

juvenile justice and delinquency prevention

# PROFILES

Oklahoma Commission on Children  
and Youth  
A Governmental Response to Monitoring  
the Juvenile Justice System

In 1982 the eyes of the nation were on the Oklahoma juvenile justice system. A highly publicized series of investigative newspaper articles, national TV coverage, and congressional hearings all uncovered the abuse and neglect of children in institutions under the auspices of the Oklahoma Department of Human Services (DHS). It was revealed that the Department, a giant agency with a \$1.2 billion annual budget, essentially answered to no one — not the governor, the legislature, nor any oversight authority, even though it received more than half of the state budget. Because funding for DHS came from earmarked sales tax revenues, the Department did not have to rely on the legislature or governor for program or fiscal approval. As a result, there were only minimal fiscal or operational controls in place. Nor were there checks and balances by outside agencies, or internal or external monitoring for compliance with forms and standards. Finally, since Oklahoma did not participate in the federal Juvenile Justice and Delinquency Prevention (JJDP) Act, DHS had no federal monitors looking over its shoulder.

Spurred by this public scrutiny, the Oklahoma legislature passed legislation that brought far-reaching changes to its juvenile justice and child welfare systems, and assured that abuses would no longer be hidden from legislative and public attention. One of the cornerstones was the creation of the Oklahoma Commission on Children and Youth, specifically to bring accountability and oversight into the child care system.

This Profile article takes a close look at the commission and its genesis, statutory authority, activities, and accomplishments. Its small but committed staff has created a climate of responsibility and openness in government that is worthy of emulation.

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# Oklahoma Commission on Children and Youth

## A Governmental Response to Monitoring the Juvenile Justice System

### An Historical Overview

In the early 1980s, three dramatic currents for change were surfacing in Oklahoma's juvenile justice system. The first, the *Terry D.* case (*Terry D. vs. L. E. Rader, et al.*), filed in 1978 in the U.S. District Court for the Western District of Oklahoma, was inching through the lengthy process of the federal court system.

The second was State Representative Don McCorkell, Jr., Chairman of the Criminal Justice Committee. Soon after being elected to his second term in 1980, he envisioned a systematic overhaul of the state's deficient and fragmented juvenile justice and child welfare systems. The third event occurred in February 1982, when reporters from the Gannett News Service began a series of shocking articles exposing abuse and neglect in facilities operated by the Department of Human Services. With the coalescing of these three efforts, the climate for real change was right.

The *Terry D.* case was filed by Steven A. Novick from Legal Aid of Western Oklahoma, later joined by the National Center for Youth Law and the National Prison Project of the American Civil Liberties Union. The case addressed a number of issues. These included: the pervasive use of illegal and lengthy solitary confinement and its consequent conditions; physical, emotional and psychological abuse by institutional staff; coerced drug-ging without medical authorization; interference with the attorney-client privilege and limited access to legal counsel; and the failure to provide "adequate, meaningful, effective and individualized educational, vocational and therapeutic programs and resources in the least restrictive environment."

*The author of this Profile, Joseph DeJames, has worked in New Jersey's juvenile justice system for the past 14 years. He has developed and monitored shelter programs for status offenders and detention programs for delinquents, conducted research, written legislation, developed policy, and has conducted JJDP compliance monitoring.*

Concerning solitary confinement, the complaint alleged that the rooms used were unsanitary, and not properly heated or ventilated; that children were denied daily exercise or recreation, education, and showers; and that handcuffs and leather restraints were sometimes used. It further noted that some children were placed in a small windowless broom closet known as "the hole," and alleged that children were subjected to a variety of forms of direct physical abuse by houseparents, security guards, social workers, teachers, and administrators.

In the course of the federal suit, Dr. Robert F. Baxter, a child psychiatrist with expertise in the residential treatment of adolescents, characterized the Oklahoma system as "exceedingly cruel and inhumane." Dr. David Fogel, former commissioner of the Minnesota Department of Corrections, was also asked to examine Oklahoma's institutions on behalf of the plaintiffs. His reaction to the conditions was "one of personal shock and outrage." "The conditions under which these children are incarcerated conform to no known corrections or treatment standards," he said, adding that Oklahoma's system of juvenile institutions "in my view, constitutes cruel and inhumane punishment for children."

