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# Child Protective Services: A System Under Stress

Chairman's Report  
New York State Senate  
Standing Committee on Child Care  
Senator Mary B. Goodhue

101353

THE SENATE  
STATE OF NEW YORK



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January 1986

Dear Colleagues and Friends:

I am pleased to transmit the Senate Child Care Committee's study of New York State's Child Protective Services system.

This report documents serious problems in the investigation of child abuse and maltreatment reports, as well as in the delivery of services to children and families in the protective services system. In response to these findings, we have presented recommendations for proposed legislation as well as administrative action to alleviate these deficiencies. We believe that these recommendations will strengthen Child Protective Services and make it a system better able to guard the safety of children in this State.

I would like to thank the many individuals across the State who provided valuable input and insight to this study. Their cooperation helps the legislative process operate in a responsive manner for the benefit of all.

Sincerely,

MBG:skm

Mary B. Goodhue  
Chairman

Encl.

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SENATE STANDING COMMITTEE ON CHILD CARE

1985 STUDY OF CHILD PROTECTIVE SERVICES

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**MAY 18 1986**

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## EXECUTIVE SUMMARY

This report represents the results of a year-long study of local child protective services in New York State undertaken by the Senate Child Care Committee. It is based upon extensive field research and case reading in a wide number of counties broadly representative of child protective operations.

The study documents a system under stress. Faced with dramatically increased reporting of child abuse and maltreatment, local governments are encountering difficulties, sometimes severe, in meeting the responsibilities assigned to them by law.

The Committee's study disclosed deficiencies in the timeliness and efficacy of the local process of investigation of child abuse reports, and major problems in the delivery of services to children and families in the protective services system.

Our State's Child Protective Services Act, first enacted in 1973, still remains a well-constructed foundation for the investigation of child abuse reports and the provision of needed services for children and families. What is now needed are legislative and administrative changes which will fine-tune our child protective service system and enable it to more realistically meet the demands of the eighties.

This report, and the recommendations contained therein, is the first of a two-part study. In 1986, the Committee will review and make recommendations concerning implementation of Article 10 of the Family Court Act, relating to proceedings affecting abuse and neglected children.

The most significant of our recommendations are summarized as follows:

- legislation establishing a single State aid formula for protective, preventive and other child welfare services;
- legislation to revise the single organizational mandate for local child protective services and to redefine their functions to exclude service delivery and emphasize investigative and monitoring roles;
- better staffing and training for personnel of the State Central Register, and improved technical capacity for this State hotline and its computer system;
- legislation to require the State Central Register to provide for referral of all cases outside the jurisdiction of the Child Protective Services Act to law enforcement agencies when there is a possibility that a crime may have been committed;
- statutory penalties for making false reports of child abuse or maltreatment to the State Central Register;
- legislation requiring the establishment of guidelines to determine the need for immediate face-to-face contact after a report has been made, and to assist in deciding whether or not credible evidence exists to indicate a child abuse report;
- legislation clarifying that the identity of a reporter be kept confidential;

- legislation to seal and retain for a period of five years, rather than expunge, records of unfounded child abuse and maltreatment reports made by identified sources. Such records will be made available to child protective service and law enforcement investigators only if a subsequent report is made;
- development of new approaches to recruit staff for local child protective service agencies;
- legislation to permit local governments to access available federal Title IV-E training dollars by providing local matching funds; and
- use of subject matter experts to assist in the development of caseworker and child protective service recruitment examinations.

NYS SENATE CHILD CARE COMMITTEE  
1985 STUDY OF CHILD PROTECTIVE SERVICES  
Chapter One

INTRODUCTION

A. Background and Scope of the Study

During the autumn of 1984, the Senate Child Care Committee commenced an intensive study of New York State's Child Protective Services system in order to evaluate the efficacy of the Child Protective Services Act of 1973 (Article 6, Title 6 of the Social Services Law), as well as Article 10 of the Family Court Act governing child protective proceedings. The study was undertaken in full awareness that no comprehensive evaluation of child protective services operations has been done by the Legislature since the enactment of these statutes. The study was conceived of in two parts: the first, and the subject of this report, a review of local systems for the reporting and investigation of child abuse and maltreatment, as well as for the provision of services to children and families in the child protective services network; the second phase, to be undertaken in the coming year, is expected to involve a comprehensive review of the implementation of Article 10 of the Family Court Act.

The impetus for the Committee's study lies in great part with the virtual explosion in child abuse reporting over the last decade. During the period 1974 to 1983, reports received by the State Central Register of Child Abuse and Maltreatment (hereafter referred to as the State Central Register) rose in number by nearly 150 percent (from 29,912 reports to 74,120). Further, by the end of 1984,

total reports had increased by still another nine percent to 80,990. Part of this massive increase certainly may be explained by greater public awareness of the problems of child abuse and maltreatment, but a significant factor in this growth may also be attributed to an increased incidence of the problem.

Associated with increased reporting were a number of other disturbing statistics. Rates of case indication (those cases where an investigation had determined that "some credible evidence" existed of the alleged child abuse or maltreatment) had been declining significantly during this period. In 1976, for example, indicated cases hovered around 50 percent of reported cases. By 1984, indication rates had dropped to 36 percent, according to the State Department of Social Services, the agency responsible for operating the State Central Register and monitoring the provision of child protective services in the State. Some of this decline may be due to the alleged unreliability of reports in recent years, but critics and State reviews of local child protective services operations had pointed to alarming deficiencies in casework investigative and service delivery practice as well. Finally, a further disturbing factor tending to lend credence to this assertion lay in the rate of subsequent reporting of child abuse and maltreatment. Subsequent reports--those on open State Central Register cases--have been increasing precipitiously: between 1981 (the first year for which statewide statistics were available) and 1984, the number of subsequent reports rose from 12,626 to 16,576. In other words, such reports had become an

increasingly significant part of child abuse reporting, approximately more than 20 percent of all reports and were still rising, raising serious concerns over the ability of the child protective network to deliver services adequate to meet the needs of abused and neglected children and their families.

Against this background, the Committee Chairman determined that an intensive, field-based study was in order to identify policy and program concerns associated with this alarming portrait, and to develop appropriate recommendations for statutory change to be considered by the State Legislature.

## B. Study Approach

### 1. Background Research

Before undertaking on-site review of local child protective services operations throughout the State, Committee staff identified and evaluated existing program audits and reviews conducted by the State Department of Social Services of county protective services activities and met with a network of knowledgeable Regional Office specialists of the Department to obtain their observations of protective services problems and concerns. In the two years prior to initiation of our study, the Department had completed almost two dozen program reviews of local operations. The findings of the Department's program reviews, although not always containing comparable information for each county studied, did disclose widely varying patterns of both poorly run and well administered child protective services operations. Some of the deficiencies disclosed by the State reviews, although not present in every county,

included: failure to initiate or complete investigations of child abuse and maltreatment reports within statutorily mandated time frames (the Social Services Law requires investigations to commence within 24 hours of receipt of a report and to be completed within 90 days of the report); investigative practices which failed to make personal contact with the child and often relied too heavily on telephone contacts rather than home visits; failure to provide needed services to children and families; excessive caseload size; delinquencies in meeting State reporting requirements; failure to provide mandated notices to subjects (i.e., alleged perpetrators) of child abuse reports or to expunge unfounded reports (reports where an investigation determined that no credible of abuse or maltreatment existed); confusion and delays in transfer of cases from protective services units to other services units in a local Department of Social Services, with negative impacts on service delivery; inadequate monitoring of open, indicated protective services cases by a local Department; and the absence of effective supervisory controls.

As noted above, these problems were not necessarily evident in every district. Furthermore, local Departments of social services appeared responsive to State program reviews and, through cooperative relationships with the State's Regional Office staffs, appeared to make sincere efforts to correct documented deficiencies whenever possible.

Given the availability of reasonably reliable information on the quality and efficacy of local child protective services at the county level, the aforementioned program reviews, local consolidated plan submissions and other material, the Committee might have been disposed to accept many of these findings as the basis for legislative policy development were it not for the fact that: (1) these data themselves were incomplete, being neither consistent nor uniform across counties and, (2) perhaps more significantly, failed to answer the fundamental questions of why the problems themselves existed and what might be done to correct them on both legislative or administrative levels. To deal with these concerns, a comprehensive, field-based research project was constructed which would be comprised of both interview and case reading protocols and generate contemporary, original data on child protective services. Of singular importance in our view, was the necessity to generate primary data on child protective services, particularly in the light of developments at the local level since passage of the Child Welfare Reform Act of 1979 (CWRA) and contentions that the emphasis and implementation of the CWRA may not have been sufficiently cognizant of the problems of abuse and neglect.

## 2. Primary Research Design

Utilizing State Department of Social Services-generated county-by-county child abuse reporting statistics, and findings of the aforementioned program reviews and discussions as well as other secondary materials, Committee staff prepared a matrix of county variables, including such data elements as reporting volume, location,

organization and management factors, and per capita personal income. From this matrix, twelve representative counties were chosen for intensive study, and included the widest possible range of protective services systems in New York State, given the responsible limitations of time and effort.

For each of the sample counties, none of which (pursuant to prior agreements between the Committee and the counties in question) were to be identified in the Committee report, detailed semi-structured interview instruments were developed for administration to the following personnel: local Department of Social Services caseworkers, case supervisors, child protective service and/or service division directors, and commissioners; local police and State Police officials; district attorneys; and public and private service providers. Prior to undertaking the field interviews, each county provided the Committee with detailed statistical, organizational, personnel and other materials so that actual interviews were conducted with a full awareness of indigenous operating conditions.

