

# Summary of Child Welfare Assessment Recommendations

February 9, 2012

The following artifacts were reviewed and compiled into the attached summary report and table of recommendations concerning the OKDHS Child Welfare Program and Plan:

1. **Children's Rights Complaint**

Complaint dated February 13, 2008 and filed on behalf of nine children in foster care and the more than 10,000 children of Oklahoma who have been removed from their homes by the State. (Sometimes referred to as the D.G. v. Henry lawsuit)

2. **Viola Miller Report**

"A Review of the Oklahoma Department of Human Services Child Welfare Practices from a Management Perspective" dated March 15, 2011, retained by the Plaintiffs in the Children's Rights Complaint and prepared by Viola P. Miller. Ms. Miller is a Commissioner of the Department of Children's Services in Tennessee.

3. **Hornby Zeller Report**

OKDHS Child Welfare Program Performance Audit commissioned by the Oklahoma House of Representatives dated February, 2009 and prepared by Hornby Zeller Associates, Inc. located in Troy, NY.

4. **Robin Williams Report**

"A Review of Management of Oklahoma Department of Human Services Child Welfare System" is an independent review of the V. Miller report prepared by Robin Arnold-Williams, D.S.W. at the request of the Defendants (OKDHS) in the D.G. v. Henry lawsuit.

5. **Kathy Simms Report**

"The Oklahoma Department of Human Services Response to Reports of Abuse and Neglect in Foster Care, Case Review of Reports in 2009-2010" requested by the Defendants (OKDHS) in the D.G. v. Henry lawsuit and prepared by Kathy Simms, a Child Welfare Consultant at the National Resource Center for Child Protective Services.

6. **Chadwick Trauma-Informed System Project Report**

"Systems Intervention Plan" was funded by a Substance Abuse and Mental Health Services Administration grant and was prepared by The Chadwick Center for Children and Families at Rady Children's Hospital in San Diego, CA.

7. **OKDHS Strategic Plan**

The OKDHS Strategic Plan for Fiscal Years 2011-2016 developed and prepared by executive leadership.

8. **Oklahoma's Federal Process Improvement Plan**

The OKDHS Child and Family Services Plan 2010-2014, 2010 Annual Progress and Services Report developed and prepared by CFSD leadership.

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9. **CFSR Report**

The OKDHS Child and Family Services Plan 2010-2014, 2011 Annual Progress and Services Report developed and prepared by CFSD leadership.

10. **Casey Safety Assessment Report**

“A Review of Safety Assessment Guidance and Practices in the Oklahoma Department of Human Services” dated May 2, 2011, requested by OKDHS and prepared by Barry Salovitz, M.S.W., Senior Director at Casey Family Programs and Sue D. Steib, LCSW, PH.D., Senior Director at Casey Family Programs.

11. **Lorrie Lutz Report**

An overview report dated June 9, 2011 of consulting work from 2005 through June 2011 done in preparation for the Child Welfare Practice Model and in concert with OKDHS child welfare leaders, managers and workers from Children and Family Services Division (CFSD) and Field Operations Division (FOD); therapeutic foster care providers; tribal liaisons; and community providers and prepared by Lorrie Lutz of Raymond, Maine.

12. **Shusterman Report**

“Priorities for Change in the Oklahoma Child Protection System” report dated Summer 2011 prepared by the Charles and Lynn Schusterman Family Foundation of Tulsa, OK.

13. **FCITF Report**

Recommendations from the OKDHS Foster Care System Improvement Task Force dated December 13, 2011.

14. **Larry Brown Report**

“A Rebuttal to Dr. Viola Millers’ Review” dated June 7, 2011 prepared by Larry G. Brown, MSW, private consultant, of Niskayuna, NY.

15. **Sawilowsky Report**

“Analysis and Evaluation of” four reports (Goad, Miller, Reynolds, Hess) dated June 7, 2011 prepared by Shlomo Sawilowsky, Ph.D. of Detroit, MI.

16. **Fluke-Baumann Report**

“D.G. v. Henry Consolidated Rebuttal of the Expert Witness Report by Jerry Milner, DSW” dated June 15, 2011, prepared by John D. Fluke, Ph.D., Vice President and Founding Director of the Child Protective Services Research Center, American Humane Association, Englewood, CO and Donald J. Baumann, Ph.D., Senior Research Fellow, American Humane Association, and Instructor at Saint Edwards University, Austin, TX.