DHS institutional inertia kept sweeping changes from being achieved immediately. Several motions for preliminary injunctions brought some relief, however, including prohibition on the use of restraints, limitation on the use of isolation, and institutional compliance with fire safety, health, and sanitation regulations. Then, in early 1982, nearly four years after the suit was filed, the Gannett News Service series about the system began. These articles opened the situation to much needed public exposure.

The newspaper articles began in February. They were the culmination of numerous interviews, and the review of hundreds of confidential DHS documents and previous investigative efforts by Steven Novick and his associates. The series alleged that Oklahoma's institutionalized children had been:

- Bound and manacled for extended periods.
- Hospitalized with serious injuries, including broken bones, from attacks by adult attendants.
- Coerced into performing homosexual acts with state employees.
- Recruited to join a prostitution ring.
- Provided with illegal drugs by supervisors.
- Thrown into solitary confinement for weeks at a time.

The Oklahoma system was characterized by a former administrator of the Office of Juvenile Justice and Delinquency Prevention as "one of the worst in the country, one of the most archaic, and one with widespread abusive practices."

Many of the children involved had not been adjudicated for criminal-type activity, since status offenders, such as runaways and truants, and nonoffenders made

up about half of the institutional population. Since Oklahoma chose not to participate in the federal JJDP Act, it was under no federal requirement to deinstitutionalize status offenders. Also, Oklahoma was one of the few remaining states to house dependent and neglected children in large, secure institutions located in remote areas.

Through 1982 the abuses were well publicized through high-profile newspaper coverage, statewide television coverage, and a segment on national TV. The U.S. Senate Subcommittee on Juvenile Justice held several hearings in Washington, D.C. solely on the abuses. Hearing the testimony of abused juveniles, senators were shocked that such maltreatment could exist in publicly operated facilities.

Over the next several years, the status of Oklahoma's youth institutions changed dramatically. Several of the large training schools were closed, sharply decreasing bed capacity. The average daily number of institutionalized youths decreased from 1,300 to 355. New procedures on reporting and investigating institutional child abuse were developed. At the federal level, investigations were initiated by the U.S. Department of Justice, Federal Bureau of Investigation, U.S. Department of Health and Human Services, and Oklahoma's three United States Attorneys. At the state level, the Oklahoma Attorney General, the Oklahoma Bureau of Investigation, and the State Auditor and Inspector also began conducting parallel criminal investigations. The U.S. District Court in Oklahoma City ordered DHS to halt all abusive practices against children under its care.

**A significant benefit of both the Terry D. case and facility monitoring by the commission has been to increase the public scrutiny of public and private children's facilities since, in his opinion, "if there is any one thing that creates an environment where abuse can flourish, it's an institution that's hidden from the public eye."**

## The "McCorkell Legislation"

At the same time that Gannett was releasing its scathing and unrelenting series on the juvenile institutional system, progress continued in the Oklahoma legislature. After hearings and research on juvenile justice in Oklahoma and other states, the House Criminal Justice Committee concluded there were major deficiencies in the Oklahoma system with its heavy emphasis on institutional care.

The *Terry D.* lawsuit and increasing newspaper coverage provided a backdrop for the legislative wrangling over a comprehensive bill introduced in 1981. Many observers feel that these events contributed to its passage, although, according to Bob Fulton, the former director of DHS, "the legislation was also responding to the fragmentation in children's services." Whatever the reasons, the result was legislation that became effective in July 1982 and contains numerous protections for Oklahoma's youths involved in its juvenile justice and child welfare systems. Still today, the legislation is informally known as the "McCorkell legislation," after its author and primary sponsor, State Representative Don McCorkell. There was a time, he recalls, when the legislature considered a proposed settlement between the plaintiffs and DHS. But it was important that it did not acquiesce to the crisis since the "legislation went ten times as far as the proposed settlement." Among its provisions, the legislation:

- Created the Oklahoma Commission on Children and Youth.
- Directed the Department of Human Services to develop and implement a diversity of community services and community residential care for the treatment and rehabilitation of children in its custody.
- Directed the Oklahoma Commission for Human Services to "establish standards for the certification of detention services and juvenile detention centers" and required accreditation by the American Correctional Association.
- Prohibited juvenile status offenders from being placed in DHS institutions maintained for delinquents.
- Directed the State Fire Marshal and the Commissioner of Public Health to make "regular, periodic, not less than quarterly, unannounced inspections" of DHS institutions with reports to appropriate state agencies and the legislature.
- Mandated that "all child care services and facilities operated by the Department shall be accredited by the American Correctional Association, the Joint Commission on Accreditation of Hospitals or the

Child Welfare League of America, as appropriate for the service or facility." (McCorkell notes that when the legislation was passed, Oklahoma was the only state that required ACA accreditation for all its juvenile facilities.)

