS' efforts to prevent shelter placements and to reduce the length of time children remain in shelters were not adequate during this period. In particular, DHS' principal practice to expedite children's exit from shelters to needs-based placements lacked sufficient leadership oversight and guidance to ensure the practice urgently and effectively identified and secured appropriate placements for children outside of a shelter. DHS leadership acknowledged that the intensity of its practice of reviewing every shelter placement request to ensure that all potential family-based placements had been exhausted before a child enters a shelter had waned. This is evident by DHS' own findings on a sample review of shelter authorizations during the months of October and November 2017.

For this period, DHS reported a nearly 30 percent increase in the number of shelter nights children ages six to twelve experienced. This represents the third consecutive period of increased shelter nights for this age group. While the number of shelter nights children 13 and older experienced declined modestly this period relative to last period, the number of shelter- nights older youth experienced this period far exceeded the Target Outcome DHS committed to of 8,850 nights by June 30, 2016. In addition, for those youth who did experience a shelter stay, an increased percentage experienced more than 30 shelter nights and/or more than one shelter stay when compared to the last report period. The Co-Neutrals do not find that DHS made good faith efforts during this period to achieve substantial and sustained progress toward the shelter Target Outcomes for Metrics 5.3 and 5.4, which measure the number of nights children ages six and older spent in shelters and Pinnacle Plan 1.17, which captures in greater detail the number of older youth who experienced more than 30 nights in a shelter and/or multiple shelter stays during the period.

The majority of children who experience shelter care in Oklahoma are placed at Youth Service Agency (YSA) shelters. During the current report period, maltreatment at these shelters increased. During the last report period, a total of four children were maltreated in YSA
shelters, as reflected in two substantiated referrals, while during this report period, 11 children were maltreated in YSA shelters, as reflected in six substantiated referrals. The high incidence of maltreatment in shelters is concerning and demands DHS' urgent attention to resolve. It also underscores the inherent challenges related to shelter care, which involves placing numerous children in one space together with diverse needs, ages, and sexes. Understanding the risks related to shelter care, it is incumbent upon DHS to effectively employ its resources, with a sense of urgency, to substantially and sustainably reduce the shelter population in Oklahoma.

Performance Standards

DHS committed that it would "ensure all children are cared for in family-like settings"

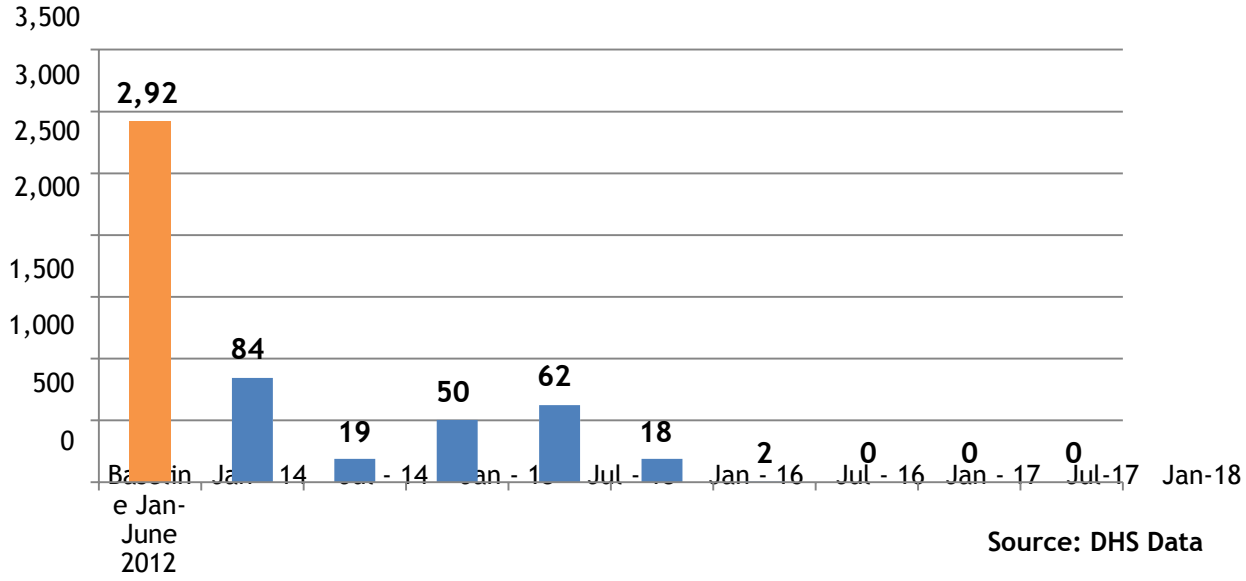
and “stop its use of temporary placement in shelters for all children under 13 years of age.” In the Metrics Plan, the Co-Neutrals selected the number of “child-nights” spent in shelters as the measure to assess Oklahoma’s progress in eliminating and reducing shelter use. One “child- night” is defined as “one child in a shelter at midnight.” The total number of child-nights is calculated by summing the number of children in shelters at midnight for each night of the reporting period. The Pinnacle Plan includes an exception for shelter placement if the child is part of a sibling set of four or more being placed together. The Co-Neutrals have also allowed for the exception to place a minor parent with their child if necessary to keep the parent and child together (note that the child must, in fact, be placed with their minor parent).[24] However, while the Co-Neutrals approved these exceptions, they are not automatic. For each child or youth in need of placement, DHS has committed to undertake reasonable efforts to place the child in a family-like setting, regardless of whether the child meets an exception.

Performance for Children under Age Six, Shelter Metrics 5.1 and 5.2

For the third consecutive period, DHS has achieved the Target Outcome of zero child-nights in shelters for children under two years of age. DHS has successfully eliminated shelter care for this youngest cohort of children from its baseline of 2,923 child-nights to zero for the third consecutive report period.

[24] Children who meet the criteria for one of the two exceptions are included in the shelter outcomes data.

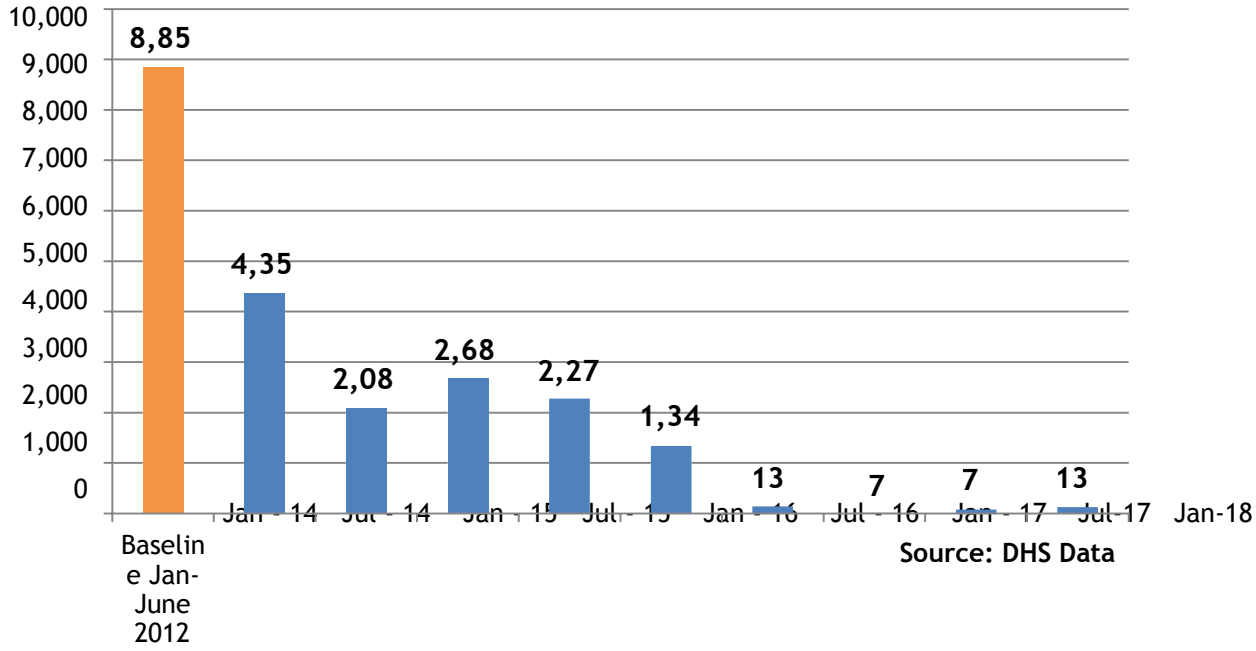
Figure 14: Metrics 5.1 – Shelter-Nights, Children Ages 0 - 1



Source: DHS Data

For children ages two to five, the original baseline recorded was 8,853 child-nights, and DHS' most recent data shows that while DHS did not meet the Target Outcome of zero-child nights for this age group, DHS remains close to meeting this Target Outcome. For this period, July 1, 2017 to December 31, 2017, four children spent a combined total of 130 nights in a shelter. In comparison to the last report period, DHS' data shows one fewer child experienced a shelter stay this period. The data also shows an increase this period in the total number of shelter- nights children this age group experienced, going from 75 nights last period to 130 shelter nights this period.

Figure 15: Metric 5.2 – Shelter-Nights, Children Ages 2 – 5

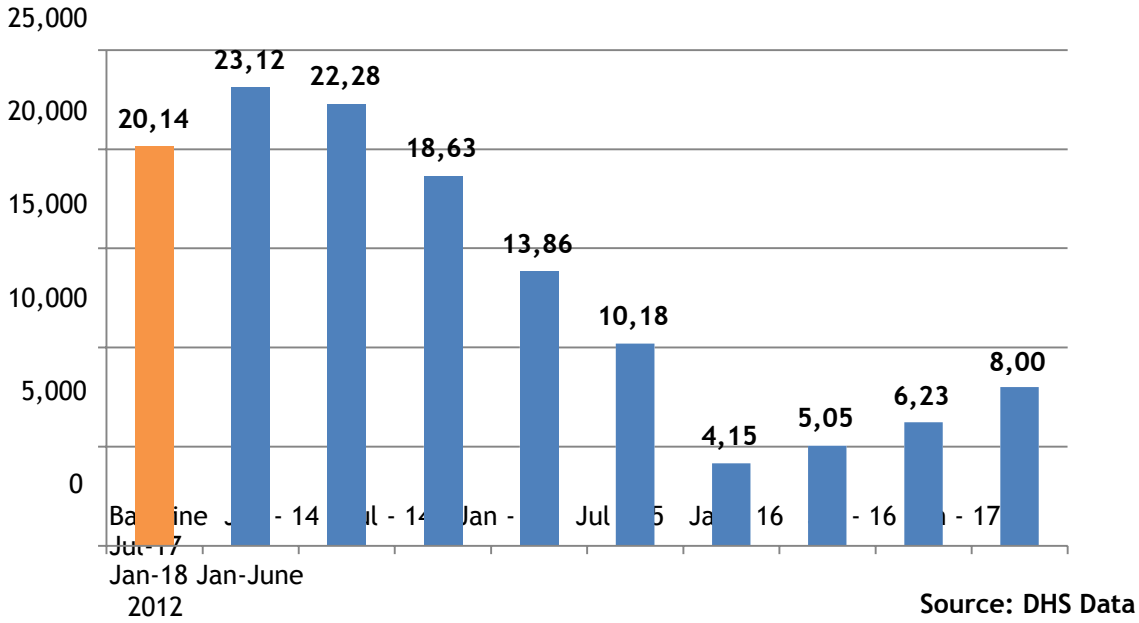


Shelter Metric 5.3 – Children Ages Six to 12

For children ages six to 12, DHS reports this period an increase in the number of child-nights experienced by this age group. This period, DHS reported 8,002 child-nights compared to 6,232 during the previous six-month period. These shelter nights represent 163 unique children, which is 13 more children than DHS reported spent a night in a shelter last period. As the Figure below presents, this is the third consecutive period the number of child-nights has increased for this age group. In particular, children ages six to 12 experienced a concerning 92 percent increase in child-nights since July 2016 when DHS achieved a record low number of 112 children in this age group experiencing a shelter stay.

It is important to highlight not only DHS' commitment to achieve zero shelter nights for children under the age of 13 but also to ensure that children under 13 years old are placed in family-like settings, which includes avoiding placements for these children in group home settings or other types of institutional care, except in rare circumstances such as when a child requires hospitalization.

Figure 16: Metric 5.3 – Shelter-Nights, Children Ages 6 – 12



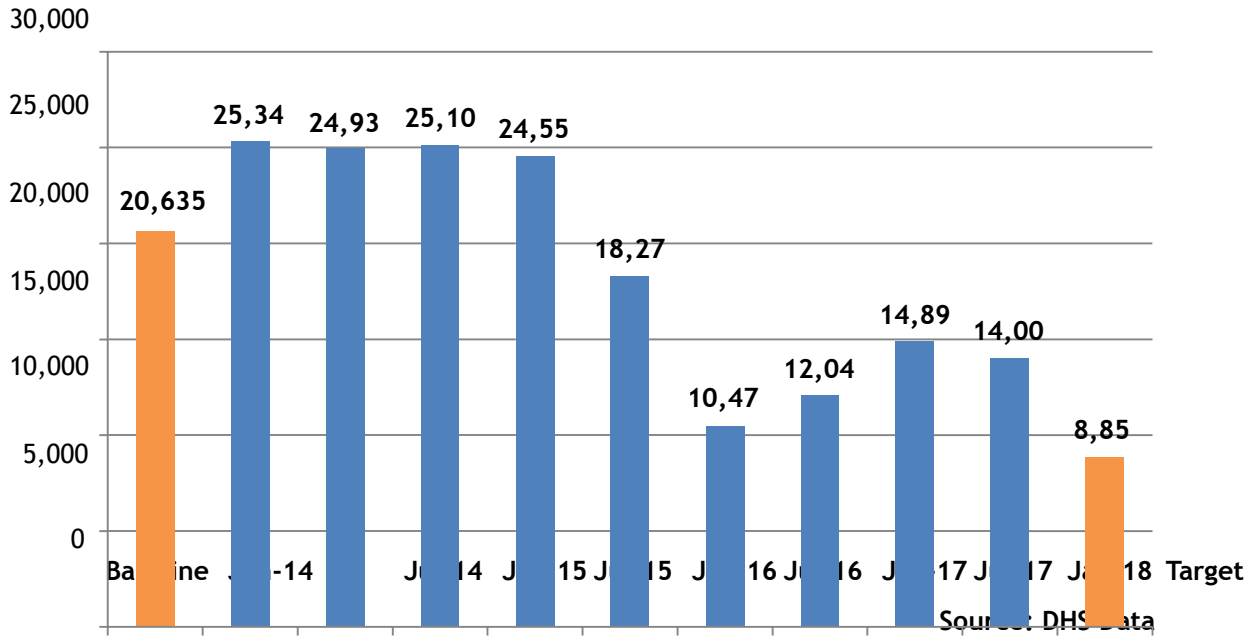
Source: DHS Data

Shelter Metric 5.4 and Pinnacle Plan Commitment 1.17 – Youth 13 and Older

Neither DHS' Pinnacle Plan nor the Compromise and Settlement Agreement require that emergency shelter usage for children 13 years and older be completely eliminated. However, DHS did commit under the Pinnacle Plan (Point 1.17) that by June 30, 2014, children ages 13 and older would be placed in a shelter only if a family-like placement is not available to meet their needs; and further, DHS would not place any child over age 13 in a shelter more than one time and for no more than 30 days within a 12-month period.

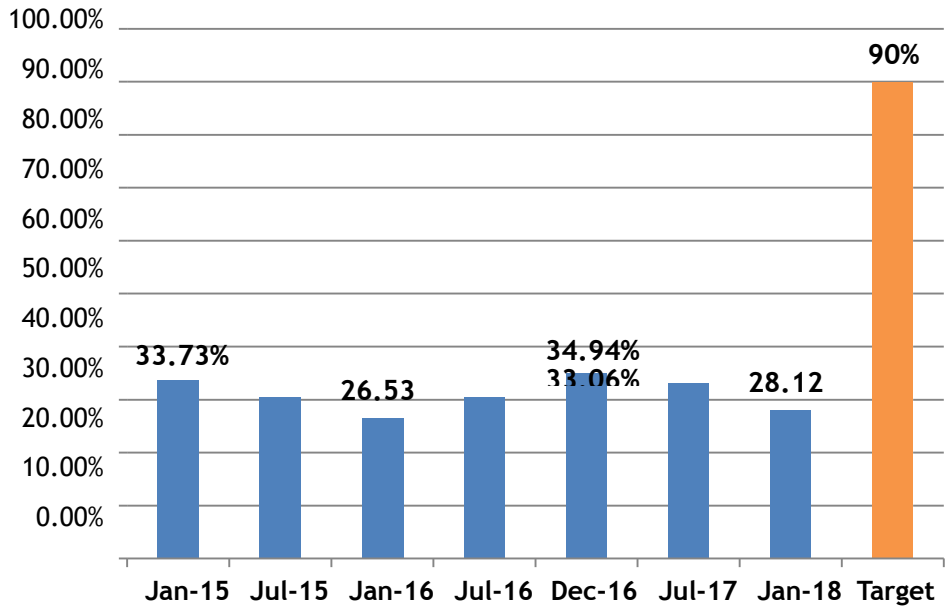
For this report period, the number of unique children ages 13 and older who spent a night in a shelter decreased from 366 children in the last period to 313 children this period. DHS reported 14,000 child-nights for this oldest group of children, which represents a slight decrease from last period when DHS reported 14,893 child-nights. As shown in the Figure below, while DHS has reduced the number of child-nights for this period, the number of nights older youth experienced in a shelter this period is still 34 percent greater than in July 2016 when DHS achieved the lowest number of shelter nights for this age-group. Further, DHS has not substantially and sustainably reduced the number of shelter nights for this age-group in order to meet its commitment of 8,850 child-nights by June 30, 2016.

Figure 17: Metric 5.4-Shelter Nights, Children Ages 13 and Older



DHS committed that by June 30, 2016, 90 percent of all children ages 13 and older who experience a shelter stay would be in compliance with Pinnacle Plan 1.17, which requires that these older youth experience no more than one shelter stay and no more than 30 shelter-nights in any 12-month period. For the period of July 1, 2017 to December 31, 2017, DHS reported that 28.1 percent (88) of the 313 children ages 13 and older with an overnight shelter stay were placed consistent with Pinnacle Plan 1.17, but 225 children were not. This represents a decline in performance from last period when DHS reported that 33.1 percent of children were compliant with Pinnacle Plan 1.17. In addition, this is the second consecutive period DHS' performance on this measure was below the baseline of 33.7 percent of children compliant with this commitment.

Figure 18: Pinnacle Plan 1.17 Performance



Source: DHS Data

Reducing Shelter Usage for Children

While DHS' performance this period for children ages six to 12 years old reflects an increase in shelter usage, DHS has significantly reduced shelter usage for children of all ages in Oklahoma over the past four years. The primary two practices DHS has utilized to effectively reduce shelter care are: multidisciplinary staffings to expeditiously identify needs-based placements for children in shelters and a heightened review process by leadership to ensure for each child placed in a shelter an exhaustive search is undertaken to identify a needs-based placement in lieu of shelter care.

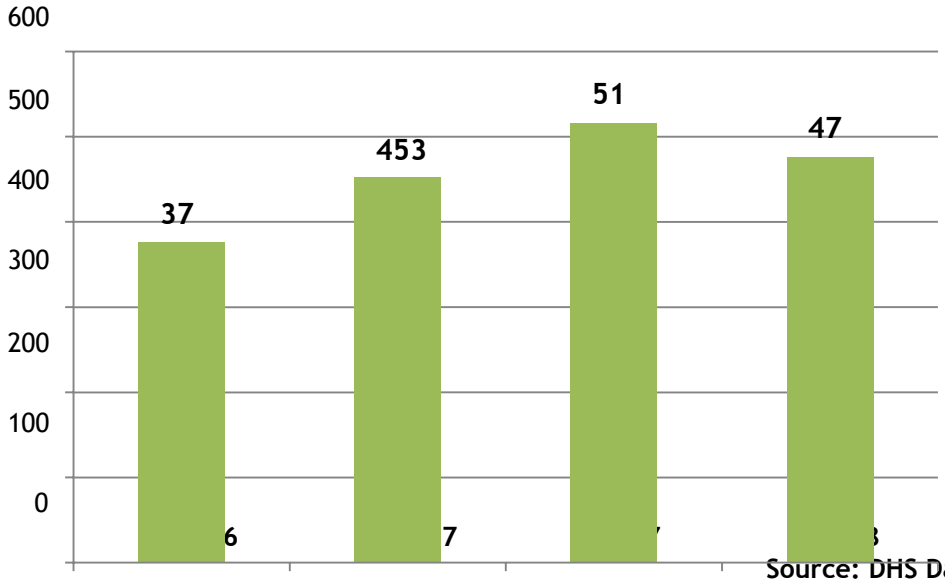
Table 4: Child-Nights in Shelters by Age, January 2017 to December 2017

Child-Nights in Shelters by Age	Baseline (Jan 2012-June 2013)	Performance (July 2017-December 2017)	Change (N)	Change (%)
0 to 1	2,923	0	-2,923	-100.0%
2 to 5	8,853	130	-8,723	-98.5%

6 to 12	20,147	8,002	-12,145	-60.3%
13 & Older	20,635	14,000	-6,635	-32.2%
TOTAL	**52,558**	**22,132**	**-30,426**	**-58%**

The progress DHS has made toward reducing shelter usage during this reform most markedly materialized during the period of January 1, 2016 to June 30, 2016 when DHS successfully reduced the total number of children using shelter care to 382 children down from 1,212 children eighteen months prior. Since June 30, 2016, DHS has not made or sustained further reductions in shelter usage for children six years of age and older, as the chart below illustrates.

Figure 19: Number of Unique Children Six Years and Older, July 2016 to January 2018



Source: DHS Data

As discussed above, the greatest challenge to DHS' ability to meet its commitment to eliminate shelter care for children 12 years of age and younger and significantly reduce shelter care for youth 13 years of age and older is the extreme lack of available needs-based placements for children with increased behavioral, mental or developmental needs. Until DHS effectively develops and retains an adequate placement continuum that is able to serve the diverse needs of children in DHS custody, DHS will continue to struggle to reduce shelter care in Oklahoma as envisioned by the CSA.

Since this placement continuum does not yet exist, DHS developed the two primary practices described above to ensure that children are only placed in shelters if there is no other placement available and, if placed, that efforts begin immediately to identify and secure a placement outside a shelter, preferably in a family-based placement, if appropriate. However, during this period, DHS' implementation of these practices lacked the necessary level of focus and rigor to ensure DHS was effectively preventing unnecessary shelter placements and reducing the length of time children were placed in shelters.

Preventing Shelter Placements

In February 2014, DHS heightened oversight and accountability of shelter placements by requiring that for children less than 13 years of age all shelter authorizations must be approved by the CWS Director and for children 13 years of age or older, shelter authorization must be approved by the regional deputy director. In order to approve a child's placement in a shelter, the CWS Director or a regional deputy director, as appropriate, is responsible for ensuring all necessary efforts to identify and secure a needs-based placement for a child were completed and documented on a pre-authorization form prior to shelter admission.

During this report period, DHS leadership acknowledged that the department had reduced its focus and attention on the shelter authorization process and this was evident, according to DHS, by a decline in the diligent efforts to prevent shelter placement documented by caseworkers on pre-authorization forms. DHS' March 2018 analysis of the shelter authorization process identified similar concerns. The analysis, which focused on a review of 184 children who were placed in shelter care at Laura Dester and YSA shelters during the months of October and November 2017, found that some pre-authorization forms presented sufficient efforts to prevent a shelter placement, while other authorization forms were approved despite a lack of information to demonstrate thorough efforts to divert the shelter placement.

In its analysis, DHS acknowledged that over time leadership had become aware that the pre- authorization form "did not lend itself to prompting the necessary guidance to ensure all appropriate levels of care are assessed prior to a shelter placement request." It is not clear when DHS learned that the form insufficiently guided caseworkers on the actions they must take to identify a needs-based placement for a child to prevent shelter care. However, in March 2018, following the close of this period, DHS revised its pre-authorization form to address these identified concerns. In addition, the revised form includes new prompts about the child's functioning, placement history, and specific needs in order to best facilitate securing a needs-based placement for a child. The analysis also recommended that the department enhance accountability at the regional deputy director level to ensure that DHS is only admitting children to shelters after all appropriate efforts are attempted to identity a family or alternate needs-based placement. The Co-Neutrals strongly encourage DHS to follow through on this recommendation immediately. DHS must establish consistent accountability to ensure that children are only placed in shelters after it has been conclusively determined that there is no other safe, needs-based placement option for a child.

Reducing Shelter Stays

In 2015, DHS implemented multi-disciplinary staffings as its primary strategy to fulfill its commitment to close the two state-operated shelters, Pauline E. Mayer and Laura Dester. Through these staffings and other efforts, DHS successfully closed Pauline E. Mayer, and significantly reduced the population of children at Laura Dester to nine in 2016. In February 2016, DHS expanded the staffing model to include children placed at the YSA shelters. The staffings were led by a shelter lead, "…whose sole responsibility is to eliminate shelter usage for children under the age of 12 by SFY16 and to significantly reduce shelter care for children 13 and over by reserving use only for circumstances in which a family-like setting cannot be obtained," and included a team of multidisciplinary specialists from within and outside of DHS, including from foster care, TFC, legal services and developmental disabilities, among others.

In the latter half of 2016, following DHS' significant reduction in statewide shelter usage, DHS made the decision to re-structure multi-disciplinary staffings. DHS reported that due to the decrease in shelter utilization and to ensure the sustainability of the staffings, it was appropriate to transition the centralized, statewide staffings to regional staffings. DHS reported each region was assigned a specific person to lead staffing efforts and this individual was provided a staffing tool to facilitate staffings and was offered ongoing consultation from the state office shelter staffing team.

Following the shift to the regional model, DHS reported that the transition to the new model had impacted the effectiveness of the staffings. As with any new practice, the new regional teams needed to build expertise and establish protocols to guide their staffing efforts. In April 2017, in response to DHS' acknowledgement that the new staffing model was not yet producing the intended outcomes, the Co-Neutrals reported that they would review, during the subsequent period (January 2017-June 2017), DHS' efforts to transfer to the regional offices the skill set and accountability to effectively and expeditiously move children out of shelters and into needs-based placements.

In response, last period DHS designated a full-time program field representative (PFR) position to lead DHS' multidisciplinary staffing efforts after the previous statewide shelter lead was assigned expanded responsibilities in another significant area of DHS' reform effort. In particular, the new lead for multidisciplinary staffings was to provide expertise and support to regional leads to strengthen the capacity of the regions to effectively conduct these staffings. Unfortunately, due to the pronounced challenges of securing placements for children placed at Laura Dester, the majority of the lead's efforts during the current period were focused on Laura Dester, resulting in a lack of support and guidance to the regions. This is particularly concerning

because most children in shelter care are not placed at Laura Dester, but at YSA shelters across the state. For these children, the regional staffings are the primary mechanism by which these children are staffed to find placements outside of the shelters.

During the current period, through discussions with DHS, it was apparent to the Co-Neutrals that regional and shelter leads needed greater support to improve the quality and outcomes of regional staffings to move children out of YSA shelters more quickly. Specifically, DHS had not developed a systemic approach among the five regions to establish clear expectations of, and accountability for, staffings and their outcomes. After this discussion, DHS committed to develop tools and guidance for the regional shelter leads to ensure that regions develop the knowledge and skills necessary to conduct staffings effectively. Following the close of this reporting period, DHS developed a uniform Progressive Shelter Staffing Form and Action Plan to be utilized by each regional lead during each child's shelter staffing with an expected start date of March 1, 2018. In addition, DHS developed an Enhanced Shelter Reduction Plan which consists of uniform shelter staffing protocols to be implemented statewide during next period. Within this report period, DHS did not establish the necessary protocols to ensure regional staffings were performed effectively to more expeditiously exit children from shelters.

Needs-based Placements for Children in Shelters

During this report period, a total of 480 children experienced shelter care. For these children, DHS was unable to identify and secure a needs-based placement, which resulted in shelter placement. As the Table below shows, the majority of children who experienced shelter care this period were placed at YSA shelters across Oklahoma. The population of children served in YSA shelters often present with increased emotional and/or behavioral needs and the great majority of children (88 percent) placed at YSA shelters are teenagers, for whom DHS has faced significant challenges to identify foster homes willing to accept their placement.

Table 5: Unique Children by Shelter, July 1, 2017 to December 31, 2017

Age Group	Total Unique Children	Shelter		% Youth Services Shelters	% Laura Dester
		Youth Services Shelters	Laura Dester		
Age 0-1	0	0	0	0%	0%
Age 2-5	4	4	1	100%	25%
Age 6-12	163	106	68	65%	42%
Age 13+	313	275	76	88%	24%
Total Children	**480**	**385**	**145**	**80%**	**30%**

Note: Children who stayed in more than one shelter category were counted for each category. Because of this, not all percentages add up to 100.

Central to DHS' efforts to reduce shelter care must be a concerted focus to develop and expand its placement continuum to meet the needs of children who are placed in shelters, including traditional and TFC foster homes, as well as higher-level, specialized placements. DHS' March 2018 Shelter Authorization Analysis, referenced earlier in this section, collected data on some of the primary characteristics of children who are typically placed in shelters to inform DHS' efforts to build an adequate continuum of care. The findings of this analysis clearly show that the population of children served in shelters has significant needs, as evidenced by developmental disabilities, aggressive/violent behavior, mental health diagnoses, placement disruptions and prior inpatient stays. The analysis also highlights the significant dearth of placement options for this population of children. Of the 184 children in the review sample, 24 percent (44 children) of the children's placements prior to the reviewed shelter placement were in another shelter. This represented the largest prior placement of the sample. The review also looked at children's placement following the reviewed shelter placement. Nine percent of children (17) moved from the reviewed shelter placement to another shelter. This means that over a quarter (61 out of 184 children) experienced two consecutive shelter stays.[25]

After the close of this report period, DHS reported to the Co-Neutrals some of its efforts to expand its placement continuum as part of it plan to close the Laura Dester shelter. These efforts included the development of four new level E group homes to

serve a maximum of 60 children. In addition, DHS has issued a Request for Proposal (RFP) for a 16-24 bed Intermediate

[25] Of the 61 children who experienced shelter to shelter placements, DHS' analysis did not identify if any of these children are duplicates, in that they experienced a shelter placement before and after the shelter placement under review.

Care Facility for Individuals with Intellectual Disabilities (ICF/IID). DHS plans to re-purpose Laura Dester and allow the provider selected through this RFP to serve children who are dually diagnosed with developmental and emotional challenges. As noted in the foster care section, DHS also is partnering with Developmental Disabilities Services (DDS) to expand family-based placements for children with developmental disabilities.

In the next Commentary, the Co-Neutrals will assess DHS' ongoing efforts and activities to strengthen its practices to prevent unnecessary shelter placements and to reduce the length of time children spend in shelters. The Co-Neutrals will also closely monitor DHS' efforts to substantially and sustainably reduce the number of children six years of age and older who use shelter care. Lastly, the Co-Neutrals strongly advise that DHS take all steps necessary to ensure the safety of children placed in shelters.

E. Child Maltreatment in Care

Children in DHS custody continue to experience abuse and neglect at an alarmingly high rate in both foster homes and institutional settings. During this report period, which covers the data reporting period of October 1, 2016 to September 30, 2017, DHS did not reduce the number of children in DHS custody who were abused and neglected when compared to the last report period. The agency's wanting efforts during and following the period, as discussed in this section, do not bode well for substantial and sustained gains in child safety in the near term. The department's inadequate efforts, contributing to the high incidence of child maltreatment, raise serious concerns for child safety.

