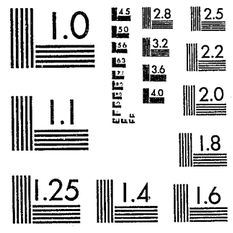

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Public Ends and Private Means: Accountability among Private Providers of Public Social Services

Some paradox of our nature leads us, when once we have made our fellow men the object of our enlightened interest, to go on to make them the objects of our pity, then our wisdom, ultimately our coercion.

Lionel Trilling
The Liberal Imagination, 1953

. . . experience should teach us to be most on guard to protect liberty when the government's purposes are beneficent.

Mr. Justice Brandeis
Olmstead v. United States, 1928

J. Michael Keating, Jr.
Institute for Conflict Management
July, 1984

esearch for this report was made possible by a grant from
ational Institute for Dispute Resolution.

EXECUTIVE SUMMARY

The Massachusetts Department of Youth Services provides daily a variety of treatment and care to over 1,750 adjudicated youngsters. The cost of these services runs to just over $30 million a year. Over the past five years the department has channelled 60 to 65 percent of its total annual budget to private, non-profit service providers operating under contract with the department a diverse array of facilities and programs. Twenty years ago, the Department of Youth Services owned and operated all of its own institutions, which contained the vast bulk of its population, and spent less than three percent of its budget on the purchase of private services.

This report represents an effort to explore some of the implications for public policy of the rapidly expanding privatization of the delivery of human services epitomized in the experience of the Massachusetts Department of Youth Services. In particular, the study focuses on the issue of the accountability of private providers to their clientele and to the agencies of government that engage and pay for their services.

Purely private providers have been dispensing social services for a long time, and the post-World War II years witnessed a steady expansion in federal contracting for a variety of technical services, especially in the mushrooming area of defense. But the privatization of human services is largely the product of the recent boom and bust in federal social commitments, with the austerity of the immediate past contributing, surprisingly, as much to the growth of the phenomenon as the preceding ballyhooed battle against poverty.

Because privatization has grown almost stealthily, with little awareness of its cumulative impact, there has been virtually no public dialogue about its usefulness, advantages and potential dangers. Public executives have found in privatization a convenient device for absorbing the shock of the rapid political and financial fluctuations that have come to dominate human services and have resorted increasingly to the private sector as a buffer against continuing uncertainty. The growing service sector of the private economy, for its part, has responded with enthusiasm, creating along the way an interesting entrepreneurial hybrid combining a commitment to public and social service with marketing and management proficiency. More recently still, several large, national corporations have begun to move aggressively into this expanding market.

5. Supervising state agencies must coordinate more effectively their program, licensing and contract review processes; and,

6. State agencies should initiate a program of regular surveys of a percentage of clients who have terminated their relationships with private providers.

All of the report's recommendations are couched in general terms; there needs to be considerable experimentation with them before they can be expressed more concretely. None of the suggestions involves vast expenditures; they all require a commitment to accountability on the part of administrators that transcends rhetoric and good intentions.

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Clearly, privatization meets the needs of public administrators, who cite principally its flexibility and cost-effectiveness to justify their increasing resort to contracting. But does it meet the needs of social service clients, of the old, the poor, the sick, the emotionally and physically disabled, the young whom we entrust to these private purveyors? The focus of this study is on the ways developed to date to hold private human service providers under contract to state agencies accountable for the care and treatment rendered to their vulnerable and frequently defenseless clients.

The study undertakes its analysis of accountability by examining existing efforts to hold private providers accountable in one area of social services, namely, those provided to children. The heart of the report is an assessment of the efforts of two state agencies, the Massachusetts Department of Youth Services and the Rhode Island Department for Children and Their Families, to devise and enforce meaningful accountability measures. The assessment, in turn, helps identify some of the principal obstacles to accountability inherent in both the contractual relationship between state agencies and providers and the nature of the services delivered.

Visits to 16 privately operated programs and facilities under contract to the two state agencies revealed three basic categories of accountability measures: 1.) those established by the providers themselves, 2.) those imposed on providers by the supervising agency and 3.) those created statutorily and presided over by a state agency other than the one funding providers' services.

Providers themselves, the study indicates, rely largely on informal procedures to ferret out complaints, supplemented by a combination of a case management process, the appointment of an in-house advocate for each youngster and regular house membership meetings in most residential facilities. Supervising state agencies depend for accountability almost exclusively on their own internal systems for reviewing programs and contracts and investigating allegations of institutional abuse, while other state watchdog agencies investigate and rigorously pursue reported instances of institutional abuse and conduct sporadic detailed reviews of provider programs.

These efforts reflect the ad hoc nature of their creation, usually in response to some media-generated crisis, and the resulting fragmentation of accountability leaves enormous potential for undetected abuse, neglect, and the inadequate delivery of services. The providers' own complaint procedures

are totally dependent on the goodwill of administrators, an adequate measure only so long as the wills of administrators are indeed "good"; state agency measures tend to escalate even simple grievances into accusations of abuse and can be activated only by the state agency's staff, who are not always vigilant, or the self-incriminating confessions of providers; and outside watchdog agencies are virtually unknown to the clientele they seek to protect. Thus, existing accountability systems, because they are the result of so little systematic, thoughtful planning, are especially dangerous; they lull the public and administrators themselves with a shadow process that has the aura of accountability while actually relying for its effectiveness on the willingness of malefactors to turn themselves in.

After examining in depth the accountability measures of the two state agencies that provide children's services, the report considers briefly the efforts of standards makers to generate criteria in the area of accountability and finds the results inadequate due primarily to inadvertence. The various standards projects simply have not considered the impact of privatization on the delivery of services in their efforts to develop a framework of policy for agencies involved in juvenile justice and children's services.

The report's recommendations, based on its review of accountability measures and standards, include six specific suggestions:

1. Private providers must be required to develop written complaint procedures that retain present informal approaches to disputes and add more formal processes for unresolved complaints;

2. Providers must initiate a much more vigorous and better planned program to make clients aware of their rights and applicable measures for enforcing them;

3. Clients must have far greater access to state-created mechanisms for monitoring institutional abuse and neglect;

4. State agencies must improve their supervision of private providers by ensuring some form of regular, detailed programmatic review of providers even if only on a randomly selected, sampling basis;

5. Supervising state agencies must coordinate more effectively their program, licensing and contract review processes; and,

6. State agencies should initiate a program of regular surveys of a percentage of clients who have terminated their relationships with private providers.

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Chapter 1

INTRODUCTION

This study represents the mingling of two rapidly developing trends, namely, the growing inclination of governmental entities to hire private contractors to deliver human services and the search for effective ways of handling conflict in the institutions and organizations that have come to dominate so many aspects of our lives. Because both these movements are relatively young, little has been written about each, and nothing at all has been written about the two together.

This attempt to fill the vacuum has its roots in the conflict resolution movement. The newly formed National Institute for Dispute Resolution has underwritten this effort to examine how private providers of human services under contract to state agencies handle the complaints of their clients. Yet, while the focus of the study is on the identification and processing of grievances, the environment within which such processing occurs obviously has a profound effect on the nature and operations of the complaint mechanisms to be observed.

Because this particular study looks closely at private contractors involved in the provision of social services to children, two different environmental aspects require analysis. Both children's services and the contractual framework have their own history, a brief recounting of which may supply a useful prelude to the research that follows.

Background: Contracting in the Human Services

Private religious and philanthropic organizations[1] involved in providing a variety of human services pre-dated substantially governmental intrusion into the field of meliorative social action. Jane Addams of Hull House in Chicago, Lillian Wald of Henry Street Settlement in New York and the Salvation Army, introduced to the United States in 1879 with its mission of mercy to "rumdom, slumdom and bumdom," epitomized the commitment to service of elements of the private sector fully a half century before the public sector evidenced much interest in the special needs of the disadvantaged, the disabled or the destitute. Only with the Great Depression and post-World War II prosperity did government in this country undertake major responsibility for cushioning the lives of its citizens against collective and individual adversity.

The expansion of federal involvement in social services peaked in the decade of the "Great Society" from 1965 to 1974 when outlays for medical care, housing, education, welfare and vocational training more than tripled. Coupled with the increased funding central to Lyndon Johnson's "War on Poverty" was a new emphasis on the development of de-centralized community action programs that would maximize the participation of citizens in the administration of local activities. One element of this new emphasis was the enactment of federal legislation that for the first time, directly encouraged local governments to contract with private, community-based providers to deliver social services.[2] The rapid increase in available funding and the incentives for contracting combined to spawn a host of private firms that offered the promise of decentralization, greater cost-effectiveness and a more humane provision of essential social services.

This increasing privatization of governmental effort, while new in the field of social services, was a trend already well underway in other areas. At least one alarmed critic was labelling as "revolutionary" the trend on the federal level toward government by contract as long ago as 1961.[3] The bellwether for this development was post-World War II defense contracting where the development of sophisticated weapons systems required research and production capabilities far beyond those of government to deliver. The inevitability of recourse to the private sector in defense lent respectability to recourse to private individuals and organizations for research and developmental expertise in a growing variety of fields. Thus consultants and organizational think tanks proliferated not just in technical areas such as defense and energy, but also in education, transportation, health, criminal justice, housing, welfare, etc. Private providers were hired to conduct an increasing array of research, training, staff development and other management services or governmental agencies.[4] By 1980, the federal government in some 18 million contracts was distributing over $150 billion annually to private providers of goods and services,[5] and pejorative terms like "Beltway Bandits" had entered our lexicon to describe the phenomenon.[6] Thus, there was ample precedent for expanding privatization of the delivery of human services during the decade of the Great Society.

When the boom collapsed in the aftermath of the 1973 oil crisis, and inflation and budget reductions combined to wring out slowly and painfully local, state and federal expenditures for social services, one well might have anticipated a

major retrenchment in governmental contracting. Exactly the opposite occurred. Conventional wisdom almost immediately adopted the position that one way for governmental agencies to cope with budget curtailment was to increase, rather than decrease, contracted services.[7] Support for this stand focused on the following asserted advantages of contracting:

1. Flexibility: Budget-cutting in the social services[8] most often assumes the form of a reduction in an agency's staff. Whether this occurs gradually through attrition and the failure to replace depleted staff or through direct cuts, the effects are equally painful. In the face of such cuts, moreover, there is no corresponding diminution in clientele or demand for services. The mental health needs of the community do not change; vocational needs do not contract; there are no fewer neglected and delinquent children in the neighborhoods. Administrators, thus, are required to maintain levels of service with a shrunken staff and, to meet this need, they have turned increasingly to the private sector.

Budgetary politics encourages this development. When a governmental agency provides a direct service, the size of staff involved in delivering that service is a specific budgetary entry, whether the budget is expressed in a line-item or a programmatic format. The staff of a residential program run by government consists, in budgetary terms, of a specified number of administrators, supervisors, professional counselors, etc. Budget cutters characteristically go after those exposed numbers ruthlessly, paring a number here, another one there. Contracted services, on the other hand, are almost always described in budgetary terms in the form of a lump sum. Thus, when the amount in a budget for a specific contract is pared by the budget-cutter, the administrator and the contractor remain free to determine a mutually satisfactory way of absorbing the loss dealt out by the budget cutter that may -- or may not -- include a staff reduction for the contractor. The result is that the manager of a governmental agency retains much greater control over the way budget reductions are applied in his or her agency.

Staff reductions are a source of high discomfort in still another way for public managers. As indicated earlier, the period from 1960 to 1975 witnessed an extraordinary expansion in governmental social services at both federal and local levels. During those expansive, halcyon days, union contracts and civil service regulations steadily enhanced the pay, benefits, security and working conditions of governmental em-

ployees. In the current austerity, however, administrators have discovered that it is extremely difficult to roll back earlier concessions and entitlements. Seniority considerations and the vested pension interests of long-term employees now combine to constrict severely the flexibility of managers in dealing with staff cutbacks. Senior employees are virtually dismissal-proof, while new staff members, typically those most involved in providing direct services, are the most vulnerable to lay-off. This pressure subtlely pushes an agency, now heavy with middle managers and supervisors, in the direction of contracting for the delivery of direct services. Senior people can be retained to monitor and supervise contracts, while staff expansion at lower levels can be reduced or avoided. Once again, the result is enhanced flexibility for public administrators in reshaping their agencies in changing times.

For these reasons, there is the growing conviction among governmental executives, given the wildly erratic history of social services over the past two decades, that the only safe way to undertake programmatic expansion is to hire private contractors, whose services can be clearly and quickly terminated with minimum direct impact on the agency in the event of further or future retrenchment.

2. Cost-effectiveness: Implicit in this discussion of flexibility is the judgment, pervasive in the general population as well as among public administrators, that private providers can deliver more effective service at a lower cost than governmental agencies. In the area of social services, and especially in the more narrowly defined human services that are the subject of this study, such a judgment is probably accurate. The delivery of human services is highly labor-intensive. Any factor that substantially reduces the cost of labor in delivering human services will enhance cost-effectiveness.

Government, as indicated already, is wedded indissolubly to collective bargaining agreements and civil service arrangements that are largely unresponsive to fluctuations in the labor market. For lots of reasons there is an acute glut currently of the social services labor market. Budget reductions in governmental social services have led to substantial lay-offs and reduced job opportunities; the appeal of work in human services has lured large numbers of women, especially college graduates returning to the labor market after a long hiatus, to seek further education and employment as social workers, counselors and therapists for whom there is little likelihood of employment outside of publicly supported social

services; and the increase in the general labor force of recent college graduates without specific technological job skills far outruns the capacity of the shrinking traditional labor market to provide jobs. All of this means that a private organization for the delivery of social services has many more applicants than jobs. Because the applicants, even the successful ones, are unorganized and unrepresented, employers are unfettered by binding and fixed agreements on pay rates, benefits and working conditions. The surplus of labor in this unregulated environment (the minimum wage excepted) means that private providers of social services can pay less to, and be more demanding of, employees without being particularly concerned about working conditions.[9] In view of these comparative advantages, it is hardly surprising that private providers can deliver more service at less cost than governmental agencies that are locked into agreements on pay, benefits and working conditions negotiated with robust bargaining units in an earlier, happier boom period.

This business of "working conditions" bears further scrutiny. Anyone who has watched a humiliated and squirming public administrator attempt to justify to a legislative committee a bloated request for supplemental funds to pay overtime to residential staff can appreciate what a boon to private providers of residential care their virtually absolute control over scheduling and overtime represents. Because human services must often be delivered in ways that defy regularly scheduled routines, they frequently create erratic and extremely flexible delivery demands that are difficult to meet when staff participation is restricted by rigid work rules on the nature of tasks that may be assigned to staff or on staff scheduling. Here, once again, those collective bargaining agreements and civil service rules negotiated years ago in flush times impose severe restrictions on the ability of administrators to maximize effective use of currently shrunken staff, while private providers, free of such restrictions, can make far better and more flexible use of their employees.[10]

Pregnant in this whole discussion is the notion of the use of contracting to "bust" public employment unionization. Organization of government employees is about the only sector of the union movement that has shown substantial growth over the past two decades, and the public, as well as public managers, has frequently expressed growing dissatisfaction with the results of that growth. To date, union efforts to organize the employees of private providers of human services have been unsuccessful. Reasons for the failure are unclear; it may be

due to lack of concerted effort on the part of the unions; to the labor surplus in social services described above; to the fragmentation of private providers in so many small, independent entities; to effective resistance by provider employers; or, perhaps, it is reflective of the malaise that currently seems to afflict the union movement generally. Not surprisingly, no one among either providers or public administrators is talking openly about breaking the back of public employment unions through privatization, but many of the arguments advanced most persuasively for contracting have their roots in dissatisfaction with the limits on employment, promotion, termination and the use of public employees established through the collective bargaining process. The ability of private providers to by-pass that process is one of the most compelling arguments for the cost-effectiveness of privatization among public administrators.

There is another subtle and psychological factor at work in the trend towards contracting. Americans by and large equate governmental operations with waste and incompetence and simultaneously treasure the tarnished but enduring myth that business really knows what it's doing. These preconceptions, whatever their validity, prejudice the views of administrators, legislators and the general public in favor of privatization. Most people simply assume that private providers can deliver services more efficiently than government can. It is impossible to predict whether these prejudices will survive actual experience, but judging from the ability of business to perpetuate the myth of efficiency in the face of an absolutely horrendous record in defense contracting, it seems likely that the predisposition in favor of privatization will endure.

3. Expansion of capabilities: While flexibility and cost-effectiveness are perhaps the strongest arguments advanced for contracting, there are other persuasive explanations for the growth of the phenomenon. One such argument, which certainly explains the early enthusiasm for contracting, recognizes that the capabilities of government employees and agencies are limited. In defense-related matters, the federal government could directly supply its needs for sophisticated weaponry only by nationalizing large segments of American industry. A variation on this theme often repeated in discussions of social services is the argument that government need not, and indeed should not, duplicate or usurp human service capabilities that already exist in the community. Government, of course, has no claim to special expertise in psychiatry or vocational training. On the other hand, government, so the

argument runs, should be involved in the process of ensuring that existing community resources are made available to the disadvantaged and disabled in accordance with appropriate statutes and regulations. This division of duties suggests quite naturally a purchase of services framework.

There is another sense in which contracting may help to reduce redundancy and waste. Not infrequently, social services demand only a portion of an expert's time. It is, for example, patently wasteful for a government agency to hire a full-time psychiatrist whose services are required for only a few hours a week. Or again, why build permanent institutions staffed by similarly permanent state employees for a small and sharply fluctuating population of service recipients?

Finally, by relying on existing resources and programs in the community, governmental agencies can avoid the frequently substantial start-up costs involved in initiating new services or programs. By eliminating such early expenses governmental agencies may become free to experiment more creatively to improve the diversity and quality of services provided.

4. Increased accountability: This is perhaps the least persuasive argument for governmental contracting. It springs basically from long-time efforts to improve public sector management and assumes that governmental agencies can articulate definable, measurable goals and objectives. If an agency can define objectives accurately and contractually hold a private provider to meeting those objectives, so the argument goes, the failure to deliver constitutes clear grounds for termination of the provider's contract. This, in theory, provides government with the ultimate accountability standard: perform or die.

Rarely has reality conformed so poorly with theory. Just one example of Pentagon hardware contracting exposes the impotence of this supposedly ultimate weapon. In 1972 the Defense Department ordered over 3,000 M-1 tanks for $1.4 million each. By mid-1981, the unit cost had risen to $2.6 million, but now the tanks would not be ready for delivery until 1987. Due to its transmission design, the prototype M-1 could not dig itself into a battlefield position as most tanks can. As a result the army had to develop a fast-moving bulldozer to keep up with the high-speed M-1 tanks and assist it in digging in. As of 1982, the unit cost for each of these bulldozer-companions was $1.6 million. The M-1 prototype, incidentally, got 3.86 miles to a gallon of fuel and needed repairs every 43 miles.

The tale illustrates in extreme fashion the fact that once a governmental agency makes a substantial investment in a contractor, whether the contractor manufactures tanks or provides residential care for delinquent youngsters, there are powerful, if subtle, pressures against termination. In the former instance the pressure may take the form of strong and effective Congressional lobbying; in the latter the pressure may come from a staggering excess of youngsters who need to be placed over potential placements. Whatever the source of the pressures, the supposedly absolute power to terminate frequently turns out to be qualified and costly to exercise.

This issue of accountability is especially crucial in contracts for the delivery of human services. Everyone reacts with a measure of anger and frustration to the catalog of incompetence chronicled, for instance, in the saga of the M-1 tank. The numbers alone tell us clearly that industry either deliberately deceived with its cost estimates or is inept in its planning and management; in either case we do not like to see our tax dollars poured down a rat-hole. But there is an enormous difference between funding a private company to build tanks and paying an organization to care for, treat, teach or provide a home-substitute for sick, emotionally disturbed, neglected, retarded or aged citizens. In the latter case human beings are at risk in a society committed to the dignity and worth of individual life.

The delivery of human services presents a grave challenge to accountability. In the first place, the population served is often weak, confused, inarticulate and powerless. The very disabilities and disadvantages shaping their misfortunes frequently leave human service clients disoriented, violent or paranoid. They often are extremely difficult to manage or help; their inclusion in public programs at all not infrequently results from an inability on the part of even loving relatives or friends to supply the care now provided by the state.

The institutionalization of this difficult clientele, whether in state or privately operated residential programs, creates additional problems, unrelated to the disability or situation of those who are institutionalized. In 1961, sociologist Erving Goffman wrote a frightening, Orwellian analysis of "total" institutions, an analysis that remains substantially unrefuted, in which he documented the dysfunctional and degrading impact of institutional needs on inmates.[11] While there has been a shift away from an emphasis on the institutionalization of human service recipients in some areas, most notably among the retarded and neglected juveniles, there has been an off-setting increase in other total institutions, such as nursing homes and prisons. There is accumulating evidence, moreover, that deinstitutionalization, that is, the effort to reintegrate the disabled into the general community, recently has generated a powerful backlash and may be waning as a movement. Early indications are that any "reinstitutionalization" likely to result from the backlash will rely heavily on further privatization, especially where former institutions have been converted to other uses and institutional staff has been disbanded.

Whether human services are delivered in a residential setting or in the community, they typically are accompanied by a measure of paternalism on the part of treatment-oriented providers toward a clientele viewed as genetically or situationally impaired. This paternalistic attitude, expressed indirectly or even subconsciously, often emerges in the conviction that, because the provider knows what is best for clients, whatever the provider does is done in the clients' best interest, even though what is done is often dictated by the needs of the provider and the provider's staff. Complaints of clients about excessive regimentation, for example, almost invariably are dismissed as frivolous because they fail to reflect sufficient understanding of the undeniably real needs of the institution.

Another troubling aspect of provider paternalism derives from the professional status of those who deliver "treatment" services. Challenges to a provider's decisions on care not infrequently are construed as attacks by untutored lay people on the competence of professional staff. Physicians are most notorious for this defensive reaction, but it is a common response among psychiatrists, psychologists, therapists, counselors and social workers. Even non-professional, general-care workers in a residence or institution that provides some form of therapy, despite the utter absence of professional training, will sometimes invoke a sort of therapeutic immunity to counter any criticism of their actions.