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## SUMMARY

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### **Child Protective Services (investigations of child abuse and neglect)**

Revising policies and practices for screening allegations of maltreatment. P. 12  
(Oklahoma's federal Performance Improvement Plan)

Revising policies and procedures related to prioritizing allegations of maltreatment and investigating complaints. P. 12 (Oklahoma's federal Performance Improvement Plan)

DHS should contract with District Attorneys (DAs) to represent DHS in deprivation proceedings  
(Hornby Zeller)

DHS should carefully monitor and refine the implementation of its dual-track CPS system in accordance  
with best practice standards (Miller).

The findings of the assessment review indicate that the appropriate response to address allegations of  
safety threats was not consistently taken by OKDHS staff. The review sample was very small so the  
issues concerning safety threats and response timeframes were noted in only four cases, and in none of  
those cases were injuries to the child victim alleged or found to have been present during the  
assessment (Simms).

Consider revisions to the safety assessment tool to include (a) re-labeling of the eleven factors currently  
shown as "Safety Threats" to "Signs of Present Danger" and delinking them in analysis from the six  
questions designed to assess emerging danger over the thirty-day period of the investigation or  
assessment; (b) expand the discussion of vulnerability and guidance for its use in determining whether  
the child is safe or unsafe; (c) include the identified caregiver protective capacities in the determination  
of child safety rather than only in development of the safety response<sup>3</sup>; and (d) determine whether the  
three different terms currently used to designate safety interventions (i.e., safety response, safety plan,  
voluntary safety plan) are adequately differentiated and understood by staff (Casey Safety Assessment).

Develop, train and implement guidelines and expectations for assessing and responding to risk/needs,  
absent a safety response (Casey Safety Assessment).

Re-evaluate the efficacy and need for court ordered services to prevent placement and insure that  
families' needs are being addressed and child's safety will not be diminished (Casey Safety Assessment).

Forensic interviewing and partnership with the MDT (Lutz)

Tools to support minimizing child trauma during the placement process (Lutz)

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## Performance Area: Child Abuse and Neglect in Foster Care

*DHS's Dangerous Monitoring and Oversight Practices of Foster Homes and Facilities harm Plaintiff Children and expose them to imminent risk of harm. P. 35 (Children's Rights)*

*DHS places plaintiff children in dangerous and inappropriate homes and facilities while in DHS custody. P. 28 (Children's Rights)*

*Plaintiff Children are Victimized while in DHS Custody P. 21 (Children's Rights)*

DHS should develop an integrated, comprehensive system of reporting, tracking, and monitoring outcomes, in particular the abuse and neglect of all children in care (Miller).

CPS should begin joint investigations with the Office of Client Advocacy for all abuse and neglect reports involving custody children in congregate care. The findings of these investigations should be included in KIDS and reported to the federal government (Miller).

Child welfare history can be made available to appropriate approved organizations in approving foster homes/foster families (Foster Care Task Force).

The types of abuse/neglect that were most frequently substantiated in the Part II review sample were threat of harm and failure to protect. In 80% of the Part II investigations, the action taken in response to the findings of the investigation was to make a placement change for the child. Further action, such as referral back to the child's permanency worker or the Resource Family Specialist for services or a written plan of compliance was recommended in only 7 of the investigations. Only 10 homes had children who remained in the home following the substantiated investigation (Simms).

There were concerns noted in the case reviews specifically:

- the history of prior reports regarding the foster parents in the sample;
- the referrals that were assigned as assessments;
- some instances of delayed initiation of assessments or investigations; and
- some cases in which safety threats were not accurately identified.

These concerns, however, did not represent a system wide failure to protect children's safety. While there were some errors in decision-making and there was not timely response in every case, this was clearly not a pattern or evidence of disregard for the safety of children. (Simms)

The review findings did indicate a concern with the assignment of the reports as assessments, only four reports were correctly assigned as assessments. As expected, the most frequent issues in the reports of abuse or neglect that were assigned as assessments were lack of supervision and threat of harm. There were, however, also allegations that involved injuries and actions of the foster parents that posed safety threats to children under the age of three. Based on the OKDHS policy concerning assessments, 13 reports should have been assigned for investigation rather than assessment. (Simms)

The majority of children who remained in the foster home following the substantiated investigation had previously received good care in the foster home and the allegations were

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such that the children could remain safely in the home if follow-up services were provided to the foster parents (Simms).