This last sentence begs additional explanation from DHS. Of 123 substantiations occurring during the period of October 17 – March 18, 54% (67) were for Threat of Harm. Threat of Harm is an allegation that the risk of abuse or neglect is possible. The Department is statutorily obligated to substantiate such instances and take appropriate action. Consequently, while this counts against DHS's MIC numbers, these 67 individual allegations and findings were actually related to a risk of abuse or neglect that had not yet occurred to that specific child. These children did not experience actual abuse or neglect. Accounting for threat of harm, which most states do not, has the unfortunate consequence of increasing Oklahoma's number of substantiations and causes a commensurate increase in the Department's rate of Maltreatment in Care.

Again, equating numbers with efforts is not an appropriate assessment and is in conflict with the Compromise and Settlement Agreement.

The Co-Neutrals stated DHS was making good faith efforts to address Maltreatment in Care and praised the department in their last commentary. Now, the Co-Neutrals make little effort to hide

what is now a systemic condemnation of DHS's efforts to address Maltreatment in Care while making no effort at all to account for their prior assessment.

DHS made progress in the number of children it diverted from care through prevention and ISS. In three years from July 22, 2015 through July 21, 2018: 767 children were eligible and have received ISS. Of that number, 611, or 80%, have been kept out of foster care. DHS served 6425 children in FY 17 in FCS and 6621 children in FY 18.

In August 2015, DHS developed and began implementation of a set of core strategies it designed to reduce the prevalence of abuse and neglect among children in DHS custody. DHS devised these strategies to address recurrent concerns surfaced in the Co-Neutrals' first maltreatment in care (MIC) case record review, which included a comprehensive analysis of all investigations substantiated for child maltreatment in foster homes and institutional settings for the period of October 1, 2013 to September 31, 2014. For this Commentary, the Co-Neutrals focused their record review on all substantiated child maltreatment investigations that closed between July and December 2017 involving children placed in foster homes and institutional settings.[26] The review identified a prevalence of the very same areas of concern surfaced in the Co-Neutrals' first case record review.

[26] Through previous Commentaries, the Co-Neutrals have discussed their findings from four MIC case record reviews covering substantiated cases in foster homes and institutional settings from October 2013 through June 2017.

With respect to child maltreatment in foster homes, the Co-Neutrals have determined that during the current report period DHS did not make good faith efforts to achieve substantial and sustained progress in preventing child maltreatment. In particular, based on discussions with DHS leadership, document reviews and field observations, the Co-Neutrals assess that DHS did not transfer in a timely and thoughtful manner many of the findings from its ongoing, monthly reviews of maltreatment substantiations to caseworker practice, training, support and guidance. The Co-Neutrals observed that while caseworkers consistently performed the case practices contained in the MIC core strategies, critical deficiencies recurred in the execution and quality of these practices, substantially weakening DHS' efforts to prevent the maltreatment of children in the state's custody. The Co-Neutrals' and DHS' MIC case reviews repeatedly, across more than two years, identified that warning signs of child abuse and neglect, or risks of the same, are often reported and visible to the agency well before DHS confirms a child is a victim of maltreatment. In too many instances, the agency's efforts did not include prompt, appropriate action when these signs were first identified and documented by DHS. Those lapses and a lack of appropriate, effective ongoing guidance from DHS leadership to caseworkers and supervisors implementing the MIC core strategies led to a less than effective statewide implementation of the core strategies and continued to expose children to an

unreasonable risk of harm in foster homes.

The intent of the Compromise and Settlement Agreement requires the Co-Neutrals to submit determinations based upon the actions of the agency and its employees. This was difficult enough when the Co-Neutrals were more actively engaged with reviewing the efforts of the agency. From the perspective of DHS, the Co-Neutrals are no longer as actively involved in the efforts to assess good faith efforts, a critical component in their assessment responsibilities.

The Co-Neutrals are called upon to make a determination of the Department's good faith efforts to achieve substantial and sustained progress. From the outset of the Co-Neutrals' involvement this obligation has always been a difficult task to fulfill. Much of their assessment is based upon data and anecdotal evidence alone, not a qualitative review of the Department's actual efforts. It is clear to DHS this approach has never provided the full measure of the Department's efforts. Three individuals not embedded within the daily operations of the agency are responsible for assessing the work of child welfare leadership and its three thousand workers covering the 77 counties of Oklahoma. Now, in the wake of verbal declarations made by the Co-Neutrals that they intend to refocus their assessment responsibilities, the dramatically diminished involvement of the Co-Neutrals over the most recent 12 months, and now the contents of the April 2018 Commentary, DHS is deeply concerned that it is no longer being judged based upon an informed and scrupulous assessment of its efforts.

To be more specific, a review of the Commentary reveals that much of the basis to justify that DHS has not demonstrated good faith efforts is founded upon the position that DHS leadership has failed in its responsibilities to communicate its strategies and quality improvement efforts to front-line staff. Given the marked lack of involvement by the Co-Neutrals in recent months, DHS questions the foundational support for these conclusions. It is no exaggeration to state that Child Welfare leadership communicates with front-line staff and local leadership on a daily basis. This is a constant, unending flow of communication. Rather than delving deep into the actual efforts of the agency and questioning leadership and staff, the Co-Neutrals appear to simply make an unsupported deductive leap that leadership failed in its responsibilities to educate and train staff and this resulted in the staff failing to fulfill its daily responsibilities. This is a conclusion based upon what? The Commentary is bereft of the detail needed to not only support the Co-Neutrals conclusions but is also needed to guide the Department as it continues to implement its good faith efforts.

The Department remains committed to the concept of assessing good faith efforts, but it is becoming more and more apparent that perhaps a review of the methods to assess good faith efforts should be revisited in light of the experiences from the previous half decade and, perhaps more importantly, in light of the diminishing involvement of the Co-Neutrals over the previous year.

DHS leadership has communicated at length the list of specific strategies, reviews, and processes that have been implemented to address MIC. The work being done related to Placement Stability and Permanency has had and continues to have a direct impact on MIC. The outcomes show that information is being transferred to the field and is impacting practice. Initial Meetings and Resource Parent Check-In calls are occurring and assist in identifying issues, concerns, needs, etc. that may lead to MIC. Since 2015, 11 CWS Memos have gone out to the field that directly or indirectly address MIC prevention practices. Oklahoma increased Kinship Placements as first placements and research indicates children have shorter periods of out of home placement when they are placed with kin. Consequently, the shorter amount of time you are in an out of home placement, the less likely a child is to experience MIC.

In the area of institutional settings, DHS' pledge to heighten its monitoring and oversight of facilities with identified safety concerns did not result consistently in timely and sustainable resolution of identified safety concerns. Of the eight group homes and shelters subject to heightened monitoring during the current period, four facilities received more than one maltreatment substantiation following the initiation of heightened monitoring. For this report period, three group homes each had at least four substantiations after DHS initiated intensified oversight of the facility, which resulted in the maltreatment of 23 children. In the six months following the close of the current period (October 2017 to March 2018), five additional children were maltreated at two of these three group homes. The repeated incidence of child maltreatment at facilities subject to DHS' heightened oversight raises questions about DHS' ability to address and resolve persistent safety risks at some of these facilities. This was particularly evident at the state-operated Laura Dester shelter, where serious safety concerns long went unresolved and contributed to the abuse or neglect of four children during the current period, and thirteen children during the next period.[27]

[27] Three children are included in both report periods, as the report periods overlap. The total number of unique children maltreated during the combined two report periods (October 2016 to March 2018) is 14.

Achieving a substantial and sustained reduction in the rate of maltreatment of children in the state's custody is the department's most imperative work. For this reporting period, DHS' performance declined on both of the two metrics (1.1: MIC by a resource caregiver and 1.2: MIC by a parent) established to measure child safety. DHS did not make substantial and sustained progress toward the Target Outcomes in the current period and preliminary data for the next report period, April 2017 to March 2018, indicates that DHS' performance does not appear to show improvement in child safety under Measure 1.1 (MIC by a resource caregiver). For the reasons discussed in this section, the Co-Neutrals do not find that DHS made good faith efforts during this period to achieve substantial and sustained progress toward the MIC Target Outcomes.

Child Safety: Abuse and Neglect by Resource Caregivers While Child is in the Legal Custody of DHS, Metric 1a

DHS tracks and reports publicly on a monthly basis the number of children abused or neglected by a resource caregiver. DHS and the Co-Neutrals adopted the federal metric applicable at the time, "Absence of Child Abuse and/or Neglect in Foster Care," which reports the percent of all children in foster care during a 12-month period who were not victims of substantiated maltreatment by a foster parent or facility staff. [28]

For this metric's current report period, October 1, 2016 to September 30, 2017, DHS reported that 184 children out of 15,113 in DHS custody were abused or neglected while in care. This represents a rate of 98.78 percent of children in DHS custody during the period who were not victims of child maltreatment. For DHS to have met the Target Outcome of 99.68 percent of children safe in custody, DHS would have had to keep an additional 136 children safe from abuse and neglect by a resource caregiver.

As shown in the Figure below, during the baseline period, April 2013 to March 2014, DHS reported that 98.73 percent of children in DHS custody were not victims of child maltreatment and reported the same outcome of 98.73 percent during the following report period from October 2013 to September 2014. Over the six subsequent reporting periods (including the current period), DHS' safety outcomes have not substantially or sustainably progressed toward the Target Outcome.

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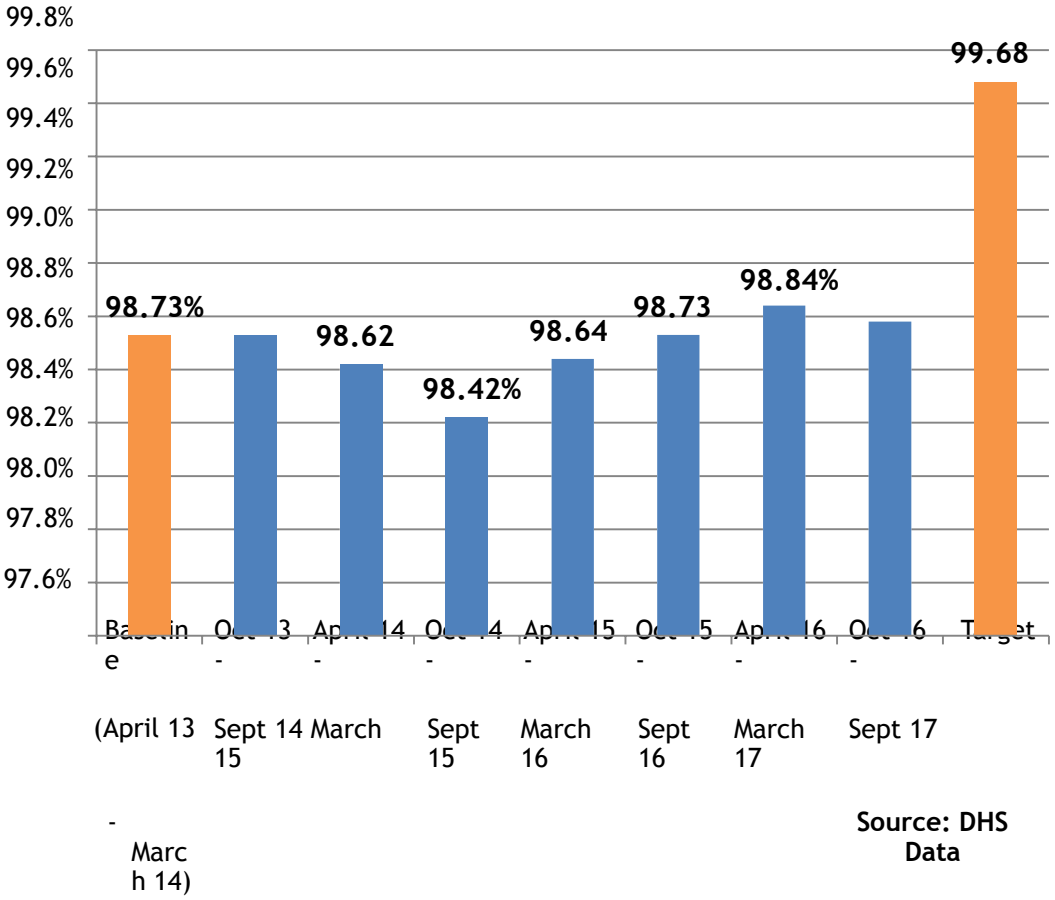
[28] In October 2014, the federal Children's Bureau changed the metric it uses to assess state child safety in care. The new federal metric combines maltreatment in care by resource caregivers and by parents, with some additional adjustments to the methodology. For consistency and comparability, the Co-Neutrals and DHS continue to use the two metrics and methodology originally established in the Metrics

Plan.

Figure 20: Metric 1a – Absence of Maltreatment in Care by Resource Caregivers



Source: DHS Data

In addition to reporting performance on this metric semi-annually, DHS publicly reports substantiations of child maltreatment monthly. Over the same 12-month period, October 1, 2016 to September 30, 2017, DHS reported 208 substantiations of child abuse and neglect by a resource caregiver. Of these, 24 substantiations are not included in the federal measure adopted by the Co-Neutrals as Metric 1a for two reasons: (1) 16 child abuse or neglect substantiations were excluded because, according to the federal methodology in place at the time the Metrics Plan was finalized, both the referral date (date when an allegation is made to DHS) and findings date (date when the case is substantiated by DHS) must exist in the same 12 month federal reporting period; and (2) eight child abuse or neglect substantiations were not counted in the federal metric because they represent multiple substantiations for the same child. The adopted federal measure only accounts for one substantiation per child within the same period. Of the 208 substantiations of maltreatment reported in the monthly data, 148 substantiations (71 percent) are for children in family-based foster care settings, while 60 substantiations (29 percent) are for children in residential facilities or higher-level institutions.

Child Safety: Abuse and Neglect by Parents While Child is in the Legal Custody of DHS, Metric

1b

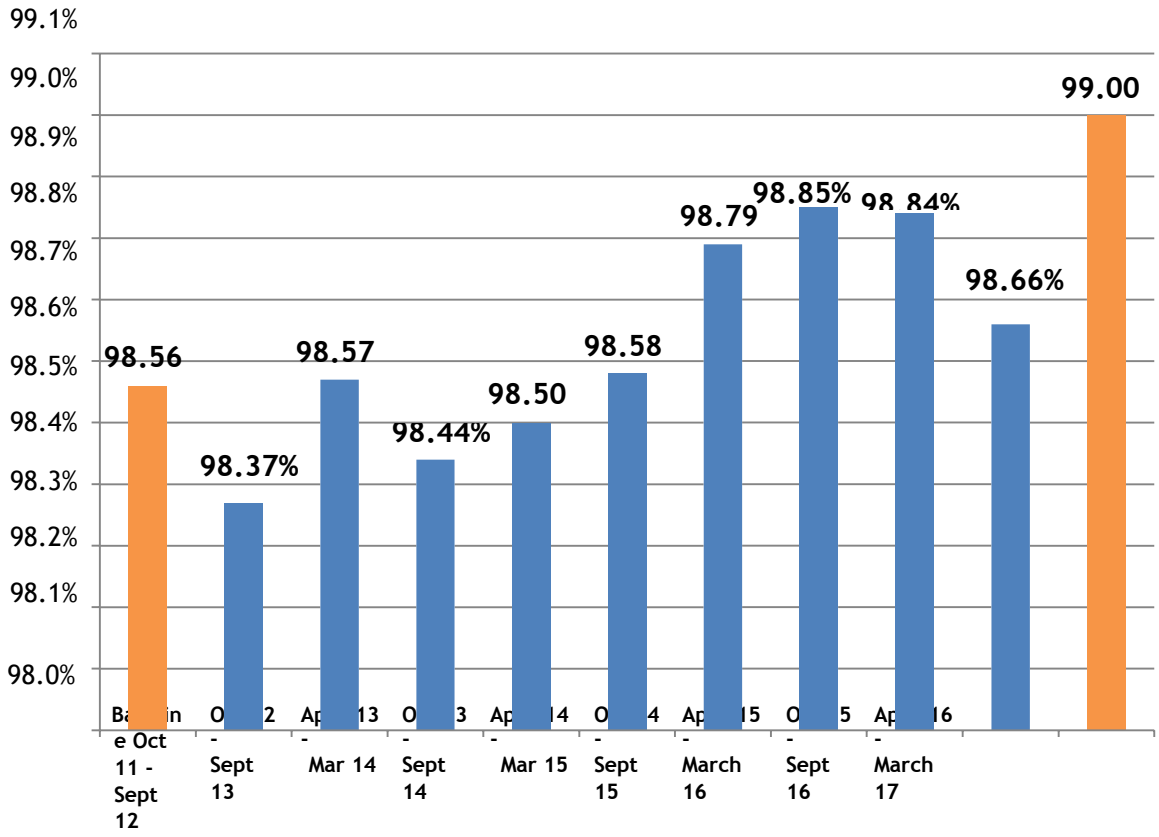
The Co-Neutrals adapted the methodology utilized in the preceding section, Abuse and Neglect by Resource Caregivers, to measure abuse and neglect by parents while a child is in the legal

custody of DHS. This includes the significant population of children who remain the legal responsibility of DHS but who reside in, or have been placed back in, their homes of origin for trial home visits. In Oklahoma, children can experience trial home visits for months, and DHS recognizes the importance of closely monitoring their safety.

This metric for "Abuse and Neglect by Parents While Child is in the Legal Custody of DHS," measures performance this way: Of all children in the legal custody of DHS during the reporting period, the number and percent of children who were not victims of substantiated or indicated maltreatment by a parent and the number of children who were victims over the 12-month period.

For this report period, October 1, 2016 to September 30, 2017, DHS served 15,113 children in custody, 202 of whom were abused or neglected by parents while in DHS custody, yielding a safety rate of 98.66 percent against a target of 99 percent. For DHS to have reached the Target Outcome during this period, the agency would have had to prevent maltreatment to an additional 51 children. As the Figure below shows, DHS' performance on this metric has declined over 18 months of monitoring.

Figure 21: Metric 1b – Absence of Maltreatment in Care by Parents



Oct 16 - Sept 17	Target

Source: DHS Data

DHS' data showed an additional 56 substantiations of maltreatment of children by their parents while in DHS custody that were excluded in the measure because of the same federal exceptions applicable in Metric 1a: 49 are excluded because the referral date (date when an allegation is made to DHS) and findings date (date when the case is substantiated) do not exist in the same 12-month reporting period or due to multiple substantiations on the same child; and, seven are excluded for other applicable criteria.[29] During this period, DHS continued to lose ground on this metric and must take urgent and appropriate actions to reverse the decline in performance in this vital area.

Comparative MIC Rates by Placement Types

The Co-Neutrals reviewed whether children are maltreated by a resource caregiver more often in certain placement types through an analysis of MIC rates for each placement type (see Table 6 below). The Co-Neutrals used the method that the United States Department of Health and Human Services Children's Bureau adopted to measure how often MIC occurs, which calculates a rate of maltreatment based on the days children are in child welfare custody. The rate signifies, for every 100,000 days that a group of children spent in custody, the number of MIC substantiations those children experienced. In the Co-Neutrals' analysis, lower MIC rates mean that children experienced less maltreatment by resource caregivers in that placement type, while higher rates mean children experienced more maltreatment by resource caregivers while residing in that placement type.

Table 6: Rate of MIC by Placement Type, Current and Prior Report Periods

Placement Type	Current Period (Oct '16 - Sept '17)		Last Period (April '16 - March '17)	
	# of Children Maltreated	MIC Rate	# of Children Maltreated	MIC Rate
Regular Foster Family Care	33	5.38	31	4.96
Foster Family Care - Supported Home	19	3.36	23	4.11
Kinship Foster Family Care Relative	73	6.48	82	6.72
Kinship Foster Family Care Non-Relative	14	4.76	15	4.97
Therapeutic Foster Family Care	7	5.08	9	5.34

Congregate Care	60	27.15	44	19.33
Other Foster Family Care	2	1.1	4	2.19
Total	**208**	**6.57**	**208**	**6.28**

[29] The exclusion criteria for these seven children are: three children experienced two removals during the period, and maltreatment occurred during the second removal, which according to federal rules does not then count; and four children's first placements following removal (i.e., hospital) is not counted according to federal rules.

The Table above shows that children in congregate care had the highest rate of maltreatment by a resource caregiver of any placement type, a rate five times higher than children placed in family-based care. Furthermore, the rate of maltreatment in congregate care settings substantially increased from last period.

Following congregate care, kinship-relative care had the second highest MIC rate[30] and the greatest number of child victims of any placement type. Children placed in regular foster homes experienced the third highest MIC rate during this period. As the Table above shows, the rate of maltreatment increased in regular foster homes this period when compared to last period. Overall, the rate of maltreatment for all children in DHS custody increased when compared to the previous 12-month report period.

Core Strategies to Reduce MIC in Family-Based Placements

In August 2015, DHS began implementing a set of core strategies to improve child safety. DHS reported the strategies were intended to address the most predominant concerns identified in the Co-Neutrals' first case record review of all MIC substantiations in foster homes between October 2013 and September 2014. The three primary concerns were:

1. **Referral Histories**: foster homes with extensive referral histories that contain screened out, ruled out, or unsubstantiated referrals for the same or similar abuse/neglect allegations that were eventually substantiated or that revealed patterns of concerning conditions in foster homes;

2. **Quality of Visits**: some caseworkers not thoroughly assessing and/or addressing child safety and caregiver discipline during monthly visits; and,

3. **Home approval**: foster homes with concerning child welfare, criminal or personal histories that raise questions about the safety of certain new foster homes.

As detailed in previous Commentaries, to assess DHS' efforts to address these specific safety concerns, the Co-Neutrals, along with DHS, have continued to review the case records for every substantiated MIC allegation, as well as a sample of investigations that did not result in a substantiation. These ongoing reviews of maltreatment investigations continue to surface, even years later, the same primary issues of concern originally noted above. In fact, the review of 73

[30] For the second consecutive report period, the rate of maltreatment in kinship homes has decreased, along with the number of substantiations in this placement type. However, the number of child maltreatment substantiations in kinship homes for this period has not reduced sufficiently to have a substantial, positive impact on DHS' performance toward the MIC Target Outcome.

substantiations in foster homes (40 unique substantiated foster homes) from July to December 2017, again showed recurrent concerns in the areas of referral histories, the quality of caseworker visits, and foster homes approved despite concerning child welfare, criminal or personal histories.

DHS committed to join the Co-Neutrals in conducting these MIC case reviews to assess the impact that implementation of the core strategies was having on child safety. The Co-Neutrals have found that DHS' reviews of substantiated and unsubstantiated maltreatment referrals in foster homes are thorough and effectively identify case specific and larger case practice areas of concern. When safety concerns for children emerge from these reviews, the department committed to engage DHS leadership, supervisors, and caseworkers to promptly intervene and address any child-specific safety concerns, as appropriate, as well as broader case practice concerns that require attention and a plan of action in the field. Through this work, DHS has developed a robust understanding of the primary risks, system-wide, that require remediation and mitigation to reduce child maltreatment in foster homes. Unfortunately, DHS did not make good faith efforts to transfer much of its qualitative learning from the Central Office review team to frontline workers and supervisors across the enterprise. As a result, new protocols and practices, designed to improve child safety, often were not executed effectively across the state due to inadequate guidance and support to the field, and failed to reflect sufficiently DHS' awareness of ongoing deficiencies in case practice required to keep children safe.

As touched upon in previous comments, this is an inaccurate conclusion reached by the Co-Neutrals and their staff. In the wake of qualitative reviews, significant efforts are made daily to provide information directly to staff that impact the Department's efforts to minimize maltreatment in care. This is evidenced by an increase in initial meetings and Parent Check-in Calls being conducted at a consistently high rate. Both of these efforts assist staff members as they identify potential issues within the home that could lead to maltreatment in care. Additionally, no fewer than 11 Memorandums have been disseminated to staff (a number of which were provided during this reporting period) that address issues impacting maltreatment in care:

15-04 Elimination of Secondary Assignments
16-09 Assessing Youth in Residential Settings
16-13 Monthly Contact with Foster Families
17-11 Weapon/Gun Safety in Foster Homes
17-14 Child Behavioral Health Screenings
17-15 Foster Parents Eligible for Restricted Registry
17-16 Placement Stability
17-17 Placement Stability – Kinship
17-19 Registry Search Requirements for Approval of Homes

18-01 National Searches
18-03 Group Home Staffing Protocols

Here is just a sample of relevant actions taken to address MIC:

- *The Foster Care and Adoption Supervisor meeting held in May 2017 included a review of the RFA Action Plan, and the updated tools including the purpose and expectation regarding assessment.*

- *Program staff discussed the findings of the RFA reviews with the RFA contractors at the contractor's meeting as well as individual conferences with contractors regarding the RFAs completed by their respective agencies.*

- *During October, November and December 2017, program staff brought together field managers and their direct supervisors to work through a case using the Resource Family Assessment Review tool. This small group training gave them more experience utilizing the tool, gave them an opportunity to ask questions, included completing a review that was discussed with their peers, walked them through the processes on decision making, and helped them gain an understanding of why each element is important to the overall resource approval.*

- *A review of all open foster and adoptive home resources was completed during the months of October through December, 2017, with a few running into January and February. This review included an assessment of all criminal and child welfare history, references, and the social history of the foster and adoptive families, utilizing the newly developed review tool, intended on identifying and addressing any possible concerns, in order to prevent MIC.*

- *Program staff provided RFA update and assessment training to all foster care and adoption staff, RFP staff, and RFA contractors in March and April 2018.*

In sum, communications with front line staff occurs on a daily basis. The Co-Neutrals' categorical declaration that leadership and quality improvement personnel do not communicate sufficiently with front line personnel is untrue. To then publicly declare this assumption without first offering DHS adequate opportunity to demonstrate its good faith efforts to communicate with staff is profoundly troubling.

Safety-Focused Case Practice to Reduce Maltreatment in Foster Homes

Included in the following sections are discussions of each of the primary safety concerns that have consistently surfaced in the Co-Neutrals' and DHS' reviews of child

maltreatment in foster homes and the efforts DHS has undertaken during the current period.

Reducing the Incidence of Foster Homes with Concerning Referral Histories

In their respective case record reviews of foster homes where maltreatment has been substantiated, the Co-Neutrals and DHS have consistently identified the existence of extensive referral histories that contain previously screened out, ruled out, or unsubstantiated allegations. These referral histories often present a pre-existing, documented pattern of safety risks to the child and overlooked concerns in the home. To address this, DHS reported it began in February 2016 to require new and heightened multi-staff joint reviews of maltreatment referrals received on children in foster homes, regardless of DHS' decision to accept a referral for investigation. Participants in these joint reviews include the assigned permanency and resource family workers and their supervisors.

A separate joint review follows referrals accepted for investigation, known as a "10-day staffing." The 10-day staffing is a long-standing DHS practice in which staff are required to determine early within an investigation (within 10-days) whether the child should be removed from the home immediately and whether the home should be closed before the investigation concludes. DHS now requires that during these 10-day staffing sessions, caseworkers review the relevant foster home's referral history in its entirety (including all screened-out, unsubstantiated and substantiated referrals) to identify any trends and/or concerns that may impact a child's safety. At the conclusion of a 10-day staffing, the caseworkers and supervisors are required to determine what appropriate actions are necessary to mitigate any safety risks in the event a decision is made not to remove the child or close the home.

The joint review that follows DHS' decision not to accept a maltreatment allegation for investigation is called a screen-out consultation, during which DHS requires an assessment of the foster home's referral history and any other information that may reveal safety concerns and require follow up action by the department.

As also reported in the last Commentary, the Co-Neutrals observed in their most recent case record review that caseworkers consistently engaged in these post-referral reviews. DHS reported that its tracking data for the months of October through December 2017 showed that all required 10-day staffings were completed for all investigated referrals. In their record review, the Co-Neutrals confirmed this and found that for all substantiated referrals closed between July and December 2017, workers conducted the 10-day staffing and higher-level management approved the outcome of each staffing. For screen-out consultations, DHS reported that 89 percent were completed during the period of October through December 2017.

Despite implementation of these post-referral staffings, the quality and depth of

these reviews remains a serious concern. In the most recent MIC case review, the Co-Neutrals identified that nearly half (48 percent or 19 out of 40) of the foster homes substantiated for child maltreatment had prior child maltreatment referrals (both investigated and screened-out) that appeared to signal safety concerns for the children placed in these homes. For those foster homes with referral histories, DHS' joint reviews showed lapses in thoroughness with respect to assessing safety concerns. [31] In some cases, the joint reviews did not effectively identify and/or address safety concerns which had surfaced in referrals prior to the substantiated referral. For example, based upon the referral histories of some homes, the review identified that it may have been appropriate for DHS to: remove a child from the foster home due to ongoing, safety

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[31] Some homes' prior referrals were not subject to the enhanced post-referral staffings due to these referrals having been received prior to the implementation of the new staffing protocols.

concerns; initiate a Written Plan of Compliance (WPC) to address and resolve identified safety concerns in the home; and/or, increase contacts, monitoring or services in a home to ensure child safety. However, in some cases, DHS did not take these actions and children remained in unsafe foster homes until the subsequent abuse or neglect was inflicted, reported, investigated and substantiated.

DHS questions whether the Co-Neutrals' analysis is utilizing hindsight bias. The Department reviews the same referrals and applies policy and statutory guidelines related to actions taken. Every referral receives some form of follow-up whether it's accepted or screened out. Also, it has been repeatedly brought to the Co-Neutrals' attention that disagreement exists on the predictive ability of past referrals with regard to future substantiations. The influence of hindsight bias impacts retrospective reviews. Contrarily, DHS is obligated to look at what was known at the time of referral receipt and whether its response was consistent with policy. Consequently, DHS has not found over one half of substantiations that included a previous referral which indicated substantiation was imminent without closure of the home.

Such oversight and review is a continuous process and, unfortunately, there may very well be instances in which a warning sign is missed. It is a delicate balance with profoundly serious consequences when it comes to considering whether the impact of providing a child with placement stability is outweighed by the prospective determination maltreatment in care may or may not occur. The responsibility of the Co-Neutrals, however, is not to assess whether a determination was in error in a specific case. Rather, it must all come down to an assessment whether the Department is conducting its systemic responsibilities with all appropriate tools and safeguards in place. This is the good faith determination that must be made, and this is exactly what DHS is doing.

For example, in October 2017, a foster home was substantiated for the sexual abuse of two foster children who were formerly placed in the home. One year prior to this substantiation, in March 2016, a referral was called in on this foster home following the child's first disclosure of sexual abuse by the foster father to her counselor. During this referral's investigation, the child again disclosed sexual abuse by the foster father; however, because the child and her sister "each reported different events regarding the same time frames" DHS closed the investigation as unsubstantiated. Following the closure of the investigation, both foster children remained placed in the foster home. DHS documented that the children were "safe" in the home as a safety plan had been established that the foster father "will not be left alone with either of the children." DHS reported that the foster mother and her adult daughter were responsible for ensuring this safety plan was enforced. However, the current, substantiated investigation found that "there is evidence to suggest [that the foster mother and her adult daughter] failed to protect [the foster children] and continued

to allow [the foster father] to have contact with them." Until this home's closure in October 2017, DHS placed a total of ten additional children in this home, despite the department's determination that foster children were unsafe in the care of the foster father in the home.