Thus, both the nature of the population and the services offered make it difficult at times to hold providers of human services, whether public or private, fully accountable for their actions. When government monopolized direct services, public institutions were never particularly adroit in developing self-critical systems for identifying and responding

to the complaints of their clients.[12] Characteristically, it has required forces external to the system, such as muckraking journalists, crusading reformers or aggressive politicians to uncover and remedy substantial abuses in state facilities and programs through media exposure, judicial proceedings or legislative action.

Contracting for services theoretically counters the obstacles to accountability by creating a sword of Damocles out of the process for reviewing and renewing contracts. Yet it has already been seen that powerful pressures exist which make the threat of termination less than absolute. Moreover, there is every likelihood that the risk of termination will increase the private provider's anxiety to repress complaints that might jeopardize contract renewal if fully aired and shared with the supervising state agency. This suggests that accountability may be even more difficult to ensure among private providers of human services than it was when services and institutions were government monopolies.

The importance of accountability in the context of privatized human services is enhanced by the vague unease generated by the apparent conflict between providing humane services to the weak and disabled and the need for rigorous cost-effectiveness so essential to success in the cruel and demanding marketplace. The general public does not fret over the possibility that governmental employees will reduce rations or scrimp on institutional heat to increase their salaries or generate a profit; public salaries are fixed in an elaborate and eminently public process, and there are few known instances of a quest for "corporate" profit in the public sphere. The fear in contemplating the private delivery of services is that austerity may be imposed to the detriment of clients to enhance the salaries or perquisites of company officials in nonprofit organizations or to benefit company stockholders in profit-making ones. From the petty machinations of Headmaster Wackford Squeers in Nicholas Nickleby to the fraudulent career of Dr. Bernard Bergman, the corrupt and convicted nursing home magnate of New York State, our literature and history are rich with scattered confirmations of our suspicions.

The possibility, the reality of holding private providers accountable for the services they deliver is what this study is all about. It attempts to measure the ability of private entities, organized to deliver human services, to hear and respond to the complaints of their clients, as well as the capacity of supervising governmental agencies to hold their

contractors accountable for answering effectively to the needs of their clientele. While it is appalling to realize the scant attention these issues have received to date, it is not entirely surprising. The explosion in the privatization of social services has been virtually noiseless. One looks in vain for a thoughtful policy analysis of privatization that carefully weighs and balances the potential advantages and pitfalls, the costs and possible benefits of the development. Perhaps the desire to avoid a confrontation with organized public employees, or the fact that privatization is more a case of seepage than organized movement, or the pervasive lack of awareness of the extent of the phenomenon may explain the silence. Whatever the cause, there has been virtually no public dialogue or debate on the privatization of the delivery of human services. Unfortunately, given the robust dimensions of the development's growth, it now may be too late for such discussion and evaluation.

One approach to grasping the extent and tempo of the development of privatization in the human services is to look at the recent chronology, within a specific area of human services, of events and circumstances that have caused or, at least, accelerated recourse to community providers by governmental social service agencies. Doing so provides a focus not only for this initial discussion, but also for the entire study.

Background: Services for Children and Their Families

It is not easy to sort out neatly and identify the causes underlying the creeping growth of contracting in children's services. Since the early 1960s, a variety of events, developments, changes and adjustments in the field have overlapped to revise drastically service needs and delivery structures. Generally, the result has been a much reduced dependence on large, state-operated and secure residential institutions and the increased development of small, privately-run community-based residential facilities and outpatient programs.

Some early momentum for change came from growing dissatisfaction with the juvenile justice system, established in most states in the early years of the twentieth century as an independent judicial process with unique rules granting virtually absolute discretion to juvenile and family judges. The dissatisfaction came from two directions. Legal reformers were outraged at the deprivation of due process prevalent everywhere

in the discretionary functioning of juvenile courts; child care specialists were increasingly alarmed over the lumping together in prisons, training schools and reformitories of delinquent youngsters convicted of adult crimes and so-called status-offenders incarcerated for truancy, "waywardness" or "incorriqibility."

With financial and persuasive pressure from the federal government, states undertook, first, to separate juvenile from adult offenders and, subsequently, youthful status offenders from delinquents.[13] Whatever the motivation, the result has been a largely successful move to reserve traditional reformitories and training schools (which, for the most part, continue to be correctional warehouses despite the euphemistic titles) for youngsters guilty of bona fide crimes. Meanwhile, new programs, small in size, with roots in the community, began to emerge for status offenders. This process of reducing and changing the nature of the population of institutions -- deinstitutionalization -- has been underway slowly for some 14 years in children's services.[14]

Deinstitutionalization occurred on the heels of,and benefitted enormously from, the tremendous expansion in federally supported social services during the era of the Great Society. Vast new undertakings in education (Head Start, special education), mental health (community mental health centers), employment training (Job Corp and CETA), community organization (community action programs), and volunteer technical assistance (VISTA) provided local funds and resources for a burgeoning network of community organizations concerned wholly or in part with children's needs and services. In response to federal agencies' solicitations for proposals and at the behest of management specialists both in and out of government, more and more assessments of community needs for children's services were conducted. Each award of funds was dependent on the identification of needs, and each new grant included money to identify still more needs. The result was a steadily mounting spiral of needs, funds and programs.

This sudden expansion in the number of organizations and people involved in defining and delivering children's services, not surprisingly, led to a substantial increase in existing levels of awareness and knowledge about the range of problems affecting children. Educators began to understand and develop strategies for tackling learning disabilities; counselors and psychologists learned to identify and treat emotional difficulties more quickly and effectively; a shocked

public was awakened to the frightening extent of the physical and sexual abuse of children in our society. All of this has meant that the number of children and families now identified as potential recipients of badly needed assistance is vastly greater than it was 20 years ago. The services required, moreover, turn out to be singularly inappropriate for distribution through large, isolated secure institutions; what is needed are small, neighborhood-based programs and facilities. This is the environment in which experimentation with contracting by administrators of children's services has flourished. Bureaucratic structures created to administer a few institutional monoliths found it difficult to adjust to the new demands. The initial efforts of private providers tended to be small, decentralized and local. In some instances, these early beginnings have matured into thriving businesses that now deliver the lion's share of direct services in some states. More will be said later of this last development; but for now, it is enough to note that the privatization of children's services is a relatively recent development and one that is characterized by incredible variety.[15] The extent of that variety will become apparent from the description of private programs and efforts to hold them accountable that follows.

FOOTNOTES

1 For the sake of clarity, this report will use the term "organizations" when referring to privately run entities and endeavors, while reserving the term "agencies" for comparable public or governmental efforts.

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8 There is a need to define terms: Within the context of this general discussion of contracting, "social services" includes broadly all those governmental activities unrelated in federal budgetary terms to defense, entitlements or debt service. Thus, social services here includes an extremely wide array of goods and services. The social or human services that are the focus of this study, however, may be defined more narrowly; they include the direct provision of care, treatment and training or education to disadvantaged, disabled or troubled citizens. Such services may be provided in a residential setting or in community-based non-residential programs.

9 One of the private organizations reviewed for this study distributes liberally pens stamped with the corporate name and the motto: "Hard Work: Low Pay: Miserable Conditions." There may be a bit of either reverse psychology or tongue-in-cheek in this, but the motto is broadly applicable to employment in private providers of human services.

10 An example will suffice to illustrate the problem: A 9:00 a.m. to 5:00 p.m. work-day is often totally inappropriate for a community-based social services program; a work-day from 1:00 p.m. to 9:00 p.m. is more reasonable. A newly organized private provider simply makes the latter schedule a condition of employment; the state agency probably cannot make the change without renegotiating the collective bargaining agreement and knows that any concession obtained on scheduling must be paid for with reciprocal concessions.

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12 Surprisingly, more innovation in the development of complaint mechanisms has occurred probably in prisons than in any other total institution. The development may be attributable to the militancy, the strident articulateness and the sheer litigiousness of prisoners, all of which have driven correctional administrators to experiment with participatory alternatives that are anathema to the administrators of total institutions with more docile populations. But even the efforts in corrections to create effective complaint mechanisms have been only marginally successful. See, for example, David D. Dillingham and Linda R. Singer, Complaint Procedures in Prisons and Jails: An Examination of Recent Experience, National Institute of Corrections, U. S. Department of Justice, 1980.

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14 The movement has grown by fits and starts in differing jurisdictions. Much of the anticipated reduction in the size of institutions, moreover, has been offset by increasing resort to incarceration of violent juvenile offenders by legislators and judges.

15 There is a difference between privately operated and funded children's services, which have existed for well over a hundred years in many states, and services delivered by private providers under contract to state agencies. Two of the programs visited for this study, for example, had long histories as private organizations engaged in delivering children's services before they became private providers under contract to state agencies. This study is concerned only with the latter although its findings may be equally applicable to the former.

and one wilderness program. The size of reviewed programs ranged from a foster home for two youngsters to a self-contained treatment facility for 73 boys. Some facilities and programs were segregated by sex, others were co-educational; some homes were only slightly less secure than state-operated training schools, others were completely open; some facilities were located in the heart of downtown Boston, at least one was situated deep in the woods of rural Rhode Island; some programs held on to clients for years, others for days; some programs were residential only, some non-residential only and others were both.

The organizational structure and history of the facilities and programs visited were equally rich. Some were part of a sizeable private bureaucracy made up of as many as 15 separate programs in two states; some had been pioneers in the development of community corrections; some were old-line religious institutions now fully converted to state contracting; some preserved a piece of private funding to supplement their state contracts; some were part of a national corporate structure operating in many states; most were non-profit but one was the local component of a nationally known profit-making corporation; one was run jointly by state and private management; one involved nothing more than a subcontracting family that took in two foster children; some contracted with only one state agency, others contracted with several; some contracted only with state agencies, two contracted with the federal government as well; some offered only one program or service; others offered a range of integrated and diversified services.

This organizational welter was not the product of chance. Because the study represented a first effort to assess accountability mechanisms among private providers of social services, there was a strong desire to observe a wide variety of privately run programs and facilities. It would be impossible to generalize about existing means for identifying and responding to complaints among the private providers of children's services without looking at the full gamut of available services. Moreover, any useful recommendations on ensuring accountability generally among private providers must obviously be applicable to a wide array of programs with vast differences of clientele, structure and services. Thus, variety was a basic criterion for the selection of programs and facilities for review.

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By contrast, the effort to develop standards for the operation of juvenile institutions and programs has had a broader focus. Because some of the impetus for developing child and foster care standards came from national associations and groups comprised substantially of privately operated and funded organizations, the resulting work has been more easily adaptable to the emerging mix of public and private services. Unfortunately, guidelines requiring the development of accountability mechanisms did not figure importantly in early compilations of standards for children's services. The rare references to complaint mechanisms tend to reflect the needs and experience of large institutions and serve primarily as devices for internal self-monitoring. The presence of standards, however, often suggests the existence of an accreditation process, which, in this instance, led to the discovery of numerous samples of complaint mechanisms among private providers, the main features and weaknesses of which will be discussed in Chapter 5.

The chief source of data for this study was neither literature nor standards, but rather a detailed review of accountability mechanisms in 16 private providers of children's services in the Commonwealth of Massachusetts and the State of Rhode Island. The Massachusetts Department of Youth Services (DYS), which in 1970-73 became the first American juvenile correctional system to undertake the systematic deinstitutionalization of its population, and the Rhode Island Department for Children and Their Families (DCF), created by statute in 1979 to unify and upgrade a faltering system of state services for children, agreed to participate in the study and grant access to their systems and providers. The cooperation of the Massachusetts agency makes available for review a relatively mature system of privatization, the one most firmly established among state agencies in the United States involved in the delivery of children's service. The Rhode Island system, on the other hand, because it embraces a more varied range of services for children and their families, offers a broader variety of clientele and programs for review than does the Massachusetts DYS, which deals with adjudicated offenders.

The material resulting from this inspection of Massachusetts and Rhode Island private providers of children's services defies easy organization. The variety of programs and facilities observed was incredibly rich and included secure treatment facilities, community treatment facilities, group homes, shelter care programs, secure detention facilities, runaway programs, foster homes, outreach and tracking programs

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recommendations of state agency personnel were elicited and heeded. The object was to find systems and procedures that worked, to assess the reasons for their success and to share the resulting understanding widely with administrators and agencies. All of this was to be accomplished, finally, during an extremely brief period of research with limited resources.

At all 16 facilities and programs visited (eight in each state), interviews were conducted with just over 175 people, including administrators, middle managers, line staff and clients.[4] Most visits also generated a wealth of paper, documenting local services, procedures, structures, complaints, etc. The openness, candor and cooperation of every program visited was exceptional. By and large, interviewees, whether administrators, staff or clients, seemed genuinely interested in the issue of accountability and offered comments and advice freely.

State personnel in the Massachusetts Department of Youth Services and the Rhode Island Department for Children and Their Families were no less cooperative. Departmental administrators, middle managers, investigators, contract officers, monitoring specialists and hearing officers gave generously of their time and contributed both understanding and insight to the study. Whatever project staff sought in the way of records, documents, contracts or budget figures was provided promptly, subject only to the confidentiality requirement relative to the identity of clients. As the substance of the report will indicate, both state and provider personnel shared information about their failures as well as their successes. The extraordinary extent of this cooperativeness prompts a general observation.

The business of accountability in providing human services is, necessarily, a largely negative one. We are, after all, talking about holding providers accountable for the abuse of clients by staff, the failure to provide needed and expected services, inadequacies of planning and management and financial irregularities. The need for measures of accountability presumes the existence of malicious or incompetent staff and administrators. That negative bias, which inescapably flavors much of what follows, contrasts sharply with the impressions that emerged from some six weeks of interviews with nearly a hundred professionals engaged in the delivery of children's services in Massachusetts and Rhode Island. I found the people I interviewed to be decent, caring, competent, dedicated and professional -- so professional, in fact, they shared completely this study's premise about the imperative need for effective accountability mechanisms.

It has already been suggested that there are two aspects of accountability involved here, one holding the private provider accountable to clients, the other focusing on the provider's contractual relationship with the supervising state agency. Regardless of whom the accountability runs to, what we are concerned with in this study is ensuring the adequacy of services provided to children. The focus throughout this report will be on the means available to clients to express and get responses to their complaints about services, whether those means are created by providers or by their state monitors. The study is not concerned, for example, with state-created auditing processes for checking a contractor's actual expenditures against budget estimates.[5] The perspective of this study is always that of the client; how does the client communicate grievances about services, treatment, care to the provider and to the state and get meaningful responses to those grievances?

Clarity about this perspective is important because of the incredible fragmentation of accountability in the privatized delivery of children's services. Pretty clearly, in the move towards privatization of service delivery, accountability has been somewhat of an afterthought, popping up here and there in a variety of guises in response to some specific crisis, media attack, irate legislative inquiry or committee recommendation on management. A youngster in a typical private program or facility in Massachusetts or Rhode Island may have access to a bewildering array of more than 20 potential channels for the expression of grievances, if only he or she is aware of them. Amidst this erratic development of so many avenues of redress, there has been no effort to sort out and and systematize the various procedural pieces established to ensure accountability. As a result, some fragments of the accountability process are much better known than others, and dysfunctional effects occur when people begin to push their complaints through inappropriate but more readily available fragments. The emphasis on institutional abuse, for example, and the creation, often by statute, of procedures to curb it makes this a highly visible part of the accountability process. In Rhode Island the procedure for handling institutional abuse recently sank beneath the overwhelming weight of every conceivable complaint inflated and labelled as "institutional abuse" to justify inclusion in this highly visible and widely known accountability component. It may be difficult to grasp the extent of this fragmentation in the abstract, but the following analysis of the Massachusetts and Rhode Island accountability systems will help to clarify the point.

The variety of potential complaints among clients of private providers of children's services contributes substantially to the confusion. There are at least five broad categories of grievances that are likely to arise among youngsters in a residential program:

1. Physical or sexual abuse: Virtually every statewide system for children's services has instituted procedures, applicable in both state-run and private facilities, to root out instances of habitual or occasional physical or sexual abuse of youngsters by staff. In most systems, however, there is considerably more ambiguity about how to handle the abuse of youths by fellow residents.

2. Discipline and inter-personal relations with staff: This category includes those rules and procedures for ensuring control and discipline that exist in every residential program and covers everything from the use of physical restraint to the way staff address residents. Complaints in this category focus most often on the appropriateness and the fairness of restrictions or the loss of privileges imposed on clients by institutional or program staff.[6]

3. Placement: Youngsters and their surrogates sometimes contest the appropriateness of initial or continued placement in programs, or termination of participation in a particular program. In some states, either placement in or withdrawal from one's home or a community setting may be cause for complaint. Usually, but not always, these decisions are made by a state agency independently of private providers, and most procedures designed to respond to this type of complaint are operated by the state.

4. Treatment-related issues: This category of complaints applies to efforts to plan for and provide therapy, counseling, and other psychological treatment to youngsters. Frequently the most important issue in this category for institutionalized clients is the determination of when and how often they may have visits home. Complaints relative to the adequacy and quality of treatment services also are included in this category.

5. Program-related issues: All of the mundane rules, procedures and services related to a specific facility or program, as well as the way in which these are applied to individual clients, fall into this category, which includes complaints about everything from food to bed-time, visiting regu-

lations, the lack of adequate recreational facilities or opportunities, etc. These sorts of complaints are grist for the mill of an internal grievance mechanism and represent the overwhelming majority of all complaints expressed by clients. They also are the complaints most likely to be dismissed by staff and administrators as frivolous and to be left unaddressed. Systems for dealing with these kinds of complaints are often ad hoc, informal and grossly inadequate.

Obviously this typology of potential complaints is not unique to children's services; it could be applied almost as well to nursing homes, hospitals, institutions for the mentally disabled, homes for the retarded or any other facility or program for the delivery of human services. Equally obviously, much of the description and analysis that follows is applicable to private providers in fields other than children's services. The problem of accountability, while it may vary somewhat according to the services provided and the clientele served, is essentially the same in all of the human services. This, incidentally, is true whether the governmental agency contracting for services is a federal, state or local entity. Privatization of human services is expanding rapidly at every level of government.

Two final characteristics of the client population that is the object of this study need to be noted before plunging into a discussion of accountability mechanisms. One is the wide diversity in the level of sophistication of clients of children's services. The age of interviewed clients, for example, ranged from eight to 18. Some interviewees were illiterate, while others were enrolled in college courses. I found one 10-year-old who might qualify easily as a jailhouse lawyer. Some older residents, on the other hand, were virtually mute. This mixture poses a severe challenge to the design of effective accountability mechanisms because it limits reliance on client-initiated processes for identifying and pursuing grievances. If some clients are incapable of articulating their complaints or are too intimidated to do so, then accountability requires the development of some effective means of reaching out to include them.

The second characteristic to be noted also affects the design of appropriate accountability measures. With the exception of interviewing and research in adult prisons and jails, I have never encountered another population among which distrust of staff is so pervasive. Evident especially among older youngsters with long exposure to state-provided juvenile ser-

vices, the antagonism expressed itself in the melancholy conviction that just and fair treatment is neither a goal nor a possibility. From the point of view of accountability, the damaging corollary to this conviction is the suggestion that it is pointless to complain because nothing will be done or, worse, it is dangerous to complain because the system will retaliate.

While both of these characteristics increase the difficulty of ensuring effective accountability among private providers of children's services, they also underline the need for and the importance of such accountability. It is time now to assess the efforts of Massachusetts and Rhode Island to meet this need.

FOOTNOTES

1 Two court cases involving state-run facilities for children, Wyatt v. Stickney, 344 F. Supp. 373 (M.D.Ala. 1972) and Morales v. Turman, 364 F. Supp. 166 (E.D.Tex. 1973), inspired considerable legal comment on judicial efforts to hold malfunctioning bureaucracies accountable for the implementation of comprehensive remedies. The federal court in Alabama created a controversial "human rights committee" to oversee implementation of changes in state facilities for the mentally disabled, primarily juveniles; the court in Texas appointed an ombudsman to monitor compliance of the state juvenile system with mandated reforms. These extraordinary judicial devices were created to correct abuses in particularly egregious state-operated institutions and have little applicability here.

Judicial findings and media exposes led in the 1970s to the development of a variety of procedures and offices for monitoring the operations of state-run facilities for children, such as the New York State ombudsman program for juvenile institutions (now defunct) and the Minnesota correctional ombudsman. These same developments led, in a number of states, to the creation of advocacy groups, offices, or individuals to represent institutionalized children and to monitor agency handling of allegations of institutional abuse. More will be said of these efforts later; all were designed as watchdogs of public agencies and institutions.

2 Seen but Not Heard: A Survey of Grievance Mechanisms in Juvenile Correctional Institutions, J. Michael Keating, Jr., et al. prepared for the Institute of Judicial Administration and the American Bar Association, October, 1974.

3 See, e.g., Allen F. Breed, "Administering Justice: Implementation of the California Youth Authority's Grievance Procedure for Wards," 10 Loyola of Los Angeles Law Review 113 (1976); J. Michael Keating, Jr., "Arbitration of Grievance Procedures," 30 Arbitration Law Journal 177 (1975); and John R. Hepburn, James H. Laue and Martha L. Becker, To Do Justice: An Analysis of Inmate Grievance Resolution Procedures, prepared for the National Institute of Justice of LEAA, 1978.

4 Appendix A contains a description of each of the facilities and programs visited and a brief list of the accountability mechanisms available in each. Appendix B. provides the interview protocol used during the visits, including the questions posed to each constituency. The original intention was to administer a questionnaire to clients in each program, but the age and literacy of clients made administration of the instrument logistically unfeasible. To compensate for loss of the questionnaire, more client interviews than originally scheduled were conducted.

5 This is not to suggest that financial integrity and cost-effectiveness are not extremely important aspects of accountability. They simply are not the focus of this study.

6 The complaint I heard most frequently from clients during my survey feel indirectly into this category; it dealt with the double standard applied by staff to house rules governing such things as smoking, language, feet on the furniture, etc. Staff enforced such rules rigorously against residents, so the complaint went, while regularly violating them themselves. Each such complaint, it need hardly be added, was delivered with a strong measure of resentment and cynicism.