Finally, in order to obtain uniform, systematic statewide longitudinal data on the actual operation of the protective services system (existing statewide data were limited) a comprehensive case reading protocol coded for computer entry was developed which concentrated on the child abuse investigative process and the actual delivery of services to children and their families. Two sample groups of two hundred randomly selected cases each were identified for case reading in the twelve counties: one group consisted of child abuse and maltreatment reports which were indicated in January and

February of 1983, and the second group of 200 cases consisted of reports currently under investigation when we undertook our site visits during the spring and summer of 1985. Data groups, once collected, would be analyzed and compared, with attempts made wherever possible at cross-tabulation of variables.

The Committee project was able to complete case reading and analysis of the targeted 400 cases. Detailed findings are included in an Appendix to this report. However, because of time constraints, only ten of the twelve sample counties were visited. The final sample choice does not invalidate the methodological basis of the study since the counties were representative of the widest range of local protective services systems in New York State.

## Chapter Two

### Overview of the Child Protective System

#### A. Intake

Reports of suspected child abuse or maltreatment are received by the State Central Register located in Albany which is a unit of the New York State Department of Social Services. These reports come into the Register via a special telephone hotline. The hotline operates on a twenty-four, seven-day-a-week basis. Calls are taken from the general public, as well as from certain professionals in the community who are mandated by law to report suspected incidents of abuse or maltreatment. Two counties in the State maintain their own local hotlines for receipt of these reports.

When a call is received by the Register, a determination will be made by State Central Register staff as to whether the particular facts constitute a situation of suspected child abuse or maltreatment falling within the purview of the Department of Social Services. If so, a report will be forwarded to the appropriate locality for further investigation. If not, the call is rejected by the Register and, in appropriate cases, referred to other agencies. In some counties, especially the larger ones, there are specific units within a statutorily mandated single organizational structure for child protective services (hereafter referred to as CPS) which handle the intake of reports from the State Central Register. In other counties, intake assignments will be given to individual caseworkers by their supervisors on a rotating basis.

Since the hotline takes calls on an around-the-clock basis, local CPS operations must have a mechanism for receiving reports after

business hours and during weekends and holidays. A number of the large counties have separate units within their CPS structure which operate for the aforementioned purpose. Other counties have case-workers "on call" to handle receipt of after-hours reports.

The information forwarded by the State Central Register to the local CPS would include available identifying data about all immediate family or household members and alleged perpetrator(s), as well as the specific allegations of abuse or maltreatment with descriptive details of the incident in question. Identifying information about the source of the report also will be relayed unless the call to the hotline was anonymous. All of this initial information about a report will be transmitted to a local district either by phone or telecopier. In those instances where the State Central Register gives the information over the phone, the local CPS worker will complete an initial report form (DSS-2221). When a telecopier is used, which is only in a few large counties, the State Central Register will complete the DSS-2221 and send it via this machine.

Once a call is accepted by the State Central Register as constituting a situation of suspected child abuse or maltreatment, the report will be assigned a case number. If there are previously reported, open CPS cases for the family in question, the previous case numbers will be given along with the current report. In almost all counties, a subsequent report generally will be investigated by the worker originally assigned to the case.

There are times when the State Central Register will be the

recipient of certain information that does not formally constitute a report of child abuse or maltreatment. Yet, there may appear to be the need for some sort of intervention and, as such, the information will be transmitted to the local district for appropriate action. Such a call is known as a "FLR" or a call forwarded for local review. The treatment of FLRs varies from county to county. Without a formal report, a CPS caseworker does not have the legal authority to conduct a full-fledged investigation.

B. Investigation

According to law, an investigation of suspected child abuse or maltreatment must commence within twenty-four hours of the receipt of a report. The investigation is a fact-finding process which includes interviewing, observing, and information gathering. Its purpose is to: (1) ensure the child's safety; (2) determine the validity of the allegations; (3) evaluate any conditions of abuse or maltreatment that were not reported; (4) determine the services necessary to ensure the protection of the child and to preserve family life. An investigation would include an evaluation of the environment of all children in the home, whether or not they actually had been named in the report.

If it is found, during the course of an investigation, that there exists a situation of imminent danger to a child's life or health, the CPS is authorized to remove the child from the home. A determination of imminent danger would be made when a child is in

substantial risk of injury or death. Factors considered in making such a determination include the child's age, the child's condition, and the family dynamics. All situations of removal would necessitate CPS's involvement with Family Court.

Within seven days after the receipt of the report, CPS must notify the subjects of a report in writing about the existence of the report and about their rights with regard to amendment or expungement. In most instances, this rights letter is hand-delivered by the worker at the time of the first visit to the home. During this seven-day period, the CPS worker also will complete the Preliminary Report of Initial Investigation which is the DSS-2222 form that is filed with the State Central Register. This form includes an evaluation of the initial report and the actions taken or contemplated by CPS.

The final step in the investigation process is the determination of whether the report is "indicated" or "unfounded." If an investigation determines that some credible evidence of abuse or maltreatment exists, the report is indicated and the family is offered appropriate services. On the other hand, if no such evidence exists, the report is unfounded and subsequently expunged. When deciding if a report should be indicated or unfounded, the CPS worker must determine whether the child has been or continues to be abused or maltreated, what factors contributed to the abuse or maltreatment, and what changes need to occur to ensure the child's future safety and well-being.

If a report is indicated, the CPS worker usually will develop an appropriate rehabilitative service plan for the child and/or family. This plan would include those services necessary to safeguard and ensure the child's well-being and development, as well as to preserve and stabilize family life. In some instances, however, even though the investigation finds credible evidence of abuse or maltreatment to substantiate a report, a worker will simultaneously indicate and close the case. Such a situation may arise because of the lack of need for, or the inability to provide, services or to utilize the Family Court to facilitate their provision.

The determination that a report is either indicated or unfounded must be made within ninety days of its initial receipt by the State Central Register. At the time of determination, the CPS worker must complete the DSS-2223 form, entitled Follow-up Report--Children in Need of Protection, which is then filed with the Register. This form is completed for both indicated and unfounded reports. Its contents would contain: (1) the reason for indicating or unbounding the report; (2) an outline of the case activity; and (3) the aforementioned service plan. In addition, for indicated cases, the State's uniform case recording process (UCR) mandated by the Child Welfare Reform Act of 1979, is initiated.

### C. Service Delivery

Among the responsibilities of CPS, as defined by law, is the provision of, or arrangement for, rehabilitative services for children and their families. Monitoring of such services is also mandated. In implementing a service plan, CPS has several options. Services may be provided directly by CPS, or CPS may arrange for and monitor services provided through (1) referrals to other units within a

local Department of Social Services; (2) referrals to other public and private agencies; and/or (3) the purchase of service from other agencies.

When services are provided by another unit within a local Department of Social Services or by another agency, CPS has the responsibility to arrange for these services. If CPS is providing direct services in conjunction with another agency, it will have case management responsibility for both coordinating and monitoring the provision of services. If the protective unit, however, is not directly involved in the provision of services, its role will be to monitor service delivery through on-going contact with the service provider and the family.

The case activity of every open case is outlined in a progress report six months from the date of the oral report and every six months thereafter until the case is closed by CPS. This six-month review is transmitted to the State Central Register via the DSS-2223 form. An individual case will be closed by CPS when: (1) the rehabilitative service plan has been completed; or (2) it is no longer appropriate that direct services or monitoring be provided; or (3) a plan for the permanent placement of the child(ren) outside the home has been accomplished.

The implementation of the differing CPS responsibilities-- investigation, service planning/provision/arrangement, monitoring-- varies according to the individual staffing structure within each county. In some places, especially the small counties, one caseworker will handle all aspects of each case. In the larger counties, there

is more of a division of responsibilities among the casework staff. For instance, there may be separate units within CPS to handle just the investigation while there are other units which are responsible for on-going services. Additionally, the monitoring role may be assumed by a specific monitoring unit within CPS, as is the situation in several large counties. On the other hand, all of the monitoring may be done by one particular staff member or each caseworker may be responsible for the monitoring of his or her individual caseload.

Actual service delivery by individual CPS units also varies from county to county. In some local districts, services actually are provided by CPS workers while in other places there is very little or no service provision within the CPS unit. For the most part, actual provision of services by CPS appeared to be quite limited with many counties relegating this responsibility to other units within the local Department of Social Services or to outside service provider agencies. In fact, many individuals acknowledged that the primary focus of their CPS units is investigation. Nonetheless, the absence of direct service provision generally is due to a lack of manpower and/or other resources.

In recent months, some counties we reviewed have formed multidisciplinary teams to handle specific CPS cases and another county in our study has long made use of this approach. These teams most often deal with sex abuse cases. They are composed of various CPS staff members, law enforcement officials, specific service providers,

and other appropriate professionals from the community. Regular team meetings are held to coordinate joint efforts for investigation and for service planning and provision. The use of multidisciplinary teams is important to note because where such teams are in existence they have proven to be a very successful component of the CPS response structure.

D. Relationships with Law Enforcement Agencies

Cases containing certain allegations, such as sexual abuse or extreme physical abuse, require CPS involvement with law enforcement agencies because of the possible criminal element in the case. The nature of the relationships between individual CPS units and the respective law enforcement agencies in their communities is quite diverse. There are those counties where a joint investigation is conducted by CPS and the police with each agency assuming a coordinated role to assist the other. At the other extreme are those communities where CPS merely informs the police and/or district attorney about cases requiring law enforcement involvement and each agency does its own investigation with no coordination between them. Somewhere in the middle of the preceding examples are the counties where there are joint CPS/law enforcement investigations but the dealings with one another are on an adversarial basis. Where good working relationships exist between CPS and law enforcement personnel, case management has proven to be more effective and case resolution has been more satisfactory as compared with those situations where such relationships have not been established.