Timeframe for consultation: 2007

Efforts included review of assessment and re-assessment tools, home study processes, child-worker visitation policies and practice. P. 5 Recommendations:

- Enhancement of the home study tools to include a greater focus on prospective family motives, skills, protective capacities and supports (Lutz);
- Enhancement of the re-assessment tools to include a greater focus on child safety (Lutz);
- Modification of contracting requirements, ensuring that providers who complete the home studies are incentivized to complete throughout and accurate home studies(Lutz);
- Improvement of the consistency and thoroughness of the review process by OKDHS foster care licensing staff (Lutz);
- Reduction in the number of children placed more than 40 miles from home—thereby lessening the use of primary and secondary workers (Lutz).

Listen to children’s insights about conditions in the home, placement problems, and their needs Why: Children in the foster care system have expertise that comes only from experience. They should be heard and part of the solution (Shusterman).

## **Performance Area: Resource Home Availability**

*DHS's failure to develop and maintain a sufficient number and array of foster care placements P. 24*  
(Children’s Rights)

*DHS fails to provide adequate foster care maintenance payments for the care of Plaintiff Children. P. 38*  
(Children’s Rights)

Foster Care Recruit, train, retain, monitor, and pay quality foster and kinship families

Why: More diverse families with quality training, support, and fair pay are needed for foster children to overcome trauma (Shusterman)

Expand partnerships in placement between state/tribal/public agencies and private sector resources for increased capacity and efficiency with proper court and agency monitoring and enforcement (not to include case management) and services to custody youth along a continuum of care, to include out-of-home placement, such as emergency foster care, traditional foster care, contracted foster care, therapeutic foster care, and kinship care or other services as might be authorized by DHS (Foster Care Task Force)

Developing and implementing county specific plans to increase resource availability. P. 12 (Oklahoma’s federal Performance Improvement Plan)

DHS should implement a continuous state, county, and community-based resource home needs assessment, including generic, targeted, and child-specific goals and strategies (Miller)

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DHS should develop, implement and monitor a plan for recruitment and retention of resource homes based on goals established from the needs assessment and should engage current resource families in this work (Miller).

Bridge Recruitment: OKDHS is in the process of developing an Oklahoma specific recruitment and retention tool kit to be used in consultation with counties on developing localized recruitment plans with their community partners, while continuing to develop a consistent statewide plan with technical assistance from AdoptUSKids. Finally, the evaluation team continues to develop survey instruments to collect data on these initiatives as well as mine data from our KIDS database in order to track challenges as well as successes and continue to make adaptations to our efforts as needed. P. 20 (CSFR)

Bridge Support: Mentoring and Support Groups – The Bridge Leadership team is planning on utilizing training clusters and the Office of Faith-Based and Community Initiatives to work on forming organic support groups of parents who experience pre-service training together. P. 29 (CSFR)

Effectiveness: Survey instruments are also currently under development to evaluate the effectiveness of the Bridge Family Portal website. The website currently provides: an overview of what Bridge Families do, the Bridge Family Orientation training, FAQs for the Bridge philosophy, family support resources, useful forms, Bridge Family stories, Bridge best practices and principles, and videos / resources on foster care and adoption. P. 29 (CSFR)

Effectiveness: We plan to use our SACWIS data to test the relationships between having contact with the Resource Support (Call) Center and the likelihood of being an approved home for all the different family types needed versus those families that are assisted in other ways (coming into a county office, internet, events, etc.). P. 29 (CSFR)

Bridge: Timeframes for consultation: 2005-2007 Efforts included development of a comprehensive and consistently applied approach to recruitment, orientation, training and retention of Bridge Resource Families. P. 5 (Lutz)

Increase support of quality foster parents through timely reimbursement rates, resource supports, quality training, customer service, targeted recruitment, and retention of quality homes (Foster Care Task Force).

Extend Foster Care System Improvement Task Force until December 31, 2014 (Foster Care Task Force).

Expand partnerships between state/tribal/public agencies and private sector resources for increased capacity and efficiency with proper court and agency monitoring and enforcement in foster care home recruitment, training and home studies (Foster Care Task Force).