Chapter III

ACCOUNTABILITY IN MASSACHUSETTS

The Massachusetts Department of Youth Services traces its lineage to the opening in 1847 of the Lyman School for Boys, one of the first institutions exclusively for juvenile offenders in the United States. That event, confirmed by the establishment of a juvenile court system in 1906, marked the beginning of the creation within the Commonwealth of a separate track of treatment for youthful offenders. The post-World War II years brought a period of expansion and frequent structural adjustment for the present department's predecessors that gave way by the 1960s to increasing concern over harsh conditions in the department's now numerous institutions. A rising tide of public and legislative criticism led to the resignation of the long-time administrator in 1969, clearly a watershed year for the department, during which, in addition to the departure of the old director, a new structural entity, now formally designated as the Department of Youth Services, was created by statute and Jerome G. Miller was appointed as the new agency's first Commissioner.

Frustrated in meeting his mandate to reform institutional conditions, the new Commissioner, amidst a swirl of controversy, proceeded in short order to close down five major state institutions and three county training schools. While much of the rest of the nation debated politely the evils of over-reliance on the institutionalization of juveniles, Massachusetts suddenly found itself deinstitutionalized. The wrenches involved in that administrative coup d'etat have never been forgiven or forgotten in the Commonwealth. When the convulsion was over, institutions were largely gone, as was Commissioner Miller, and a wild scramble was underway to develop community-based residences and programs for youngsters. In 1974, legislation transferred jurisdiction over status offenders out of DYS, leaving the department with a substantially reduced population, consisting almost exclusively of adjudicated delinquents.

In the aftermath of deinstitutionalization, DYS was virtually reconstituted. The abrupt change in the structure of service delivery from an institutional to a community base could not be carried out with existing resources. With generous financial support from a then flush Law Enforcement Assistance Administration of the U. S. Department of Justice, DYS

reached out frantically to private providers in the general community to deliver a wide range of services. The department, together with state purchasing and budgeting agencies, scurried to develop appropriate regulations and procedures to meet the new situation and impose a measure of control over the movement even as it developed and accelerated. By 1979, DYS was struggling to manage over 130 contracts with private providers; the contracting office within the department employed 17 workers and was empowered, uniquely, to overobligate departmental funds. That same year marked a peak in the chaos and unruliness attendant on the growth of privatization in DYS; thereafter, departmental managers began successfully to reorganize, consolidate and control the wild proliferation of providers and provider contracts.

During the past tumultuous decade the framework for the care and treatment of juvenile offenders in Massachusetts has been radically restructed. Completely gone are the large old reformitories and training schools. DYS currently runs a forestry camp for boys with a capacity of 50 beds; the next largest facility in the department can handle a maximum of only 28 boys for limited periods. Of the some 40 residential facilities and programs in the state, only eight have a capacity of over 18 youngsters; the typical residential program today, whether a treatment, detention, group care or shelter facility, includes no more than 12 residents. In the world of juvenile corrections, small may not be beautiful, but it is, in the consensus of virtually every expert in the field, better. How much better depends, of course, on the ability of administrators and staff, now largely employees of private providers rather than the state, who run these residential programs for the department.

What all of this means is that deinstitutionalization has not ended the use of institutions for juvenile offenders in Massachusetts. Rather, the change has resulted in an institutional restructuring that replaces traditional training schools with small, urban-centered residential programs, often integrated with community-based educational, vocational employment and treatment resources. Massachusetts, moreover, no less than other states, has witnessed recently the increased public outrage over juvenile crime and experienced a growing demand for stricter sanctions with the inexorable pressure for greater use of incarceration. So far, the department has met much of this demand by relying on the private sector to set up and operate more small residential facilities, although the pressure on DYS to build or acquire new institutions of its own has been intense and irresistible.

A second remarkable change, reflecting more closely the intended impact of deinstitutionalization, is the extent to which much of the DYS population is no longer institutionalized at all. One by-product of the restructuring of the department was the evolution of a model, called "outreach and tracking," for the provision of intense supervision and increased services for adjudicated youngsters in the community. The model provides for close monitoring according to a prearranged schedule of meetings and phone calls of youths who live at home, in a foster home or independently. The model was pioneered by a private organization, the Community Aftercare Program, whose present descendant, the Key Program, runs similar or related programs in some 200 Massachusetts communities. A number of variants of this model allows the overwhelming bulk of the population supervised by DYS to remain firmly rooted in the community.

The department's effort beginning in 1979 to consolidate and systemize contracting has reduced chaos to order. A streamlined contracts office manages the department's purchase of services under taut regulations developed by the Executive Office for Administration and Finance for all of the Commonwealth's human service agencies. In addition, financial arrangements with providers are subject to individual review and general oversight by the Rate Setting Commission, which establishes fixed rates of compensation for "units of service" for all social services providers under contract to the Commonwealth.

One striking aspect of the department's consolidation effort has been its impact on providers. The number of service contracts awarded by the department was reduced by nearly half to under 75, in part to realign contracts with the new regional organization of the department and in part to weed out marginal performers. The result is that fewer contractors are providing more services. Among the 40 private providers currently working for DYS, eight account for 50 per cent of all existing contracts (37 of 73 contracts).[1] While this does not yet represent a stampede in the direction of oligopoly, it is a trend that bears watching. We probably should not be surprised that the privatization of social services assumes a shape so characteristic of privatization in other fields unrelated to human services. One curious note to this development is its occurrence despite the department's inability to do business with profit-making contractors.[2] Non-profit organizations, it appears, respond no less than their profiteering kin to the call of the marketplace.

There is a final need to put this trend toward privatization in some sort of budgetary perspective before pushing on to the issue of accountability. Since consolidation of contracting in 1979, DYS has served as a conduit to private providers for between 60 and 65 cents of every dollar allocated to it by the Commonwealth. In a departmental budget that has now grown to $30 million annually, approximately $18 or $19 million goes each year to private providers of social services to children under contract to DYS. That percentage has remained relatively constant over the past five years. The stakes, then, in holding private providers accountable for their activities are substantial.

Accountability, for the purposes of this study, comes in varieties:

1. Accountability for the effectiveness of the services provided: does whatever the provider do for the client really work? The measure of effectiveness applied most often is recidivism, expressed usually in terms of how often and how quickly a youngster exposed to the department's purportedly rehabilitative influence commits some new offense once he or she is "released." Recidivism as a measure of effectiveness has its detractors since rehabilitation has proven an extremely elusive goal in both juvenile and adult corrections. Few providers, public or private, lay claim to possession of any sure rehabilitative formula; most providers of services to delinquent youth simply do what they can and hope for the best. Providers and critics of recidivism as a measure of effectiveness point to advances in schooling, the acquisition of a specific vocational skill, the procurement of a job and the accumulation of a small financial stake as more meaningful and realistic measures of their work. Recidivism continues to dominate as a measure of accomplishment because it has on its side both tradition and the appearance of quantitative certitude, a tough combination to depose.

Recidivism may have its weaknesses as a measure of the effectiveness of services provided to troubled children, but at least it is a measure of some sort. Providers involved in the delivery of services, for example, to the terminally ill, to the old, to the mentally disabled and to the retarded often have no such measure at all. This, of course, is one of the core problems of social services; we know so little about both human psyche and physique and their operations that we rarely understand what works and why it works. The little we do know fits uneasily in an institutional setting, which frequently has

a damaging dynamic all its own. The result is that there are few universally accepted standards for judging with any measure of accuracy the effectiveness of human services. This study, obviously, is not prepared to tackle so quixotic an endeavor as attempting to define such standards.

2. Accountability for the expenditure of funds: Contracts for services require providers to deliver enumerated programs for specified sums of money, expressed typically in the contracts under scrutiny in this study in terms of a daily rate paid for care in a residential setting delivered to youthful clients of DYS by the hired providers. The auditing measures established by state agencies to ensure that contractors expend state-provided funds for authorized purposes only and in accordance with submitted budget estimates, likewise, are not the object of this study. This is not to suggest that auditing practices and procedures are unimportant; they frequently provide the first clue to a provider's difficulties, whether caused by mismanagement or fraud, that can have a direct and devastating impact on clients, and no governmental agency can hope to utilize contractors wisely without an elaborate auditing process. Because recognition of the need for effective auditing systems is so prevalent, however, and the knowledge for creating them readily available, this study elects to pass over this particular accountability measure to focus on another, the need for which is generally unappreciated and about which there is so little understanding.

3. Accountability for the delivery of services in a professional and humane manner: This measure looks at whether a provider actually delivers general and specialized care competently and in a way that respects the individual integrity and dignity of each client. Assuming that the outcome of the services rendered, however that may be defined, is at least acceptable and assuming, further, that the provider is at least marginally proficient and honest with public funds, how do we ensure that private providers, for whatever motive, do not abuse, mistreat, harm, tyrannize, intimidate or neglect the old, the sick, the mentally disabled and the young entrusted to their care? It is this measure of accountability that the special nature of the typical human services clientele and the professional and institutional paternalism of providers make so hard to fashion and implement. Yet, accountability in this regard is, perhaps, the most essential measurement of all.

The Massachusetts DYS provides this last sort of accountability in a process so fragmented and diverse it can

hardly be called a system for accountability at all. Because the fragments tend to coalesce at different levels and places among the involved entities, the framework for the ensuing analysis will focus on the primary location of each separate accountability mechanism. Thus, some of the fragments exist and may operate in private providers, while others may be located primarily in the supervisory state agency (DYS) or in state agencies other than DYS or, finally, in a potpourri of governmental and public forums external both to providers and executive agencies. From the descriptions that follow, it will become clear that some of the described mechanisms overlap in a variety of ways that defy the neat compartments catalogued here. For example, most accountability measures within DYS, although designed and operated by the department for departmental purposes, require providers to submit reports, forms and other data in order to function. The categories simply suggest the primary locus for mechanisms that often require input from a variety of organizational and agency levels.

A. Provider Mechanisms for Accountability:

With the exception of one outreach and tracking program in Massachusetts, all of the facilities visited for this project were total institutions; they all provided residential care for troubled youngsters deemed to be in need of supervised treatment and care. Whether placed in a foster home or in a large group care facility, the young DYS clients, in some sense, were isolated from their normal community environment while contractors exercised extensive control over them and offered various forms of assistance.

Inevitably, given the intense nature of the relationship between clients and providers, the accountability mechanisms established by providers are fundamentally important. Providers supply several such mechanisms, a description of which follows, although they rarely think of them as accountability mechanisms at all:

1. Informal procedures: Although written formal complaint mechanisms were virtually unknown among providers, they all possessed some sort of informal system for processing grievances. Everywhere, interviewed staff and residents reported that unresolved complaints, brought initially to a child care worker or some other member of the line staff, could be appealed informally to a supervisor, to an administrator and, finally, to the director of the program or residence. In view of the small size of the facilities and programs operated by

providers, the hierarchical organizational structure prevalent among them and the extremely high ratio of staff to clients,[3] the evolution of this type of informal, multi-tiered procedure was probably inevitable. It is axiomatic among knowledgeable designers of institutional grievance mechanisms that the smaller the size of a facility and the higher the staff-resident ratio, the less the need for and incidence of, structured, formal grievance procedures.

All of the administrators and staff interviewed evaluated their informal processes for the handling of complaints as entirely adequate. Most could cite some examples of specific complaints dealt with expeditiously by this means. All expressed themselves certain that youngsters knew about and used the informal processes often. Some lamented that residents occasionally abused informal processes by attempting to avoid some levels of review or to "jump channels." Staff indicated that whenever a complaining client skirted an appropriate individual or level, he or she invariably was directed to the by-passed step. Finally, some administrators admitted candidly that they rarely would reverse the resolution of a complaint formulated by a subordinate staff member because to do so would undermine staff's authority.

The complaints submitted to this informal process tended most often to involve minor discipline, i.e., the imposition by staff of local, brief punishments or restrictions for minor infractions of the "institutional penal code." Even when discipline was not involved, complaints funnelled through this informal system usually concerned the way in which staff applied program rules and regulations to individual youths. The grist for this complaint mechanism, then, was the daily, grinding interaction between staff and youngsters.

The perceptions of clients about this informal process differed sharply from those of staff. Almost always the clients focused on the attitude and behavior of one or two specific staff members, whose treatment of clients was viewed as arbitrary, capricious and disrespectful. Clients expressed the conviction that complaints pursued through this channel about such staff members were rarely, if ever, acted upon. Supervisors and administrators were perceived as totally unwilling to uphold clients against staff even when it was apparent that staff had acted unprofessionally and exercised poor judgment. Not all, but most youngsters expressed the conviction that complaints about house rules or resources expressed through informal channels were heard willingly enough,

but rarely, if ever, did they produce any acceptable resolution that was actually implemented. Because this was their experience with informal processes recounted by most residents, they tended to characterize such mechanisms as "useless," and a "waste of time." The cynicism implicit in this judgment was strongest among older clients with long exposure to DYS institutions and programs and may have reflected either growing personal alienation or legitimate frustration with the repeated shortcomings of the system.

For all of their complaints about informal mechanisms, residents confessed readily to a knowledge of the existence and operation of these processes. Clearly, too, clients had easy access to supervisors, administrators and even the directors of programs, and most cited such access as their first recourse in the event of any sort of serious problem with rules or staff's application of rules to them.

2. Formal procedures: Three of the facilities visited in Massachusetts, the only three of all 16 facilities and programs reviewed for the study, possessed a formal, written grievance procedure.[4] The procedure, adopted during an accreditation process to meet American Correctional Association standards, was little more than a formal version of the informal process described above. Under the procedure, an aggrieved resident, failing to resolve his complaint with a staff member informally, can obtain the assistance of a representative on the resident committee, a sort of house council, and seek to work out a resolution formally with the involved staff member. In the event of failure, the resident submits a written complaint to the staff member's supervisor, who is obligated to hold an adversarial hearing within five days and furnish a written response with reasons within two days of the hearing. If still unsatisfied, the grievant may submit an appeal in writing to the program director, who, at his or her discretion, may repeat the adversarial hearing and, again, must render a decision in writing within two days.

The merits of this particular procedure are irrelevant for the purposes of this study because the process is not used. Neither staff nor residents could recall a single instance in which the written procedure had been invoked. Interviewed residents were startled to learn of its existence, despite the fact that the policy embodying the procedure was posted prominently on the main and highly visible bulletin board in each of the three facilities.

In all three of these programs, the informal process was readily available; all had ten or fewer residents; all allowed residents daily access to supervisors and the director. There was no perceived need for following an elaborate process involving the preparation of written complaints and the holding of adversarial hearings when a resident could corner the director in the hallway and get a response almost instantly. The only value served by such a process would be to document efforts to seek relief for some reviewing body, but under the terms of the policy, the director's decision was final; the procedure called for no reviews at corporate or state agency levels.

3. Open-door policy: This avenue for the expression of grievances is included with some misgivings. Not only is the term redolent of the hypocrisy of much of industrial management in the 1930's, it is also, to some extent, repetitious of the first accountability mechanism described above. It is included here because interviewed youngsters repeatedly expressed their conviction that they have remarkably free and easy access to the people who run their programs. Coming from clients, this is encouraging confirmation of the ability of existing informal procedures to allow the expression of complaints.

4. Case-management process: In response both to court and professional child care requirements, an elaborate system for the diagnosis and treatment of youngsters has evolved in DYS and other agencies involved in children's services around the country. This system typically involves a multi-disciplinary team of experts in psychology, vocational training, education and child care that initially evaluates the vocational and therapeutic needs of an individual youth and prescribes a regimen of services to meet those needs. Progress in following the recommended regimen is reviewed periodically by caseworkers for the state agency or the private provider or both. Ideally, both the affected youngster and his or her family participate in the planning and at least some of the reviews.

The treatment approach encountered most frequently in the facilities and programs visited for this study was reality therapy,[5] often in combination with a patina of behavioral modification in the form of contracting within a multi-tiered framework of enhanced privileges and status, rewarding positive behavior. Planning and contracting together generate a process heavily freighted with paperwork and a multiplicity of

conferences. Typically, a caseworker or counselor employed by the provider will meet on a scheduled basis with each client; similarly meetings with family or with a caseworker from the state agency may be scheduled at regular intervals.

When it works, the case management process presents opportunities for youngsters and their surrogates to express their complaints about the services of providers. Many of the interviewed directors of private providers expressed their strong reliance on case management meetings for surfacing clients', and particularly parents', complaints. When youngsters, parents and agency (DYS) caseworkers all participate, the meetings can be especially useful in encouraging the resolution, as well as the expression, of complaints. The DYS caseworker, as an agent of the supervising state entity, provides a powerful incentive for successful resolution of complaints raised either by youths or their parents in conferences.

The weakness of this process is the limited extent in practice to which departmental caseworkers and parents actually participate in scheduled meetings, an occurrence that varies wildly among programs, and within programs, among individual caseworkers and parents. The difficulty with parents identified most often by administrators and social workers of private organizations was not the problem of dealing with the grievances expressed on behalf of their children, but simply getting the parents involved in some positive way with youngsters' treatment and care. According to interviewed staff and clients, regularly scheduled meetings between provider and DYS caseworkers, youngsters and parents have proven to be the exception rather than the norm. Even when they occur, the focus of such meetings tends to be the therapeutic progress of youths, some of whom report hesitation in voicing grievances lest they be perceived as unrepentant and unreformed.

At best, then, the case management process is of only limited use as a means for identifying complaints and ensuring effective responses. The case management process was never intended to serve as a grievance procedure, and its limited usefulness for such a purpose should not be surprising.

5. Assignment of a prime counselor or child care worker to each client: Most private providers make sure that each youngster in their program is assigned to a specific caseworker, counselor, advocate or child care worker, who meets with that youngster at least weekly for a minimum period of time to determine whether the client is experiencing any par-

ticular difficulties or problems. So long as a youngster's problems do not involve the very caseworker or child care worker assigned, this measure assures each youth of a regular opportunity to express complaints to a staff member. Interviewed clients down-played the importance of this opportunity and viewed the arrangement as a normal, functioning part of the informal process within a program for handling complaints. It simply provided access to the informal process on a regular schedule.

6. Regularly scheduled house or residence meetings: All five of the group care facilities visited in Massachusetts (as opposed to the detention facility, the foster home and the outreach and tracking program) featured regularly scheduled meetings of all residents, the director and other available staff. The meetings occurred weekly in most programs; the agenda was relatively free flowing, and complaints about rules, regulations and resources, if not encouraged, were widely tolerated. One program allowed clients to raise any subject or complaint at the weekly meeting, providing only that the names of allegedly offensive staff were not used by carping residents. This allowed the program director to return to staff with general admonitions not couched in specific allegations against any one individual.

Staff and clients alike had mixed reactions to the usefulness of these house meetings. Several interviewees could recall specific policies or conditions rectified as a result of complaints repeatedly raised in these meetings. In one program, persistent complaints at weekly meetings led to the discharge of a particularly gross cook. On the other hand, the meetings could be cantankerous affairs and, in some programs, staff were happy to find excuses to cancel or postpone them. Clients found the meetings generally useful especially as a place to articulate grievances with support from other residents, but some complained that the issues raised at meetings frequently were not resolved expeditiously. On further probing, it turned out that these unredressed issues most often involved the expenditure of funds for such things as more and better food, cooking equipment, recreational equipment and weekend excursions. The "indifference" of staff to these complaints often reflected the fiscal reality of extremely tight budgets.

These convocations of the full house membership served both therapeutic and managerial functions. Savvy program directors used them to inform, to anticipate problems, to

assess the mood and needs of clients and to foster a sense of participatory management and responsibility. Their accountability functions were viewed as secondary, but they were seen as extremely useful for identifying causes of complaint and weighing the extent of dissatisfaction among clients.

7. Resident councils: Two programs visited for the study possessed a framework for clients' participation in the management of their residences in the form of a resident executive committee, a body composed of clients and entrusted with a measure of control over house operations.[6] In both facilities, the machinery for client management was in some disrepair, and the committees were largely moribund. Staff talked of revival and cited the lack of client leadership as principal reason for the committees' current decline. Residents expressed indifference to the absence of the formalities of the committees and looked to the weekly house meetings for discussion of issues important to them.

The constant turnover in so small a population makes the maintenance of a resident council structure difficult. The size of the programs, both have ten or less residents, also militates against a representative machinery; after all, everyone has direct access to the chief executive of the program and the right to participate directly in weekly meetings. The council idea may simply be redundant in so small a universe.

8. Provider board of directors: Virtually every non-profit provider of services sports a large and varied group of directors recruited from all walks of community life to assist the professional staff in the development, funding and running of the organization. Some such boards of directors are encouraged to participate actively in the life of the program or the corporate provider, to visit facilities, to talk with staff and clients, to evaluate and critique programs. When they do so, directors can became a useful "outside" resource, ready to hear and investigate the problems and complaints raised with them by staff and residents. Unfortunately, this model for a board of directors is exceptional; most meet infrequently and endorse in a trance the organization's activities. The device is suggested as an accountability mechanism because both staff and residents in one program visited for this project mentioned specifically their contact with board members, which they viewed as providing a useful outlet for the expression of complaints. Certainly, such an aspect is peripheral to the traditional role of directors and external to normal complaint processes.

9. Corporate provider monitoring: One aspect of the growth and consolidation of private providers in Massachusetts is the development of a corporate bureaucracy among larger providers that parallels the structure of the supervising state agency. Each of the three corporate bodies[7] responsible for the programs reviewed in this study had central offices with a wide range of administrative responsibilities, including control over personnel, budgeting and finance, contract development and management, purchasing, public relations, legal affairs, etc. The Key Program, for example, which has a unique personnel policy limiting the tenure of child care staff to 14 months, conducts annually an aggressive recruiting program on college campuses to replenish departing staff and runs the large training effort required by this policy at its Framingham headquarters. Each of the three corporate providers prides itself on its management capabilities, which may include sophisticated computer technology, the latest innovations in employee motivation or elaborate goal-setting and planning techniques. One senses in meetings with these corporate managers the development of a refreshingly new hybrid of public servant and entrepeneur, interested as much in the human side of the services they sell as the challenge to their management skills.

Inevitably, part of the function of these new bureaucrats is to monitor and supervise the facilities and programs operated by their company for DYS. In the case of the Robert F. Kennedy Action Corps, it was central office personnel, as well known to some residents as local staff, who heard and responded to the grievances of residents at the Fay Rotenberg School, a secure treatment facility for girls, about excessive use of shackles. The policy was reviewed and changed as a result of that intervention. Despite this example, however, none of the providers to date has developed any formal, written mechanism for accountability running from individual programs to the corporate central office. This represents an opportunity most unfortunately lost, for no one has a greater stake in the development of effective means for identifying and resolving clients' grievances than corporate providers.