- Established the Office of Advocate Defender in DHS to investigate grievances of juveniles and staff, investigate allegations of abuse or neglect of juveniles in Department-operated facilities or juveniles who are in the custody of the Department and placed in private facilities, and work closely with the Office of Juvenile System Oversight.
- Directed DHS to submit an annual report to all three branches of government "analyzing and evaluating the effectiveness of the programs and services being carried out."

As is evident, much consideration was given to developing checks and balances, oversight, monitoring, and accountability for a system that had been devoid of such features.

To address the abuses brought to its attention, the legislature went so far as to specify institutional operational policies, including such things as daily exercise, education, mental health services, access to an attorney upon request, and no censorship of mail. The legislation encompassed a number of changes already made by the *Terry D.* case as well as other issues raised by the case. Indeed, Steven Novick believes that "the public debate of these issues would never have been sustained without the filing and vigorous prosecution of the lawsuit."

Bob Fulton, former director of the Oklahoma Department of Human Services, says of the legislation: "We had to deal with problems involving the care of youth promptly. We had to assure that we were protecting their rights, and we had to be accountable in our services in a new way. There was a definite impact."

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**It is a measure of the distance travelled that there is now talk of innovative leadership in youth issues.**

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## Oklahoma Commission on Children and Youth

From an oversight point of view, the cornerstone of the legislation was the creation of the Oklahoma Commission on Children and Youth. It directed that the commission's Office of Juvenile System Oversight (OJSO) "shall have the responsibility of investigating and reporting misfeasance and malfeasance within the juvenile service system, inquiring into areas of concern, and conducting periodic audit evaluations of the juvenile service system to ascertain its effectiveness and compliance with established responsibilities." The OJSO may be viewed as the heart of the commission, since this Office performs the inspection, investigative, and oversight functions.

Don McCorkell recalls that "we wanted to develop a separate, independent agency that had the capacity to monitor our system, to provide leadership on children's issues, and to support and help develop innovative programming in juvenile justice."

In addition to the OJSO, the commission is the umbrella agency for the following advisory committees and task forces that address child welfare and juvenile justice concerns:

- Oklahoma Council on Juvenile Justice. A 50-member advisory body that makes recommendations regarding juvenile justice and child welfare issues.
- Juvenile Justice and Delinquency Prevention Advisory Committee. Oversees Oklahoma's participation in the federal JJDP Act.
- Interagency Child Abuse Prevention Task Force.
- Interagency Coordinating Council for Early Childhood Intervention. This council and a full-time staff member of the commission address Oklahoma's service delivery system for high risk and handicapped infants and children through age five.
- Oklahoma's Permanency Planning Task Force. This project ensures the state's compliance with P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, which mandates permanency planning for children by the federal government.

The commission was created by the legislature in May 1982. It has 13 members, four of whom are heads of state agencies — Director of the Department of Human Services, Commissioner of Health, Commissioner of the Department of Mental Health, and State Superintendent of Public Instruction. Six of the remaining nine members are appointed by the governor, but must have had "active experience in services to children and youth," and must be recommended by various legal or youth-serving organizations, including the Oklahoma Association of Youth Services, the Oklahoma Bar

Association, and the Oklahoma District Attorney's Association.

The commission, which meets approximately ten times a year, is required to consider agency budget and personnel needs, make appointments to the Oklahoma Council on Juvenile Justice and the State Child Abuse Prevention Task Force, approve agency operating procedure and policy, and publish and distribute an annual report of its findings. Commission meetings are frequently used to clarify and define agency roles in programs where there is a multi-agency relationship: child abuse prevention, juvenile justice, and services to handicapped infants and children. Commission meetings are viewed as a high priority since three of the four state agency heads regularly attend. This not only engenders personal involvement in problem solving, but facilitates interagency solutions to crises and situations that cross agency lines.

The annual report, prepared with the assistance of the Oklahoma Council on Juvenile Justice, includes the activities of the commission, recommendations for further development and improvement of services, and budget and program needs. The statute requires distribution to the governor, the Speaker of the House, the president of the senate, the chief justice of the Oklahoma Supreme Court, and the chief administrative officer of each agency affected by the report.

