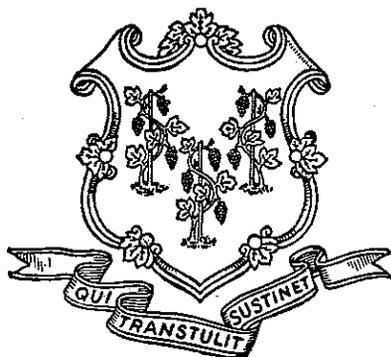


**DEPARTMENT OF CHILDREN  
AND YOUTH SERVICES:  
CHILD PROTECTIVE SERVICES**

**Connecticut  
General Assembly**



**LEGISLATIVE  
PROGRAM REVIEW  
AND  
INVESTIGATIONS  
COMMITTEE**

**JANUARY 1991**

CONNECTICUT GENERAL ASSEMBLY

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three of those members.

1989-1990

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**DEPARTMENT OF CHILDREN AND YOUTH SERVICES:  
CHILD PROTECTIVE SERVICES**

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**LEGISLATIVE PROGRAM REVIEW AND  
INVESTIGATIONS COMMITTEE  
JANUARY 1991**



## TABLE OF CONTENTS

Summary . . . . .	i
Introduction . . . . .	1
Chapter I: The Nation and Connecticut . . . . .	3
Chapter II: Central Management and Regional Operations . . . . .	15
Chapter III: DCYS Children Protective Services Process . . . . .	41
Chapter IV: The Social Worker . . . . .	63
Chapter V: Case Management and Evaluation . . . . .	83
Chapter VI: DCYS-Funded Community Programs . . . . .	93
Chapter VII: Findings and Recommendations . . . . .	113
Appendix A: Employee Survey and Results . . . . .	129
Appendix B: DCYS Funded Program Matrix . . . . .	141
Agency Response	



## SUMMARY

The Legislative Program Review and Investigations Committee concludes that the Department of Children and Youth Services (DCYS) is in need of major changes. The proposed changes will have a significant impact on the operations of Connecticut's child protective services system. The emphasis of the committee's recommendations is on strengthening the role of the social worker in managing cases of child abuse and neglect. The program review committee found that if there is to be any improvement in the handling of cases, it can only be achieved by enhancing the social work function, the first line of defense against child abuse and neglect. Ultimately, it is the social worker, much like a teacher, who will make the difference in a child's life.

The legislative program review committee propose recommendations in four areas: 1) management and regional operations; 2) staff training and development; 3) case management and evaluation; and 4) the operations of DCYS and community programs. It is these areas where the greatest benefit can come for improving the agency's effectiveness and ability to prevent child abuse and neglect cases.

## RECOMMENDATIONS

1. The Legislative Program Review and Investigations Committee recommends that the Program Development Division should be reorganized to incorporate the function of case evaluation. The new division would become the Program Development and Evaluation Division. This new division shall also be responsible for evaluating client outcomes to determine the most effective methods in preventing and treating child abuse and neglect. The existing program evaluation unit within the Quality Assurance Division should be transferred to this division and, in addition to monitoring programs, shall also conduct evaluations that measure program effectiveness. Information collected shall be submitted for review to the management team. This division would also be responsible for developing a grant processing system, as proposed in a later recommendation, linking program evaluations with the distribution of grant monies. This recommendation should also be implemented with a later recommendation on the department's management information system.

2. The Legislative Program Review and Investigations Committee recommends that the department develop an independent case audit unit that will monitor each region's compliance with DCYS promulgated procedures and standards. The Quality Assurance Division within the central office of DCYS shall be responsible for the unit's operations.

3. To ensure more equitable treatment between regional offices, the Legislative Program Review and Investigations Committee recommends that the department develop standards for regional performance. At a minimum, these standards should address the appropriate case load for social workers, and under what circumstances a case should be opened, closed, and reopened. (Case load will be addressed further in a separate recommendation).

4. The Legislative Program Review and Investigations Committee recommends the Quality Assurance Division shall issue monthly reports listing any recommendations that arose as a result of the administrative case reviews or investigations of out-of-home abuse. Each region should report back to the division once the recommendation has been implemented. The division shall maintain a record that includes the child's name, the region in which the review or investigation occurred, and the recommendations and date issued, on a monthly basis until the region has implemented the recommendation.

5. The Legislative Program Review and Investigations Committee recommends the department create a Staff Development and Training Division. This division shall be responsible for assessing training needs, and providing and coordinating all training requirements.

6. The Legislative Program Review and Investigations Committee recommends that no social worker trainee be assigned a case load prior to completing 20 days of structured training.

7. In addition, the department should expand its current training requirement to include an additional 20 days of in-service training to be completed within the first two years of employment.

8. All child protective service social workers shall, within the first 10 years of employment, obtain a master's degree in social work or closely related academic field. The department shall provide 100 percent reimbursement for the cost tuition. The social worker's educational program requires approval by the commissioner. The 10 year requirement shall begin on the hire date or the date upon passage of the legislation, which ever comes later. At the completion of the masters of social work degree, the social worker shall remain employed by DCYS for a period of 2 years, at the option of the department.

9. The Legislative Program Review and Investigations Committee recommends that the department recruit applicants for the social worker position who possess a bachelor or masters' degree in social work or a closely related field, as determined by the commissioner.

10. In an effort to reduce staff turnover and caseworker "burnout", the Legislative Program Review and Investigations Committee recommends that the department develop a program that allows social workers to obtain the necessary skills to become trainers. As trainers, the workers would be allowed a temporary respite from managing cases while providing the department with an important resource needed to fulfill these new training mandates.

11. The Legislative Program Review and Investigations Committee recommends that the newly created Staff Development and Training Division conduct a formal evaluation of the current training curriculum and an assessment of training needs of the department's social workers. The results of the evaluation and needs assessment should be reported to the management team.

These new training requirements shall become effective January 1, 1992.

12. The Legislative Program Review and Investigations Committee recommends that the department should, as a department-wide goal, limit workers to 25 ongoing cases at any point in time. It is also recommended that social worker trainees be limited to a case load that is, on average, half that of the permanent social worker. Funds shall be provided in the budget to achieve this goal by July 1, 1994.

13. The Legislative Program Review and Investigations Committee recommends that the Department of Children and Youth Services; 1) revamp its current case management system and replace it with an on-line computer system with 24-hour access; and 2) design a process for evaluating the effectiveness of client interventions.

14. The Legislative Program Review and Investigations Committee recommends that the newly created Program Development and Evaluation Division design and implement a case evaluation system that measures client outcomes throughout the case history to better determine the progress being made by the social worker.

15. The Legislative Program Review and Investigations Committee recommends that the Department of Children and Youth Services design a grants processing system that funds community service programs proportionate to their success in treating clients, and be allowed to impose a reduction in funds against those programs found to be ineffective.

This sanction would require that funding be phased out over a three-year probationary period. During the first year a program is on probation, it will receive 75 percent of the total grant expenditures from the previous fiscal year. If the program fails to satisfactorily comply with the department's recommendations for improving service, funding will be decreased to 50 percent during

the second year. Funding will cease at the end of the third year if the program is unable to comply with the departments requirements.

The success of the program will be measured based on the following:

- evaluating a program's effectiveness in treating clients, including analysis of case outcomes;
- assessing the regions' needs for treatment services;
- rating of the programs by protective services social workers; and
- analyzing performance data consistently and uniformly collected from each program, including availability to DCYS clients.

16. The Legislative Program Review and Investigations Committee further recommends that the newly created Program Development and Evaluation Division collect, maintain, analyze, and provide the evaluation data to be used in the grants process. This recommendation shall apply to all grants made in fiscal year 1991-92 and the evaluation and resulting sanctions would take effect in fiscal year 1992-93.

17. As part of the evaluation process conducted by the Program Development and Evaluation Division, the Legislative Program Review and Investigations Committee recommends that the protective services social workers and their supervisors be routinely surveyed regarding their opinions of the operations of community programs, and asked to rate the effectiveness of each program according to predetermined standards and performance measures.

18. The Legislative Program Review and Investigations Committee further recommends that the Program Development and Evaluation Division, in conjunction with other divisions of DCYS, develop and maintain a computerized data base listing all available community service programs. The data base would provide information on the following:

- a listing by region of all DCYS-funded community service programs;
- a description of the program's operation and the treatment services it provides;

- the name of the program's contact person (DCYS liaison), address, and telephone number;
- the cost per client;
- an updated availability assessment (how many DCYS clients the program can accommodate);
- brief outline of the program's evaluation rating from the division and what areas the program is most successful in treating; and
- identify those programs which have been placed on probation by the grants process, and the level of funding they are receiving from DCYS.



## INTRODUCTION

The crisis of child abuse and neglect is one of the most difficult problems faced by society. To the extent that children represent the future, the physical and emotional trauma they experience reduce the cultural and economic contributions they are able to make to the community. Not all childhood trauma can be avoided; however, minimizing willful mistreatment, or mistreatment due to ignorance, of children is an important public policy objective. The grounds for intervention by the community are two-fold: the consequences of abuse or neglect result in great expense to the state in terms of present and future care of children; and a child has a right to expect protection and adequate care, not abuse, neglect, or exploitation at the hands of adults.

The responsibility for protecting children also falls to the entire community: parents, neighbors, relatives, educators, police, medical practitioners, and the courts. However, when socially defined minimums are not met, or where children are in clear and present danger, the government's protective service agency is called upon to act. The protective services agency is, therefore, the agency of last resort. If it fails then society has failed.

In Connecticut, the Department of Children and Youth Services (DCYS) has the ultimate responsibility for the protection of children from family abuse and neglect. It also faces the most difficult job of any department or agency in state government today. The problems of dysfunctional families have steadily increased, the severity of the cases has grown, and the number of cases has increased. There is no single solution to the child protection dilemma.

Many of the problems that affect a client simply lie outside of the control of the department, such as unemployment, drug and alcohol abuse, school dropouts, poverty, lack of housing, and teenage pregnancy. The department is called upon to treat only the symptoms of these problems and even in treating the symptoms of child abuse and neglect, it must choose between its role as an enforcement agency and that of a social service agency. The department is constantly confronted with the question of offering services to restore a poorly functioning family or removing a child involuntarily for his or her protection. It is a judgment that must be made on over 13,000 cases that come to agency yearly.

The Legislative Program Review and Investigations Committee voted to do a study of the Department of Children and Youth Services in February 1990. The focus of the committee's study is on the organization, management, and policies of the Department of Children and Youth Services. The study is concentrating particularly on the department's programs and policies in the area of child abuse and neglect. Two major responsibilities of the

department are not part of the study. These are: the department's role in the treatment and custody of juvenile delinquents (see LPR&IC report Juvenile Justice in Connecticut, 1989) and psychiatric services provided by the department (see LPR&IC report Psychiatric Hospital Services for Children and Adolescents, 1987).

The study has attempted to examine the manner in which the judgments on the operations of child protective services are made. The judgment of whether or not to become involved in a case, when to close a case, and the way in which the agency intervenes in the case rests with the social workers and their supervisors. It is here where the critical decisions are made, and where the strengths, or weaknesses, of the agency lie. The social workers who manage the cases are the foundation upon which the protective services' system is built.

The committee developed and used varied research methodologies to conduct the study. These included interviews with DCYS personnel in both the central and regional offices. The committee also conducted a survey of department personnel to obtain information on the employees' view of the department's operations. In addition, the program review committee developed a case review methodology that examined a random sample of the department's current caseload. Staff also spent time working with DCYS intake and treatment social work staff to obtain firsthand knowledge on case management.

The report is divided into seven chapters. The first chapter is an overview of and trends in children protective services in Connecticut and throughout the nation. The second chapter discusses the department's central management and regional operations. The third chapter details the DCYS protective services process, including foster care. The fourth and fifth chapters focus on the role of the social worker and the importance of case management in child abuse and neglect cases. The sixth chapter analyzes the department's administered and funded programs and the impact on treatment. The final chapter represents a summary of the findings of the study and recommendations to improve and strengthen the department's ability to deal with child abuse and neglect. Appendix A contains a summary of a survey administered by the program review committee of the department staff, and Appendix B contains a matrix of the department's continuum of care model.

## CHAPTER I

### THE NATION AND CONNECTICUT

It is estimated that in 1988, 1,125 child fatalities resulted from abuse in the United States. From 1985 to 1988, national reports of child fatalities increased 36 percent according to the National Committee for the Prevention of Child Abuse. Many more children are living with abuse. In 1987, the most recent year for which there are data, the American Association for Protecting Children estimates there were 2.2 million reports of child abuse and neglect involving 1.4 million families. Although not all these reports of abuse and neglect were substantiated, an estimated 37 percent to 40 percent were, which places the number of children suffering abuse in the 814,000 to 880,000 range for 1987.

In Connecticut, 22,797 children were referred in fiscal year 1989 to the Department of Children and Youth Services, the state agency responsible for investigating allegations of abuse and neglect. Of those referrals, 20,233 children were suspected of suffering abuse and neglect. The remaining 2,564 children were referred for non-abuse and neglect reasons such as delinquency, substance abuse, and emotional disturbance.

An overall picture of the number of children referred to DCYS indicates a steady increase over the past few years. Table I-1 shows that during state FY 85 through FY 89 the number of children referred to DCYS increased 20 percent. However, between FY 88 and FY 89, the number of children referred to DCYS' protective services has actually decreased by one-half of a percent. In relation to the general population of children between birth and 18, there has also been a 23 percent increase in the number referred per 1,000 population for the same period. This population has remained stable from FY 85 to FY 89, as Table I-1 shows, increasing by less than three-tenths of a percent.

Another measure of the prevalence of child abuse and neglect in Connecticut is the number of cases opened by the Department of Children and Youth Services. During FY 89, DCYS had 11,385 newly opened and 4,454 reopened abuse and neglect cases. Similar to the decline noted in Table I-2 on the number of children referred, Table I-2 shows that the total number of cases opened decreased in FY 89 from FY 88. This is due primarily to the number of reopened cases dropping by 6.3 percent. However, between FY 84 and FY 89 the total number of cases grew by 24 percent.

During this same period DCYS steadily increased the number of abuse and neglect cases it closed. During FY 89, 13,028 cases were closed. Figures I-1 and I-2 shows the total caseload change, comparing reopened and new cases. All cases peaked in FY 88;

however, with only one subsequent year of data, it is too early to conclude that a downward trend in caseload has begun.

Table I-1. Children Referred to DCYS Protective Services.					
FISCAL YEAR	84-85	85-86	86-87	87-88	88-89
POPULATION UNDER 18 YRS.	762,206	756,946	757,648	757,784	764,366
CHILDREN REFERRED (PERCENT CHANGE)	16,804 (*)	17,059 (1.5%)	18,552 (8.8%)	20,354 (9.7%)	20,233 (.5%)
RATES PER THOUSAND PERCENT CHANGE	22 (*)	23 (4.5%)	25 (8.7%)	27 (8%)	27 (0%)

Source: DCYS Statistical Summary.

Table I-2. Six Year Comparison of New and Reopened Cases.						
FISCAL YEAR	84	85	86	87	88	89
NEW	10,030	10,785	10,196	10,023	11,318	11,385
REOPENED	2,698	3,031	3,572	4,178	4,751	4,454
TOTAL	12,728	13,816	13,768	14,201	16,069	15,839
CLOSED	10,678	12,031	12,589	12,523	12,597	13,028

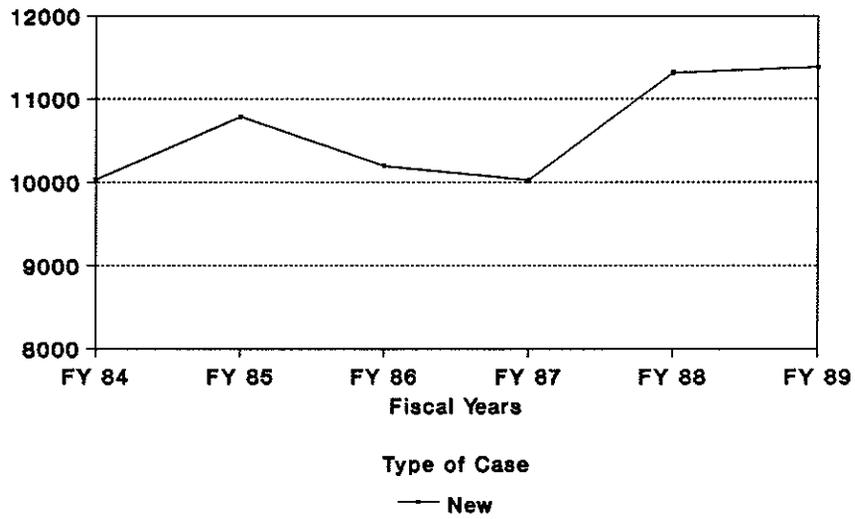
Source: DCYS Statistical Summary.

Although DCYS receives numerous referrals, not all become DCYS cases. Each referral or allegation is screened and investigated to determine if it can be substantiated. Figure I-3 contains a table and graph that compare the number of children referred and the number of children involved in confirmed or substantiated cases for the last six fiscal years. For the six year period, the graph indicates that about 70 percent of children referred become confirmed cases.

It is important to note that children may be referred for one reason but confirmed for another. It is also possible for a child to be referred for more than one reason but confirmed for only one.

**FIGURE I-1**

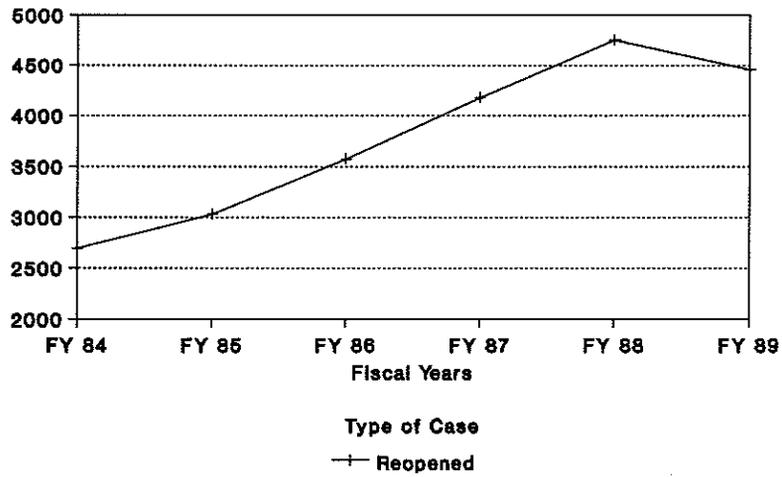
### New Cases Six Year Comparison



DCYS Statistical Summary

**FIGURE I-2**

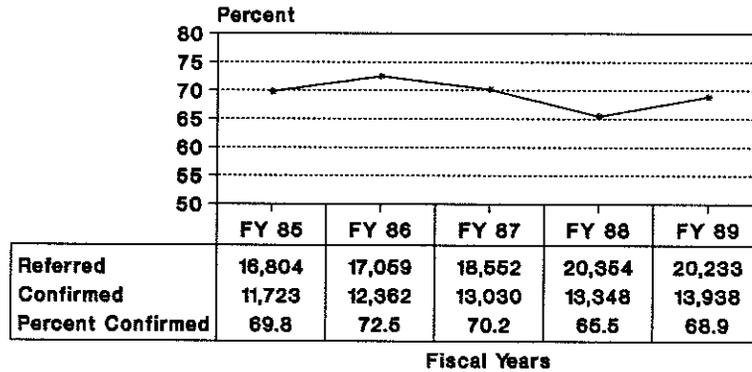
### Reopened Cases Six Year Comparison



DCYS Statistical Summary

**FIGURE I-3**

**Referrals and Confirmations  
Six Year Comparison: Percent Confirmed**



Type of Case  
— Percent Confirmed

Source: DCYS Statistical Comparison

Analysis also reveals the preponderance of cases confirmed involve single-parent families. Table I-3 provides the family structure of all confirmed cases. Over the past six years, children from single-parent families account for more than 50 percent of those confirmed as abused, over 70 percent of the neglect confirmations, and over 60 percent of the at-risk confirmations.

A broader view of child welfare throughout the nation was recently evaluated by a Washington, D.C. research organization. The study, conducted by the Center for the Study of Social Policy, ranked Connecticut second in the nation in meeting ten key indicators of child and family well-being. The study evaluated each state based upon indicators related to health, education, and social and economic well-being of children. According to the Center, the status of children, measured by these selected indicators, improved or stayed the same in Connecticut in all but two categories between 1980 and 1987. The two exceptions were in the percentage of children living in poverty and the rate of juvenile incarceration.

<b>Table I-3. Family Structure of Confirmed Cases.</b>						
<b>FISCAL YEAR</b>	<b>84</b>	<b>85</b>	<b>86</b>	<b>87</b>	<b>88</b>	<b>89</b>
<b>CONFIRMED ABUSE</b>						
ONE PARENT	55%	54%	53%	52%	52%	53%
TWO PARENTS	36%	38%	37%	38%	37%	39%
STEP-PARENT	8%	7%	9%	8%	9%	7%
GUARDIAN	1%	1%	1%	1%	1%	1%
<b>CONFIRMED NEGLECT</b>						
ONE PARENT	72%	72%	70%	74%	75%	74%
TWO PARENTS	23%	24%	26%	22%	21%	23%
STEP-PARENT	2%	3%	2%	2%	3%	1%
GUARDIAN	2%	2%	2%	2%	2%	2%
<b>CONFIRMED AT RISK</b>						
ONE PARENT	65%	64%	64%	65%	67%	64%
TWO PARENTS	31%	32%	31%	30%	29%	32%
STEP-PARENT	3%	4%	3%	4%	4%	4%
GUARDIAN	1%	1%	1%	1%	1%	1%
<b>Source: DCYS Statistical Analysis.</b>						

The ten indicators chosen by the center to measure child welfare were as follows:

- 1) percent of births with no early prenatal care;
- 2) infant mortality rate;
- 3) percent low birth weight babies;
- 4) AFDC and food stamp benefits as percent of poverty threshold;
- 5) percent of children living in poverty;

- 6) percent not graduating high school;
- 7) education expenditures per pupil;
- 8) teenage unemployment rate;
- 9) percent births to teen mothers; and
- 10) juvenile incarceration rates.

The two categories where Connecticut has shown a deterioration, juvenile justice and poverty, have a direct impact on DCYS' responsibilities. Poverty, in particular, affects the physical and mental well-being of individuals and may be one of the most serious problems facing Connecticut's children. While these ten indicators may not present a complete picture of the problems facing the state's child welfare system, they offer a comparison of Connecticut relative to the other 49 states.

The above is a broad overview of child abuse and neglect in the nation and Connecticut. The program review committee conducted more detailed analyses of the problems faced by DCYS and it is presented throughout the report.