Ensure that any changes to the foster care system be based on best interests of children and youth. Prior to legislative or policy changes to the foster care system an impact analysis from the affected parties should be sought and considered (Foster Care Task Force).

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## **Performance Area: Frequency and continuity with which child welfare case workers visit children**

Caseworkers should be required to visit with children privately at least every few months, and preferably at every visit. (Hornby Zeller)

Continue progress meeting federal expectations in the area of monthly visitation between case workers and children (Williams).

OKDHS child welfare staff conducts at least one monthly visit with children who are in out-of-home care. Contact guidelines focus on safety, permanency, and well-being (OKDHS Strategic Plan).

OKDHS plans to utilize an enhanced visitation model in ten select counties. These sites will conduct a self-assessment, identifying areas of strength and those needing improvement, to be addressed as part of the county program improvement plan. Training will be provided to these CW staff regarding the visitation protocol. The outcomes of this plan will be utilized to identify the resources necessary for statewide implementation. P. 30 (CFSR)

Intentional Visitation practices (Lutz)

## **Performance Area: Number of Placements Children Experience**

*DHS frequently moves children from one inappropriate placement to another, causing them severe emotional and psychological harm. P. 30 (Children's Rights)*

Increase placement stability for foster children Why: In FY2010, 55.4% of Oklahoma children had three or more placements; 21.9% had six or more (Shusterman).

Trauma Training for Resource Parents: Although child welfare workers and supervisors identified resource parent training as a strength, the youth and resource parents themselves expressed a need for more training specific to trauma for substitute caregivers. Implementation of Caring for Children who have Experienced Trauma: A Workshop for Resource Parents (NCTSN) would improve the resource parent's ability to manage trauma reactions and therefore increase stability and well-being for children in care. The Foster Parent Newsletter Regarding Trauma-Informed CW Practice could be used to educate resource parents statewide (Chadwick)

Continue to develop and implement a broader array and depth of necessary services to address needs of children and families who come into contact with the child welfare system as well as support foster and kinship providers. Specific priority should be placed on expanded quality placement options and supports to provide safety of children in out of home care, continue to reduce utilization of shelter care, and improve placement stability (Williams).

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## **Performance Area: Number of Children in Shelters and How Long They Remain**

*DHS houses plaintiff children in dangerous and inappropriate placements that fail to provide adequate protection to meet their needs. P. 24 (Children's Rights)*

*DHS unnecessarily institutionalizes plaintiff children in dangerous and inappropriate emergency shelters for extended periods of time. P. 25 (Children's Rights)*

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

The Commission on Children and Youth should assume responsibility for licensing all congregate out-of-home care facilities operated directly by DHS (Hornby Zeller).

DHS should immediately develop and implement a plan to eliminate the use of emergency placements (particularly shelters), and reallocate those resources to develop an adequately funded, supported, and monitored placement system (Miller)

As the rate of out of wedlock birth continues to grow, as do the removal rates for children under age one and the prevalence of drug affected-infants, reducing the use of emergency shelters will also require the development of special services primarily for infants. The vision includes development of implementation projects, which create standing capacity for emergency foster care homes that should virtually eliminate the need for shelter care for children under age five. OKDHS has had preliminary discussions with some providers who have expressed an interest in providing this service. The financial analysis has been preliminarily determined to be feasible for the projects. P. 44 (CFSR)

## **Performance Area: Permanency**

*DHS prevents plaintiff children from maintaining critical family ties while in State custody. P. 32 (Children's Rights)*

*DHS fails to plan for and take mandated steps to find permanent and safe homes and exits from State custody for plaintiff children. P. 40 (Children's Rights)*

Increase frequency and quality of parent-child visitation Implement a reunification process that ensures a smooth and safe return to family Why: We need to make sure the 52% of children removed from their homes who are later reunified with their families don't come back into the system (Shusterman)

Prepare youth for successful living within the community after leaving state custody Why: In FY2010, 7% of youth in state custody aged out of the system with few permanent connections (Shusterman).



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Funding for transportation, extracurricular activities, and a foster child's personal needs Why: At-risk youth who participate in even one extracurricular activity are less likely to drop out of school (Shusterman).