By way of another example, in October 2017, DHS substantiated a foster home for the sexual abuse of two siblings. This foster home's referral history included two prior investigated referrals from 2014 and 2015 which contained allegations of sexual abuse against the foster father by several foster children placed in the home at that time. In reference to the home's referral history, DHS stated, "While acting as a foster home, allegations of sexual abuse by [the foster father] were investigated in 2014 and 2015. Children in the home disclosed [that the foster father] had become extremely intoxicated and touched them inappropriately. Three separate foster children disclosed fondling and grooming type behaviors by [the foster father]." Despite these disclosures, both referrals were unsubstantiated at the time and the home continued to care for foster children.[32] In its internal review of the substantiated October 2017 case, DHS wrote, "The Department continued to place children in the home for two more years while having this information [referral history that contained child disclosures of sexual abuse] available to review." The sibling pair referenced above was placed in the foster home in

[32] Reviews by DHS in 2017 found there was sufficient evidence at the time of these investigations to meet the agency's substantiation policy.

May 2016, nearly two years after the initial child disclosures of abuse in the home. While only placed in the foster home for one month, both siblings were sexually abused by the foster father.

Offering up specific cases to justify the Co-Neutrals' assessment is inappropriate, particularly when they fail to provide the full context and circumstances of the event. Such efforts fall outside the scope of the Co-Neutrals' responsibilities to assess good faith efforts on a systemic scale. Good faith, as envisioned by the Compromise and Settlement Agreement, is not and should never be measured based upon individual case-by-case outcomes.

In foster homes substantiated for physical abuse, the case record review identified missed opportunities to identify and address prior referrals that contained similar allegations of physical abuse in the foster home. Specifically, the case review identified that nearly half of the foster homes substantiated for physical abuse had prior referrals (both investigated and screened-out), which included allegations of physical abuse. Even when there were repeated disclosures by children of inappropriate discipline in the home, the follow up joint reviews of these prior referrals indicate that DHS either took no action to address referral allegations or took insufficient action(s) that did not effectively eliminate the use of inappropriate discipline in the home.

In July 2017, for example, a foster home was substantiated for the physical abuse of a six year old boy. This home had two prior investigated referrals, which contained disclosures by the boy that he was subject to inappropriate discipline in the home. In the first of the two referrals (January 2016), the investigation documented that the child reported that "he was hit with a flyswatter." In the second referral (September 2016), the child disclosed to his daycare provider that his "[foster mother] hit him with a belt." During this investigation, the child disclosed that "when he gets into trouble at home, he is hit with a belt while his clothes are on." The 10-day staffings following each of these investigations did not result in caseworkers taking any actions to address the foster home's use of inappropriate discipline. Further, following these investigations, during monthly contacts, the caseworkers in the home did not discuss with the foster parent the discipline methods used in the home. The third substantiated referral was called into the DHS Abuse and Neglect Hotline in June 2017 when the boy was observed to have scratch marks on his face that he reported during the investigation were caused by the foster mother, who "had whooped him with a wood backscratcher." The boy's younger sister, four years old, disclosed during the investigation that she had "gotten whopped with a belt" in the home. During the 10-day staffing for the substantiated referral, DHS documented, "There was a discussion of Foster Care having concerns with inappropriate discipline, but it has not resulted in any written plans."

Given that the most common type of substantiated maltreatment in foster homes

from this review was physical abuse, which most commonly took the form of foster parents using inappropriate and harmful methods of discipline, DHS' efforts must strengthen the assessment of referral histories to identify patterns of similar allegations and concerns, and take immediate and appropriate actions to mitigate risk to children.

DHS has strengthened the assessment of referral histories to identify patterns of similar allegations and concerns, and, when indicated, the Department takes actions to mitigate risk to children.

DHS' efforts must better support caseworkers' and supervisors' ability to make safety-focused decisions during these post-referral joint reviews. The Co-Neutrals' case record review showed that in some cases, caseworkers interpreted screened-out, ruled out or unsubstantiated referrals as indicating a particular foster home was safe for children. DHS must strengthen its training, coaching and support on the relevance of previous history, particularly emphasizing that screened-out, ruled out or unsubstantiated referrals do not unequivocally mean that safety concerns or risks are not present in the home and that no action by DHS is necessary to ensure child safety.

Again, this statement reflects the concerns DHS has about hindsight bias. When workers involved are reviewing the history, they are making contemporaneous determinations based on the information they have at that time. The Co-Neutrals should take this into account but that does not appear to be the case.

This period, DHS conducted a quantitative and qualitative review of its screen-out consultation practice and completed their analysis after the close of the current reporting period. The analysis reviewed a random sample of 125 screened-out consultations completed and entered into DHS' KIDS database for the 12-month period of October 1, 2016 to September 30, 2017. A primary finding of the review was that of the 125 consultations reviewed, 74 consultations (59 percent) documented all required information to be covered during the consultation. However, the review also found that in 51 consultations (41 percent) all required information was not covered during a consultation. Further, of the 51 consultations that did not include all required information, 40 (32 percent) consultations lacked any discussion of the foster homes' referral history. The gap undercuts in these instances the stated purpose of screened-out consultations to assess child safety in foster homes through a comprehensive review of foster homes' prior referrals.

DHS reported it has begun development of an enhanced screened-out consultation guide in KIDS to address some of the findings from its review. According to DHS, the new guide will be released in KIDS in the Fall of 2018. The Co-Neutrals have urged DHS to ensure that staff receive sufficient guidance and instructions on the new guide as soon as possible while the technical components of the KIDS system are completed

and the field is trained on appropriate use and documentation in KIDS.

DHS reported that during this period, DHS' Continuous Quality Insurance (CQI) staff participated in five 10-day staffing calls to provide quality assurance support and technical assistance and the Office of Performance Outcomes and Accountability (OPOA) participated as a silent observer on four post-referral staffings. In total, DHS' quality assurance teams participated in a total of nine post-referral joint reviews during this period. Due to this limited number of nine shadowed calls, DHS reported that no recommendations could be made to strengthen the 10- day staffings.

During this report period, the efforts the department undertook to prevent harm to children by strengthening the quality of post-referral staffings were insufficient in scope, focus and
timeliness.

Quality of Caseworker Visits; Assessing Child Safety

This period, the principal concern that DHS identified in its review of foster homes substantiated for maltreatment was the insufficient quality and consistency of caseworkers' monthly visits to identify and/or address issues related to child safety. In fact, DHS identified that the quality of caseworker visits was inadequate for the majority of foster homes substantiated for maltreatment in the current review. In its review, DHS evaluated the quality of worker visits to assess child safety through the following eight questions:

- Did the caseworker conduct any unannounced visits to the foster home?;
- If the child is an infant, was the infant observed unclothed?;
- If applicable, did the caseworker address any contradicting information learned about the home?;
- Did the caseworker attempt to gather information from non-verbal/pre-verbal children to assess safety?;
- Did the caseworker discuss discipline practices with the child?;
- Did the caseworker discuss safety with foster children and foster parents?;
- Did the casework discuss with foster parents services to support child's well-being?;
- Did the caseworker discuss if any other people are in the home to visit or care for the foster children?

DHS found the following concerns with the quality of worker visits: caseworkers did not consistently and/or thoroughly discuss with children the discipline methods used in the foster home; caseworkers did not regularly discuss child safety with foster parents; caseworkers did not routinely interview children alone; and, caseworkers did not, as appropriate, address any contradictory information identified about the foster home that may impact child safety.

The ongoing concern that caseworkers are not consistently and/or thoroughly

discussing discipline methods and safety with foster children during visits is particularly troubling in light of the prevalence of child maltreatment substantiations that involved inappropriate discipline methods this period. In fact, of the 17 referrals that involved physical abuse this period, DHS identified 14 referrals with concerns related to the quality of caseworkers' visits. While in some of these referrals, caseworkers failed altogether to discuss discipline and safety with children, in other instances caseworkers attempted to discuss discipline and safety, but the discussions appeared cursory and lacked a skillful and trauma-informed approach that would more effectively support children in disclosing maltreatment in their foster home.

Further, the review identified that some of these foster homes substantiated for physical abuse had referral histories that contained prior allegations of inappropriate discipline. Given these histories, it was incumbent upon DHS to heighten its review and assessment of child safety during monthly visits. From a review of these prior referrals with allegations of inappropriate discipline, it did not appear caseworkers appropriately addressed these concerns and allegations with the foster children or parents.

DHS reported that its permanency planning program staff trained seven classes of new child welfare specialists, impacting approximately 140 new staff, on various areas related to child safety, including the quality of worker visits and safety assessments during visits. DHS indicated the training highlighted the importance of discussing discipline and supervision during visits, conducting three unannounced visits per year, and increasing contact with children and foster families during times of change and stress. This is a valuable step; however, DHS did not indicate that this training would be delivered to its hundreds of permanency caseworkers already deployed to the field.

DHS at first reported that efforts were being made to develop a tool for supervisory staff to evaluate, among other areas, the quality of caseworker monthly visits to assess child safety. However, DHS later reported these efforts were suspended due to its ongoing work to develop a new supervisory framework, which DHS indicated will include efforts related to worker visits. DHS shared some tools it developed through its supervisory framework to improve worker visits, including guidance on the topics and issues that must be addressed during a worker visit, and assessment tools for supervisors to use to evaluate caseworkers' visits to ensure child safety. (See Appendix E) DHS reported that region by region, staggered implementation of this new framework will not begin until August 2018, with a goal for full, statewide implementation by February 2020. Given the serious and ongoing concerns about child maltreatment and the department's own observations related to the quality of worker-child visits, the department must more quickly provide statewide guidance and support to staff in the field to identify and address risks to child safety during monthly visits.

Improving the Foster Home Approval Process

The Co-Neutrals' case record reviews have historically revealed concerns regarding the approval of some foster homes with concerning child welfare, criminal and/or personal histories. This period, the Co-Neutrals' review of substantiated maltreatment referrals continued to identify foster homes with concerning histories that were documented during the home approval process but were still approved to care for children in DHS custody. This period, the Co-Neutrals conducted their second comprehensive review of 50 Resource Family

Assessments (RFA)[33] of new homes (DHS and private agency traditional homes, and kinship homes) approved by DHS and private agencies between the months of October and December 2017. DHS' and the Co-Neutrals' record reviews of new home RFAs and foster homes with substantiated MIC referrals reinforced the urgency with which DHS must improve its home approval process. As described below, both reviews identified child safety concerns with the home approval process.

The central finding of the Co-Neutrals' review this period of 50 new home RFAs was that nearly a quarter (24 percent) raised concerns about the family's protective capacities to safely care for foster children. The Co-Neutrals' review last period of 50 new homes opened between January and June 2017 produced a similar finding, with 23 percent raising questions about the decision to approve each home. The most frequently cited concern in both the current and former RFA review was related to the personal backgrounds of prospective foster families, which called into question the suitability of foster parents due to issues such as: drug and/or alcohol abuse, domestic violence and/or child welfare histories involving the resource parents and/ or family members. The Co-Neutrals shared with DHS their findings from these reviews and the department reported that it has followed up on specific cases as needed to ensure the home was approved appropriately and is using the information gathered to further assess where the resource family assessment process requires additional improvement.

The Co-Neutrals reviewed and analyzed all substantiated maltreatment referrals this period for children in care, which is distinct from the Co-Neutrals' review of 50 new home RFAs described above. The maltreatment review identified foster homes with concerning home approvals. In particular, the review found some homes were approved to care for foster children despite child welfare histories, the identified use of inappropriate discipline, and, in a few cases, criminal histories. It was unclear from the review if DHS addressed these issues during the home approval process. The review also found that in some cases the maltreatment substantiated in a foster home was related to the concerning issue identified during the foster home's approval process.

DHS considers this an exaggerated, if not misleading paragraph. The summary log from the Co-Neutrals indicated there were seven homes that had some past history, five having a single previous referral, one having two previous referrals and one that was unknown based on what they sent back following their review.

Any child abused while in the custody of DHS is a matter of concern and requires action, but it is not fair to morph these individual instances that imply systemic indifference. Despite all of its best intentions and good faith efforts, DHS is not error free just as no other child welfare system

in this country is error free. It is important that the Co-Neutrals fairly represent the contexts and acknowledge the rigorous safety assessment processes that DHS has implemented.

During the home approval process for a kinship home substantiated for maltreatment this period, for example, DHS failed to identify the home's prior substantiated child welfare history. DHS reported that during the investigation, it was found that the foster mother had "a

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[33] The RFA is a compilation of information that includes the background of each foster parent, all household members and closest family members of the applicant as well as information about the family's physical home, finances and medical histories. The RFAs for DHS' traditional and kinship foster homes are developed by five contract agencies charged with objectively compiling all the relevant information so that DHS can assess the quality of each home and determine if there are any concerns that DHS may need to review and consider in greater depth.

substantiated child welfare history for failing to protect her grandchildren against sexual abuse by another one of her sons." The current investigation, substantiated in July 2017, involved similar confirmed allegations of the foster mother allowing her other son (a convicted sex offender) access to the one year old foster child. Documented in the 10-day staffing notes, DHS wrote, "Additionally, participants discussed [foster mother's] substantiated CW history from 2004 for failure to protect when another one of her sons sexually abused her grandchild and she refused to believe it.

Again, this case anecdote does not represent a trend. This was an isolated incident of a worker not finding a previous referral on a foster home applicant, rather than a situation in which staff failed to assess the history appropriately. According to independent consultants DHS maintains an extremely rigorous background check process.

DHS' Efforts to Strengthen Home Approval Process

Last period, in response to the findings of DHS' and the Co-Neutrals' first review of 50 new home RFAs, DHS proposed, and the Co-Neutrals approved, a detailed action plan to address the specific concerns surfaced through the RFA review. The RFA Action Plan includes: ongoing, quality assurance through resource home case reviews; training for staff and supervisors to enhance their assessment skills and use of new resource home review tools; the development of new training for all resource staff on conducting thorough home assessments; and guidance on higher-level reviews and approval of homes with concerning histories. During this period, DHS began to implement its RFA Action Plan. Specifically:

- Effective September 15, 2017, DHS established a new protocol that requires field managers to review prospective foster families that have any noted history involving physical violence, substance abuse or any type of sexual-involved maltreatment. This new protocol was developed in response to historical concerns of foster homes approved with these concerning backgrounds.
- DHS provided trainings to relevant staff and supervisors to build the competencies and critical thinking of the individuals charged with developing home assessments and those responsible for approving them.
- Continuous Quality Insurance (CQI) staff assisted with a review of 72 recently approved homes that were considered high risk due to having a prior child maltreatment referral or Written Plan of Compliance (WPC). DHS reported the findings of this review raised similar concerns about the home approval process decisions.
- In October 2017, DHS reported it began a review of criminal, child welfare and family histories, and references on all open traditional and kinship resources.
- At the very end of the period, DHS revised the Record Check Documentation

form to promote workers' review and documentation of identified criminal and child welfare history. The revised form includes three new public searches for foster and adoptive applicants, which are required per state statue. In addition, the form was updated to include an applicant's account of any criminal or child welfare history and the disposition validated by higher-level staff.

- Lastly, also at the end of the period, DHS developed the Initial Kinship Safety Evaluation and Approval tool. According to DHS' February 2018 Semi-Annual Summary Report, the "tool assists resource staff to ensure all initial kinship requirements are met and the child's safety is ensured prior to placement in a kinship placement." The tool requires supervisory approval prior to a child's placement in the kinship resource.

DHS also decided to rely more substantially on resource family supervisors in the review and approval process of new homes. Central to this work is ensuring that supervisors conduct thorough reviews of all RFAs of prospective foster homes developed in their respective management areas. Supervisors have always been required to document their decisions to approve a new home. However, the long-standing practice had been that a team of DHS readers undertook the primary review and approval of RFAs statewide. DHS found that supervisors were not consistently conducting thorough reviews of new home RFAs, as required, instead relying on the readers. DHS is in the process of removing the role of the readers and re- establishing the primary role of supervisors to review and approve new homes.

DHS developed a Resource Family Assessment Review Tool to facilitate supervisors' review of RFAs.[34] This tool comprehensively captures requirements that must be met by prospective foster parents and prompts supervisors to assess any identified deficiencies or concerns surfaced through the home approval process and document, if the home is approved, how DHS was able to resolve the issues to ensure child safety. DHS requires that supervisors upload the completed review tool to the KIDS digital file cabinet for the new, approved home. In a review this period of 50 new home RFAs, the Co-Neutrals observed that implementation of the review tool is still in its initial stages. The Co-Neutrals found that supervisors are not yet routinely using the new form to document the actions taken by DHS to address and/or mitigate any identified safety concerns in the home and the form is not consistently uploaded to new homes' resource file cabinets in KIDS.

Core Strategies to Reduce MIC in Facilities

Throughout this report period, there continued to be an overwhelmingly disproportionate rate of child maltreatment in institutional settings. Based on the MIC data reported for this period, which showed that 16 more children were abused and neglected in institutional settings than during the last period, the Co-Neutrals have serious concerns about DHS' efforts to achieve substantial and sustained progress for child safety in institutional settings.

Again, context is critical in this consideration. Based upon data from the most recent semi-annual report submitted by DHS, there was an increase in the number of incidents classified as maltreatment in care. It is equally, if not more important though, to point out that 23 of the

cumulative MIC incidents occurred in facilities whose contracts were terminated or who are no longer providing services.

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[34] This period, DHS created the Resource Family Assessment Review Tool by combining two prior tools - the Resource Approval Checklist, which was completed by the assigned supervisor to ensure all requirements are met by applicants for full resource approval, and the RFA Review Tool, which is used by both the Co-Neutrals and DHS in their respective reviews of the home approval process.

Between October 1, 2016 and September 30, 2017, DHS substantiated the maltreatment of 60 children placed in institutional settings, compared to 44 children for the prior period. These 60 child victims were identified in 41 distinct substantiated referrals. Investigators determined children were abused or neglected in 24 distinct institutional settings in Oklahoma this period. As the Table below illustrates, the majority of child victims and distinct substantiations during the current period were heavily concentrated among six institutions.

Table 7: Institutions with More Than One Substantiation, October 2016 to September 2017

Resource	# of Distinct Substantiations	# of Child Victims
Facility 1*	8	9
Facility 2**	4	9
Facility 3	4	5
Laura Dester	3	4
Facility 4	2	2
Facility 5	2	3
TOTAL	**23 of 41**	**32 of 60**
Percent of Total Substantiations This Period	**56%**	**53%**

*This facility is now closed.

** DHS placed a hold on new placements at this facility as of March 28, 2018.

The recurrence of child maltreatment at these six institutions this period raises questions about DHS' capacity to effectively address and remedy identified safety concerns in institutions where it places children. Following the close of this data report period, three of these institutions continued to report additional, confirmed child maltreatment.

During the fall of 2015, DHS began implementing a series of commitments to expand and strengthen protocols for oversight, monitoring, and engagement with higher-level institutions to reduce the risk of maltreatment of children and youth living in institutional settings. Specifically, these protocols require DHS to initiate and enforce corrective actions to mitigate any identified safety concerns in an institution. For those institutions with confirmed child maltreatment, DHS is to apply heightened monitoring and oversight to ensure the timely and full resolution of safety concerns.

DHS also committed through new contract requirements to ensure that all group home facility staff are trained on Managing Aggressive Behaviors (MAB), a model of positive youth development selected by DHS to prevent child restraints and de- escalate behavioral challenges presented by children and youth.

During this report period, the Co-Neutrals observed DHS' continued implementation of these commitments, with varied rigor and to varying degrees of effectiveness. Despite these efforts,

the rate of maltreatment increased in institutional settings for this report period. In a review of three institutions that were the sites of multiple child maltreatment substantiations this period, the Co-Neutrals found, as documented by DHS, ongoing safety concerns that placed children at increased risk of maltreatment during the period. One of these institutions is the state- operated shelter, the Laura Dester Children's Center. Included below is a detailed summary of the safety concerns identified by DHS and the Co-Neutrals at the shelter that led to a dramatic increase in child maltreatment between October 2017 and May 2018.

DHS' Efforts to Reduce Child Maltreatment in Institutional Settings

In 2015, DHS designed a protocol to delineate the steps DHS and facilities must take during and following an investigation of maltreatment, or when any issue affecting child safety is identified. In a review this period, the Co-Neutrals observed that Specialized Placement and Partnership Unit (SPPU) liaisons initiated actions following an investigation but did not consistently remedy the identified concerns. DHS often initiated a corrective action plan (CAP) following an investigation to address any employee-specific concerns. However, the review found that Facility Action Steps (FAS) were less often initiated to address facility-wide (or agency-wide) practices or conditions of concern, including contract compliance, inadequate training, poor staffing levels, over-use of restraints and inadequate supervisory oversight. Given that some of the facilities had systemic or cultural concerns identified by DHS that were not effectively addressed to reduce the risk of harm to children, the department missed critical opportunities to promote child safety.

DHS committed in 2015 to undertake heightened monitoring of institutions with the highest number of maltreatment substantiations. This is supposed to include, among other activities, quarterly audits with facility leadership to review agency data and performance; bi-weekly heightened monitoring meetings within DHS to track safety and progress on risk mitigation; and a formal accountability process when improvements are not implemented by established deadlines. The facilities subject to heightened monitoring are selected quarterly based on DHS' most current child maltreatment data, which identifies institutions with the highest number of MIC substantiations for the period. Since the inception of heightened monitoring in 2015, DHS has identified 21 group homes and shelters it determined required intensified oversight to address identified child safety concerns. Nineteen of these facilities participated in heightened monitoring, while two declined. Of these 19 facilities, nine are no longer providing placement to children in DHS custody due to contract termination or closure. One of these facilities is the state-operated Laura Dester shelter, which the Co-Neutrals ordered DHS to cease using due to concerns for children's safety. As of July 31, 2018, eight of the 19 facilities have not had any confirmed child maltreatment following the implementation of their heightened monitoring improvement plans. The remaining two facilities are currently subject to heightened

monitoring and, as discussed below, have experienced recurrent maltreatment after the initiation of heightened monitoring.

As DHS committed in its core strategies, each facility subject to heightened monitoring had an active Facility Services Plan (FSP) during the report period. The FSP is a rolling document created and maintained by the assigned SPPU liaison to track and monitor a facility's maltreatment referral history and all identified child safety risk factors. The Co-Neutrals observed that on the FSP for each facility subject to heightened monitoring, the SPPU worker recorded their observations monthly from their visits to the facility, and made note of issues that needed to be addressed. For three of the institutions with multiple substantiations, SPPU workers documented ongoing, unresolved concerns with the facility in the FSP as DHS continued to place new children there. For example, in DHS' FSP for a Level E group home, DHS documented its efforts, observations, and concerns for each month the institution was subject to heightened monitoring from January 2017 to December 2017. During 12 months of monitoring and engagement by DHS at this facility, DHS consistently documented concerns of a prevailing culture of "control and compliance" with children that did not adequately include "trauma responsive elements" of care, staff failing to engage with youth, and facility leadership's reluctance to take steps toward improving the quality of care provided to children. As these concerns continued despite DHS' oversight of the facility, maltreatment of five children was confirmed at the facility between June 2017 and December 2017. As of June 2018, there were four additional pending investigations at this institution with allegations of child abuse and neglect while DHS continued to place children there.

The Co-Neutrals found similar issues at another Level E group home that cares for children who are 12 years of age and younger with higher-level behavioral and emotional challenges and needs. This group home first became subject to DHS' heightened monitoring in November 2015. The Co-Neutrals observed that over nearly two years, DHS has provided enhanced oversight and increased its presence, particularly during periods of instability at the facility. However, these efforts have not prevented continued incidents of child maltreatment at the facility. Significant concerns for child safety remain regarding a lack of adequate staff supervision and errors in the administration of prescribed medications, which have continued to result in harm to children. During this report period, investigators determined nine children were abused and neglected at this institution. Since the close of the reporting period, four additional children were maltreated. As of June 2018, there were an additional two investigations pending with allegations related to lack of supervision and improper medication

administration.[35]

Supporting Group Homes to Therapeutically Manage Child Behavior

During this report period, institutional staff physically abused 19 (32 percent) of the 60 child maltreatment victims in institutional settings. In response to historical concerns of children being subject to improper and/or unnecessary physical holds and restraints, DHS contractually required all group homes to adopt the MAB positive behavioral management model, which emphasizes de-escalation techniques. DHS committed to reduce the number of restraints and other non-therapeutic interventions that were used against children and youth in the state's custody. DHS made available to group home staff the resources of Oklahoma's Trauma- Informed Care Project (TICP) to coach and build the expertise of each group home's MAB experts and help to address child-specific challenges. This period, DHS reported higher-level institutions participated in a number of MAB related trainings. However, a DHS investigation of child maltreatment at Laura Dester, initiated in February 2018 (three months after MAB was reportedly fully implemented at the shelter and two months after the close of the reporting period), identified the following:

- Concerns that staff do not fully understand the concepts of MAB;
- Floor restraints of children, which are prohibited under MAB, are commonly used at the shelter. In addition, the investigation identified that floor restraints appear to be under-reported at the shelter and shelter administration is not monitoring the occurrence and use of floor restraints;
- It was reported the staff use whatever means necessary when in a physical restraint with children; and,
- It appears no one from administration is following up to ensure staff completes the required MAB training.

As the Co-Neutrals reported in the last Commentary, staff at some institutions have not fully adopted the MAB practice model.

Laura Dester and Child Safety

During the reporting period, the Co-Neutrals continued to express grave concerns about child safety at Laura Dester to DHS leadership. For more than two years, DHS used Laura Dester as a placement for children from across the state with complex behavioral, medical and developmental challenges or who, for other reasons, DHS could not locate a family or needs-

[35] As of this report writing, DHS currently has a hold on any new placements in this facility.

based placement. Despite the acute nature of the behaviors and therapeutic and medical needs of many of the children placed at Laura Dester, DHS did not establish conditions that would ensure a reasonable level of safety.

As referenced previously, DHS was compelled to contend with a loss of approximately 222 facility beds due to voluntary or forced closure. This left the Laura Dester facility as a necessary option to provide this state's high-needs foster children with the most intensive and highest level of care possible. The agency dedicated significant numbers of personnel and financial resources into the facility to create a safe resource capable of caring for these special categories of children. Without prior discussion and with an arbitrary deadline, the Co-Neutrals ordered the closure of Laura Dester at an unrealistic pace that increased the risk of harm to the children housed there. DHS complied, as ordered by the Court, despite the consensus of its own child welfare experts that closure of the facility at the pace demanded by the Co-Neutrals was detrimental to the children. It is concerning that, between March and June of this year, the Co-Neutrals focused their efforts, to the exclusion of most everything else, in order to have the Laura Dester physical facility closed down. They could have, instead, addressed DHS's efforts to remedy any risks that existed at Laura Dester and assisted to create a facility that could safely house a reasonable number of children until they were ready to transition.

In the third Commentary issued in October 2014, the Co-Neutrals first began to report concerns regarding incident reports and the lack of sufficient staffing and expertise to meet the higher- level medical and therapeutic needs of many of the children placed at both Laura Dester and Pauline E. Mayer, the other state-operated shelter open at that time. The Co-Neutrals have continued to present to DHS ongoing, similar and at times more serious concerns about the care and safety of children at Laura Dester. DHS had previously announced plans to close or discontinue using Laura Dester as a children's shelter by December 31, 2015. DHS made this decision as an extension of its original commitment under its Pinnacle Plan to discontinue by July 2014 placing any child ages 12 and under in a shelter or other non-family based setting unless they met an allowed exception to keep siblings together or a child with a minor parent in custody.

After closing the Pauline E. Mayer state-operated shelter in November 2015, DHS announced that due to a lack of family and need-based placements, it would not be able to close Laura Dester until January 2017 but that routine, new admissions would end by October 2015. Any new child placements would be allowed only by permission of the child welfare director and in very specific circumstances after exhaustive efforts were shown to have failed to secure an alternate needs-based placement for the child, preferably in a family based setting. DHS announced that it would close the shelter after the last child was placed out of Laura Dester. By February 2016, DHS had made efforts to reduce the population at Laura Dester to nine children. However, by

November of 2016, the number of children placed at the shelter rose again to 20- 30 placements at any given time and DHS leadership reported that closure of the shelter by January 2017 was unlikely.

Throughout the most recent 2017 calendar year, the Co-Neutrals had numerous discussions with DHS about ongoing concerns with respect to the safety of children at Laura Dester and the quality of their care. Some of these discussions were prompted by specific incidents, including: a child who was tased and handcuffed at the shelter by local police; a child whose medical needs were reported by medical professionals to exceed the medical care capacity of the shelter; and the Co-Neutrals' direct observations at the shelter of poor supervision of children and limited resources for staff. Throughout these discussions, DHS promised repeatedly to expand staff capacity through additional hiring and training.

As noted above, the need for additional, well-trained staff was exacerbated when DHS' child placements at Laura Dester raised the population to 44 children by June 30, 2017. After a visit to the shelter in July 2017, the Co-Neutrals conferred with DHS leadership about a number of

concerning observations, primarily regarding shelter staff's lack of supervision, engagement and ability to safely manage the needs of children at Laura Dester. DHS leadership pledged that improvement work was in progress.

In September 2017, the Co-Neutrals met with a broad group of DHS and shelter staff and leadership, as DHS requested the opportunity to present all of its efforts to improve safety and the quality of care at Laura Dester. DHS presented a number of actions planned or underway, including that:

- DHS reported it had developed a Continuous Improvement Model plan as part of its SPPU Heightened Monitoring team work. The plan addressed physical interventions with appropriate documentation and debriefings, including new incident forms, to ensure more accurate accounting of incidents and as a self-reflecting learning tool to improve de-escalation skills. The plan also included specific tasks to improve engagement and use of skill-based activities with the children and quality assessment of staff's use of MAB and additional MAB coaching as needed.
- DHS assigned a SPPU liaison to work solely with Laura Dester and to employ Heightening Monitoring full time.
- DHS said it planned to hire 15-20 additional direct care staff to reach a 1:4 ratio and allow for 20 direct care staff for each shift.
- DHS planned to bring on four child welfare specialists (one assigned to each cottage); three recreational staff and a program coordinator; a full-time (M-F, 8am – 3pm) teacher to provide educational instruction for children not attending public school at any point in time; and, a resident advocate. The shelter director said that they had already identified the program coordinator and resident advocate.
- DHS was retrofitting Cottage D, which was previously designed for infants and toddlers, to have more living space for older children and to better separate children based on their sensory needs.
- DHS was continuing to implement the Journey program designed to help children progressively learn to manage their behaviors. This program had been in place at Laura Dester for some time through a contract with River Parks Developmental Center.
- DHS was mapping the best way to complete an intake on a new placement (getting information about the children, sharing information with staff, and developing safety plans).
- DHS was continuing multi-disciplinary staffing to identify alternate placements that best meet the needs for permanency and well-being for children at Laura Dester.
- DHS was continuing to coordinate and expand efforts of DDS and child welfare to meet the therapeutic placement needs of children with developmental disabilities.

Unfortunately, DHS' plans did not adequately ensure children's safety or mitigate the substantial risks to child safety that reoccurs in the allegations of child maltreatment investigated by OCA over the past year. The increase in child maltreatment observed at Laura Dester over the last year coincided with a sharp increase in the number of children placed at the shelter. DHS reached its lowest population of children at Laura Dester during the first half of 2016, which corresponds to a much lower number of maltreatment substantiations recorded for the first semi-annual period from October 2016 to March 2017. During the following period, April 2017 – September 2017, DHS substantiated two referrals that involved a total of three children. And following that, from October 2017 – March 2018, DHS substantiated eight more abuse and neglect referrals that involved 10 children. DHS' own records present, with an overwhelming and compounding amount of detail, the unacceptably high level of risk and unsafe conditions created by placing together in one facility so many children with significant and complex needs and behaviors without ensuring an appropriate level of staff, training, and organizational and programmatic management and oversight.