### National Overview

While all states are faced with child abuse and neglect, there is no one organizational model for dealing with the problem. States vary considerably in the coordination of systems that refer children for child welfare services. Some states operate distinct child welfare, juvenile justice, mental health and residential treatment systems for different populations of children. In several states, children may be moved from one agency to another depending on their treatment needs.

All states have a child protection services (CPS) system. Likewise, all states have child abuse reporting laws requiring reports of suspected abuse to be made by specified professionals and others whose work brings them into regular contact with children. In most states, abuse and neglect investigations are conducted by CPS personnel, although law enforcement officers may frequently be involved.

Mandatory reporting laws and the degree of immunity conferred by such statutes vary from state to state. In many states, there are penal sanctions for failure to report. Most of these involve fines, but in a few states, the offender may be subject to imprisonment upon conviction.

During the last few years, there has been a steady increase in state legislative activity related to child abuse. For instance, 10 states, including Connecticut, initiated new family preservation services by legislation. Family preservation services are very intensive home-based services that include 24-hour crisis intervention, therapy, parenting education, skills development, day care, employment assistance, housing, and other basic supportive services.

Another avenue often utilized in treating abusive behavior is educational programs that offer training in family management skills. These programs stem from the belief that stress in managing a family is often a precipitator of abusive behavior. Short term crisis intervention can play a crucial role in preventing child abuse. For this same reason, 24-hour hotlines have been established in many states to provide around the clock coverage for families in crises. States provide additional programs such as:

- short-term child drop-off centers for parents unable to deal with their children; and
- parent aides to assist families identified as at risk of abuse.

Another recognized approach for handling abuse and neglect cases is the use of an interdisciplinary child protection team. Central to this approach is that cooperation between child protective service agencies, law enforcement officials, and court personnel is essential to the successful handling of child abuse cases. One means of achieving such cooperation is the formation of interdisciplinary teams of workers. These teams are usually composed of law enforcement officers, child protective service workers, prosecutors, the child's advocate, mental health professionals, and medical personnel, among others. Benefits of such teams are greater efficiency, shared information and expertise, and greater coordination in the delivery of essential services to the child and family.

Connecticut has developed many of the programs found in other states. Chapter VI of this report will identify and describe the operation of these programs in more detail.

### Department History

The legislature created the Department of Children and Youth Services in 1969 to deal with child welfare issues. First established to administer two juvenile correctional facilities, Long Lane School in Middletown (for girls) and the Meriden School for Boys (now closed), the department's mandate has since greatly

expanded. Subsequent legislative changes gradually led the department to take a comprehensive role in all areas of public policy dealing with children.

In 1974, the legislature expanded DCYS' responsibilities by transferring certain child welfare services from the Department of Social Services. The following year, mental health services for children were also transferred. By 1976, there was a consolidated Department of Children and Youth Services with responsibility for delinquency, child welfare, and mental health services for children and youth. In that year, the agency had a budget of \$23.8 million and 1,065 staff.

Community-based, child-welfare programs, such as parent aide services, child protection teams and consultation services, were established in all of the department's service regions beginning in FY 79. Also in FY 79, statewide funding of youth service bureaus began.

In 1987, a new regional management plan (discussed in the central management chapter) was instituted establishing a community-based service delivery system. Six geographical regions were created, as well as seven suboffices within the regions.

In 1989, the department functioned as lead agency in the development of a proposal to the Annie E. Casey Foundation as part of a national effort to test innovative approaches to service delivery leading to comprehensive child welfare reform. Connecticut will receive approximately \$7.5 million in foundation funding over a five-year period, which will be matched by state and local funds.

### **Federal and State Statutory Mandates**

**Federal legislation.** In general, federal laws pertaining to child abuse and neglect are not mandatory, but provide guidelines to states in establishing child welfare programs. Federal reimbursement is available to states implementing such programs. However, these funds are contingent upon state conformance with federal guidelines. Noncompliance can jeopardize federal support.

In order to receive federal funding pursuant to the Child Abuse Prevention and Treatment and Adoption Reform Act states are required to promptly investigate all reports of known or suspected instances of child abuse and neglect. The states must attempt to substantiate the accuracy of the report and take immediate steps to protect the children at risk of abuse or neglect. The states must also have administrative procedures, trained and qualified personnel, and adequate facilities to deal effectively with child abuse and neglect cases.

To obtain funding, states are directed to:

- submit an annual service plan for approval by the Secretary of the U.S. Department of Health and Human Services;
- make reasonable efforts to provide services to enable children to remain with their families or to be returned to their families whenever possible;
- ensure that children placed in foster care are placed in the least restrictive, most home-like environment;
- provide children written case plans developed with certain specified components and reviewed within specified time periods;
- ensure proper planning and care for children while in foster care to address each child's needs and to assure each child's permanent placement;
- maintain homes or institutions in which children are placed conform to national standards;
- provide foster care payments that are appropriate; and
- provide dispositional reviews no later than 18 months after placement.

Finally, the federal Adoption Assistance and Child Welfare Act (P.L. 96-272) requires state compliance with the federal Child Abuse Prevention Act (P.L. 93-247). DCYS receives substantial federal funds under the child welfare act to partially offset the costs of foster care and adoption services.

**State legislation.** The department of youth services is statutorily mandated to "create, develop, operate or arrange for, administer and evaluate a comprehensive and integrated state-wide program of services, including preventive services, for children who are delinquent, mentally ill, emotionally disturbed, abused, neglected or uncared for". This includes court committed children as well as those voluntarily admitted. Protective services are given to any child found in need of such care, not only those children committed to DCYS by the courts. The commissioner is required to:

- issue regulations to assure the adequate care, health and safety of children under her care;
- provide temporary emergency care for any child deemed in need;
- provide care for children in her guardianship through the resources of appropriate voluntary agencies;
- provide protective supervision to children, when required by the court;
- report and investigate suspected child abuse, and provide services, where needed;
- make reciprocal agreements with other states and agencies outside the state in matters relating to the supervision of the welfare of children;
- establish, maintain, and encourage an ongoing program of subsidized adoption; and
- prepare a written plan for the care and treatment of every child committed to DCYS.

The department must also submit a five-year plan biennially to the legislature, which outlines major goals and objectives of the department, as well as previous accomplishments. The plan provides a description of the services available and the cost of those services. It also projects future needs of the targeted population, as well as cost projections to meet those needs. It includes a plan for the prevention of child abuse and neglect, and an overall assessment of the adequacy of the services provided.

Public participation. By statute, there is a fifteen-member state advisory council (SAC) appointed by the governor that meets quarterly. The council approves the gubernatorial appointment of new commissioners, and advises the commissioner on the planning and development of programs. The DCYS commissioner attends the meetings but does not vote.

There are also regional advisory council's (RACs) appointed by the commissioner and responsible for advising her on the development and delivery of services in their region. The RACs must also meet at least quarterly.

Mandatory abuse and neglect reporting requirements. There are a number of professions for which reporting suspected child abuse or neglect is mandated. The mandated reporter is required to make an immediate oral report to DCYS or the local or state police followed by a written report to DCYS within 72 hours.

A physician has the authority to keep a child in the custody of a hospital up to 96 hours without parental consent, if he or she suspects abuse.

If an investigation produces evidence that a child has been abused, the commissioner has several options available in statute to protect the child. These include:

- immediate notification of the appropriate law enforcement agency; and
- removal of the child from his or her home with the consent of the parent or by order of the superior court.

Out-of-home placement. Following an investigation, if there is probable cause to believe that the child has suffered serious physical illness or serious physical injury or is in physical danger from his surroundings, and immediate removal is necessary to insure the child's safety, the commissioner may authorize any employee of his department or any law enforcement officer to remove the child without the consent of the child's parents. Temporary custody cannot exceed 96 hours during which time either a petition must be filed with the superior court or the child must be returned home.

The commissioner may petition the court for the termination of parental rights to any child committed or voluntarily placed in her care. The superior court may grant the petition if it finds that the termination is in the best interest of the child or if a parent has voluntarily consented to relinquish parental rights. However, termination of rights may be contested by a parent.

All out-of-home placements by DCYS must be made to a licensed facility. Thus, residential facilities, foster homes and homes of relatives all must be licensed before they can be used by DCYS. However, DCYS may place a child with a relative who is not licensed for a period of up to 45 days provided an initial home visit is done.

The department's primary objective is to maintain children and youth in their own homes. If substitute care is necessary, the objective then is reunification. If this is not possible, the department seeks an adoptive home for the child or effects

placement in the most permanent, least restrictive, and most family-like setting possible. These out-of-home placement options will be discussed in greater detail in the DCYS-administered programs chapter of this report.

## CHAPTER II

### CENTRAL MANAGEMENT AND REGIONAL OPERATIONS

The Department of Children and Youth Services has a broad mission in dealing with problems that families face. It is the state's key agency in controlling child abuse and neglect. The department is also responsible for other child welfare areas including juvenile delinquency and psychiatric services. Specifically, the agency provides services beyond child protection, including the operation of facilities for juvenile delinquency, psychiatric rehabilitation, and temporary shelter.

The agency's mission statement guides the operations and activities of the department. The mission of the department is to join with others to create the conditions within which all children in Connecticut:

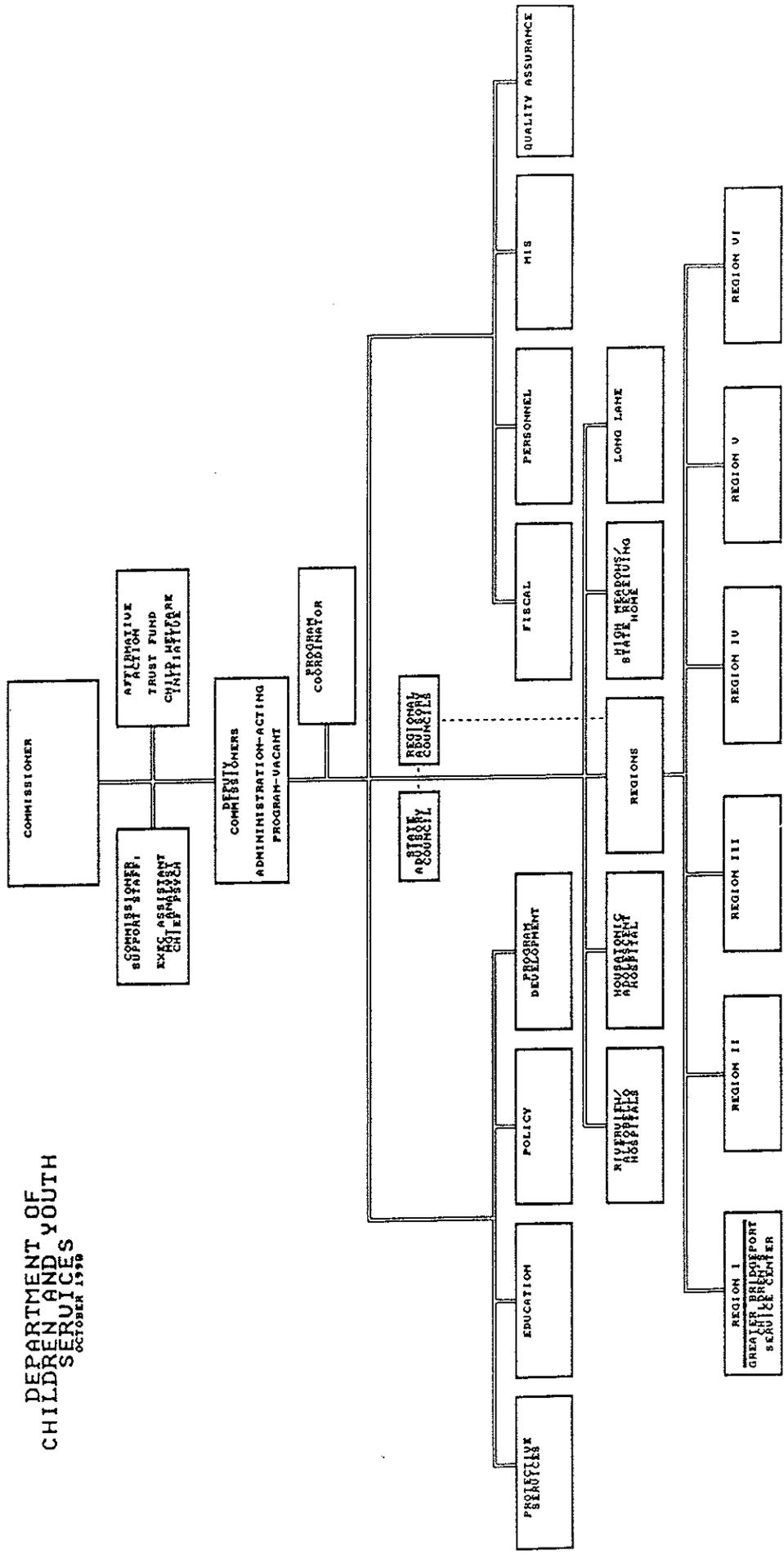
- develop as healthy, productive, and caring persons, free from harm and injury;
- experience enduring, nurturing relationships as members of permanent families;
- are supported in their transition to adulthood; and
- receive services that are respectful of child time, responsive to children's individual and developmental needs, and sensitive to their heritage.

This chapter outlines the major responsibilities of the management team (the primary policy-making body within DCYS), the central office, and the regions. In addition, as part of the examination of DCYS operations, staff discovered significant variations in the way cases are handled among different regional offices and that analysis is also presented. The quality assurance process, the method by which the department ensures services provided to clients are adequate, is also addressed at the end of this chapter.

**Organizational structure.** The current organizational structure of the department is shown in Figure II-1. The commissioner of children and youth services is assisted by a deputy commissioner for administration, a position that is currently vacant. The central office coordinates all statewide financial,

FIGURE II-1. DCYS ORGANIZATIONAL CHART

DEPARTMENT OF  
CHILDREN AND YOUTH  
SERVICES  
OCTOBER 1999



policy, planning, and personnel functions through its eight divisions, while client services are handled through six regional offices, managed by directors. Four mental health facilities, one day treatment program, the State Receiving Home, and Long Lane School for delinquent juveniles are also managed by DCYS.

The Department of Children and Youth Services is operated on a highly decentralized basis. Day-to-day decision making affecting individual clients and programs is the responsibility of the regional directors. In each region there is a program assistant director, an assistant director for administration, and a child protective services administrator.

As noted earlier, public participation in the department's operations is statutorily required. Two types of advisory groups have been established by the legislature to ensure public input: the state advisory council (SAC), and the regional advisory councils (RACs) for each of the six regions.

As shown in Figure II-1, there are eight divisions within the central office. The major functions of the central office and each division is provided below.

### Central Office Organization

Central Office. The major function of the central office is to develop policy and provide coordination and technical assistance to the regions. Currently, the central office is responsible for the following functions on a statewide level:

- affirmative action;
- policy development;
- program development;
- budget preparation and options;
- resource allocation;
- data management;
- statewide strategic planning; and
- quality assurance.

The Division of Child Protective Services is responsible for four functions. The division operates the department's Careline,

a 24 hour, toll-free, telephone "hot line" for off-hour reporting of abuse and neglect, as well as providing referral information to families and the general public. The division also manages the Connecticut Adoption Resource Exchange (CARE), which finds permanent families for children who are freed for adoption. Administration of the three interstate compacts, relating to the appropriate placement and supervision of children across state boundaries, is carried out in this division. Lastly, the Staff Development and Training Unit is located in this division.

The Division of Education is responsible for the educational needs of all children in the care of DCYS. In particular, the division operates the Unified School District #2, which serves children who reside in or attend day treatment at department operated facilities. The school district is also responsible for assuring that educational services are provided for children who reside in private residential facilities when no other school district has jurisdiction.

The Division of Quality Assurance monitors and licenses out-of-home placements activities. The division also holds administrative case reviews, administrative hearings, monitors and evaluates programs that are funded by the department, and investigates allegations of abuse or neglect of children placed in out-of-home care.

The Division of Program Development develops program models, and manuals for a continuum of mental health, juvenile justice, child welfare, and substance abuse programs. Technical assistance is also provided by this division to the regions on a variety of program initiatives for children and their families.

The Division of Fiscal Services audits private grantees, as well as DCYS regional offices and institutions. The division also is responsible for leasing space for the regional offices and institutions, and for capital renovations. Rate setting is done by this division, as well as authorization for all payments for board and care for children in out-of-home placement.

The business office is located here and is currently undergoing significant changes. Prior to regionalization, this office was responsible for all purchasing transactions and grant transactions. At the present time, these functions are being transferred to the regions.

The Personnel Division's operations can be divided into two categories: administrative functions and field operations. Administrative responsibilities include the operation of agency payrolls, monitoring of position budgeting, administration of the civil service statutes, Worker's Compensation, and the retirement system. In the field operations, which involves the regions and institutions, the division pre-screens regional and institutional

staff, becomes involved in the grievance process, and negotiates labor contracts for each of the 11 bargaining units.

The Division of Management Information Systems supports the regions and facilities through the development and maintenance of data collection and management systems, procurement and installation of computer equipment, and statistical analysis.

The Division of Policy, Planning and Communication provides public policy analysis and review, and formulates specific policies and regulations as they are required by law. It is also responsible for coordinating the development of statutorily mandated agency plans. Another function of the staff is to act as liaison for the commissioner with the General Assembly and provide information to the public about the programs and services.

### Management Team

The department established an "agency management model" to set the policies necessary to achieve the goals set forth in the mission statement. Although the commissioner is ultimately responsible for the overall direction of the department, goals and priorities are established through a cooperative effort involving agency upper management. The management team is composed of the deputy commissioner, executive assistants, regional directors, and statewide facility superintendents. Central office divisional directors provide support to the management team. According to the department, the team meets regularly to establish policy and determine priorities with the goal being comprehensive and uniform program development and administration.

Specific responsibilities of the management team include the adoption of:

- policy and regulation;
- procedures;
- program models, descriptions, and grant applications; and
- budget options.

Committee staff attended meetings of the management team to obtain an understanding of how it operates. Although the purpose behind the management team, as stated by the department, is to "establish policy and determine priorities with the goal being comprehensive and uniform program development and administration", program review committee found, given the significant differences in regional operations, that this goal is not being achieved in the area of child protective services. Several departmental policies

dealing with internal operations, such as uniform risk assessment, have been developed, but the team has not addressed areas such as grants management, uniform standards for many areas of child protective services, training, and caseload analysis.

For example, a review of the department policy manual showed that although space for a section on the distribution of grants has been reserved since 1985, it has never been developed. Considering that responsibility for grant distribution has been recently transferred to the regions from the central office as well as the cost of operating community programs, it is particularly disturbing that no overall policy was developed to ensure consistency among the six regions.

The department has also failed to establish uniform standards for child protective service intervention. Although the department has begun to develop standards, time-frames set by the department for completion of various tasks have not been met. According to the department, it is waiting for the federal government to review drafts for compliance with federal laws. However, the program review committee believe that in a regional structure it is essential to have written standards so that all clients receive equal and consistent treatment. This should be a top priority of the management team.

**Employee survey.** The program review committee conducted a survey of all DCYS employees. Although complete responses to the survey are presented in Appendix A of this report, material pertinent to areas under review are used here and throughout the report. One survey question asked department employees to evaluate how well, on a scale of 1 (excellent) to 5 (poor), the management team plans, coordinates, and communicates to achieve the agency's goals and objectives.

Table II-1 shows the responses from central office and regional employees who classified themselves as either managers or direct service workers. In the central office there was a total of 43 replies. In the regions, 234 managers and direct service workers responded. For purposes of analysis, program review committee collapsed the ratings of excellent through fair into a positive or favorable response, and those below fair as negative or unfavorable.

As the table shows, the area in which the management team received the most positive evaluation was in its planning efforts. However, even in this area, 44 percent of the respondents in both the central office and the regions responded negatively. Furthermore, 67 percent of central office and 54 percent of regional respondents evaluated the team negatively in its ability to coordinate. Even more overwhelming was the 74 percent of central office survey respondents who rated the team unfavorably in its

efforts to communicate along with two-thirds of the regional employees.

Table II-2 shows that there is not much variation in the response when employee function is substituted for work location. Only those survey respondents who indicated they were central office and regional managers or direct service workers are included in the table. A total of 71 managers and 206 direct service workers responded.

Table II-1. Evaluation of the Management Team by Work Location.										
Location	Total Re-sponse	Plan			Coordinate			Communicate		
		1	2	3	1	2	3	1	2	3
Central Office	43	28%	44%	28%	16%	67%	16%	16%	74%	9%
Regions	234	42%	44%	14%	36%	54%	11%	29%	66%	5%
1=Positive Response    2=Negative Response    3=Don't Know										

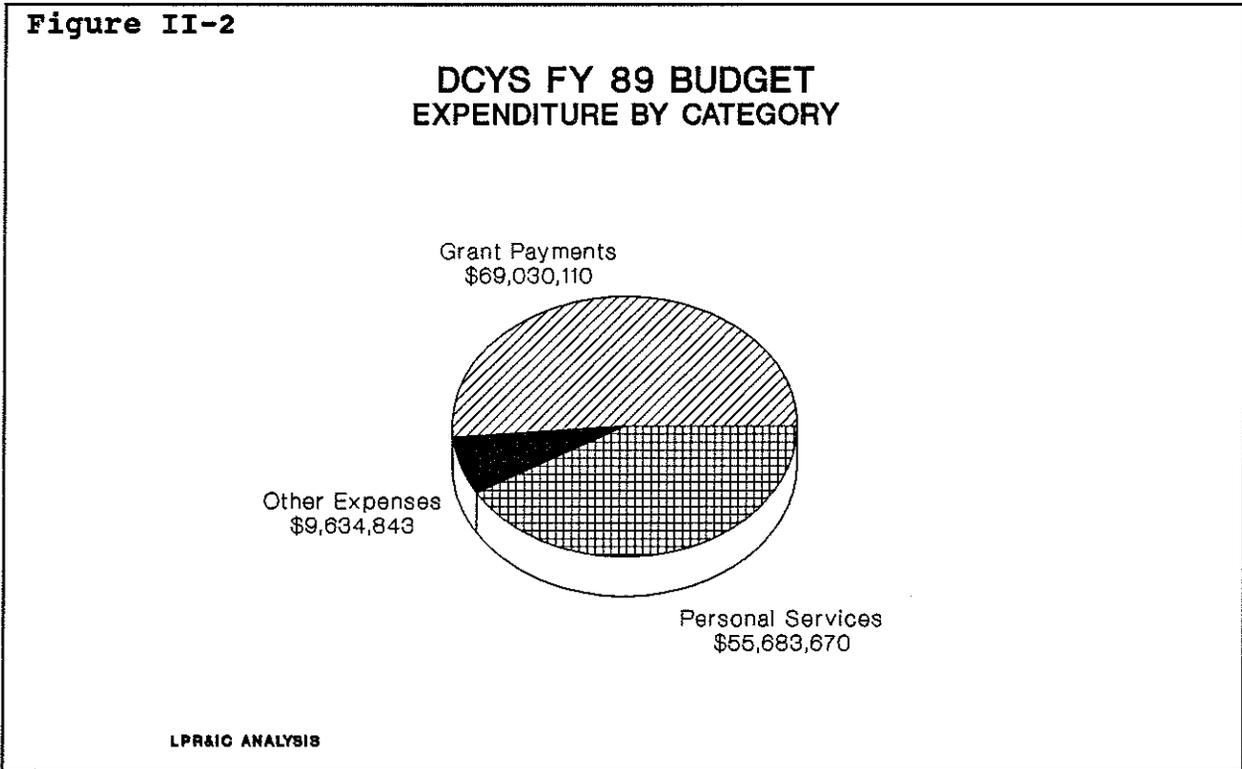
As the table shows, in all three categories, over 50 percent of the managers responded negatively when asked to evaluate the management team. The category in which both managers and direct service workers rated the team the poorest was in its communication efforts, with 80 percent of all managers and 63 percent of direct service workers responding unfavorably.