Pursuant to the enabling legislation, the director of the commission "shall be a person having experience in the operation and administration of services to children and youth," who is appointed for a term of two years, and may be reappointed. A statutory safeguard against political interference is that the director may be dismissed only for cause.

Tom Kemper, appointed in 1982, has been the commission's only director. His background in child advocacy issues is evident, reflecting his involvement with Oklahoma's child care system for years prior to being appointed commission director. Considering the heavy negative publicity about the abuses, and the confrontation surrounding the legislation and the *Terry D.* case, Kemper's low-key style proved invaluable in getting the commission off to a good start. Don McCorkell notes that "Tom probably has the right personality for the director's position because he is a very competent professional but also very low-key in the way he talks to people. He doesn't come across as a threat. He's got a lot of respect."

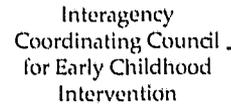
Given its inherent powers and the long-standing abuses it had to correct, it would have been easy for the commission to take on an aggressive attitude of confrontation. That has not been the case. Rather, it leans in the direction of interagency cooperation. Although the press has been involved in investigations over the years, Kemper does not use it to enforce regulations and believes that heavy reliance on the press often can be counterproductive.

Judicial

Executive



----- represents reporting requirements only



The commission's political style of consensus building is reflective of Oklahoma politics in general, explains Eva Carter, executive director of the Oklahoma Institute for Child Advocacy. "The commission does things in a very quiet way and is able to get changes made without the hostility. If the commission had taken a different direction and had been this hard-nosed adversarial sort of group, I don't think we would have seen any progress," she adds.

## Juvenile Justice Issues

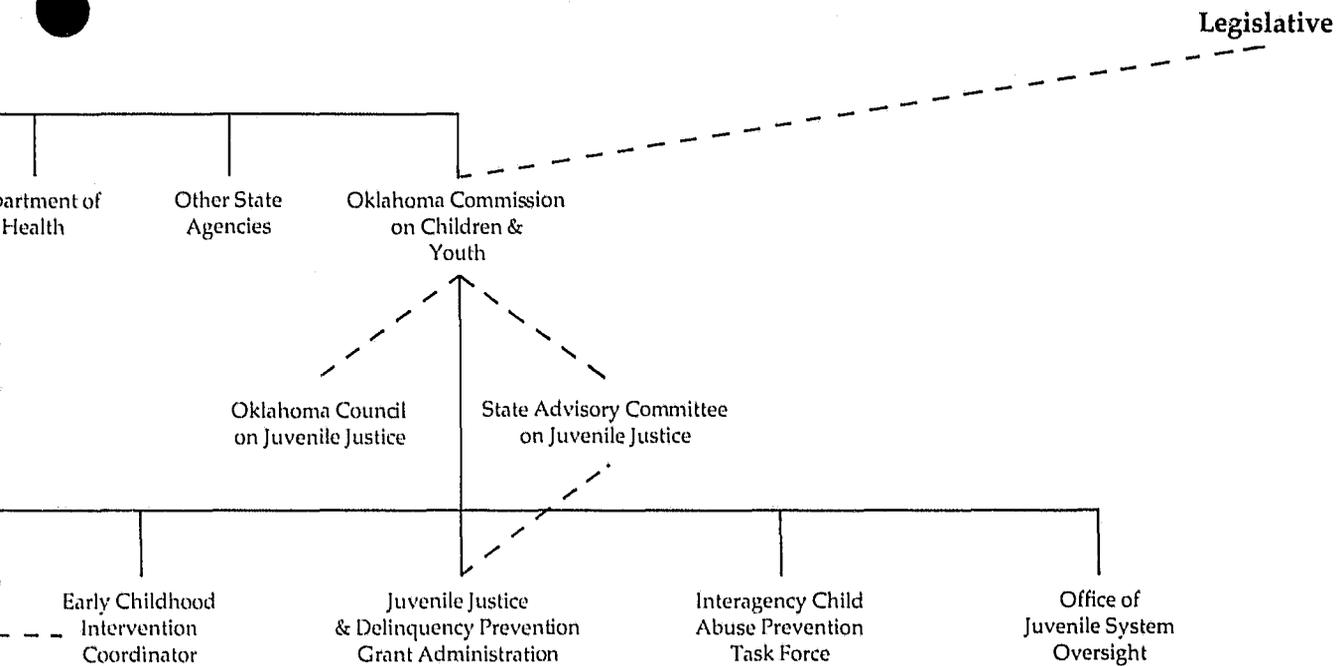
Beyond the juvenile justice issues raised by the OJSO, the commission has two entities under its jurisdiction that address juvenile justice concerns — the Oklahoma Council on Juvenile Justice and the administration of Oklahoma's JJDP program.