E. Staffing

Staffing patterns vary throughout the State. The basic staff positions in all CPS units are caseworker, supervisor, and director. There are also positions entitled senior caseworker in some counties. Many of these senior caseworkers have as their primary responsibility the oversight of all cases requiring Family Court involvement. Additionally, in some very large counties, there are various levels of supervisors and/or administrators. Responsibilities of each individual position will vary according to the actual organizational structure of the particular CPS unit. A few counties have developed job titles for exclusively CPS functions.

The rate of staff turnover also is different in each county. The greatest turnover of CPS personnel generally occurs in large counties with very high caseloads. Yet, even in these localities there are people who have worked in child protective services for over ten years. Most individuals attribute high staff turnover not only to the stresses of the job itself but also to the overall nature of the working environment within the agency.

Chapter Three

Detailed Findings & Recommendations

A. Intake of Reports

1. FLRs

a. Findings

The actual number of FLRs received by counties throughout the state is generally thought to constitute one percent or less of actual reports of child abuse and maltreatment in any given county. However, in the counties we studied the number of FLRs ranged from a low of 1.6 percent in one county to as high as 11.2 percent in another, with a mean of 5.3 percent. Such proportions are not large figures but are of sufficient significance to command public attention, especially when the life and safety of children may be involved.

With the generally high volume of formal reports, no real priority is given to FLRs. Each local district has its own method of dealing with these "nonreports." No consistent pattern for the processing and investigating of FLRs was found.

The availability of staff often determines how FLRs will be treated. In some counties, an intake worker will try to get additional information through phone contact with the source in an attempt to make a FLR into a report. In other places, a home visit actually will occur in order to get this additional information. Even when a FLR cannot be made into a report, some child protective service units will make service referrals.

Generally speaking, many people expressed concerns about the entire concept of a FLR. It was noted that there are times when FLRs

present situations more serious than actual reports. Indeed, a number of situations have been reported when an inadequately investigated FLR subsequently led to a child fatality. Individuals pointed out that there is a lack of consistency in what is accepted by the State Central Register as a report. Furthermore, many workers felt that "their hands are tied" because, as previously noted, without a report they have no legal authority to conduct a formal investigation.

b. Recommendations

The Committee notes with interest recent communications of State Social Services Commissioner Cesar Perales with local social services districts which clearly intend to minimize the use of FLRs by encouraging callers to (1) use local information and referral or emergency afterhours numbers whenever possible to meet service needs, (2) contact local law enforcement officials in crisis situations or when it appears a crime has been committed, or (3) refer complaints about school teachers and camp counsellors (which do not fall within the jurisdiction of this State's child abuse reporting system) to Education or Health Department officials.

Such actions are commendable but may not be sufficient. It is recommended that the Department of Social Services, through the avenues noted by Commissioner Perales as well as other measures, ensure better State Central Register screening of FLRs so as to totally eliminate all referrals to local GPS which do not constitute a report of child abuse or maltreatment. When in doubt, the State Central Register should have sufficient latitude to

accept a questionable complaint as a report. To this effect, legislation will be offered to clarify that the State Central Register must accept a phone call as a report whenever it has "reasonable suspicion to believe" that an act of abuse or maltreatment may have been committed.

Further, legislation will also be recommended to codify administrative practice and require the State Central Register to contact counties which, in turn, would be required to refer calls outside the jurisdiction of the Child Protective Services Act--i.e., allegations of abuse or maltreatment by school teachers, camp counsellors, paramours not living in the home and the like--to appropriate local law enforcement personnel when there is a possibility that a crime may have been committed (i.e., with respect to the more serious allegations of abuse or maltreatment).

## 2. State Central Register

### a. Findings

Several criticisms of the State Central Register were related by persons working in the local Departments of Social Services and by the mandated reporters outside of these departments who deal with cases of child abuse and maltreatment. There is a general lack of consistency in what the State Central Register actually will register as a report. One week a call to the State Central Register relating a specific set of circumstances will be taken as a report while the next week a similar call will not be registered as such. Additionally, the State Central Register is inconsistent in terms of how it registers reports, as abuse or as

neglect. Again, one week a set of facts would constitute abuse while the following week these facts would be a situation of neglect. Another concern expressed by child protective service staff is that when there are cases involving more than one county because of different locales of the named subjects in the report, the State Central Register is inconsistent in its determinations of which county will have primary responsibility and which one will have secondary responsibility of investigation and service provision for those cases.

A common complaint in many counties was that the reports from the State Central Register often contain incomplete and/or inaccurate information (which is a function of what information the Register obtains from a caller). Moreover, those districts with telecopiers often receive illegible reports. The State Central Register does not always send information about prior reports to the local child protective service along with the current report, and often this useful data may not be forwarded by the Register until an investigation is well-underway.

Many child protective service units maintained that the Register is far behind in case closings. A child protective service will make the determination to close a case and forward this information to the State Central Register but it will often take months before the case is actually closed out in the Register's files. This situation irritates CPS officials because they are often accused by the State Department of Social Services of being delinquent with their paperwork when the delays may actually be caused by shortcomings of the Register. Further, significant delays have been noted in registering reports of local child abuse hotlines, which may impede the initiation of investigations.

Difficulties in getting through to the State Central Register on the telephone were noted numerous times by child protective workers and mandated reporters as recently as this past summer. These access problems were particularly serious for the mandated reporters who stated that it frequently took many hours for them to get a call through. A number of reporters have become so frustrated with the State Central Register that they will only contact their local child protective service unit so that the child protective service can make a report to the Register.

Many community professionals, who are mandated reporters, also noted that the State Central Register staff often are impolite in their dealings with them. They believe that their professional judgement is rudely questioned. In one county it was contended that the State Central Register may be more willing to take calls from anonymous sources than it is to accept reports from mandated ones.

The State Central Register is the State's primary mechanism for the intake of reports about child abuse and maltreatment. Great efforts have been made to encourage people to make these reports. Many communities have worked closely with mandated reporters, who are required by law to make reports of abuse or maltreatment, so that they fully appreciate and understand their important role. Yet, the prevailing tensions with the State Central Register have made it less likely that community agencies and professionals will follow through with their responsibilities in every case.

Finally, many of the problems that a local child protective service has with the Register ultimately effects the agency's own ability to do a timely investigation. When a child protective service receives incomplete or inaccurate data, valuable time can be spent trying to collect the correct information. It is understandable that mistakes will be made but these situations appeared to be common reoccurrences.

b. Recommendations

The Committee is aware of the great technical strides taken by the State Department of Social Services in attempting to meet the demands of ever-increasing telephone calls to the State Central Register and wishes to applaud the Department for its efforts. However, the stridency and persistence of criticisms of the Register related to us during the course of site visits throughout the State point to the need for improved performance by the Department. We recommend that the Department pay particular attention to four major areas:

1. improvement of the Register's technical capacity to respond to calls expeditiously--possibly through the use of additional telephone lines, expansion and improvement of the use of telecopiers, and other devices;
2. recruitment, training and maintenance of a full complement of personnel to staff the State's hotline, a grueling task even at the best of times. Many of the problems cited during the past spring and summer appear to be a function of staff numbers and staff training;

3. clarification and consistent dissemination to local child protective services and reporters of standards and guidelines used by State Central Register personnel for accepting reports and assigning investigative responsibilities to counties; and
4. establishment of expeditious computer redesign of the State Central Register as a major priority of the Department, given the fact that the Register system was established more than a decade ago and was never designed to respond to its current complex and far-reaching responsibilities. Such revision can easily alleviate document turnaround time and related issues described above.

### 3. Information from Other Sources

#### a. Findings

Protective workers, in varying degrees, will consult other sources besides the report at the initial stage of an investigation. These additional sources include data from the local Department central files regarding a family's involvement with other units within the Department (e.g., public assistance, services), as well as any prior abuse or maltreatment reports on file within the protective unit itself. Such information may be helpful to workers in initially assessing a situation. Whether or not such materials are consulted often is based on the CPS unit's internal organization and manpower availability. Furthermore, the emergency nature of a case might preclude inquiries into departmental files because a worker may be most concerned with getting out into the field as soon as possible.

In some counties, consultation of these informational sources is not done at all. For instance, in one large county it takes CPS workers months to get copies of prior reports from within their own unit. Consequently, information that may have aided a worker with his or her investigation and assessment of family problems and service needs is of limited value due to the time constraints of the investigative process.

The problems in this area primarily do not center on the actual availability of these sources of information but rather on easy and timely accessibility to them. An excellent pattern, which was found in several large and small counties, addresses this issue. In these places, the initial intake of a report from the Register usually is done by the clerical staff or a special intake unit within the local child protective service. When the report is given to the caseworker for investigation, already attached to it will be any relevant internal local Department data about the family. Thus, from the very beginning, a worker has information which may ultimately help with the timely and thorough completion of an investigation and identification of service needs.

(b) Recommendations

It is recommended that the Social Services Law be amended to mandate that the State Department of Social Services assure that CPS design and implement procedures to make available to its investigators on a timely basis, all relevant information from sources other than the State Central Register. Such information may pertain to the investigation of a child abuse

or maltreatment report or assessment of the need for services by the child and his or her family.

Further, the Committee is aware that the Department of Social Services is in the process of redesigning the State Central Register computer system, which will be integrated to some degree with other State generated data systems like the Child Care Review Service. Therefore, in this context the Chairman recommends that special consideration be given to the development of consolidated data systems output forms. These forms should provide convenient summary materials of prior CPS reports, public assistance, service provision and other related family history, to assist CPS workers in the investigation of reports and the delivery of services to children and families.