This, then, is the array of channels for redress supplied by providers to clients with complaints. More than anything else the list demonstrates the ad hoc nature of providers' responses to the need for accountability. Providers have not yet undertaken the task of analyzing the services, structures, programs and personnel involved in the delivery of residential care to youngsters to decide how best to create and

integrate effective accountability mechanisms. The results reflect this poverty of effort. The scene, alas, is not much different among state agencies charged by law with the task of monitoring private providers.

B. State Agency Accountability Mechanisms

Because state agencies like DYS have been around much longer than most providers, the processes they have developed for ensuring accountability tend to be more complex and ornate. They are no less fragmented and perform only marginally better. In addition, they, too, betray a history of episodic and uncoordinated responses to specific crises.

1. The contracting process: As with most state agencies, when DYS wishes to initiate a new program or facility by contract it issues publicly a request for proposal (RFP) setting out the programmatic specifications the provider must meet. Whomever DYS selects as a result of the bidding process, the winning provider can expect a three-year lease on the life of the new program, barring some terrible gaffe on its part. Although there is an annual review of the contract, it is conducted internally by DYS, which is not obligated to return to the competitive bidding process for three years.

With responsibility for the launching of all new contracts, some 25 a year, and renewal of 73 existing contracts DYS contract personnel, including a supervisor, two managers and three auditors, are busy people indeed. Since 1979, review of program elements has been shifted elsewhere, so the major concerns of contracts people are the administrative and fiscal aspects of renewal. The input of regional program managers and budget personnel set pretty firmly the parameters for renewal so the annual negotiations tend to be limited. Once terms are agreed to with a provider, the renewal process becomes a long march through the state bureaucratic maze.

In all of this, there is little room for accountability. The sheer volume of business and stretched resources mean that the relationship between department personnel responsible for contracts and providers is a friendly and supportive one. Occasionally DYS personnel will even provide technical assistance to providers with administrative difficulties. The basic purpose, then, of the contracts administration function is to facilitate the granting, operation and renewal of contracts while assuring that all applicable state and agency purchase-of-service regulations are complied with. Obviously,

clients in a provider program with a complaint about services are unlikely to find much solace among DYS contract personnel nor indeed are they likely to look for it. For all of that, it is the contracts office that issues the pink slip to disengaged contractors or, if you will, lets slip the contractual sword of Damocles. The last, however, represents more of a ceremonial finale than a substantive decision, which is made elsewhere in the department.

2. Program review: Within the DYS Support Services Directorate, a small office carries out the function of program review, which used to be part of the contracting process until the 1979 reforms. Because of the size of the unit, two full-time staff members and occasional part-time draftees from other offices, there is no question of reviewing the programmatic aspects of all contracts. Instead the office looks at programs with problems identified by regional and district administrators or the deputy commissioner; or at expensive programs ripe perhaps for a trimming to help meet budgetary pressures on the department; or at programs not plagued by problems that are targeted for review for a variety of reasons by regional directors. There are no regularly scheduled reviews of programs on either a rotational or random basis.

Once a facility or program is selected for a critique, program review staff will contact key agency personnel who deal on a daily basis with the targeted program both to obtain some advance information and, if possible, to narrow the scope of the review. A team of staff will be assembled to visit the program, review a variety of files and interview staff and clients. The interviews, formulated on the basis of applicable American Correctional Association and American Bar Association standards, are structured, long and detailed. Based on the team's findings the program review office will issue a report on the strengths and weaknesses of the program. If appropriate, it may recommend remedial steps for deficiencies it has uncovered to the contracts officer or the deputy commissioner. On occasion, contract renewals have been made contingent on compliance with program review recommendations.

Thus, reviews, when they occur, are thorough, competent and professional. No mere superficial probing, they are detailed and comprehensive evaluations of contractors. The trouble is that they are too few and can be initiated only by agency administrators, who are, alas, frequently the last to be aware of disasters that are fermenting in a foster home or small group care facility in the field.

3. Field supervision of contractors: Within the administrative structure of DYS, there are five regional directors with supervisory responsibility for local community programs and departmental caseworkers, as well as three district supervisors who oversee the department's institutional operations and contracts. This decentralization of middle management functions means that DYS administrators are physically close to field activities, at least in the case of regional directors, and their relations with individual programs tend to parallel those of corporate providers to their separate programs or units. Because, however, the scope of responsibility of the local DYS supervisory personnel is far larger, their presence in programs and units is less visible than that of their corporate provider counterparts, at least among staff and residents interviewed for this study. Administrators of private provider programs acknowledged regular contacts with local DYS officials, especially in regard to the processing of incident reports, the principal departmental means for identifying provider problems and alerting DYS personnel to past and potential crises. Interviews also hinted at a discernible, though not verifiable, tug of war between departmental supervisors in the field and corporate provider representatives, who desired to serve as the primary conduit for contacts between DYS and individual programs of the corporate providers. If such a subliminal struggle exists, DYS seems, thus far, to be firmly in control.

Even this brief description of local DYS middle management involvement with contractual programs suffices to demonstrate that it is primarily reactive in character. This does not mean that local DYS personnel do not ever spot and anticipate problems; occasionally they do and their assistance in these instances can be invaluable. Nonetheless, regional and district supervisors do not conduct regular, intensive reviews of program activities; that is the role of program review personnel. They do, however, demand, participate in and scrutinize closely investigations of irregularities that occur in programs within their jurisdiction, irregularities that come to their attention most often through either the incident reporting system or their network of DYS caseworkers.

4. Incident reports: Pursuant to Commonwealth statutes relative to the reporting of abuse of children,[8] and in response to the need for the immediate information on a wide range of serious incidents, DYS has created a reporting system applicable to all facilities and programs, including those of private providers. DYS policy requires the submission of a

written incident report whenever an untoward incident occurs. In nine enumerated instances, including[9] allegations of staff abuse of residents, information about the incident must be relayed immediately by telephone to an appropriate DYS middle manager and an incident report mailed within three days to the provider's local or central office supervisor; in all other cases, i.e., those not on the enumerated list of serious incidents, the report must be completed and filed in the program or facility's permanent file.

These incident reports are the lifeblood of the department's system to monitor operational activities. They single out for regional and district personnel programs or facilities with persistent problems; they may be a trigger for initiating broad, detailed program reviews; they can lead to a probing investigation of specific occurrences or individuals; and they are the principal continuing source of information about field units for local administrators and central office staff.

Needless to say, these incident reports always are initiated and written by staff, with the concurrence of an immediate in-house supervisor. They represent, thus, a one-sided and potentially self-serving version of the events that have occurred. This right of authorship confers on a staff member or program desirous of down-playing an incident ample opportunity to do so with relative impunity because it is the incident report itself which is likely to determine whether further investigation occurs. The opportunity is circumscribed only by the existence of other avenues of complaint for the clients involved in the misrepresented or suppressed incident.

5. DYS investigations: Directly under the commissioner in the department's organizational table is the chief investigator, whose task it is to investigate on behalf of DYS a wide variety of alleged abuses. The investigator is a busy individual, handling some 80 to 100 investigations a year running the gamut from alleged rape to possession of a gun. Directives or requests for an investigation from the commissioner, the deputy commissioner, assistant commissioners for aftercare and facility operations or district supervisors activate the investigative process. Relying on his experience as a police investigator and his understanding of DYS, the chief investigator himself digs, explores and interviews in order to determine the truth about alleged infractions and abuses. On occasion, his findings, once reported to the commissioner, have resulted in the termination of a foster home

and the discharge of private provider staff. He has never recommended non-renewal of a private provider's contract, however, analogizing that to the folly of chucking out "the baby with the bath." The focus of a particular investigation might be a specific incident, an element of the program or some financial irregularity. Upon completion of his investigation, the investigator submits a report to the legal counsel, his organizational superior, for general review, before taking it to the appropriate administrator, normally the one who sought the investigation in the first place.

The investigator's task is large but his resources small. He does all investigating himself; he has no professional staff. His function is purely reactive; he can respond only to requests from other managers. He has no authority to initiate his own investigations, much less the manpower to do so. Among staff and clients interviewed for this project, I found several whom the investigator had talked to in the course of one of his inquiries. Outside of this limited number, I could not find a single client who knew the chief investigator by name, office or function. None viewed him as a resource to which a client with a difficulty or complaint might nave access.

6. DYS caseworkers: Youngsters in the DYS each have a departmental caseworker assigned to shepherd them through the system from court-directed entry and initial placement until exit from the department's supervision. As with caseworkers filling similar roles around the country, caseloads are extremely high and the demands on each caseworker's time extraordinary.

When DYS caseworkers do their job well, they contribute much to ease a youngster's passage through the system by acting as a constant advocate and friend with the court, with providers and with parents. The caseworker's role in the procurement of aftercare services and placement in the community is critical; they can sometimes provide invaluable, steady counseling as a youngster wanders through a veritable kaleidoscope of departmental programs and personnel. They are almost always the main bond between youngster, parents and the department and usually represent the department to the family.

Based on the evidence derived from interviews with staff and clients in private provider programs for this study, most DYS caseworkers meet the demands of the role just outlined. On the other hand, some do not. Just under half of all youngsters interviewed claimed not to have seen their DYS case-

worker within the past month; several said they never saw their caseworkers at all except at court appearances. Each description of a warm, caring caseworker deeply involved in the progress of a client was offset by recounted instances of indifference and callous disregard, of failures to return telephone calls, of unexplained missed meetings, of delays in the processing of paperwork, of leaving youngsters awaiting transportation stranded.

When asked to comment on this mixed performance, one DYS administrator noted the autonomous nature of casework in the department. Caseworkers are not closely supervised because they cannot be; it is nearly impossible to nail a shirking one down. This means that they must be self-starters, answerable only to their own internal values and commitments. Not surprisingly, the responses vary widely from person to person. This variety of response is critical from the standpoint of accountability. Caseworkers are the only DYS personnel with regular, direct contact with clients entrusted to the care of providers. As such, they represent the department's only clear "window-in" to the daily operations of providers. Conversely, for clients, caseworkers are the only representatives of DYS, outside of providers, to whom youngsters have ready and regularly scheduled access. Thus, caseworkers are a vital accountability link between the provider and the department; they are, for example, the only source of regular, repeat information the department receives about a provider that is not supplied by the provider itself. It is their reports of problems and difficulties in provider programs based on interviews with their clients that filter up through immediate supervisors to regional and district administrators and create the unease that can prompt a request for a program review or an investigation. The regular presence and interaction of caseworkers with clients in a private provider's program is also a powerful prophylactic against the filing of self-serving and dishonest incident reports by providers. Thus, it is difficult to exaggerate the importance of caseworkers in the business of creating accountability among private providers of services under contract to DYS.

It is not just the absence of caseworkers that undermines this accountability link. There is an almost irresistible temptation on the part of caseworkers to allow themselves to be co-opted by provider personnel. The accusations of troubled and troublesome youngsters naturally have to be shared by a caseworker with provider staff. If the caseworker always accepts the exculpatory explanation of the provider, never

probes beneath the proffered bland assurances and consistently dismisses the client's allegations, the value of the link is fatally weakened. It is not always easy for caseworkers to undertake the advocacy aspects of their responsibility on behalf of often deceitful, manipulative clients against fellow professionals. All of this means that this most vital of links can become disturbingly tenuous.

7. Placement decision review: The department has established a sophisticated classification process that incorporates a tripartite panel and a set of classification guidelines to determine whether and for how long a client may require a secure treatment setting. The process includes a weak appellate provision which allows aggrieved parties to file a written request for review with the deputy commissioner, who may decide the appeal without a hearing and within no set time period.[10] Presumably, clients or their surrogates with a complaint about placement would be required to take that complaint to the classification panel, although it is not clear how a client mechanically might do so. Departmental policy in this regard is a curious mixture of advanced classification theory and primitive procedural practices.

8. Liberty revocation process: The department also has established a hearing process for the revocation of clients who have been placed in the community. The revocation procedure comports with existing norms of due process articulated by courts for adult parole and includes a pre-revocation administrative determination of probable violation of some community placement condition and an adversarial hearing before a hearing officer within five days of a youth's reincarceration. Any client with a complaint about his or her recall from placement in the community presumably must direct such a complaint through this process or forfeit the right to pursue it further.

9. Letters to the Commissioner: Several interviewed clients indicated that they had written letters of complaint directly to the Commissioner of DYS, with mixed results. Two claimed that they received no response at all; one reported a non-committal response after long delay and another, a more rapid non-committal response; one chastened client alleged that he "had been yelled at in writing" by the commissioner. This last turned out to mean that he had been directed to take his problem to the provider, which he did -- successfully.

For the frustrated client, this letter-writing gambit may be an extreme and not entirely satisfactory method for

communicating grievances over the heads of the provider, but if a client has not seen his or her DYS caseworker for a long period, it may be the only way to obtain direct access to the department. As a means of handling grievances, which ought to be resolved at the lowest possible level, the approach is full of debilites, but administrators should be wary of referring importunate clients back to non-existent complaint mechanisms.

This concludes our list of DYS means for establishing accountability, but it still does not exhaust the potential avenues of redress available to clients.

C. Other State-provided Accountability Measures:

1. Office for Children (OFC): DYS is not alone in its responsibility for monitoring the delivery of services to adjudicated children in the Commonwealth. Since 1972, coincident with the reform wave that led to deinstitutionalization of DYS, the Office for Children (OFC) has existed to serve as an advocate for children with all other state agencies and to be a coordinator and facilitator of the full range of children's services provided by the Commonwealth. Pursuant to this broad mandate, the OFC has promulgated a series of detailed, specific regulations for each of the different kinds of facilities and programs offering services to children. These regulations are enforced directly in other state agencies like DYS and the Department of Social Services and through the licensing process among all private providers involved in providing services. OFC views as its basic function the task of assuring the health and safety of children in every state-run and state-supported facility and program in Massachusetts. It is the quintessential "regulator" of children's services in the Commonwealth.

The licensing process is the primary vehicle through which OFC interacts with private providers. To operate a group home, a shelter care facility or foster home, as well as to serve as a placement agency, requires a license from OFC. Procurement of a license means the wholesale acceptance of OFC regulations, which cover administration, staffing, programming, finance, medical care and mental health, recreation, discipline, insurance, fire safety, etc. Once a license is obtained, it must be renewed every two years, a process that requires an OFC staff review. If such a review turns up deviations from regulations, OFC will issue a "deficiency correction order," requiring remedy of identified deficencies within a reasonable period. Such orders may be appealed, but OFC decides the appeal within seven days without a hearing. Failure

to comply with a correction order can result in nonrenewal of the license, although such a drastic action is subject to a more elaborate hearing process.

The OFC also gets specific complaints about programs and facilities from a variety of sources, including telephone calls from parents and others; legislative inquiries; interviews with youngsters; media reports; and state agencies themselves. During the period from July 1 through December 31, 1983, OFC responded to between 60 and 70 such individual complaints.

For the purpose of the accountability that is the focus of this study, there are two serious limitations to the effectiveness of OFC. The first is jurisdictional; by statute OFC has responsibility for programs and facilities for youngsters under 16 years of age. Three of the Massachusetts facilities visited for this study avoided the need for OFC licensure by confining its clientele to older youths over 15 years old. For these facilities, no state license was required at all.

A second limit on the potential usefulness of OFC is the fact that clients simply do not know of its existence. Not a single client interviewed for this study could describe with even reasonable accuracy OFC's purpose and function; none knew how to contact it.

The OFC, then, is a wonderful example of a top-down accountability mechanism. It is an independent, feisty, competent watchdog that has the respect of both public and private professionals and of the general public. But if it is to function fully as the Commonwealth's primary accountability mechanism for children's services, it must develop some means to make itself known to the affected clientele and encourage children themselves to participate in the task of holding facilities and programs accountable.

2. The judicial process: Clients come to DYS because they have been adjudicated delinquent and committed to the department's care by the courts. This means that, in theory at least, DYS is accountable to some extent for what they do with youngsters to the courts. In practice, however, the courts have largely abdicated any accountability function they might have served. Occasionally courts refer a youngster to a specific program or impose particular conditions, but they do little to ensure the delivery of mandated services unless the

delinquent happens to return subsequently on new charges to the same judge, who may sputter and fume, but to little practical effect. Only slightly more involved are the attorneys who represent youthful offenders either by appointment or for a fee. In all of the Massachusetts interviews conducted for this study, there was only one mention of the involvement of an attorney in a client's complaint.

One interesting footnote to this picture of judicial indifference to accountability is the so-called Roslindale Consent Decree, the product of a 1976 case against the department for conditions of confinement in the Judge John J. Connelly Youth Center in Roslindale. In addition to the host of reforms included in the consent decree, the department was directed to implement a grievance procedure in the facility that provided for a hearing of appealed grievances before a departmental hearing officer whose decision, in turn, could be appealed to the commissioner, who was obligated himself to conduct a full administrative hearing in compliance with the requirements of the Commonwealth's Administrative Procedure Act. The department's present monitor for the consent decree indicated that the grievance procedure has never been used in her experience, and there do not appear to be any records of such use. Whatever the technical infirmities of the procedure adopted by the parties to the consent decree, it apparently was never implemented in any meaningful way. The procedure remains as an interesting artifact of a failed effort of the judicial process to impose accountability on at least an element of DYS.

Aside from these major categories of accountability mechanisms, there is a potpourri of outlets for clients that deserve at least some mention. One has already been alluded to and consists of letters or telephone calls from clients or their surrogates to political figures. Most often, the politicians involved are state legislators, who sometimes refer complaints about children's services to the OFC for investigation. Still another means for the expression of complaints, at least of egregious ones, may be the media.[11] Usually, however, by the time the media becomes interested in a complaint, it has risen to the level of a catastrophe. Finally, because many clients of DYS are involved in community educational, vocational, recreational or employment activities, they sometimes will discuss their complaints and problems with the people they meet in the course of those activities, who, in turn, may pursue any of the avenues of accountability we have described.

One recent means of accountability remains to be described. The explosion of interest in standards for correctional, juvenile and child care facilities in the past decade has spawned a number of accreditation efforts. Typically, a national association will adopt standards and, for a substantial fee, conduct an independent audit of an institution or system to determine whether the applicant meets standards sufficiently well to pass muster and become "accredited." At its best, accreditation encourages applicants to develop policies and procedures and to ensure conditions and programs that meet reasonably demanding standards. Because the process is a one-time affair, it sometimes leads applicants to formulate acceptable policies that may or may not be implemented subsequently. We have seen an example of that in the probably inappropriate grievance procedure developed by one certification-seeking provider agency which never developed much beyond its enshrinement on institutional bulletin boards. For our purposes, the most serious drawback to the accreditation movement is the fact that the standards developed to date by the various national associations have had virtually nothing to say about accountability.

This, then, concludes our review of accountability mechanisms available to clients of children's services in the Massachusetts DYS. We will see again in only slightly modified form many of these same mechanisms in Rhode Island's Department of Children and Their Families, to which we now turn.

FOOTNOTES

1 The breakdown is as follows: The Key Program holds 12 contracts; DARE, Inc., Justice Resource Institute, Massachusetts Half-way Houses, Inc., and Robert F. Kennedy Action Corps each hold four; Center for Human Development, Northeastern Family Institute and the Old Colony YMCA each hold three.

2 DYS is statutorily restricted to the purchase of services from private non-profit agencies. Mass. Gen. L. 18A § 1.

3 Of the seven residential facilities visited in Massachusetts, one had a capacity of 24; one, 15; three, 12; one, 10-12; and one, 10. The staff, once part-time people and volunteers were included, always substantially outnumbered the clientele, due primarily to the need for maintaining three shifts of staff daily, seven days a week.

4 The figure is deceptive, since all three facilities were operated by the same provider, Massachusetts Half-way Houses, Inc. The process was imposed on the three group homes by the corporation.

5 Reality therapy is a method of treatment pioneered by William Glasser, the California psychiatrist, in which the therapist's role is to help the client do better and be more responsible, while leaving on the client responsibility for changing his or her behavior. Glasser developed his unique approach to therapy while serving as a consulting psychiatrist for the California Youth Authority.

6 The two programs were Ambrose House and METRO (see Appendix A).

7 The Key Program, Inc., Massachusetts Half-way House, Inc. and the Robert F. Kennedy Action Corps Inc.

8 Mass. Gen. L. 119 § 51.

9 The exceptional and serious incidents that require special, emergency handling include: 1) escapes; 2) suicide attempts; 3) fires; 4) riots or disturbances; 5) serious injury of staff or resident; 6) any incident requiring police assistance; 7) alleged staff abuse of residents; 8) AWOLs from passes (secure treatment only); and 9) alleged or actual felonies by staff, residents, visitors.

10 Massachusetts Department of Youth Services Classification Policy: Guidelines Governing Entrance with Secure Treatment Facilities, August 1982, pp. 5-6.

11 An example occurred during this study: On Christmas night, 1983, a foster parent working for a corporate private provider refused to allow a late returning client into the foster home. The lock-out was imposed pursuant to a policy, apparently approved by one negligent corporate supervisor, of refusing to allow foster children into their homes if they missed curfew. After wandering around in zero-degree weather, the client finally flagged down a police cruiser at 2:00 a.m. The story of a child named Tim locked out of a state-supported facility on a snowy Christmas day made great copy. The incident resulted in the termination of the $410,000 a year program run by the corporate provider. The Boston Globe, January 6, 1984, p. 17.

Chapter IV

ACCOUNTABILITY IN RHODE ISLAND

Just as tempestuous times in the early 1970's produced dramatic changes in the Massachusetts DYS, a storm of mounting criticism over Rhode Island's ineffectual handling of children's services in the late 1970's led to thorough reorganization of those services and creation of the present Department for Children and Their Families (DCF). Adverse media coverage and political pressure led Governor J. Joseph Garrahy in 1977 to appoint a blue-ribbon task force to assess the State's existing apparatus for the delivery of children's services and to make recommendations appropriate to its findings. The result was a proposal to transfer responsibilities from the various state agencies then charged with operating institutions and programs for children in corrections, mental health, community affairs, and social services to one new cabinet-level department. Legislation incorporating this reorganization was passed in 1979, and a first Director was recruited in Massachusetts to lead the new entity to glory. The temporary lull generated by formation of the new bureaucratic structure did not endure, however, and DCF has been plagued by continuing controversy, primarily over its handling of several spectacular cases of child abuse, leading in 1983 to the departure of the young agency's first executive.