Increase Training for Birth Parents: While the results of the current assessment suggest that staff members actively engage with birth parents and recognize that many of them have experienced their own trauma, the results also suggest that there is no mechanism in place to provide training and education to birth parents on understanding trauma and working with their children regarding trauma behaviors and reactions. It is recommended that training for birth parents on trauma become embedded in the service plan to increase the likelihood of successful and permanent reunification (Chadwick)

Family engagement and involvement of extended family can often lead to safer and quicker reunification for children (family team meetings) (OKDHS Strategic Plan).

Simplifying the individual service plan and implementing protocols to increase family involvement in all aspects of service delivery. P. 12 (Oklahoma's federal Performance Improvement Plan)

Implementing protocols to increase family (especially absent fathers) and tribal involvement in all aspects of service delivery. P. 12 (Oklahoma's federal Performance Improvement Plan)

Family Team Meetings: The FTM forms have been enhanced to include a closer look at sibling placement and at efforts to place siblings together if they have been separated. A focus has been placed on the need for every child to have frequent Family Team Meetings to improve family participation in decision making. This is being supported through CFSD Permanency Planning staff contacting Child Welfare field staff when a report indicates the child/family has not had an FTM and offering to assist with planning, coordinating and facilitating an FTM. P. 19 (CFSR)

Concurrent Planning: OKDHS plans to revise and clarify the concurrent planning process and anticipates this will positively affect establishing permanency goals in a timely manner, attaining permanency goals timely, achieving adoptions timely, and ensuring long-term placement. On-going work with concurrent planning practices is provided through the use of Family Team Meetings and Permanency Roundtables. Both of these activities are focused on helping children achieve timely permanency, which includes a review of the Poor Prognosis Indicators. This information has been enhanced in the Permanency Planning CORE Level 1 and 2 training sessions to reinforce the need for early and periodic assessment for timely permanency. Oklahoma has three types of funded guardianships. The first is supported permanency using TANF funds, the second is Title IV-E funded guardianship and the third is a state funded program for those rare cases that guardianship is in the best interest of the child(ren), but the inability to meet the requirements of the other two programs, hinders the family's ability to obtain guardianship. P. 32 (CFSR)

Broaden Service Array/Resource Development: OKDHS plans to approach the lack of services through implementing Resource and Capacity Development Plans within the individual counties of the state. Technical assistance will be accessed to gain information on how service array has been successfully improved in other areas of the nation. This will lay the foundation for providing individual counties with training and support in developing plans to increase services at the local level. P. 42 (CFSR)

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Concurrent Planning: Timeframes for consultation: 2005. Efforts included review of existing policies and provision of training on concurrent planning to a cross section of OKDHS leadership and staff. P. 5 (Lutz)

Functional Assessment and Behaviorally Focused Individual Service Plans (ISP) (including the development of a new Functional Assessment and ISP) (Lutz)

Planning for Permanency (including the implementation of Permanency Pacts) (Lutz).

Expand partnerships between state/tribal/public agencies and private sector resources for increased capacity and efficiency with proper court and agency monitoring and enforcement in the involvement of community groups for local support, community resource development, and participation (Foster Care Task Force).

Child welfare history can be made available to any federally recognized tribe seeking to approve individuals as placement resources or appointed as legal guardians (Foster Care Task Force).

## **Performance Area: Adoption**

DHS should move the SWIFT Adoption workers to the Field Operations Division and integrate them into the agency's local offices (Hornby Zeller).

Enact legislation that eliminates jury trials for termination of parental rights (Foster Care Task Force)

## **Performance Area: Reasonable Caseloads for Child Welfare Workers**

*Excessive Caseloads, Inexperienced Caseworkers, Inadequate Supervision, High Turnover and Inadequate Training threaten basic child safety. P. 33 (Children's Rights)*

The Legislature and the Governor should provide a consistent means of funding salary increases for DHS staff based on performance (Hornby Zeller).

DHS should experiment with recruiting staff with different demographic characteristics to determine which groups are more likely to stay with the agency longer periods of time (Hornby Zeller).

DHS should abandon its antiquated workload analysis and develop a sustainable approach to workload management. This approach must not only include adherence to acceptable caseload standards, but it must also establish a mechanism for ensuring equity in assignment. Use of aggregate data and averages to determine caseload compliance must cease. Caseloads can only be managed at the individual staff level (Miller)

DHS should initiate a "right sizing" initiative and seize the opportunity to reallocate staffing to child welfare as necessary (Miller).