Table II-2. Evaluation of the Management Team by Employee Function.										
Employee Function	Total Re-sponse	Plan			Coordinate			Communicate		
		1	2	3	1	2	3	1	2	3
Direct Service	206	42%	42%	16%	36%	52%	12%	30%	63%	7%
Managers	71	34%	51%	16%	23%	68%	9%	17%	80%	3%
1=Positive Response    2=Negative Response    3=Don't Know										

**Resource Analysis**

The program review committee reviewed the budget and staffing levels for the Department of Children and Youth Services for FY 82 through FY 91. As described below, current resources as well as budget and staffing trends were analyzed.

**Current budget.** The department expended \$143,454,372 in FY 89. Of this, \$134,348,627 were general fund monies. Figure II-2 shows the breakdown by expenditure category for this period. The categories of "other expenses" and "equipment" are combined in the figure. "Grant payments" to community organizations and local towns was the largest expenditure category, consuming \$69,030,112 or 48 percent of the total general fund budget. "Personal services", which include all staff for the department, accounted for \$55,683,672 or 39 percent of total general fund expenditures. The category "other expenses" amounted to \$9,277,118 or 7 percent, while only \$357,725 was expended on equipment.

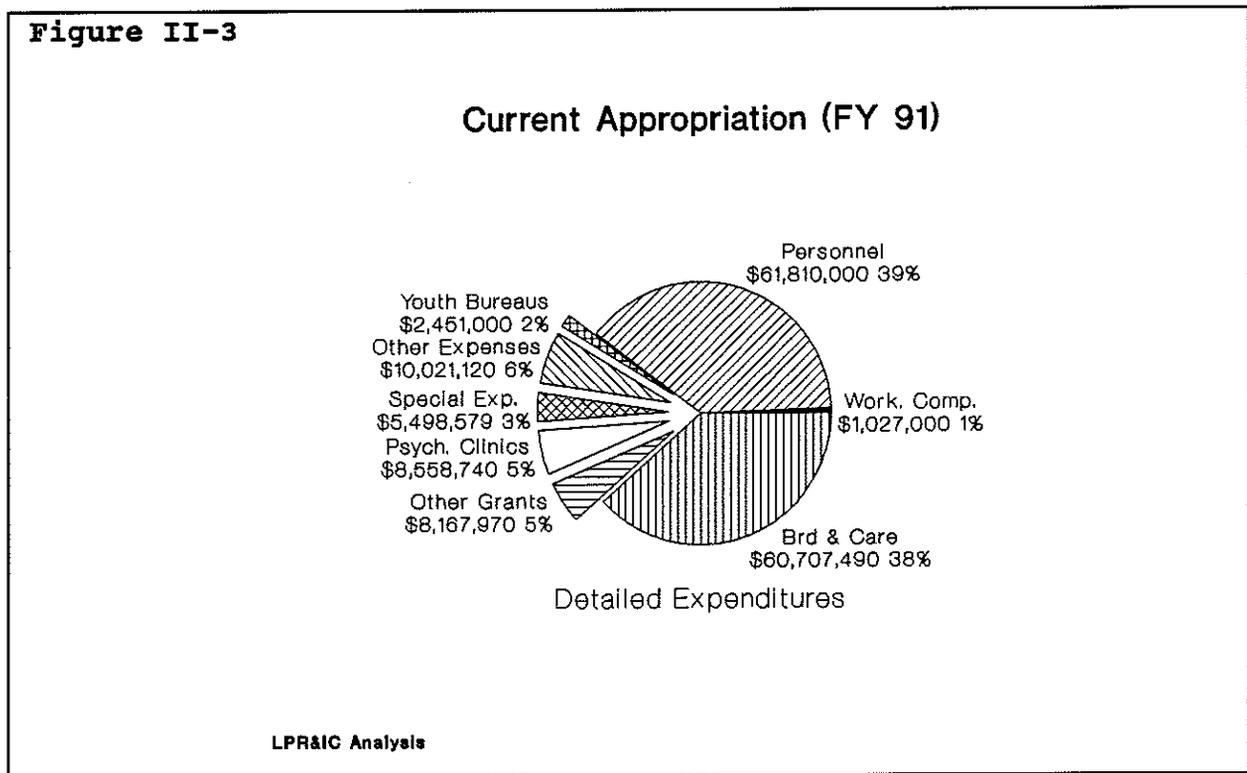


The program review committee examined the department's recently appropriated budget for fiscal year 1991. The department received a \$144,685,259 general fund appropriation for FY 90 and \$158,241,902 for FY 91. Figure II-3 shows the expenditures by slightly different categories than Figure II-2. In this graph,

staff has divided the agency's budget into detailed program and functional areas to show the categories in which the monies for FY 91 are slated to be spent.

The two largest categories are funds for "agency personnel" and the "board and care account" for children in out-of-home placement, which together account for 77 percent of the total FY 91 general fund appropriation. "Other grants" (5 percent of total) range from such programs as community preventive services to aftercare for children. "Special expenses" are grant payments that have been allotted for specific programs, such as the Casey Initiative and substance abuse treatment programs. Local governments also receive grants for the operation of Youth Service Bureaus (YSBs).

Figure II-3



**Budget trends.** Figure II-4 represents the department's sources of revenue from FY 87 through FY 89. The greatest source of revenue for the department was from general fund monies. Revenue from the federal government made up a small portion of the department's budget, accounting for only 6 percent (\$8,906,882) of the department's total budget in 1989. Over the past three fiscal years (FY 88 - FY 90), the federal portion has increased by \$474,662 or 5 percent.

The program review committee compared monies appropriated to actual expenditures for FY 84 through FY 89 to determine if the department was over or under spending its budget. In each of the six years examined, the committee found that expenditures closely equaled the legislature's appropriation. The committee found that the department spent 99.7 percent of its appropriated budget in FY 84, 100.8 percent in FY 85, 98.8 percent in FY 86, 100.2 percent in FY 87, 105 percent in FY 88, and 101 percent in FY 89. In the years where the department exceeded its appropriation, the difference was the result of an increase in federal funds.

From FY 82 through FY 89, the DCYS budget has increased at a variable rate. Overall, expenditures increased 123 percent or \$79,136,534, with the largest increases in budget expenditures occurring in FY 87, FY 88, and FY 89. Those increases amounted to 12.9 percent, 22 percent, and 14.1 percent, respectively.

When inflation is taken into account, the department budget increases are somewhat less dramatic. Figure II-5 compares the budget from FY 82 to FY 89 in both real and nominal dollars. To adjust the department's budget for inflation, program review committee staff used the GNP price deflator. Adjusted to 1982 dollars, the budget increase for FY 87 through FY 89 amounted to 8.5 percent, 15.5 percent, and 8.7 percent respectively. Overall, the increase in real dollars for the total period examined was 63 percent; almost one-half lower than the unadjusted figure. Prior to 1987, the department received smaller increases ranging in nominal dollars between eight and nine percent and in real dollars between three and six percent.

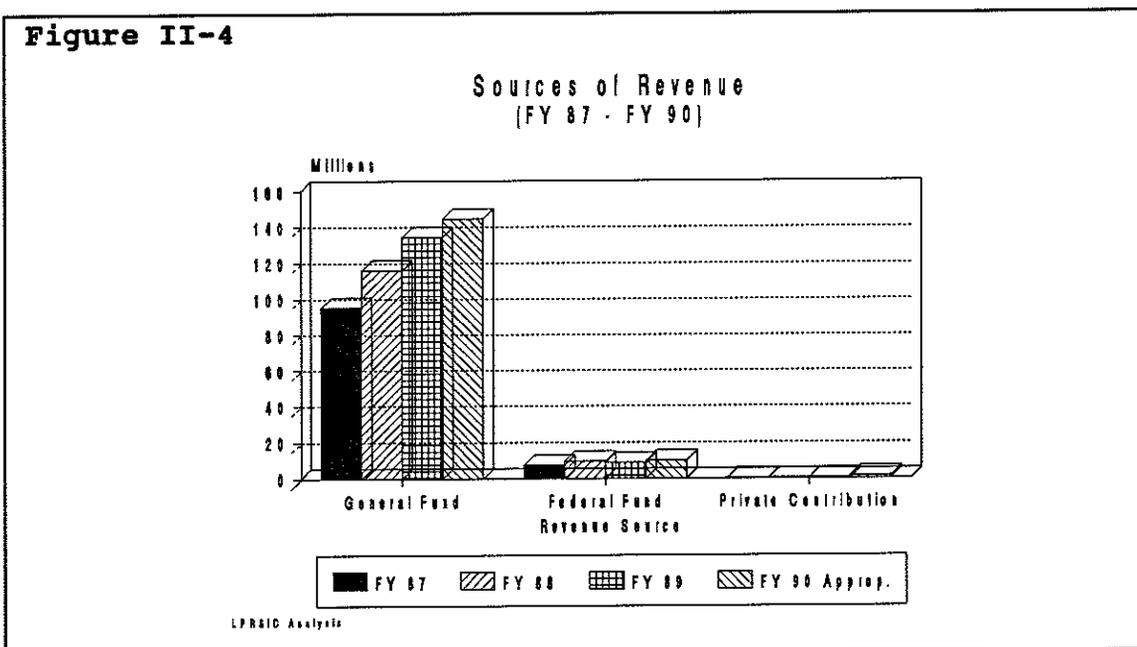
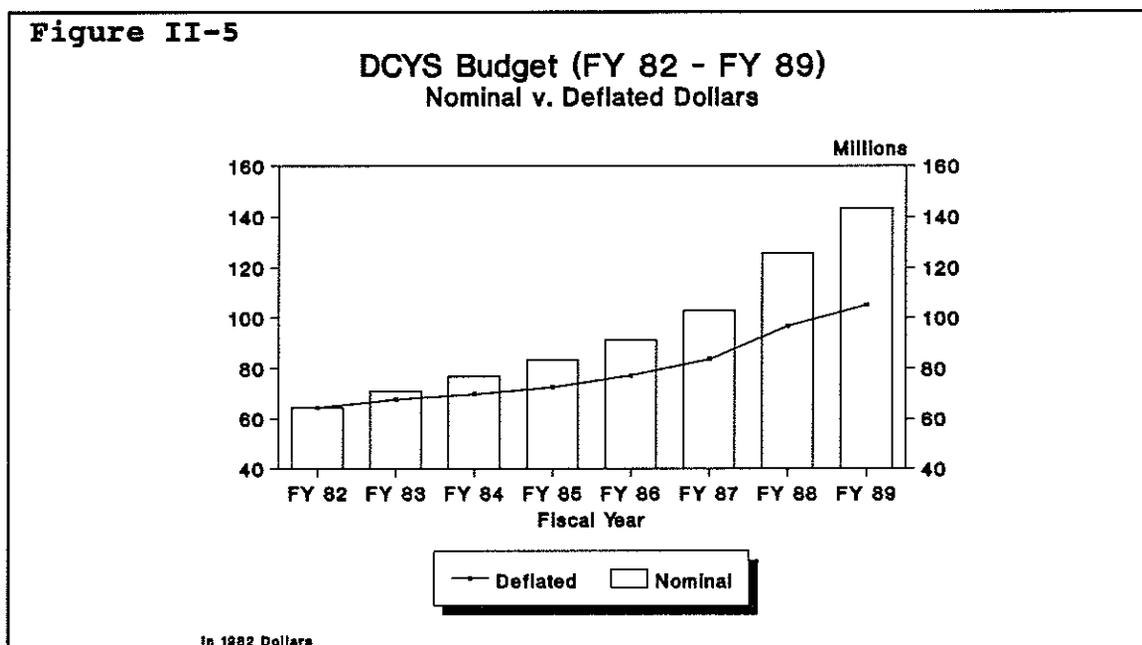


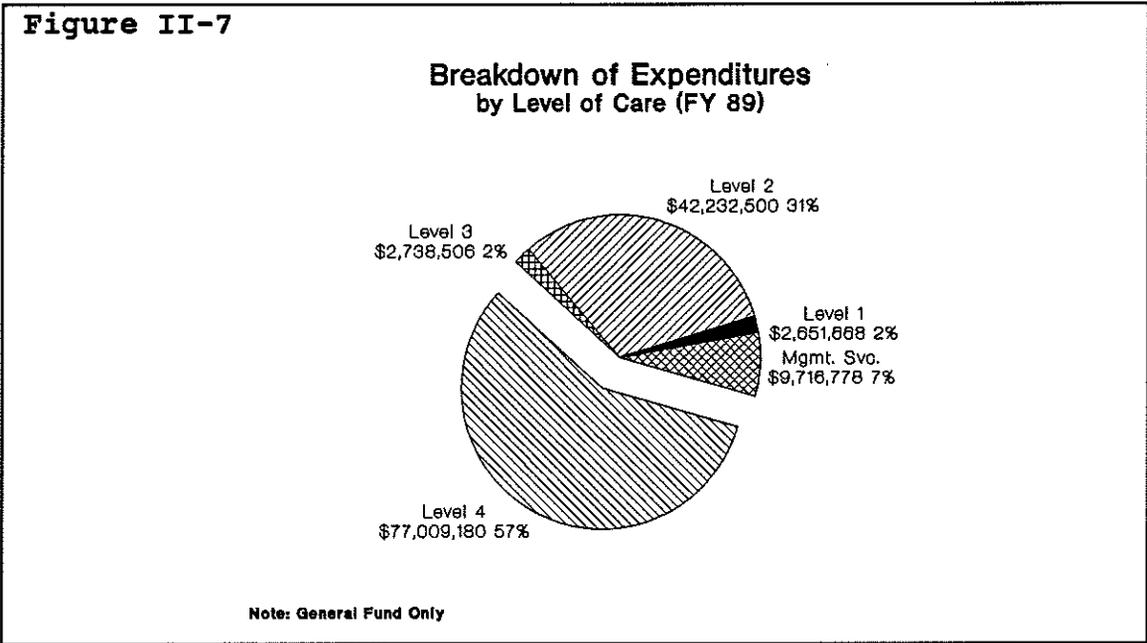
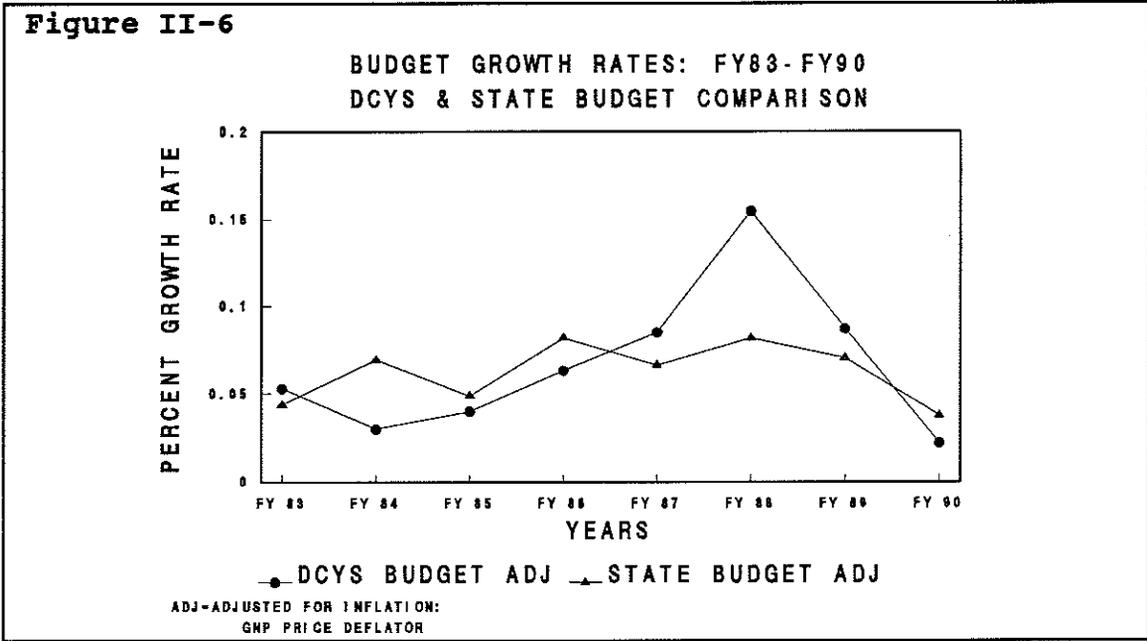
Figure II-6 compares the percentage growth rate (general fund only) of the DCYS budget and the total state budget, from FY 83 through FY 90. Both budgets have been adjusted for inflation in 1982 dollars. In four of the years, the state budget outpaced the department's funding growth, while in the other four, DCYS'S growth was greater. As the figure shows, the state budget grew at a faster rate from FY 84 through FY 86. By FY 88, DCYS'S growth rate exceeded 15 percent - nearly double the state budget rate of eight percent. However, by FY 90, the growth rate for the state budget was four percent compared to a 2 percent DCYS rate.



The department delivers services through a four-level continuum of care. As services become more intensive, the level of care increases. Level One of the continuum, youth and community development services, encourages involvement of families in their schools, among peers and in the community. Services provided within Level Two include counseling, child protective services, adoption services, and permanent foster family homes for children with physical and emotional disabilities. Level Three services are day treatment programs or children educated through Unified School District #2. Finally, Level Four services include comprehensive services for all children in out-of-home placements. Chapter VI of this report will describe each of these levels and programs connected with each in greater detail.

Presented in Figure II-7 is a breakdown of FY 89 expenditures for each level of care. An examination of the FY 89 DCYS budget

shows that Level Four services are the most costly of all levels. This level consumed 57 percent (\$77,009,178) of the total \$134,348,627 budget. Expenditures for Level Two services were the next greatest, accounting for 31 percent of the FY 89 budget (\$42,232,497).



Levels One and Three are the smallest categories in terms of expenditures for services provided, each consisting of only 2 percent of the agencies total budget. Lastly, management services consumed 7 percent of the department's funds.

### **Regionalization**

In 1987, the department expanded the scope of regional operations by transferring administrative and programmatic responsibilities to five regions (region six became operational in January 1990). Day-to-day decision-making affecting programs, including the authority to fund community programs, was shifted from the central office to the regional directors. According to DCYS, the department's current management structure reflects the need for central management of statewide functions and regional management of field operations.

Prior to 1987, DCYS operated five regional offices and seven suboffices that dealt exclusively with protective services. The main function of each office was to investigate allegations of child abuse or neglect, provide treatment if abuse or neglect was substantiated, and place the child out-of-home if necessary. Each office was managed by an administrator, who reported directly to the Division of Child Protective Services in the central office. All administrative functions and programmatic planning for each office were performed by the central office.

**Purpose of reorganization.** The intent behind the 1987 reorganization was to strengthen regional involvement in the administration and evaluation of community programs. Authority to award contracts and distribute grant monies was shifted from the central office to the regions to enhance regional control through the funding of services.

Regions were to determine which programs received grant monies by an on-going process of community program evaluation. If the program was responsive to community needs, funding would be continued. According to the department, one reason behind expanding the scope of regional authority was that services could not only be added or expanded, but ineffective services could be discontinued and funding transferred to other, more responsive programs.

Furthermore, needs assessment was to be conducted by each region and that information communicated to the Division of Program Development within the central office. Regions were expected to work closely with the program development division and provide the division with the information needed to develop programs.

**Current structure.** At present DCYS operates six regional offices and seven suboffices. The boundaries of each region are presented in Figure II-8. A layer of management was added to the existing regional structure when reorganization occurred. A regional director was appointed to each region, as well as an assistant director for programs and an assistant director for administration. A Children's Protective Services administrator, responsible for the management of child welfare activities, is also in each region. Support personnel, including fiscal and planning staff, have also been shifted to the regional level.

**Regional office responsibilities.** The regions are responsible for managing all field operations. Regions must also provide the appropriate division within the central office with information necessary for the central office to develop policies and programs, compile fiscal information, and perform any other necessary functions. Each region is responsible for the following functions:

- contract management;
- planning (i.e., needs assessment for programs), program development, and community networking;
- budget preparation and administration;
- personnel functions (hiring, recruitment, selection, grievances);
- business office (purchasing, travel, etc.); and
- homefinding (recruitment of foster and adoptive homes).

### **Regional Differences**

The program review committee used information from a data base of protective service cases that was provided by the department from its Case Management System (CMS). The data base contains 22,447 cases that were closed between July 1, 1987 and June 30, 1990. Analysis was conducted on several variables to identify significant differences in the way regional offices handled cases. The committee examined by office:

- the length of time taken to close a case;
- the length of time taken to complete an investigation;



- the percentage of cases that are closed at intake compared to those that opened for treatment; and
- the percentage of cases that are re-opened.

In all four areas examined, the committee found there was wide variation not only between regions, but also between offices. In the program review committee's view, the variation can be attributed to a lack of criteria that define the conditions by which a case should be opened, closed, or transferred to treatment. Each office appears to be acting independently in managing its protective service cases. A further reason that may contribute to the difference is that case loads managed by social workers vary from office to office and thus, pressures to close cases may also vary.

On average, most offices closed between 55 and 60 percent of their cases within 120 days. (Willimantic is excluded from the analysis because it is a recently created regional office and the case load reported was very small compared to other offices). However, Table II-3 shows a significant variation between offices in cases closed within the first 15 days, ranging from 5.5 percent in Danbury to 26.7 percent in Torrington. Interestingly, both these offices are located within region 5. Although some variation would be expected in a highly decentralized agency like DCYS, it would be presumed that offices within the same region would act similarly.

There is a wider variation in the percentage of cases closed within 45 days. These range from 20.6 percent in Middletown to 57.7 percent in Torrington. Almost three times as many cases are closed in Torrington within 45 days than in Middletown.