The Co-Neutrals' concerns snowballed with the precipitous increase in child maltreatment at Laura Dester between October 2017 and March 2018. The Co-Neutrals reviewed over 100 abuse/neglect referrals prior to March 2018; over 1,000 incident reports; DHS internal records, policies, and operational documents and communications. The Co-Neutrals visited the site and made direct observations at Laura Dester before, during and after the report period, and participated in years of discussions with DHS leadership regarding concerns about DHS' efforts to establish safe, quality care for children placed at the shelter.

Summary of Operational and Safety Concerns at Laura Dester

Amid growing concern that the rate of maltreatment at Laura Dester showed an alarming and substantial upward negative trend with respect to the number of children in the state's custody who were abused or neglected while placed at the shelter, the Co-Neutrals, on March 5, 2018 directed DHS to cease placing any additional children in this state-operated children's shelter. Under Section 2.14 of the CSA, the Co-Neutrals are granted the authority to require DHS to undertake and maintain diagnostic and remedial activities when the department fails to achieve positive trending or begins to trend negatively in any area. Further, the Co-Neutrals directed DHS to develop and submit a transition plan to place all children out of the Laura Dester shelter by a date to be determined but not later than June 30, 2018.

Despite the Co-Neutrals' order of March 5, 2018, that DHS cease all admissions to the shelter due to serious concerns about child safety, DHS placed a 13-year-old boy at Laura Dester on March 7, 2018. On March 28, 2018, a staff person at Laura Dester physically punched that same child. On April 25, 2018, DHS substantiated child abuse. In its investigation, OCA documented that the staff person failed to employ de-escalation techniques in his

engagements with the child, and instead escalated the situation by engaging physically and aggressively.

This statement omits the contextual details necessary to understand the circumstances of this situation. Instead, it attempts to convey either sinister motives or lack of good faith by the agency. The real story is as follows: The Co-neutrals issued their directive to immediately cease placements to the Dester shelter via email around mid-day March 5 without warning and without prior discussion, despite the fact a "meeting of the parties" had previously been set for the morning of the 7th. In meeting separately with the Co-neutrals on the 7th, the agency explained why it believed the directive to be arbitrary and without regard to realities of the placement system at the time and proposed a reasonable phased-in approach. The agency clearly and unequivocally explained what the consequences might well be of implementing the directive so precipitously. We stated then that if no placement could be secured for a given child on a given day despite undertaking all reasonable efforts, the agency's leadership would not condone or sanction the likely result that a child would be housed in a DHS office overnight. Two days later that scenario did in fact arise. Despite the combined, concentrated efforts of local, district, regional, and central office staff over several hours extending well into the night, no placement could be found for that child. At that time, the child welfare director herself, who had been working with staff all along, made the decision to authorize placement at Dester. We believe there is no question that the decision at that moment was professionally and ethically correct and without any doubt, in the best of interest of that child. This was, in fact, the sole placement at the Shelter following the directive. It's a testament to the agency's good faith efforts and diligent, non-stop work from March through June that no further placements were made, not just a tidbit to include in the narrative that otherwise omits the highly relevant context.

On March 15, 2018, DHS submitted to the Co-Neutrals a memorandum with its Proposed Plan to Eliminate Laura Dester Children's Center as an Emergency Shelter, including an express commitment that "[g]oing forward, the Office of Client Advocacy will ensure all pending and incoming investigations involving [Laura Dester] are completed within required timeframes so that critical information needed to make safety and/or personnel decisions is available in a timely manner," which the department simply never honored. [36] The department's latest plan also listed other efforts which the agency represented would improve safety conditions and oversight at the shelter, but subsequent child abuse/neglect referrals at Laura Dester after the plan's submission strongly suggested otherwise.

Numerous attempts have been made to explain to the Co-Neutrals that the actual impact of meeting the rules-established deadline is of very little consequence in the context of Child Welfare's response to allegations of abuse or neglect. While the current, interim Advocate General is committed to the timely completion of OCA investigations, she would like to reiterate that child safety is not dependent upon the completion of an investigation. It certainly has no impact whatsoever with efforts to ensure the immediate protection and treatment of those

subjects identified in the abuse or neglect referral. The moment an allegation comes to light, personnel from Child Welfare Services, the Office of Client Advocacy, Child Care Licensing, and the involved facility coordinate to address any immediate and ongoing safety concerns:

- *A safety plan is implemented immediately when necessary*
- *OCA communicates safety issues immediately to the SPPU liaison in all cases where necessary*
- *The safety plan can restrict a staff member(s) to "no client contact"*
- *The safety plan can be modified as necessary.*

When a serious issue is encountered, the Advocate General communicates directly with the DHS Director and the CWS Director.

Again, whether the investigatory report is completed within established timeframes or not has no impact on implementation of efforts to immediately ensure the safety of the child involved.

With that said, each case on the current backlog was initiated in a timely manner. Additionally, the Co-Neutrals were kept well informed of the issues that handicapped operations within the Office of Client Advocacy. From the continuing challenge of finding an individual to fill the position of Advocate General to fully staffing vacant positions throughout the division itself, the Office of Client Advocacy has performed remarkably to fulfill its statutory and regulatory responsibilities. To say DHS "simply never honored" its commitment is disingenuous as the Co-Neutrals were kept well apprised of these continuing difficulties.

DHS Documented Areas of Concern at Laura Dester

DHS records reveal many safety and quality of care concerns at Laura Dester. Two primary areas of concern were the use of excessive force or other inappropriate actions by staff against children and the lack of adequate staff supervision of children. In June 2016, the University of Oklahoma's National Resource Center for Youth Services completed a program assessment of Laura Dester. The program assessment, while completed two years ago, offers a cogent summary of the risks to child safety that remained present in the reporting period. The assessment listed the following areas as needing programmatic improvement:

- Current staffing and programming is not designed to meet the specific needs of many of the young people currently residing at the shelter. (The assessment reported that the last child maltreatment substantiation was due to staff not having proper training in the use of a feeding tube, resulting in a child not being fed.)
- Staff continue to struggle in positively engaging those young people at the

shelter who exhibit more challenging behaviors, often referring to these young people as “delinquent.”

- Requests for specialized equipment to assist with the activities of daily living for some of the residents have been difficult to meet.

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[36] The Office of Client Advocacy (OCA) is part of DHS’ organization but is separate from the main child welfare agency. OCA investigates reports of child abuse and neglect in institutional settings while Child Protective Services (CPS), which is part of DHS’ child welfare agency investigates reports of child abuse and neglect in family settings, including foster homes.

- Staff are struggling to keep all the young people actively engaged in meaningful, developmentally appropriate activity.
- Staff need training and supervision regarding working with young people with intellectual disabilities or require assistance in self-care, mobility, and communication, as well as those young people whose development, behavior, and relationships are impacted by traumatic histories.
- In order to keep shifts covered, many staff are working double shifts and extensive overtime. Staff are tired and get little relief from this highly stressful situation. This can have an impact on their ability to provide consistent therapeutic interactions.
- Some staff forget the developmental level or the traumatic histories of the youth they are working with. Some staff may not understand the needs of the youth or what sorts of interventions would be helpful.
- Some staff are not skilled at noticing when youth are in the initial stages of crisis, so interventions do not come until much later in the escalation.

Over a year after this program assessment identified concerns with the quality of care at the shelter, Tom Bates, who at the time served as Special Adviser to Governor Mary Fallin and Interim Advocate General of the Office of Client Advocacy (OCA) at DHS, forwarded to DHS child welfare leadership in a January 12, 2018 email a list of safety and quality of care concerns at the shelter observed by OCA staff familiar with abuse/neglect investigations at Laura Dester. The email contained the following:[37]

> *Attached are a list of concerns about the shelter that were submitted to me by OCA staff. I know you continue to work on securing adequate staffing, but one issue that continues to come up is the availability of supervisors and the support they are providing to staff on the floor. Is there a plan to address that issue? In order to take full advantage of our time with Jim Powell, it is imperative that supervisors and MAB trainers be on the floor with him. I understand that those personnel may have been covering other duties so let us know what we would need to do to get you the support you need. Director Lake has made clear that he will make that support happen.*

[37] Through an independent review of substantiated, unsubstantiated and screened out referrals from Laura Dester, the Co-Neutrals identified a number of the specific referrals and reports that directly formed the basis of Mr. Bates' January 12 email, some of which are summarized below.

Concerns regarding Laura Dester:

1. [Staff X] been observed in the Cottages since he has been placed on no contact. [Staff X] has a current referral where he is seen on video and placing his hands around a child's neck and forcing him to the floor. He is also seen on video on top of a child during a restraint. Safety Plans are not being followed.

2. Not enough staff in the cottages. It was reported the ratios that are currently in place do not match the level of supervision needed for the types of children placed at the facility.

3. It was reported the staff have been given the task of supervising up to 8 residents, which is an unreasonable expectation.

4. Supervisors stay in the administration building, even though the supervisors are aware the staff are struggling to maintain order in the cottages.

5. It was reported when the supervisors are called for assistance they either do not answer the phone or they arrive after the incident passed.

6. It was reported the administration that comes in on the weekend is no help to the staff and does not serve a purpose, as they are not on the cottages assisting the staff.

7. It was reported staff are working multiple 16 hour shift a week, which makes them irritable and less effective. LDCC has a policy in regards to mandatory overtime, which does not give them any choice as to when they can go home. This was reported to be occurring 3-4 times a week. This alone puts the children at great risk for neglect and or abuse, not to mention we are forcing staff to neglect their own families in order to keep their jobs.

8. Staff are having conversation about not feeling supported from their supervisors and administration.

9. It was reported the staff are not receiving adequate training for the population that is currently placed at the shelter.

10. It was reported a countless number of children are not enrolled in school and not on homebound services.

11. It was reported the CWS assigned to the children placed at the facility are not receiving daily/weekly incident reports on their children, therefore they are unaware as to how bad the environment and behaviors are at the facility.

12. There are concerns children are discharging from the facility with more issues than they arrived with.

13. It has been reported there is a disconnect between the Shelter SW's and the CWS assigned to the children.

14. It has been reported the kitchen is not serving adequate amounts of food for the children, and the food that is served is terrible quality.

15. It was said that African American residents do not have the appropriate products to keep their hair healthy, and are not be taken to get their hair cared for.

16. It was reported the residents are not receiving adequate therapy at the facility and have severe trauma, abuse, and neglect in their history. These children are staying at LDCC for extended periods of time and need/deserve treatment.

17. Residents are being sexually abused by other residents, and then remain on the same campus with them. We would not allow this in a home setting, so why is this happening at a DHS shelter?

18. Staff are moved around from cottage to cottage therefore they do not build solid relationships with the children.

Heightened Monitoring at Laura Dester

During the report period, in September 2017, following two substantiated referrals of child maltreatment at the shelter, DHS decided to make Laura Dester fully subject to heightened monitoring through the SPPU program office. In addition, beginning in October 2017, a lead DHS staff person began bi-monthly visits to the shelter to observe both shelter staff and leadership and to address identified concerns that impact children's safety while placed at the shelter. The Co-Neutrals' review of the Laura Dester shelter's FSP for September 2017 through December 2017, as well as over 100 SPPU contact notes from January through March 2018 revealed that DHS' SPPU unit's ongoing, documented observations mirror, but did not ameliorate, many of the child safety concerns lifted up by DHS' Office of Client Advocacy, as summarized in Mr. Bates' January 2018 email, and those highlighted in the program assessment completed in June 2016.

The confirmed allegations of maltreatment at Laura Dester include incidents of children being choked, punched and kicked. In one instance, a referral was made on October 4, 2017 that on an unknown date, in the cottage kitchen, a 12 year old child knocked a container of Gatorade

on the kitchen floor. Since he had just cleaned the kitchen floor, the staff person was reportedly upset by the spilt juice. The staff person placed the child in a headlock, which is an unapproved hold. On March 30, 2018, OCA substantiated child abuse. The staff person substantiated in this referral is the same staff person responsible for abuse in three other maltreatment referrals. Following the first abuse referral on August 18, 2017 this staff person was subject to a Plan for Immediate Safety (PFIS), which stipulated that he was not to have any contact with residents. As evidenced by three subsequent incidents of substantiated abuse after this initial August 18th referral, DHS did not comply with the safety plan and the staff person continued to abuse children. This typifies much of DHS' approach to child safety at Laura Dester: warning lights that often went unheeded in a timely way.

Again, the Co-Neutrals' inflammatory recitation of their perceptions is in conflict with the circumstances the Department was addressing in real-time with the children at the Laura Dester facility (not to mention the conflict with the Co-Neutrals' good faith determination of the Department's praiseworthy efforts made in the prior Commentary).

Due in large part to a lack of available beds throughout the state to care for a population of children who are notoriously difficult to place and maintain, significant resources and personnel were dedicated by DHS to ensure the Laura Dester facility could address these children's needs and behaviors. No reports of harm or threat of harm at the facility went unheeded. Issues brought to the attention of DHS leadership were immediately addressed.

There are numerous instances, as well, where DHS did not substantiate maltreatment, but the investigation revealed serious harm to the child. In one such case, a first-hand report was made by shelter staff that on December 1, 2017, a seven year old child who is non-verbal and deaf, was found in the bathtub with water pouring onto the bathroom floor and into the hallway. A direct care staff person was observed jerking the child out of the bathtub, pulling the child's ears and slinging the child across the bathroom and bedroom floors, causing the child's hip to hit the edge of the bed. Heightened monitoring and child welfare staff confirmed observing the staff person becoming increasingly agitated with children and holding another child, in a separate incident, on the ground in a threatening manner. Several days after this bathtub incident, the seven year old child presented with a large bruise on his buttocks, a nickel-size bruise on his hip and a 1-2 inch scratch. The investigation interviews and notes reported that the staff person in question lacked credibility and did not provide appropriate care to children. OCA's investigation resulted in an unsubstantiated finding of abuse on December 14, 2017, but did confirm caretaker misconduct.

Staffing challenges: lack of supervision

Child neglect in the form of inadequate supervision was the most frequently reported allegation in the records the Co-Neutrals reviewed at Laura Dester. Given the medical

behavioral, and/or developmental challenges of many of the children placed at the shelter, adequate supervision of children is imperative to protect children. In its first month (September 2017) of heightened monitoring at Laura Dester, SPPU documented that "youth were roaming around the cottages and outside unsupervised." In each subsequent monthly update through January 2018, SPPU documented observations regarding the lack of supervision, including concerns that children with problematic behaviors were observed without any supervision at the shelter.

Some of the children at the shelter, due to their specialized needs, require one-on-one, line of sight supervision. In some cases, these children who require constant supervision were documented as unsupervised by shelter staff. For example, on January 11, 2018, SPPU "observed a client on heightened supervision alone." Referrals monitored by SPPU in contact notes also documented the unsafe outcomes that resulted from a lack of supervision, including children: physically assaulting one another; presenting with unexplained injuries; and missing from care (MFC).

A leading factor contributing to a lack of supervision was the significant deficiency in DHS' efforts to establish and implement accountability processes at the shelter. Most notably, shelter management did not adequately train staff on a process to identify, document and track which direct care staff person was assigned to which child(ren) for each shift.[38] DHS also did not establish a process to ensure that direct care staff consistently was made aware of all precautions they needed to take in order to safely care for each child assigned to them. DHS implemented new accountability processes that were intended to inform staff of each child's specialized needs and supervisory requirements (i.e., food allergies, aggressive or SAO behaviors, requirement for 1:1 supervision) but during an unannounced visit to Laura Dester commencing at 6:00am, the Co-Neutrals on April 9, 2018 observed a substantial lack of consistency in staff's implementation of these improved accountability processes. In particular, the Co-Neutrals observed concerns related to staff documenting the required, minimum 15-minute checks for each child and when the supervision of a child changes within a shift from one staff person to another. Further, staff were not documenting if they observed a new injury on the child(ren) assigned to them. Of the 22 accountability sheets (one for each child on campus) completed for the first shift on April 9, 2018, the Co-Neutrals found that this new injury section was completed on only five of the sheets.

Numerous substantiated child maltreatment referrals revealed ongoing problems regarding shelter staff supervising children, particularly those who have specialized needs and vulnerabilities. An eight year old child who is autistic and non-verbal and requires 1:1 supervision due to his specialized needs and vulnerabilities was able in March 2018 to enter a bathroom and put himself in the bathtub with water without staff knowledge. Once staff became aware the child was in the bath, they proceeded to leave him unattended in the bathtub with the exception of implementing five-minute checks. The investigation clearly identified that the safety risks on this day

were due to inadequate supervision and training of new DCS staff, especially as related to children with heightened needs. On the day of the incident the shift supervisor assigned two staff to the cottage where the child was placed. The two staff were new, both having worked less than a week in the cottages. In addition, staff person A was instructed to shadow staff person B who reported it being only her third official

[38] There are three shifts in each day's 24-hour period: first shift is 6:45am – 3:15pm; second shift is 2:45pm – 11:15pm; third shift is 10:45pm – 7:15am. These shift overlaps by 30 minutes to allow for shift change briefings and continuous supervision.

day working in the cottages. The supervisor said that his rationale for placing two new staff in the same cottage without supervision was that this cottage had the lowest census and the residents in the cottage were typically "easier" to take care of. However, as the Co-Neutrals discovered, the children typically placed in that cottage were children with developmental disabilities who required heightened supervision and care. The supervisor reported that the supervision level for children in that cottage was "Line of Sight," reflecting the increased needs of this population of children. However, the supervisor reported that the Master Log did not notate that "Line of Sight" supervision is required for children in this cottage. According to DHS, "[The new staff] had not been made aware of [the child's] diagnosis or level of supervision…[The supervisor] had a responsibility to ensure the safety of the resident by providing adequate supervision with an appropriate caretaker, as he was the supervisor on duty. [The supervisor] admitted the children in Cottage D were to have Line of Sight supervision; however, he failed to advise either [new staff member]."

Both new staff reported that their training was limited in regards to the care of children, the guidelines of care in the cottages, and daily schedules. Both reported that during training they were not informed of children who could not be left alone in the bathtub. In addition, they both reported being unaware of the eight year old child's diagnoses and specialized needs.

The DHS investigative report stated that the supervisor "failed to ensure [both new staff] had the necessary need-specific information to provide appropriate care and supervision to [the child], which could have resulted in serious physical injury." On June 28, 2018, DHS substantiated Neglect – Threat of Harm to the supervisor on duty.

This investigation found that the same child had been observed at school with dried feces on his socks and legs. It was also reported that school staff attempted to contact Laura Dester when the child needed to be removed from school and it would sometimes be hours before any one from the shelter arrived to attend to the child.

On July 5, 2017, staff brought a non-verbal nine year old child on an outing to the Tulsa Air and Space Museum. Two vans transported the children to the shelter and four staff were responsible for supervision during the outing. After the visit to the museum, while traveling back to the shelter in one of the vans, a staff person received a phone call that the nine year old child was still at the museum, having been left behind at the museum by shelter staff. The investigation identified that the outing to the museum was poorly organized and the appropriate level of planning and supervision to ensure child safety was not demonstrated by shelter staff. In particular, the investigation found that safety protocols such as conducting a head count of children prior to leaving the museum and documenting which van transported which children, were not followed. On January 31, 2018, DHS substantiated Neglect – Lack of Supervision against the four staff responsible for supervision during the outing. After returning

to the shelter, the child was observed with a burn on his left forearm that measured 2X2 inches and was identified by the nursing staff as a second degree burn. Due to the child being non- verbal, the investigation was unable to determine how the child sustained the injury. The investigation notes that the child did not have the mark prior to the outing to the museum. OCA substantiated Neglect – Failure to Protect against an unknown caretaker. This same child was physically injured and maltreated several months before this incident as confirmed in a separate maltreatment investigation at Laura Dester.

In addition to the numerous substantiated allegations of maltreatment for lack of supervision, the Co-Neutrals reviewed 36 maltreatment investigations that closed between September 2016 and March 2018 with an unsubstantiated finding. The majority of these investigations (25) involved allegations of a lack of supervision. One referral involved a six year old who is non- verbal and autistic missing from the campus for 45 minutes on October 15, 2017, during which time a car had to stop abruptly to avert hitting the child as the child had crossed the busy thoroughfare in front of the shelter. The investigation report showed that Laura Dester staff was aware that this child was a "runner" but still did not maintain sufficient supervision to prevent the child from leaving the shelter campus alone.

A plan for immediate safety (PFIS) was established the next day stating, "shelter staff will maintain line-of-sight supervision of [this child] at all times." Two days after this PFIS was established, this same six year old again went missing and was later found by staff in a vacant room taking a bath unsupervised. (Note: the vulnerable child involved in this incident is different from the children involved in similar bathtub incidents referenced above.)

It was reported that on November 10, 2017, two children, one who is autistic and non-verbal (age six) and the other who is non-verbal and deaf (age 12) were left unsupervised, outside in the shelter courtyard and unable to re-enter the shelter for 30 minutes. Both of these vulnerable children were assigned one-on-one supervision but their assigned staff were on a smoking break. A shelter staff person who was on light duty (could only sit) observed this incident. DHS screened out the allegations and did not assign this referral for investigation, noting that lack of supervision is a licensing violation.

Staffing Challenges

Throughout DHS' records, staffing shortages are reported to have limited staff's ability to sufficiently supervise and engage children at the shelter. DHS reported to the Co-Neutrals in September 2017 that Laura Dester intended to hire what the agency reported to be 42 direct care staff, including two recreation staff and three child welfare specialists. However, the shelter director reported on April 9, 2018 that because of high turnover, there had been a very limited net gain of direct care staff. Further the new resident advocate and program

coordinator positions that DHS promised in September 2017 were not filled until after the Co- Neutrals' order of March 5, 2018.

SPPU documented in January 2018 that the shelter "continues to struggle with not having enough staff to meet the needs of the youth, requiring staff to work numerous doubles in a row." On March 16, 2018, SPPU documented that two youth were arguing in a cottage and staff wished to separate the youth to de-escalate the situation. However, since there were only two staff assigned to the cottage, staff were unable to separate the youth. SPPU documented some of the consequences of staffing shortages on staff morale, citing that shelter staff report being "exhausted, frustrated and unsupported in their work." SPPU also documented that staff appear "overwhelmed" and "tired."

In its investigations, OCA has also repeatedly documented that Laura Dester was understaffed and chaotic. Several investigations reported that supervisors often did not assist direct care staff with supervision of the children and when staff requested assistance from supervisors, particularly when children's behaviors escalated, supervisors frequently did not respond until the incident was over. OCA reported that staff at Laura Dester was known to work double shifts, as long as 16 hours, which inhibited their ability to provide proper care to the children due to fatigue, and caused some staff to become short tempered and inappropriately react to the challenging behaviors of some children.

Despite repeated warnings from SPPU, OCA, the Governor's liaison and the Co-Neutrals about unsafe conditions for children at Laura Dester, and an increase in referrals of abuse and neglect of children at the Center, DHS did not make good faith efforts to address the risks to child safety. From March 2017 thru February 2018, OCA substantiated seven distinct referrals of child maltreatment at Laura Dester involving 10 children in DHS custody. During the same period, DHS accepted 46 child maltreatment referrals that were either ruled out or unsubstantiated, and screened out an additional 53 referrals.

Under Section 2.14 of the CSA, the Co-Neutrals are granted the authority to require DHS to undertake and maintain diagnostic and remedial activities when the Department fails to achieve positive trending or begins to trend negatively in any area. In light of the agency's performance with respect to child maltreatment in care, and grave concerns for child safety at Laura Dester, the Co-Neutrals required DHS on March 5, 2018 to cease any new placements at Laura Dester. Further, the Co-Neutrals required that DHS develop a transition plan to place all children out of the shelter by a date to be determined but not later than June 30, 2017. As additional referrals and substantiations of child abuse and neglect at Laura Dester surfaced after March 5, 2018, the Co-Neutrals filed with U.S. District Court Judge Frizzell a request to adopt the Co-Neutrals' directive as a judgment of the Court, to which DHS objected. Judge Frizzell ordered on June 5, 2018, that "the Oklahoma Department of Human Services

must,

among other things, relocate the remaining children currently placed at the Laura Dester Children's Center in Tulsa, Oklahoma to alternate, safe, needs-based placements by June 30, 2018." (See Appendix F)

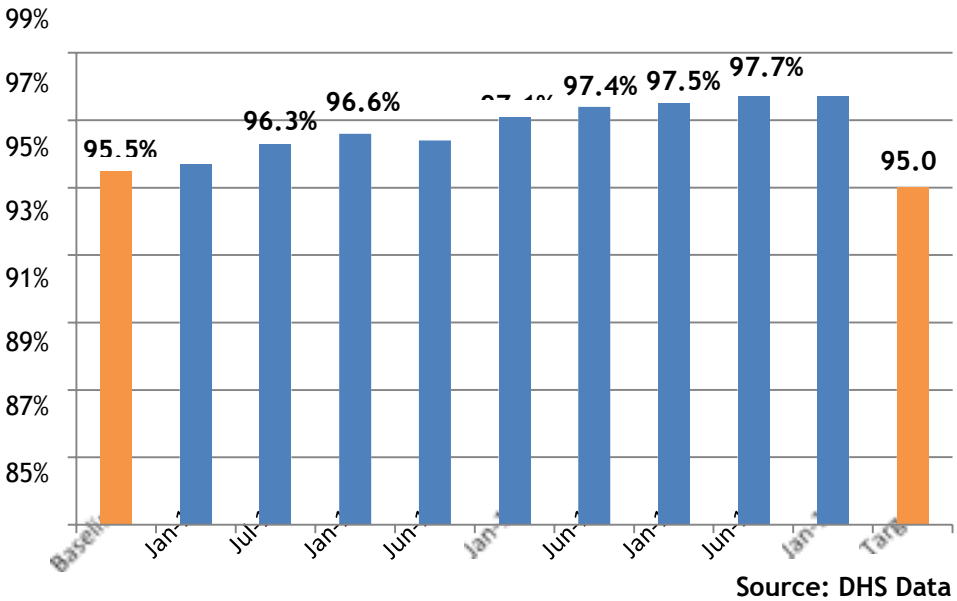
F. Caseworker Visitation

Quality visits by the same caseworker with the same child is fundamental to achieve stable placements and timely permanency for children, provide opportunities to assess and address children's safety and well-being, and support foster parents in their care of foster children. DHS reports on two performance areas related to caseworker visits: the frequency of caseworker visits, which is defined as the number of required monthly visits completed with children in care; and, the continuity of visits by the same caseworker. For frequency of visits, DHS reports on the following:

> Metric 3.1: The percentage of the total minimum number of required monthly face-to-face contacts that took place during the reporting period between caseworkers and children in foster care for at least one calendar month during the reporting period.
>
> Metric 3.2: The percentage of the total minimum number of required monthly face-to-face contacts that took place during the reporting period between primary caseworkers and children in foster care for at least one calendar month during the reporting period.

Regarding Metric 3.1, DHS reported that caseworkers made 102,032 (97.7 percent) out of 104,427 required visits with children during the reporting period of January 1, 2017 to December 31, 2017. DHS started strong with an original baseline performance of 95.5 percent of all required visits made. DHS has consistently shown in every report period performance that exceeds the Target Outcome of 95 percent for this metric. DHS' performance this period remained the same as last period, which has been the highest performance outcome reported during this reform.

Figure 22: Metric 3.1 – Frequency of Visits by All Workers

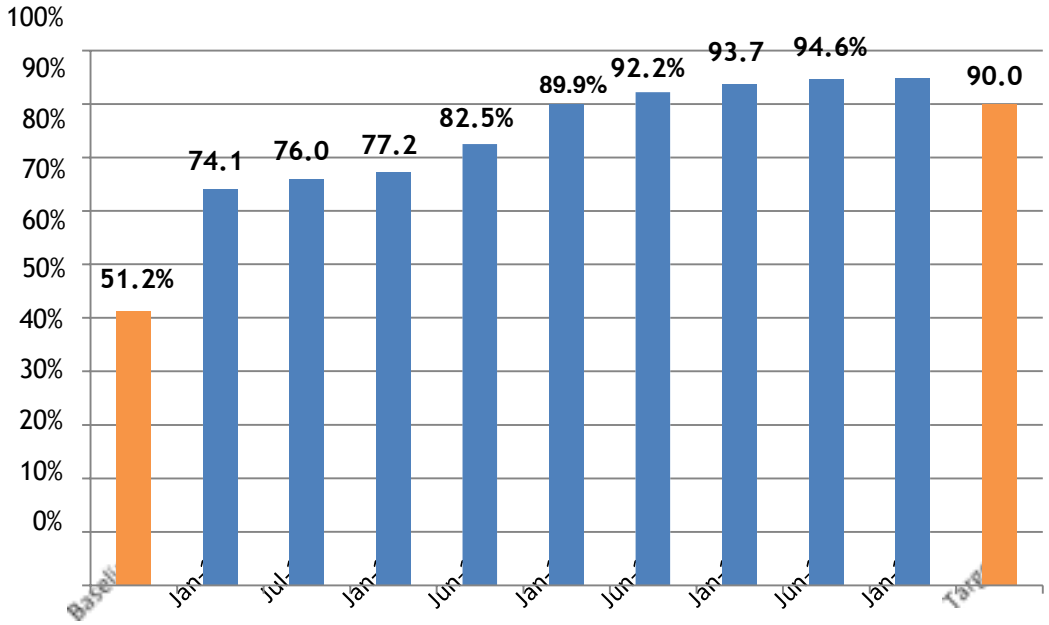


Source: DHS Data

DHS' consistent, strong performance on Metric 3.1 demonstrates DHS' commitment to regular monthly visits between children and a caseworker. The Co-Neutrals conclude that DHS has made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for Metric 3.1.

The second indicator, Metric 3.2, measures monthly required visits made by primary caseworkers only. To improve casework practice, DHS committed to end the use of secondary workers across the state by January 2014. During the current report period (January 2017 through December 2017), DHS reported that primary workers made 96,217 (94.9 percent) of the 101,378 required monthly visits with children in DHS custody. For monthly visits conducted by primary workers only, the baseline for DHS' performance was 51.2 percent and the final target of 90 percent for this metric was due on June 30, 2016. DHS has surpassed the final target for this metric the last three report periods.

Figure 23: Metric 3.2 – Frequency of Primary Worker Visits



Source: DHS Data

Through its ongoing, focused work to end the use of secondary workers, DHS has substantially shifted case practice by prioritizing the importance of having the same, primary worker meet with the same child each month. This enhanced practice supports better outcomes for children through consistent case planning by the same worker to secure a child's placement stability, safety, and permanency. The Co-Neutrals conclude that DHS has made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for Metric 3.2.