This period of administrative realignment also coincided, quite unfortunately, with the Reagan administration's substantial reductions in federal funding for social services. Due to the extent to which unionized state workers in Rhode Island have incorporated security provisions in existing collective bargaining agreements, the inter-departmental reshuffling of staff amidst the sudden austerity touched off an internecine scramble for survival that left administrators and organized employees demoralized and shaken. Existing departments, moreover, while willing enough to turn over responsibilities to the fledgling agency, were more reluctant to provide the concomitant resources. Faced with a succession of budgets allowing for little or no growth, daily increasing demands for services and aroused public expectations, DCF underwent a torrid baptism of fire during its early years.

DCF differs from the Massachusetts DYS in at least two important aspects. In the first place, DCF's clientele is much broader and more varied; it includes adjudicated juveniles,

like DYS, and, in addition, all of the abandoned, abused, neglected and emotionally and developmentally disabled youngsters in the State. This difference in clientele is reflected in the varied nature of the private providers surveyed for this study. One was designated to handle exclusively non-deliquent, emotionally disturbed girls and boys; another handled only delinquent boys; another, only very young emotionally troubled boys; another, a mixture of adjudicated and non-adjudicated girls; another, older delinquent boys on probation.

A second major difference is that Rhode Island never experienced the surge of deinstitutionalization that reshaped DYS by substituting numerous small, privately operated residential facilities for large state-run ones. The State's major secure training school, which over the past decade has advanced from certified unconstitutionality to accreditation by the American Correctional Association, has over a hundred residents; two of the programs run by private providers visited for this study were larger than any single DYS facility or program, public or private. There has been some shifting and expansion of residential facilities for youth in Rhode Island over the past decade, but there has been nothing like the shaking-out of institutional populations into the community that occurred in 1970-73 in the Bay State.

This second difference has influenced the much slower development of the privatization of children's services in Rhode Island. Most private providers presently under contract to DCF pre-date the agency's creation. Two of them visited for the study have been providing services to Rhode Island children since, respectively, 1852 and 1877.[1] While the relations of these providers with the State are of a much more recent vintage than the date of their founding, they and some of their fellow contractors have been doing business with DCF and its predecessors for many years. Most of these old-line providers were religious,and specifically Catholic, in origin, hardly surprising since some 60 percent of the population of Rhode Island is Catholic.[2] Reorganization, however, and the preferences of the first DCF director led to the introduction of a new breed of private providers, comprising,in the main, corporate entities from outside the State with a proven record of performance in the delivery of children's services. The result is an interesting amalgam of private providers with a rich and diverse history and structure that matches well the eccentric character of Rhode Island.

This absence of a system-wide deinstitutionalization movement has resulted in a more gradual shift to privatization. Over the past four years, the percentage of the DCF budget that has gone in contracts to the private sector has remained relatively constant at just about 33 percent. Thus, some 33 cents out of every dollar allocated to DCF in the current fiscal year ends up with a private provider; this comes to approximately $15 million out of the agency's nearly $40 million budget.

The means adopted by DCF and its private providers to ensure accountability for the services delivered to their youthful clientele resemble those fashioned by their Massachusetts counterparts with some local variations.

A. Provider Mechanisms for Accountability

1. Formal procedures: None of the facilities or programs visited in Rhode Island possessed a formal, written complaint mechanism or even a written policy governing the handling of complaints. One program director's proud production of a written policy for dealing with grievances in his organization turned out to be applicable only to employees with complaints against the provider. Personnel in some organizations maintained that clients could, in effect, initiate a complaint on just about anything by requiring a staff member to generate an incident report pursuant to DCF's system for tracking and investigating charges of institutional abuse, but nowhere were clients informed of this nebulous right in writing. This sort of staff encouragement of misuse of the institutional abuse process, moreover, well might explain the difficulties that have plagued that tracking system; but even if this practice were widespread among provider staffs, which it did not appear to be, it still would not constitute a formal, written complaint mechanism for clients.

2. Informal procedures: Every private provider under contract to DCF visited for this study relied heavily on informal processes for identifying and responding to grievances. Clients were expected and encouraged to pursue unresolved complaints through staff, supervisors and administrators to the program or facility director. In some larger private providers, this climb to the summit with a complaint could be an arduous trek. One mitigating factor was the tendency of larger facilities to be divided organizationally into small individual living units of about ten clients. Within these living units, staff-client ratios were high and access to supervisors and administrators relatively free.

Interviewed staff pronounced themselves generally pleased with the informal process, and several could point to specific grievances resolved successfully by means of this informal approach. Some programs cited differences in clientele or programmatic philosophy that precluded a more formal, written procedure. One provider, for example, pointed out that the tender age and low educational levels of youngsters in the facility made the use of a written process an obstacle to handling complaints rather than an aid; another argued that its dependence on group cohesion and interaction as a primary vehicle for building a supportive and mutually responsible sense of community was incompatible with a more formal, written process.

Both of these exceptions were pled by programs with largely non-adjudicated, long-term populations, in which interviewed clients expressed little of the hostile cynicism prevalent among older, adjudicated youngsters. Because of their age, dependence and relative innocence, these populations obviously represented an extremely vulnerable clientele; the arguments against a formal process advanced by the providers testified equally to the need for some special, alternative form of protection and accountability, which, fortunately, both programs seemed aware of and responsive to.

The evaluations by interviewed clients of informal mechanisms used by private providers in Rhode Island for handling complaints were both more varied and somewhat kinder than the reactions of DYS clients. While some dismissed such informal approaches as pacifying shams, many others were satisfied with the fairness of the process and most of the resulting resolutions. As in Massachusetts, the distrust seemed to grow in direct proportion to the extent and duration of most clients' exposure to the system. Among those who disparaged informal processes, the principal complaint was that supervisors, administrators and directors unfailingly supported the actions of their subordinates, often without hearing in any meaningful way the grievances of clients. Nothing was so quick to arouse the scorn of clients as this reflexive, unthinking supervisory response, with its damning implication that clients always lie, while staff never prevaricate or make mistakes.

3. Open-door policy: In Rhode Island, as well as in Massachusetts, administrators and directors of facilities and programs universally viewed their own total accessibility as a key internal accountability measure. They pointed to their peripatetic physical presence within institutions, the central

location of their offices and, in some instances, their residence on grounds or within the facility as clear evidence that every client possessed frequent and easy access to the boss. For their part, clients generally confirmed the ready availability of administrators and directors, even in large facilities and even in those programs where clients expressed a measure of cynicism about the value of that availability. The objection of clients to the open door as a measure of accountability was a reprise of the criticism just noted, namely, that while administrators and directors were willing to listen to clients' complaints, they rarely heard what clients were saying. Thus, while clients appreciated a posture of openness among program leaders, they wanted supervisors and directors to keep more than their doors ajar.

4. Case-management process: Reality therapy does not have quite the sway in Rhode Island that it exercises among private providers elsewhere, but it is still the dominant treatment approach. The structure of casework is also much the same in both states, except that private providers in Rhode Island tend to devote proportionally more resources and personnel to casework than their Massachusetts counterparts. Thus, every visited residential program operated by private providers for DCF possessed a casework staff of considerable size with small caseloads that made possible comprehensive treatment planning, the delivery of individual and group therapy and counseling and the maintenance of family and other community ties.[3]

What this meant in practice was that long-term clients of DCF-funded private providers were assigned specifically to a program or facility social worker, psychologist or family worker, who met with the client at least weekly and normally for a set minimum period of time. Although still part of the provider's staff, this caseworker or counselor was not someone involved in daily residential care; as such, the caseworker represented an alternative to residential staff to whom clients might bring complaints, an especially valuable outlet in the event of serious complaints about particular residential staff. Interviewed caseworkers and program directors saw these regular meetings between caseworkers and client as a useful means for learning about and defusing potential staff and programmatic difficulties.

Youngsters interviewed for the study were less certain about the value of the means provided by assigned caseworkers for expressing and seeking resolutions of grievances. While many confessed to having shared complaints with counselors or

caseworkers, the responses, according to clients, most often seemed to focus on how the clients might best use their difficulties to enchance their ability to cope with the individual or situations giving rise to the complaints, while little or nothing was ever done about the individuals or situations that caused the difficulties. One especially articulate and probably over-processed youngster suggested facetiously that a notoriously short-tempered and disrespectful staff member be given the counseling presently devoted to persuading ten of his charges to react to his antics in socially acceptable ways.

These observations of clients serve to underline one of the curses of treatment in all of its myriad forms. When process becomes the content of therapy, it tends to crowd real content out of the picture. In the drive to equip youthful clients with better ways of handling their grievances, caseworkers sometimes slide right over the actual grievances. It is surely important that a youngster learn not to respond explosively to teasing banter about his manhood -- or her womanhood -- couched in insulting and demeaning terms by an adult staff member. It is no less vital that the purveyor of the objectionable banter, hired and paid to perform at public expense, be either re-educated to function effectively as a child care worker or terminated.

The use of behavioral contracts and graduated levels of rewards is also common among Rhode Island private providers of children's services. Fulfillment of level requirements is a rich source of disputes that fall into an uneasy no-man's land between discipline and treatment. The ability of child care workers to promote or block clients' progress through the level system gives these workers a prodigious measure of control over the lives of youngsters, whose weekend recreational passes and even furloughs home depend on careful passage through the successive tiers of behavioral management.

During the early days of a client's residence in a program a plan is worked out that includes elements of treatment, education, vocational training, employment and residence and points to some eventual reintegration into home or community life. This plan normally is developed in conjunction with a DCF caseworker who participates in a planning session and, perhaps, some review sessions with program caseworkers. Some providers worked hard to involve parents in this important planning process. One provider held biweekly, mandatory meetings with youngsters and their families; another held regular family therapy sessions for its clients. In all of the pro-

grams and facilities visited, caseworkers were the main source of the providers' contact with families whether to field complaints, provide information on clients' progress or simply to answer parents' questions. With caseworkers present everywhere with assigned caseloads, Rhode Island providers did not routinely designate a specific residential staff member to act as an advocate or monitor for each client.

5. Regularly scheduled house or residence meetings: All of the smaller, residential programs[4] held regularly scheduled meetings of all clients with available staff and, usually, the program director. These meetings were viewed by interviewed staff and clients as useful for the airing of complaints about house routine and logistics, e.g., food and cooking, chores, etc., but as less useful for dealing with complaints arising from the interaction between staff and clients.

One relatively long-term program had a highly developed residential council with elected officials that convened independent weekly meetings with a staff member acting only as an observer where residents could voice their problems freely. Council officers also could meet with supervisors or the program director about difficulties with facility rules and regulations. Despite the more elaborate structure, interviewed clients in this program seemed no more impressed with the council than residents in other programs were with their less structured weekly meetings.

6. Provider board of directors: Only one Rhode Island program even mentioned its board of directors as a potential, peripheral accountability resource. Unless a board becomes deeply involved in the operations of a program, its members are unlikely to know much about what is going on within a specific facility or program, and some program directors neither seek nor welcome such intrusive board participation.

7. Corporate provider monitoring: One of the programs visited in Rhode Island (Camp E-Hun-Tee, operated by the Eckerd Wilderness Educational System camping program) demonstrated the fullest measure of corporate provider monitoring encountered during the study. From the recruitment of personnel (done nationally with intensive screening), to training (again, done nationally and to an extent unparallelled among other private providers), to the establishment of corporation-wide standards and policies (more detailed and demanding than those of any of the national standards projects), to the provision of an institutional abuse process (far more thorough and

responsive than the processes created under Massachusetts or Rhode Island statutes), the Eckerd program represented a model for careful, responsible, efficient and humane corporate involvement in the delivery of social services. The intensive recruitment process, the centralized training of all personnel at its Florida headquarters, and the wilderness or outward bound aspects of the program all combined to generate an esprit de corps among program administrators and staff that was tantamount to zealotry. Wisely eschewing the self-image of a treatment program, the Eckerd approach emphasized education and individual inter-dependence among groups of ten youngsters who lived with staff amidst all of the rigors of the great (and in New England winters, chilly) outdoors. The exceptional dedication of staff and their willingness to embrace the same hard conditions which clients must endure generated a corresponding enthusiasm among clients. To one youngster, the program was "like drying out." He explained his simile by describing the sense of physical well-being and the feeling of pride over control of self generated by his detoxification experiences.

The monitoring of Camp E-Hun-Tee by Eckerd seemed to be done almost entirely by paper and telephone; there was no evidence of a parade of corporate personnel through the program. Because existing corporate accountability mechanisms were well thought out, however, they worked. Forms for reporting and following up unusual incidents and allegations of child abuse required the alerting of a veritable network of corporate officials, and local program personnel learned quickly that their success with the corporation depended on full compliance with the company's reporting requirements.

The one element missing in all of this was any corporate requirement that local programs have a formal, written internal grievance procedure. This missing element, however, was not an oversight; the Eckerd programs viewed such a requirement as a distinct threat to the sense of group commitment that is the core of their model. If a group member could appeal group decisions to some external power, the cohesiveness and authority of the group structure, it was felt, might be undermined. Obviously this same rationale applies to informal, as well as formal, procedures, and one can only wonder how receptive to informal appeals from group decisions supervisors and program directors might be. The program seems to buttress the predisposition of program administrators, cited critically by so many clients, simply to rubber-stamp decisions made at lower levels. This dilemma reflects the inevitable tension between the potential tyranny of the group and the value of

cooperative conformity, which existing Eckerd accountability mechanisms have not yet successfully addressed.

Another Rhode Island provider was the local representative of a Fortune 500 corporation, RCA Service Company, and also was the only profit-making provider visited for this study. While RCA corporate personnel provided centralized accounting, purchasing, legal work, public relations, contract management, etc., the local program had far more autonomy than the individual Eckerd program seemed to possess. The Rhode Island RCA program used local staff with the exception of the director and conducted its own, limited training; there also seemed to be little central control of local policies and procedures. Part of the explanation for the difference may lie in the fact that RCA operates a considerable variety of programs for youngsters rather than one model, like the wilderness program conducted by Eckerd. This does not mean that RCA was uninvolved in local operations. During start-up of the Rhode Island program, RCA staff from corporate headquarters and other programs were instrumental; in the event of an emergency, RCA apparently would fly in corporate administrators and staff to help out; the reporting requirements of the local program to the corporate entity were extensive.

In neither corporate provider, however, did a Rhode Island client have access to a procedure for pursuing complaints through the corporate structure of the provider. Unlike corporate providers in Massachusetts, whose central office personnel were frequent visitors to local programs, sometimes with a direct relationship with clients, RCA and Eckerd corporate officials were virtually unknown to local clients. They were in no sense accountable to clients directly for conditions and treatment, whatever their participation may have been in reviewing and shaping responses to allegations of serious staff misconduct.

This completes our list of internal accountability mechanisms devised and operated by private providers of service to DCF. The individual entries suffer from many of the same infirmities noted in our discussion of DYS private providers. There is a uniform absence of formal procedure; informal procedures are everywhere totally subject to the goodwill of program personnel; and all procedures begin and end within the programs themselves. No single, visited provider in either state involved outsiders, except for corporate personnel, in its internal accountability process.

B. State Agency Accountability Mechanisms.

1. The contracting process: In an interesting contrast with DYS illustrative of the "big bang" theory of bureaucratic organization, which asserts that, like the universe, bureaucracies go through an eternally repetitive cycle of decentralization and consolidation, DCF apparently is moving towards a combination of all of its management functions for contracts in one office because of growing dissatisfaction with the current division of programmatic and budgeting aspects of the contracting process. Programmatic review of contracts currently lies within the purview of the Division for Community Services, while the Division of Management and Budgeting has oversight responsibility for financial aspects of contracts. You may recall that all contractual management functions in DYS were concentrated in one office until the 1979 "reform," which split up oversight functions because of growing dissatisfaction with the combination in one office of programmatic and budgeting aspects of the contracting process.

Like Massachusetts, the letting of DCF contracts involves the preparation and publication of an RFP (request for proposal), which is designed to spark a highly competitive struggle in the marketplace of private providers. Experience in both Massachusetts and Rhode Island indicates, however, that the marketplace is not replete with competitive potential providers. Although DCF has not yet encountered an utterly inert marketplace like DYS recently did in response to a major RFP, Rhode Island's pool of providers is small. That fact led DCF, shortly after its formation, to seek providers elsewhere with the result that three of the department's latest, substantial contracts have gone to out-of-state corporate providers.

Contracts are reviewed and renewed annually, although the department now is considering the possibility of extending the term of contracts to two years. The renewal process is neither rigorous nor demanding. An incumbent provider submits a program description for the upcoming year together with a budget that meets the overall price ceiling set by the Division of Management and Budgeting. The Division for Community Services reviews and approves the program description, which seldom varies much from the existing description, while DCF budget personnel review the provider's proposed financial figures. If no problems emerge, the contract is renewed; when problems do arise, they are usually resolved through negotiation. There is no requirement that DCF resubmit contracts to the competitive process periodically. The department appears

to emerge from this process with the vaguely uneasy feeling that it exerts inadequate control over contracts generally, while those providers who would like to push for additional services or new delivery techniques express disappointment over their inability to influence the allocation priorities of the department. The tight budget caps in recent years have exacerbated substantially the frustrations on both sides.

2. Departmental liaison: Once a contract is operable, departmental supervision of providers is the responsibility of liaison personnel of the Community Services Division. Normally, each liaison worker is responsible for oversight of two or three providers, but two may be appointed to monitor larger facilities. The department's use of liaison workers has not satisfied all providers, some of whom expressed a degree of exasperation with the reshuffling of personnel, the lack of operational experience and understanding of some monitors and the general uncertainty about the functions proper to the position. Other providers, however, have found liaison workers to be extremely helpful in communicating a contractor's difficulties and problems to the department and in securing, on occasion, support and understanding from different parts of the departmental bureaucracy. None of the interviewed private provider administrators or directors viewed their liaison personnel as aggressive departmental watchdogs or agents of surveillance; they were seen more often as spokespersons for providers with the department with primary responsibility for ensuring a steady flow of communication between the state agency and the contractor.

Liaison workers also played a role in the department's process for handling claims of institutional abuse. Together with DCF caseworkers, they were responsible for the preliminary investigation of allegations of institutional abuse, although serious allegations of physical or sexual abuse were referred to the department's small investigative staff, which had the overwhelming responsibility of conducting inquiries into all claims of child abuse, whether in the community or in institutions.

Interviews with line staff and clients indicated that they had little contact with liaison workers, whose dealings characteristically were with program and facility administrators. In most respects, then, the activities and functions of DCF liaison personnel were comparable to those of regional and district supervisors in the Massachusetts DYS.

3. Institutional child abuse process: The newly created DCF inherited from its mixed bureaucratic parentage responsibility for curbing instances of "institutional child abuse and neglect."[5] The system established by the department to address this need required DCF staff who either received a complaint of institutional child abuse or became aware of one to fill out DCF Form 020, which triggered an elaborate reporting, investigative and tracking process. Most often, the DCF caseworker whose caseload included the alleged victim was assigned to conduct a preliminary investigation, although in larger residential facilities, the caseworker and the appropriate liaison worker together carried out this function. If the preliminary review indicated that a child was "at risk" in the present environment, he or she could be removed immediately. Serious incidents were turned over to the department's Office of Inspections/Critical Incidents for further investigation. Less serious episodes were documented and made part of the provider's file.

Two persistent problems plagued this process. The first was the inability to pin down an acceptable, operative definition of "child abuse and neglect." Because the institutional child abuse process was the closest thing to a formal grievance procedure the department possessed, it became the receptacle for every imaginable form of complaint, exaggerated and inflated to qualify as child abuse or neglect. In addition to legitimate charges of physical or sexual abuse or intimidation, caseworkers and liaison personnel ended up investigating alleged deprivations of supplies, charges of stolen property and claims of unsanitary conditions, which could turn out to involve nothing more than an inadequate supply of toothpaste, a missing pillow case or the unpleasant sighting of a cockroach. The trend towards the inflation of charges sprang both from the absence of any clear understanding of what constituted "abuse" and "neglect" and from the fact that, under the system, only hearsay allegations of abuse made their way into the process. Thus, for example, a client's parent might contact a DCF staff member who initiated a report that kicked off the investigative process. Whatever appeared in the actual report was usually a third- or fourth-hand account, with all of the creeping inaccuracies likely to be generated in each retelling.

The second problem derived from the fact that complaints could be filed against individuals or programs without their knowledge. The first inkling a staff member might have of a pending charge was a sudden summons to appear before a program administrator (often embarrassed and irate because the

staff member had not reported the alleged incident to him or her), the liaison worker for the program and a DCF caseworker. How often this scenario actually occurred is uncertain, but several interviewed staff members expressed heatedly their concern over such occurrences and the potential use of the process by manipulative and vindictive clients to destroy the reputation of staff with deliberately vague or false accusations.

These problems, in combination with serious deficiencies in the investigation and tracking of child abuse claims in the general community, have moved DCF to revamp its entire process for dealing with child abuse, institutional or otherwise. Some of the contemplated reforms include a computerized tracking system, initiation of reports through a centralized investigative team activated by telephone calls, the establishment of clear criteria defining serious instances of abuse that will trigger investigations, and notice to providers whenever an investigation is to be conducted. DCF's difficulties in fashioning an effective system for investigating and tracking child abuse reflect the conflict between the need to simplify and encourage use of the system as much as possible and the need to protect the rights of the accused abuser. It remains to be seen whether this new approach will succeed.

4. DCF caseworkers: Each client in DCF is assigned to a primary service worker or caseworker whose task it is to plan for, and monitor the delivery of, services to the youngster. This process requires the elaboration of a specific, written plan and regular reviews of progress in accomplishing the treatment and other goals articulated in the plan. The caseworker is a key figure in arranging appropriate placements for youngsters and is the communications link between the department and the client, as well as all of the client's surrogates, including, importantly, the family and the court. As indicated above, the caseworker conducts the department's initial inquiry into allegations of abuse or neglect. The caseworker, then, is a central figure in the department's efforts to ensure provider accountability.