### Investigations

Program review committee also found broad office to office variation in the length of time it takes to complete an investigation. The median range in time varies from 3 days in Stamford to 28 days in Meriden. Table II-4 presents the median for each of the 13 offices as well as the statewide figures. Even within a region there can be a significant difference in the time it takes to complete an investigation. For example, the Hartford office completes three-quarters of its investigations in 16 days, while New Britain takes 33 days.

In the opinion of the committee, a number of reasons could account for these office variations, including case load differences and complexity of cases received by a particular office.

Table II-3. Cumulative Percentage of Cases Closed By Days for Each Office.							
Office	1-15 Days	16-30 Days	31-45 Days	46-120 Days	121-365 Days	Over 1 Year	
Bridgeport	15.0	26.1	40.7	66.8	86.0	100	
Danbury	5.5	16.6	28.1	59.8	83.7	100	
Hartford	6.9	15.9	25.4	52.8	77.5	100	
Meriden	10.2	26.1	39.1	58.9	84.6	100	
Middletown	6.2	13.7	20.6	56.9	84.4	100	
New Britain	11.5	22.0	29.0	57.6	82.6	100	
Hamden	10.6	21.1	32.1	63.0	83.2	100	
Norwich	14.3	23.0	32.8	61.6	83.2	100	
Rockville	16.4	26.0	33.1	56.1	80.7	100	
Stamford	10.5	22.7	33.3	60.5	84.6	100	
Torrington	26.7	45.7	57.5	73.5	86.6	100	
Waterbury	22.2	35.2	42.5	60.0	77.4	100	
Willimantic	44.1	67.6	72.5	96.1	100	.	

Source: LPR&IC staff analysis of DCYS CMS database.

Table II-4. Days Needed to Complete an Investigation by Office.				
Office/Region	Median	# of Cases	Days to Complete Investigation on 75 % of the Cases	Days to Complete Investigation on 90 % of the Cases
Bridgeport/I	6	2,045	20	45
Stamford/I	3	975	8	20
Hamden/II	13	2,840	26	31
Meriden/II	28	730	31	33
Norwich/III	8	3,223	24	49
Middletown/III	13	667	25	31
Hartford/IV	6	2,417	16	31
New Britain/IV	13	1,082	33	65
Danbury/V	20	1,053	32	63
Waterbury/V	10	987	23	34
Torrington/V	16	465	30	47
Rockville/VI	7	1,344	21	48
Willimantic/VI	9	100	19	29
State-wide	9	17,946	25	40

Source: LPR&IC staff analysis of DCYS CMS database.

Case load to worker ratios will be examined in detail in a later chapter. However, too much difference in regional operations exists in the time taken to investigate cases and the time cases remains open to attribute the differences solely to the above factors.

**Case intervention.** Table II-5 shows the percentage of cases that are investigated and then closed without treatment (i.e. closed at intake) compared to those transferred to treatment. Again, program review committee discovered significant variation among offices. As the table depicts, the overwhelming majority of cases that are opened in Hamden (82 percent) are closed at intake, while only 18 percent are transferred to treatment. Conversely, 46 percent of the cases opened in the Hartford office are accepted for treatment. However, New Britain, which falls in the same region as Hartford, accepts only 25 percent of the cases for treatment while 75 percent are closed at intake.

Further evidence concerning the differences in regional office operations can be found in the ratio of new cases to reopened cases. The DCYS case management system contains information concerning whether a case is new or has been reopened in the last year. An analysis of that information shows that, with the exception of Willimantic where the number of cases is too small to draw accurate conclusions, the percentage of cases reopened ranges from 17.4 percent in Danbury to a high of 41.3 percent in Norwich. This represents a major variation in the number of cases that are reopened throughout the regions. Table II-6 ranks the variation from high to low.

<b>Table II-5. Percentage of Cases Closed at Intake v. Transferred to Treatment by Office.</b>		
<b>Office</b>	<b>Closed at Intake</b>	<b>Transferred to Treatment</b>
Hamden	82%	18%
Torrington	81%	19%
New Britain	75%	25%
Middletown	75%	25%
Rockville	75%	25%
Danbury	74%	26%
Norwich	72%	28%
<b>Statewide Average</b>	<b>71%</b>	<b>29%</b>
Waterbury	69%	31%
Bridgeport	68%	32%
Willimantic	66%	34%
Stamford	66%	34%
Meriden	61%	39%
Hartford	54%	46%

Source: LPR&IC staff analysis of DCYS CMS database.

Clearly, there are substantial differences between offices, which cannot be explained solely on the merits of individual cases. The type of cases may differ somewhat from office to office, but not enough to affect such fundamental operations as case openings

and closings, case investigations, and case interventions. It would be reasonable to conclude that each office has its own informal standard as to how cases are handled. In light of the lack of emphasis on uniform procedures for case administration by management, as well as its perceived inability to communicate policy to the staff, much of the variation can be attributed to the operational styles of each office.

Table II-6. Regional Comparison: Cases Reopened.	
Office/Region	Percentage of Cases Reopened <sup>1</sup>
Norwich/III	41.3
Meriden/II	38.8
Hamden/II	36.7
Middletown/III	36.7
Stamford/I	34.2
Hartford/IV	32.5
State-wide	32.2
Bridgeport/I	31.1
New Britain/IV	27.6
Rockville/VI	25.2
Torrington/V	21.1
Waterbury/V	18.2
Danbury/V	17.4
Willimantic/VI	1.0

<sup>1</sup> Percentage of cases opened within one year of closing.  
 Source: LPR&IC staff analysis of DCYS CMS database.

Given the lack of knowledge within the department concerning differences on how cases are handled among offices, it is reasonable to conclude there is a shortage of information available to policy-makers. The program review committee believe the management team should be provided these types of data through the quality assurance system, which focuses on gathering and disseminating information on department inadequacies. In order for the management team to exercise its policy-making responsibility in this area, case administration guidelines must be issued, compliance carefully monitored, and this information provided to and acted upon by the team. Although DCYS does have a quality assurance division, it currently supplies little feedback on regional operations to managers within the department. The following is a description of the quality assurance system.

## Quality Assurance

The underlying purpose of quality assurance is to assure that services licensed, funded, and operated by DCYS comply with state and federal law, that department policies and regulations are followed, and that children are protected. The Quality Assurance Division is located in the central office of DCYS and has six units and 38 staff. This division is responsible for convening case reviews involving clients and social workers (referred to as administrative case reviews), investigating allegations of abuse or neglect of children placed in out-of-home care, evaluating department-funded programs (described in the Chapter VI), assessing compliance with federal requirements for reimbursement, licensing out-of-home placements, and conducting administrative hearings.

Legislative Program Review and Investigations Committee identified several inadequacies in the operations of this division. The committee found:

- no reporting mechanism in place to track individual clients who have been inappropriately placed;
- no follow-up of problems identified in administrative case reviews, investigations of out-of-home abuse or neglect, or program evaluations;
- no systematic method of reviewing cases for compliance with DCYS policies; and
- no analyses of systemic failures.

**Administrative review of the treatment plan.** Once a case has been accepted for services through the intake process, a treatment plan must be developed. The plan contains a summary of the overall case, the goals of treatment, barriers to achieving the goals, and primary participants. According to federal law, an administrative review of the treatment plan must be held for all children in out-of-home placement every six months.

Responsibility for the administrative case review rests with the Individual Review and Evaluation Unit within the Quality Assurance Division. A meeting is scheduled by the unit and includes the social worker assigned to the case, the case supervisor, and the quality assurance staff person as well as the child's parents and foster parents or facility staff where the child is placed.

Each review takes approximately 15-30 minutes to complete. According to the director of quality assurance, unit staff act as

facilitators by encouraging communication among the parties involved to promote discussion of the treatment plan and the case goals for the child and family. As a result of the administrative review, the treatment plan may be amended. Department policy states that the purpose of the administrative review is to:

"determine the continuing need for and the appropriateness of each placement, the extent of compliance and progress made with the previous treatment plan and to project a likely date by which the child may be returned home or in another permanent placement."

Table II-7 shows the number of individual administrative case reviews held by the Quality Assurance Division for FY 90, as well as the participants involved. In addition to the 8,559 individual reviews held, the division also conducted 3,253 family reviews.

Program review committee staff were unable to determine what components of the review (appropriateness of placement, time-frames being met, etc.) were addressed since these data are not aggregated by quality assurance staff. Instead, a log of completed monthly reviews is maintained by the division and forwarded to the appropriate region. Each log entry is by individual case and contains:

- the child's name and date of birth;
- the names of the child's parents;
- the type of placement the child is in;
- the date of the last treatment plan;
- the last date of DCYS contact with the child,
- the names of the participants; and
- any recommendations or comments made as a result of the review (often the overall case goal is just reiterated).

Once the log is received by the region, it is the region's responsibility to implement any recommendations made. Program review committee staff found there is no follow-up by quality assurance staff to ensure that recommendations issued have been implemented until the next administrative review is done six months later.

**Information analysis.** In the opinion of the program review committee, the lack of aggregated data available on the adminis-

trative case reviews seriously impedes the department's ability to plan for the future needs of both the child and the agency. Hypothetically, if the administrative case review determines that 30 percent of the children in a region are shown to be inappropriately placed, or 25 percent of the time-frames in another region are not being met, policy-makers could deal with these issues. Furthermore, regional and office comparisons could be drawn and regional performance assessed if this information were available.

**Table II-7. Administrative Case Reviews for FY 90.**

	Reg 1	Reg 2	Reg 3	Reg 4	Reg 5	Reg 6	Total
# of Reviews	1,301	1,861	1,137	2,054	1,396	810	8,559
# Termination Parental Rights	306	286	160	310	211	115	1,388 (16%)
# and % with Participation	386	602	344	575	520	267	2,694 (32%)
Mothers Participating	190	253	195	308	265	152	1,363
Fathers Participating	58	102	96	120	121	77	574
Facility Participating	89	146	29	107	74	35	480
Foster Parents Participating	108	236	106	154	214	102	920

Source: DCYS Quality Assurance Division.

**Investigation of abuse and neglect in out-of-home placement.**

The Investigations Unit within Quality Assurance was also examined by the program review committee. This unit is responsible for all investigations of abuse and/or neglect that occur in out-of-home care. Table II-8 shows the number of investigations conducted and their outcomes for FY 90.

As the table shows, there was a total of 218 investigations of abuse and neglect in out-of-home placement. Of these, 58 cases were substantiated and 84 were unsubstantiated. The category "with concerns" means that although abuse or neglect did not occur, other situations may be causing stress on the family (for example, marital problems).

A comprehensive investigation is performed by unit investigators. If abuse or neglect is substantiated, this unit may refer the matter to the licensing unit, also within the Quality Assurance Division, which may determine whether to place the facility or home on provisional licensure or proceed with revocation.

The program review committee examined four cases that were investigated by unit staff. The committee found the reviews to be exhaustive and well documented. Findings and recommendations were issued by the investigator to the appropriate region, as well as the facility or foster home involved. However, once issued no follow-up was performed to ensure the recommendations had been implemented. This, in the view of the program review committee, is a serious deficiency in the quality assurance system.

Table II-8. Investigations Performed for Out-of-Home Placement.			
Outcome	Group Care	Foster Care	Total
Substantiated	28	30	58
Unsubstantiated	44	40	84
At Risk	23	14	37
With Concerns	7	11	18
Other	10	11	21
TOTAL	112	106	218

Source: DCYS Quality Assurance Division.

Although the division should be commended for the thoroughness of the investigations conducted, the program review committee believe that follow-up is necessary to determine if the desired results have been achieved.

**Case audit.** The program review committee found there is no random audit of cases for compliance with DCYS policies. The program review committee believe that cases should be audited on a regular basis, chosen randomly from the regions throughout the state.

The Revenue Enhancement Unit within Quality Assurance currently performs random case audits solely for compliance with federal requirements in order to receive federal reimbursement. This involves monitoring the timeliness of case treatment plans, administrative case reviews, and dispositional hearings. This

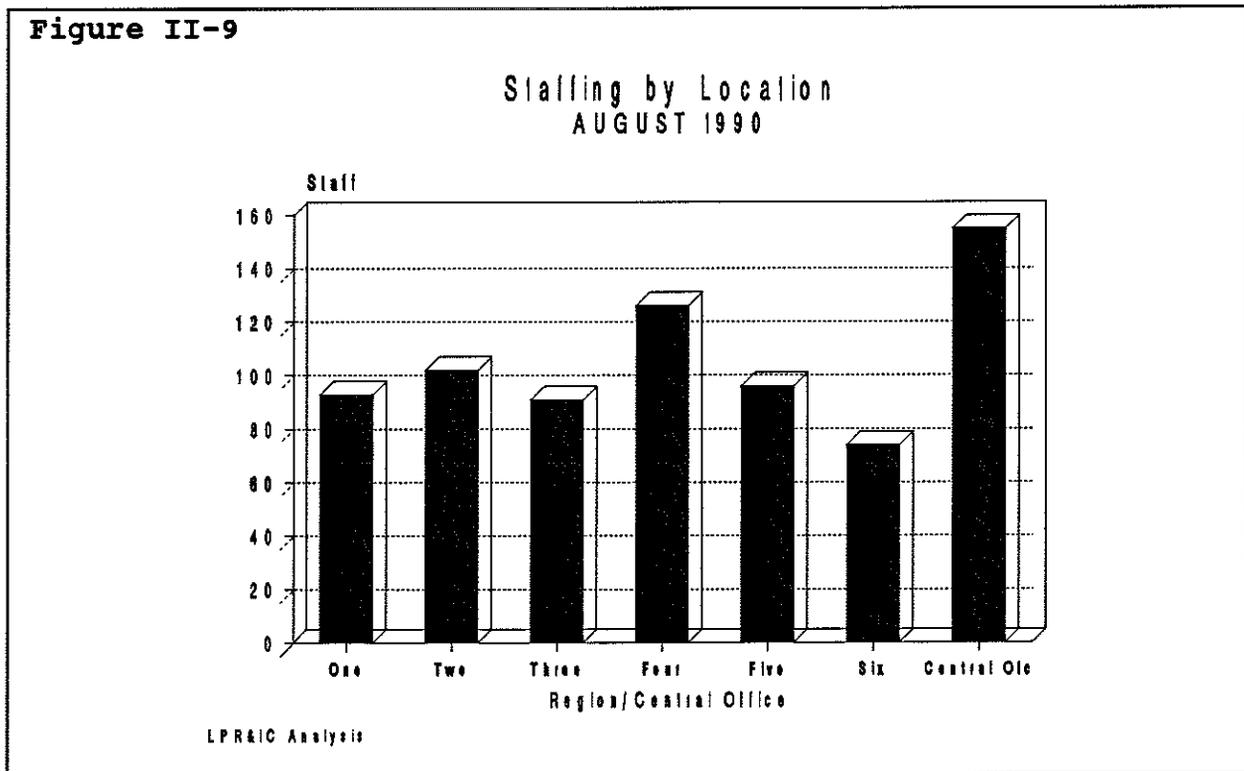
review is a purely technical review to ensure forms have been filled out correctly, rather than a review for content.

## Staffing

**Current staffing.** Figure II-9 shows the distribution of permanent full-time staff (general fund only) by geographic location. In addition to this, there are 818 permanent full-time staff who are employed at DCYS operated institutions.

As the figure shows, the greatest number of staff are employed in the central office of DCYS and makeup 9.7 percent of the total 1,590 permanent general fund full-time employees. In addition, region four has the greatest number of staff among the six regions, while region six has the least (74 permanent full-time employees). The program review committee conducted further analysis on the relationship between regional staffing patterns and caseloads. The information is presented in the case management chapter of this report.

**Staffing trends.** General fund permanent full-time staff increased 11.4 percent from 1,427 employees in FY 85 to 1,590 employees as of August 1990. Excluding DCYS operated institutions, staff in the central office and regions increased 15.3 percent from 639 staff in FY 85 to 737 in FY 91.





## CHAPTER III

### DCYS Children Protective Services Process

The mandate of the Department of Children and Youth Services is to plan, create, develop, operate or arrange for, administer, and evaluate a comprehensive and integrated statewide program of services for children. DCYS provides its services through either DCYS-administered programs or privately run programs funded by the department. Both types of programs are offered through the department's continuum of care consisting of the four treatment levels.

As part of its evaluation, the program review committee identified several DCYS-administered and DCYS-funded programs as those which deal primarily with the investigation and treatment of abused, neglected, or abandoned children. The committee's definition of a program was broadened from its usual meaning to include some of DCYS's functions and units. These functions and units were identified as programs because of the specific duties performed and clients served.

The three DCYS-administered programs reviewed by the committee are: 1) regional children protective services, including risk assessment; 2) Careline; and 3) foster and adoptive families. These programs were chosen because of their role in investigating or caring for abused, neglected, or abandoned children either committed to the DCYS or those in home settings.

The DCYS-funded programs that were reviewed by the committee are those that specifically address the needs of abused and neglected children. As with the DCYS-administered programs, the DCYS-funded programs were chosen because of their work diagnosing, treating, preventing, and caring for abused, neglected, or abandoned children and their families. These department-funded, community-based programs along with the continuum of care model will be discussed in Chapter VI of this report.

The following is a detailed description of DCYS-administered programs aimed at abused and neglected children. The children protective services is the main operation of DCYS regional offices. It is through this process that cases enter the system, are investigated, and receive treatment. The protective services process is a means to ensure that all situations requiring DCYS intervention are handled consistently.

#### Children's Protective Services

Protective services is a specialized department responsibility extended to families in behalf of children who are abused,

neglected or abandoned. It is different from other DCYS and social services in that it is involuntary; the parents or guardian of the child usually do not ask for DCYS involvement and DCYS cannot allow the child to continue in the present situation. DCYS protective services are in behalf of the child and services continue until the child is receiving proper care either in the home or placement facility.

Goals of protective services. DCYS protective services operate on three basic concepts, which are:

- that families have the right, within certain limitations, to rear their own children;
- that children belong in the homes into which they were born unless a caretaker's behavior or the nature of the home environment suggests a child cannot remain there safely; and
- that once a child has been removed from the home, the child should be returned to a safe environment-- the child's own home or an alternate home.

However, protective services recognizes that intervention by the state should occur when a child has been injured, neglected or threatened with serious harm. Situations that indicate a need for protective services are those in which someone, outside or inside the home, is concerned about the care given to a child and makes a complaint to DCYS, such as the following:

- lack of physical care and protection of a child;
- consistent lack of supervision, guidance, or discipline;
- sexual abuse, molestation, exploitation of a child; or
- abuse and/or physical cruelty.

Intake. The Department of Children and Youth Services is mandated to investigate abuse and neglect allegations. The protective services units perform this function through the intake process. DCYS protective service workers do not determine whether a specific perpetrator has committed a crime, but rather assess whether or not an alleged abuse took place and the relative safety of the child. DCYS intervention is aimed at determining if a

family will benefit from voluntary intervention or if there is sufficient cause for the law to intervene. However, DCYS does not have the legal authority to enter a home or remove a child without the consent of a parent or guardian or the court.

In the case of a known emergency or imminent danger of serious physical harm to a child, DCYS works in conjunction with local or state police to gain entry or obtain a court order to remove a child from a home. Absent this situation, the department has several options in attempting to see a child to substantiate an allegation. DCYS protective service can attempt to see a child by:

- convincing a parent that cooperation is needed to settle a complaint;
- visiting that child at school or another environment outside the home; or
- obtaining a court order commanding the parent or guardian to show cause why cooperation with the investigation is not needed.

Before an investigation can be initiated, the referral or allegation is screened to meet certain criteria. The referral or allegation must: (1) provide sufficient identifying information to locate the child and family; (2) the child must be under 18 years of age; and (3) be in reference to abusive and/or neglectful behavior by the parents that have an effect on the child.

A protective services investigation can include such activity as follows:

- confronting the parents or guardians;
- assessing the parents' or guardians' demeanor and response to the allegation;
- assessing the child's physical condition;
- assessing the condition of the home; and
- collecting information from witnesses.

Information gathered during the investigation is used to determine whether or not the allegation can be substantiated. An unsubstantiated allegation does not mean that the abuse or neglect did not occur. It simply means that DCYS did not find observable or credible evidence to document the abuse. In this situation,

DCYS has no legal basis for further intervention unless the parents voluntarily accept services.

Cases not accepted for services after an intake evaluation can include those where:

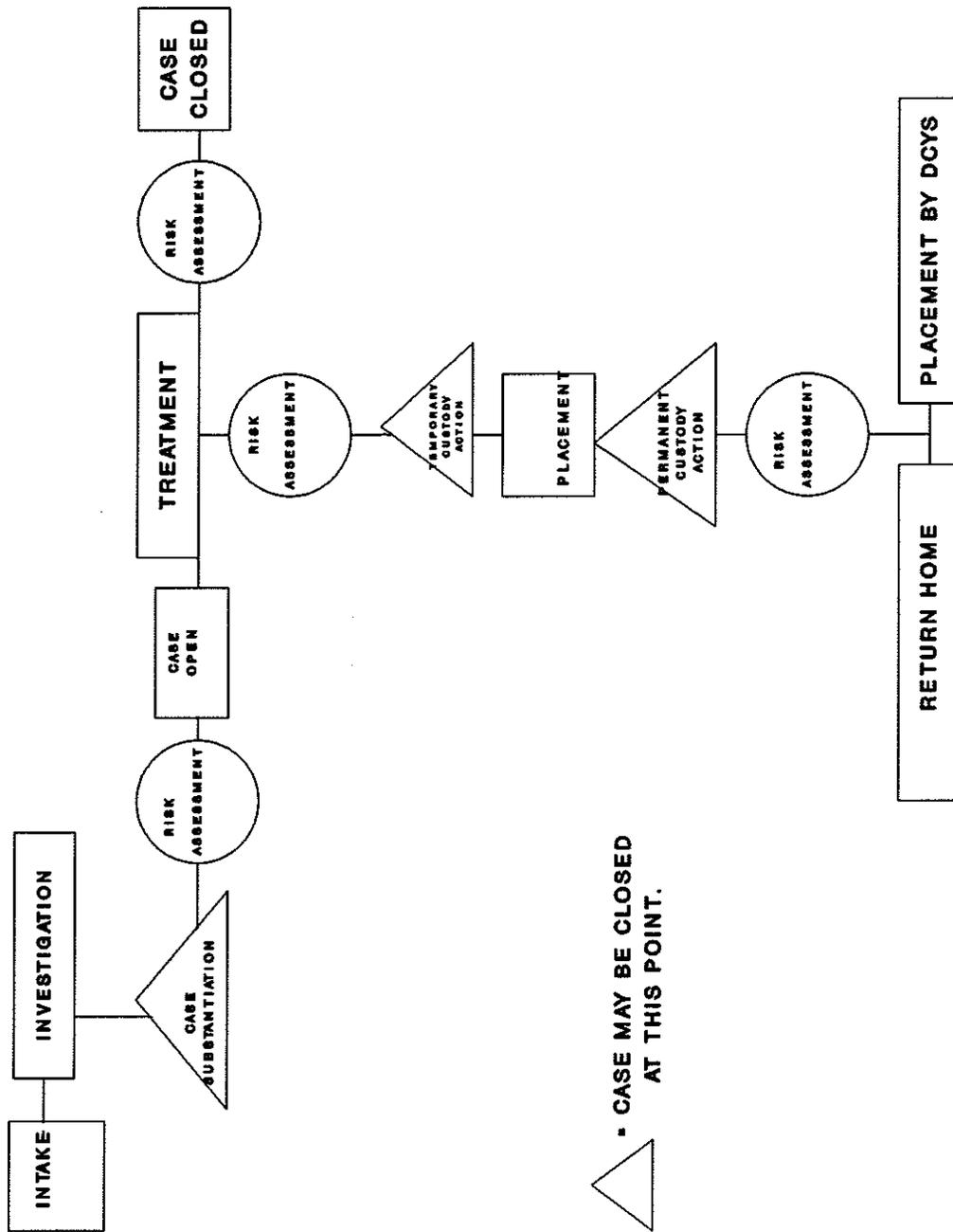
- reports of abandonment, abuse, or neglect were not substantiated;
- parents or relatives work out satisfactory plans and DCYS services are not needed;
- parents are unable or unwilling to work with DCYS toward improvement but the situation is not serious enough to warrant DCYS involvement; or
- treatment of the cause for concern comes within the purview of another public or private agency and parents accept referral to that agency.