#### 4. Subsequent Reports

##### a. Findings

A subsequent report is a report involving either new allegations or a new incident of the same allegations occurring in an open case with an existing Register number (i.e., one under investigation and/or in receipt of services). Specific statistics relative to subsequent reports can be found in the Appendix. The State Central Register's stated policy is that the open Register number will be assigned to a subsequent report, except in a few very limited circumstances. This classification of a report as a subsequent is transmitted to the appropriate county. Such information obviously can be an aid in the local district's investigative process.

One problem regarding subsequents noted by many child protective service workers is that the State Central Register

is inconsistent in how it registers such reports. Sometimes a subsequent report will be forwarded with the Register number of the existing open report which is being investigated. At other times, a subsequent report will be treated as an entirely new report and assigned a different State Central Register number. Only when CPS is assigning or conducting an investigation will a county discover that this particular report is actually a subsequent report on an open, active CPS case. This inconsistency makes it difficult for local districts to establish uniformity in their own investigative procedures.

An additional concern highlighted by CPS staff members is that if a subsequent report is received on an open, pending case (one where a determination has not yet been made) no additional time is given for the investigation of this report. Thus, the investigation(s) of the initial report, as well as any subsequents, must be completed within the ninety-day mandate. This requirement creates serious problems when a subsequent report is received near the end of this time period. Indeed, there are certainly situations which require additional completion time if a thorough investigation is to be conducted.

The most significant reoccurring problem relative to subsequent reports is the result of the abuse of the Register's hotline by certain reporters. A substantial number of subsequent reports are based on harassment calls such as disputes between neighbors. Further, many subsequent reports are due to continuous, and often unsubstantiated, reports made by parents against each other during custody battles. A parent in such a situation is trying to obtain documented evidence of alleged child abuse

or neglect to be used against the other parent in any legal proceedings involving child custody. A local CPS unit is required to investigate each and every subsequent report even if the abundance of such reports is the obvious result of harassment and/or custody disputes.

There is the recognition among CPS staff of the validity of certain subsequent reports. It was acknowledged that these reports can represent (1) unresolved service needs; (2) inappropriate or inadequate prior investigations; or (3) new problems. Although an ultimate goal would be the reduction and, hopefully, by better investigation and service provision, the elimination of subsequent reports, the current system is in need of some fine-tuning in order to better deal with such reports.

(b) Recommendations

A uniform system for the registering of report numbers must be included as part of the State Central Register redesign. However, even prior to development and implementation of an advanced data system, it is imperative that the State Central Register provide consistency in assigning numbers, as well as appropriate investigative response time, to child abuse and maltreatment reports. State guidelines, where available, appear to be misunderstood by local districts and not uniformly applied. We urge the Department to pay particular attention to correction of this important problem.

In addition, to reduce the use of the State Central Register for harassment purposes, legislation will be recommended to discourage inappropriate use of State Central Register reports in custodial and matrimonial actions.

B. Investigation Process

1. High Risk/Low Risk Assessment

a. Findings

As previously noted, the legal requirement is that a CPS investigation be commenced within twenty-four hours of the receipt of the oral report. Exactly how and when this commencement of an investigation will occur depends on the seriousness of the report; in other words, whether the particular facts constitute a high risk or low risk situation in terms of the life, health or safety of the child. This high risk/low risk assessment is done by the caseworker and/or supervisor in the local CPS unit which receives the report.

In all counties, some priorities are set for investigating cases. The high caseloads across the State emphasize the need for such priorities. It simply is impossible for a worker to visit the home of an alleged abused or neglected child in each and every case immediately. Nevertheless, in high risk cases, there is face-to-face contact with families as soon as possible by workers from every county in this study.

Assigning cases into high risk and low risk categories is done on both a formal and informal basis, depending on the locality. In some large counties there are written guidelines for making a determination of high risk or low risk, as well as procedures for acting upon the specific assessment. In most other places, however, these determinations are made informally.

Across the State, there are certain situations that are almost always considered to be high risk. Examples of such instances would be when there are allegations of a child under five years of age being left alone or allegations of extreme physical abuse. There are also those circumstances that are consistently considered to be low risk, such as reports containing allegations of educational neglect (e.g., chronic nonattendance at school). However, the Committee is concerned with those situations that constitute a wide middle ground by having allegations that are not regularly classified as either high risk or low risk (e.g., inadequate guardianship, or lack of supervision of an eight-year old child). The scope of allegations contained in the child abuse reports in our case readings are discussed in the Appendix.

b. Recommendations

Legislation will be recommended to amend the Child Protective Services Act to require the State Department of Social Services to develop guidelines to assist local departments, when initiating a child abuse or maltreatment investigation, to determine under what circumstances immediate face to face contact is necessary. Such guidelines should also address approaches to investigation priorities in dealing with the large volume of anonymous reporting to the State Central Register (described in greater detail later in this Chapter).

2. Investigation Techniques

a. Findings

There were few consistent patterns of investigation techniques found in our target counties. In most places, seeing the child alone during the investigation is standard practice. Nevertheless, many workers acknowledged that this practice often is contingent upon the age of the child, as well as the nature of the allegations. In most counties, the child will be seen before the parent. But again, there are those CPS units that firmly believe in most instances it is better to see the parent before making contact with child.

The taking of photographs also varies from county to county. Some CPS units rarely, if ever, make use of photographs in their investigation process. Other places make regular use of this investigative technique. Photographs will be taken by CPS, a medical facility, or the police department. Some child protective services may have their own cameras. Other CPS units are dependent on the police or medical personnel for photographing a child, which sometimes is complicated by lack of cooperation between CPS and such agencies.

It should be noted that one consistent pattern of investigation was found in this study. Caseworkers and administrative personnel alike stated that generally all children in the family were seen during an investigation, regardless of whether the children

were the primary subject of the report. However, the degree of the contact with these children will not always be the same. For instance, some workers always will undress the other children when there are allegations of physical abuse of one child while other workers will not do so.

Exactly what investigative techniques are used by workers often may be contingent upon the availability of resources in a particular CPS unit. The availability of personnel can determine how an investigation is conducted which, in turn, affects its thoroughness.

The findings of our case reading, as set forth in greater detail in the Appendix to this report, serve to confirm much of the interview data on the investigation process except in one vital aspect. Case statistics indicate a small but nevertheless significant incidence where no contacts whatsoever were made with the child and family during the course of the investigation process (six percent of the 1983 sample and 8.2 percent of the 1985 sample). Further, the case reading data indicate that no home visits were made in the more than 15 percent of the 1983 cases under investigation and in more than a fifth of the 1985 cases. These statistics may be attributable at least in part to the rising number of allegations of a nonserious nature which were disclosed in the case reading. Nevertheless, they certainly point to deficiencies in investigative practice as well.

b. Recommendations

Legislation will be recommended to amend the Social Services law to clarify and make explicit requirements for the conduct of investigations. These include seeing and interviewing the child and other children in the home, taking photographs and/or x-rays, and utilizing medical facilities, as appropriate, to examine the child and to document allegations contained in a report.

3. Time Frames/Reports/Indicating-Unfounding

a. Findings

The seven-day report, Form 2222, usually is completed on time. On the other hand, the ninety-day report, Form 2223, is not always finished on time. Its timely completion often is a function of the ability to finish an investigation given staff resources within a particular CPS unit. On a statewide basis, our case reading data indicated that in only 43.1 percent of 1983 sampled cases were investigations completed within the statutory ninety day time period, pointing to serious deficiencies in local investigation practices.

Interestingly, however, local CPS acknowledged that an investigation may be completed earlier than ninety days but the actual determination of the case may be held off until the end of this period. In fact, in some counties, it was noted that quite a few cases can be indicated or unfounded within the first month or less. In such instances, caseworkers often use the remainder of the period

to assess family problems, identify service strategies, develop additional information on allegations, and monitor the family. Frequently, the caseworker then will unfound the case at the end of this period, when it probably could have been indicated early on. This pattern is often followed to avoid completing the detailed paperwork required on indication of a report, specifically the State's Uniform case record and any local accountability requirements.

There are many instances when cases are indicated and then closed immediately. Such situations could occur when problems within the family had been alleviated and any service provision had been completed. The indicating and immediate closing of these cases would appear to be appropriate.

It may not always be appropriate to indicate and close cases but, nonetheless, this fact occurs with some regularity. Often it is even done out of necessity. For example, in some CPS units there is no operational ability to provide services for any but the most serious cases. Furthermore, CPS may not be able to get families to agree to accept services voluntarily and may not have sufficient evidence to go to Family Court to force such acceptance. Justification for these actions centers on the belief that there is no reason for these cases to remain open in CPS although there actually was sufficient cause to indicate them.

Across the State, there is quite a bit of contrast in the ability of individual CPS units to provide and/or arrange for services. The child protective service is often confronted with severe

personnel shortages. Additionally, CPS may be dependent on available resources in their respective communities which, in many counties, are quite limited. (Further discussion of service provision appears later in this Chapter.)

In order to indicate a case, a CPS worker must find some credible evidence of abuse or maltreatment during an investigation. This evidentiary standard obviously is used by all workers but in varying degrees. The consensus among workers is that credible means "believable," although workers were sometimes found to confuse credible evidence with requirements under higher evidentiary standards. Exactly what constitutes believable evidence of abuse or maltreatment, however, depends on the precise facts in a given situation. What may comprise credible evidence in one set of circumstances may not do so in another. Good casework practice dictates that workers have discretion. However, CPS staff also need appropriate guidelines to conduct their investigations and make their conclusions. As such, CPS personnel maintain that with proper training and experience workers are able to identify credible evidence, although application of this standard may vary from case to case.

b. Recommendations

Legislation will be recommended to require the State Department of Social Services to establish what we believe are much-needed guidelines to assist local child protective service in determining whether or not to indicate a report of child abuse or maltreatment.