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DHS should ensure the presence of a sufficient number of caseworkers and supervisors at all times by developing strategies to mitigate vacancies and turnover(Miller).

Increase the number of staff and continue to improve the experience level and practice competencies of staff responsible for day to day work on child welfare cases (Williams).

Improve the tracking, reporting and management of child welfare caseload and workload to assure effective allocation and utilization of available staff resources (Williams).

Provide Increased Staff Support to Decrease Staff Turnover, Secondary Trauma, and Increase Stability and Support for Families: One of the great challenges to becoming a trauma-informed child welfare system is providing support to the child welfare workforce. Due to the increasing demands of time, high caseloads, and decreased funding, coupled with the emotional toll it takes to work with traumatized children and families on a daily basis, turnover rates for workers are high. Traditionally, training designed to address secondary trauma has focused primarily on providing workers with strategies on how to take care of themselves once they leave the office. However, this has not proven to be enough. There is a need to integrate self-care strategies into the daily practice of workers and to address vicarious trauma on an organizational level. This includes integrating processing of challenging cases into supervision, providing training on secondary traumatic stress and related coping skills during initial training and ongoing staff training, and utilizing a curriculum designed to address secondary trauma in child welfare workers (Chadwick).

Explore ways to eliminate duplication in required CPS documentation, particularly with regard to the information contained in the Assessment of Child Safety and District Attorneys Report (Casey).

Consider conducting a brief workload estimation study of child protection casework and supervisor positions to inform future requests for positions and to support retaining staff even in the face of reduced caseloads (Casey)..

Workforce development is critical in improving the level of service provided to our children and families. We must develop, recruit, retain and raise the rate of compensation and then tie salary increases to on-the-job performance to maintain a quality workforce (Foster Care Task Force).

## **Organizational Structure**

Area offices should assume direct responsibility for functions which cross county lines (Hornby Zeller).

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

The central office program divisions should conduct a periodic statewide services needs assessment and allocate funding to each Area office for contracted services, and the Area offices should assume responsibility for deciding which contracts to fund within their boundaries (Hornby Zeller).

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DHS administrators should act with greater speed to correct personnel performance problems, especially among Area and County Directors whose positions are unclassified (Hornby Zeller).

DHS should develop a dynamic leadership team to drive the child welfare change initiative over the coming years. The systemic reform needed will require strong leadership with a clear vision of work that is child-centered, family-focused, strengths-based, and culturally responsive (Miller).

DHS should develop well-defined responsibilities and accountability for every position in the child welfare system, and set clear goals and objections for its child welfare staff (Miller).

## **Training/Workforce Development**

Workforce development is critical in improving the level of service provided to our children and families. We must develop, recruit, retain and raise the rate of compensation and then tie salary increases to on-the-job performance to maintain a quality workforce (Foster Care Task Force).

DHS should revise its training materials to create a formal curriculum which provides information in a logical order and helps workers gain the competencies they need to perform their jobs at a high level (Hornby Zeller).

DHS should ensure that every worker receives job-specific training as soon after starting a position as possible (Hornby Zeller).

DHS should develop an enhanced professional development program that is integrated and monitored; based on accepted principles of adult learning, including coaching and mentoring; and focused on outcomes for children and families (Miller).

DHS should develop a more integrated approach to professional development in cooperation with the state's university system (Miller).

DHS should develop specific curricula for both pre-service and in-service training for the child welfare workforce (Miller).

DHS should continue to enhance its child welfare supervision training curriculum, including a performance competency evaluation (Miller).

New worker training should require successful completion of a performance competency evaluation prior to caseload assignment (Miller).

DHS should ensure that private provider caseworkers meet the same professional development standards as the public system staff (Miller).

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Fully integrate the Child Welfare Practice Model into all training, policy, practice and performance expectations of child welfare staff at all levels and of management staff who supervise or provide support services to them (Williams).

Increase Training: The theme of “increased training” emerged multiple times in both the focus groups and within responses on the TSRT. Large scale efforts related to trauma training are recommended to be initiated across the system, including child welfare staff, mental health providers, and parents. The training should cover topics such as types of trauma, impact of trauma across domains, and how to effectively manage and address trauma (Chadwick).