A flowchart illustrating the process of a case of abuse, neglect or abandonment is shown in Figure III-1. The flowchart begins with the intake stage and continues through treatment and removal to the close of a case. The treatment phase is also illustrated as part of the process of a case, this phase will be discussed later in this section.

**Risk assessment.** The department has an established policy for determining the level of risk a child faces. For those cases that have been substantiated, DCYS conducts a risk assessment to determine the level of danger to the child in the home. The level of danger is determined as (1) emergency; (2) severe; or (3) non-severe. The response time by DCYS protective services is as follows:

- emergency requires a same day home visit and completed investigation within 30 days;
- severe requires home visit within 24 hours and completed investigation within 30 days; and
- non-severe requires home visit within three working days and completed investigation within 45 days.

FIGURE III-1: DCYS CASE FLOW CHART



Risk assessment is an on-going process for the duration of the case which determines the level of safety of a child by identifying and weighing certain factors of the family life. The decision-making guidelines help social workers determine in a systematic and uniform manner the accurate response time for a referral, when to open a case, when to consider removal or return of a child, and when to close a case.

Risk assessment can be applied at every stage of a case. However, it is required that a risk assessment form be completed at four major points in the case. The completion of the risk assessment may support and document the need for DCYS intervention in a particular situation. The flowchart of the case process illustrates the points when risk assessment is applied. The social worker and supervisor complete a form at the following points:

- intake disposition when it is decided to close the case or transfer to treatment, the next step in the protective services process;
- removal from or retention of a child in the home;
- return of a child to the home; and
- closing a case.

The factors considered during risk assessment are rated for frequency, intensity and duration of the various risks of abuse, neglect, or abandonment. Also, those indicators which may decrease the risks or increase the positive effect of intervention are identified and considered. The risk assessment uses both the weaknesses and strengths of the family when making decisions regarding the child.

Risk assessment identifies seven major areas of concern when evaluating a family in crisis. The risks and strengths in these areas are weighed to determine the course of intervention or action that would best suit the child and family. The areas of concern in risk assessment are:

- referral-- nature, severity, frequency, previous referrals;
- children-- age, physical, emotional and intellectual status;

- caretaker(s)-- relationship to child, quality, parenting skills, history, drug or alcohol abuse, impulse control;
- alleged perpetrator(s)-- relationship and access to child, and personal history, such as drug or alcohol abuse;
- family strengths-- relationships with family, friends, neighbors, church, community, and social groups;
- environment-- condition of shelter, clothing, food, and resources; and
- stress-- state of health, income, relationships, and family violence.

**Treatment.** Treatment is the next major step in the protective services process after intake. The treatment process is usually slow and requires patience and understanding on the part of the DCYS social worker. Treatment workers must make it understood to families where maltreatment has been substantiated that DCYS has a right to offer services to children, and an obligation, regardless of parental attitudes, to remain active until the abusive or neglectful behavior has been reduced or removed. The workers often must sustain long-term and sometimes exhaustive relationships with the families in treatment while also being sensitive to the families' behavior and progress.

Once a case has been accepted for services through the intake process, a treatment plan must be developed and the case transferred to a treatment social worker. An important obligation for DCYS in treatment planning is the on-going measurement of the progress toward the plan's goals and objectives. The plan must be flexible enough for revisions from the initial goals when appropriate. The flowchart of the case shows that the treatment phase is a process in and of itself, however, it is still part of the whole case process.

Treatment can include techniques such as the following:

- increasing supportive resources to reduce stress;
- helping individuals identify and express feelings such as fear, anger, anxiety, and guilt;

- identifying crisis elements and alternative ways to cope with stress and controlling behavior;
- family problem solving;
- utilizing supportive services, such as day care;
- focusing on needs and setting goals by outlining necessary behavior; and
- using positive reinforcements.

Cases in treatment are reviewed every six months. The review includes an assessment by parents and all parties involved; reaffirmation of case goals and/or redefinition of goals; and updating the treatment plan for the next six months.

Removal from home. Treatment for an abused or neglected child may require removal from home. However, intervention by the state does not always result in removal.

When allegations of abuse, neglect, or abandonment have been substantiated by protective services, removal of the child from the home is not automatic. A risk assessment of the child's safety and a determination of the cause for the maltreatment is made to assist the department in providing the appropriate services and treatment.

Since removal of a child is such a drastic step and all other alternatives should be considered prior to removal, DCYS and the Yale University Child Study Center developed guidelines to be used when removal from home becomes necessary. The primary assumption of the guidelines is that every child needs and deserves to feel physically and emotionally secure in his or her home environment. The security of a child is usually best served by a permanent and enduring relationship with a parent or caretaker.

A child who has been physically or sexually assaulted and whose life or physical safety is threatened must be assured of being in a safer environment by being removed from the danger in the home. However, the guidelines list two conditions whereby an exception to removal can be granted. They are:

- the factors that caused the abuse are identified, such as dismissing an abusive babysitter or leaving an abusive boyfriend, and the parent(s) make changes or use services that will prevent a recurrence; or

- sufficient services are used to alleviate the risk to the child in the home until either a long-term service or a change in the caretakers can assure that the child's safety is no longer at risk.

If the two exceptions to removal are not met then the child must be safeguarded by separating that child and the suspected perpetrator of the abuse. When removing a child from the home, DCYS must consider the following:

- identifying a specific alternative home for the child; and
- that the specific alternative is a more appropriate and safer place to live than the one in which the child currently resides.

The guidelines address two types of removals: emergency and planned. An emergency removal is used in situations of non-accidental serious physical injury, sexual abuse with physical injury, abandonment, or a physically demonstrated threat to the life of the child. A planned removal is used when there is physical damage or imminent risk of physical damage, physical or sexual assault, abandonment, or at the parents' request for removal of the child from the home.

These removals require that a conference be held between the social worker, supervisor, program supervisor, parents, and foster parents before and after the removal of the child. For emergency cases the conference is held within two working days of the removal. A written plan for removal, custody, and treatment is developed for the child. In developing the plan the following factors are considered:

- danger to the child;
- identification of the child's unmet needs;
- support mechanisms for the family;
- placement options available;
- number of siblings and impact of removal on them; and

- special needs of the removed child.

The DCYS policy manual requires that all assessments resulting in removal of a child from a home are administratively reviewed every three months for children 0 - 5 years of age and every six months for children 6 - 18 years of age. However, the cases on children from 0 - 5 years are actually reviewed every six months. The cases are clinically reviewed on a monthly basis, but can be reviewed on a more frequent schedule when necessary.

**Legal status of removal.** Children are removed from their homes through either voluntary placement, a 96-hour hold, an Order of Temporary Custody (by the court), or court commitment to DCYS. A child is removed through voluntary placement when a parent has requested placement for a period of up to 90 days. This type of removal is usually used for short-term problems within the family. The parent retains all rights to and responsibilities for the child. At the request of the parent, the child must be returned immediately to the home.

A 96-hour hold is used by DCYS when serious conditions pose imminent danger to a child. The department will protect the child by immediate removal from the home without the parents' permission or prior knowledge. A 96-hour hold can be granted by a regional director, commissioner of DCYS, or medical personnel in a hospital setting. The commissioner of DCYS or the hospital becomes the child's guardian.

A 96-hour hold is a very serious decision and can have significant impact on the child and family. It is not a decision that is reviewed by the court and, therefore, the length of the removal is brief and the criteria to grant the hold is strict. The 96-hour hold is usually used when the child is seriously abused, abandoned, afraid to go home, or in a dangerous situation at home.

The Order of Temporary Custody is granted by the Superior Court for Juvenile Matters after filing of a petition by DCYS based on facts showing that a child is in imminent danger of serious physical harm. When determined that the child is in need of court protection and the order is granted, the commissioner of DCYS becomes the guardian of the child for a period not to exceed ten days.

A limitation on the use of an Order of Temporary Custody is the grounds on which the court can grant the order. The basis for the court is imminent danger of serious physical harm which excludes all other damaging and dangerous activity inflicted upon children. For example, the court could, and according to DCYS has, legally denied cases of sexual abuse with no penetration and cases when the child is afraid to go home without taking into consideration the age of the child and the reason for the fear.

Within the ten-day limit of an Order of Temporary Custody, a show cause hearing is held whereby the parents through legal representation "show cause" why the child should be returned to their care. The child and DCYS also have legal representation present. If it is decided that DCYS maintain custody, the court continues the custody for 30 days. If DCYS custody is denied, the child is returned home. In either case, a full hearing is scheduled by the court within 30 days to determine if the allegations can be substantiated to warrant that the child be committed to DCYS care.

The fourth way a child can be removed from home is through commitment. Commitment is used when there is no imminent danger to the child and, therefore, cannot be removed until there is a court hearing. A child is committed when a Superior Court for Juvenile Matters has found, through a neglect petition filed by DCYS, the child is in need of protection, and granted care and custody to DCYS. Commitment of a child is for a period not to exceed 18 months.

During the 18-month commitment, DCYS works with the parents towards reunification of the family. The parents retain certain rights to and responsibilities for the child, such as the right of visitation, availability of services, and access to the court process. Also, every six months DCYS must report to the court on the progress of the case.

At the end of the 18 month commitment, DCYS can petition for the following:

- revocation, which is a return of the child to the home;
- extension of the commitment for another 18 month period; or
- termination of parental rights to free the child for adoption.

### Careline

The second DCYS administered program for abused, neglected or abandoned children is Careline. Careline is an operational unit within the Division of Children Protective Services but connected to the regional protective services units. It is housed at Long Lane School.

Careline is the DCYS 24-hour emergency telephone service. It is similar to the 911 emergency service provided by law enforcement, and is the central office's most reactive unit to child

abuse, neglect, and abandonment. Careline responds to all reports or referrals of child abuse, neglect, or abandonment and all inquiries for information or referrals to local social or medical services.

**Operation.** Careline is staffed by six social workers, two telephone operators, and a supervisor, who are not assigned to any particular region nor are they responsible for a regular intake or treatment caseload. The social workers remain on call during Careline hours and investigate all emergency reports or mandatory referrals. Careline is also staffed by regional social workers who rotate on-call shifts.

After receiving a report or referral of child abuse, neglect, or abandonment, Careline assesses the situation to determine if an immediate response is necessary. As with cases investigated by the regional child protection services' intake units, the calls are categorized as emergency, severe, and non-severe. When responding to an emergency or severe case, Careline sends an on-call social worker to the home. Non-emergency calls are forwarded to the appropriate regional office for action on the next working day.

In addition, all information on emergency and severe calls is forwarded to the appropriate regional office and responsibility for those cases then lies with the regional protective services offices. The central office receives reports on all calls responded to by Careline, and Careline reports are reviewed by the risk assessment social workers.

Careline has additional responsibilities in that it acts as a public information and referral service. Careline makes referrals in response to informational requests and non-emergency calls to local government or private services and programs statewide. A listing of all children within the DCYS system is also kept by Care-Line to inform doctors and hospitals as to who can authorize medical services to be performed. Careline acts as a liaison between parents and medical facilities. Careline is also responsible for maintaining the DCYS central registry, which is a mandated index of confirmed cases of child abuse and neglect accessible to child care professionals, and is used in conjunction with closed case files.

**Caseload.** Since its inception in 1973, Careline has had an increasing number of calls. Table III-1 represents the total number of calls, including reports, referrals, and informational requests, responded to on a yearly basis. As shown in the table, Careline received 2,359 calls during its initial year (FY 1973-74) of operation and, during its last full year of operation (FY 1988-89), received 26,013 calls. The graph illustrates that overall Careline has had an increasing number of calls each year, with a few years experiencing minimal decreases.

Careline is operational evenings, weekends and holidays. Table III-2 shows the breakdown of the time of day the calls were received during the period of 1984 through 1989. As shown, the majority of calls were received between the hours of 4:30 pm through 12:30 am.

FIGURE III-2. DCYS CARELINE: 1974 TO 1989

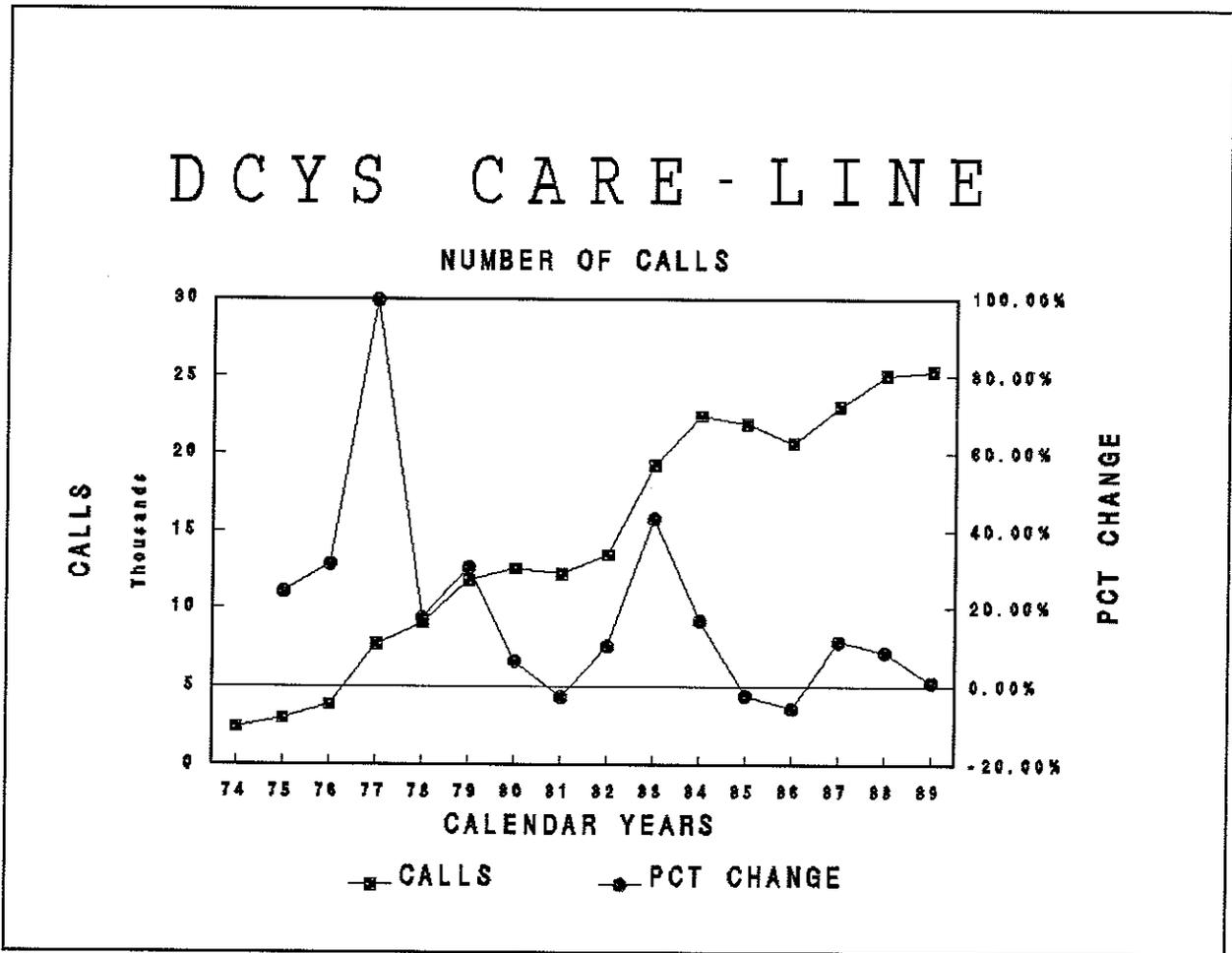


Table III-1. Total Number of Calls to Careline. 1973-1989.		
CALENDAR YEAR	TOTAL NUMBER OF CALLS	PERCENTAGE INCREASE
1973-74	2,359	*
1974-75	2,930	24.21%
1975-76	3,846	31.26%
1976-77	7,681	99.71%
1977-78	9,023	17.47%
1978-79	11,769	30.43%
1979-80	12,524	6.42%
1980-81	12,181	-2.74%
1981-82	13,434	10.29%
1982-83	19,222	43.08%
1983-84	22,452	16.80%
1984-85	21,931	-2.32%
1985-86	20,688	-5.67%
1986-87	23,056	11.45%
1987-88	25,069	8.73%
1988-89	25,314	0.98%
TOTAL	233,681	
Source: DCYS.		

Care-Line receives reports or referrals on various types of activity, such as:

- abuse, abandonment, and neglect;
- death of or dying child;
- substance abuse related problems;
- placement resources problems;
- legal issues;

- runaway and suicidal issues;
- sexual abuse;
- permission to give medical treatment to DCYS committed children;
- informational requests on protective services;
- marital problems and parental stress;
- custody and child-rearing issues; and
- foster care issues.

Table III-2. Careline Calls and Time Received. 1984-1989.							
TIME OF DAY	1984	1985	1986	1987	1988	1989	TOTALS
12:30AM-8:00AM	844	1,604	1,627	1,947	2,662	3,094	11,778
8:00AM-4:30PM	9,741	9,982	9,168	10,339	10,498	8,967	58,695
4:30PM-12:30AM	11,867	10,310	9,893	10,770	11,909	13,253	68,002
TOTALS	22,452	21,896	20,688	23,056	25,069	25,314	138,475
WEEKEND*	4,606	5,021	4,917	5,831	6,936	7,512	34,823
HOLIDAY*	572	604	621	695	752	1,012	4,256

\* weekend and holiday statistics are included in the breakdown of the time of day.

Source: LPR&IC analysis of DCYS Careline statistics. 1984-1990.

The calls are made by both mandated and non-mandated reporters. As noted on Chapter I, a non-mandated reporter is not legally responsible for reporting child abuse, and includes family members, neighbors, or friends. Mandated reporters are legally responsible for reporting suspected abuse, neglect, or abandonment to DCYS, and include:

- teachers;

- day care workers;
- medical professionals;
- state or local law enforcement officers;  
and
- mental health or social service workers.

The disposition of the calls made to Careline vary as widely as the type of inquiries, reports, or referrals received. For the purposes of analysis, the program review committee categorized the Careline outcomes into five dispositions. They are: (1) removal/placement; (2) referred to regional office/DCYS staff; (3) referred to other agency/program; (4) record or information request; and (5) other. Table III-3 shows the frequency of the disposition categories during the period of 1984 through 1989.

The total number of dispositions is greater than the actual number of calls received by Careline because a call can have more than one disposition. For example, a caller can be referred to a regional office and also have received informational material about DCYS. The most frequent disposition of a Careline call is record or information request (37%) which includes doctors calling for permission to administer medical treatment, closed record requests, information given out verbally or in writing, and central registry inquiries. Since Careline has the responsibility of storing closed case files it processes all the requests for information on these cases.

Referrals to regional offices or other DCYS staff was the next most frequent disposition (26%). The referrals to regional offices include all reports of abuse, neglect, or abandonment that were determined to be non-severe by Careline and referred for investigation by regional offices' protective services. Referrals to other agencies or programs represented 17 percent of the dispositions and other types of dispositions totalled 19 percent.

Removals or placements of children resulted in only .2 percent of the dispositions of Careline calls. The removals were all 96-hour holds, which are used only in extreme emergency cases.

### **Foster Care**

The third DCYS-administered program includes foster and adoptive families. Foster families are an intrinsic part of the program for abused, neglected, or abandoned children because they offer these children an alternative to their dangerous home environments. Foster families are used as temporary substitute families that are a part of treatment plans to reunite children with their natural parent(s).

**Recruitment.** Once the decision is made to remove a child from the home, DCYS must find the most suitable, least disruptive foster care possible. The home of a relative is usually viewed as the most desirable. However, if it is not possible to place the child there, a foster family of similar ethnic background and living nearby so as to allow visitation by the natural parent(s) is best.

Table III-3. Careline Report of Referral Disposition. 1984-89.						
DISPOSI- TION	1984	1985	1986	1987	1988	1989
REMOVAL/ PLACEMENT	23	19	12	107	139	67
REFER TO REGIONAL OFFICE/- DCYS STAFF	7,549	7,036	7,203	7,961	8,830	6,670
REFER TO OTHER AGENCY/- PROGRAM	5676	5366	5404	5035	4832	2781
RECORD OR INFO REQUEST	11,047	10,517	7,148	12,144	12,773	9,994
OTHER	4,422	5,790	5,176	5,688	6,834	5,802
TOTAL	28,717	28,728	24,943	30,935	34,408	25,314
Source: LPR&IC analysis of Careline data.						

The reality of foster care placement is quite different from the "most desirable". Because caseloads are so large and the number of foster families so small, the selection of placements are generally made on availability. The DCYS homefinders units locate temporary foster homes for children pending permanent placement or reunification with families. There is a Homefinders Unit in each region.

Recruiting foster families is a continuing effort on the part of DCYS. According to the department, over the past few years more foster families have been lost than have been replaced. Recruitment of foster families has become progressively more difficult as the type of children needing foster care changes to include violent behavioral problems, substance abuse, fetal alcohol syndrome and "crack babies", AIDS and HIV positive children, and children with

severe emotional or psychological problems. Foster parents must initially want to help care for these children in addition to receiving specialized training and state funds.