Other recommendations to clarify the appropriate functions of CPS will be offered later in this report.

4. Police and District Attorney

a. Findings

Consistent with the comments in Chapter Two, the working relationships between CPS and law enforcement officials range from total cooperation to virtual nonexistence. In a few counties, the attitudes between these agencies actually border on open hostility. It is quite evident, however, that where good cooperation exists, it is most beneficial for both the social welfare and criminal aspects of child protective cases, as well as for those cases requiring police assistance but without a criminal component (e.g., removal of a child). One of the significant outcomes of these cooperative efforts has been an increase in the satisfactory resolution of sex abuse cases. An additional, noteworthy by-product of these relationships is better casework documentation within CPS units because of the recognized need to adhere to the strict evidentiary standards of potential criminal cases.

It should be noted that the cooperative endeavors among child protective services, police departments, and district attorneys certainly have not occurred overnight. There has been a cultivation of these relationships which often has occurred over many months' time. Generally, the impetus for working together and alleviating problems has been the recognition by these agencies that much more is accomplished when there are congenial relations between them. Initially, what has been required is an understanding of the unique

and important role that each of the concerned parties plays in the reporting, investigation, and, if necessary, prosecution of child protective cases.

People in some of the larger counties stated that it is very difficult, if not impossible, to establish cooperative ventures between CPS and law enforcement agencies due to the size of their communities. Our research found, however, that good relationships exist in large counties, as well as in small ones. The size of a community need not be an impediment to satisfactory working arrangements.

Important to note here is the Child Abuse Prevention Act of 1985. This new legislation specifically provides for access to CPS information by law enforcement officials. Additionally, the Act requires that local Departments of Social Services include in their multi-year services plans a summary outlining the cooperative procedures to be followed by CPS and district attorneys in investigating incidents of child abuse and maltreatment. Finally, in terms of the role of the police and district attorney as mandated reporters, the statute mandates that child protective services in each locality conduct a continuing appropriate education program for these individuals.

b. Recommendations

It is anticipated that implementation of provisions of the Child Abuse Prevention Act of 1985 will do much to alleviate the problems cited above. Additional legislative action may not be appropriate at this time.

5. Source of Report

a. Findings

There are differing views on whether the source of a report impacts how a caseworker conducts an investigation. Some individuals maintain that identity of the source has no impact whatsoever. Other persons view reports made by anonymous sources in one light and reports from mandated reporters, such as hospitals or police, in another manner (i.e., having more credibility).

In every county, there is a high level of unfounded reports. On a statewide basis 64 percent of all 1984 reports of child abuse and maltreatment were unfounded. However, the unfounded rate from anonymous reporters was a higher, 85 percent. This fact often is cited as another example of abuse of the hotline especially in harassment situations.

Since there are also a significant number of unfoundeds among reports from mandated reporters (nearly one out of every two in 1984), we believe that there is a need to improve the education of mandated reporters and to improve the actual relationships between CPS and these reporters. Often the mandated reporters in a community lack an understanding of the role and limits of the local child protective service, as well as not fully comprehending the significance of their reporting responsibility.

One recurring problem with certain reporters has been their unrealistic expectations of what CPS can and should do in various situations. For instance, some mandated reporters always expect CPS to remove a child when there are reports containing

certain allegations. They do not realize that it is not always possible or practical for there to be a removal. Another common complaint is that many public schools will not make reports of educational neglect until the very end of the school year, although the situation actually had been ongoing for many months.

Some counties are cognizant of the fact that they must assume a more active role in educating and improving relations with mandated reporters. One CPS unit has sent educational pamphlets to all health care professionals, while another holds meetings with such professionals to discuss the results of the investigations. Still another locality sends letters to reporters on the results of investigations, a notification which is authorized in the law. These simple organizational tools have greatly increased awareness and improved relationships with reporters in the community.

Finally, a concern raised by some mandated reporters is that their identity is not always kept confidential by CPS when they have asked that it be so. Consequently, these individuals will start making reports anonymously. This anonymous reporting often effects the timeliness and thoroughness of CPS investigations.

b. Recommendations

It is recommended that the Social Services Law be amended to clarify the statutory mandate that the identity of a person making a report of child abuse or maltreatment be kept confidential. More rigorous adherence to this mandate can do much

to reduce the level of anonymous reporting to the State Central Register. Similarly, statutory guidelines for investigation priorities recommended earlier in this chapter, can assist localities in realistically dealing with this group of reports.

In addition, legislation will be recommended to amend existing provisions of Section 422 of the Social Services Law which currently require that certain mandated reporters be notified of the results of a child abuse investigation only if they make a request for such information. For a busy professional, the statutory provision is an undue obstacle. Instead, it is recommended that all mandated reporters, who are themselves bound by the rules of confidentiality, be automatically notified of the results of the investigation of a report. Such legislation builds on sound information sharing practices found in a number of the counties studied by the Committee, which do much to facilitate positive cooperative relationships between CPS and mandated reporters.

In this vein, the Committee wishes to underscore the imperative that the State and local Departments of Social Services emphasize their continuing, ongoing responsibilities for the education of mandated reporters in their responsibilities under the Child Protective Services Act, as well as for the development of innovative approaches to positive interaction between mandated reporters and the child protective service in each county.

The role of the mandated reporter is central to New York's child abuse reporting law and the report required of a dedicated professional ought to be given the weight intended in the law.

To this end, it is recommended that the Social Services Law be amended to require that the State Central Register accept as reports all calls made by mandated reporters.

6. Expungement

a. Findings

The statutory requirement to expunge unfounded reports reflects an inconsistent policy. Within child protective services, the Committee staff found that FLRs, unsubstantiated allegations on an open case, and a locality's own case records if different from the State Central Register's documents will not be destroyed, and will remain within the files. Additionally, records of district attorneys, police, service providers, hospitals, and medical professionals, are not expunged although a report ultimately is unfounded by CPS. There would be no realistic manner in which to enforce expungement of these non-CPS records even if clearly stated in the Social Services Law that they must be expunged. Further, such a rule actually is not possible because of the confidentiality and record retention requirements of other systems, and the confidentiality mandates of at least some of them.

Some of the material in unfounded cases may be useful at a later point in time. All investigative support details, service assessment data, medical records if in the report, and other details related to the unfounded case can aid in an investigation and service assessment if there is another child abuse or maltreatment report on the same family in the future. Furthermore, such information could reflect a pattern of behavior which would

better enable CPS workers to evaluate family dynamics and the safety of the children in that family.

6. Recommendations

It is recommended that Section 422 of the Social Services Law be amended to provide that unfounded reports of child abuse or maltreatment, when made by an identified source, be sealed rather than expunged. Unfounded reports from anonymous sources will continue to be expunged as provided by current law. The sealed records will be retained for a period of five years and then expunged, and only be released during this period if a subsequent child abuse or maltreatment report is received. In such circumstances, such information on unfounded reports will only be made available to a child protective service or a law enforcement official. Codification of this recommendation will create additional safeguards to protect the life and safety of children and, as a corollary, will also serve to encourage better and more complete case recording practices.

C. Service Planning and Provision

1. Findings

a. Problems in Service Delivery

Our Committee's research has disclosed significant variations in the delivery of supportive and rehabilitative services to CPS families. The efficacy of service delivery efforts appear to be principally functions of a series of factors, including family motivation, the availability of services themselves, the orientation of the service provider to the involuntary service client, as well as approaches to the organization of services generally.

Moreover, particularly in those counties with high reporting volumes, service delivery problems have become so intense that child protective units have become preponderantly investigative bodies, having made uneasy and ineffective compromises with the other important aspects of the CPS responsibility as mandated by law--i.e., service provision and case monitoring.

Services to families in need of child protective system intervention are offered, either directly by a local Department of Social Services, or by purchase from public and/or voluntary service agencies. They are authorized under a variety of labels related to the child's and family's situation at a given point in time. As such, services may be "protective," that is, designed to protect the child from abuse or maltreatment and alleviate familial problems leading to child abuse or maltreatment. Alternatively, services may be called "preventive" which, under State law, connote

those services provided to avert placement or reduce a child's stay in foster care. The views of those in charge of authorization and delivery of services in local Departments of Social Services and in other public and voluntary service agencies were virtually unanimous that it makes no difference in practice whether a family is a "protective" or "preventive" case. Generic services are delivered, it is maintained, regardless of eligibility classification. As will be discussed later in this chapter, barriers to service delivery lie not in nomenclature but rather in the way such services may be organized, administered, and financed.

The availability of services to CPS families was found in the counties surveyed to be a major function of a local government's ability and commitment to provide generally needed levels of fiscal support for the delivery of services to children and families and not just to families in particular need of protective services. In varying degrees, the counties we studied reported deficiencies in the availability of services in the following salient areas bearing on child protective needs: sex abuse treatment for the victim and offender; service modalities to meet the needs of families with multiple service problems; services for families with special needs (i.e., physically handicapped, developmentally disabled); transportation; homemakers; day care; housing; and mental health services.

As significant as the waiting lists for services were the attitudes of service providers in many areas we visited.

Some agencies refuse to provide services to CPS families, and others which do, often have orientations unsuited to understanding the needs and dynamics of the often poorly motivated, involuntary client. In these instances, services either have not been offered, inappropriately terminated, or continued at length with little regard to time-oriented protective treatment goals. Gaps and deficiencies in service delivery disclosed in Committee staff interviews, were dramatically documented in our case reading statistics, as discussed later in this chapter.