Facilitate Agency Culture Change by Embedding Consultation and Education Related to Trauma into Supervision and Team Meetings: While it is critical for individuals to receive training on trauma, it is only the first step. In order to support workers’ efforts to integrate trauma knowledge and awareness into their daily practice, it is vital to embed trauma language and discussion into existing supervision and team meeting structures (Chadwick).

Give priority to provision of coaching and mentoring support for caseworkers and supervisors, particularly in the areas of safety assessment and decision making, safety planning and monitoring, and family engagement (Casey).

Establish “Practice Model” specialists in each Area for ongoing training and consultation. (Note: This should be in addition to the Child Welfare Field Liaison. (Casey)

Increase qualifications for child welfare workers and pay them a competitive salary  
Why: Currently, a new child welfare investigator must have a generic bachelor’s degree and be on call 24/7. Beginning salary is only \$25,730 — well below the national average (Shusterman).

Increase and improve skills-based training for child welfare workers and management  
Why: A quality, trained workforce provides better outcomes for children (Shusterman).

Improve retention by addressing secondary trauma for front line workers  
Why: In FY2010, the turnover rate for entry level child welfare workers in Oklahoma was almost one-third (Shusterman).

Increase staffing levels within child protection-related public agencies  
Why: Provider-to-child ratios need to meet or exceed national standards (Shusterman).

## Quality Improvement

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

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DHS should implement a child welfare Performance Quality Assurance (PQA) office answering directly to top child welfare leadership. This office must have as much independence from bureaucratic interference as possible. The PQA should include the use of a standardized quality services review process for measuring the casework and outcomes of individual custody children. This office should also provide leadership for the implementation of a continuous quality improvement process that involves all staff across the agency as well as stakeholders outside the agency, including providers, community partners, service recipients, and foster parents (Miller).

DHS should implement a Quality Services Review (QSR) for evaluating cases of children in custody, which should include external reviewers along with DHS staff (Miller).

DHS should implement a process to ensure that QSR recommendations are followed and action steps implemented (Miller).

PQA should become the repository for all contracts and provider monitoring information. It should regularly review all information available on each provider to determine the safety and well-being of children, and should make recommendations in writing regarding the continuation of contracting based on the information reviewed (Miller).

Continue to execute the established Continuous Quality Improvement (CQI) case review process to provide both quantitative and qualitative performance data and take steps to improve the CQI case review process with respect to involvement of outside individuals and entities, transparency of results, and more formalized feedback and follow up processes (Williams).

Developing and implementing a supervisory case review protocol incorporating CFSR values and expectations. P. 12 (Performance Improvement Plan)

Developing and implementing a peer case review which integrates the expectations of the supervisory review. P. 12 (Performance Improvement Plan)

## **Other Recommendations**

DHS fails to arrange mental health services for Plaintiff Children. P. 41 (Children's Rights)

Plaintiff Children are denied adequate and effective legal representation in the juvenile courts. P. 42 (Children's Rights)

Breach of the Oklahoma State Plan Contracts Harms Plaintiff Children. P. 43 (Children's Rights)

DHS should establish and monitor performance outcome measures for both public and private service providers and hold both accountable for those outcomes (Miller).

DHS should implement performance based contracting (Miller).

DHS should ensure that all private agency monitoring and licensure information is integrated and used to inform contract decision-making (Miller).

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DHS should implement a high-quality data management system. This system must be staffed with the expertise necessary to ensure data integrity, and must allow the use of data reporting and analysis to inform decision-making and evaluate agency effectiveness on measurable outcomes (Miller)

Resource Lists: Line workers and supervisors expressed a strong interest in having a list of the resources that are available in their community (particularly mental health programs that provide trauma-focused services for both adults and children) that is easy to access and use. While creating such a database may be time-consuming on the front end, it will help save time and create an infrastructure for appropriate treatment referral in the long run (Chadwick).

Promote Regular Communication and Care Coordination with Other Service Providers: The results from the current assessment suggest that workers feel strongly that increased care coordination and communication across service systems is a key component of a trauma-informed child welfare system. They identified that, while they feel it is important to increase this communication, it is somewhat challenging to work with other systems. Therefore, there are a number of strategies that may be used to increase coordination across systems: (1) Collaborate with mental health partners to provide cross-trainings to judges, schools, etc., on the topic of trauma and its impact on children; (2) Utilize a trauma-informed court report; (3) Conduct family team meetings that include all individuals who work with the child and family in the same meeting; and (4) Conduct multi-disciplinary team meetings regarding a specific child or case that includes individuals from multiple systems at the table, discussing the best ways to support the child and family (Chadwick).