Performance Metrics for Continuity of Visits, Metrics 3.3a and 3.3b

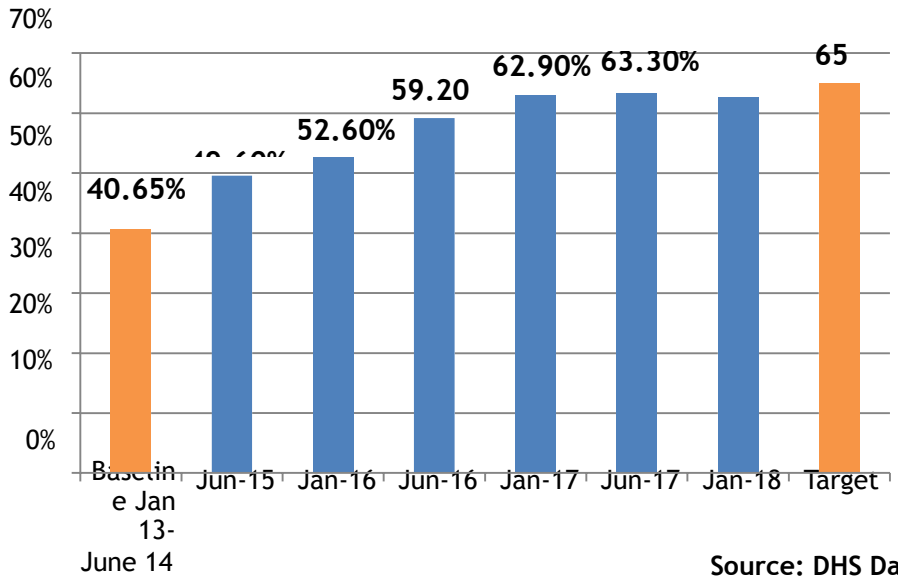
The measure the Co-Neutrals use to assess Oklahoma's progress on continuity of children's visits with the same caseworker was staged in two phases. First, DHS reported on the continuity of visits over three months (Metric 3.3a).[39] DHS is now in the second phase, reporting for the sixth time its performance outcomes on continuity of visits over six months (Metric 3.3b). Metric 3.3b measures the following:

[39] DHS is no longer required to report on Metric 3.3a, which measured three month continuity of visits with the same primary caseworker.

The percentage of children in care for at least six consecutive months during the reporting period who were visited by the same primary caseworker in each of the most recent six months, or for those children discharged from DHS legal custody during the reporting period, the six months prior to discharge.

DHS' performance for this period continued to improve from the baseline that was set at 40.65 percent. For this reporting period from January 1, 2017 to December 31, 2017, DHS reports that 8,370 children required at least six consecutive visits. Of these 8,370 children, 5,238 children (62.6 percent) were visited by the same primary worker in their most recent six months in care. This represents a decline from last period when DHS reported performance on this metric at
63.3 percent, however, DHS remains in close proximity to the final Target Outcome of 65 percent and substantially above the starting baseline of 40.65 percent.

Figure 24: Metric 3.3b – Continuity of Primary Worker Visits Over Six Months



Source: DHS Data

DHS' substantially improved performance on Metric 3.3b also reflects DHS' commitment to end the use of secondary workers and to support and retain caseworkers through more manageable caseloads. This strengthens DHS' efforts to ensure the same caseworkers perform visits each month with children in DHS custody more often. The Co-Neutrals find that DHS has made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for continuity of visits over a six-month period.

G. Placement Stability

Over the last year, DHS has worked to implement a number of strategies that were developed or approved at the beginning of 2017 to strengthen practices impacting placement stability outcomes for children in DHS custody. These strategies focused primarily on stabilizing children in their first placements, and included increasing the number of children who are placed in kinship homes as their first placement in care; improving supports and services to foster parents; and conducting ongoing reviews to understand where DHS needs to focus its efforts to improve placement stability.

During the current period, DHS undertook a number of efforts to improve how these new practices are being implemented throughout the state. As reported in the last Commentary, the Co-Neutrals presented some concerns regarding the level of detail and thoroughness of the department's communications to the field on the expectations for staff to implement the new placement stability practices. As presented below, the department responded accordingly by enhancing trainings and guidance to reinforce accountability among staff, clarifying the processes and reporting requirements of the new practices, and reiterating the value and importance of these efforts to improve placement stability outcomes. As a result, DHS reported improved outcomes with respect to the implementation of these practices over the current period. However, as DHS recognizes, continued improvements are necessary to strengthen both the consistency and quality of these practices to reduce the number of placements children in DHS custody experience.

Performance Standards

The Co-Neutrals and DHS agreed to use the federal Adoption and Foster Care Reporting System (AFCARS) files and definitions for placement moves to measure children's placement stability. This report reviews performance data for the period October 1, 2016 to September 30, 2017 for Metrics 4.1 a, b and c and Metric 4.2.

Performance Outcomes

For this report period, DHS' performance improved marginally in three of the four placement stability metrics, while performance declined in the remaining metric, as detailed in Table 8 below. Metrics 4.1 a, b and c report on the number of children who experience two or fewer placements within different lengths of time in DHS custody (e.g., 0-12 months, 13-24 months, over 24 months), while Metric 4.2 reports on the number of children who experience two or fewer placements after their first 12 months in care.

Table 8: Placement Stability Baselines, Targets, and Current Performance

Metric	Baseline Oct 2011 - Sept 2012	Performance April 2015 - March 2016	Performance Oct 2015 - Sept 2016	Performance April 2016 - March 2017	Performance Oct 2016 - Sept 2017	Target 6/30/2016
4.1(a): percent of children in custody with 2 or fewer placements who are in care less than 12 months	70.0%	73.1%	75.2%	76.0%	76.6%	88.0%
4.1(b): percent of children in custody with 2 or fewer placements who are in care more than 12 months but less than 24 months	50.0%	54.5%	53.4%	55.5%	58.0%	68.0%
4.1(c): percent of children in custody with 2 or fewer placements who are in care at least 24 months	23.0%	29.7%	30.6%	30.2%	28.6%	42.0%
4.2: percent of children in care more than 12 months, with 2 or fewer placements after their 12 months in care	74% (Apr.'12–Mar.'13)	77.8%	77.4%	78.0%	78.4%	88.0%

Kinship as First Placement

DHS has made increasing the number of children whose first placement upon removal is in a safe kinship relative or kinship non-relative placement a key objective to improve placement stability for children in DHS custody. If a child welfare system determines that a child must be removed from their birth family, placing the child with relatives or families who are familiar to them is most often in a child's best interest when such placements are determined to be safe and able to meet the child's needs. In addition to reducing the unease or trauma that children can experience when placed in an unfamiliar home, DHS' data analysis shows that children are more stable and experience fewer placement moves and disruptions when placed with kinship families. As such, DHS has made it a priority to increase the number of children placed with kinship families as part of its strategies to improve placement stability outcomes for children in DHS custody.

Starting with a focus on first placements, DHS developed guidance and strategies to enhance the department's efforts to identify kinship placements early in a case

starting with gathering pertinent information from any person who calls the statewide Hotline to report suspected abuse/neglect and from the beginning of any investigation regarding abuse/neglect allegations for children living with their birth families. The overarching message to staff is that family

engagement must be a priority through every step of the child welfare process and improving this practice will advance placement stability and other outcomes for children.

While placing children with kinship families has always been a priority, DHS' placement data suggested that the department had missed many opportunities to make a child's first placement with an available kinship family, as evidenced from a data analysis completed for DHS by the Annie E. Casey Foundation, which found that a large number of children were placed in a stable kinship home on their second or third placement after removal, not their first. To ensure that staff, particularly CPS investigators, have sought out and assessed all kinship placement options for children entering state custody, DHS established that in order for a non- kinship placement to be approved, a caseworker's supervisor must document for a district director's review and approval all efforts undertaken to identify a viable kinship placement, including the specific kinship placement options reviewed and ruled out. The supervisor is required to document all efforts made to locate a kinship placement on the Non-Kinship District Director Approval form and record these efforts and the district director's approval in KIDS.[40]

Although the main focus of increasing kinship placements has been on children's first placements, DHS requires a district director's approval for all non-kinship placements, not only those requested for a first placement. Currently, DHS has not developed a mechanism to track and report data on how consistently caseworkers complete Non-Kinship District Director Approval forms. Further, it is not clear if district directors are appropriately approving requests for non-kinship placements and if caseworkers are sufficiently documenting their efforts to identify kinship families that can serve as placements. To ensure this recently established practice is being implemented at an increasing rate in the field, DHS should review its records to assess where improvement may be needed and what information may be gleaned from the completed forms to further improve on this practice. However, DHS' data for children's first placement type clearly shows that the department's efforts to increase first kinship placements are achieving the intended result. As shown in Table 9 below, the percentage of children whose first placement is in a kinship home has improved significantly over the last year. DHS established baseline data for kinship first placements during the six-month period of July to December 2016, with 34.6 percent of children being placed in kinship homes as their first countable placement. Kinship first placements subsequently increased during the following two six-month periods to 38.5 percent (January to June 2017) and 44.6 percent (July to December 2017).

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[40] Before DHS makes a decision to remove and seek custody of a child, the department's required practice is first to hold a child safety meeting (CSM) to assess if there remains any opportunity to maintain the child safely with their birth family with supports and services from DHS and the family's available support system. If a CSM is held where a decision is made to remove a child and during the meeting kinship options are reviewed and determined not to be an option at that time, a district

director’s approval for a non-kinship placement is not required.

Table 9: Percent of Children Whose First Countable Placement is a Kinship Home[41]

Month	Children Placed in Kinship as 1st Placement	Children Removed during the Month and Entered in Countable Placement	% of Kinship as 1st Placement
Baseline: Jul - Dec 2016	**878**	**2,540**	**34.6%**
Jan-17	122	399	30.6%
Feb-17	190	443	42.9%
Mar-17	206	517	39.8%
Apr-17	162	432	37.5%
May-17	151	397	38.0%
Jun-17	170	410	41.5%
Jan - June 2017	**1,001**	**2,598**	**38.5%**
Jul-17	176	398	44.2%
Aug-17	240	489	49.1%
Sep-17	158	373	42.4%
Oct-17	149	357	41.7%
Nov-17	136	344	39.5%
Dec-17	150	303	49.5%
July - Dec 2017	**1,009**	**2,264**	**44.6%**

Source: DHS Data

During this period, DHS took a number of steps to support the earlier identification of viable kinship placements to ensure children did not, whenever possible, go to non-kinship homes while waiting for kin to be identified. As discussed in the Co-Neutrals' previous reports, there was a history at DHS of inconsistent practices and communication to the field that lead caseworkers to understand that they could not request an initial assessment of a prospective kinship family until the child needing placement was in DHS' physical and legal custody. This created a barrier to kinship as a first placement as DHS started its initial kinship assessment process too late, such as when a child was in immediate need of a placement.

In December 2017, the child welfare director issued a communication to all child welfare staff confirming that staff can and should request that the resource family unit begin assessing kinship families identified for possible placement if DHS has determined that a child cannot safely remain in their own home and DHS has initiated the process to request custody of the

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[41] Countable placements include foster care, kinship, shelters, TFC, group homes, and tribal homes. Examples of placements that are not countable include inpatient, hospitals, or trial reunification.

child. In the same communication, the director informed all caseworkers that if it appears a determination could be made at a Child Safety Meeting to remove a child from their own home and a kinship family has not yet been identified, the CPS investigative worker should invite the local foster care recruiter to observe and listen for possible kinship options in the event removal is deemed necessary. Further, foster care recruitment staff was instructed to use the guidance outlined in the Actively Seeking Kinnections (ASK) process to continue a follow up conversation with any family participating in the Child Safety Meeting to discuss further possible kinship options for the child.

Efforts to Stabilize First Placements

As discussed in the Co-Neutrals' last report, DHS has focused on two specific efforts to help stabilize a child's first placement in a foster home, which includes foster homes of all types. These are the two-day call and the Initial Meeting. Following a child's first placement in care, DHS now requires caseworkers to call the foster family within two days of placement as a mechanism to help ensure a child's needs are being met and that the resource family feels supported. This is referred to as the two-day call.

Further, following a child's first placement in care, DHS has had a standing requirement that an Initial Meeting is held within 10 days after a permanency worker is assigned to a child newly placed in DHS custody.[42] The meeting is to include birth parent(s), the foster family, the child's permanency worker, the foster family's resource worker and the CPS worker, who is also responsible for scheduling and coordinating the meeting. DHS now includes a requirement that during the Initial Meeting, DHS must develop a child and resource family support plan, which includes any services and/or supports identified as important to ensure stable placements.

For these practices, which DHS identified as core strategies to improve placement stability, the department established baseline data to assess how implementation of these practices improves over time. For the two-day call, DHS reported a starting baseline for the three- month period of February to April 2017 (only two months after this practice began) with 13.2 percent of the newly required calls completed. For the last three months of this period (October to December 2017), DHS reported that 53 percent (528 out of 1,004) of the two-day calls were documented as complete.

For the same three-month baseline period (February to April 2017), DHS reported that only 5. percent of the required Initial Meetings were completed, which confirmed DHS' earlier

[42] Previously the requirement was for the initial meeting to be held within seven days after the permanency worker is assigned to a child newly placed in custody and during this report period, DHS changed it to within 10 days.

assessment that these meetings, although a long-time requirement, had not become a common practice in the field. In comparison, from October to December 2017, DHS reported that 53 percent of the required Initial Meetings were documented as complete. While work remains for DHS to further increase implementation of these practices, the department has clearly shown progress to advance the strategies that it believes will further improve placement stability outcomes.

As with other core strategies and practices that DHS has implemented to improve child outcomes in a performance area, implementation of the practice on its own is just one component. Ensuring strong case practice is equally important. To assess the quality of DHS' Initial Meetings, the Co-Neutrals reviewed the contact notes in KIDS for 50 Initial Meetings completed during the month of December 2017. The review focused on documentation of two key areas of Initial Meetings: 1) were the needs of foster parents' discussed and addressed; and, 2) was a visitation schedule established, when appropriate, for the children to have regular contact with their biological parents.

Although the Co-Neutrals found limited documentation in KIDS from the 50 Initial Meeting contact notes reviewed, the records showed that in the majority (28) of the cases there were references to a discussion about the child's needs, likes or habits or the foster parents sharing that they were already familiar with the child. In 12 cases, the foster parents indicated that everything was going well and there were no unmet needs at that time. In 20 cases there were notes indicating a discussion of the foster parents' needs was had during the Initial Meeting, with seven of these cases documenting specific supports identified and planned for the foster parents. During focus group discussions in the field, caseworkers shared with the Co-Neutrals that foster parents often are not yet aware, understandably, of the supports they may need when a child is newly placed with them. This is why it is important for DHS' assigned permanency and foster care caseworkers to continuously assess the needs of foster parents to support placement stability. DHS has committed to such an ongoing assessment through the monthly and quarterly contacts that resource workers must complete with their assigned foster families and the monthly contacts required (at minimum) between permanency caseworkers and foster families.

DHS identified that ensuring frequent and regular visitation between a child in custody and their biological parents, when appropriate, is key to help advance not only permanency but also placement stability. The Co-Neutrals found that in 22 of the 50 initial meeting notes reviewed, plans for child-parent visitation were discussed, including frequency and transportation. In seven of 50 cases, child-parent visitation was not discussed, either because the birth parents were not present for the discussion or would not be available for visitation such as when the parent(s) is incarcerated.

As DHS continues to improve the completion rate of these Initial Meetings above 53 percent, focus must also remain on improving the quality of the discussions around identifying, confirming and documenting foster parent and child support needs and visitation plans. The child welfare director sent a communication to all child welfare staff on December 21, 2017 reinforcing the department's Initial Meeting practice and the need to use the established Initial Meeting guide to develop a Child and Family Support Plan and to document the information in KIDS. (See Appendix G) DHS must also ensure that all caseworkers required to participate in the meetings are present[43] and understand the importance of attending these meetings, as well as their responsibilities during and following the meetings to support foster parents.

Further, the Co-Neutrals understand DHS' priority at this time is to focus on firmly establishing quality and consistent practices for these two selected placement stability strategies (two-day call and Initial Meeting). However, these strategies are currently required only for a child's first placement after removal and not any subsequent family-based placements. As such, DHS must assess how these strategies should be applied to any new family-based placement for a child to support foster parents in the same or modified way for all new placements, not just the first, in order to further advance placement stability.

Assessments of Placement Stability

To support more stable placements for children in DHS custody, in January 2016, DHS began implementation of the monthly "Two-Moves" tracking report. The original focus of the report centered on those children who experienced a move from their second to third placement each month. For each of the children who experienced a move to their third placement in a given month, DHS required the child's permanency caseworker to document in the Two-Moves report the reason the child was moved, the specific efforts undertaken to prevent the child's placement move, and the efforts taken to collaborate with the foster family's resource worker to avoid a third placement. During this period, DHS changed the focus of this report (now referred to as the "One-Move" report) to all children who moved from their first to second placement.

The objective of the One-Move report is two-fold: first, it establishes an accountability process by requiring that permanency workers and their supervisors assess if children who moved to their second placement, as well as their foster families, received the appropriate supports and services to help prevent the first placement move, and second, it focuses workers on ensuring the child's new placement is prepared for and supported in caring for the child to secure

[43] The Co-Neutrals found that only in eight of the 50 Initial Meeting records reviewed, was it specifically noted that all the required caseworkers participated in the Initial Meeting.

stability in the second placement. DHS reports that the children directly targeted by DHS' One- Move report are those included in the Metrics 4.1a (children in care for less than 12 months who are in their first placement) and 4.2 (children who remain in their same or "first" placement they were in when they entered their 13th month in care).[44]

The One-Move report from December 2017, the last month of the current period, showed that statewide a total of 145 children exited their first placement. As the chart below illustrates, the primary reason children exited their first placement during the month of December was to be placed in a kinship home (27 percent). The other most common reasons for children exiting their first placements were: foster parents' request due to personal issues (22 percent) and foster parents' being unable to work with a child's behavior (15 percent).

Table 10: First Placement Exit Reasons, December 2017

Reason Child Moved from 1st Placement	# of Children	Percentage
Placement in kinship home	39	27%
Provider requested due to personal issues	32	22%
Provider unable to work with child's behavior	22	15%
Placement with sibling	21	14%
Placement in lower level of care	14	10%
Pending investigation	11	8%
Placement closer to family	3	2%
Other	3	2%
Grand Total	**145**	**100%**

Central to DHS' work related to the One-Move report has been reducing the number of children who experience placement disruptions due to foster parents requesting that a child be moved due to behaviors. To best learn from those cases where children disrupt from placements due to behaviors, supervisors call the former foster parents of each child who experienced a disruption from their first placement to understand from foster parents what specific child behaviors led to the disruption and what actions, if taken by DHS, could have prevented the disruption.

[44] Metric 4.2 measures the percent of children who experienced two or fewer placement settings after

their first 12 months in care. Since this metric functions as a re-set for children who during their first year in care experienced more than two placements, DHS included these children in their One-Move report efforts in order to work toward the stabilization of the child's placement upon entering their 13th month in custody.

From these supervisor calls, DHS has collected information from foster parents that, if systematically addressed, could better support foster families in meeting the needs of children with behavioral challenges and prevent placement disruptions. For example, One-Move reports from this report period documented the following actions, reported by foster parents, that, if taken by DHS, might have prevented the placement disruption:

- Provide better information about a child's behaviors and needs prior to placement;
- Improve communication between foster parents and caseworkers, and between different caseworkers in the home;
- Place fewer children in foster homes (particularly fewer children two years of age and younger); and,
- Provide more timely and improved access to services, particularly in rural counties.

In other cases, the One-Move reports indicate that no additional actions, if taken by DHS, would have prevented the disruption. For example, some foster parents reported that caseworkers took all appropriate actions to support the home and child but due to the severity of the child's behaviors, it was necessary for the child to be moved from the home. Other foster parents reported that they declined caseworkers' attempts to put services and supports in the home and thereby it is unclear what additional actions, if any, caseworkers could have taken to prevent the disruption.

To further inform DHS' efforts to prevent placement disruptions due to child behaviors, each regional placement stability lead conducts a case record review of two disruption cases a month. These in-depth case record reviews showed both the strengths and weaknesses of caseworkers' case practice to support foster homes that experienced a placement disruption due to a child's behaviors. In particular, the review found that in some cases, caseworkers appeared to: initiate services and supports for children and foster parents; use monthly visits to address any needs/ concerns of foster parents; and, respond timely to requests made by foster parents. The review also found that in other instances, caseworkers did not appear to provide adequate support to foster families and children. For example, some caseworkers did not consistently use monthly visits to assess and address the needs of foster parents or children; services and supports were not timely initiated or offered to foster parents; and, foster parent concerns or requests were not followed up on by caseworkers.

For those children who disrupted from their placement due to behaviors, DHS has committed to ensuring a child's second placement receives the appropriate preparation, services and supports to prevent a subsequent placement disruption. Beginning in December 2017, DHS instructed staff that if a child is moved from their first placement due to behaviors and the second placement is a kinship or traditional foster home, a Systems of Care (SOC) referral should be made in order to ensure the child's new placement is adequately supported to care

for the child and his or her needs. DHS also sent a notification to all resource parents informing them about SOC services and the department's intended plans to support them and children placed with them through SOC wraparound services. DHS reports that through SOC, foster parents and children are supported through wraparound services that seek to address the needs of the child and family. An SOC referral may not be required if a child is already receiving services or a caseworker prefers to establish services through a known and credible provider in the local area where the child is placed. DHS has revised the One-Move report in order to track if these referrals are being made, if appropriate.

As noted in the TFC section of this Commentary, DHS will need to continue to assess with its partners at ODMHSAS how best to match foster families and children in custody to these and other necessary services to achieve the goals set for improved stability and well-being for the child in custody and their caregivers.

Focusing on DHS' priority to increase the number of children whose first placement is in a kinship home, DHS has revised its One-Move report to include for those children who are moved from their first placement into a kinship placement the barriers for why this kinship placement was not secured as the child's first placement. Some identified barriers documented in the One-Move report include:

- A lack of upfront family identification;
- Personal issues of a kinship family prevented placement at the time of a child's removal; and,
- Delays in foster care's approval of a kinship home.

DHS' records also show that for a number of these children, their first placements were in kinship homes; however, due to various reasons, the initial kinship placement was not stable, which resulted in the child being moved to a second kinship placement.

Over this period, DHS has both strengthened and expanded its One-Move report to support its efforts to improve placement stability. Through its One-Move report, DHS is gathering valuable information on the specific case practice areas that need to be strengthened to prevent children from experiencing multiple placements. Through this reporting structure, DHS is positioned to, and must, transfer its findings from the One-Move report to efforts to continue to improve children's placement stability.

Enhanced Efforts to Improve Implementation of Core Strategies

As discussed in the Co-Neutrals' last Commentary, there were deficiencies in DHS' initial implementation of its placement stability core strategies. These deficiencies were evidenced by the findings of the Office of Performance Outcomes and Accountability's (OPOA) analysis of 48

in-depth case reviews last period, which showed that the enhanced placement stability practices were not yet being performed consistently and at a high quality. In response to these findings, DHS, in August 2017, provided mandatory Guided Application Practice (GAP) trainings for supervisors in each region. The training focused on how best to support foster parents, the importance of kinship first placements, and the role of supervisors in advancing caseworkers' placement stability practice. DHS reports that after the completion of the GAP trainings, their data indicated that the occurrence of the enhanced placement stability practices had not improved as hoped. As a result, DHS identified that an additional training was necessary to address remaining barriers to caseworkers completing as required the new practices and protocols, including the two-day call and Initial Meetings. In November 2017, the placement stability leads delivered the enhanced placement stability training to all regional deputy directors, district directors, and field managers. DHS reported that district directors and field managers trained all caseworkers by January 2018.

In addition to these efforts, the child welfare director issued two instructional memos to staff in November 2017 which contained a detailed overview of each of the placement stability strategies, case practice expectations of each, and the roles and responsibilities of caseworkers (Hotline, CPS, and Permanency) to identify and assess potential kinship placements for children in DHS custody. Lastly, to support caseworkers' real-time tracking of the placement stability practices they need to complete for new child removals, DHS developed a new report (yi867b) this period. The new report runs each night and offers caseworkers a daily tracking tool to ensure they timely complete each new practice. Once the new practices have been completed and properly documented, the case no longer appears on the report. This new report supplements DHS' initial tracking report (yi867), which runs on the 20th of each month and is used as a management tool to assess DHS' progress monthly towards increasing the rate of completion of each of the placement stability practices.

Since the beginning of this reform effort, DHS has made some outcome improvements in all four placement stability measures; however, progress has been incremental and not always sustained. For Metric 4.1c, which measures the placement stability for children who have been in DHS custody for the longest period of time, DHS reported for the second consecutive period a decline in performance. The Co-Neutrals acknowledge and appreciate the value of DHS' efforts to achieve stability for children in their first placements. However, for most children reviewed under 4.1c, these efforts cannot be applied as these children have already experienced one placement move. For these children, who have been in care for an extended period of time (at least 24 months), DHS must intensify its efforts to ensure this population of children achieve long-term stability as the department works toward achieving their permanency.

It is important to highlight that children reviewed under Metric 4.1c are automatically reported as non-compliant for this metric if they were previously reported as non-compliant in either Metric 4.1a or b, or both, and still remain in care for at least 24 months as the same standard of compliance (children must have two or fewer placements) is applied to all three metrics (4.1a, b, c), despite a progressive increase in the length of time children have been care (e.g., 0-12 months, 13-24 months, over 24 months).

The Co-Neutrals completed a more in depth quantitative review of the children who were eligible for placement stability measured under Metric 4.1c (i.e., prior to the reporting period, these children had two or fewer placements). The Co-Neutrals identified the percentage of children who entered Metric 4.1c for this and the previous three report periods who were eligible for placement stability compliance because they had experienced two or fewer placements prior to the entering at least their 24th month in care.

As shown in Table 11 below, for the current period, 4,646 children were reviewed under Metric 4.1c. At the start of the current period, only 33 percent (1,529) of these 4,646 children in the cohort had two or fewer placements and were thereby eligible to be in compliance for the metric should DHS maintain their placement stability during the current period. The majority of these children (3,117 or 67 percent) had already experienced two or more placements prior to the start of the period and therefore was already out of compliance on Metric 4.1c. The Co- Neutrals' review found that DHS maintained the placement stability of 87 percent of the 1,529 children who entered the Metric 4.1c cohort with two or fewer placements. This more detailed data review of Metric 4.1c shows that DHS achieved placement stability for a higher percentage of children this period when compared to three periods ago (April 1, 2015 to March 31, 2016), increasing from 80 to 87 percent of eligible children maintaining two or fewer placements. DHS experienced a one percent improvement (86 to 87 percent) from the last report period. This closer review of Metric 4.1c data informed the Co-Neutrals' determination of its good faith finding on this measure, despite DHS' performance outcome showing a decline in performance from last period. DHS will need to focus on improving performance toward the established Target Outcome which, in part, includes increasing the percentage of children reviewed under Metric 4.1c who enter the measure as eligible for compliance. Placement stability efforts and improved outcomes demonstrated in Metrics 4.1a and 4.1b are key to helping DHS achieve this goal.

Table 11: Measure 4.1 C, Number of Children Eligible, Performance, and Total Cohort[45]

4.1 C	Report Period			
	Current	Prior	Two-Prior	Three-Prior
	Oct 1, 2016 to Sep 30, 2017	Apr 1, 2016 to Mar 31, 2017	Oct 1, 2015 to Sep 30, 2016	Apr 1, 2015 to Mar 31, 2016
Number of children eligible for numerator at start of FFY (i.e. had 2 or fewer placements at start of FFY)	1529	1771	1899	2106
DHS Performance (Numerator)	1331	1524	1670	1687
Cohort Total (Denominator)	**4646**	**5060**	**5492**	**5681**
Percent of Children Effected	**87%**	**86%**	**88%**	**80%**

DHS over the last year has dedicated more focus and attention to establish case practices, primarily focused on children's first placement in DHS custody, to increase placement stability and reported some improvement in the other three placement stability metrics. The Co- Neutrals find that DHS made good faith efforts to achieve substantial and sustained progress toward the Target Outcomes for all four placement stability measures.

H. Permanency

In order to achieve permanency for children in DHS custody, the department has implemented core permanency strategies for children with the goal of reunification; for children who are legally free with a goal of adoption but do not yet have a permanent family identified; for children who are legally free and have an identified permanent placement and for older legally free youth without an adoption goal at risk of aging out of foster care.

As presented in greater detail below, the Co-Neutrals find that DHS has made good

faith efforts to achieve substantial and sustained progress toward the Target Outcomes for 10 of the 11 permanency metrics. The Co-Neutrals have determined that for this report period DHS has not made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for Metric 6.2a, timely permanency for children within 12 months of entering DHS custody, which is also the sole permanency performance area for which the department has not achieved substantial or sustained progress toward the Target Outcome during this report period or throughout the entire reform.

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[45] Note that these numbers do not exactly match the numbers in the reports because of different data sources.

Timeliness of Children's Permanency, Metrics 6.2 (a-d)

The four 6.2 Metrics (a, b, c and d) measure DHS' progress to achieve timely permanency for children who entered DHS' custody at a designated time and who achieved permanency in 12, 24, 36 or 48 months from the child's removal from their family. For more than two years, DHS has worked to implement the Permanency Safety Consultation (PSC), its primary core strategy, to achieve timely permanency for children, with an emphasis on those children with the goal of reunification. DHS' efforts to implement PSCs are discussed below.

Permanency Safety Consultation (PSC) to Expedite Reunification

PSCs are structured case conferences scheduled to occur at regular intervals and are designed to assess through a team approach the viability of a child's safe reunification with their family. PSCs are required to be conducted for every child whose permanency plan is reunification.

PSCs begin 90-days after a child's removal from his or her birth family to identify, address and monitor opportunities for safe reunification as well as ongoing concerns preventing a child from returning to the parental home. As part of a PSC, the participating team records a recommendation of safe or unsafe, indicating if a pathway for safe reunification has or has not been identified. When reunification is determined to be possible, a plan of action is developed to move the child timely back home with their family, with a follow up PSC occurring every 30 days until the child is placed in trial reunification. For PSCs that conclude with an unsafe finding, subsequent PSCs are required at least every 90 days as long as reunification remains the child's permanency goal. DHS established this schedule for ongoing PSCs for all children with a goal of reunification at the conclusion of the last report period. Prior to setting this schedule, DHS focused first on ensuring that all children with a goal of reunification had at least one PSC, through phased implementation of the PSC practice throughout the state, while the department simultaneously developed a Continuous Quality Improvement process and proceeded to implement PSCs statewide by October 2016.

The Co-Neutrals observed in DHS' PSC data report (Y1838) that the department completed between July 1 and December 31, 2017 a total of 6,140 PSCs for 4,203 unique children, as some children received more than one PCS within the period, which is an indicator that the PSC process has become a central part of DHS' statewide permanency practice. As discussed in the previous Co-Neutral Commentary, DHS developed a PSC Guidebook and Fidelity Review Tool to support staff in building consistent and quality PSC casework practice. The PSC guidebook describes the responsibilities and expectations for every DHS staff person who participates in a PSC, including the child's caseworker, the caseworker's supervisor, the district director, and

permanency program staff from DHS state office. The PSC guidebook also provides a detailed explanation of the activities caseworkers must complete and safety questions the worker must

review to prepare for an effective PSC and support a thorough assessment of any safety concerns that have prevented reunification to date. DHS has also established a leadership structure and process to conduct quality assurance for the PSC practice. The designated statewide PSC coordinator participates in consultations in districts of every region to review the quality of the PSC process and, in individual cases, assists staff as needed to assess if safe reunification is possible. The PSC coordinator further focuses on the quality of the PSCs by conferencing with district directors before participating in a PSC in their area to discuss progress and challenges with the PSC process, as well as practice trends or barriers to reunification that have surfaced through the PSCs in their district. The coordinator further conducts a debriefing with district directors and supervisors following a PSC session and maintains a log of issues identified during the pre-calls and debriefings. The PSC coordinator and designated PSC regional leads also confer to review completed PSC tools to determine if there are systemic practice concerns or other barriers DHS may need to address to improve permanency outcomes.