A further critical factor in determining the availability and efficacy of many services for CPS families, was seen in the manner counties provided for their organization and administration. Significant problems were apparent in many counties, although certainly not in all. A number of local governments we surveyed have in place integrated, coordinated and efficient administrative systems for the delivery of services.

Committee staff found serious administrative obstacles to the delivery of services when provided by local Departments of Social Services. In those instances where, upon completion of an investigation, a CPS case required ongoing services, administrative procedures established for case transfer to a services unit of the Department were often cumbersome and time-consuming. Consequently, caseworkers often chose or were constrained, especially when faced with high investigative caseload volume, to close cases prematurely without the delivery of needed services. Indeed, because of

administrative difficulties, in a number of instances services which were provided were delivered during the investigation period and discontinued on indication.

Further, serious obstacles to service delivery within a local Department of Social Services were seen in the personal and organizational rivalries and misunderstandings which were apparent in ongoing relationships between CPS and service units. Particular weaknesses included failure on the part of CPS and service unit personnel to understand each other's duties and responsibilities. In addition, service unit staff frequently displayed ignorance of the requirements of the child protective service statutes and regulatory requirements, and the dynamics of services for the involuntary client. Coupled with such difficulties were clear lapses in coordination of mutual responsibilities and in needed case communications between CPS and service units.

These problems were compounded when CPS was required to exercise its monitoring responsibilities over indicated cases. Monitoring was carried out in a confusing and inconsistent manner in a number of counties, with resultant failures to address the progress of the family and the protective needs of the child.

To compound what in many counties have become major operating burdens because of rising caseloads, local government concerns over CPS performance and accountability have created additional workload requirements. Among the counties we

visited, some large counties had imposed their own case management requirements on local CPS staff in addition to the comprehensive Uniform Case Record mandates imposed by the State Department of Social Services pursuant to CWRA. In response to mounting caseload pressures, one of the counties eliminated its own local requirements. Another has still retained them, making the delivery of services virtually a nightmare for the average worker.

When services for CPS families were provided by public and private agencies outside the local Department of Social Services, problems arose in those counties where service providers were poorly educated in CPS laws and regulations. In these instances, provider expectations of CPS often exceeded the capacity or the legal authority of the protective service unit. Service delivery problems were also noted when CPS was not aware of or could not meet provider agency information needs about the client. Provisions of the Child Abuse Prevention Act of 1985 relating to access to information by service providers may alleviate some of these difficulties.

Additional stresses between CPS and outside service agencies were evident when administrative systems failed to provide for appropriate sharing of necessary service information or for the coordination of respective responsibilities.

Mounting demands have been placed upon CPS in recent years, while the service delivery function has burgeoned and CPS service needs have become increasingly specialized. Further, this study has documented the inability of CPS to efficiently and effectively discharge all of its mandated functions--i.e., those of investigation, service delivery and

case monitoring, within the confines of a statutorily mandated single organizational unit. However, the functions of CPS are central to the protection of children from abuse and maltreatment and, as such, need to be refined and strengthened.

b. Case Reading Statistics

The Committee's case reading underscored our interview findings. As described more fully in the Appendix, the protective services system appears in a significant degree to have become a revolving door for a consistent percentage of families whose problems have not been previously resolved by CPS intervention. Thirty-five percent of our two-hundred case sample of 1983 indicated child abuse and maltreatment cases had had prior experience with CPS as documented by prior reports on file with the State Central Register. The 1985 pending cases under investigation we reviewed had a smaller, although significant proportion of prior reports, noted in 23.5 percent of the sample. Of course, this significant volume of prior reports is also explainable in part by the incidence of Register reports made for harassment purposes.

Additional factors contributing to a pessimistic assessment of service delivery to CPS families were disclosed by the case statistics. A significant percentage of families, more than 25 percent of the 1983 sample and nearly half of the 1985 group, received no services while the child abuse or maltreatment report was being investigated, and approximately one-fifth of all cases in the 1983 sample received no services after the case was indicated. Part of the reason for nondelivery of services may be attributed to difficulties in getting families to agree to services, as well

as to the growing incidence of nonserious harassment reports made to the State Central Register. However, significant deficiencies in the ability of CPS to delivery services at all are clearly part of the underlying problem.

Services actually delivered, at least insofar as documented in the case records we studied, are illuminating. For the families which did receive services, the most frequently cited services were foster care and counselling (provided by the local Department of Social Services). For example, foster care was provided to nearly 32 percent of the 1983 sample which received services after case indication and counselling was provided to about half of this group. These statistics were considerably reduced during the investigation periods in both samples with serious deterioration in the delivery of these services noted by 1985.

Other services provided to children and families were virtually nonexistent or were simply not documented in the case records we studied: mental health services were delivered only to between five and ten percent of families receiving services in the case samples. Other services generally were given to only three percent or less of the sample groups, including those provided by mental retardation, alcoholism, drug abuse, and probation agencies and the Division for Youth.

Finally, our case reading disclosed further findings related to the provision of services to children and families. Under the child protective services system, the Family Court is regarded, at least statutorily, as an integral tool to assure the delivery of services when they are not accepted on a voluntary basis. As described in the Appendix, local Departments of Social Services utilized the Family Court for filing abuse and neglect petitions for only about 25 percent of the 1983 sample cases, and adjudications

generally were made when petitions were filed. The reasons for the low level of court involvement in abuse and neglect cases will be explored more fully by the Committee in the coming year.

c. Funding Supportive Services; The Impact of the Child Welfare Reform Act.

Services provided to children and families in the protective services system may be considered supportive and rehabilitative in nature and constitute the identical generic services regardless of what they are called. However, New York State Law links such services with situational eligibility requirements and defines them as either "protective" or "preventive." Moreover, these services are differentiated by imposing State aid formulas which vary for each service label, serving to confuse organizational arrangements and statutory mandates. Further, such practices have also sometimes discouraged the delivery of necessary services. This funding problem had its genesis in the enactment of the Child Welfare Reform Act of 1979, as well as in the major fiscal impediments to the delivery of supportive services to children and families, created by the U.S. Congress in its imposition of annual ceilings on the amount of federal aid available to states pursuant to Title XX of the Social Security Act.

Under Federal Title XX, states receive fixed sums each year to finance 75 percent of the cost of approved supportive services, and New York State and its local governments share equally in the remaining 25 percent of the costs. Local Departments of

Social Services utilize these funds first in order to minimize local tax levy disbursements, and only when federal Title XX funds are completely expended, will a locality resort to more limited State aid formulas to fund what are normally regarded as Title XX "overclaims."

The most liberal of the State aid provisions for child and family services lie in the preventive services entitlements created by CWRA. Under this statute, State aid of 75 percent of program costs, after application of available federal aid, will be paid for those supportive and rehabilitative services defined as mandated preventive services. Pursuant to the provisions of Title Four of Article Six of the Social Services Law, mandated preventive services are those intended to avert or shorten a placement in foster care. They must be provided whenever a local social services official makes a finding that the child will be placed or remain in foster care unless such services are provided, and that it is reasonable to believe that provision of such services will enable a child to remain with or be returned to his family. Given this liberal funding arrangement, intended as it was to reduce overreliance by the child welfare system upon foster care as a desired service alternative for children and families in crisis, preventive services have become a major funding stream for local social services districts. Localities find it comparatively easy to make the requisite findings to qualify a family reported for child abuse or maltreatment as a preventive services case, given the fact that most protective

services cases would, almost by definition, meet the requirements for mandated preventive services. However, the incentive for utilization of preventive services funding for protective cases is more than programmatic, given the progressive reduction of federal Title XX funds, and the fact that services provided as "protective" services which are federal Title XX overclaims, receive only fifty percent State aid.

The practical impact of reliance upon preventive services reimbursement to meet the service needs of protective services cases has been the referral of CPS cases to preventive agencies, public or private, outside the protective unit of a local Department of Social Services. However, as noted earlier in this chapter, local administration of procedures for the transfer of services cases out of CPS to other units and agencies, as well as case monitoring responsibilities, have not been discharged efficiently. The combined impact of these factors has produced a fragmented service delivery system, characterized by service voids and inefficiency, for those families most in need.

It must be noted, that, however inefficient the protective-preventive supportive service system for CPS families has become, it does not appear to have had an adverse impact on the life and safety of children. Both our site interviews and case reading data support this thesis. Local CPS personnel throughout the State, when questioned about CPS intervention to protect children from situations of imminent danger, almost

unanimously agreed that the Child Welfare Reform Act, with its emphasis on keeping families together, has had no impact on judgments of whether or not removal of the child from the home is necessary. Indeed, as described above and in the Appendix, our review of 1983 and 1985 CPS cases clearly indicates the sizeable use of foster care both during the investigation of child abuse and maltreatment reports as well as after cases are indicated. In fact, as noted above, the very paucity of service provision to CPS families apart from foster care (and counselling) may underscore major sensitivity to placement needs, especially when other service options either are not explored or are unavailable. Of course, a number of persons we contacted did acknowledge that implementation of CWRA has produced extreme pressures on caseworkers to avoid placement of a child whenever possible and that many placements may have become shorter than necessary.