The Oklahoma Council on Juvenile Justice is made up of 50 members who represent every geographic region of the state and most services affecting children. By law, the council "shall serve as an advisory body for the planning, coordination, development and improvement of services to children and youth." Recommendations are made by the council to the Oklahoma Commission on Children and Youth, and the Departments of Health, Human Services, Mental Health, and Education.

The council, which meets monthly, has five standing committees — Prevention, Judicial, Mental Health, Education, and Legislative. In recent years the issues considered most important by the council have been the removal of juveniles from adult jails, funding issues regarding the operation of juvenile detention facilities and juvenile detention alternatives, teenage pregnancy, and prevention and diversion services for youths.

Oklahoma first came under the auspices of the JJDP Act in October 1983. In July 1986, the program was transferred to the commission. The major challenge in complying with the JJDP Act, is the removal of juveniles from adult jails. In 1980 there were 7,641 juveniles held in adult jails and lockups in Oklahoma. By 1986, the number was 2,038 — a decrease of 73 percent. State legislation now requires the complete removal of juveniles from Oklahoma's jails and lockups.

In recent years, most of the federal JJDP Act funds have been used to achieve this, though programs in 15 different counties received JJDP funding to develop or maintain local or statewide projects such as alternative education, wilderness experiential treatment, emergency shelter services, youth employment opportunities, foster parent training, family counseling, and homebound detention.



## Office of Juvenile System Oversight

An overriding issue in the revelations of abuse in Oklahoma's DHS institutions was the lack of accountability for program operations. DHS did not answer to the governor, the legislature, any commission or advisory body and, least of all, the public. The legislation that created the commission changed all that. In fact, Oklahoma is generally recognized as the most scrutinized public youth correctional system in the United States.

Much of the oversight function is vested in the Office of Justice System Oversight (OJSO), which is the inspection and investigative arm of the commission. The legislature was unequivocal in its mandate to the OJSO—that it had the “responsibility of investigating and reporting misfeasance and malfeasance within the juvenile justice system” and to ascertain the system’s “effectiveness and compliance with established responsibilities.”

The legislature gave it some powerful tools to carry out these functions:

- The OJSO is required “to conduct regular, periodic, but not less than quarterly, unannounced inspections of state-operated children’s institutions and facilities.”
- The OJSO has the authority to examine all records and budgets in juvenile facilities and be permitted

- access for site visits and interviews with residents.
- The OJSO may subpoena witnesses and hold public hearings.
- The OJSO has the authority to issue reports to the governor, Speaker of the House, president of the senate, chief justice of the Oklahoma Supreme Court, any appropriate prosecutorial agency, and other parties.

Although the major focus of the legislation was for the OJSO to monitor state-operated facilities, it is also empowered to inspect private youth facilities periodically. In all, the OJSO is responsible for overseeing more than 100 facilities (about 3,300 beds) including 24 state operated, and 90 county or privately operated.

This oversight by the OJSO is not the only monitoring of these facilities. As noted earlier, state facilities must be accredited by the American Correctional Association, Joint Commission on Accreditation of Hospitals, or the Child Welfare League of America, depending on the type. Private facilities must comply with licensing standards promulgated by DHS. Thus, the facility oversight by OJSO represents an institutionalized system of checks and balances to ensure consistent facility monitoring by appropriate authorities.

## OJSO: Monitoring of Facilities

State, county, and private facilities are monitored by a staff of six oversight specialists in the OJSO. State-operated facilities that are monitored include training schools, mental health facilities, schools for the mentally retarded, group homes for delinquents, group homes for dependent and neglected children, emergency shelters, and other specialized facilities for blind, deaf, or handicapped children. In all, 24 state-operated facilities are inspected at least quarterly through unannounced visits required by statute.