Develop a statewide system for trauma informed child welfare system (OKDHS Strategic Plan).

National Youth in Transition Database (OKDHS Strategic Plan)

Collaborative Partnerships w/ Stakeholder Participation: The development of a statewide Child Welfare Stakeholder collaborative was identified as a strategy within Oklahoma's Program Improvement Plan. During this process, major progress has been made. An already existing committee, which includes the membership desired for this collaborative, has indicated the interest and capacity to serve as the state-level community collaborative for child welfare. In addition, this collaborative has the ability to achieve state-level barrier "busting" in service array improvements. A final decision on their commitment will be made this month. In order to help inform the state-level collaboration of service array improvement needs at the local level, efforts are also being targeted at already existing local collaboratives. The Oklahoma Commission on Children and Youth has identified two staff members to help the local county collaboratives get the technical assistance they need to become better functioning collaboratives. P. 16 (CFSR)

Communication: OKDHS has identified the need to improve communication within the Child Welfare system and between Child Welfare workers, tribes, and resource families providing care for the children placed in their homes. Enhanced communication will not only assist in identifying areas of concern in the home but will also add needed support for the families involved. OKDHS has recognized that there has been some confusion among Child Welfare workers regarding the difference between alleged policy violations and alleged abuse or neglect in out of home care. It is anticipated that increased communication will clarify this issue along with the centralized hotline. P. 22 (CFSR)

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These two-day conferences will have workshops on numerous issues including safety, permanency, well-being, ASFA, Team Decision Making, etc. A presentation will be made at the annual Juvenile Judges Statewide Conference regarding the changing focus of CPS from incident based to an assessment model. OKDHS meets quarterly with the Juvenile Judges of the OK Supreme Court's Juvenile Oversight & Advisory Committee for the purpose of exchange of new ideas, review of on-going joint training, and resolution of issues. Update: One yearly meeting was held on August 18 and 19, 2011. The agenda included the following presentations: "Adverse Childhood Experiences, the ACES Study", "Understanding Historical Trauma", "National Child Traumatic Stress Network", "Trauma Informed Systems Project", a panel of subject matter experts in trauma, and "Common Seeds Planted by Harvesters of Hope". The Court Improvement Project anticipates an enrollment of approximately 600 attendees consisting of judges, district attorneys, CASA, PARB, private attorneys, and county OKDHS staff. P. 42 (CFSR)

Consider revisions to the Practice Model Guide to clarify the agency's responsibility for providing services and possibly for obtaining court intervention in situations of high risk which do not, at the time of initial assessment, meet the criteria of *unsafe* (Casey).

## Collaboration

Within Oklahoma communities, public and private agencies and Tribes should work together in these ways:

- Meet regularly to facilitate communication
- Train in multi-disciplinary settings
- Share information

Why: Child welfare and community stakeholders have determined that collaboration is vital for permanency, safety and the well-being of children.

Improve data coordination

- Registry of individuals convicted of crimes against children
- Timely record-sharing when a child moves
- Share information

Why: Lack of information sharing, such as diagnoses, may lead to long-term adverse consequences for a child (Shusterman)

## Education

Improve literacy and graduation rates

Why: 70% of youth aging out of custody do not have a high school diploma or GED.

Improve collaboration among child welfare, foster families and schools

Why: Foster children often fall significantly behind in school because of poor communication and delays in getting paperwork.

Promote the use and availability of online education

Why: For many foster youth, online education is a viable alternative to disrupted traditional education.

## Priorities for Change

Improving the Quality of Life for Children and Youth in the System (Shusterman)



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## Advocacy

Educate decision-makers about the Child Protection System

Why: Informed leaders can invest wisely in programs and policies that impact whether our children and youth become tax payers rather than tax spenders.

Educate legislators on the importance of expert input and public review before enacting laws affecting the Child Protection System

Why: Oklahoma is in the top 5 states for child abuse and neglect deaths. Constituents need to elect lawmakers committed to legislating protection for at-risk children.(Shusterman)