## 2. Recommendations

It is strongly recommended that the Social Services Law be amended to accomplish two major purposes: (a) creation of an integrated State aid formula for all child welfare services; and (b) refinement of CPS functions, and their organizational placement within a new administrative framework for the delivery of child welfare services.

a. State Aid Formula

Legislation will be recommended to create a single State aid formula which will integrate State funding not only for protective and preventive services, but which ideally should also include other traditional child welfare federal aid categories (e.g., foster care and adoption). Such programs must compete under unrelated State aid formulas once federal Title XX dollars have been exhausted, often creating the same sorts of service administration issues described above. The proposed State aid reimbursement rate will be equitable, so as not to discourage the delivery of needed services, and will be so constructed so as to minimize adverse fiscal impacts on both the State and local governments.

b. Reorganization of Child Welfare Services

The CPS function is one of the major intake points for all child welfare services within a local Department of Social Services. We propose that its role be redefined to include current CPS intake, investigative, case assessment, planning and monitoring functions. We would eliminate CPS responsibilities relating to the delivery of supportive services to children and families. And the CPS monitoring function would be defined in law to encompass a broad range of activities, including contact with the family to assure protection of the child, implementation of appropriate service plans, as well as involvement with Family Court

cases. Consonant with our proposal for the integration of State aid service categories, responsibility for all child welfare service delivery within a local Department of Social Services should be assigned to one ongoing service division or grouping. And, in this context, the service labels "protective," and "preventive" should be renamed in law along with other service categories under the title "supportive services to children and families."

The Committee is aware that various administrative arrangements may be possible to effectuate these objectives and that a single organizational prescription may be inappropriate in statute. Consequently, we recommend a modification of the single organization mandate contained in Section 423 of the Social Services Law which will provide for the organization of public child welfare services around discrete child protective and service delivery units with functions as outlined above. Under such structure, CPS involvement would cease, and a case would no longer be classified as a protective case when risk to the child is minimized, and service needs may be met on a voluntary basis by the ongoing service units of a local Department. Definition of risk to the child would be based on standards of risk assessment to be developed by the State Department of Social Services, utilizing risk assessment protocols extant throughout the country.

Pilot testing and evaluation of this new organizational approach to child welfare services should be undertaken in at least six counties widely representative of local CPS problems and organizations, prior to any statewide implementation. The recommended statutory provisions will accordingly include a multi-year phase-in period to accommodate the development and implementation of a variety of administrative alternatives to meet local needs, as well as the need for possible refinements of the statutory mandate.

A further, and essential component of this proposed organization of children's services, to be mandated in legislation, will involve training of both CPS and ongoing service division personnel in the functions and responsibilities of each, including education in dealing with the involuntary client. Such training will form the prototype for Statewide efforts. We also urge the State Department of Social Services to emphasize as a priority, the appropriate training of service providers outside a local Department of Social Services to overcome the deficiencies described in this chapter.

Within any such organizational arrangement for the provision of services to children and families, that proposed or those currently in existence throughout the State, it is recommended that the State Department of Social Services continue to take whatever steps may be necessary to eliminate duplicative, overbearing and unnecessary local, and where applicable, State paperwork requirements. Their effects have been to dilute and degenerate the quality of child protective work. The Department's recent revision of the Uniform Case Record may have alleviated some of the problems with State requirements.

D. Personnel Issues

1. Training

a. Findings

The statewide training conducted by Cornell University under contract with the State Department of Social Services (Child Protective Services Training Institute) generally was given high marks by all CPS personnel. This opinion was expressed for both the basic training for new workers and the advanced courses.

Ongoing in-house training is also an important component of CPS work. However, regular local training sessions are found in only a few counties. Often the lack of such training is attributed to insufficient funds. Nevertheless, many administrators believe that the federally financed Cornell training is adequate and see no need to have additional training on a local basis.

While workers believe that existing training is very good, most of them maintain that there is a definite need for more of it. They particularly are concerned with having continuing training in practical issues. The areas most frequently noted were medical and legal issues. One noteworthy example of such practice-oriented training recently was held in one of the large counties in this study. The county attorney's office, in conjunction with CPS, conducted a half-day workshop on legal issues which included mock trials to better familiarize workers with courtroom procedures.

A number of other training deficiencies were highlighted by CPS personnel across the State. Workers in one large

county noted that in-house training only centered on paper flow management. In some large counties, workers did not even have a familiarity with different sections within child protective services and/or with different units within their own local Departments of Social Services. Additionally, workers in some localities lacked appropriate information about community resources. Finally, several supervisors and administrators noted the lack of training specifically geared to their management responsibilities.

The availability of local funds plays a significant role in on-going training for CPS workers. Often when there are budget cuts, funding for training is one of the first items to be eliminated. Limited local funds frequently means that the only training some CPS workers receive is the State-mandated basic training course and that workers are not even able to attend any of the Cornell advanced courses.

b. Recommendations

The Committee, cognizant of the mandates for statewide training of CPS workers contained in the Child Abuse Prevention Act of 1985, urges its full implementation by the State Department of Social Services, utilizing many of the practical suggestions for improvement in the provision of training noted above. Further, emphasis should be placed upon the training of supervisors, given the continuing high incidence of CPS caseworker turnover.

Further, in order to establish additional opportunities for training which are compatible with local needs, legislation will be offered to permit local governments in their discretion to provide the non-federal match for uncapped U. S. Social Security Act Title IV-E training funds. In such manner, it is anticipated that new and effective training opportunities in child protective services may become available.

Finally, it is recommended that the provisions of the Social Services Law relating to the development and submission of local consolidated services plans be amended to require the inclusion of local procedural manuals and service directories for use by child protective service workers, service providers and other professionals in the child protective services system. Such devices, which have been utilized successfully in some of the counties the Committee visited, are useful tools to enhance the work of CPS professionals.

## 2. Staffing

### a. Recruitment

#### 1. Findings

Job qualifications for child protective workers vary from county to county. For instance, some localities require a baccalaureate degree for CPS positions. Other places do not have this requirement but instead rely on the relevant human services experience of an applicant. Interestingly, some administrators thought that the qualifications in their counties were appropriate

while others were dissatisfied with them. It is important to note that the Child Abuse Prevention Act of 1985 specifically gives local districts flexibility to choose the appropriate qualifications for CPS workers.

This study found a uniform dissatisfaction with: the generic civil service exam for caseworkers from which CPS staff are drawn; the civil service requirement for selection of one of the three highest scoring candidates on an examination, and what are regarded as inadequate probationary periods. As such, many individuals have called for the development of special exams for CPS personnel and the extension of probationary periods, as well as the establishment of trainee positions.

These Statewide complaints reflect ignorance of, or inability or unwillingness to use clearly available options under the Civil Service Law. Such options include: the establishment, generally at State cost, of separate job titles and tests to meet a locality's need (a number of counties have already utilized this option); local rating of qualifications, including the use of oral tests; introduction of zone scoring to replace the rule of three selection process; the use of open competitive examinations rather than in-house promotions; flexible probationary terms; creation of trainee positions; and the like.

## 2. Recommendations

Two administrative recommendations are offered to facilitate recruitment of CPS personnel statewide. In the first place, we urge the State Department of Civil Service to recruit and

have available on a continuous basis subject matter specialists to assist in the development of civil service examinations for case-workers as well as specific examinations as may be required by local governments for child protective service workers. Such committees of experts are now successfully utilized in the development of examinations for law enforcement professionals.

Second, it is strongly recommended that the State Departments of Civil Service and Social Services jointly review recruitment in key jurisdictions throughout the State to identify problems and ranges of possible recruitment approaches now available under the Civil Service Law. Based on such reviews, the Department of Civil Service should provide necessary technical assistance to counties to install and implement new recruitment systems.

b. Retention

1. Findings

High turnover of CPS staff occurs sporadically around the State. Retention problems are most prevalent in large counties with high reporting rates.

One reason cited for turnover problems in several counties, both large and small, was non-competitive salaries. In these counties, other positions with similar qualifications offer higher salaries (i.e., probation agencies). In fact, we found that some public agencies have "raided" local CPS units with the lure of higher pay scales.

Caseload size is another factor which accounts for difficulty in keeping staff. Initial high caseloads are compounded in some places by frequent personnel departures which further burden remaining staff members. High caseloads are a significant source of discontent with many workers across the State. These individuals maintain that their ability to do their jobs in the best possible manner is greatly hampered by what are uniformly regarded as excessive caseloads.

Another element of frustration for workers in some communities is the perceived lack of respect for the CPS role by other professionals involved in the child welfare system, such as law enforcement, treatment specialists, and the judiciary. This fact not only contributes to low morale among workers but also can be an impediment to satisfactory resolution of child protective cases.

## 2. Recommendations

We are cognizant that the problems of retention of CPS workers are not easily dealt with, bearing as they do on complex, interrelated issues of caseload size, remuneration, and working conditions generally. We are hopeful, however, that many of the recommendations made elsewhere in this report will have, as their combined effect, a more manageable workload for CPS. The Committee in future research will study still more closely those legislative and administrative criteria for intake of abuse and neglect reports which may have become dysfunctional for the 1980's.

Further, in developing new approaches to recruitment of protective workers as suggested above, we urge the Departments of Civil Service and Social Services, as they work with local governments, to draw upon the experiences of some counties which already have adopted the use of salary differentials for CPS workers. Increased remuneration, combined with other improvements, may be an important answer to retention of qualified and experienced personnel.

APPENDIX

## APPENDIX

### Case Reading Findings

The Committee's review of 400 child abuse and maltreatment cases was constructed in order to identify patterns over time, when they existed, in: (1) the process of investigation of reports; (2) the provision of services to children and their families; and (3) the involvement of the child and family in family court and criminal court proceedings. However, as a word of caution, it should be noted that the findings of the case reading are limited to what was included in the case records. As amply supported by our on-site interviews throughout the State, deficiencies in case recordings are rife, especially in a number of high reporting districts included in the study sample. In this context, therefore, data presented below, which represent a distillation of the more significant variables included in our analysis, should be regarded as illustrative rather than conclusive of child protective trends and issues. Nevertheless, much of the data appear to validate information collected in our interviews with child protective service system personnel throughout the State.