At the local level, five county-operated juvenile detention facilities are monitored, as are 85 county and privately operated youth residential facilities, emergency shelters, and group homes. In 1987, only 10 of these 85 facilities received site inspections, a weakness in the OJSO noted by Tom Kemper and several of those interviewed. One observer commented that because institutions in the private sector are as likely to have abusive practices as those in the public sector, the commission should routinely monitor all private facilities. Another noted that the commission has been given insufficient resources to effectively monitor all private facilities, and suggested that alternative means be developed.

Virtually every year a recommendation has been made to the legislature to increase the size of the OJSO staff to allow adequate inspections of the private juvenile facilities. However, staffing has yet to be increased to accomplish this.

On-site inspections evaluate whether the facilities meet their own written policies and procedures, DHS licensing standards for child care facilities, or national standards, such as the ACA standards. Different inspections might address physical plant concerns, cleanliness of the facility, a review of inspection reports made by the state fire marshal or Department of Health, supervision of children, behavior management programs, grievance procedures, medical services, counseling programs, or educational activities.

A typical inspection might include a tour of the facility, a review of staff and children's files, a review of incident reports and medication logs, interviews with staff, and interviews with children. Reviewing personnel files might determine the following: criminal background checks, documentation of required training, evidence of a required physical examination, and/or evidence of CPR and first aid training. From this review, compliance with appropriate standards can then be measured.

The staff of the OJSO has prepared detailed and comprehensive protocol instruments to complete the on-site tasks and evaluate compliance. The juvenile interview guide is noteworthy since it addresses virtually

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every facet of the program. Questions explore the following topics: physical environment, grievance procedure, discipline, victimization/child abuse, perceptions of safety, court process, individual treatment plan, counseling and education programs, and health and medical care.

After an on-site program assessment is completed, a report that delineates the findings coupled with recommendations is prepared and released. An important function of OJSO is to identify problems and recommend corrective action before improper practices become ingrained. Most observers interviewed feel that conditions have improved and that institutional oversight has made the difference. Steven Novick, the lead attorney on the *Terry D.* case, notes the "investigations and monitoring have led to the cleaning up or closure of facilities that were abusive to kids, particularly in an area that is very difficult to bring to public scrutiny — the private facilities." He feels that a significant benefit of both the *Terry D.* case and facility monitoring by the commission has been to increase the public scrutiny of public and private children's facilities since, in his opinion, "if there is any one thing that creates an environment where abuse can flourish, it's an institution that's hidden from the public eye."

These accomplishments have been made without the use or threat of sanctions because the commission has no enforcement authority, but must rely on recommendations. If, however, violations of criminal statutes are uncovered, the commission may work closely with appropriate prosecutorial authorities.

## The Children's Shelter

A striking example of the commission's ability to uncover criminal misconduct and work with law enforcement authorities came in an audit of the Children's Shelter. Issued in 1982, it was a "blistering report" (as one newspaper called it) on a facility that provided long-term residential services for the severely retarded. Summarizing a three-month investigation, it revealed that some children were "skin and bones," others had not had their teeth brushed in years, and most had not eaten solid food for years. Further, no education was provided, physical therapy was nonexistent, and social services were severely lacking.

The facility was eventually closed due to the investigation. But an equally important victory, in retrospect, was flexing the muscle of the commission's independent watchdog status. The report accused three state agencies — Department of Health, Department of Human Services, and Department of Education — of giving special treatment and protection to the shelter. Examples of this treatment included allegations that the Department of Health knowingly accepted false information from shelter officials, and waiver of state regulations by both DHS and the Department of Education.