DHS has implemented statewide the PSC process and practice with attention to ongoing quality improvement. However, by the end of the report period, the PSC process had not yet shown to have a measurable, positive impact on permanency outcomes achieved for children who have been in DHS custody within one year of removal as measured under Metric 6.2a. As the Co- Neutrals have previously commented, it is insufficient for DHS to continue to rely primarily on a singular strategy to impact timeliness to permanency, particularly when, over the course of numerous reporting periods, the strategy has not helped the department achieve substantial and sustained progress toward the Target Outcome. The Co-Neutrals have repeatedly extended the benefit of the doubt to the department with respect to its efforts to achieve permanency pursuant to Metric 6.2a, but at some point, progress must be evident and the CSA anticipates some positive trending toward the Target Outcome. The department has maintained that its implementation of the PSCs would improve permanency for the shortest-staying children, reflected in the Metric 6.2a measurement, and would remain its primary strategic effort. After more than five years, DHS' performance on Metric 6.2a remains worse than it was at the beginning of this reform, and is headed in the wrong direction. DHS must assess its performance for these children, diagnose the barriers to permanency for short-staying children and implement measures to achieve substantial and sustained progress toward the Metric 6.2a Target Outcome.

The Co-Neutrals create a misimpression within this Commentary by apparently focusing exclusively on Permanency Safety Consultations as the exclusive strategy to attain permanency. While PSCs are a valuable strategy, they are by no means an exclusive strategy. The Department has allocated significant resources and attention to the complete implementation of PSCs, but it has also dedicated time and resources to develop a wider-ranging plan to achieve permanency. In November of 2017, the Co-Neutrals engaged in a discussion that addressed implementation of

permanency support calls, development and implementation of the supervision framework and quality practice supports, support services to families, and court improvement efforts. During this meeting, the Co-Neutrals expressed no concerns about the type, quality, or quantity of efforts being made to improve the permanency metrics. DHS has further demonstrated its good faith efforts by committing resources to improve the frequency of workers visits, the continuity of worker visits, worker caseloads, quarterly supervisor caseloads, and placement stability. Viewing these efforts in their entirety more than capably demonstrates the good faith efforts of the agency to address each and every permanency metric, including Permanency achieved within 12 months of Removal.

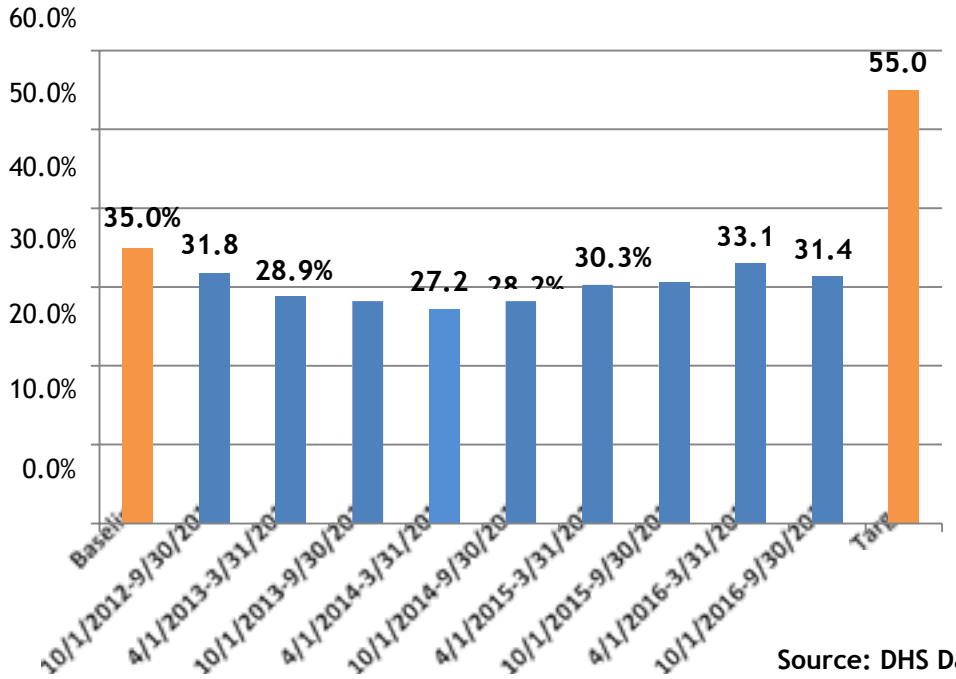
Permanency Outcomes - Timeliness

The following summaries and tables detail the baselines, performance to date and targets for each of the 6.2 Metrics.

Metric 6.2a, Permanency within 12 months of removal: DHS reported that of the 2,512 children who entered foster care between April 1, 2016 and September 30, 2016, 788 children achieved permanency within 12 months of their removal date. This represents a permanency achievement rate of 31.4 percent for Metric 6.2a, which is a decrease of 1.7 percent from the previous period. The Target Outcome is 55 percent. DHS has not made substantial or sustained progress on this measure and has not yet achieved during any period of this reform performance above the starting baseline of 35 percent.

Of the 2,512 children reviewed in this cohort, 598 (24 percent) were reunified, 73 (3 percent) were adopted and 117 (5 percent) achieved permanency through guardianship or custody with a relative.

Figure 25: Metric 6.2a – Permanency within 12 Months of Removal



Source: DHS Data

In the sixth Commentary issued in April 2016, for the report period of October 2014 through September 2015, the Co-Neutrals found for the first time that DHS had made good faith efforts

to achieve substantial and sustained progress toward the Target Outcome for Metric 6.2a. DHS' performance outcome was 28.2 percent, as shown in the Table above. At that time, this represented a small, one percent increase from the prior period and performance remained below the baseline and far from the Target Outcome. However, despite DHS' low performance for Metric 6.2a, the Co-Neutrals made a good faith finding based on DHS' efforts to systemically implement the statewide PSC process, which the department reported was beginning to contribute to positive permanency results.

The Co-Neutrals, in the three subsequent reporting periods, determined that DHS' efforts to achieve substantial and sustained progress toward the 6.2a Target Outcome rose to the level of good faith despite DHS' performance remaining below the baseline, as performance showed moderate, incremental progress while DHS continued to implement the PSC process statewide. The Co-Neutrals recognized that it would take time for DHS to implement a new statewide permanency practice and for the potential impact on permanency outcomes to be evidenced. In each of the three report periods, progress, though modest, toward the Target Outcome was evident.

In the current report period, however, DHS did not sustain the progress previously achieved, with performance declining from 33.1 percent in the previous period to 31.4 percent in this report period. In fact, in this report period, not only did performance decline, it remained below the baseline of 35 percent and further from the Target Outcome of 55 percent.

The Co-Neutrals continue to recognize the value of PSC as a core strategy to assess the viability of timely and safe reunification. However, DHS' efforts to implement and improve the quality of the PSC process are not adequate to make substantial and sustained progress toward the 6.2a Target Outcome. DHS must also address barriers to timely family reunification, on both an individual case and systemic level, which DHS identified recently in a CQI assessment of 125 permanency cases; in recent collaboration with court system partners; and during the many PSCs that have been completed over the past several report periods. Some of these challenges are described below.

Challenges to Timely Reunification

DHS reports that it has made concerted efforts over the last three years to prevent the removal of children from their families. As presented in the Table below, DHS' data shows a significant decrease in the number of children removed between fiscal year SFY14 with 6,078 removals and SFY15 with 5,328 removals. For the following two years, the number of children DHS removed from their families remained fairly constant with 5,143 removals in SFY16 and 5,158 in SFY17. Between the last two state fiscal years DHS experienced a decrease in removals, going from 5,158 in SFY17 to 4,639 during SFY18. This reduction has not yet resulted in any significant

decrease in the number of children reviewed in Metric 6.2a. The population of children included in the denominator for Metric 6.2a increased from 2,340 in the last reporting period (April 2016 to March 2017) to 2,512 in the current federal fiscal year report period (October 2016 to September 2017). For the next reporting period under review for 6.2a (April 2017 to March 2018), the denominator is 2,375.[46]

Table 12: Total Number of Children Removed During the SFY14-18

State Fiscal Year	Total Number of Children Removed
SFY14	6,078
SFY 15	5,328
SFY16	5,143
SFY17	5,158
SFY18	4,639

DHS reports that it is focusing more on averting the need for removal and addressing identified safety threats through the development of statewide prevention services. These services are provided to families when it is determined that risk factors can be safely addressed while the child remains living at home. DHS reports that prior to the development of these prevention services many more children would have been taken into custody while staff worked to create and implement a service plan, after which children could be returned home. Many of those children, as DHS reports, would have experienced shorter lengths of stay in custody while service plans were developed. Now, however, according to DHS, those children remain at home with prevention services in place. The department indicates that children who now experience removal are those whose parents present with more complex, severe challenges and cannot safely remain home with services. DHS reports that, for these children, it takes longer to address the serious issues their families confront and, as a result, they experience longer lengths of stay, having an impact on 6.2a performance.

DHS also reports that there have been challenges, at times, to obtain courts' approval to reunify children or to place a child in trial reunification when DHS recommends it is safe to do so. To address these issues, DHS initiated in May 2017 a court improvement project (CIP) team in three jurisdictions (Adair, Pottawatomie, and Canadian counties) to improve exits to permanency within 12 months. The teams, which include DHS supervisors and district directors, judges, assistant district attorneys, children's attorneys and other community

46.The data for child removals and the 6.2a denominator referenced here are for state fiscal years and federal fiscal years, respectively, and not the exact same time periods.

partners, has begun to review 12 months of permanency data for a cohort of children entering care from October 1, 2017 through March 31, 2018. The teams will track and analyze outcome data from the identified cohort in order to develop action plans to advance timely permanency. The Co-Neutrals will report in future Commentaries on the results of progress made by the CIP team after DHS provides information regarding the results of the data analysis.

As reported in the Co-Neutrals' last Commentary, DHS conducted during this review period a quantitative and qualitative analysis of permanency trends for children in DHS custody through an assessment of 125 cases utilizing Child and Family Services Review (CFSR) protocols for the period of October 2015 through March 2016. The analysis is based on a more in-depth review of permanency related items identified in the Child and Family Services Reviews (CFSR) as needing improvements as well as a review of 234 PSCs completed between October 2016 and March 2017. DHS analyzed that the "lack of quality engagement with parents and families and assessing their needs is a reoccurring theme found throughout the study." The study showed that another practice area needing significant improvement is the frequency and quality of child visits with their birth parents. DHS also reported that the PSC feedback process observed deficiencies in these same practice areas related to engagement with a child's birth family and the quality and frequency of child-parent visits, both of which are essential to support reunification.

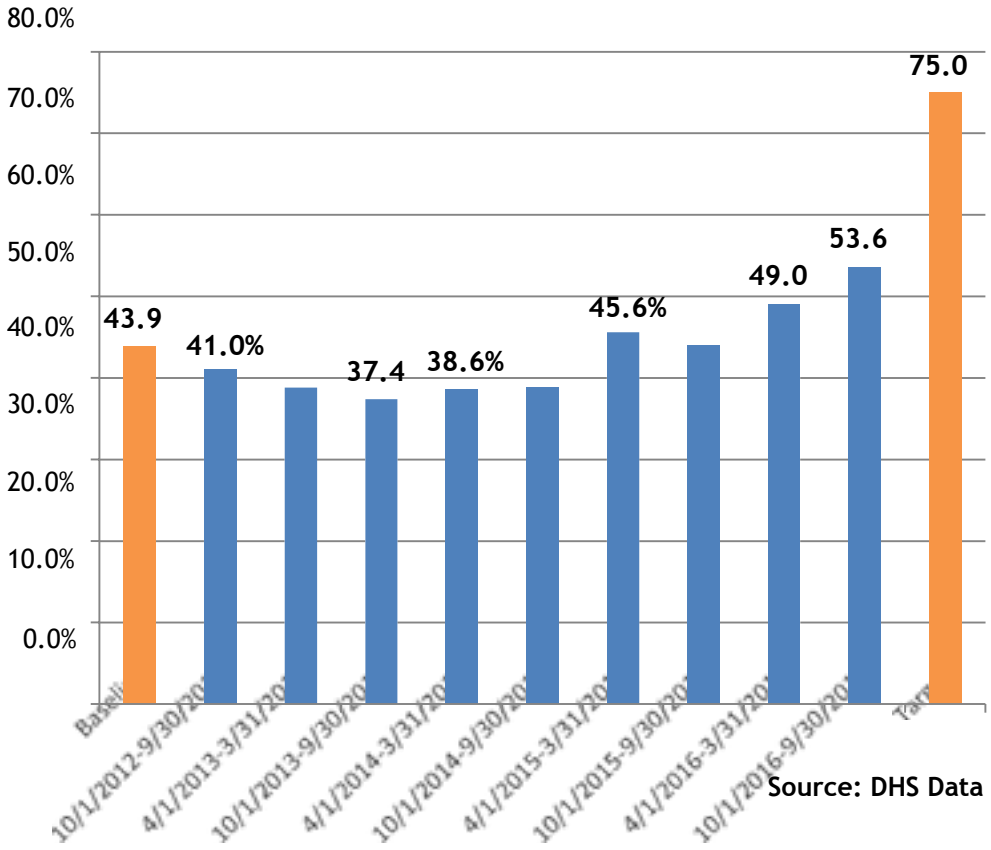
As discussed in other areas of this Commentary, DHS developed during calendar year 2017 a new Supervisory Framework designed to improve practice and child outcomes statewide, primarily in the areas of permanency, maltreatment and placement stability. The framework, which DHS tested in three districts this period, sets forth expectations and includes tools for supervisors to regularly and effectively assess and guide case practice in the field. The framework focuses, in part, on the "ongoing assessment of child safety and application of the safety threshold in determining safe reunification based on findings from the PSCs."

The Co-Neutrals will report in future Commentaries on DHS's efforts to address challenges identified above and its work to implement strategies to impact timely permanency and achieve substantial and sustained progress toward the permanency Target Outcome for 6.2a.

Metric 6.2b, Permanency within two years of removal: DHS reported that of the 1,793 children who entered foster care between April 1, 2015 and September 30, 2015 and stayed in foster care for at least 12 months, 961 children achieved permanency within two years of their removal date. This represents a permanency achievement rate of 53.6 percent for Metric 6.2b, and an increase of 4.6 percent since the last report period. The starting baseline for this metric was set at 43.9 percent and the target is 75 percent.

Of the 1,793 reviewed in this cohort, 446 (25 percent) were reunified, 434 (24 percent) were adopted and 81 (five percent) achieved permanency through guardianship or custody with a relative.

Figure 26: Metric 6.2b – Permanency within 2 years of Removal



Source: DHS Data

Over the last two report periods, DHS' performance for this measure has increased by almost 10 percent. Over the last four periods, the percentage of children in the reported 6.2b cohorts who achieved permanency through reunification remained steady between 23 and 25 percent. However, the percentage of children who were adopted increased from 17 percent two periods ago to 24 percent this period.[47] DHS' work to achieve timely permanency through adoption, when reunification is determined no longer viable, has allowed DHS to make substantial

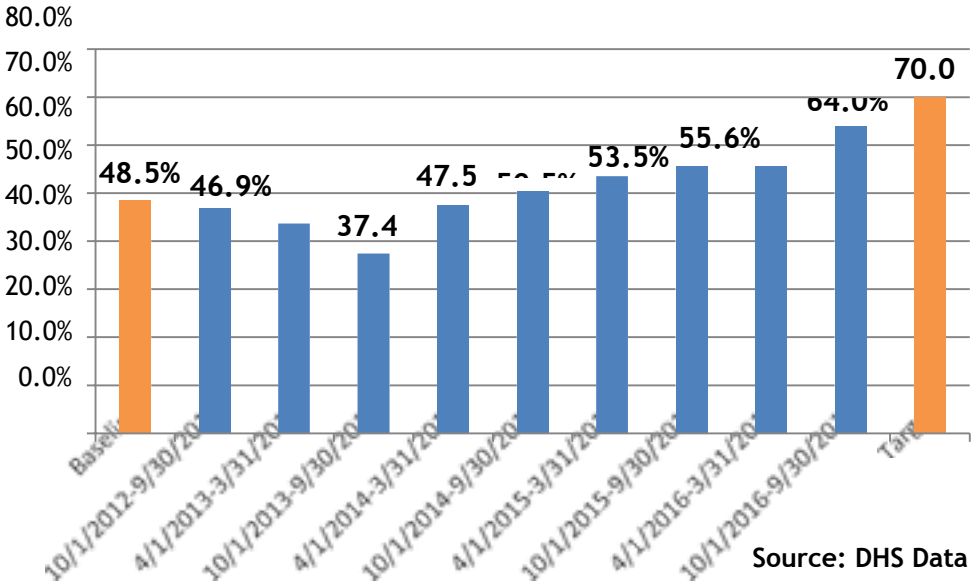
47.In the September 2013 baseline data for this measure, 22 percent of children in the cohort achieved permanency through reunification, which holds fairly constant with the outcomes of 23 to 25 percent of children being reunified during the last four report periods. The data also showed 19 percent of children in the baseline period achieved permanency through adoption, compared to 17 to 24 during the last four report periods, with the current period at 24 percent achieving adoption within 12 to 24 months of entering care. Adoption outcomes within this measure have shown a significant increase.

progress over the last three report periods. For this report period, the Co-Neutrals find that DHS has made good faith efforts to achieve substantial and sustained progress toward the Target Outcome for Metric 6.2b.

Metric 6.2c, Permanency within three years of removal: DHS reported that of the 989 children who entered foster care between April 1, 2014 and September 30, 2014 and stayed in foster care for at least 24 months, 633 children achieved permanency within three years of their removal date. This represents a permanency achievement rate of 64 percent for Metric 6.2c and an improvement of 8.3 percent since the last report period. The Target Outcome is 70 percent and the baseline for this metric was set at 48.5%.

As with the previous measure (Metric 6.2b), DHS' practice to achieve permanency through adoption has improved over the last several periods for the cohort of children reviewed in this measure, 6.2c. For this metric, permanency was achieved most often through adoption. During this report period, 454 (46 percent) children in the cohort of 989 were adopted and 152 (15 percent) were reunified with their families. In the baseline data for this measure, 33 percent of the cohort children were adopted, which has since significantly increased to 46 percent.

Figure 27: Metric 6.2c – Permanency within 3 years of Removal

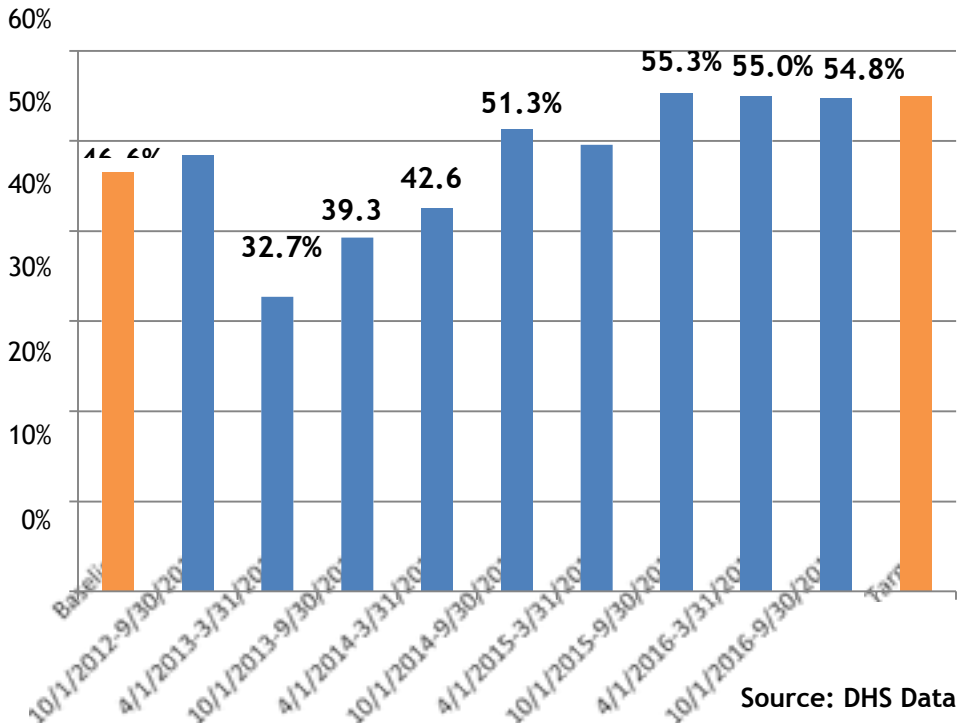


Source: DHS Data

As depicted in the Figure above, DHS has been approaching steadily the established Target Outcome for Metric 6.2c. The Co-Neutrals find that DHS had made good faith efforts to achieve substantial and sustained progress toward the Target Outcome.

Metric 6.2d, Permanency within four years of removal: DHS reported that of the 482 children who entered foster care between April 1, 2013 and September 30, 2013 and stayed in foster care for at least 36 months, 264 children achieved permanency within four years of their removal date, primarily through adoption. This represents a permanency achievement rate of
8. percent, and despite a slight decrease of 0.2 percent from the last period when the department met the target, DHS remains very close to the Target Outcome set at 55 percent. The Co-Neutrals find that DHS has made good faith efforts to achieve substantial and sustained progress toward the Target Outcome.

Figure 28: Metric 6.2d – Permanency within 4 years of Removal



Source: DHS Data

Children's Re-entry to Foster Care within 12 Months of Exit, Metric 6.3

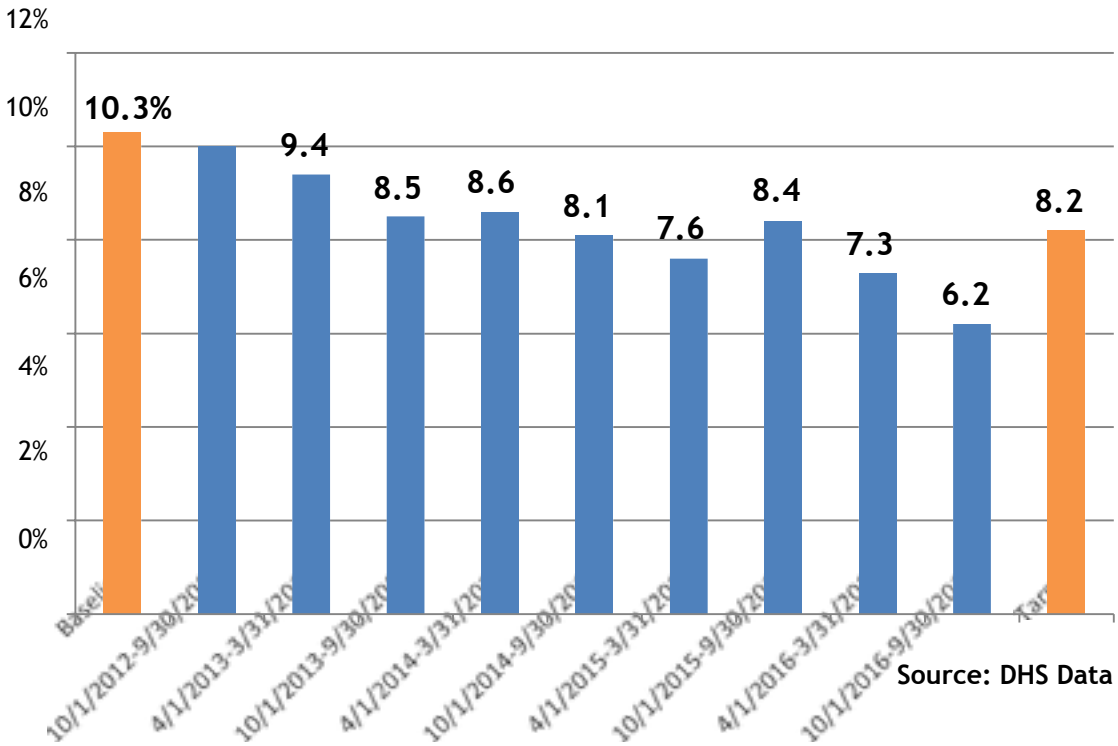
Metric 6.3 measures how well DHS ensures that children who achieve permanency remain with their permanent families and do not re-enter foster care in a short period of time. Specifically, Metric 6.3 measures re-entry to foster care within 12 months of a child's discharge to permanency (not including adoption) in the 12-month period prior to the reporting period.

The baseline for this metric is 10.3 percent of children re-entering care and the final Target Outcome is no more than 8.2 percent of children re-entering care. For this period, DHS

reported that of the 3,004 children who discharged to permanency (not including adoption) between October 1, 2015 and September 30, 2016, 187 children re-entered care within 12 months, which represents 6.2 percent of child re-entries, DHS' best performance to date on the measure, and progress of 1.1 percent since the last report period. For this report period, DHS met and exceeded the final Target Outcome of 8.2 percent, representing the second consecutive period that DHS has exceeded the Target Outcome for this measure. The Co- Neutrals find that DHS made good faith efforts to achieve substantial and sustained progress for Metric 6.3.

DHS attributes the requirements of PSC practice, including the assessment and documentation of safety prior to reunification and the provision of services and supports to families during trial reunification, as key efforts leading to improved performance outcomes and reduced child re- entries into the state's custody.

Figure 29: Metric 6.3 – Re-entry within 12 Months of Exit

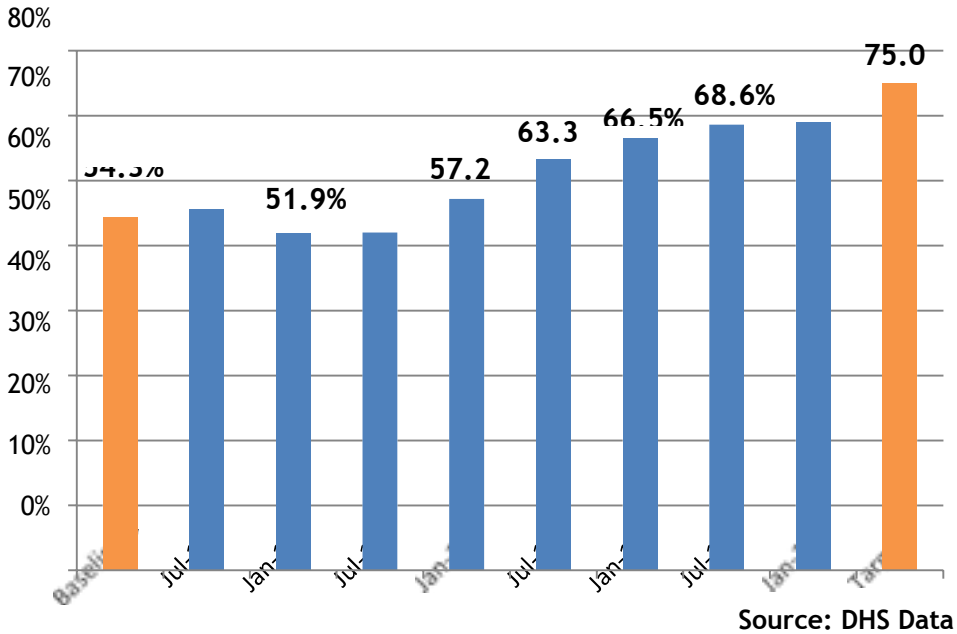


Source: DHS Data

Timeliness to Adoption for Children Who Become Legally Free, Metric 6.5

Metric 6.5 measures the timeliness to adoption for children who became legally free for adoption in the 12 months prior to the reporting period. The baseline for this metric was established at 54.3 percent with the performance target set at 75 percent. In the current report period, DHS data shows that of the 2,734 children who became legally free between October 1, 2015 and September 30, 2016, 1,886 (69 percent) were adopted within 12 months of becoming legally free. This represents a small positive increase of .4 percent since the last report period, and DHS' strongest performance during the course of this reform effort. Further, this is the sixth consecutive period for which DHS has sustained progress toward the Target Outcome.

Figure 30: Metric 6.5 – Permanency Performance



Source: DHS Data

It is notable that DHS achieved improved outcomes for Metric 6.5 in every report period at the same time the number of children subject to the metric increased in every report period. Table 13 below shows for each period the underlying number of children (denominator) who became legally free in the 12 months prior to the period and the number of children (numerator) who achieved permanency through adoption in the 12 months after becoming legally free.

Table 13: Number of Children who became Legally Free Every Report Period under Metric 6.5[48]

Metric 6.5	Jan 2014	July 2014	Jan 2015	July 2015	Jan 2016	July 2016	Jan 2017	July 2017	Jan 2018
Numerator	898	857	839	935	1200	1459	1567	1754	1886
Denominator	**1474**	**1540**	**1618**	**1797**	**2099**	**2304**	**2355**	**2558**	**2734**
Performance Outcome	60.9%	55.6%	51.9%	52%	57.2%	63.3%	66.5%	68.6%	69.0%

DHS' regional Adoption Timeliness Accountability Teams (ATATs) continue to set and track target dates for adoption finalizations and address barriers that have delayed permanency for legally free children, with a focus on timely permanency for children who have an identified adoptive family.

For the last five report periods, DHS has been on a steady trajectory toward the Target Outcome for this measure. The Co-Neutrals find DHS has made good faith efforts during this report period to achieve substantial and sustained progress toward the Target Outcome for Metric 6.5.

Adoption Permanency, Metrics 6.6, and 6.7

Permanency Metrics 6.6 and 6.7 measure how well DHS avoids pre-adoption placement disruptions and post-adoption finalization dissolutions.

Metric 6.6 measures the percentage of adoption placements that do not disrupt over a 12- month period, of all new trial adoption placements made during the previous 12-month period. The baseline for this metric was set at 97.1 percent and the Target Outcome was set at 97.3 percent. For this reporting period, DHS' data shows that of the 2,513 children who entered a trial adoption placement between October 1, 2015 and September 30, 2016, 2,413 children (96 percent) did not disrupt from their placements within 12 months of entering trial adoption.

In the prior two report periods, DHS met the Target Outcome for this metric. However, for this period, the department reported a decrease of 1.3 percent from the 97.3 percent outcome achieved last period. A total of 100 children disrupted from their trial adoption placement this period and DHS needed 33 fewer pre-adoption disruptions to maintain performance at the

[48] The column headings contained in this table reflect each semi-annual report date measured for this metric. The semi-annual report dates listed in the table correspond to the 12-month reporting periods contained in Table 9.

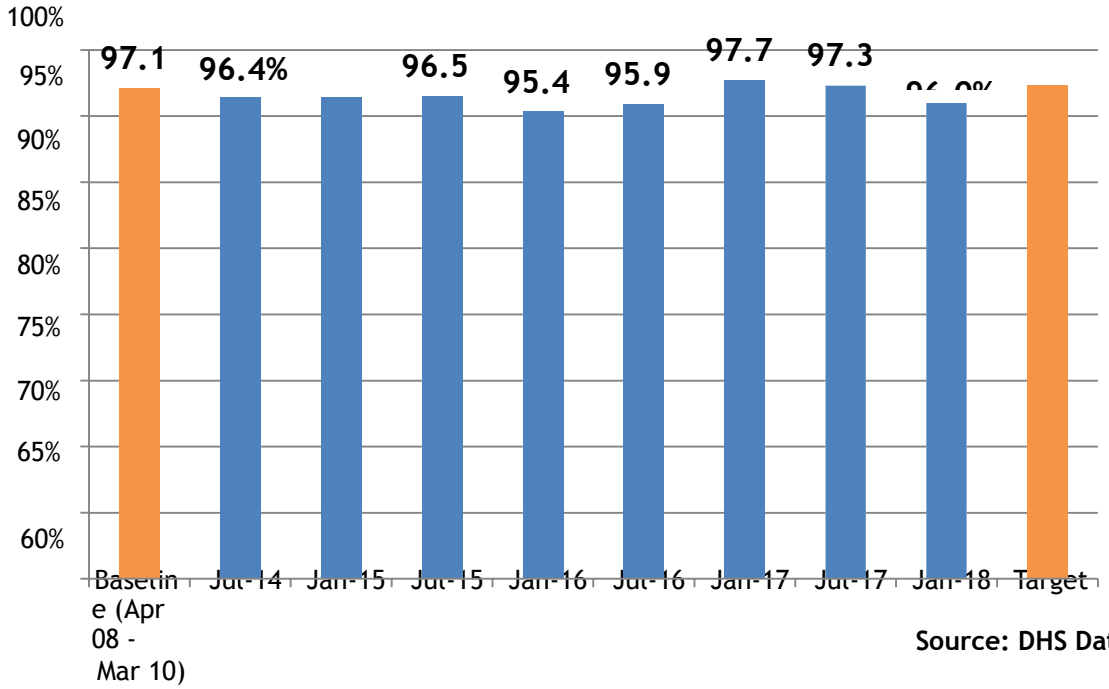
Target Outcome. This performance outcome is below the baseline of 97.1 percent, after two previous periods of performance at or above the Target Outcome.