DCF caseworkers, like their counterparts in Massachusetts, carry heavy caseloads. The demands of court appearances, the processing of case management and logistical paperwork for each client, the continuing struggle to find appropriate placements, the difficulties of monitoring services in the general community, the need for sometimes intensive family counseling and assistance, all combine to contract the

time left for meetings with clients placed in the relatively stable and supportive environment of a group care facility operated by a private provider. The result is that, for some caseworkers, clients in structured residential programs assume a very low priority. At least half of the clients interviewed for this study reported that they had not seen their DCF caseworker within the past month; six of those interviewed had not seen their DCF caseworkers in over three months. Others claimed that they saw their caseworkers only at court appearances; one reported being left stranded twice, without warning or explanation, by a caseworker who had promised to drive him back from home furloughs. Interviewed staff members of private providers confirmed the accuracy of these reports of often infrequent contacts between clients and their DCF caseworkers. An almost universal complaint among interviewed clients was the constant delay in processing clothing allowances by caseworkers. Clients also charged that when they communicated complaints about facilities or programs to their DCF caseworkers the response consisted most often of a stern lecture on their good fortune to be in the program and a warning against further grousing.

Again, as with DYS caseworkers, this rather dismal picture was not universal. Both clients and staff could describe DCF caseworkers who were diligent, enthusiastic and supportive of their clients. Just under half of the clients interviewed reported that they saw their DCF caseworkers at least biweekly, while some saw them weekly. These dedicated caseworkers were not, then, the exception; they constituted nearly a half of the primary service worker staff. But, given the importance of the accountability functions of the DCF caseworker, who often is the only living link between the client and the department, performance by 50 percent of the staff is simply not good enough.

5. The licensing process: In DCF the licensing function is exercised by the same personnel who manage contracts, i.e., the Division of Community Services. In 1979, standards for group home care, foster family care and child care institutions were developed and promulgated to guide the licensing process. These collections of standards established rules to govern admission and discharge policies, physical conditions and safety, personnel, health and nutrition, programs, records and administration of potential license applicants.[6] Successful applicants are required to renew their licenses annually, and the licensing agency must conduct a yearly review of licensees' compliance with applicable standards.

With the creation of DCF, the licensing function was moved from the Department of Social and Rehabilitative Services to the new agency. Eventual placement of that function within the Division for Community Services consolidated in one office program review, contracts management and monitoring, and licensing. What has happened is that all three functions have tended to merge into one process. The only aspects of license renewal conducted independently of this office and process are the annual health and safety inspections carried out by other appropriate state agencies.

Earlier discussion of the department's management of contracts indicated that contractual renewal reviews are not particularly rigorous. Much the same can be said of reviews conducted for license renewals. Unless some report of substantial abuse exists or DCF caseworkers have relayed unfavorable information on a provider, contracts and licenses together tend to be renewed perfunctorily. DCF staff responsible for provider relations claim to be working on models for thorough, regularly scheduled program reviews (one for providers with identified problems, one for routine reviews), but current staffing levels preclude much progress in this effort.

What this means is that private providers currently under contract to DCF need not concern themselves much with aggressive monitoring by the department of their delivery of services. Barring some extraordinary instance of flagrant abuse, they can look forward confidently to continued renewal of their contracts, especially in the absence of a requirement that the department resubmit contracts to competitive bidding periodically. Providers can find further comfort in the knowledge that the department's need for residential placements far outruns current availability. All of this reduces that supposedly ultimate accountability weapon, the Damoclean sword of termination, to a shadowy threat at best.

The relative disarray of DCF's accountability mechanisms for private providers in comparison with those of DYS and Massachusetts is the product of the history and extent of privatization in both states. While the phenomenon has been characterized by sudden and explosive growth in Massachusetts and consumes nearly two-thirds of the entire DYS budget, the more qradual development and smaller proportional dimensions of privatization in DCF have yet to generate grave concern over the impact of inadequate accountability mechanisms. DCF, moreover, is not unaware of or indifferent to the need for improvement in its procedures for imposing a greater measure of ac-

countability on private providers. The newly appointed director of the department is currently wrestling with the development of a more effective process for managing contracts, and changes are promised.

6. The section 203 complaint process: Section 203 of the General Provisions of DCF policy establishes a hearing process for complaints of clients and their surrogates, as well as private providers, relative to a wide range of issues.[7] The process allows for relatively informal administrative hearings at supervisory and divisional levels and culminates in a full-blown adversarial hearing before a departmental hearing officer. To the knowledge of the incumbent hearing officer, no youngster under the supervision of DCF has even initiated a Section 203 grievance. Foster parents, protesting the removal of youngsters, the denial or revocation of a license or foster-care rates, have been the principal users of the process. Providers also have used Section 203 to contest a denial of eligibility for funding pursuant to the State's program for Mental Health Services for Children and Youth (MHSCY). Thus, the hearing process has become almost exclusively a device for private providers to seek review of adverse agency decisions; it has evolved into a mechanism by which private providers hold DCF accountable for the agency's administrative judgments. The process is not used to hold providers accountable for their services to clients or their surrogates, whatever the language or the original intent of its designers may have been. It is an ironic and sobering measure of the relative power of clients and providers that the department feels compelled to operate an elaborate process for the review of providers' complaints but no comparable compulsion to make available to clients a process for the review of their complaints.

Fortunately, this last mechanism, while completing the list of accountability measures within DCF, does not represent the State's final effort in the struggle to impose accountability on private providers of children's services.

C. Other State-provided Accountability Measures

1. The Child Advocate: Simultaneously with the reorganization of children's services and establishment of DCF, the Rhode Island Legislature created by statute the Office of the Child Advocate. The statute confers on the Child Advocate a curious mixture of nebulous duties falling into three general categories:

a. The Child Advocate is responsible for ensuring that clients know their statutory rights; reviewing DCF's procedures for the protection of those rights; and taking action, including legal action, to protect those rights. Note that it is not the Child Advocate's duty to inform clients, but only to ensure that they are informed. Similarly, it is not the Child Advocate's task to implement procedures to protect rights, but only to review the department's procedures to do so. Finally, the only effective action the Child Advocate may take to vindicate clients' rights is to bring suit.

b. Next, the Child Advocate is required to "review" clients' complaints and investigate "those where it appears that a child may be in need of assistance..."; to "review" public and private child care facilities and programs; and to "recommend changes in the procedures for dealing with juvenile problems and in the systems for providing child care and treatment...". Does this mean that the Child Advocate has some direct role in handling complaints? Probably not. To whom and with what effect is the Child Advocate supposed to report the results of his[8] investigations of complaints? To whom and to what effect should he recommend procedural changes "for dealing with juvenile problems"? The statute provides no answers to these questions.

c. Finally, the Child Advocate is saddled with the duty of training attorneys and special advocates for appearances before the Family Court and the review of Family Court decisions involving children, with the power "to request reviews as required by the best interests of the child."[9]

Other provisions of the statute confirm the independence of the Child Advocate from DCF, empower him to take direct steps to advertise his presence with clients and require him to report annually and in detail his activities and recommendations to the governor and general assembly. The Child Advocate, then, is to be part ombudsman, advocate, administrative officer of the courts, appellate judge, legislative fact-finder and executive trouble-shooter. Beneath the statutory litany of his duties, however, his only real power is the ability to sue on behalf of childrens' rights, but only those enumerated in R.I.G.L. 42-72.

Despite the ambiguities of this poorly drafted statute authorizing his existence, the Child Advocate has managed to make his presence felt in a number of ways related to the accountability that is the subject of this study. He has caused

to be printed and posted prominently in every visited program and facility a copy of the Children's Bill of Rights, which is a reprint of R.I.G.L. 42-72-15 enumerating specific procedural rights and entitlements due each DCF client.[10] The posted copy bears the title, address and telephone number of the Child Advocate.

He has established a system to monitor DCF's institutional abuse and neglect process. A copy of each report of institutional abuse is filed automatically with the Child Advocate, who compiles from time to time statistics on allegations of abuse, the percentage of substantiated complaints and the array of remedial actions adopted by DCF. The Child Advocate's role in this area is restricted to reviewing the DCF process; only in extraordinary cases would he become involved directly in an actual investigation.

The Child Advocate also has obtained funding to support staff for what is called the Council for Community Services. The Council, operating with a pool of child care professionals, has sent three-person teams to conduct extensive program reviews in some 30 DCF programs and facilities around the State. During their site visits, the reviewing team, which always include a volunteer citizen from the general community, tour the facility, review records and policies, interview administrator and staff and talk to clients. The product of these visits, a final report incorporating the team's findings and recommendations, is submitted both to the provider and DCF. The Council conducts comparable visits to and assessments of foster homes licensed by DCF. The Council's work is especially useful in view of DCF's lack, to this point, of an effective process for contract and program review. The Child Advocate's expressed determination to review each facility and program and subsequently to repeat the cycle of review makes the Council one of the best accountability mechanisms encountered in the course of this study.

It can be seen from this review of activities that the Child Advocate and the Massachusetts OFC (Office for Children) have much in common. One important difference is that the latter's scope of activity is clearly defined by the standards or rules and regulations applied in the licensing process, while the parameters of the Child Advocate's activities are, as yet, unclear. The two agencies, unfortunately, also share a common problem. Despite the fact that the Child Advocate's title, address and telephone number all appear at the bottom of the copy of the Bill of Rights posted prominently in every

facility, not a single interviewed client had ever heard of the Child Advocate, or knew how he might be contacted. Even after the posted telephone number of the Child Advocate was pointed out to clients, most indicated that they would not be much inclined to submit a complaint to him. On the other hand, based on an interview with the Child Advocate, he would lack the resources to respond to many complaints in a meaningful way.

2. The judicial process: The Rhode Island family court system does rather better in the accountability business than does its Massachusetts counterpart. This is due less to the superior wisdom of its judges than to the ancillary process for providing continuing legal assistance to clients and their families. Through a traditional guardian ad litem[11] program, the ready assignment of public defenders (the State Public Defender has a special juvenile unit) and an innovative program of court-appointed special advocates (CASA), which provides both legal and non-legal advocates for Providence County juveniles, youthful litigants in Rhode Island have access to relatively extensive and competent assistance. Interviewed staff members and clients praised several individuals involved in these programs, particularly CASA volunteers, for the caring, effective help they had provided clients on occasion. While disinclined generally to respond to every grievance of clients, once these independent, voluntary representatives of the legal process offered to intervene on behalf of a grieving client, complaints tended to be either rapidly resolved or dismissed with finality.

Outside of these state-provided mechanisms, clients and their surrogates sought help wherever they could find it. In most of the programs and facilities visited clients were involved in community education, vocational training employment or volunteer work. Clients participating in these activities sometimes shared their complaints with the people they met in these endeavors, but most were reluctant to do so for fear of bringing attention to themselves as "different." Unlike their Massachusetts counterparts, DCF clients did not appear to be great letter writers; only one interviewed client spoke of a letter, which went unanswered, sent by her parent to a state legislator.

Accreditation also has made its appearance in Rhode Island, and one visited provider had gone through the process successfully.[12] Others were interested but found the cost associated with accreditation prohibitive and, thus far at least, DCF has been unwilling to help underwrite the expense.

Accreditation both ends our review of accountability mechanisms among private providers of children's services in Rhode Island and points ahead to our next undertaking, an examination of the standards for accountability mechanisms developed by national associates involved in juvenile justice and child care.

FOOTNOTES

1 These facilities are St. Aloysius (founded in 1852) and St. Mary's (in 1877). See Appendix A for the listing and description of visited programs and facilities in both states.

2 One interviewed Protestant provider confessed to some frustration and confusion at finding himself, upon arrival in Rhode Island, in a political and social minority.

3 In one Rhode Island program (RCA), in-house counselors provided each client with a minimum of 15 hours a week of therapy, while the director of treatment held a group meeting with all clients five days a week.

4 Ocean Tides and Whitmarsh held such meetings weekly in all of their residential facilities (a total of six); RCA held regular meetings of its council and daily treatment meetings: Eckerd spoke of "doing group 24 hours a day," reflecting the place of group decisions and intra- group support as the key element in its counseling philo- sophy. Larger and short-term programs did not have a comparable device. The larger programs with long-term residents were St. Aloysius and St. Mary's; short-term facilities included New Routes (a shelter home) and the shelter program at St. Aloysius, both of which had a 45-day cap on the stay of youngsters.

5 The term is defined statutorily to include "situations of known or suspected child abuse or neglect where the person allegedly responsible for the abuse or neglect is a foster parent or the employee of a public or private residential child care institution or agency; or situations where the suspected abuse or neglect occurs as a result of such institution's practices, policies or conditions." R.I.G.L. 40-11-2.

6 The standards do not include a provision requiring licensees to make a complaint mechanism available to clients. Department staff shared with me a proposed draft standard that would require providers to develop a grievance procedure for clients, but the standard is so weak it would add little to existing procedures.

7 A complaint is defined as "any oral or written expression of dissatisfaction made to a social worker in the field or office, to supervisory or administrative staff concerning the administration of agency policies and programs, or the Department's decisions in regard to:

- Visitation
- Placement or removal of children from foster homes,
- Closure of a foster home,
- Disagreement in planning,
- Other dissatisfaction surrounding services provided by staff,
- Other dissatisfaction with agency rules and regulations,
- Claims of discrimination based on age, handicap, sex, race, religion, national origin, or color."

DCF Policy: General Provisions, Sec. 203: para I.

8 The first and current Child Advocate is male.

9 R.I.G.L. 42-73-7(1)-(8).

10 The Bill of Rights is a triumph of legal paternalism, long on due process and other procedural protections, but woefully short on entitlements to care and services.

11 A guardian ad litem is a guardian appointed by a court to represent a minor in any suit to which he or she may be a party. In Rhode Island, the DCF budget includes an appropriation for the payment of guardians ad litem, a form of privatization not included in earlier budget calculations of the extent of the phenomenon.

12 St. Mary's received accreditation from the Child Welfare League of America.

CHAPTER V

ACCOUNTABILITY AND STANDARDS

One byproduct of the conviction, so prevalent in the mid-1960s, that the federal government must assume the lead role in the "war" against every societal problem was the President's Commission on Law Enforcement and Administration of Justice. Task force reports issued by the Commission in 1967 set off a wave of reform in corrections and juvenile justice that sought to impose change on antiquated, destructive systems from the top down by identifying goals and objectives acceptable to most practitioners and articulating standard policies and practices to accomplish them. The great criminal justice standards boom of the 1970's that followed was fueled initially with funds from the Law Enforcement Assistance Administration of the U.S. Department of Justice, which underwrote that fountainhead for all subsequent standards projects, the National Advisory Committee on Criminal Justice Standards and Goals.

But much more was involved in this movement than federal hubris. Outrage over intolerable conditions in the nation's prisons and juvenile institutions revealed almost daily in the media and courts, increased interest in the application of principles of public administration to correctional institutions and growing concern over the promiscuous mingling of youthful with adult criminals and young status offenders with adjudicated delinquents all contributed to the escalating demand for change. The federal interest and involvement was important because it provided reformers with the resources to convene and fashion a vast blueprint for change and a national podium from which to urge its adoption.

In 1976 the Task Force on Juvenile Justice and Delinquency Prevention of the National Advisory Committee on Criminal Justice Standards and Goals published its volume of standards. Standard 20.2 in the Task Force's report required institutions and programs for juveniles to implement grievance procedures for their clients. One year later the tentative draft of the Institute of Judicial Administration/American Bar Association Juvenile Justice Standards was issued. The volume on correctional administration included Standard 9.2, which spelled out in considerable detail essential principles for the establishment of effective grievance mechanisms in institutions for juveniles.

This surprisingly early consideration by standards makers of the issue of accountability in juvenile justice was no accident. The drive in both adult and juvenile corrections to establish effective grievance mechanisms was already half a decade old and had scored some notable triumphs, the most significant of which was a model procedure introduced and tested successfully in the California Youth Authority in the early 1970's.[1] The research generated by the push for administrative grievance mechanisms in corrections provided those first committees struggling to develop feasible standards with data, evaluative materials and a body of principles that seemed to work.[2] Subsequent compilations may have expanded, refined and modified somewhat the standards for grievance mechanisms adopted in those early efforts, but all have accepted the need for such mechanisms and certain basic design features, such as written responses, time limits, independent review and the involvement of staff and clients.[3]

Because the standards movement swept through the field of juvenile justice before reaching the shores of general child care and children's services, some of the standards developed in the former have not always fit well in the latter. Standards for grievance mechanisms in juvenile justice, for example, grew out of experience principally in institutions for adjudicated delinquents, usually aged 14 through 21. Child care, however, embraces a much broader and generally less sophisticated clientele, including abandoned infants, neglected children, emotionally and physically disabled youngsters, status offenders and some adjudicated deliquents. The last, however, represent typically only a minority of the clientele of local and state agencies providing childrens' services.

The difference in the levels of sophistication and vulnerability of the clients of child care agencies also helps to explain the paternalism that pervades the delivery of children's services. Whether that paternalism responds to the age of clients, the absence in their lives of a normal family structure, their need for education or treatment, the professional background of providers, the paralyzing doctrine of the best interests of the child, or naked self-interest, the result is that, in the field of children's services, young clients frequently are judged to be incompetent to participate in efforts to hold providers accountable for services delivered - or not delivered. Given that judgment, it is not surprising that early makers of standards for child care facilities and programs did not adopt wholesale those standards on client grievance mechanisms developed in juvenile justice.

The first major collections of standards on residential care for children were issued simultaneously in 1978 by the Child Welfare League of America and the National Association of Homes for Children, both competing national membership organizations. The latter group's standards did not mention grievance mechanisms,and their sole foray into accountability required members to have written policies for handling discipline and abuse. The Child Welfare League of America first issued separate standards for institutions and group homes, which were revised and combined in 1982. The League's standard on "procedures for appeal" (Standard 9.20) recognizes that agencies should be accountable for their "care, services or plans," but only to parents or guardians; children are excluded from participation in the appellate processes spelled out in the standards. The League also acknowledges that "a voluntary agency" might be providing services on behalf of a public agency; if so, provision should be made for filing complaints with the public agency, as well as the "voluntary " one. This represents, at least, a bow in the direction of privatization with a hint of accountability on the part of the private provider to the state agency.

The Interstate Consortium on Residential Child Care, an organization of private providers and public regulators of children's services in the northeast, developed and issued a set of standards in 1980 that abandoned some of the paternalistic tentativeness of other child care associations and asserted boldly:[4]

> If a child sees himself/herself as powerless to affect situations he or she perceives as unfair, the child may be less motivated to change. If, however, a child is taught that to challenge and criticize is an acceptable part of social life, he or she may be more open to the ideas and suggestions of others.

The stirring rhetoric, alas, was followed by a rather limp standard requiring residential facilities simply to have a grievance procedure, written in a clear and simple manner, that allows children to complain "without fear of retaliation."

Enthusiasm for standards also infected state governments in the 1970's. State agencies with responsibility for the supervision of juvenile justice and children's services began to articulate rules and regulations, reflecting the norms gen- erated by national standards projects, that all local

public and private providers were required to follow. Occasionally these state standards addressed the problem of accountability less hesitantly than the national associations of child care organizations.

An early and exceptional example was a requirement imposed on private providers by the Michigan State Department of Social Services for the implementation of a grievance procedure for clients that included some sort of independent review and client input. In response to this mandate, the Michigan Federation of Private Children's and Family Agencies in 1973 designed a client grievance procedure for member private providers calling for the creation of a grievance subcommittee within providers' boards of directors to hear complaints and the appeal of decisions of this subcommittee to the director of the supervising state agency.[5] Other states' requirements developed in the succeeding decade have ranged from a one-line admonition confirming the right of clients to register complaints and grievances[6] to a 25-page, complex compendium devoted entirely to grievance mechanisms.[7]

Like the Michigan federation, other state-wide associations also have begun to generate standards for their membership. In the absence of statutes mandating accountability mechanisms, such as the federation was forced to respond to in Michigan, state associations have followed the lead of their national counterparts and adopted generally weak standards on grievance mechanisms.[8] At least one state association, however, has broadened its view of accountability to include a requirement for a system of advocacy for clients in addition to a grievance procedure.[9]

This last example provides a useful reminder of the sometimes counterproductive fragmentation of the accountability process in children's services. Virtually every state has enacted legislation for reporting and tracking instances of child abuse in the general community and in institutions and programs for children, and both public and private groups have issued a variety of preventive standards.[10] No one, however, has yet attempted to integrate the variety of standards on abuse, grievances, discipline, rights and placement in a comprehensive accountability system.

The nearest approach so far to an integrated system for accountability appears in the work of the American Correctional Association's Commission on Accreditation for Corrections. In 1978 and 1979, the Commission published four separ-

ate manuals of standards for juvenile training schools and services; juvenile detention facilities and services; juvenile community residential services; and juvenile probation and aftercare services. In succeeding years, the Commission has revised and reissued its standards and produced all sorts of additional materials in support of the standards. In August, 1983, it published policy guidelines consisting of sample policies incorporating the standards for juvenile detention facilities.[11] The policy on juvenile rights in the guidelines calls for the creation of a grievance procedure for clients that incorporates independent review and client participation and an institutional ombudsperson. Because the policy is designed for relatively large, secure institutions, it is not relevant to some residential facilities and programs engaged in the delivery of children's services. Nonetheless, the policy's call for both a participatory grievance mechanism and an ombudsperson/advocate to ferret out complaints from less aggressive and articulate clients marks it as a significant advance over the other standards.

It is the tremendous variety of programs in the field of child care that frustrates comprehensive approaches. Take, for example, the creation of accountability mechanisms for foster care. Clients, often alone and ranging in age from infancy to adulthood, are subject to almost complete control by foster parents. Efforts to devise useful standards for accountability in such circumstances simply have not met the challenge. The American Public Welfare Association's basic standard on grievances, for example, requires a supervising state agency to ensure that clients receive "copies of procedures for resolving grievances," while its more advanced or "Goal Standard" urges the supervising state agency to be "readily accessible to service users for the redress of grievances."[12] These are empty platitudes that provide absolutely no guidance to administrators. By contrast, the Colorado Department of Social Services has developed a process in which it promises to send a representative to visit any facility that is the subject of a complaint from an identified complainant. The result of any visit and investigation becomes part of the licensing renewal process.[13] That seems a far more practical and promising approach to accountability than the exhortations of the American Public Welfare Association.