**Licensing.** In order to become a foster family, an individual or family must obtain a license from the Department of Children and Youth Services. Typically, prospective foster parents contact one of the six regional offices and attend orientation sessions. It is required that prospective foster parents attend eight sessions where they are taught about their and DCYS's roles in foster parenting. They must concurrently apply in writing and provide in-depth family histories. DCYS requires fingerprints and references, as well as financial and medical statements.

During the licensure procedure, DCYS makes up to three home visits to interview the parents and any other family members, including children. The DCYS homefinder worker concludes the assessment by submitting a written home study report, which is subsequently processed by the Quality Assurance Unit. The process is scheduled to take four to eight months from the time of application to license issuance.

In addition, during FY 88 a new policy required licensure of relatives' homes used as out-of-home placements. Because the licensing process of relatives must be completed within 45 days of placement of the child in the home, the licensing studies, which are done prior to placement for potential foster and adoptive homes, must be postponed. Currently, non-relative foster and adoptive homes are waiting 8-12 months for study and licensure.

**Placement of child.** Once licensed, the foster family waits to be notified by DCYS of a child ready for placement. The family is given background information on the child, including behavioral problems, physical disabilities, and previous placement histories. It is the decision of the foster family to accept the child or refuse placement.

Once placed, contact with DCYS continues, the degree of which is determined by the natural and foster parents and the department's social worker. Placements can be as brief as one week or as long as three years. The responsibilities of a foster parent include:

- providing a safe, nurturing and stable environment;
- promoting physical, mental and emotional well-being of a child;
- respecting and encouraging an understanding of religious, linguistic, cul-

tural, and racial heritage of the child and that of the child's birth family;

- supporting reunification of the child and family;
- permitting and supporting visits between the child and parent(s) or siblings;
- not using any physical punishment;
- participating in the child's service plan and DCYS training programs;
- supervising the child's medical treatment and routine health care; and
- participating in child's educational development.

**Rates.** DCYS reimburses foster families approximately 70% of the cost of raising the child. These rates vary according to the child's needs and age. The federal government reimburses DCYS less than half of the amount to care for a foster child.

For each age range there are different rates with the larger amount going to the child with the greatest needs, as determined by a DCYS social worker. Families are paid monthly and the rate includes board, care and clothing replacement.

As of July 1, 1990, the foster care rates were increased, and the levels of needs were condensed from four to three levels. The levels of need were changed in order to assist social workers in classifying children. Rate I is the standard rate applicable to the child of any age who requires normal care and attention of foster parents. Rates II and III are designed to meet extra or specialized care and/or services in individual case situations, and are more than the standard rate.

All rates, with the exception of Rate I, require prior authorization by the Program Supervisor. The rates do not include medical or dental care, hospitalization, clothing expenses, and special recurrent and/or non recurrent expenses. Table III-4 reflects these changes in rates and levels.

Table III-4. New Foster Care Rates by Age Grouping.			
AGE GROUP	RATE I/ MO.	RATE II/MO.	RATE III/MO.
0-5 YEARS	\$331	\$436	\$541
6-11 YEARS	\$369	\$480	\$591
12+YEARS	\$422	\$543	\$663

Source: LPR&IC analysis of DCYS Foster Care Data.  
1990.

### Adoption

The Connecticut Adoption Resources Exchange (CARE) has been in operation since the 1950s; however, it was established in its present form in 1977. In October 1977, legislation was enacted that mandated the maintenance of photo-listing of children free for adoption, registration of all children legally free for adoption, and recruitment of families to adopt those children.

CARE is the unit within DCYS with the responsibility for facilitating or actually matching families and children who are in need of adoption. Special needs children can have problems which include intellectual, emotional, or behavioral problems, or physical disabilities. Most of the children handled by CARE are in foster care or institutions. CARE operates several programs for matching families and children, which are:

- maintaining a registry of all children who are legally free for adoption;
- photo-listing certain hard-to-place children in the department's CARE book;
- sending newsletters to other agencies and interested families;
- keeping a registry of adoptive families; and
- having histories about certain children published or televised.

CARE also works with the state's licensed private adoption agencies. Altogether, these agencies place about one half of the children adopted each year. Also part of this relationship is the

Permanency Placement Services Program in which DCYS contracts with private adoption services to place children.

CARE staff act as liaisons to the DCYS regional offices' social workers and provide consultation on specific cases and are a source of information on general adoption issues. CARE staff also offer private agencies, residential treatment staff, adoptive, birth and foster parents, prospective adoptive parents, and adult adoptees support services and training.

**Process.** The adoption statute requires a home study and approval of a prospective adoptive family as well as placement of the child by a licensed child-placing agency. Private or independent adoptions are prohibited by law. The first step in the identification process a family must take is contacting a child-placing agency and requesting a home study be done. After completing the home-study and obtaining approval for placement, the family search and/or locate a child through any of the CARE programs or networking with appropriate sources. No placement can be made until the home is approved and licensed by a child-placing agency.

**Outcomes.** Table III-5 shows the number of children adopted during fiscal years 1988 and 1989. The table shows that, like foster families, the reality for children in need of adoptive families is that there are fewer placements available and a growing number of children. Table III-5 shows that the number of children legally available for adoption increased from 191 in FY 1988 to 250 in FY 1989. The number of children adopted, however, decreased by nine children, and the number of children withdrawn from CARE also decreased.

Table III-6 represents a two-year cumulative breakdown by age group and race of the children registered with and adopted through CARE during fiscal years 1988 and 1989. During the two years analyzed, 442 children were registered and almost two thirds (62% or 273) were adopted.

The table shows that the majority of children registered as free for adoption are caucasian and black, with 45 percent black, 44 percent caucasian, 10 percent hispanic, and one percent other. Most of the children in the other category are asian.

Of those children actually adopted, caucasian children represent the plurality at 47 percent. Black children, who represent the largest share of the adoptive pool, have a slightly lower ratio among adoptions. Seven percent of the hispanic children and one percent of the others (Asian) were adopted.

Not surprisingly, the most frequently adopted child is between the ages of 0 to 5 years and has no emotional, intellectual, behavioral, or physical problems or disabilities. These children

represent 35% of the adoptions during FY 1989 through 1989. However, children with special needs between the ages of 0 and 5 years are adopted in numbers close to those of the problem-free children. Children with special needs represent 32% of the adoptions. Children between 6 and 10 years of age totalled 26% and those 11 years and older accounted for 7% of the adoptions.

Table III-5. Children Registered and Adopted. FY 1988-89.			
ACTIVITY	FY 1988	FY 1989	TOTALS
Children registered	191	250	441
Children withdrawn	49	25	74
Children placed	149	140	289
Children with special needs that were placed*	66%	59%	

\* percentage of total number of children placed.

During fiscal year 1989, a total of 133 new families were added; 91 families accepted adoptees; and 56 families withdrew from CARE. As of June 30, 1989, CARE had a total of 180 families registered to accept an adoption.

Table III-6. Children Registered and Adopted by CARE. FY 1988-1989. Breakdown by Age Group and Race.								
AGE GROUP	CAUCASIAN		BLACK		HISPANIC		OTHER	
	REG.	ADOPT	REG.	ADOPT	REG.	ADOPT	REG.	ADOPT
unborn	2		2		0		1	
0-5 years problem free	59	42 (71%)	88	49 (56%)	16	4 (25%)	0	0
0-5 years special needs	44	38 (86%)	51	42 (82%)	12	5 (42%)	2	2
6-10 years	52	41 (79%)	45	24 (53%)	11	7 (64%)	1	0
11+ years	36	8 (22%)	15	6 (40%)	5	4 (80%)	0	1
TOTALS	193	129 (67%)	201	121 (60%)	49	20 (41%)	4	3

Source: LPR&IC analysis of CARE data. FY 1988-89.

## CHAPTER IV

### THE SOCIAL WORKER

As shown in Chapter III, protective services for the department of Children and Youth Services is a complex system of programs within a highly diversified department serving the most vulnerable residents of the state. It is a system with intangible products, fleeting successes, a host of critics, and few controls over the forces that created and sustain it. If one element is the linchpin of the system, it is the social worker. As a class, the social worker confronts the symptoms of society's failure to its people on a daily basis.

The social worker is responsible for managing all activity related to the protective services case. Case management and intervention are the key responsibilities. The next two chapters focus on two areas: the social worker; and DCYS case management and intervention. This chapter is an examination of the social worker's duties, training, and background, beginning with a narrative describing a week in the life of the worker. The narrative is a composite of the program review staff's field observations of social workers in their daily routine. Identities, places, and situations are masked to protect the privacy of the individuals involved. The next chapter discusses DCYS case management, including analysis of case load ratios, case processing times, and conformance with DCYS policies. It also examines the way cases are evaluated.

#### The Social Worker

Program review staff spent eight days in the field with social workers throughout the state. The social workers were chosen by program review and represented a range of experience and backgrounds. The social workers were those involved in the intake process, treatment, and the Careline. In addition, their supervisors were interviewed on the duties and operations of the unit. From this field work the program review staff were able to obtain a first hand look at what the social worker handling abuse and neglect cases faces each day. Staff were also able to obtain information on the time devoted to a case as well as the working conditions confronting and resources available to the social worker. The following presentation is a composite picture of those visits by the staff to portray a week in the life of a social worker.

#### Day One

In several of the visits, the day began with a crisis that developed the previous day. In one case the worker was confronted with the problem of placing a child in an emergency shelter. The

placement had to be done on this day because the child's current placement, also a temporary emergency shelter, could no longer keep the child. The case originally involved physical abuse of the child by the stepfather necessitating removal from the home.

The worker located a placement in another town about 15 miles from the home, but had to obtain permission from the mother to move the child because the placement was on a voluntary basis. This took several hours because there was a reluctance on the part of both the mother and child concerning the move to another town. Once the worker obtained agreement, after spending considerable time convincing the mother this would be in the best interest of the child, arrangements were made with the new shelter to accept the child.

Prior to picking up the child, the worker made one stop to visit a client, check on the condition of her children, and drop off some clothes that had been donated by charities. The client was living in a third-floor apartment with her three children. This particular case involved neglect of the children due in part to the poverty faced by the young mother. There had also been some evidence of drug abuse and prostitution.

The worker discussed the current living situation with the mother and if the children were receiving adequate medical care. The children appeared to be healthy at this visit but the worker felt the case merited further DCYS involvement because the mother was considering moving out of state. This would require that the case be transferred to the child protective agency of the destination state.

This visit lasted about 20 minutes and was unannounced although the client did know that the worker would be stopping by sometime soon. The worker was very interested in assessing the living conditions of the client as this had contributed to the neglect allegations in the past.

After obtaining the appropriate paperwork, the next stop was to the emergency shelter where the first child was residing. The worker discussed the move with the child, who was very unhappy about going to another town. The worker had prior experience with the shelter and persuaded the child this would be a good place to spend some time until the problems being encountered could be resolved. By early afternoon, the child was driven to the new shelter and the worker spent about 45 minutes with the director discussing paperwork and rules.

The final visit of the day involved a family case that had been with DCYS, on and off, for several years. The case involved a family of five children, a mother, and grandparents who attempted to keep the family together. At one time the family was homeless and the children were in out-of-home placements. They were

currently being housed in a local apartment that had been designated as an emergency shelter. The social worker made this visit to check out the condition of the apartment. This was the first visit to the family at this new location. Earlier the worker stopped by the DCYS office to pick up some food for the family. At a visit several weeks prior, they had very little food.

The apartment was on the fourth floor and the worker had a little difficulty finding it at first. The worker entered through the rear of the building because she felt the front entrance was too dangerous. The entrance was in a courtyard surrounded by the apartment building and not visible from the street. There was also an individual who appeared to be watching the entrance and the worker felt that the back of the building would be the best approach to take.

The apartment was filthy, cluttered, and heavily infested with cockroaches. The children, in their teens, seemed healthy, but several had not gone to school in awhile. The social worker told them that they had to go to school and that she would be checking on their attendance. Some of the other children had been attending school.

The mother was not home when the worker arrived, but the grandfather was present. However, he did not seem to have much control over the family. The worker said the grandmother had the most influence, but she had been hospitalized for some time. As the worker was leaving, the mother returned, and the two discussed the reason for the visit. Later on the street, the worker talked to two of the younger children, both girls, who asked if they could return to the state receiving home, saying it was a better place to be than the current living arrangements.

After leaving, the social worker explained it would be difficult to return the children to the state receiving home because openings at the home were very limited and the children's mother would not agree to the placement. There would have to be another determination of neglect before a placement could occur.

## Day Two

The second day began much like the first. School officials had lodged a complaint concerning abuse of a child after the child had become disruptive in class. When asked to explain his behavior, the child told of being beaten by his mother. In this case a file had already been opened and there was a history of prior referrals, not only in Connecticut, but in other states as well. This crisis precipitated a meeting of the regional office management and the social workers involved in the case. One worker would not be allowed to go out on the case because it was a potentially volatile situation and the mother had a history of being

uncooperative. It was agreed that program review staff would be allowed to substitute for the additional social worker.

After locating the house, the worker knocked and the mother came to the door. She asked what the worker wanted and said she was not interested in talking to DCYS. She blamed the school for not being able to control her son's behavior, swearing profusely and claiming school officials were incompetent. The worker stated that they had another allegation of abuse, which the mother forcefully denied. She said there were no marks on the child and she didn't hit him, acknowledging that she now uses other forms of discipline. With that she went back inside and slammed the door. Her boyfriend came out to talk for awhile about the boy's behavior. As a family unit they moved often, their work bringing them to different parts of the country. The mother did return outside to talk again and apologized for her behavior. The social worker explained the responsibilities of the department when a complaint of abuse is received.

Because this was already an open case in treatment, the worker asked whether or not the client was attending counseling as required. She indicated that both she and the child were attending counseling and there had been significant improvement in their life. She did mention, however, that she had missed a few sessions recently. The worker said she would follow up this latest referral by the school and be in touch with the family.

The next call was with a client who recently obtained a new apartment, which the social worker wanted to visit. The client was a young mother who had had a problem with drugs and alcohol and had physically abused her five-year old son. The child was placed in the custody of the mother's grandparents. (The mother had also been a DCYS case when she was younger). She also had another child, an infant, that remained in her custody. There were never any allegations or referrals for abuse or neglect of the infant.

The mother was not at her apartment, and the worker drove to the grandmother's home. Finding her there, the worker interviewed the client for about an hour. She discussed her current living arrangements and involvement in various programs. The worker also spoke with the grandmother who had custody of the five-year old child. The grandmother said the child was doing very well and they had been taking him to a clinic for counseling. The mother had visitation rights and was allowed to take the child for a few hours each day. The client had asked for an overnight visit with the child but the worker denied the request at this time.

The client also discussed an incident involving the infant that occurred over the weekend. The child was brought to a local hospital because he had fallen on a cement floor while the mother was doing her laundry. The worker discussed this situation at length with the client in an attempt to get the complete story.

While the worker felt the incident was accidental and that the mother had shown appropriate concern for the infant, she did obtain signed release forms for medical information from the hospital and doctor who treated the case. She intended to follow up with both.

The last visit of the day was to a client with five children living in a motel. This case came to DCYS because the mother was drug addicted and neglecting her children. She was also homeless for a while and the children had been placed in foster care. When the worker arrived, the client was not receptive to the visit, but invited the worker in to discuss her present situation. She was in a substance abuse treatment program and had attended all meetings since her residence at the motel. The worker believed the client was doing much better than she had in the past. She was showing remarkable improvement, but still had some major obstacles to overcome.

The client had to move out of the motel within the month and was seeking housing through the local authorities. Given the size of her family and limited resources this was a difficult task. The motel was a single room housing six people, totally inadequate for the family's needs. As the social worker left, the client told her she was pregnant again. This was discouraging news. There had been some success on this case and it might have been closed in the near future once the family was in adequate housing and the children were no longer at risk. Under the circumstances, the social worker felt the strain of having another child would be very difficult for the mother to handle. This new child would result in long-term involvement by DCYS in this case.

### Day Three

It began with the worker organizing the files of the cases to be handled during the morning. There were 10 cases that required attention, although not all clients would be seen this day. Four of the ten cases were recently assigned and required an initial client contact by the social worker.

The first contact was with a young mother who was reported for neglecting her two children by leaving them unsupervised. It was alleged the client was involved in prostitution to support a drug habit, and the children, a second grader and a toddler, were often left alone in the apartment. The worker's investigation was unable to substantiate the allegations. The client was always polite and cooperative with the worker. The apartment was in good condition; the children were healthy; mother and children were adequately bonded; and she was always found supervising the children. Drawing upon her experience and intuition, the social worker coached the client in parenting skills, developing a relationship with the mother by offering help and services when she needed them.

Eventually the client phoned the worker and asked for a home visit. This was the day of the visit. From the phone conversation, it was clear to the worker that the client did drugs and prostitution. The client also has AIDS and one of the children was HIV positive.

During the visit, the client said she wanted to enter an inpatient drug rehabilitation program that would not conflict with her AIDS treatment program. The worker discussed several options with the client, along with the client's plans for placing the children with close friends. Because the children were in no danger of being removed from the home by DCYS, they could be voluntarily placed by the client without DCYS intervention. The worker explained some of the ways the probate court could help protect her legal rights to the children and provide for them in the event of her death. The worker offered to accompany her to probate court.

Before leaving, the worker asked to see the youngest child, who was sleeping in the other room. Despite the illness, the child looked healthy and well-cared for. The other child was attending school. The worker left promising to check into drug rehabilitation services for the young mother.

The next two clients visited by the worker resided in low-income housing. The first had several children, aged 2 through 18. She had a long history with DCYS and was known to be extremely uncooperative. The case involved many referrals covering several areas of neglect and abuse. Some of the children in the family had been in out-of-home placements, but at this point all were home with the mother and the client's unmarried partner.

On this day the worker was dealing primarily with the charges of educational neglect. The client didn't register the younger children for school or ensure that any of the older ones attended. She was under court order to register all the children and the worker was following up on the court's edict.

When the social worker arrived, the client was getting ready to leave the apartment. Several of the smaller children were in a van and others were seen peering out of the upstairs windows. It was a weekday, during school hours, and apparent that many of the children were still home. The client explained that all the children were scheduled to receive immunization shots at the clinic. She also said that after leaving the clinic, the children were going to register at school and begin regularly the next day.

When the worker questioned her sincerity the client became angry, profane, and threatened to take the children out of the state if DCYS continued to intervene. During the tirade in the parking lot, the client also told the worker the family was being evicted from the housing project. The worker diffused the charged

atmosphere speaking softly and outlining the problems a move out of state would cause the family.

With the client calmed, the worker informed her that DCYS, as per court order, had scheduled psychological studies to be done of her and all the children. She was given the appointment schedule and told to appear with all the children. Although subdued and apprehensive about the interviews, she agreed to attend. The worker then visited with the children in the van for a few minutes. They appeared very happy to see her.

After leaving, the worker explained that the client had a history of teaching the children to shoplift. They would all spend a day at a mall stealing, and were taught to give aliases or use the name of the youngest child if one were caught.

On one occasion, an older child refused to participate in the shoplifting spree and was physically assaulted by the mother. That child was then committed to DCYS and placed in a residential facility. After several months at the facility, the client's parental rights were reinstated and the child sent home. Since that time, the child continually requested to be placed out of the home. Though the child did not want to remain in the home, the social worker explained that the mother refused to voluntarily place the child and there were no substantiated reasons for DCYS to commit the child .

The second client visited by the social worker dealt with an accusation of abuse. The local hospital and police department had reported to DCYS Careline that an infant had been dropped on the floor during a fight between the parents. The father then assaulted the mother. The paperwork the social worker received was difficult to understand because it listed several different family members involved and indicated that all family members had taken custody of the child. The worker could not determine which member had taken the infant after release from the hospital. She decided to visit the mother first.

The social worker had difficulty locating the apartment because of the maze of buildings making up the housing project. She said this type of visit poses very serious safety issues, since the worker is alone searching for an apartment in a potentially dangerous environment.

After 15 minutes, the worker found the apartment. The client, a teen-age parent, answered the door. The worker identified herself and asked to discuss the allegations with the young mother. She agreed and allowed the social worker in.

Standing in a cluttered room with overturned furniture, the worker told the client of the allegations and that the hospital had made the report. She then tried to draw out some information on

the altercation and the family. Withdrawn and slow to answer the questions, the client did her best to provide the necessary information.

The client had the infant, and said the baby's father was in jail for the assault. Her face was swollen and bruised.

The client told the worker she lived with her mother and infant in the apartment, and occasionally stayed with her father. The client was not receiving AFDC or any other financial assistance, and not working or attending school. She and the baby were supported by the client's mother, who herself had recently gotten a job and discontinued AFDC.

The social worker offered to contact the AFDC social worker assigned to the family to assist the client in receiving benefits. The worker then asked to see the infant. The baby was healthy, but dirty and overweight. The worker asked about the baby's feeding habits, diet, medical care, and immunizations. The mother said the baby had received no immunizations nor regular check-ups. The worker stressed the importance of proper medical care for infants and children and suggested the baby begin to receive immunization shots.

After leaving the apartment, the worker said she would not close out this case at intake even though the child was not in danger from the reported allegations. The worker would monitor the client's compliance with the medical treatment and immunizations, and attempt to get the client community services in parenting skills.

The social worker then tried to contact and visit several other clients; however, none were home or the addresses listed were not correct. The worker left a DCYS letter asking the clients to contact her regarding an allegation of abuse or neglect. In those cases in which the address was incorrect, the worker would contact the reporter for more accurate information.

The next stop involved a case of alleged neglect due to the parent's drug abuse. The mother of the client had reported to DCYS Careline that the client would leave the children alone in the apartment while doing drugs, and that the teen-age daughter was required to stay home from school to baby-sit for the younger siblings. The teen-age daughter was reported to be pregnant and attending a school program for unwed mothers.

When the client answered the door, the worker identified herself and stated that DCYS had received a report of neglect. The client then became angry and demanded to know who made the report. The worker informed the client that it had been her mother. The client became verbally abusive and began to scream at and about her

mother, who was not present in the apartment. The client insisted her mother was crazy.

It was obvious the client was not going to calm down or be cooperative at this point, so the worker asked the client what her plans were for later in the day. The client screamed she was taking her children to the doctor for shots, and that was proof she was not neglectful. The worker asked if the client would agree to schedule another visit to discuss the report. This calmed the woman somewhat and she agreed to meet later in the week.

During the entire visit, the client did not stand still and respond to the worker's questions. She paced back and forth in the doorway and refused to look at the worker. After leaving the building, the worker said that the client had lost control and she had attempted to give back some control by letting the client reschedule the visit. Most likely, the worker said, the client would not be at home on the next scheduled visit, but they would eventually meet. The worker felt it was better to end the visit positively than to force the client to face the accusations that could cause more harm to the children.