#### A. Types of Allegations

Allegations contained in the oral reports of child abuse or maltreatment made to and accepted as the basis of a report by the State Central Register, are usually indicative of the seriousness and character of cases investigated by local child protective agencies. Allegations may be multiple--i.e., more than one can form the basis of a registered report. The ultimate reason for case indication

may be related to all or some of them or to an allegation not made in the original report. However, fact patterns reported to the State Central Register from the basis of the formal allegations, as determined by State Central Register personnel, which are forwarded for local investigation and, as such, are more complete than locally maintained case records.

As described in the following table, the kinds of formal allegations contained in State Central Register reports are, at the same time, becoming somewhat more numerous with respect to certain types of abuse and maltreatment, as well as considerably more nonspecific in terms of allegations of child maltreatment.

TABLE I.  
Allegations Made in the Oral Report

Types of Allegation:	Included in Reports Indicated in 1983	Included in Reports Under Investigation in 1985
Percentages (nonadditive)		
Physical Abuse:		
Fatalities	1	1.3
Fractures	3.2	.6
Internal Injuries	.6	-
Lacerations/Bruises	19.8	19.1
Burns/Scalding	.9	5.3
Sex Abuse	8.1	11.4
Maltreatment:		
Corporal Punishment	24.4	29.3
Child Drug/Alcohol Use	3.1	1.3
Drug Withdrawal	1.0	-
Lack of Medical Care	8.3	13.2
Malnutrition, Failure to Thrive	.9	1.0
Educational Neglect	11.2	9.2
Emotional Neglect	4.6	4.0
Lack of Food, Clothing, Shelter	15.5	10.4
Lack of Supervision	23.9	18.0
Abandonment	3.2	4.1
Other (Inadequate Guardianship)	53.2	75.9

As noted in Table I, in the physical abuse categories, allegations concerning burns and scalding were contained in less than one percent of the 1983 sample and had risen to 5.3 percent in 1985, an increase of 489 percent. Sex abuse allegations increased during the same period by some 40 percent (from 8.1 to 11.4 percent).

With respect to allegations of child maltreatment, significant changes were noted in allegations of corporal punishment (up 20 percent), lack of medical care (up 59 percent), educational neglect (down 18 percent), lack of food, clothing and shelter (down 33 percent), and lack of supervision (down 25 percent). Further and perhaps most significant, were changes in the incidence of inadequate guardianship. This is a catchall category for reporting which, upon investigation, may disclose serious instances of abuse or maltreatment, but more often than not connotes the least specific and least serious of all allegations especially when forming the only basis for a report. In 1983, allegations of inadequate guardianship were noted in 53.2 percent of all reports in the sample. Two years later, this proportion had risen to 75.9 percent, a 43 percent increase, strongly suggesting that allegations reported to the State Central Register are becomingly increasingly less serious and nonspecific.

B. The Investigation Process

In reviewing investigative response time and the nature of investigative contacts, the 1983 and 1985 sample groupings

revealed a similar pattern: approximately half the cases in each sample were contacted within a day of receipt of the child abuse or maltreatment report and another forty percent were contacted within the first week. Significantly, no contacts were made in six percent of the cases in the 1983 sample and in 8.2 percent of the cases in 1985. This difference may not be significant inasmuch as the cases in the 1985 sample were still under investigation. Nevertheless, the data still emphasize that investigative response time was deficient. Indeed, the differential response time of child abuse investigators, where the majority of cases were not contacted immediately, points to the deficiencies encountered by child protective service staff in dealing with high reporting volumes as well as to resultant local practices which set priorities in investigative response time on a case by case basis. This matter is documented in greater detail in Chapter Three of the report.

The types of contact included the parent somewhat more often than either the child or the source of the report: parents were contacted in somewhat more than 45 percent of the cases while the child and the source were each contacted in a little more than a third of the cases. Again, percentages are not additive because multiple contacts are possible. This relationship also was maintained in reviewing caseworker attempts to make investigative contact. Also, attempts at first contact were equally likely to be a telephone call or a home visit (some forty percent for each category). In cross-tablulating contact time with source and type of contact, data for

the 1983 and 1985 samples indicated that the source of the report would be more likely to be contacted by telephone within the first day of the report and that the parent would more likely to be contacted by a home visit within the first week after the report was made.

Significantly, for the 1983 sample, actual home visits were made within the first day after receiving the report in 26 percent of the 1983 sample cases but only in 21 percent of the cases under investigation in 1985. Another 40 percent or more of the cases in both samples were visited within the first week after the report was filed. Importantly, no home visits were made in 15.6 percent of the cases in 1983 and in nearly 22 percent of the 1985 cases under investigation (the latter figure may be attributable to the increasing lack of specificity and possibly seriousness of allegations which could contribute to decreased home visiting).

Finally, in the 1983 sample, in only 43.1 percent of all the sampled cases were investigations completed within the statutory 90 day time period, pointing either to serious deficiencies in the local investigation practices, or deficiencies in case recording and documentation, or both.

#### C. Cases Known to the System

As indicated earlier in this report, a significant and growing percentage of child abuse and maltreatment reports constitute cases known to the protective services system. Indeed, in 1984 some

twenty percent of all reports made to the State Central Register were subsequent reports--those made on open Central Register cases. Our case reading data looked at this phenomena in a slightly different, although related manner by collecting, for the 1983 and 1985 samples, cross reference numbers--those Central Register data relating to prior indicated reports of child abuse or maltreatment. The 1983 sample disclosed that 35 percent of the cases had one or more cross-reference numbers (some had as many as four). The 1985 sample of pending cases revealed a smaller, although still significant proportion of 23.5 percent. Although statewide data on subsequent reports view cases prospectively and our case samples analyzed historical prior report data, and neither set of data necessarily constitute the same cases, it is fair to assume that at any one time somewhat more than a quarter of all child abuse reports include families known to the child welfare system. The fact that this number is so large may point to either (1) an inability of the protective services system to deliver adequate services to children and families, so as to alleviate problems of abuse and maltreatment which appears to be borne out by the Committee's interview materials as well as in case reading material presented below, and/or (2) a significant, and often unmanageable incidence of reports to the State Central Register which are made for harrassment purposes. This latter subject is also explored more fully in Chapter Three of this report.

#### D. Service Delivery

Data on the provision of services to children and families revealed a number of significant observations. In the first instance,

during the report's investigation phase, more than 25 percent of the 1983 cases received no services. By 1985, this proportion had nearly doubled to 47.7 percent of the cases, raising serious policy concerns over: (1) the ability of the protective services system to deliver services to significant numbers of children and families in need; (2) the difficulty of getting families to agree to services; and (3) the growing incidence of either nonserious or harrassment reports which may not require services at all. With respect to services delivered after case indication, the 1983 sample similarly disclosed that nearly one-fifth of all cases received no services.

Conversely, the data indicate that significant numbers of children and their families did receive assistance from the protective services system. Nearly three-quarters of the 1983 sample received one or more service during the investigation period, although this proportion dropped to slightly more than fifty percent by 1985. Further, more than four-fifths of the 1983 sample received one or more service after the report was indicated.

The type of services provided are revealing (and the same families may have received more than one service). The two most preponderant services in both sample groups were counselling and foster care. The 1983 sample showed that some 21 percent of families received foster care services during the investigation phase. This figure was halved to some 11 percent in 1985. Also, during the investigation period, 51 percent of the 1983 sample

received counselling services. This proportion also was halved in the 1985 sample group.

With respect to post-indication period, the 1983 sample showed 31.7 percent of the cases receiving foster care and nearly 54 percent receiving counselling.

Other services provided to children and families were virtually nonexistent or simply not documented in the case record. During the investigation period, public mental health services were provided to approximately ten percent of the cases receiving services in 1983 and private mental health services were delivered to approximately five percent of the 1983 sample. By 1985 these small proportions declined by about one half. After case indication, public and private mental health services were delivered to approximately ten percent of the sample. Other services generally constituting three percent or less of each of the sample groups, both during investigations or after case indications, included mental retardation, probation, alcoholism, drug abuse and Division for Youth services, with even these small proportions generally declining after case indication. Ten percent of all cases in both samples received undifferentiated services lumped in a catchall category, both during the investigation of reports and after case indication.

In summary, then, the sampling of four hundred cases revealed significant lapses in service delivery, with principal services provided consisting of foster care and counselling, and the incidence

of service delivery appeared to worsen during the two year period 1983 to 1985, again at least insofar as documented in the case record.

E. Court Activity

Data from the 1983 sample indicated a relatively low level of Family Court involvement for children and families in the protective services system. As indicated above, nearly one-third of the cases received foster care services in the post-indication period. Case record data showed that the manner of placement was almost evenly split. Approximately 14 percent of the sample was placed in foster care by means of a court order under Article 10 of the Family Court Act and a similar slightly larger percentage (17.6) was placed in care by means of a voluntary placement order approved by the Family Court pursuant to Section 358-a of the Social Services Law.

Further court data for 1983 reveal that abuse or neglect petitions were filed and adjudications made in approximately one-quarter of the case sample. And orders for adjournments in contemplation of dismissal, authorized pursuant to Article 10 of the Family Court Act, were made in only five percent of the cases. Further, court-ordered supervision was noted in slightly less than a fifth of the sample, and temporary orders of removal were documented in 17.2 percent of the sample.

Data from the 1985 sample, because the cases involved reports still under investigation, revealed almost no court involvement (i.e., generally in less than three percent of the sample).

Court activity data from this statewide sample raise a major policy question as to the reasons for the low volume of Family Court involvement in child abuse and neglect cases, even despite the fact that the Family Court generally made adjudications of abuse and neglect when petitions were filed. These concerns, beyond the scope of the current study, will be pursued by the Child Care Committee in the coming year.