In New York City, each contract between the City's Special Services for Children (SSC) and foster care agencies requires the latter to establish complaint procedures for clients with appeals to SSC, the State Department of Social

Services and the courts. In addition, in 1983, SSC implemented a children's rights unit to respond to clients' complaints and offer protective services. A feature of the latter program is a catchy bilingual poster and hand-out informing youngsters of the availability and purposes of the children's rights unit.[14]

Discussion of the standards movement cannot end without a word about the accreditation process. Standards, by themselves, represent little more than general ideals; unless they are integrated into the operational life of agencies, they are largely useless. Thus, wherever standards pop up, they are followed before long by some sort of organized effort to implement them. In juvenile justice, the American Correctional Association's Commission on Accreditation has preempted the field. In the broader area of child care, the accreditation process is more competitive. The National Association of Homes for Children offers certification, as does the Council on Accreditation of Services for Families and Children (sponsored by the Association of Jewish Family and Children's Agencies, the Child Welfare League of America and the Family Services Association of America), to interested facilities and programs, while the Interstate Consortium on Residential Child Care offers a limited clearinghouse service in addition to its compilation of standards.

As described earlier, the process of accreditation involves commitment on the part of a public or private provider to the accreditors' set of standards. After a period of preparation in which the provider, usually with some technical assistance from the accrediting agency, exerts efforts to comply on its own with as many standards as possible, the accrediting agency dispatches a team to review the candidate provider's policies and procedures, records, files and contracts; to talk to administrators, staff and clients; and generally to assess the candidate's compliance with standards. If deficiencies are uncovered, the provider is usually given a period of time to rectify them. Once the candidate complies with a stated percentage of applicable standards, the institution or facility is certified as meeting standards.

Because the accreditation process involves a great deal of paper review, as well as possibly extensive site visits, by professional peers, it gets expensive. The benefits accrued as a result of certification include both the improvements in management resulting ineluctably from compliance with rigorous standards and the enhanced prestige deriving from recognition as a certifiably well-run facility or program.

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Criticisms of the accreditation process have focused on the cost and the emphasis on policies and procedures sometimes to the exclusion of actual services and conditions. Moreover, while there is some follow-up after certification, the process is basically a one-time affair; as such, certification says very little about the status of a program in subsequent years.15

From the perspective of this study, there are some serious fissures in the standards movement that has evolved over the past decade. No set of standards has yet confronted in more than a superficial way the issues raised by the increasing privatization of children's services. Particularly, none has addressed the complex problem of accountability created by the contracting out to private providers of responsibility for the care and treatment of the young. How does a supervising state agency ensure that the clients of a provider receive the services scheduled for delivery in a competent and humane way that is respectful of their dignity? How does a supervising state agency ensure that a provider's clients have the means to complain about unsatisfactory services, as well as to protest physical or sexual abuse, harrassment or intimidation?

The answers to these inquiries cannot be found in the standards developed for children's services and juvenile justice because the standards makers have yet to put these questions to themselves. The quiet growth of privatization and uncertainty about the impact of this new relationship between the private and public sectors have permitted these questions to go unasked right up to the present.

Services and the courts. In addition, in 1983, SSC implemented a children's rights unit to respond to clients' complaints and offer protective services. A feature of the latter program is a catchy bilingual poster and hand-out informing youngsters of the availability and purposes of the children's rights unit.[14]

Discussion of the standards movement cannot end without a word about the accreditation process. Standards, by themselves, represent little more than general ideals; unless they are integrated into the operational life of agencies, they are largely useless. Thus, wherever standards pop up, they are followed before long by some sort of organized effort to implement them. In juvenile justice, the American Correctional Association's Commission on Accreditation has preempted the field. In the broader area of child care, the accreditation process is more competitive. The National Association of Homes for Children offers certification, as does the Council on Accreditation of Services for Families and Children (sponsored by the Association of Jewish Family and Children's Agencies, the Child Welfare League of America and the Family Services Association of America), to interested facilities and programs, while the Interstate Consortium on Residential Child Care offers a limited clearinghouse service in addition to its compilation of standards.

As described earlier, the process of accreditation involves commitment on the part of a public or private provider to the accreditors' set of standards. After a period of preparation in which the provider, usually with some technical assistance from the accrediting agency, exerts efforts to comply on its own with as many standards as possible, the accrediting agency dispatches a team to review the candidate provider's policies and procedures, records, files and contracts; to talk to administrators, staff and clients; and generally to assess the candidate's compliance with standards. If deficiencies are uncovered, the provider is usually given a period of time to rectify them. Once the candidate complies with a stated percentage of applicable standards, the institution or facility is certified as meeting standards.

Because the accreditation process involves a great deal of paper review, as well as possibly extensive site visits, by professional peers, it gets expensive. The benefits accrued as a result of certification include both the improvements in management resulting ineluctably from compliance with rigorous standards and the enhanced prestige deriving from recognition as a certifiably well-run facility or program.

FOOTNOTES

1 The procedure was selected by LEAA as a so-called exemplary project and, as such, was the subject of much descriptive and evaluative literature and a national series of conferences. See, e.g., D. McGillis, J. Mullen, L. Studden, Controlled Confrontation: The Ward Grievance Procedure of the California Youth Authority, National Institute of Justice, 1976.

2 Virginia McArthur, "Inmate Grievance Mechanisms: A Survey of 209 American Prisons," Federal Probation, 1974; J.M. Keating, Virginia McArthur, Michael Lewis, Kathleen Sibelius and Linda R. Singer, Grievance Mechanisms in Correctional Institutions, National Institute of Justice, LEAA, 1975.

3 See, e.g., Standards for the Administration of Juvenile Justice, Report of the National Advisory Committee for Juvenile Justice and Delinquency Prevention, 1980, Standard 4.8: Grievance Procedures:

> Written grievance procedures should be established for all residential and nonresidential programs. Each juvenile should be provided with an explanation and a copy of these procedures at the time the juvenile is admitted to the facility.
>
> Although the form of grievance procedures may vary, all such procedures should provide for:
>
> a. Review of grievances by an agency official above the level of the facility director, and by an independent review board, or an impartial individual not employed by the agency;
> b. Time limits for resolution of the grievance; and
> c. Involvement of staff and juveniles

4 Standard R4.68 and Commentary, Guidebook on Residential Child Care, 1980.

5 Michigan Federation of Private Children's Agencies: Client Grievance Procedures, March, 1973. The federation's title was expanded after 1973.

6 Standard for Group Home Facilities and Child Caring Institutions, Division of Family Services, Missouri Department of Social Services, May 1981.

7 Grievance Policy and Procedure, Oklahoma Commission for Human Services, 1983. This is a remarkable document that seeks to address abuse, grievances and placement in a complex process in a variety of institutional and programmatic contexts. It provides a blueprint for the most thorough accountability system developed to date, although its length and complexity create serious challenges to effective implementation.

8 An example from the standards of The California Association of Children's Residential Centers, Inc., 1976, illustrates the point:

> The agency shall have written policies and appropriate procedures for receiving and responding to child/adolescent/family comments, questions and/or complaints.

9 Proposed Standards for Discipline Policies and Proposed Procedures for the Reporting, Investigating and Correction of Incidents of Child Abuse/Neglect, Ohio Association of Child Caring Agencies, Inc., 1981.

10 An example is the project on federal standards for child abuse and neglect prevention and treatment programs and projects, which has published guidelines for child care institutions, Child Abuse and Neglect in Residential Institutions: Selected Readings on Prevention, Investigation, and Correction. U. S. Department of Health, Education and Welfare, 1978.

11 American Correctional Association Commission on Accreditation for Corrections, Guidelines for the Development of Policies and Procedures, Juvenile Detention Facilities, 1983.

12 American Public Welfare Association and the Children's Bureau of the U. S. Department of Health, Education and Welfare, Standards for the Foster Family Services System with Guidelines for Implementation Specifically Related to Public Agencies, 1975.

13 Minimum Standards and Rules and Regulations Governing Family Foster Homes, 1974.

14 A copy of the poster is enclosed as Appendix C. One of the most serious obstacles to accountability in children's service is the difficulty of communicating successfully to youngsters the availability of avenues for the expression of grievances and charges of abuse. This poster is the only example encountered in the entire course of the study of a well thought-out, written effort to communicate with clients on their level about accountability.

15 Shortly after the Menard Correctional Center in Chester, Illinois received certification from the ACA Commission on Accreditation, medical services in the institution were found by a local federal district court to be a violation of the Eighth Amendment's prohibition against cruel and unusual punishment. Lightfoot v. Walker, 486 F.Supp. 504 (S.D.Ill. 1980).

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

The private providers of human services visited during the course of this project were among the very best in their business in their respective states; all had struggled to establish enduring and successful relationships with their public partners, and most operated a multiplicity of diverse and innovative programs and facilities. Their stability and longevity instilled in them a confidence that is the envy of their competitors among the ranks of private providers. Yet, nothing encountered during this project diminished in any way recognition of the need for formal accountability on the part of private providers of children's services under contract to state agencies.

Security and durability simply do not eliminate forever serious internal problems. The following list records only some of the incidents involving provider staff that occurred during the brief life span of this project and were described in interviews:[1]

1. One staff member was fired summarily for punching a 13-year-old boy;

2. Another counselor, often in a situation where he could be alone with young boys, was dismissed for homosexuality;

3. A child care worker, provoked by the racial slurs of a client, decked the provoker;

4. Two staff members of another provider were dismissed for attempting to peddle cocaine to clients; and

5. One long-time staff member was forced to resign after repeatedly slapping a youngster in full view of the program's whole population.

Interviews with clients also produced accounts of one privately operated emergency shelter facility that was sparsely supplied with broken and decrepit furniture and fed reduced rations to clients for months before it was finally closed down. It was reported earlier how sensational media coverage led to the revocation of the contract for a foster home that locked out youngsters who violated the house curfew.

It should come as no shock to us that these kinds of incidents can occur when we read with horror almost daily tales of parental abuse of children. If the bonds of blood and parental love work so poorly to restrain the abuse of offspring, how can we expect strangers, rendering services for pay to neglected, troubled and delinquent children, to avoid entirely the ill-treatment of their charges? Services, moreover, are often delivered in a total structural and organizational framework that distorts normal relationships and imposes on keepers and kept alike psychic burdens that we are only beginning to understand and respond to. Add to all of this the deficiencies and limitations of recruiting and training of child care staff that plague the providers of children's services, and you have a sure prescription for recurrent neglect and maltreatment.[2]

Because these services are funded with tax dollars, private providers charged with their delivery acquire a public character that subjects them to careful public scrutiny. While any provider theoretically is answerable to its clients, providers here are answerable additionally to the tax-paying public. Surrogates for young clients of purely private providers may tolerate deprivation and abuse if they are simultaneously relieved of the burden of providing care themselves, but the state cannot and will not be so tolerant. Acceptance of public funds imposes on private providers a responsibility to deliver services competently and humanely, just as delegation of the state's statutory obligation to provide services imposes on it a compelling duty tc ensure that private providers deliver their services in a competent and humane way.

The frailties of human nature, the unnatural environment of total institutions, inadequacies of staff selection and training and the public character of tax-supported human services all bespeak the importance of relentless agency vigilance, but the thrust of the need for accountability is as much prophylactic as it is retrospective. The best way to prevent mistreatment is to ensure that, if it occurs, abuse will be exposed swiftly and surely and bring down upon its perpetrator certain retribution. The vulnerability and weakness of the clientele and their frequent isolation in residential facilities makes imperative a prophylactic accountability system in children's services.

Fortunately, just about everyone concedes the need for accountability; the difficulty is that this concession has not yet driven responsible officials to think through and develop

an accountability process appropriate to the privatization of the delivery of human services. While expressing their awareness of the need for, and genuine concern about, accountability, the two state agencies involved in this study have yet to address the issue squarely. Instead, they have relied on a potpourri of pre-existing, ad hoc measures that make no distinction between direct and contracted services and treat contracts for programs and facilities no differently than food service contracts.

It is not just inadvertence that has prevented the development of effective accountability mechanisms; they are difficult to design and implement. The sheer diversity of private providers in terms of delivered services, organizational framework and the nature and size of clientele impedes the identification and articulation of broadly applicable criteria for accountability. The inability of some clients of children's services to initiate and pursue complaints aggressively on their own imposes a special burden because it means that the system or service that is the cause of complaints must also process and respond to them, a situation inherently inimical to accountability. Finally, the range of activities subject to accountability is so broad, running as it does from abuse to discipline, placement, simple grievances and interpersonal disputes, the design of sufficiently flexible and versatile accountability measures has proven elusive.

What follows is no single or specific model for a particular accountability mechanism, but rather a collection of principles and structural outlines that any state agency interested in developing accountability measures for its private providers of services must consider. While the suggestions here are rooted in observations gleaned from examination of the privatization of children's services in the Massachusetts DYS and the Rhode Island DCF, they also reflect the work of standards makers in juvenile justice and child care and experimental efforts and research in the development of institutional grievance mechanisms. The structures and principles enumerated here are merely the starting point for the elaboration of any specific accountability process; each state agency and provider must take the principles and structures and use them carefully to handcraft mechanisms appropriate to their own circumstances.

1. Accountability or complaint procedures for private providers: Either in contracts with private providers or in licensing regulations, state agencies ought always to require providers to have a written complaint procedure for clients.

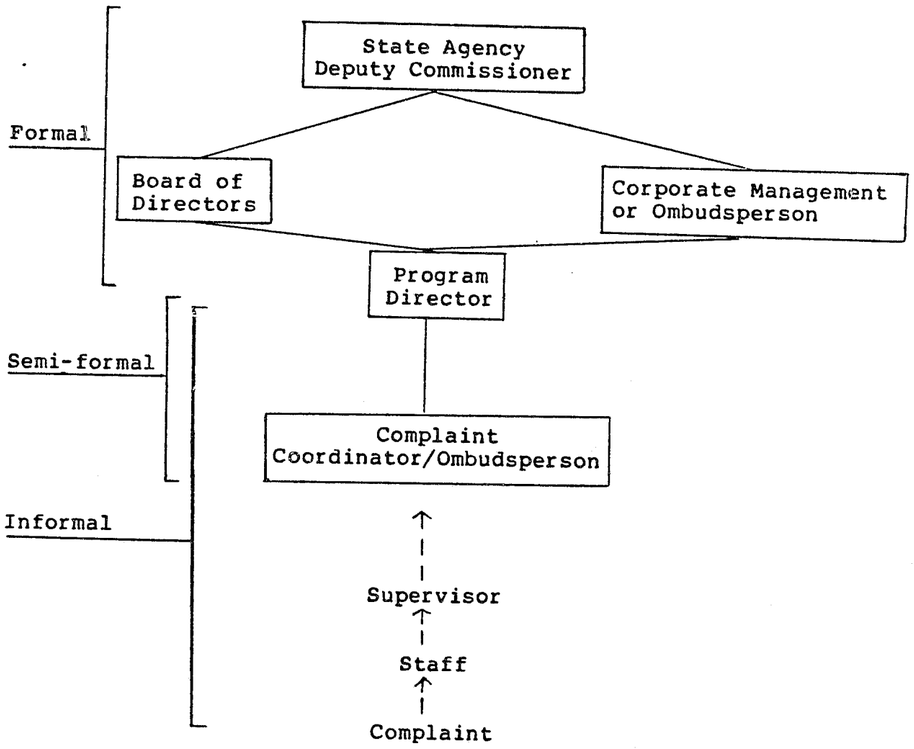
The procedure should be "written" in the sense that it is incorporated in the provider's written policies and a description of it is made available in writing to clients. The final form of the procedure in any program or facility may vary with the size, structure and nature of services of the provider, but every procedure should include the following three elements:

a. Informal process: Clients here are required to seek informal resolution of complaints at the lowest possible level. Complaints that remain unresolved may be pursued verbally through appropriate staff levels to supervisors and administrators. A complainant may be required to seek informal resolution of grievances, but the informal process must consume no more than a day or two.

b. Semi-formal process: Each private provider should designate someone to serve as an institutional or program complaint coordinator or ombudsperson. When clients are unable to resolve their complaints satisfactorily through informal means, they may take them to the complaint coordinator, whose primary tasks are to investigate complaints, make recommendations for their resolution and persuade parties to adopt mutually acceptable resolutions. If the complaint coordinator or ombudsperson is unable to resolve complaints, he or she may assist clients who wish to pursue complaints further to write up grievances and push them into the formal process. This semi-formal process also must consume no more than a few days.

c. Formal process: Once a complaint is formalized and filed, the program or facility director must respond to it promptly in writing with reasons for the response. This decision may be appealed to the provider's board of directors or to the provider's corporate management,[3] either of which must respond in writing in timely fashion after granting the client a hearing on the merits of the complaint. Finally, the grievant may be entitled to appeal unfavorable decisions at these levels to a designated administrator (say, the commissioner or a deputy commissioner) of the supervising state agency, who, also, is obligated to return timely, written responses.

Private Provider
Accountability or Complaint
Procedures



This three-tiered process preserves intact the informal approach to complaints that is the backbone of existing accountability mechanisms, but also provides an intermediary step that reinforces and assists the informal one. It also assures a dissatisfied client, whatever his or her limitations of intelligence or ability, of access to a formal and somewhat independent review of grievances. The complaint coordinator or ombudsperson is charged with helping a grievant obtain satisfactory resolution of his or her complaint and, in the absence of a satisfactory outcome, with guiding the client's appeal through the various levels of review. The formal process allows a client to participate to some extent in efforts to resolve the complaint by guaranteeing a formal hearing of appealed grievances. Providers would do well to fashion a meaningful participatory hearing process to give their accountability process credibility with clients, the supervising agency and the general public.

While this process may seem at first blush impossibly elaborate and demanding, it is neither. Most programs and facilities have some middle manager, whether a director of treatment, house manager or child care supervisor, who already serves informally as a complaint coordinator. The structure suggested here simply requires that this informal role be defined and systematized. During the semi-formal process, the complaint coordinator almost always will be working with the program or facility director to resolve issues; if the director's decision is unsatisfactory to the grievant, the first step in the formal process requires only that the director's rejection be put in writing so it can be referred directly to the provider's board of directors or corporate headquarters. Given the easy access of clients to the administrators and directors of private providers documented in this report, informal and semi-formal processes and initial steps of the formal process all might consume no more than a few hours or, at most, days.

Another useful innovation might be the designation of a client representative to work with each complaint coordinator, whose task would be to provide to other incoming clients an orientation to the complaint procedure and assist the coordinator in developing acceptable resolutions to disputes. Almost always the principal meaningful source of information for newly arrived clients on facility and program procedures and routines is other clients. This suggestion simply recognizes that fact and turns it to good use.

2. A "client rights awareness" program: Every private provider of social services ought to be required to provide clients with a written copy of their rights. The rights to be enumerated should be spelled out by state agencies in regulations formally adopted and applied to all providers. Probably more important than the content of the statement of rights is the form in which it is prepared for dissemination, especially to young clients. Each state agency ought to develop a comic book or videotape for the expression of rights in a style and manner intelligible to the least educated of its clients. Any statement of rights must also be provided in the language of any substantial ethnic minorities in the provider's clientele.

At the time of placement of a client in a facility or program, he or she should be assigned a primary counselor or advocate, preferably someone other than a child care worker with direct supervision over the youngster. This advocate should ensure that his or her clients receive, read and understand the statement of rights and know how to contact their advocate, as well as their state assigned caseworker and any other state agency with responsibility for monitoring the abuse of clients. The advocate should be required to meet at least weekly with each assigned client for a minimum period of, say, 30 minutes.

This requirement reflects the fact that some clients are incapable of initiating on their own a formal grievance or may be so intimidated they are afraid to do so. Private providers ought to be required by contract to provide an internal advocate for each client.

3. Client access to mechanisms for monitoring abuse: Although state legislatures and agencies have developed a variety of offices and procedures for investigating claims of institutional abuse, clients frequently know nothing of the existence or operations of such mechanisms. Complaint coordinators (and their client assistants) and client advocates should be charged with responsibility for ensuring that all clients understand these accountability mechanisms and know how to obtain access to them. In addition, where a process exists for the reporting of incidents of alleged abuse, clients, either alone or with the assistance of their advocate or the facility or program complaint coordinator, ought to be able, whenever possible, to append to the incident report their version of what occurred. This begins to address the problem of the self-serving incident report which prevents further inquiry

by downgrading the seriousness of the reported incident. It also involves a client's advocate early in investigations of abuse.

While these suggestions may be helpful in upgrading accountability among private providers, they share a common infirmity. All are largely dependent on the good will of the private provider's management and personnel. Unfortunately, accountability is most easily and effectively obtained in programs and facilities that need it least, while those with the greatest need for accountability are least likely to welcome it. This means that internal mechanisms, while important, will never suffice to ensure accountability effectively.

4. Supervision of private providers by state agencies: The key to effective state agency supervision of private providers rests not with regional or central office personnel assigned to coordinate private providers' activities, but rather with agency operatives who have direct and frequent contact with clients. Caseworkers, social workers or primary service workers detailed to plan and monitor the progress of clients are the state agency's and the larger public's eyes and ears among private providers. Obviously they can detect and report past abuses and inefficiencies and prevent future ones only if they maintain regular contact with their clients. It is up to the managers and supervisors of caseworkers to make sure they have the time and resources to fulfill this essential monitoring task.[4]

5. State agency program, licensing and contract reviews: To some extent the fragmentation of agency efforts to conduct programmatic reviews, licensing inspections and reviews for contract renewals is probably inevitable and irreversible. On the basis of this study, such fragmentation may even be decidedly advantageous; the experience in Rhode Island suggests that when the three review functions are merged in one office, none gets done very thoroughly.

The major problem with the various program and facility monitoring efforts of state agencies, whether fragmented or consolidated, is the fact that the sheer volume of privatized services makes whatever review that occurs virtually totally reactive. Somewhere in the monitoring capacity of a supervising agency there has to be room for a program of annual reviews of randomly selected private providers that involve an analysis in depth of conditions, programs and policies, complete with structured interviews of a substantial cross-section

of clients and line staff, as well as administrators. The failure to provide some sort of regularly scheduled, detailed review gives private providers with serious problems a strong incentive to conceal their difficulties. On the other hand, if providers know they will be subjected periodically to probing analysis, they may be more open and candid about their problems to forestall negative reviews. This measure is completely prophylactic and absolutely necessary if the various review processes are ever to become fully meaningful accountability measures.