Before returning to the office, the worker stopped at a client's apartment to delivery a baby stroller that had been donated by a church. All the family members were DCYS clients. The younger children were reported as being physically and educationally neglected and the teen-age children had children of their own. The worker was informed that the mother was not at home at that time, and legally the worker was not allowed to enter the apartment. However, the worker did go into the apartment to drop off the stroller.

There were three teen-age girls with several infants and toddlers on the couch and a few children could be seen in other rooms of the apartment. The worker asked if any one of the children in the family was at school and was told no. The worker asked the children to tell their mother she would be back to visit later in the week, and left the apartment.

Returning to the office around 1:30 p.m., the worker had messages that two of the clients she attempted to visit earlier that morning called in response to the letters left at their apartments. The worker took a half hour lunch and returned the telephone calls, scheduling visits with the clients for later in the week. She did not discuss details of the reports with the clients over the telephone. The social worker then reviewed three new cases assigned her that morning, started the paperwork, and began making telephone contacts and inquiries for the cases handled that day.

#### Day Four

The fourth day involved visits to the superior and probate courts. Dealing with the courts can consume a great deal of a social worker's time. The worker is responsible for preparing petitions for the court as well as social histories on the cases that come before a judge. When in superior court, the worker is usually represented by the attorney general's office.

The social worker had to be at superior court by 10:00 a.m.. The case had begun with the arrest of a woman for severe abuse of a non-relative child who had been placed in her custody by the child's mother, a friend of the woman. The woman was charged criminally with the abuse; however, it was unknown whether the woman had committed the abuse or she was covering for the real perpetrator. The case was still pending in criminal court.

The woman had three young children of her own living at home. Based on the abuse of the non-relative child, DCYS opened a case on the three biological children and petitioned the court for custody. The basis for the DCYS case was that the three children were at risk of abuse by remaining in the home with the woman, either because she had or she was allowing someone into the home that had committed child abuse. According to the social worker, this had been an extremely complex and time-consuming case.

After closely monitoring the woman and her three children, the department's intention was to drop the petition since, after eight months, there was no evidence of abuse or risk of abuse. Furthermore, psychological tests that had been ordered by the court showed no indication that the woman would harm her children and in fact, indicated she had a healthy attitude toward her children. The social worker planned to testify about this information and prepared for the case to be closed after this court proceeding.

Arriving at the courthouse (Superior Court - Juvenile Matters) the worker passed through a metal detector into a small crowded waiting room. The social worker knew a lot of time would be wasted at court waiting for the clerk to call the case. In the waiting room, social workers, clients, and client's attorneys talked to each other. There is no privacy and it's easy to overhear the particulars of various cases. The social worker did not meet with the assistant attorney general to discuss the case while waiting to be called. After about 45 minutes the case was called.

The case was heard in a room where the judge, defendant, the defendant's attorney, an assistant attorney general for DCYS, the DCYS social worker, a bailiff, and a court clerk were present. The purpose of the hearing, as stated by the defendant's attorney, was a motion for dismissal of a DCYS petition. To the social worker's surprise, the assistant attorney general, DCYS's legal representative, explained that the state didn't feel that the motion should be dismissed due to the severe nature of the abuse inflicted on the non-relative child. According to the assistant attorney general,

the state felt that the three biological children were still at risk and should be monitored. This was obviously contrary to the social worker's expectations and she hadn't been informed of this change in the state's position. She had been prepared to testify on behalf of dismissal of the DCYS petition.

The judge asked the social worker a few questions about DCYS's involvement with the family. The social worker explained that the mother appeared to have a good relationship with her biological children. However, the social worker was in an awkward position since the assistant attorney general and DCYS had differing positions on the case. Though the worker was prepared to drop the petition, given the assistant attorney general's statements in court, she could not now recommend such action. The social worker answered the judge's questions as best as she could.

The judge then noted that the psychological tests, as well as the case record, had not detected any risk to the woman's three biological children. The debate between the two attorneys revolved around whether or not the children would be at risk. The assistant attorney general kept noting the severe nature of the abuse that had been inflicted on the non-relative child while in the woman's custody, and thought that for this reason alone the woman should receive some type of services that would ensure the biological children would be protected against any possibility of abuse.

In spite of the assistant attorney general's efforts, the judge decided that the petition should be dismissed. He based this decision on the documentation submitted by DCYS, and stated that the state's case was not strong enough to warrant continued DCYS involvement. However, he did stipulate that counseling be received by the woman as part of the dismissal.

In the afternoon, the social worker moved on to the probate court for a matter involving guardianship in a DCYS case. This case was in probate court instead of Superior Court, because the grandparents of the child had initiated the guardianship action, rather than DCYS. Numerous referrals had been received by DCYS from the local police department and the child's grandmother regarding the parents' inability to care for the child.

The father had an alcohol abuse problem and often would become physically violent towards the mother. The mother would call the police, have the father arrested, and then drop the child off at the grandparents. This cycle had been repeated a number of times over the past few years.

DCYS had recommended counseling for the parents, as well as attendance at Alcoholics Anonymous meetings for the father. The parents had responded well to treatment. In addition, the social worker had regularly monitored the parents through phone calls and home visits.

The parents and the grandparents of the child each had an attorney. The worker believed that custody of the child should remain with the parents, since they had been receptive and responded well to treatment. Furthermore, several of the grandparent's accusations were unfounded and deep-rooted family problems appeared to be the cause of some of the allegations made by the grandparents.

The probate judge acknowledged that both parents had shown progress in their relationship and denied custody to the grandparents. However, he advised the parents to allow the grandparents greater visitation at scheduled times instead of only when there were problems. He also recommended group counseling for the parents and grandparents to improve their relationship, so that all involved would be working towards the best interests of the child.

### Day Five

A social worker's schedule includes at least two days a week spent in the office doing the required paperwork, follow-up telephone calls, arranging for services for clients, opening the several new cases assigned each week, and assisting in answering and screening in-coming reports of abuse and neglect. During one of the office days, the worker is on call for emergencies.

When on call, the worker must remain in the office or contact the office every 30 minutes when absent. There is also a worker on standby for the situation when an emergency has been reported and the on-call worker responds and, subsequently, a second emergency call is received. The emergency calls must be responded to immediately by a social worker.

On this particular day, the social worker was the designated emergency response worker. After several days in the field, there were seven new cases on the worker's desk to be opened and initial telephone contact attempted. In addition, the worker had to complete the required paperwork and case history narratives on the cases handled during the previous few days, and make all the contacts and referrals that were discussed with the clients.

This was a very busy day for the office and the telephone rang constantly. The office has a full time intake screener responsible for handling all the telephone reports and a receptionist experienced in screening the calls. However, in an effort to keep up with the calls, some of the social workers in the office had to answer the telephones and screen the reports of abuse and neglect.

Several reports of abuse received that morning were classified as severe, requiring social worker response within 24 hours. These cases were assigned to social workers for the next morning. One of the reports required a decision by a social worker supervisor because it was an emergency situation. A local hospital called to

report that a Hispanic child was being treated for serious injuries and that the doctors suspected abuse by a parent. The doctors and hospital are mandated reporters.

The problem faced by the social worker supervisor was that the child and parent only spoke Spanish, and the office's Spanish-speaking worker was not available. Because the child was to be kept as an in-patient at the hospital for a few days, the case was classified as severe instead of emergency. This allowed the Spanish-speaking worker to respond the next morning rather than immediately.

The social worker was having a difficult time locating an in-patient drug treatment program for the young mother with a severe abuse problem. The reason was her AIDS infection.

While dealing with this case, the worker was informed that an emergency report of abuse was received. The report was that a child, toddler age, had been severely burned on the legs by a parent. The toddler was being treated at a local hospital, which would require several days as an in-patient. The parent was at the hospital and was acting hostile toward the medical staff and not exhibiting a proper parental reaction toward the child's injuries.

Around lunchtime, the worker was dispatched to the hospital and immediately placed the child on a 96-hour hold, which gives DCYS immediate temporary custody. Upon arriving at the hospital, the social worker found the parent was still extremely agitated, verbally abusive toward anyone on the ward, and very angry that DCYS was intervening. The parent was shouting that the toddler had self-inflicted the injuries while playing and was denying any guilt in causing the burns. The worker spoke calmly with the parent until the parent was composed enough to sit still and discuss the situation.

The worker then attempted to interview the client about the abuse, the child's injuries, composition of the family and number of other siblings, and the home life of the family to determine the reasons for the abuse. Although the client began to provide some information, the client was still argumentative and belligerent. The client was advised of the procedure for a 96-hour hold and the subsequent involvement of DCYS and, most likely, the police and criminal court in the client's life. The client was informed that more than likely the child would be placed in a foster home upon release from the hospital.

After learning of the foster home placement the client again became extremely agitated and the worker tried to calm the client enough to get further information on the child and have departmental forms completed and signed. The worker was also asked by the hospital staff to escort the client out of the hospital because

the child was now committed to DCYS and there could be no unsupervised parental contact with the child.

Before leaving the hospital, the worker met with the child's doctors and was updated on the condition and plan for treatment of the burns.

At approximately 3:00 p.m., the worker drove the client home. Upon arrival, she asked the client's permission to view the apartment and to see the other children. The client told her the children were in good condition and with a baby-sitter. An appointment was made for the worker to visit on another day to meet the other children and begin the investigation into the physical abuse. The worker again directed the client not to attempt to visit the child and repeated the hospital administration's warning that the client would be arrested if repeated outbursts were made or harassment of the hospital staff continued.

After returning to the office, the worker learned that another emergency report had been received and responded to by the standby social worker. The social worker had to then open the emergency case and complete all the required forms along with the 96-hour hold paperwork. Because the doctors said the child would remain in the hospital for at least several days, it was not critical that a foster home be found that day. However, the worker did contact the homefinder unit in the DCYS office to determine some possible homes for placement. This also gave the homefinder unit some latitude in locating the most suitable placement for the child.

Before leaving for the day, the worker responded to several telephone messages left by clients and community resource staff. The worker also contacted the hospital for an update on the burned child's condition. The child had been placed in the intensive care unit.

#### Day Five: An Evening at Careline

At the close of the 13 DCYS offices each weekday, the calls concerning abuse and neglect begin coming into Careline, the department's 24 hour statewide toll free hot-line. Careline's primary function is to screen and assess the immediate risk to the children who are referred for abuse, neglect, or abandonment. It operates on weekends, holidays, and after normal work hours, and is generally staffed by two social workers.

The evening hours at the Careline office are very unpredictable. At times the one room office in Middletown is quiet, while other times the activity level soars and the telephones ring constantly. The nature and source of the incoming calls varies greatly, as does the response required of the DCYS social worker.

One of the first calls received was from a teen-aged DCYS client who had run away from her home. The client wanted to spend the evening at a friend's house. The social worker gathered information from the teen regarding the crisis at home which caused her to run away, and general information about the friend's family and home-life. The social worker also obtained the teen's location and a telephone number.

In order to resolve this situation the social worker had to contact several people involved with the case, including the teen's parents, the friend's parents, the DCYS regional social worker handling the case, and the police. The police department had been notified the teen had run away.

The Careline social worker determined that the friend's home was not licensed by DCYS as a foster family. The teen was told by the worker that because of this and the fact she was a current DCYS client, another placement would have to be made. Arrangements were made for her to be placed in a licensed foster home for the evening. The DCYS on-call social worker from the region handling the teen's case was called to pick-up and escort her to the foster home.

Before all the paperwork on the runaway could be completed, the social worker received a referral from a police officer concerned about a child who was a friend of his own child. The child's parent is an alcoholic. The child had told the officer that the parent had a habit of drinking heavily with friends and then driving around with the children in the car. The child was nervous and afraid for his well-being as well as that of his younger siblings. The officer wanted to make DCYS aware of the situation.

The social worker spoke at length with the police officer and conducted a DCYS background check. Background checks on referrals can be made at Careline through a computer system, which has the most recently inputted information on each DCYS case.

The worker asked the officer for as much information on the family as he could provide since a detailed account must be filed on each report of abused, neglected, or at risk children. The social worker wrote up the officer's allegation, a description of how the child had confided in the officer, the relationship of the officer to the child and family, and an account of the alleged substance abuse of the parent. Because the report was assessed as non-severe, all the information compiled would be forwarded by the social worker to the appropriate regional protective services office for investigation.

The next call was from a hospital requesting permission to treat a child exhibiting psychiatric problems. The child was currently committed to DCYS. The Careline worker obtained

information on the child and asked what type of treatment was being considered, and then informed the hospital she would call back with the department's decision. The social worker checked the child's file and confirmed the status of the treatment plan. The Careline social worker wanted to contact the DCYS social worker assigned to the case to discuss the treatment request. However, the social worker ID number on file was outdated, and the Careline worker had to make several telephone calls before locating the current social worker.

The Careline social worker called the hospital and authorized treatment for the child. The information from the hospital was detailed in a report that would be forwarded to the current social worker at the regional office.

When the telephones momentarily fell silent, the Careline social workers discussed the situations that they were handling, and attempted to catch up with the required paperwork.

A few minutes later, the phone rang again. This time it was a frequent caller asking for counseling and someone to talk to. The social worker spent approximately one half a hour counseling the caller on dealing with the stress of raising children and alternative discipline techniques.

On another line a call was received from another hospital. A child had been admitted for attempting suicide. The hospital reports the family was uncooperative and asked Careline to determine if the child was a DCYS client. The social worker ran the name through the computer and found a similar name match but needed more information such as the child's birth date or parent's name. The hospital staff said it would call back with the information.

After approximately 15 minutes of silence the telephone rings again. It was not the hospital calling back, but a shelter. One of the DCYS clients placed in the shelter is giving the personnel a difficult time, and the shelter wants the child removed. The social worker calmly but firmly reminded the shelter of its agreement to take the child, and persuaded the shelter to keep the child for another night. The social worker promised to notify the child's current case worker of the problem, and to request other placement options for the child.

Dispersed throughout the evening, Careline social workers received requests for general information about DCYS and other community programs. A couple of the telephone calls were for the Parents Anonymous, and the social workers gave out the correct telephone number. All the calls received by the Careline are logged and routed to the corresponding regional office the next working day where DCYS supervisor would decide whether or not to investigate.

The social workers job encompasses many of the problems faced by families in today's society. To achieve optimum performance, the skills and backgrounds workers bring to the job are of utmost importance.

### Training and Background

By legislative mandate and agency mission, the child protective service worker has many duties. The worker is the key to the system and must perform a variety of skilled services for children and youth. The worker maintains medical, physical, social and psychological histories; investigates cases; evaluates clients; recommends disposition of cases; recruits and selects foster and adoptive homes; arranges out-of-home placement; and consults with other service providers to develop and administer appropriate treatment plans. In addition, the social worker must possess the skills to interview and elicit information from clients, provide basic counseling services, assess the clients' needs, and arrange for the delivery of services.

However, the social worker's job does not end there. Many unofficial duties have been incorporated into the job. The worker must develop non-threatening relationships with clients; transport clients to various programs; build working relationships with charitable organizations not funded by the state; promote community relations; provide basic resource information on hygiene, health care, finances and legal matters; be knowledgeable in welfare and public housing matters; and be a friend and confidante to children. In short, the Department of Children and Youth Services' capacity to accomplish its mission is dependent upon the ability of its social workers, and the workers are dependent upon the department for resources to do the job.

Qualifications. A social worker enters the DCYS system as a trainee. To be hired, a candidate must possess a bachelor's degree from an accredited college or university and pass a state exam. The trainees are not required to have a degree in social work. With approximately two years of social service experience, a social worker trainee may be promoted to social worker status. Individuals with a master's degree in psychology or counseling may substitute their academic training for one year of social work experience. Both years of work experience may be substituted for a master's degree in social work. Table IV-1 shows the current breakdown of DCYS regional protective service workers and corresponding qualifications.

The table indicates that only 16 percent of all workers have formal educational training in the field of social work. Given the fact that only 9 percent of the current trainees have a background in social work, this percentage is not likely to improve in the

near future. Although 24 percent of all social workers do have advanced degrees, less than half of those have a masters in social work. To compensate for a lack of formal education in social work, a strong training program would be required. Even with all workers trained in social work, it would still be necessary to provide specialized training in child protective services.

Table IV-1. Background Qualifications of DCYS Protective Service Workers.						
Job Position	Bachelors	Masters	Bachelor of Social Work	Masters of Social Work	Less Than Bachelors	Total
Supervisor	60 64%	17 18%	3 3%	12 13%	2 2%	94 100%
Social Worker	151 62%	40 16%	18 7%	31 13%	4 2%	244 100%
Trainee	83 86%	4 4%	7 7%	2 2%	0 0%	96 100%
Total	294 68%	61 14%	28 6%	45 10%	6 1%	434 100%

Source: DCYS Personnel Files (8/29/90).

**Training.** The resources provided by the Department of Children and Youth Services for training are very limited. Orientation and training for all DCYS service providers and support staff is provided by the Division of Children's Protective Service's Staff Development and Training Unit. It is the responsibility of the unit to assess the professional needs of each employee group in the agency and develop a training program based on those needs.

The staff development and training unit offers two major training components. They are:

- Interventions: a 15-day basic skill training session aimed specifically at new social workers; and
- Core Skills: a five day session providing additional training in special issues such as working with the involuntary or substance abusing client.

Occasionally, voluntary in-service training sessions are offered covering the development of intermediate and advanced skills. The department also offers some professional development workshops designed primarily for clerical, business service, food service, and maintenance staff in the institutions and facilities. Also offered is a medication administration program designed for unlicensed persons working in DCYS operated or licensed institutions and facilities. In addition to providing training sessions, the Staff Development and Training Unit also maintains the social work internship program and tuition reimbursement program.

**Resources.** The Staff Development and Training Unit consists of one director, one supervisor and one part-time clerk. Due to budget constraints, six positions in the unit have remained vacant. Four of these unfilled positions are trainers. Currently, presenters for the training sessions are recruited volunteers from the agency. When no volunteers are available, the unit's staff does the training or, occasionally, trainers are hired from outside the department. The unit is extremely understaffed to perform even the limited amount of training the department is currently offering.

**Training Needs Assessment and Evaluation.** Further evidence concerning the lack of training was drawn from the survey of department employees. In the questionnaire, the respondents were asked to rate the overall training provided by DCYS. Table IV-2

Table IV-2. How would you rate the overall training provided by DCYS?				
Ratings	Excellent	Good	Fair	Poor
Managers	1%	16%	21%	61%
Direct Service	5%	21%	39%	35%

Source: LPR&IC Survey of DCYS Employees.

shows how training was rated by both managers and direct service workers. As the table indicates, both managers and social workers had a negative opinion. It is interesting to note that more managers consider training to be poor than did direct service workers.

Well-trained personnel, especially if they lack formal academic credentials, are essential to the implementation of a quality child protective services system. The total amount of required training is only 20 days and it may be completed before the worker has spent six months on the job. The program review

committee found that it is possible for new social workers to maintain active case loads before completing the mandatory training sessions. There is also no requirement that a social worker pursue outside academic work in the field, as is the case with teachers who are required to obtain a master's degree within 10 years of entering the profession.

As indicated by Table IV-1, 86 percent of current social worker trainees have only a bachelor's degree with no social work credentials. Given this fact, it is crucial that adequate pre-service and in-service training be provided.

Table IV-3. DCYS Staff Turnover for Social Workers: By Regional Office		
	Percent Staff Turnover FY 89	Percent Staff Turnover FY 90
Region I	23.9	11.3
Region II	12.3	10.3
Region III	9.7	13.0
Region IV	15.7	14.2
Region V	6.8	9.5
Region VI	12.5	6.4
Careline	4.0	18.2
Average	13.4	10.1
Source: DCYS Staff Turnover Report.		

**Staff turnover.** While there has been some reduction in staff turnover from the high levels in 1988, the loss of experienced social workers remains a significant problem. Social workers attributed staff turnover to two factors: the size of the caseload; and the increasing complexity and severity in the types of cases confronting social workers. Both of these areas will be discussed in detail in the next chapter. Turnover, inadequate training, and inappropriate employee background, severely weaken the frontline of defense against child abuse and neglect.

## CHAPTER V

### CASE MANAGEMENT AND EVALUATION

As evident from the previous section, the cases and clients a social worker faces each day are complex and diverse. A case usually includes one or more children and perhaps a family member, and a single family may include several cases. The social worker has to manage cases in a variety of ways. Most require the workers to do investigations, make referrals, contact clients, propose interventions, assess family situations and risks to children, and decide when a case should be opened and closed.

#### Case Management

Case load ratios. Program review calculated cases-to-worker ratios by matching the number of filled line social worker positions by month with the number of cases handled for the same month.<sup>1</sup> The number of cases for each office was divided by the number of workers to produce a case load ratio. This was done for one month in each fiscal quarters from July 1989 to July 1990.

DCYS collects monthly case load statistics in two ways. One method counts each case that was served during the month and the other counts only cases that are open on the last day of the month. The former count yields a higher number because a case could be served sometime during the month, but be closed by the end of the month, and thus not counted under the latter figure. Case load ratios are presented for both methods. The true ratio lies somewhere between these two measures.

The five quarter average for the period of July '89 to July '90 shows a case load size range for the DCYS offices. The lowest ratio found for cases served (all cases that were served during the month) was 21 cases per worker (trainees weighted at 75 percent of the social worker caseload) for Torrington and a high of 41 cases per worker for Hartford. This compares to 18 cases per worker in Torrington and 38 cases per worker in Hartford for only those cases that are open at the end of each month. Table V-1 displays a

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<sup>1</sup> Workers were separated by job classification -- supervisors, intake workers, treatment workers, homefinders, and trainees -- and also by regional offices. The capacity of trainees to handle cases was weighted at 75 percent of that for full-time workers. Regional managers indicated that 75 percent is a good approximation of the trainee caseload. (While this figure is taken as the current practice, program review staff will discuss the appropriateness of having trainees handle this number of cases in the findings and recommendations section of this report.)

complete list of the computed caseload ratios for all offices for both cases served during the month and cases open on the last day of the month.

Table V-1. Caseload Ratios for DCYS Offices: July '89 to July '90.		
Office	Cases Served <sup>1</sup>	Cases Open <sup>2</sup>
Hartford	41	38
New Britain	40	38
Hamden	40	36
Meriden	40	33
Danbury	39	35
Rockville	38	33
Stamford	33	28
Norwich	32	28
Willimantic	29	26
Waterbury	27	24
Bridgeport	26	22
Middletown	23	20
Torrington	21	18
Average	34	30
<p>1 Cases Served are all cases that are part of the DCYS caseload even if they were closed before the end of the month.</p> <p>2 Cases Open are only cases that are open on the last day of the month.</p>		

The statewide average worker-to-case ratio was 34 for cases served and 30 for cases open. These averages are higher than the standard set by the National Association of Social Workers, which suggests a ratio of between 20 and 25 cases per worker. The association also recommends that a supervisor manage five to seven workers. The department is well within that ratio in all of its regional offices. The span of control is five social workers for each supervisor on average, with no office exceeding six workers per supervisor for the period analyzed.