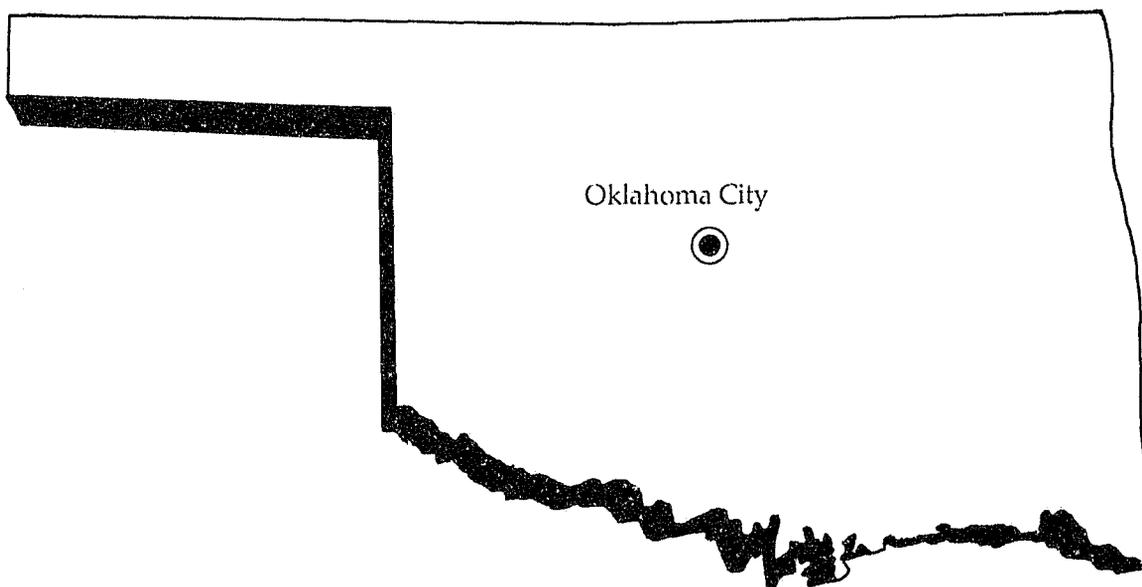
The commission successfully weathered this first test of its independent status. Although it prefers to address problems in a nonadversarial process, in retrospect it was important that the inherent independence and integrity of the agency were established.

## OJSO: Responding to Complaints and Grievances

The Department of Human Services is required by statute to provide a grievance process to all youths in its custody. Copies of grievances that DHS does not resolve to the satisfaction of the complainants are forwarded to the Office of Juvenile System Oversight. In the most recent fiscal year the OJSO received 27 unresolved grievances from DHS. The majority concerned placement decisions, while others concerned institutional policy and loss of personal property. After review, the OJSO agrees with the DHS resolution in 25 of the 27 grievances.

Another function of the OJSO is to investigate any complaint it receives regarding improper personnel practices in the system. These investigations focus on violations of law, policy, or procedure. During 1987, 37 complaints (20 from private citizens and 15 from professional staff) were lodged against the public and private facility staffs, and staffs of the Department of Human Services' state office, Court Related and Community Services, and Division of Child Welfare.

The OJSO found that nine of the complaints could be substantiated. Three complaints concerned unsatisfactory conditions at juvenile facilities (two private, one public), and one alleged an inadequate inspection of a juvenile facility by a DHS licensing worker. The remaining five involved violation of procedures by DHS county child welfare workers.



An example of a substantiated complaint concerned allegations against a shelter facility where residents were routinely AWOL and there were a number of assaults on residents by other residents. In its finding OJSO noted: "We do not believe the Department of Human Services is fulfilling its mandate to provide appropriate care and treatment for children in its custody ... legal liability dictates a safe and constructive environment that requires a redefinition of the shelter's role with a budget to enact change."

In another case, a complaint alleged that a 12-year-old in the custody of DHS was not being allowed to visit with his adoptive mother. After investigation it was determined that policy was not followed, and that visits should not have been denied. The report also delineated several recommendations to address resolution of this case, and ensure that policy will be followed in similar cases.

## OJSO: System Issues

Two of the different ways in which the OJSO provides oversight have been discussed: at the facility level through site inspections and facility reports, and at the individual case level through grievance and complaint reviews. A third form is by addressing system-wide issues that affect juveniles.

As an example, several years ago the office examined the district courts' implementation of a statute that created a statewide system for citizen review of children in foster care. It sought to measure the extent to which the specific requirements of the law were being followed by looking closely at the operations in approximately half of the state's 42 foster care review boards. The OJSO interviewed 23 associate district judges, 10 review board coordinators, and 55 volunteers serving on the boards. In addition, 137 cases were randomly selected from 26 courts and reviewed for compliance with statutory requirements. Analysis of these cases revealed noncompliance with several sections of the statute. As a result, specific recommendations to improve the system were made.

Another system-wide project coordinated by the OJSO evaluated compliance with selected mandated minimum licensing standards by the state's youth services shelters. Twenty-seven shelters were visited and 256 resident case files were reviewed. The resulting report offered recommendations for the Department of Human Services, the Oklahoma Association of Youth Services, and shelter directors.

## Accomplishments

Several years have passed since the Oklahoma Commission on Children and Youth has become a key agency among many in the state's juvenile service system. What have been the commission's accomplishments over this period? Certainly there are measured indices, such as the two institutions it was responsible for closing, the number of its legislative recommendations that became law, or the number of facility violations that were corrected.