The Co-Neutrals reviewed the records of the 100 children whose trial adoptions disrupted during this report period. This review showed that challenging child behaviors identified by prospective adoptive parents were the predominant factors that contributed to placement disruptions. Child behaviors were noted as a factor for 65 of the 100 children whose adoption disrupted. Based on documented notes in the KIDS records for these 65 children, it appeared that for 61 (94 percent) of the children, DHS provided or offered services and supports for the child and/or family as needed in an effort to stabilize and preserve the placement. For 24 children whose adoption placements disrupted, there were varying levels of concerns noted about the family that appear to have impacted the placement, with the record showing DHS attempted in 17 of these child cases to address these concerns, when feasible, in order to preserve the placement. For ten children, the records showed that the pre-adoptive families recommended or the record indicated that the child (or children in the case of some sibling groups) should not be placed in a home with other children. For some cases, this was due to the child's intensified needs that require the full attention of adoptive parents or the ability of a child to be placed safely with other children. However, these children were placed in pre- adoptive homes with other children and this appeared to be a contributing factor to the disruption.

The Co-Neutrals will review in future report periods DHS' efforts to assess and continue to provide supports to prospective adoptive families. It is important to highlight that the number of children who are reviewed under this measure has more than doubled since earlier in this reform effort. Three years ago, in the review period of October 1, 2013 to September 30, 2014, there were 1,239 children whose pre-adoption success was reviewed in this measure (with an outcome of 96.4 percent that did not disrupt), which is less than half of the 2,513 children in pre-adoption reviewed in this report period.

Despite the performance downturn in this report period, the Co-Neutrals found evidence in the case file review of 100 children that DHS routinely supported families through the pre-adoption placement process and provided services meant to stabilize placements. DHS has done so even as the population of children placed pre-adoptively has increased by 85 percent since the beginning of the reform. That said, the Co-Neutrals urge DHS to closely track and assess any barriers that might prevent improved outcomes in this performance area. For this report period, the Co-Neutrals find that DHS made good faith efforts to achieve substantial and sustained progress to achieve the Target Outcome for Metric 6.6.

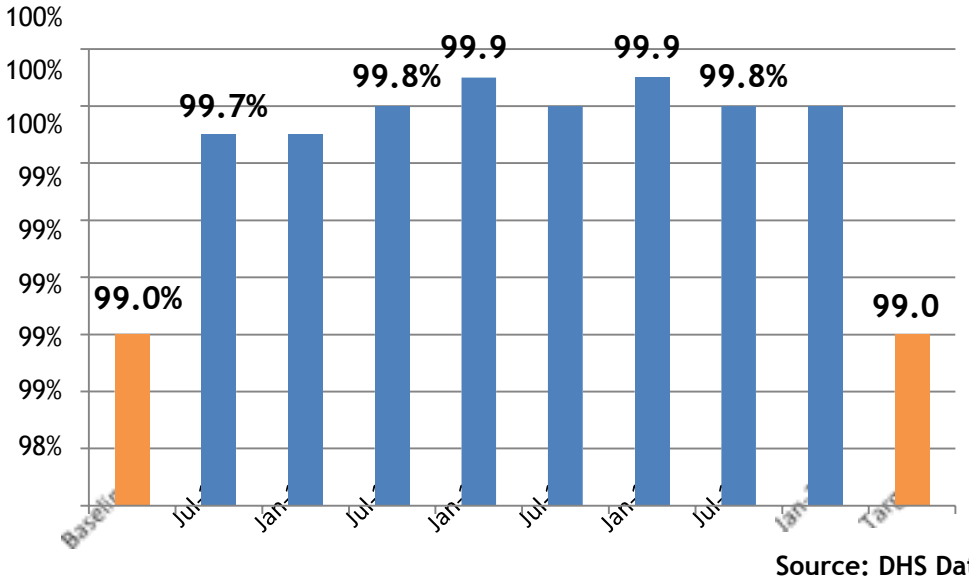
Figure 31: Metric 6.6 – Permanency Performance



Source: DHS Data

Metric 6.7 measures the percentage of children who achieved permanency through adoption over a 24-month period and did not experience adoption dissolution within 24 months of adoption finalization. The baseline for this metric was established at 99.0 percent and the Target Outcome was set to maintain a 99.0 percent performance outcome. For this reporting period, DHS' data shows that, of the 3,655 children who were adopted between October 1, 2013 and September 30, 2015, the adoptions of 3,647 children (99.8 percent) did not dissolve within 24 months of being adopted. DHS has consistently exceeded the Target Outcome for this metric in every report period. (See Figure 32 below) The Co-Neutrals find DHS has made good faith efforts to achieve substantial and sustained progress for Metric 6.7.

Figure 32: Metric 6.7 – Permanency Performance



Source: DHS Data

Legally Free Children without an Adoptive Family on January 10, 2014, Metric 6.1

DHS, under Metric 6.1, committed to move to permanency an identified cohort of children and youth who are legally free without an identified family. DHS and the Co-Neutrals established the point-in-time cohort of 292 children who were legally free for adoption and did not have an identified adoptive placement as of January 10, 2014. The Co-Neutrals established permanency targets for these children and youth as follows:

- By June 30, 2016, 90 percent of the 207 children who were ages 12 and under on January 10, 2014 will achieve permanency.

- By June 30, 2016, 80 percent of the 85 children who were ages 13 and over on January 10, 2014 will achieve permanency.

DHS reported that 167 (80.7 percent) of the 207 children in the younger segment of the cohort (ages 12 and under) achieved permanency as of December 31, 2017. This is an increase of five children since June 30, 2017 when DHS last reported that 162 children in the cohort had achieved permanency. At the end of the period, 39 children in the younger cohort remained in DHS custody.

For the 85 youth in the older group (ages 13 and older), DHS reported that a total of 39 youth (45.9 percent) achieved permanency as of December 31, 2017, an increase of two youth since June 30, 2017.

Table 14: Metric 6.1 – Permanency Performance

Permanency Metric	Baseline	Permanency Target by 6/30/2016	Permanency Achieved as of 12/31/2017
6.1: Of all legally free children not in an adoptive placement on 1/10/14, the number who have achieved permanency.	207 children: Age 12 and younger	90%	167 children (80.7%) achieved permanency
	85 children: Age 13 and older	80%	39 children (45.9%) achieved permanency

DHS also reported that as of December 31, 2017, 39 youth (45.9) percent) in the older cohort have aged out of custody without achieving permanency, an increase of three youth since June 30, 2017, the end of the previous report period. At the end of this period, seven youth in the older cohort remained in DHS custody.

Efforts to Identify Permanent Families for Children and Youth in the 6.1 Cohort

A primary strategy DHS has implemented to advance permanency, primarily with a focus on adoption, for the children in the 6.1 cohort is to assign an Adoptions Transition Unit ("ATU") worker to help identify and secure a permanent family for children in this cohort, regardless of the child's permanency goal. DHS reported that these ATU workers, along with the child's permanency caseworker, review each child's progress toward permanency, and develop plans to identify permanent placements for each child and youth. ATU workers specialize in locating permanent homes for children by performing diligent searches to identify family connections and by using information gathered from discussions with children and youth to help identify potential adoptive or guardianship families.

In order to further support the ATU process and to bring ATU workers closer toward agreed upon caseload standards, DHS reported that it allotted during this report period additional full- time ATU positions, which expanded the statewide ATU team to eight supervisor groups with four to six ATU specialists in each Region. As of June 30, 2017, there were 27 ATU workers carrying at least one case, which increased to 38 by

December 31, 2017. Further, DHS highlighted that this is the first period during which ATU workers were not assigned any non- ATU related cases, allowing them to focus solely on advancing permanency for children in the

6.1 cohort, as well as all other children who are legally free for adoption and do not yet have an identified adoption placement.

The Co-Neutrals find that DHS has made good faith efforts to achieve substantial and sustained progress toward the 6.1 Target Outcomes.

Permanency for Older Legally-Free Youth, Metric 6.4

Metric 6.4 includes a cohort of legally free youth who turned 16 years of age within two years before the report period and tracks those youth to measure the percentage who exited foster care to permanency, defined as adoption, guardianship or reunification, before the age of 18. The final Target Outcome for this metric is set only for the percentage of youth who achieve permanency. However, the outcomes for youth exiting care without permanency or who remain voluntary in DHS' care after the age of 18 are also publicly reported to provide transparency into their overall experience. DHS' baseline for this permanency metric was set at
30.4 percent of youth exiting with a permanent family. The final target was set at 80 percent by June 30, 2016.

For this period, DHS reported that 136 legally free youth turned 16 years of age between October 1, 2014 and September 30, 2015. Fifty-nine of these youth, representing 43.4 percent, achieved permanency as follows: 41 youth were adopted, 13 youth exited through guardianship, four youth exited through custody with a relative and one youth was reunified. This is a substantial increase of 12.3 percent from the last period, when performance was at
31.1 percent, and represents the largest performance increase DHS has reported within one period for this measure.

During the previous period, DHS leadership developed a number of strategies to improve the outcomes for the youth who are reviewed in this measure and for whom, historically, DHS has faced some of the greatest permanency challenges. Because youth in this cohort are 16 years of age or older, limits on time loom large with respect to achieving permanency before youth reach the age of 18 and exit DHS custody, and so it is critical that DHS continue to implement strategies to support permanency for these youth.

The strategies DHS has implemented to improve outcomes under this measure focus on both reducing the number of children who enter this metric's cohort and applying additional focus and resources to youth in the cohort who are at the greatest risk of aging out. To reduce the number of children entering the cohort, DHS has sought to achieve more timely permanency (through adoption and guardianship primarily) for legally free youth before they reach the age of 16 and to stabilize and maintain youth with their families, when safely possible, as older youth sometimes have higher protective capacities and can remain in their homes with supports and services.

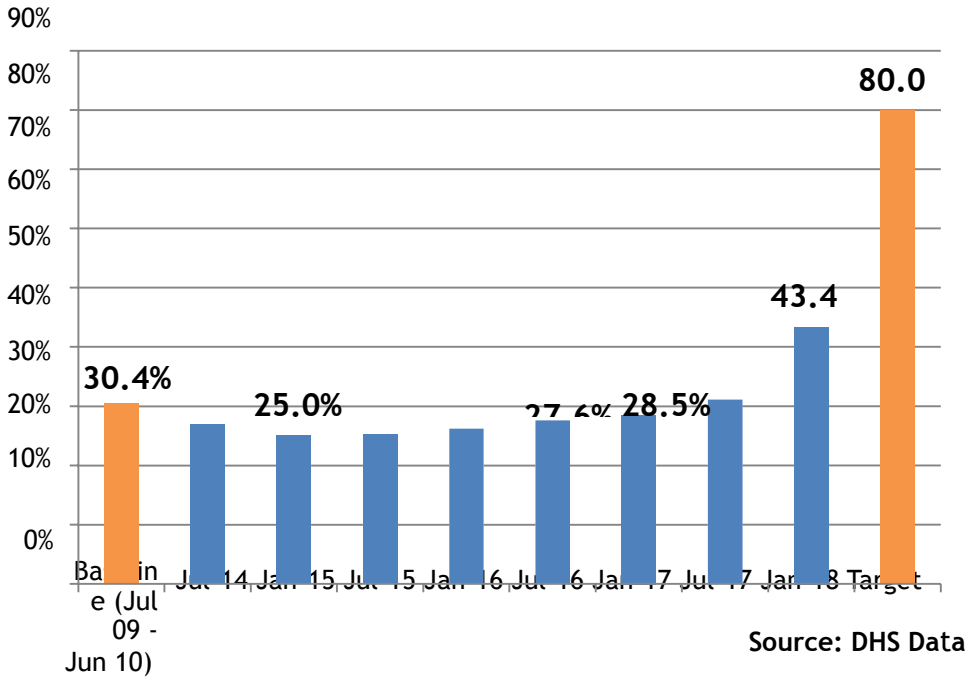
For children who enter the cohort, DHS developed a caseworker position type, Permanency Expeditor (PE), who is assigned to youth with a permanency case plan goal of planned alternative permanent placement (PAPP). PEs provide added support to the child's permanency worker to identify and advance all remaining opportunities to achieve permanency before the youth ages out of care. DHS decided to implement this permanency specialist position, as some caseworkers found it challenging to engage and communicate effectively with some youth who request a PAPP goal and struggled to support youth toward achieving stability and legal permanency with a family.

As reported in past Commentaries, the majority of youth reviewed in the 6.4 measure during prior report periods had a PAPP goal, not a goal of adoption, guardianship or reunification. For these youth DHS no longer made concerted efforts to achieve permanency and focused instead on preparing the youth to age out of DHS custody and for independent living. For example, in the 6.4 Metric review period of October 2015 to September 2016, 81 of the 123 youth (66 percent) in the cohort had a PAPP case plan goal and 78 (96 percent) of the 81 youth with a PAPP goal aged out of foster care without a permanent family during that timeframe. For this report period, October 2016 to September 2017, 67 (49 percent) of the 136 children in the 6.4 measure cohort were reported to have a PAPP goal, and 61 of these 67 children aged out.

Two important changes positively impacted the reduction of youth assigned a PAPP goal from 81 (review period September 2015 to October 2016) to 67 for the current review period. First, a new federal law went into effect in September 2015, which no longer allows child welfare systems to establish PAPP as the case plan goal for children ages birth to 15.[49] Second, during this period, DHS leadership communicated to staff new requirements to change a child's case plan goal to PAPP, including the pre-condition that supervisors approve the change only after the child's caseworker has explored and documented that all other permanency options have been determined not to be feasible or in the child's best interest. (See Appendix H) Further, staff must identify a sufficient number of permanent connections upon whom the child can depend after aging out of DHS custody. When a youth is assigned a PAPP goal, DHS now assigns a PE to continue final efforts, working with the child and permanency worker, to achieve permanency.

[49] P.L. 113-183, Section 112(a), signed Sept 29, 2014.

Figure 33: Metric 6.4 – Permanency Performance



Source: DHS Data

As shown in Figure 33 above, DHS' performance for this metric remained below the starting baseline until the last report period when DHS' performance exceeded the baseline of 30.4 percent. DHS' performance in this report period improved significantly to 43.4 percent.

Since implementation of the strategies DHS has undertaken for the 6.4 cohort, specifically the assignment of PE and limitations on the assignment of PAPP case goals, permanency outcomes for this performance area moved significantly in a positive direction in this report period and the Co-Neutrals find DHS has made good faith efforts to achieve substantial and sustained progress toward the 6.4 Target Outcome.

Appendix A: Metric Plan Baselines and Targets (Updated September 2015)

Oklahoma Department of Human Services Compromise and Settlement Agreement in D.G. v. Henry

Under Section 2.10(f) of the CSA, the Co-Neutrals shall issue Baseline and Target Outcomes, which shall not be subject to further review by either party but may at the discretion of the Co-Neutrals, after providing the parties an opportunity to comment, be revised by the Co- Neutrals. These Baselines and Target Outcomes are currently in effect.

1. MALTREATMENT IN CARE (MIC)			
Metric	**Reporting Frequency**	**Baseline**	**Target**
1.A: Of all children in foster care during the reporting period, what percent were not victims of substantiated or indicated maltreatment by a foster parent or facility staff member in a 12 month period.	Semi-Annually, in the January and July monthly reports	98.73% (April 2013 – March 2014)	99.68%
1.A (2): Number of children in the legal custody of OKDHS, found to have been maltreated by a resource caregiver over the 12 month period.	Monthly	N/A	N/A
1.B: Of all children in legal custody of OKDHS during the reporting period, what number and percent were not victims of substantiated or indicated maltreatment by a parent and what number were victims.	Semi-Annually, in the January and July monthly reports	98.56% (Oct 2011 – Sept 2012)	99.00%
1.B (2): Number of children in the legal custody of OKDHS, found to have been maltreated by a parent over the 12 month period.	Monthly	N/A	N/A

2. FOSTER AND THERAPEUTIC FOSTER CARE (TFC) HOMES				
Metric	**Reporting Frequency**	**Target SFY 14***	**Target SFY 15***	**Target SFY 16***
2.A: Number of new foster homes (non-therapeutic, non-kinship) approved for the reporting period.**	Monthly	1,197 (July 1, 2013 Baseline: 1,693)	End of Year: 904 Interim Target: 678 by 3/31/15 (July 1, 2014 Baseline: 1,958)	End of Year: 1,054 Interim Targets: 12/31/2015: 527 3/31/2016: 790 6/30/2016: 1,054 (July 1, 2015 Baseline: 1,858)
Net gain/loss in foster homes (non-therapeutic, non- kinship) for the reporting period***	Semi-Annually, in the January and July monthly reports	615	356	534
2.B: Number of new therapeutic foster homes (TFC) reported by OKDHS as licensed during the reporting period.	Monthly	150 (July 1, 2013 Baseline: 530)	150 (July 1, 2014 Baseline: 473)	172 Interim Targets: 12/31/2015: 86 3/31/2016: 129 6/30/2016: 172 (July 1, 2015 Baseline: 437)

Net gain/loss in therapeutic foster homes (TFC) for the reporting period.	Semi-Annually, in the January and July monthly reports	n/a	56	81

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*By May 30 of each year, DHS shall conduct annual trend analysis to set annual targets for the total number of new homes developed and the net gain for foster and TFC homes needed to meet the needs of children in and entering care. The Co-Neutrals also set an interim target of newly approved homes for the year.

DHS and the Co-Neutrals established criteria for counting new non-kin foster and TFC homes toward the annual targets set under 2.A and 2.B.

DHS and the Co-Neutrals established a methodology for counting net gains/losses of non-kin foster and TFC homes.

3. CASEWORKER VISITS			
Metric	**Reporting Frequency**	**Baseline**	**Target**
3.1: The percentage of the total minimum number of required monthly face-to-face contacts that took place during the reporting period between caseworkers and children in foster care for at least 1 calendar month during the reporting period.	Monthly	95.5% (July 2011-June 2012)	95%
3.2: The percentage of the total minimum number of required monthly face-to-face contacts that took place during the reporting period between primary caseworkers and children in foster care for at least 1 calendar month during the reporting period.	Monthly	51.2% (July 2011-June 2012)	Final: 90% Interim – Last reported month of: FFY 2013 - 65% FFY 2014 - 70% FFY 2015 - 80% FFY 2016 – 90%
3.3(a): The percentage of children in care for at least three consecutive months during the reporting period who were visited by the same primary caseworker in each of the most recent three months, or for those children discharged from OKDHS legal custody during the reporting period, the three months prior to discharge. Phase One: for period Jan – Dec 2012 *This metric is no longer reported on*	Semi-Annually, in the January and July monthly reports	53% (January - June 2013)	75%
3.3(b): Percentage of children in care for at least six consecutive months during the reporting period who were visited by the same primary caseworker in each of the most recent six months, or for those children discharged from OKDHS legal custody during the reporting period, the six months prior to discharge. Phase Two: for period Jan 2015 until the end of the Compromise and Settlement Agreement (CSA)	Semi-Annually, in the January and July monthly reports	40.6% (January 2013 – June 2014)	65%

4. PLACEMENT STABILITY			
Metric	**Report Frequency**	**Baseline**	**Target – by June 30, 2016**
4.1 (a): Percent of children in legal custody of OKDHS that experience two or fewer placement settings: Of all children served in foster care during the year who were in care for at least 8 days but less than 12 months, the percentage that had two or fewer placement settings.	Semi-Annually, in the January and July monthly report - same for all placement stability metrics	70% (Oct 2011 – Sept 2012)	88%
4.1(b): Percent of children in legal custody of OKDHS that experience two or fewer placement settings: Of all children served in foster care during the year who were in care for at least 12 months but less than 24 months, the percentage that had two or fewer placements.	Same	50% (Oct 2011 – Sept 2012)	68%
4.1(c): Percent of children in legal custody of OKDHS that experience two or fewer placement settings: Of all children served in foster care during the year who were in care for at least 24 months, the percentage that had two or fewer placement settings.	Same	23% (Oct 2011 – Sept 2012)	42%
4.2: Of those children served in foster care for more than 12 months, the percent of children who experienced two or fewer placement settings *after* their first 12 months in care.	Same	74% (Apr 2012 – Mar 2013)	88%
4.3: Of all moves from one placement to another in the reporting period, the percent in which the new placement constitutes progression toward permanency. (Note: the Co-Neutrals have suspended this metric.)	N/A	N/A	N/A

5. SHELTER USE			
Metric	**Report Frequency**	**Baseline (January-June 2012)**	**Target**
5.1: The number of child-nights during the past six months involving children under age 2 years.	Monthly Analysis of usage every 6 months – same for all shelter metrics	2,923 child-nights	0 by 12/31/12
5.2: The number of child-nights during the past six months involving children age 2 years to 5 years.	Same	8,853 child-nights	0 by 6/30/13
5.3: The number of child-nights during the past six months involving children age 6 years to 12 years.	Same	20,147 child-nights	0 for children 6-7 by 7/1/14 0 for children 8-9 by 10/1/14 0 for children 10-12 by 1/1/15 unless in a sibling group of 3 or more 0 for children 10-12 by 4/1/15 unless with a sibling group of 4 or more
5.4: The number of child-nights during the past six months involving children age children 13 years or older.	Same	20,635 child-nights	Interim Target by 6/30/15 # child-nights: 13,200 80% of children 13+ in shelters will meet Pinnacle Plan (PP) Point 1.17 rules* Final Target by 6/30/16 # child-nights: 8,850

1.17: Number of children ages 13 or older in shelters that had only one stay for less than 30 days.		33.7% (January-June 2014)	90% of children 13+ in shelters will meet PP Point 1.17 rules

*Pinnacle Plan Point 1.17: "By June 30, 2014, children ages 13 years of age and older may be placed in a shelter, only if a family-like setting is unavailable to meet their needs. Children shall not be placed in a shelter more than one time within a 12-month period and for no more than 30 days in any 12-month period. Exceptions must be rare and must be approved by the deputy director for the respective region, documented in the child's case file, reported to the division director no later than the following business day, and reported to the OKDHS Director and the Co-Neutrals monthly.

6. PERMANENCY			
Metric	**Report Frequency**	**Baseline**	**Target**
6.1: Of all children who were legally free but not living in an adoptive placement as of January 10, 2014[50], the number of children who have achieved permanency.	Semi-Annually, in the January and July monthly reports - same for all permanency metrics	Jan 10, 2014 Cohort 292 children	90% of children ages 12 and under on Jan 10, 2014 will achieve permanency 80% of children ages 13 and older on Jan 10, 2014 will achieve permanency
6.2(a): The number and percent of children who entered foster care 12-18 months prior to the end of the reporting period who reach permanency within one year of removal, by type of permanency.	Same	Total = 35% Reunification = 31.4% Adoption= 1.6% Guardianship = 2%	Total = 55%
6.2(b): The number and percent of children who entered their 12th month in foster care between 12-18 months prior to the end of the reporting period who reach permanency within two years of removal, by type of permanency.	Same	Total = 43.9% Reunification = 22.3% Adoption = 18.9% Guardianship = 2.7%	Total = 75%
6.2(c): The number and percent of children who entered their 24th month in foster care between 12-18 months prior to end of reporting period who reach permanency within three years of removal, by type of permanency.	Same	Total = 48.5% Reunification = 13.0% Adoption = 32.7% Guardianship = 2.9%	Total = 70%

[50] The legally free cohort for Metric 6.1 was to be set originally on March 7, 2013, the date the Metrics Plan was finalized, but due to since-corrected data challenges the cohort was established for January 10, 2014.

6.2(d): The number and percent of children who entered their 36th month in foster care between 12-18 months, prior to the end of the reporting period who reach permanency within four years of removal.	Same	Total = 46.6% Reunification = 8.8% Adoption = 37.3% Guardianship = .4%	Total = 55%

6. PERMANENCY			
Metric	**Report Frequency**	**Baseline**	**Target**
6.3 Of all children discharged from foster care in the 12 month period prior to the reporting period, the percentage of children who re-enter foster care during the 12 months following discharge.	Same	10.3% Discharged year ending 9/30/11 re-entered as of 9/30/12	8.2%
6.4: Among legally free foster youth who turned 16 in the period 24 to 36 months prior to the report date, the percent that exited to permanency by age 18; stayed in foster care after age 18, and exited without permanency by age 18.	Same	30.43% (July 2009-June 2010)	50% by 12/31/14 75% by 12/31/15 80% by 6/30/16
6.5: Of all children who became legally free for adoption in the 12 month period prior to the year of the reporting period, the percentage who were discharged from foster care to a finalized adoption in less than 12 months from the date of becoming legally free.	Same	54.3% (Oct 2011-Sept 2012)	75% by June 30, 2016
6.6: The percent of adoptions that did not disrupt over a 12 month period, of all trial adoptive placements during the previous 12 month period.	Same	97.1% (Apr 2008-Mar 2010)	97.3%
6.7: The percent of children whose adoption was finalized over a 24 month period who did not experience dissolution within 24 months of finalization.	Same	99%	99%

7. CASELOADS				
Metric	**Report Frequency**	**Standard**	**Baseline**	**Target**
Supervisors	Quarterly, every Jan, April, July and Oct – same for all caseloads	1:5 ratio	58.8% (as of June 30, 2014)	90% meet standard by June 30, 2014
Child Protective Services (CPS)	Same	12 open investigations or assessments	Same Baseline for All Case Carrying Workers: *27% - meet standard* *8% - 1-20% above standard* *65% - 21%+ above standard*	Same Interim Target for All Case Carrying Workers – by Dec 31, 2013: *45% - meet standard* *30% - 1-20% above standard* *25% - 21%+ above standard* Final Target: 90% of all workers meet their standard by June 30, 2014
OCA (Office of Client Advocacy)	Same	12 open investigations		
Family Centered Services (FCS)	Same	8 families		
Permanency	Same	15 children		
Foster Care	Same	22 families		
Adoption	Same	8 families & 8 children		

Appendix B: Suggested Foster Parent Training Opportunities

Month of Foster Parent Customer Service Calls	Suggested Topics for Ongoing Training
April 2017	potty training, training in local areas, kinship foster care, the child welfare process from removal to reunification, training on specific behaviors, court, provide more real life case experiences from foster parents who have been there, trauma training, separation issues with bio parents, visitation, cultural diversity, transitioning a teenager to adult, behavioral health needs of children in care, ICWA, how to handle the placement - what questions to ask, paperwork needed, names and numbers to get, etc., positive benefits of bridging, working with older children in the home
May 2017	working with birth families, time management, confrontation and interaction, drug exposed infants, trauma, bridging with families, foster parent rights, children with disabilities, emotional health for children and parents, children's response from trauma, empowered to connect, understanding the court system, general parenting and child safety, CPR, what to expect at court hearings, handling children who melt down, teen behaviors and how to handle them, dealing with mental health issues, encouraging teenagers to make good choices
June 2017	how to handle behaviors, CPR, drug exposed children, more training opportunities in rural counties, water safety, hot weather, booster safety and requirements, mileage reimbursement, understanding the child welfare system, foster care protocol/expectations and rules, cultural diversity, panel of birth parents to help understand their perspective, dealing with bio families and what to expect, what to ask prior to accepting placement, communicating with children about the legal process and permanency, trauma, child development, discipline techniques, dealing with children with ADD/ADHS/FAS, adoption process
July 2017	dealing with behaviors from traumatized children, dealing with the emotional strain on the foster family and their kids, sign language, adoptive parent training, practical parenting for first time parents, attachment, trauma informed care, enlist counselors to come to the foster home to talk with the family and offer training credit, bridging with the bio family, coping and managing behavioral issues, training about when kinship placements go home and how to deal with that change in dynamics, discipline techniques, foster parent rights, dealing with children who act out, dealing with teen behaviors, family meetings, what to do if a child is removed in the middle of the night, caring for addicted newborns
August 2017	completing travel claims, CPR, dealing with teens, aggressive behaviors, autism, trauma experiences, crisis cycle, integrating children currently in the home, medical information, working with older children, self-esteem, discipline
October 2017	specific behaviors - sexual and defiant behaviors, trauma informed training, ICWA, discipline and behavioral modification, car seats, coping when the children leave, dealing with attitudes, children with attachment disorder, adjusting to different age groups

Appendix C: Workload Improvement Plan

Workload Performance Improvement Plan (Effective date: 10/31/17)

A significant strength of our Child Welfare system is our robust continuous quality improvement (CQI) system. In addition to showing what is working in our system, CQI processes that involve the routine review and analyses of data draw attention to unexpected changes in trend lines and alert leadership to the need for focused attention.

For the first time since June of 2016, a review of data shows that our overall workload has surpassed our overall workforce capacity. Over the last several years, we have focused heavily on stabilizing our workloads by ensuring adequate resources are allocated based on where the workload need is located. We make adjustments as the workload shifts. The data shows that our most recent shift in need is due to the increase in the CPS workload resulting from a spike in referrals assigned for investigation with a simultaneous net decrease in number of caseload carrying staff.

An increase in the number of overdue investigations and assessments combined with an increase in the overall number pending, is an indication that if we do not make adjustments quickly, we will lose the workforce stability we've diligently worked to achieve. Therefore, in addition to expediting recruitment, hiring, and onboarding efforts to ensure the right number of staff are in place, immediate adjustments in workload distribution are required to stabilize the workforce.

The following action steps will be implemented beginning immediately. Some strategies are ongoing, and some are temporary strategies that will be utilized only to fill a gap while other efforts begin to take hold.

1. Immediate Workload Adjustments

Starting October 30, 2017, the following temporary adjustments in workload calculations can be utilized. These changes will be in effect for 90 days only.

A. Graduated Workloads:

The purpose of assigning graduated workloads is to avoid overwhelming new staff and to provide them opportunities for coaching and training before they receive a full caseload so that they can acquire and practice the necessary skills. This strategy is intended to positively impact turnover of staff within their first year of employment. It has, and we must be careful not to reduce that impact. However, feedback from the field indicates that minor adjustments could preserve the impact while increasing our ability to equalize distribution of workload.

- Previous methodology (based on length of employment):
  - 3 months (approximately) = 25% workload
  - 6 months = 50% workload

- 9 months = 100% workload

➢ New (temporary) methodology (*):

- 3 months (approximately) = 50% workload
- 6 months = 75% workload
- 9 months = 100% workload

*(*Careful consideration should be given to the skill level and development of individual staff members.)*

B. Workload Standard:

Workload standards were adopted to ensure staff have manageable workloads, so that they have adequate time to devote to engaging families to ensure safety, permanency, and well- being of children served. Further, establishing a workload methodology allows for leadership to allocate resources based on workload need.