6. Regular surveys of clients: Any state agency that contracts with private providers to deliver human services ought to develop a simple written survey to be administered to a set percentage of "released" clients some 60 to 90 days after their exit from a privately operated facility or program. The purpose of the surveys would be to provide a continuing evaluation of provider services by recipients of those services. Occasional surveys can provide state agency personnel with clues to budding difficulties, while regularly repeated surveys give agency supervisors a valuable "window in" to monitor troubling situations or personnel in private providers that can be shared with provider management. The advantage of the device is the freedom from intimidation it promises to clients no longer subject to the control of an inhumane or incompetent provider.

Some may view this last suggestion as little more than an invitation to malevolent clients to malign perfectly competent, caring staff. Much the same criticism can be leveled at all of the suggestions for accountability offered here. Unquestionably, the more opportunities clients are given to complain, accuse and impugn, the more frequently they will do so, and it is inevitable that an escalating output of grievances will include occasionally frivolous, mendacious and downright malicious ones against provider staff and administrators. But none of the approaches suggested here requires or envisions the abandonment of the rights of provider personnel. Serious allegations against staff must always be investigated and substantiated before they are allowed to have any negative impact. A concerned skepticism should continue to characterize investigative efforts, just as it does now.

No one of these suggestions alone will suffice to constitute an effective accountability system. Any effective system must recognize that some clients are fully capable of initiating, pursuing and participating in the settlement of

their own disputes and complaints, while others may lack the will or the wherewithal to do much of anything for themselves even in the face of extreme hardship or abuse. A complete accountability system, then, must be available to both groups.

The focus of this study has been exclusively on accountability in the delivery of services to youthful clients who sometimes are violent, militant and articulate. This narrow focus tempts one to overlook or forget the intense vulnerability of many clients of private providers of social services. That vulnerability can be both subtle and pervasive. Consider, for example, a stay you may have had in a hospital when you, educated and articulate as you may be, suppressed complaints about the rough or negligent treatment dished out by a particular nurse for fear of effecting adversely subsequent care. How often do the relatives of elderly nursing home patients acquiesce in shoddy treatment and shabby conditions out of fear that complaints will result in a loved one's eviction? More difficult yet, how many retarded and emotionally disturbed clients, young and old, are so trapped in their innocence and disabilities they accept with simple resignation whatever cruelties and deprivations are visited on them?

Not all of the accountability measures suggested here will be equally useful to these different client populations, but most of them can contribute usefully to the attempt, long overdue, to hold private providers of social services accountable to their clients and the general public.

FOOTNOTES

1 The list includes only those incidents which were verified by provider and state administrators.

2 One recent news item describes the indictment of the founder and staff of a California nursery school who sexually molested up to 150 of their charges. The accused apparently mutilated small animals in front of their young victims and threatened to do the same to the children's parents if the children talked to anyone about what had happened. New York Times, March 25, 1984, p.25.

3 Virtually every private provider has a board of directors or trustees from which a committee on grievances might be constituted. The distinction here is between a provider operating a sole program or facility and corporate providers operating two or more programs or facilities. In the latter case, the corporate provider is urged to develop innovative complaint mechanisms including, perhaps, a corporate ombudsperson or a committee of clients and staff to resolve complaints.

4 Part of the answer may be in the way monitoring schedules for institutionalized clients are structured. If one or two caseworkers can take responsibility for weekly visits with all clients in a small facility, for example, then service workers might be able to reduce their personal visits with individually assigned clients to a monthly basis.

Nowhere is the need for regular caseworker visits more urgent than in the case of foster children who, most often, lack a provider advocate and must depend on the state caseworker as advocate, complaint coordinator and state agency monitor. There is simply no excuse for irregular and infrequent caseworker contact with foster children.

APPENDIX A

Description of Private Facilities and Programs Visited for Project

Description of Private Facilities and Programs Visited for the Project

MASSACHUSETTS

1. Fay Rotenberg School
   1100 Princeton Boulevard
   Chelmsford, Massachusetts 01863 (617) 453-0556
   Director: Jennifer M. King
   Operated by Robert F. Kennedy Action Corps, Inc.

   A secure treatment facility for 12 girls, ages 14-18. The length of commitment of residents runs from eight months to two years.

2. Hastings House
   66 Chestnut Street
   Cambridge, Massachusetts 02139 (617) 868-6199
   Project Director: Michael A. Radon
   Operated by Massachusetts Half-way Houses, Inc.

   A group home for up to ten boys, ages 14-18, taken over by Massachusetts Half-way Houses, Inc. in April, 1983 from another corporate provider. The program takes referrals from both the Department of Social Services and the Department of Youth Services. The average length of time in the program for residents is nine to 12 months.

3. Joseph M. Ambrose House
   31-1/2 Dwight Street
   Boston, Massachusetts 02118 (617) 482-0602
   Director: Thomas E. Boydell
   Operated by Massachusetts Half-way Houses, Inc.

   A community-based group home for up to ten boys, ages 16-18. The program consists usually of three to six months in the residential facility with a like period of supervision in the community. Ambrose House, opened in 1977, was Massachusetts Half-way House, Inc.'s first juvenile program. The facility also houses a federally supported program for violent offenders.

4.& 5. The Key Program, Inc.: Alternatives for Youth
49-51 Franklin Street, Fall River, Massachusetts 02720
(617) 675-0686
Regional Director: Raleigh M. Jenkins

The Fall River site is the Southeastern Regional Office for the Key Program, out of which a number of programs are conducted, including:

a. Outreach and tracking: A program that supervises intensively up to 25 male and female youngsters in the community and provides a variety of support services. Caseloads are kept to six or seven per staff worker. The average length of the term of involvement in the program for youngsters is about six months.

b. Foster care: The regional office operates three to four foster homes, all private homes contracting with The Key Program. Placed children range in age from 14 to 17 and generally spend about one to three months in a foster home.

6. Metropolitan Boston Group Home (METRO) 699 Massachusetts Ave.
Boston, Massachusetts 02118 (617) 445-0450
Director: Philip F. Murphy
Operated by Massachusetts Half-way Houses, Inc.

A community-based group home for up to ten boys, ages 16-19, with emphasis on developing community educational and work placements. After youngsters leave the house, they receive continuing supervision and counseling services in the community. The average length of stay in the group home is about five months.

7. Robert F. Kennedy School/Westboro Westboro State Hospital
Westboro, Massachusetts 01581 (617) 366-1969
Director: G. Michael Welch
Operated by Robert F. Kennedy Action Corps , Inc.

A secure treatment facility for up to 15 boys ages 14 to 18. The average length of stay at the facility is 12 months.

8. Westfield Detention Center/RFK Action Corps Detention Project
51 East Mountain Road
Westfield, Massachusetts 01815 (413) 568-8636
Project Director: Everett F. Noel
Operated by Robert F. Kennedy Action Corps , Inc.

A maximum security detention facility for up to 24 boys, ages 14-18, for short periods, usually less than 90 days. The facility is run by a mixed staff of private and public employees, with the former providing program administrators and treatment staff, while the latter provide custodial personnel.

MASSACHUSETTS PROVIDERS' ACCOUNTABILITY MECHANISMS

Program or Facility	Type of Accountability Mechanism: Formal Procedure	Informal Procedure	Case-management Process	Assigned Staff Member/Advocate	Client House Meetings	Corporate Provider Procedure
Fay Rotenberg School		x	x	x	x	x
Hastings House		x	x		x	
Ambrose House	x	x	x		x	
The Key Program						
a. Outreach and tracking		x	x			
b. Foster care		x	x			
METRO	x	x	x		x	
RFK/Westboro		x	x	x	x	x
Westfield Detention		x				x

RHODE ISLAND

1. Camp E-Hun-Tee — Rural Route #1, Box 607A
Exeter, Rhode Island 02822 — (401)539-7775
Resident Director: David J. Lemmerman
Operated by the Eckerd Wilderness Educational System of the Jack & Ruth Eckerd Foundation

A residential, wilderness program for up to 56 boys, ages 11-17, providing education and group living in an outdoors environment. The average length of time spent in the program is 12 to 14 months. Participation in the program is completely voluntary. Camp E-Hun-Tee is one of 12 similar camps run nationwide by the Eckerd Wilderness Educational System.

2. New Routes — 939 Douglas Avenue
Providence, Rhode Island 02908 — (401) 831-4630
Program Director: Katie Shannon
Operated by Tri-Cap, Inc.,
Executive Director: L. Joseph Testa

An emergency shelter residence for up to ten boys, ages 12-17. Placements are temporary and rarely exceed 45 days. Tri-Cap, Inc., founded in 1973,also operates a group home, a federally funded runaway program and an ACTION-sponsored community volunteer program.

3. Ocean Tides, Inc. — 635 Ocean Road
Narragansett, Rhode Island 02882 — (401) 789-1016
President: Brother Robert W. Hazard, F.S.C.

Ocean Tides consists of three facilities: a main campus in Narragansett, once a Christian Brothers novitiate and retreat house, which houses up to 24 adjudicated boys, ages 13-17, and has a school; and two community-based group homes for five to seven boys each in Providence, from which residents return to school at the Narragansett facility. The average length of stay in the program, which involves moving from the Narragansett campus to the Providence group homes, is nine to 12 months. Ocean Tides, founded in 1975, also operates a diversionary program that provides counseling for youngsters who remain in their homes.

8. Whitmarsh House — 530 Dexter Street
Providence, Rhode Island 02907 — (401) 467-7216
Executive Director: Brother John T. McHale, O.L.P.
Operated by Whitmarsh Corp.

A long-term group home for up to eight boys, with an additional six boys in two satellite houses. The youngsters range in age from 13 to 19 years, but most are older high school students who attend community schools. The average length of stay in the program is about two years, although some have stayed as long as three or four years. Whitmarsh Corp. also operates an emergency shelter program for five boys.

RCA Evaluation and Treatment Center
Cranston, Rhode Island 02920 - 400 New London Avenue
Project Manager: James E. Patrick (401) 732-2111
Operated by RCA Service Company, Division of Government Services

A residential treatment facility for up to 22 male and female youngsters, ages 13-18. The average length of stay is nine to 12 months. The RCA Evaluation and Treatment Center began operation of this Rhode Island program in mid-1981.

5.& 6. St. Aloysius Home
Greenville, Rhode Island 02828 40 Austin Avenue
Director: Rev. Robert J. McIntyre (401) 949-1300

St. Aloysius Home is an agency of the Catholic Diocese of Providence and is operated solely under contract to the Department for Children and Their Families:

a. Residential treatment facility: Has a capacity of 73 boys, ages 6-14, who require long-term intervention and treatment. The average length of stay in the program is about one year.

b. Emergency shelter program: Serves up to 15 boys, ages 3-14, who need short-term emergency care and evaluation, generally for 45 days or less.

7. St. Mary's Home for Children
North Providence, Rhode Island 02911 420 Fruit Hill Avenue
Executive Director: Paul Adams (401) 353-3900

Affiliated with the Episcopal Church, St. Mary's Home includes both a residential program for up to 23 girls, ages 9-15, and a group home for seven female high school students, 16 years and older. There is a school within the facility for the younger girls, while the older ones attend a local high school. The length of stay for youngsters in the program is approximately 14-16 months. Founded in 1877, St. Mary's also operates day care and family day care programs for a fee and an outreach program.

RHODE ISLAND PROVIDERS' ACCOUNTABILITY MECHANISMS

Program or Facility	Type of Accountability Mechanism				
	Informal Procedure	Case-management Process	Assigned Staff Member/Advocate	Client House Meetings	Corporate Provider Procedure
Camp E-Hun-Tee	x	x	x		x
New Routes	x				
Ocean Tides	x	x	x	x	
RCA	x	x	x	x	
St. Aloysius:					
Home	x	x	x		
Shelter program	x	x	x		
St. Mary's	x	x	x		
Whitmarsh House	x	x		x	

APPENDIX B

Interview Protocol

INTERVIEW PROTOCOL

The following guidelines for the conduct of interviews in privately-run service provider facilities and programs are intended to ensure some measure of uniformity in the data generated during site visits. At the same time, it is recognized that differences in the nature, size and purpose of various homes and programs will require some measure of flexibility in the use of this protocol. Nonetheless, the following sequence of events ought to be observed at each facility or program visited.

1. Director/Superintendent/Senior Manager:

   a. Description of this project;
   b. Explanation of site visit components:
      1.) Number of interviews; desired interviewees; copy of protocol; selection of staff and client interviewees and arrangements for interviews.
      2.) Questionnaires for clients; selection of clients; arrangements for administration.
   c. Confidentiality assurance;
   d. Conduct interview (see attachment 1)

2. Manager, supervisor, staff person in cnarge of responding to complaints:

   a. Description of this project;
   b. Confidentiality assurance;
   c. Conduct interview.

3. Line staff (three to four operational staff members with direct supervisory responsibilities for youngsters):

   a. Description of project;
   b. Confidentiality;
   c. Conduct interview.

4. Residents/clients (three to four residents/clients).

5. Administer questionnaire to full population of a facility or to as many clients of an out-patient program as possible.

6. Touch base with senior manager before leaving facility/program to share impressions while preserving confidentiality.

INTERVIEW: DIRECTOR

1. Position

2. Length of time in position? in program? with service provider? in youth programs?

3. Brief sketch of educational/professional background.

4. Brief description and history of this program/facility.

5. Define "grievance"; within that broad definition what are the most frequent types of grievances in this program/facility? With what frequency do they occur?

6. Any formal mechanism for handling "grievances"? Written? Records? Copies of complaints? Statistics? Characteristics (timeliness, written responses, etc.)?

7. Any informal mechanisms? Is there some individual with responsibility for grievances or to whom grievances are most often referred? Who? Why? How do residents know of it/him/her?

8. Suppose a youngster were unhappy with the way he/she had been treated by a staff member, what could he/she do?

9. Suppose a youngster were unhappy with a departmental, institutional or program rule or policy, what could he/she do?

10. Do parents, guardians, friends, relations, others (specify) ever have "grievances"? Nature and frequency. What happens to them?

11. What would a youngster do with a complaint about physical or sexual intimidation or assault? Ever had such a complaint in this facility/program? What result?

12. Child Advocate or Departmental Inspector ever visit this institution? Why? What result? Would youngsters in this program or facility know how to contact Child Advocate or Departmental Inspector?

Interview: Director

13. Does this facility/program need a formal grievance mechanism? Why? Why not? If so, what would you expect it to do for you as a manager?

14. Does the state require you to have any form of grievance mechanism? Should it?

15. If there were many complaints here -- or in any private facility/program under contract with the State -- how would a supervising state agency be likely to find out about them? Should the number and gravity of complaints ever be a component in a state agency's decision to renew or not to renew a contract? Why? Why not?

Thanks for your assistance.

INTERVIEW: COMPLAINT SPECIALIST

1. Position.

2. Length of time in position? in program? with service provider? in youth programs?

3. Brief sketch of educational/professional background.

4. Brief description and history of this program/facility.

5. Define "grievance"; within that broad definition what are the most frequent types of grievances in this program/facility? With what frequency do they occur?

6. Any formal mechanism for handling "grievances"? Written? Records? Copies of complaints? Statistics? Characteristics (timeliness, written responses, etc.)?

7. What is your role in this formal mechanism? How chosen? Any training? Do you provide an orientation in the mechanism for residents/clients? How?

8. If there is no formal mechanism, what is your role in the informal mechanism? How chosen? Any training? How do you handle complaints? Records? Statistics? Orientation?

9. Suppose a youngster were unhappy with a departmental, institutional or program rule or policy, what could he/she do?

10. Do parents, guardians, friends, relations, others (specify) ever have "grievances"? Nature and frequency. What happens to them?

11. What would a youngster do with a complaint about physical or sexual intimidation or assault? Ever had such a complaint in this facility/program? What result?

12. Child Advocate or Departmental Inspector ever visit this institution? Why? What result? Would youngsters in this program or facility know how to contact Child Advocate or Departmental Inspector?

Interview: Complaint Specialist

13. Does this facility/program need a formal grievance mechanism? Why? Why not? If so, what would you expect it to do for you as a manager?

14. Does the state require you to have any form of grievance mechanism? Should it?

15. If there were many complaints here -- or in any private facility/program under contract with the State -- how would a supervising state agency be likely to find out about them? Should the number and gravity of complaints ever be a component in a state agency's decision to renew or not to renew a contract? Why? Why not?

Thanks for your assistance.

INTERVIEW: STAFF MEMBER

1. Position.

2. Length of time in position? in program? with service provider? in youth programs?

3. Brief sketch of educational/professional background.

4. Brief description and history of this program/facility?

5. What happens to such complaints in this facility/program? Is there a formal mechanism? An informal one? Do complaints get referred to one individual? Who?

6. If there is a formal mechanism, describe it? How did you find out about it? Know any residents/clients who used it? With what result?

7. Have you ever been the subject of a formal grievance? What result? Was the outcome fair to you? Was the process fair to you?

8. If there is an informal mechanism, how does it work? How did you find out about it? Know any residents/clients who have used it? With what results?

9. Have you ever been the subject of an informal grievance? What result? Was the outcome fair to you? The process?

10. Suppose a youngster were unhappy with a departmental, institutional or program rule or policy, what could he/she do?

11. Do parents, guardians, friends, relations, others (specify) ever have "grievances"? Nature and frequency. What happens to them?

12. What would a youngster do with a complaint about physical or sexual intimidation or assault? Ever had such a complaint in this facility/program? What result?

Interview: Staff Member

13. Child Advocate or Departmental Inspector ever visit this institution? Why? What result? Would youngsters in this program or facility know how to contact Child Advocate or Departmental Inspector?

14. Does this facility/program need a formal grievance mechanism? Why? Why not?

15. Does the state require you to have any form of grievance mechanism? Should it?

16. If there were many complaints here -- or in any private facility/program under contract with the State -- how would a supervising state agency be likely to find out about them? Should the number and gravity of complaints ever be a component in a state agency's decision to renew or not to renew a contract? Why? Why not?

Thanks for your assistance.

APPENDIX C

New York City Special Services for Children,

Children's Rights Unit Poster and Handout

INTERVIEW: RESIDENT/CLIENT

1. How long have you been in this facility/program?

2. Have you ever been in other similar facilities/programs? Which ones?

3. Define "grievance": Within this broad definition, do you or your fellow residents/clients ever have grievances? What kinds of grievances? How often?

4. Is there a formal grievance mechanism in this facility/program? If so, how does it work? How do you know about it? Have you ever used it? With what result? If so, was the outcome fair? Was the process fair?

5. If there is no formal mechanism, what happens to grievances? Is there some person to whom you take grievances? Who? Why? With what result?

6. Suppose you or a fellow resident/client were convinced that a departmental, institutional or program rule was very unfair, what would or could you do about it?

7. Suppose you or a fellow resident/client were convinced that you had been treated very unfairly by a staff member, what would or could you do about it?

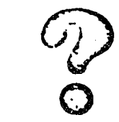
8. Do your parents, guardians, attorney, relations, friends, etc., ever have complaints about what happens to you? What kind of complaints? What can they do about those complaints? Have they ever complained? With what result?

9. What would a resident/client do if they were struck or sexually abused by a staff member? Do you know of anyone who has made such a complaint? With what result?

10. Who is the Child Advocate/Chief Investigator? How would you contact him if you needed him?

Thank you for your assistance.

NIÑOS
En Hogares De Crianza
ESTAN USTEDES



Obteniendo información sobre escuelas y programas de entrenamiento para trabajos?

Viendo a sus padres, hermanos y hermanas?

Recibiendo ayuda de un trabajador social para resolver sus diarias preocupaciones?

Recibiendo ayuda para planear su futuro?

Discutiendo las decisiones con las cuales ustedes no están de acuerdo?

Obteniendo ayuda para hacer las decisiones que afectan su vida?

Si Cualquiera De Estos Problemas Se Parece A Los Suyos...

Primero, hable con su trabajador social Y SI ENTRE LOS DOS NO PUEDEN RESOLVER EL PROBLEMA

entonces llame a la: UNIDAD DE DERECHO DE LOS NIÑOS

433-7783 o al 433-2645

EN LA UNIDAD DE DERECHOS DE LOS NIÑOS USTED PODRA HABLAR CON UNO DE NUESTROS TRABAJADORES ACERCA DE SUS PROBLEMAS. UNA VEZ QUE NOSOTROS SEPAMOS SU QUEJA, LA DISCUTIREMOS CON LA AGENCIA Y DESPUES DE OIR LA OPINION DE LAS DOS PARTES NOSOTROS PROPONDREMOS UN PLAN O SOLUCION. NOSOTROS SEGUIREMOS COMUNICANDONOS CON USTED Y CON LA AGENCIA PARA ESTAR SEGUROS QUE NUESTRAS RECOMENDACIONES SE CUMPLIRAN.

UNIDAD DE DERECHO DE LOS NIÑOS

SPECIAL SERVICES FOR CHILDREN • 80 LAFAYETTE STREET • NEW YORK, NY 10013

CHILDREN in Foster Care ARE YOU

Getting information about school and job training?

Seeing your parents, brothers, and sisters?

Having a staff worker to help you with your day-to-day concerns?

Getting help in making decisions about your life?

Questioning decisions with which you do not agree?

Getting help in planning for your future?

If Any of These Sound Like Your Problems...

First, talk to your caseworker AT THE AGENCY ABOUT THEM.
IF THE TWO OF YOU CANNOT AGREE ON HOW TO SOLVE THE PROBLEM,

then call: THE CHILDREN'S RIGHTS UNIT
433-7783 or 433-2645

AT THE CHILDREN'S RIGHTS UNIT YOU WILL BE ABLE TO TALK WITH ONE OF OUR WORKERS ABOUT THE PROBLEM. ONCE WE HEAR WHAT YOU THINK IS WRONG, WE WILL DISCUSS THE PROBLEM WITH THE AGENCY. AFTER HEARING BOTH SIDES OF THE STORY, A PLAN WILL BE WORKED OUT. WE WILL FOLLOW UP WITH YOU AND THE AGENCY TO SEE THAT OUR RECOMMENDATIONS ARE CARRIED OUT.

THE CHILDREN'S RIGHTS UNIT
SPECIAL SERVICES FOR CHILDREN • 80 LAFAYETTE STREET • NY,NY 10013

END

CONTINUED

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