Yet many of the accomplishments cited by those interviewed are less easily measured, though equally important. These include, among other things, increased professionalism in the system, more humane institutions, and increased coordination among agencies. Dave Allen, the commission's chairman, feels the most significant accomplishment has been in the oversight area. He makes an interesting point that the commission's oversight activities over the years have led DHS to become more responsible in enforcing its own regulations. Don McCorkell, likewise, feels that the most significant accomplishment has been in the oversight and monitoring area. "People in the child care system do listen to them, and they've been able to get some results in regard to quality of care," he notes.

Considering the nature of oversight activities, it's no surprise that commission staff and oversight reports are not universally accepted with open arms. There is some admitted friction between the commission and some facility operators, as well as some DHS middle management. Interestingly, however, the work of the commission is viewed positively by administrators at the highest levels of DHS. Likewise, according to those interviewed, the commission is on very good terms with the judiciary and the legislature.

Still another contribution of the commission over the years has been its role as coordinator. The commission structure, whereby heads of agencies are forced to deal with each other, has facilitated considerable communication and coordination among agencies. Likewise, it has brought together the executive and judicial branches of government, as well as the public and private child care sectors, on common youth issues.

It is noteworthy that the commission is viewed both as an effective oversight agency and as an agency that facilitates coordination and cooperation. The successful accomplishment of these two seemingly disparate functions certainly speaks to its success.

## The Future

The filing of the *Terry D.* case in 1978 set the stage for the subsequent restructuring of the Oklahoma juvenile justice system. The documents in the case were not only used to a significant extent in the investigative reports by Gannett News Service, but prompted legislative review of the state's system of providing care for troubled youths. Oddly enough, 10 years later the case still has not been fully settled.

The consent decree to the case was filed in 1984. It proposed to rely heavily on the commission to monitor its provisions: "The Office of Justice System Oversight (OJSO) of the Oklahoma Commission for Children and Youth is hereby designated to monitor and oversee the implementation of the terms of this Decree. . . . The OJSO shall have the authority to retain qualified expert consultants to assist it in monitoring compliance with this Decree . . . It shall be the duty of OJSO to prepare and submit to the Court periodic written reports regarding progress and compliance with the terms of this Decree."

Since 1984 attorneys from DHS and Legal Aid of Western Oklahoma have been negotiating the details of the implementation plan developed by DHS in response to the consent decree. As a result, the commission has not yet provided any monitoring and oversight for the *Terry D.* consent decree. It is expected that once the details are settled, the commission will act as the court's designated master in the case. A proposed contract with DHS will provide additional staff to monitor the provisions of the consent decree.

It is also expected that the commission will increase its role in the planning and coordination of children's services. Over the years, the commission has assumed additional responsibilities in this area, such as annexing the JJDP Advisory Committee, the Interagency Coordinating Council for Early Child Intervention, and the Permanency Planning Task Force. Also, the membership of the commission's governing board is statutorily designed to reflect a broad base of expertise and perspective, and is a powerful mechanism for sharing information, reducing duplication of services, and pooling resources to maximize existing services to children.

Oversight and planning are intertwined. The oversight function ensures that institutional standards are met in the present; the planning function should modify the system to address new-found problems in the future. In a sense, the commission is evolving to incorporate both functions, especially when one views the work of the Office of Juvenile System Oversight in the system-wide issues discussed earlier.

Perhaps it was inevitable that the planning and coordination function of the commission has increased in importance as it matures. When it was created, the

message from the legislature was clear: the commission, along with other components of the sweeping legislation, was to stem the tide of institutional abuse, primarily through its oversight function. From a political perspective that had to be the first order of business. Now that monitoring and oversight are more entrenched at both the commission and DHS, planning and coordination will most likely increase.

Don McCorkell never envisioned the work of the commission to be inflexible and static, which is one reason the commission has independent status and is not buried in an executive department. McCorkell now encourages the commission to enlarge its role by providing leadership in coordinating a wide range of youth services, including prevention, aftercare, and education.

It is a measure of the distance travelled that there is now talk of innovative leadership in youth issues. Only a few, short years ago, the Oklahoma youth system was a relic of the 19th century. Now other states are looking to Oklahoma's system of responsible government in the areas of program oversight, monitoring, and accountability. Increasingly it becomes evident that the work of the commission has contributed greatly to this system.

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