- ➢ Current methodology:
  - Staff "meet standards" when their workload is 100% of the standard or less
  - Staff "almost meet standards" when their workload is greater than 100% of the standard but less than 120%
  - Staff "do not meet standards" when their workload is greater than 120% of the standard.
- ➢ New (<u>temporary</u>) methodology (*) for CPS and PP in <u>*approved districts*</u>:
  - All staff who are not eligible for a graduated workload may carry a workload up to 120% of the standard. (For a permanency planning worker, this could be up to 18 children. For a CPS worker, this could be up to 14 investigations.)
  - No staff member will carry a workload greater than 200% of the standard at any given time.

*(*Careful consideration should be given to the skill level and development of individual staff members.)*

<u>Any district currently at less than 100% capacity in comparison to overall workload is approved to</u> <u>utilize the new temporary workload methodology.</u> As of 10/30/17, those districts are 4, 6, 7, 8, 10, 14, 20, 21, 25, 26, and 27.

We will continue to monitor the data, to determine whether the increase in CPS workload is a temporary spike or a new trend. This information will be utilized to make long term decisions regarding the allocation of resources.

2. Conduct turnover analyses to understand the uptick and turnover this SFY. The analyses will be used to provide focused attention to targeted districts using the "target district" model we've used in the past.

3. Update workload analyses to reflect the increase in CPS workload. This will inform decisions related to staffing distribution.

4. Implement training and quality assurance plan at the Hotline to ensure appropriate screening decisions are occurring.

5. Utilize overtime plans in districts with highest number of investigations and assessments in backlog status.

We are interested in hearing feedback from you and your staff throughout the process of implementing these temporary adjustments. We need to understand what's working and what's not working related to these changes. Therefore, we have created the following email address for staff to send feedback to: cws.workload.feedback@okdhs.org.

Appendix D: Statewide Workload and Hiring

Plan Workloads Compliance

As DHS closes in on its workload compliance goal of 90% of all caseload carrying staff will be meeting standards by December 31st, 2018 and move past the 70% range which has been a place that DHS has flattened out. In order to meet that goal DHS must ensure it has adequate staff hired and able to carry cases so that the capacity is greater than the workload. Currently there are 276 positions vacant which leads to the following hiring pattern to have them filled by December 31st:

Currently Vacant Positions needing to be filled

District	March	April	May	June	July	August	September	October	November	December	Total to hire
1											0
2	1	1	1	1	1						5
3		1									1
4	1	1	1	1	1	1	2	1	2	1	12
5	1	1	1	1	1	1	1				7
6	1	1	1	1							4
7	5	5	5	5	5	5	5	5	5	6	51
8	1	1	1	1	1	1	1	1	1		9
9	1	1	1								3
10		1	1	1	1	1	1	1	1	1	9
11	1	1									2
12	1	1									2
13											0
14	3	3	3	3	3	3	3	3	3	4	31
15	1	1	1	1	1	1					6
16	1	1									2
17	1	1	1	1	1	1	1	1	1	1	10
18	1	1	1	1	1	1	1				7
19	1	1	1	1	1						5
20	1	1	1	1	1	1	1	1	1	2	11
21	1	2	1	2	1	2	1	2	2	2	16
22	1	1	1	1	1	1					6
23	1	1	1	1	1						5
24	1										1
25	1	1	1	1	1	1	1				7
26	1	1	1	1							4

27	1	1	1	1	1	1	1	1			8
FC	1	1	1	1	1	1	1	1	1	2	11
AA	4	4	4	4	4	4	4	4	4	5	41
Totals	34	36	31	31	28	26	24	21	21	24	276

During this time there will be turnover leading to additional positions needing to be filled. Based on current turnover the number of positions that need to refilled will be 271 with the following breakdown:

Caseworkers needed to be replaced due to turnover											
District	March	April	May	June	July	August	September	October	November	December	Total to hire
1	0	1	1	0	0	1	0	0	0	0	3
2	1	0	1	0	1	0	1	0	3	0	7
3	1	0	1	0	0	0	1	0	0	0	3
4	2	1	1	1	1	3	1	1	2	0	13
5	0	1	0	1	0	2	0	1	0	1	6
6	1	1	2	1	0	0	1	2	0	0	8
7	5	5	4	5	5	4	4	6	4	4	46
8	2	1	0	1	0	2	0	1	1	0	8
9	1	1	0	0	1	1	0	0	1	0	5
10	0	0	1	0	0	0	1	0	0	0	2
11	0	0	0	0	0	0	3	1	1	0	5
12	0	1	0	0	1	0	0	1	0	0	3
13	0	0	0	1	0	0	0	0	0	1	2
14	2	4	2	3	2	4	2	3	2	4	28
15	1	1	1	0	1	0	1	0	1	1	7
16	0	1	0	0	0	1	0	1	2	0	5
17	0	1	2	0	0	1	0	0	1	2	7
18	2	0	0	0	0	1	0	1	0	0	4
19	1	2	0	0	1	1	0	0	1	1	7
20	0	0	2	0	0	2	1	0	1	0	6
21	1	1	1	1	0	1	0	2	1	1	9
22	1	0	0	1	0	0	1	2	0	1	6
23	1	0	1	0	2	0	0	0	2	0	6
24	0	1	1	1	0	0	1	0	0	0	4
25	0	0	0	1	1	1	0	1	0	0	4
26	2	0	0	0	1	0	0	1	1	0	5
27	1	1	0	2	1	1	0	2	1	1	10
FC	4	4	5	4	4	6	3	5	4	5	44
AA	1	0	2	0	1	0	1	0	2	1	8
Totals	30	28	28	23	23	32	22	31	31	23	271

This brings the total number of positions to be filled up to 547 positions with the breakdown of:

Total Caseworkers to be hired											
District	March	April	May	June	July	August	September	October	November	December	Total to hire
1	0	1	1	0	0	1	0	0	0	0	3
2	2	1	2	1	2	0	1	0	3	0	12
3	1	1	1	0	0	0	1	0	0	0	4
4	3	2	2	2	2	4	3	2	4	1	25
5	1	2	1	2	1	3	1	1	0	1	13
6	2	2	3	2	0	0	1	2	0	0	12
7	10	10	9	10	10	9	9	11	9	10	97
8	3	2	1	2	1	3	1	2	2	0	17
9	2	2	1	0	1	1	0	0	1	0	8
10	0	1	2	1	1	1	2	1	1	1	11
11	1	1	0	0	0	0	3	1	1	0	7
12	1	2	0	0	1	0	0	1	0	0	5
13	0	0	0	1	0	0	0	0	0	1	2
14	5	7	5	6	5	7	5	6	5	8	59
15	2	2	2	1	2	1	1	0	1	1	13
16	1	2	0	0	0	1	0	1	2	0	7
17	1	2	3	1	1	2	1	1	2	3	17
18	3	1	1	1	1	2	1	1	0	0	11
19	2	3	1	1	2	1	0	0	1	1	12
20	1	1	3	1	1	3	2	1	2	2	17
21	2	3	2	3	1	3	1	4	3	3	25
22	2	1	1	2	1	1	1	2	0	1	12
23	2	1	2	1	3	0	0	0	2	0	11
24	1	1	1	1	0	0	1	0	0	0	5
25	1	1	1	2	2	2	1	1	0	0	11
26	3	1	1	1	1	0	0	1	1	0	9
27	2	2	1	3	2	2	1	3	1	1	18
FC	5	5	6	5	5	7	4	6	5	7	55
AA	5	4	6	4	5	4	5	4	6	6	49
Totals	64	64	59	54	51	58	46	52	52	47	547

The total of 547 is a large number and a difficult feat. CW has noticed that there are two large pockets of districts that all need help in getting positions on board. Those pockets are

district 6, 20, and 21 being the first pocket and districts 8,10, and 14 making the second pocket. CW will need to work with HR to form an aggressive strategy to increase the number of applicants and therefor hires in those districts. The reality of the situation is that some districts will not be able to hire the number of staff needed while other districts will reduce the number of staff that is needed through the reduction of turnover and workloads but retain staff to put their capacity well above the total workload. Finding a way to leverage extra capacity in some districts to cover the capacity deficit in others will be paramount to having 90% of workers meeting the standard by December 31st.

Appendix E: Quality Worker Visits - Guidance and Tools

Quality Worker Visits (Children)

Definition: Quality contacts are purposeful interactions between caseworkers and children, youth, parents, and resource parents that reflect engagement and contribute to assessment and case planning processes by ensuring child safety, supporting permanency planning, and promoting child and family well-being.

Impact of Quality Contacts:

- Improved assessments of safety, risk, and needs
- Joint development in case plans
- Shared understandings of progress toward goals, strengths, and needs
- Improved family and youth engagement and empowerment

Key Phases:
Before: Planning and Preparation
During: Engagement, Assessment, Exploration, and
Adjustment After: Documentation, debriefing, and follow-up

Before:

- Plan for length and location of visit to support honest conversations
- Contact all service providers and medical providers for the child and review most recent service provider report. Evaluate any change of behaviors, current treatment plans, and medical reports/medications prescribed.
- Review educational needs/review any IEP or other educational plans for the child
- Review case plan goal and make a plan on how we will discuss this goal with the placement provider and child.
- Contact Resource Worker for foster home to discuss any WPC's, Concerns for the Home, etc. Review Resource and any associated investigations.
- Identify all issues/concerns that will be discussed during the contact

During:

- Review agenda with resource parent and child and incorporate any input
- Using DHS Practice Standards- suspend biases, be culturally competent, and demonstrate empathy and respect.
- Utilizing the 6 key questions of the Assessment of Child Safety assess safety and risks.
    - Child Functioning: How does the child in the home function on a daily basis?
        - Emotional/Physical Health
        - Child Development

        - Relationships/ Role within the family
        - Mood/Behaviors
        - Sleeping Arrangements
        - Social Skills
        - Education and the parents role/participation in the child's educational needs
        - Functioning within cultural norms
        - Who all cares for you on a day to day basis- even when worker is not here
        - Obtain Collateral information regarding these areas
    - Discipline: Describe the discipline methods used by PRFC and under what circumstances they occur. Discuss how the type of discipline impacts the child emotionally and ensure that discipline techniques for all children in the home are assessed.
        - Methods used
        - Frequency
        - Purpose
        - Emotional State of PRFC
        - Cultural Implications
        - Effectiveness
        - Obtain Collateral information regarding these areas
    - Parenting: Overall family values and typical and pervasive parenting practices used by all PRFC(s).
        - PRFC(s) knowledge and expectations of each child in their home and their own biological children
        - Perceptions of each child
        - Interactions between parent and child
        - Protective Capacities
        - Reasons for fostering
        - Decision-making parenting practices
        - Level of agreement between all PRFC's
        - Cultural Practices
        - Obtain collateral information regarding these areas
    - Adult Functioning: How does the adult function with respect to daily life management and general adaptation? Mental health and/or substance abuse?
        - Feels, thinks, and acts on daily basis with a focus on functioning and coping skills
        - Communication Skills
        - Coping/Stress management
        - Self-Control
        - Problem Solving/Decision Making
        - Finances
        - Employment
        - Community Involvement

        - Substance Use
        - Mental Health
        - Family and/or Domestic Violence
        - Obtain Collateral information regarding these areas
- Explore Well-Being of the child/youth and family
- Have a conversation in regards to case goals and progress/lack of progress since the last visit and assess feedback on feelings associated to this information
- Observe the child in the home
- Ask child for any other input, concerns, feelings, needs, etc. they might have; including, but not limited to the child's desires for permanency
- Discuss how the agency can help support the family
- Summarize visit and make arrangements for the next

<u>After:</u>

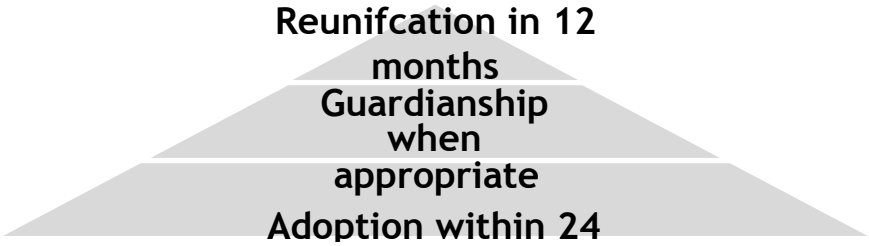
- Document key information, observations, and decisions without using "buzzwords", instead describe behaviors and document exact information.
- All worker visits will be documented within 5 days in order to ensure accurate information
- Debrief visit with supervisor and follow up on commitments made and next steps

Intentional Case Staffing Guide for Permanency Planning (PP) Supervisor

Case Name: _____ Date:_____

Supervisor: _____ Specialist:_____

Practice Note: An intentional case staffing is completed on each case every 90 days from the date of removal. The purpose of intentional case staffing is to ensure the quality and consistency of practice through supervisory oversight and coaching. The questions in this guide assist supervisors in identifying the occurrence of quality practice. This tool is a guide to coach specialists in thinking critically about case practice and support positive safety, permanency, and well-being outcomes.



1. **Review of Child's Safety and Wellbeing in Current Placement**
   - ü How is the child functioning in his or her placement?
   - ü Can the specialist describe how he or she observes the non-verbal child for signs of being unsafe?
   - ✓ Can the specialist describe how he or she interacts alone with the verbal child each month and initiating conversation about the child's safety?
   - ✓ How does the specialist describe the placement provider's relationship and interactions with the foster child?
   - ü Is the child placed with kinship? If applicable, is the placement Indian Child Welfare Act (ICWA) compliant? If not, what ongoing efforts are being made to place with kin or in an ICWA-compliant placement?
   - ü Has a diligent search been completed and letters sent to identified relatives as stated in policy?
   - ü Are there siblings and if so, are they placed together? If not, is the quality and consistency of visitation meeting the children's needs?
   - ü Is there any reason to believe that this placement may not be able to continue to meet this child's needs? If so, what is being done to support the child and placement provider?
   - ü What services is the child receiving, such as physical health, counseling, Individualized Education Program (IEP), developmental disability (DD) services, or tutoring?
   - ü Are the services currently in place meeting all the identified needs?
   - ü Does the specialist have any concerns with the child's placement?

2. **Review Visitation between the Child and Parent(s)**
   - ✓ What is the frequency and duration of the parent/child visits? Does the specialist believe it is sufficient to meet the child's needs to remain connected and bonded to his or her parent(s)?
   - ü Does the location support the family's needs and the case plan goal, for example, visitation in the parent's home when the case plan goal is reunification?
   - ü What is the specialist's observation of the quality of parent/child interaction?
   - ü How does the person responsible for the child (PRFC) display protective capacities during visits?
   - ü Has the specialist observed any unsafe behavior during the visits?
   - ü What contact outside of visitation is occurring between the parent/child, such as phone, email, or social media?
   - ü Can the specialist describe what safety condition needs to occur to increase the frequency and duration of visitation? If visits are currently supervised, what safety condition needs to occur to move to unsupervised visitation?

3. **Review of Specialists Contact with PRFC(s) Case Assessment and Progress**
   - ü How does the specialist describe the family's involvement in case planning?
   - ü Can the specialist give specific examples of how he or she made efforts to improve family involvement?
   - ü Based on the underlying causes, what services has the parent(s) been referred to?
   - ü Can the specialist describe how the individualized service plan (ISP) is behaviorally based? How is it addressing the safety threats?
   - ü What services are the parent(s) engaged in? Can the specialist relay what the parent's service providers report as barriers to child safety?
   - ü Can the parent(s) articulate what he or she thinks has changed in his or her behaviors and the family home since the child was removed?
   - ü Does the specialist have contact with the parent(s)/PRFC(s) in the home at least once a month? If not, discuss the barriers to monthly contact and relate back to continually assessing a parent's progress and safety. An ongoing assessment of child safety requires monthly contact with the PRFC(s).
   - ü What is the specialist's assessment of the PRFC's current behaviors and protective capacities? How is he or she gathering information from ongoing collaterals - service providers, friends, family, and foster parents; the child(ren); and the PRFC to make this assessment?
   - ü Is the current permanency goal appropriate for the case circumstances? If not, have a discussion around changing the goal.

Practice Note: Potential reasons for changing case plan goal.
- **The case plan goal is reunification, but the child has been in out-of-home care for more than 12 months.**
- **90-calendar days since adjudication and the parent(s) is making minimal behavioral changes.**

4. **Review of Assessment of Ongoing Child Safety**
   - ü Can the specialist describe the safety threats and specific behaviors that caused the child to be unsafe and required initial safety intervention?
   - ü Can the specialist describe what the parent(s) behaviors looked like and how that made the child unsafe?
   - ü What specific behaviors occurred to cause the safety threat to meet the safety threshold?
   - ✓ What, if any, is the family's history of involvement with the Oklahoma Department of Human Services? How has this impacted the current case progress?
   - ü What underlying causes were identified that contribute to the safety threats?
   - ü Can the specialist compare, contrast, and discuss the original safety threats to the current safety threats.
   - ü What steps has the specialist taken to support the family in understanding the safety threats and conditions that need to occur to reunify?
   - ü Does the specialist believe the PRFC understands what led to the child being unsafe? If not, discuss with the specialist what can be done to help them understand. If the PRFC does not understand why there was a safety intervention he or she will struggle with understanding what his or her role is in correcting it.

5. **Do any of these safety threats <u>currently</u> apply to the family's circumstances?**
   - ☐ Living arrangements seriously endanger a child's physical health.
   - ☐ PRFC(s) in the home lack the knowledge, skills, motivation, or abilities to perform parental duties and responsibilities.
   - ☐ PRFC(s) intend(ed) to hurt the child.
   - ☐ PRFC(s) does not have resources to meet basic needs.
   - ☐ Child has exceptional needs which the PRFC(s) cannot or will not meet.
   - ☐ Child is extremely fearful of the home situation.
   - ☐ PRFC(s) is violent and/or is unwilling or unable to control the violence.
   - ☐ PRFC(s) cannot or will not control behavior.
   - ☐ PRFC(s) has extremely unrealistic expectations or extremely negative perception of the child.

   - ü If yes, how does the threat meet the safety threshold of: specific; severe; observable; occurring now or likely to occur within the next few days; out-of-control; and applicable to a vulnerable child?
   - ✓ What do ongoing collaterals, service providers, original collaterals, and family members, report the PRFC's current functioning and protective capacities to be? If the case is more than six months old and an active safety threats still exists, discuss with the specialist concurrent planning and the steps needed to ensure safe and timely permanency.

Supervisory Feedback: In this section, the supervisor coaches the specialist and provides feedback to identify barriers to achieving timely permanency for this case. Based on the information gathered during the intentional case staffing, discuss with the specialist how his or her practice on this case contributed to safety in the placement, timely permanency, the placement's stability, and the well-being of the child(ren) while in out-of-home care. The supervisor discusses both what could have been done differently to improve practice and what was done well. Document below any action steps and due dates for the specialist to complete to achieve safe and timely permanency. Also document below any coaching notes.

Specialist/Date

Supervisor/Date

Field Observation Guide for Permanency Planning (PP) Supervisor

Case Name:_____ **Date: _____**

Supervisor:_____ **Specialist:_____**

Observation Type

____Monthly Parent Worker Contact **____Family Meeting (CSM/FTM)**

____Court Hearing/Related Activity **____Monthly Contact with Child(ren)**

Practice Note: Field observations should occur minimally with each worker every 90 days from completion of new worker certification. Observation types above should be rotated with each worker being observed in each setting annually.

6. **Worker/Parent Contact Observation**
   - ü Was the worker able to engage the parent/PRFC?
   - ü Did the worker go over the ISP and discuss progress and changes in behavior?
   - ü Did the worker adequately address the issues/barriers preventing the child from returning home?
   - ü Was the worker able to clearly discuss safety with the family?
   - ü Was the worker able to adequately answer and address any questions/concerns the PRFC(s) had?
   - ü Did the worker discuss the importance of timely permanency and address the 12 months to permanency goal?
   - ü Did the worker display any bias in their interactions with the parent/PRFC?

7. **Court Hearing/Related Activity Observation**
   - ü Was the worker able to articulate the current circumstances and behaviors impacting the safety of the child at the bench?
   - ü Was the information presented in the court report consistent with what was discussed during the court hearing?
   - ü Was the worker able to advocate for the recommendations made in the court report?
   - ü Did the worker present themselves in a professional manner?
   - ü Did the worker request the appropriate court findings?

8. **Family Meeting Observation**
   - ü Did the worker engaged and included the family in the decision making process?
   - ü Was the worker respectful of all participants?

- ü Did the worker include the child in the family meeting?
- ü Was the FTM focused on child safety, family functioning and permanency?
- ü Were all options for timely permanency explored and discussed with the family?
- ü Was the worker knowledgeable about all aspects of the current case circumstances and case history (provider reports/previous history/current placement situation etc.)?
- ü Did the worker display any bias during the family meeting?

9. Monthly Contact with Child Observation

- ü Was the worker able to engage the child and placement provider in conversations about safety, permanency and well-being?
- ü Was the worker able to gather the needed information to assess how the child(ren) are functioning in their out of home placement?
- ✓ Does the worker have any concerns with the child(ren)'s placement? If so, were they able to effectively discuss them with the placement provider?
- ü Was the worker able to engage the child(ren) in discussion about their relationships and feelings with other adults and children living in the home?
- ü Did the worker see the child alone and discuss how the child feels safe in their placement?
- ü Did the worker complete the child behavioral health screener during the visit?

5. Debriefing of the Field Observation

Supervisory Feedback: In this section, the supervisor coaches the specialist and provides feedback to identify practices strengths and areas needing improvement. Based on the information gathered during the field observation, discuss with the specialist how his or her performance contributed to safety in the placement, timely court outcomes, the placement's stability, and the well-being of the child while in out-of-home care. The supervisor discusses both what could have been done differently to improve practice and what was done well. Document below any action steps and due dates for the specialist to complete to achieve safe and timely permanency. Also document below any coaching notes.

Practice Strengths Identified and Discussed

Practice Areas for Improvement Identified and Discussed

_____

_____

_____

_____

_____

_____

_____

_____

6. Follow -up items and due dates, if applicable

_____ _____

Worker/Date Supervisor/Date

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

G. ., by Next Friend G. Gail Stricklin, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 08-CV-074-GKF-FHM
	)	
BRAD YARBROUGH, Chairman of the Oklahoma Commission for Human Services, *et al.*,	)	
	)	
	)	
Defendants	)	
.	)	
	)	

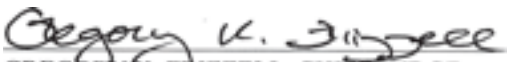
JUDGMENT

Pursuant to this court's order denying the Motion to Vacate Pursuant to 9 U.S.C. § 10(a) [Doc. No. 875] of defendant Oklahoma Department of Human Services, the court hereby enters judgment as follows:

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that the decision of the Co-Neutrals of March 5, 2018 [Doc. No. 871, pp. 5-6] is adopted in its entirety, attached hereto, and entered as a judgment of this Court. Pursuant to the March 5 decision, the Oklahoma Department

of Human Services must, among other things, relocate the remaining children currently placed at the Laura Dester Children's Center in Tulsa, Oklahoma to alternate, safe, needs-based placements by June 30, 2018.

ENTERED this 5th day of June, 2018.



GREGORY K. FRIZZELL, CHIEF JUDGE

March 5, 2018

Ed Lake
Director
Oklahoma Department of Human
Services Sequoyah Building
2400 N. Lincoln
Oklahoma City, OK
Via Electronic Transmission

Dear Director Lake:

During the last 12 months (March 2017 thru February 2018), DHS substantiated seven distinct referrals of child maltreatment at the Laura Dester shelter involving 10 children in DHS's child welfare custody . During the same period, DHS accepted for investigation 46 child maltreatment referrals that were either ruled out or unsubstantiated, and screened out an additional 53 referrals. Currently, there are five open investigations involving the treatment of children at the Laura Dester shelter. We are deeply concerned that DHS has not established a safe environment for the children who are placed in this state-operated facility.

Over the same 12-month period, DHS steadily increased the number of children (many with complex needs) placed at the shelter, often without establishing the necessary resources and organizational oversight and planning required to ensure these children receive the therapeutic care they need to live in a reasonably safe environment.

As DHS is aware, the Co-Neutrals have raised concerns regarding the lack of quality care and safety for the children placed at the Laura Dester shelter over the most recent 12 months, and well before then. In response to concerns discussed in March 2017, when DHS had approximately 25 children placed in the shelter, DHS reported that it would hire nine additional staff to improve the child-to-staff ratio and bring on specialized individuals to meet the specialized needs of the children placed in the facility. The Co-Neutrals conducted a site visit to the Laura Dester shelter in August 2017, and observed multiple safety issues and continuing staffing problems, which the Co-Neutrals reported to the Department.

After the Co-Neutrals found that ongoing and grave concerns for child safety at the shelter persisted, DHS in September 2017 developed a Continuous Improvement

Model Plan that included heightened monitoring by DHS' SPPU team and the

assignment of a full time SPPU liaison dedicated to monitoring the Laura Dester shelter. DHS also, again, committed to hire additional staff.

Currently, there are 44 children placed at the Laura Dester shelter. Despite DHS' past or ongoing plans, the Laura Dester shelter continues to present an unreasonable risk of harm to children placed there. This is evidenced by the ongoing and alarmingly high number of child maltreatment referrals, investigations and substantiations of maltreatment of children placed at the shelter, and the monitoring notes of the SPPU liaison, which cite a wide range of serious concerns, many of which have also been observed directly by the Co- Neutral team. The Department's diagnostic and remedial actions over the last year have not adequately improved the safety of children in the facility.

Under Section 2.14 of the Compromise and Settlement Agreement, the Co- Neutrals are granted the authority to require OHS to undertake and maintain diagnostic and remedial activities when the Department fails to achieve positive trending or begins to trend negatively in any area. In light of the negative trending DHS is showing with respect to the maltreatment of children in care and the number of children placed in shelters, particularly children ages six and older, the Co-Neutrals require DHS to cease immediately any new placements at the Laura Dester shelter.

Further, the Co-Neutrals require that DHS develop and submit to the Co- Neutrals a transition plan by April 1, 2018, to place all children out of the Laura Dester shelter by a date to be determined but not later than June 30, 2018.

Sincerely,

Eileen Crummy, Kathleen Noonan and Kevin M. Ryan

Appendix G: Placement Stability Communication

All

Child Welfare Services strongly believes in the practice surrounding Initial Meetings (IMs) and the positive impact they have on placement stability for children placed in out-of-home care. Therefore, it is imperative that the information gathered through the attached initial meeting guide that is used to develop a Child and Family Support Plan for the child's placement is documented in the KIDS contact. This allows the team to easily assess, review, and update the Child and Resource Family Support Plan on an ongoing basis.

The intended purpose of the Child and Resource Family Support Plan is to include the specific supports, services and/or other tools identified by the CPS, PP and Resource Specialists, Biological and Resource Parents, and Child(ren) that best support the safety, well-being and stability of the child in his or her resource home. A few examples of what supports or services could be in the Child and Family Support Plan, include, but are not limited to respite care, transportation, visitation, specific ways a child is best comforted, child's likes or dislikes, and contact information for a local resource parent support group.

It is the expectation that the permanency planning specialist documents the completion of the IM within 5 business days and the contact screen provides detailed information from the IM.

The body of the contact must include:

- Efforts made to ensure all parties attended IM
- Details from the initial meeting guide about the child(ren)
- Details from the initial meeting guide about the Child and Resource Family Support Plan.
- Identification of staff responsible for implementing the Child and Resource Family Support Plan.

Please refer questions to [Name Deleted] or to your regional placement stability lead.

Thank you

Jami Ledoux, MSW
Child Welfare Services Director

Appendix H: Memorandum from child welfare director regarding Permanency Plan Selection

TO: CW Supervisors, District Directors, Deputy Directors, and Program Staff FROM: Jami Ledoux, Director Child Welfare Services (CWS)
DATE: December 21, 2017
RE: Permanency Plan Selection

To clarify expectations in the selection of a child's permanency plan, revisions will be made to Oklahoma Administrative Code (OAC) **340:75-6-31. Permanency planning for the child in Oklahoma Department of Human Services (DHS) custody.** In the interim, this memo outlines specific requirements that are effective immediately.

The permanency plan indicates the intended or desired outcome for each child and influences the services and interventions used to achieve the outcome. The permanency plan must be consistent with each child's legal status and in the child's best interests. Permanency plan options are:

(1) reunite the child with the child's parent or legal guardian;
(2) terminate parental rights and place the child for adoption;
(3) establish guardianship; or
(4) planned alternative permanent placement (PAPP), provided the child is 16 years of age or older, and there is a compelling reason for the court to determine that returning home, or placement of the child for adoption or guardianship is not in the child's best interests.

The PAPP goal often results in the child aging out of care, which is the least desirable permanency plan. Research indicates children who age out of care are more likely to experience:

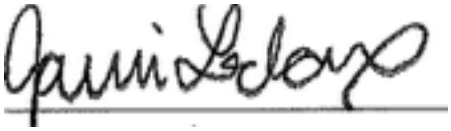
- unemployment;
- living at or below poverty level;
- serious untreated health conditions;
- a crime as a victim or involvement in a criminal activity;
- post-traumatic stress; or
- homelessness.

To improve outcomes for children in OHS custody, additional efforts are required before PAPP is selected for a child 16 years of age or older. The child welfare (CW) supervisor must ensure these requirements are met and documented prior to considering PAPP as the permanency plan. **These additional requirements are effective immediately.**

- Must explore and document all other permanency plan options determined as not feasible or in the child's best interests.

- Identify a sufficient number of permanent connections the child can depend on after exiting care. Best practice is to identify at least six to 10 connections.
- Hold a family meeting (FM) with the child, all identified permanent connections, CW specialist, CW supervisor, and regional permanency expediter (PE) to discuss and agree upon the permanency plan that is in the child's best interests. The FM report must include a detailed description of how and why all other permanency options were ruled out and what ongoing steps will be taken to achieve permanency for the child.
- Ensure the child is actively engaging and participating in Oklahoma Successful Adulthood (OKSA) services.
- Assign the PE secondary assignment to the child when the child's goal is changed to PAPP.

If you have any questions, please contact any Permanency Planning Programs staff.



Jami Ledoux, Director
Child Welfare Services

Glossary 1:

Acronyms ATAT Adoption Timeliness Accountability Team **CANH** Child Abuse and Neglect Hotline

CAP Corrective Action Plan

CHBS Comprehensive Home-Based Services

CPS Child Protective Services

CQI Department of Human Services Continuous Quality Improvement

CSA Compromise and Settlement Agreement

CWS[51] Child Welfare Specialist

DDS Developmental Disabilities Services

DHS Oklahoma Department of Human Services

FAS Facility Action Step

FFY Federal Fiscal Year

FSP Facility Services Plan

ITS Instructions to Staff

LD Laura Dester Shelter (state-operated)

MIC Maltreatment in Care

MST Mobile Stabilization Team

NCANDS National Child Abuse and Neglect Data System

OAYS Oklahoma Association of Youth Services

OCA Department of Human Services Office of Client Advocacy

ODMHSA Oklahoma Department of Mental Health and Substance Abuse

[51] CWS additionally is the acronym for Child Welfare Services – the agency within DHS that is charged with improving the safety, permanence and well-being of children and families involved in the Child Welfare system.

OHCA	Oklahoma Health Care Authority
PEM	Pauline E. Mayer Shelter (state-operated)
RFP	Request for Proposals
RFP	Resource Family Placement
PRT	Permanency Roundtable
PSC	Permanency Safety Consultation
SFY	State Fiscal Year
SPPU	Specialized Placements and Partnerships Unit
TFC	Therapeutic foster care
WPC	Written Plan of Compliance
YSA	Youth Services Agency