## Case Load Description

Two data bases were used to examine DCYS management of cases. One data base consists of 22,447 cases that were closed between July 1, 1987, and June 30, 1990. These cases came from the department's information system, otherwise known as the case management system (CMS), mentioned earlier in this report. This system is used by the department to gather information on individual cases and make it available to workers in the regional offices. The program review committee aggregated many of the variables collected by the department to obtain general information on the way cases are handled.

A second, smaller, data base was obtained by selecting a random sample of cases from the first. The sample consisted of 209 cases that were read by the program review committee to assemble detailed information on DCYS case management practices. Thus, the committee analysis of DCYS cases is divided into parts. The first part describes some of the broader trends of various aspects of the 22,447 cases. The latter discusses an in-depth review of 209 randomly selected cases.

**Overall caseload trends.** The data collected by the department allowed the program review committee to examine important aspects of DCYS cases. Those include the length of time a case remains active, the time taken to complete an investigation, case outcomes, the percentage of cases reopened, the type of placement, court action, and the reason for closing cases. Each area is examined below.

One note of caution: The coding of computer information does not always give an adequate picture of how a case was handled. In addition, important information about cases is not being captured by DCYS's case management system. For instance, a complete history of referrals, case openings, and case closings are not readily available on the current system. This deficiency in the information systems will be addressed later in the report.

**Case processing times.** The CMS data base yielded information on the time taken to process DCYS cases. The median time a case remains open is 84 days while 75 percent are closed within 221 days of being opened. The following table shows the number of cases closed in the range of days displayed.

The number of cases closed within each range is evenly spread, with the largest proportion of cases remaining open longer than 45 days. However, 60 percent of the cases were closed within the first four months of being opened. The fact that cases can vary greatly in the time they remain open, 10 percent are closed within 5 days, while 17 percent remain open for more than a year, attests to the complexity of problems encountered by DCYS. While some cases can be resolved with short-term intervention, others will

require DCYS to be involved with a child's case from early in his or her life until adulthood. The range complexity makes it difficult to categorize and draw conclusions about the nature of cases. As noted earlier, similar results were found when the regional offices were compared in terms of the amount of time a case remained open.

Table V-2. Number of Days a Case Remains Open.			
Days	Cases	Percent	Cumulative Percent
1-5	2,793	12.5	12.5
16-30	2,370	10.6	23.1
31-45	2,261	10.1	33.1
46-120	6,101	27.2	60.4
121-365	4,961	22.1	82.5
Over 1 Year	3,927	17.5	100.0

Source: LPR&IC staff analysis of DCYS CMS database.

### Investigations

The length of time it takes DCYS to complete an investigation into an abuse or neglect referral was also examined. Again, information was taken from the 22,000 cases obtained from the case management system.

On average (using the median), it takes DCYS nine days to complete an investigation into an abuse or neglect referral. The following table shows that 63 percent of the referrals were investigated within 15 days and 91.8 percent are completed in 45 days.

An important finding is that at least 8 percent of the DCYS cases reviewed are not in compliance with the department's 45-day standard to complete investigations on all cases. Out of the 17,951 cases, 1,467 were not investigated within the time frame established by the agency. It must also be noted the information on investigations was incomplete for 4,496 cases.

According to the DCYS policy manual, emergency and severe cases of abuse and neglect are to have an investigation completed within 30 days of referral and non-severe case investigations are to be completed within 45 days. Program review was unable to

differentiate between severe, emergency, and non-severe cases because this information is not captured by the case management information system. The closest information available was on

Table V-3. Number of Days Taken to Complete an Investigation.			
Days	Cases	Percent	Cumulative Percent
1-15	11,401	63.5	63.5
16-30	3,460	19.3	82.8
31-45	1,623	9.0	91.8
46-120	1,247	6.9	98.7
121-365	136	.8	99.5
Over 1 Year	84	.5	100.0

Source: LPR&IC staff analysis of CMS database.

whether or not abuse, neglect, or at risk was confirmed as a result of an investigation. This information was used as an approximation to determine how long severe and non-severe case investigations have taken.

After an investigation is completed, DCYS cases are divided into four categories: 1) abuse confirmed; 2) neglect confirmed; 3) at risk confirmed; and 4) no confirmation of abuse, neglect, or risk to the child. Overall, the category of "at risk confirmed" was identified in 40 percent of the cases. Twenty-two percent were confirmed as abuse upon investigation and 18 percent were confirmed as neglect. The remaining 21 percent of the cases had either no information on the results of the investigation or fell into the last category of "no confirmation". Severe, emergency, and non-severe labels could be applied to each of the categories of abuse, neglect, and at risk, depending upon the circumstances of the individual case. However, it is reasonable to conclude there is a greater probability of an abuse case being an emergency or severe than an at risk case. Neglect cases could fall within any three classifications.

The following table shows the length of time to complete an investigation for each of the categories of confirmed abuse, neglect, and at risk.

Table V-4 examines the relationship between these categories and the time taken to complete an investigation. The question explored is whether cases that are more severe have their investigations completed more quickly than those cases that are considered less severe. The program review committee found that, statewide, a higher percentage of confirmed abuse or neglect cases are investigated within 15 days than at risk cases. This would indicate, as expected, that DCYS puts a higher priority on the more severe cases when pursuing an investigation, assuming that these two categories fall more frequently into the classification of emergency or severe referrals.

Table V-4. Days to Complete an Investigation: By Type.				
Category	1-15 Days	16-30 Days	31-45 Days	Over 45 Days
Abuse:				
Cases	3,262	844	368	365
Percent	67%	17%	8%	8%
Cumulative	67%	84%	92%	100%
Neglect:				
Cases	2,614	690	303	292
Percent	67%	18%	8%	7%
Cumulative	67%	85%	93%	100%
At Risk:				
Cases	5,372	1,888	932	794
Percent	60%	21%	10%	9%
Cumulative	60%	81%	91%	100%

The program review committee also found there is no difference between the time taken to complete an investigation on new cases when compared to cases that have been reopened in any of the categories. For example, the same percentage of cases that are investigated for abuse are completed within 15 days whether they are new cases or ones that had been previously opened. As noted earlier, the committee found a wide variation in the time taken to complete an investigation when this measure is compared from office to office.

### Case Sample

To obtain a more in-depth understanding of the nature of DCYS's cases and how they are managed, the program review committee randomly selected 209 cases for reading. The cases were from all 13 offices with a distribution among the offices similar to that

for the larger data base. This case sample reading was done to familiarize the program review committee with cases as well as to collect information not available from the computerized management information system. The sample was not large enough to draw any office to office comparisons as has been done on the large case data base.

The case sample yielded different information than was available on the computer system. For example, while the computer data contained cases open for an average of 84 days, the sample showed a case history that was more than twice that. From the time a case is first opened by DCYS to the last time it was closed averaged 194 days. This is based upon a complete history of a case, not just the most recent case opening and closing information as found on the computer data base.

The sample was also able to give a more complete history on the number of investigations that occurred throughout the entire case history. Here, 53 percent of the sample cases had only one investigation listed in the file, but in 46 percent of the cases, the files indicated that two or more investigations had been conducted throughout the history of the case. In 11 percent of the sample cases, information pertaining to the investigation was not found in the case file.

### Case File Requirements

The Department of Children and Youth Services has established standards of practice for handling protective service cases. The policy manual requires that key elements of the process be documented present in the files. In all cases, including those where abuse or neglect is not confirmed, a complete history of the risk, services offered, and actions of DCYS and family members must be in the file.

In cases accepted for service by the department for short-term treatment during the intake phase of the process, the department's policies contain broader case file requirements. For instance the policy manual states that:

The intake worker must then include in his written evaluation of [the] family a clear, concise diagnosis of the problem and a treatment plan based upon the strengths and weaknesses of the individual involved and the ongoing needs of the children. <sup>2</sup>

This is a specific requirement of the case file and an important function of the social worker.

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<sup>2</sup> DCYS Policy Manual, Chapter II, Volume 2, Standard 226

The sample review of case files reveals that these basic elements are not being met. In 60 percent of the files reviewed there was no treatment plan on the cases that had been opened. Also, the department only prepares a formal treatment plan for cases that are accepted into the "treatment" phase of the process, not when they are in the intake phase. The intake phase was discussed in Chapter III of this report, however, it should be noted the intake phase will usually involve some social worker intervention that could be considered treatment. However, while this is the current practice, the department's policy manual requires that a treatment plan be prepared even for those cases that are closed during the intake phase. This is an important requirement since approximately 75 percent of all cases opened by DCYS are closed at intake, with only 25 percent moving on to long-term treatment. Without this information, it is very difficult to evaluate whether or not the appropriate action was taken on a case.

In only a few of the cases that were not accepted for services did the program review committee find any summary that included a description of the type of help offered to clients or a statement as to why the case was not accepted as required by department policy.

Another area reviewed was the placement of children out of the home. In 34 percent of the cases, a child (or children) was removed from the home. Half of those children removed were later returned. Of cases where a child was removed, 24 percent had only one placement, another 24 percent had at least two placements, and the remaining 51 percent were placed out-of-home three or more times during the history of their cases.

During the reading of cases, the program review committee was struck by the lack of information in the files on most out-of-home placements. In a few cases the only indication that a placement had even occurred was found in the case narrative written by the social worker. There is a form that was used in a third of the files that indicates the history of child placement.

DCYS has a detailed set of policies and standards for the removal and return of children. These policies require a written assessment of both the parent and child. The policy further specifies that:

All assessments resulting in the removal of a child must be thoroughly reviewed administratively every three months for children 0-5 years of age and every six months for children 6-18 years of age. This assumes that each such case is being reviewed clinically by the staff worker and her/his supervisor at least once a month. These reviews again should include the worker, supervisor, or program supervisor who should consider any changes in the circumstances of the

child and family. Again, a written record should be kept in the case file.<sup>3</sup>

The only assessment found in case readings involving out-of-home placement was the information contained in a treatment plan. In addition, treatment plans were not found for 17 percent of the cases where a formal placement was made. Even when a treatment plan was found, there was no monthly clinical assessment of out-of-home placement, as required by the policy manual. Treatment plans are reviewed every six months.

In one extraordinary case, a placement was made with a foster home, and the case was closed with a final notation indicating that the foster parent should seek guardianship of the child. This particular case was closed contrary to DCYS policy.

Another DCYS policy not properly carried out deals with voluntary placement of children. The policy sets forth the criteria for voluntary placement:

The utilization of a voluntary placement in a protective services situation is often a therapeutic step for the child and for the family. When this process is discussed with the family, the worker must explain that the voluntary placement is time-related, with a maximum duration of ninety days.... A written social service contract must be drawn up clearly indicating what the parent(s) and the Agency will each do to facilitate the child(ren)'s return.<sup>4</sup>

Program review found an absence of this process in voluntary placements, and contrary to this policy, staff found cases that were closed when a voluntary placement had been made with a relative.

**Case management system deficiencies.** The department's current case management system is burdened with excessive paperwork and does not meet the needs of the social workers nor the clients. Even case files with relatively short histories contained numerous forms, many requiring similar pieces of information. Filling out forms by social workers and inputting information from those forms by clerical staff results in a duplication of effort on the part of both workers. Moreover, much of the information on the forms is not used, but information that could be useful is not collected. For example, out-of-home placement information is neither adequate nor systematically collected. Information concerning the programs used at all phases of intervention, as discussed in the next

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<sup>3</sup> DCYS Policy Manual, Volume 2, Chapter II, Standard 242 p. 2.

<sup>4</sup> DCYS Policy Manual, Volume 2, Chapter II, Standard 243

section, is not compiled. And most importantly, information on department and community resources are not centrally available nor readily accessible even within the regional offices.

The department's case management system is severely deficient and needs to be revamped. Case management is a critical tool for social worker serving clients.

Evaluating client outcomes. Currently, most of the data gathered by the department are productivity statistics such as types of services provided and number of clients served. The department collects information on case outcomes, but it is very broad and not very descriptive. For example, according to the automated data base, a case was closed 36 percent of the time because "case goal achieved". However, individual case files analyzed by staff found that reason cited for a wide range of circumstances, from a client having attended a particular program to a child being placed with a relative. There is no analysis of case outcomes to determine if referrals to programs were in fact successful, or even if they were attended.

The data collected do not capture the effectiveness of programs or intervention. In short, there is no systematic monitoring of client progress or outcomes.

Substantial sums are spent on treatment services, and it is impractical not to monitor the clients' use of services or progress. The department administratively reviews cases in treatment and the division of quality assurance periodically examines cases randomly. However, the program review committee found the administrative reviews to be weak and lacking in substantive documentation. The quality assurance review is primarily a random audit for federal standards and does not analyze client outcomes. In the sample examined, the program review committee rarely found any documentation of the client's rate of participation in or use of a service, nor was there any information concerning the program's effectiveness on altering the problems encountered.

It is necessary to monitor the client's progress periodically to determine whether the recommended services for the client have been successfully implemented. This is especially important in re-opened cases, to determine if past interventions failed and identify new problems since the last treatment plan.

## SECTION VI

### DCYS-FUNDED COMMUNITY PROGRAMS

Central to the DCYS mission for dealing with abuse and neglect is that every child is entitled to grow up in a permanent family or, when that is not possible, the most suitable substitute placement. When out-of-home placement becomes necessary, the ultimate objective is reunification with the child's family. The department attempts to achieve this by providing families with services and programs aimed at either preventing placement of a child outside the home, or rehabilitating a family for reunification after the child has been removed.

#### Treatment

For the purposes of this report, treatment is defined as the effort to reduce the risk and likelihood of further abuse or neglect and to make the home physically and psychologically safe for a child.

Treatment of a child or family can occur during intake or the formal treatment phase of DCYS involvement. Treatment is mostly done categorically, in that a client is diagnosed as having one or more specific problems. Each problem is then addressed by a service or program. For example, a parent can be referred to a substance abuse clinic for a drug or alcohol problem and also to a parent aide for instruction in proper parenting and discipline practices. There are few services designed to concurrently address all the problems of a client.

DCYS-funded programs are managed according to the type of treatment and service they provide. This briefing package contains a description of the continuum of care management model used by DCYS. As previously noted, the continuum consists of four levels, and the programs are contained in the appropriate level that relates to the service. Part of the program review committee's review and analysis included the evaluation of community programs. However, the department's continuum of care model must be understood before a more program-specific analysis can be done.

#### Continuum of Care

The DCYS continuum of care consists of four levels of treatment aimed at addressing the needs of all children serviced by DCYS, including abused children, delinquents, or children with emotional or psychological problems. The primary objective of the continuum of care is the same as that of the department: to maintain children in their own homes and communities.

The continuum of care contains:

- Level I: Youth and community development;
- Level II: Support services;
- Level III: Supplementary services; and
- Level IV: Substitute services.

**Level I: Youth and community development.** Programs at this level are designed to provide services to children and youth who are at risk of abuse, neglect, mental illness, substance abuse, or delinquency. Services are provided through DCYS community preventive-service grants awarded to privately run community-based agencies. Level I serves the largest number of children and families for the lowest unit cost, and is the least restrictive form of intervention among the four levels.

Social service organizations provide indirect services by helping communities develop programs to meet the needs of children and their families by assessing the need for various programs, determining availability of resources, and developing resources. Some of the programs currently being used in communities are:

- in-school programs that teach youngsters personal decision-making skills;
- vocational internships and after-school employment programs;
- training in child development and behavior management skills for parents;
- training in peer counseling skills;
- training in youth leadership; and
- parent education and support programs.

The parent education programs are intended to improve parenting and enhance family functioning in order to provide children and youth increased opportunities to grow and develop in positive ways. School-home liaison programs link families and community resources with schools to prevent delinquency. Substance abuse prevention programs provide children, youth, and their families with skills and opportunities that promote positive and healthy lifestyles without the use of alcohol or drugs. Early

intervention programs provide parent education and training for dealing with high risk children under the age of six years.

**Level II: Support services.** Level II of the continuum is aimed at protecting children from abuse or injury, preventing children's removal from their families and homes, enabling children and their families to manage their problems, and reunify children with their families. Level II clientele differ from Level I in that the child has most likely already been abused or neglected and/or is in imminent danger of being removed from the home.

Support services include screening and referral for appropriate level of care; evaluation, diagnosis, and treatment; parent aid; case review and follow-up; and locating adoptive or permanent homes for children who cannot remain in or return to their own homes. The seven types of programs offered in Level II are as follows:

- children protective services;
- community child protective services;
- adoption services;
- community child psychiatric services;
- youth service bureaus;
- permanent foster family; and
- community living.

Regional children protective services (discussed in detail in Chapter III), protects children from abusive parents by offering parents services to help modify their behavior. The regional protective services units investigate cases of child abuse, neglect, or abandonment, and treat the children and their families. Services are delivered by children protective services regional staff, community child protective groups, adoption services, permanent foster family homes, child guidance clinics, youth service bureaus, and community living programs.

Community child protective services are designed to reduce the incidence of serious abuse of children and to enable children to remain with their families. Community child protective services offer the following types of programs:

- child protective case consultation teams, which assess, plan, and arrange treatment services for individual cases.

The teams also educate public and professional groups about child welfare;

- parent aid and homemaker programs that teach parenting and home management skills, and demonstrate appropriate parent/child interaction to help stabilize the family;
- parental self-help resources, which teach parents how to deal with their feelings in order to manage their children more effectively; and
- child care resource programs that protect and treat abused and neglected children and children of high-risk parents through infant, preschool, after school, respite, and therapeutic day care programs.

Adoption services care for children who can not return home. Adoption Services include: legally freeing a child for adoption; preparing a child for adoption; planning with the adoptive family; providing subsidies for children with special needs; and post-placement supervision of the homes.

Community child psychiatric services provides mental health services for abused children and youth.

Community-based Youth Service Bureaus (YSB) offer services to troubled, delinquent, and pre-delinquent children.

Permanent family residences are homes for children with a combination of severe physical and emotional disabilities who cannot remain with their families and for whom adoption is unlikely.

Community living programs are for children with behavioral problems. These programs include: crisis intervention, supervision, counseling, experimental education, referral for community services, and consultation with police, school, and court officials.

**Level III: Supplementary services.** Level III of the continuum of care is supplementary services which serves children who are mentally ill, emotionally disturbed, substance abusers, behaviorally disordered, or have multiple handicaps. The programs offered in Level III compensate for parental limitation or the child's serious impairment by treating children who require a comprehensive intensive day program but return home each evening. These programs

attempt to prevent the removal of the child from the home. This level serves a small number of children and their families.

**Level IV: Substitute services.** These services provide out-of-home placement for children, including residential treatment and foster family care. This level treats children who require the most intensive level of care and protects children who have been seriously abused and removed from their homes.

The most intensive substitute services are provided by DCYS-operated institutions. Less intensive services are offered by private non-profit temporary shelters, group homes, residential facilities and substance abuse treatment facilities. However, the least restrictive and intensive services are offered by foster family care.

The program review committee developed a matrix of the four levels of care funded by DCYS, broken down by level of care and region. Within each level of care are the types of services and treatment offered, and then each specific program offering those services and treatment is identified by region. The matrix can be found in Appendix B of this report.

### **Programs**

The program review committee reviewed six DCYS-funded programs for treating abused and neglected children and their families. These were chosen from the many programs offered through the department's continuum of care model. The six programs are from Level II of the continuum of care, the most reactive and preventative of services for abused children. As previously stated, Level II children have most likely already been abused or neglected and/or are in imminent danger of being removed from home.

The DCYS-funded program reviewed are:

- intensive family preservation;
- parent aides;
- therapeutic child care;
- child guidance clinics;
- day treatment; and
- child protection teams.

The programs are the most frequently used by social workers in treating DCYS clients, and represent a large share of the budget for DCYS-funded programming.

The intensive family preservation program is the newest innovation in social work treatment. It is being developed nationwide and, to date, has been generally accepted as a successful way to help troubled families without placing the child out-of-home. It also differs from other forms of treatment by addressing all problems of a client and family rather than categorically treating the person.

### Program Descriptions

Intensive family preservation. This program is the most recent trend in treatment for abused children and abusive parents. Intensive family preservation programs intervene at crisis points with families who have children at imminent risk of placement and provide an alternative to placement through the provision of a range of intensive, home-based, family-focused services. Family preservation has been defined as short-term, face-to-face support and therapy services provided in the homes of families who are at immediate risk of a DCYS-ordered separation. The program places a "foster parent" in the family's home to assist in reaching a level of functioning that eliminates the need to remove the child.

The greatest single indicator of whether a child released from foster care will eventually return to foster care is the length time spent in the first placement home. The longer the placement, the more likely the return. The intensive family preservation program is aimed at preventing that first placement and treating the child in the home. Most children, despite the conditions in which they live, will respond better to treatment when left in their homes.

An intensive family preservation social worker has a case load of no more than two families. The program continues for no more than eight weeks, with five and a half weeks being the average. Although short in duration, the program offers very intensive services. The social worker is available to the family 24 hours a day seven days a week. DCYS has stated that an eight-week intensive family preservation program equates to approximately two years of out-patient therapy.

The intensive family preservation program:

- is family focused;
- teaches family, parenting, and life skills in an effort to reduce the client's dependency; and
- intervenes at crisis points when families are most receptive to treatment.

Because the social worker treats the family in its own home, the program offers benefits over traditional services. The benefits are as follow:

- an assessment of the family is more accurate through continuous observation in homesetting; and
- treatment and services can be offered at irregular schedules convenient to the families. The social worker is at the home during times when it makes sense for a treatment worker to be there, for example, crisis points.

DCYS has stated that two pilot intensive family preservation programs, begun in 1987, achieved a 70 percent success rate measured by the number of families kept united during the year after treatment. Thirty percent of the families in the intensive family preservation program experienced some type of placement of the child.

**Parent aides.** Parent aide programs are designed to teach and improve parenting skills through home management, appropriate disciplinary techniques, and knowledge of child development. The parent aide worker helps the parent develop a support network, access community resources, improve self esteem, and assume personal responsibility.

Clients referred to parent aide programs are generally unable to relate to their children in a positive way. A parent aide helps create a trusting parent/child relationship, and provides preventive and remedial intervention to the family. The new relationships formed through a parent aide program and the presence of the worker in the home, can reduce the risk and incidence of child abuse and neglect.

The key to a successful parent aide program is the relationship between the parent and parent aide worker. The relationship is: parent focused; informal and non-authoritarian; non-judgmental; and caring, supportive, and nurturing.

Parent aide programs achieve their goals by:

- helping the client develop skills to anticipate, prepare for, and cope with crises;
- improving self-confidence, self-esteem, and self-awareness through problem-solving, coping skills, and personal responsibility;

- enhancing parenting skills and strengthening parent/child relationships;
- improving home management, budgeting, and organization skills;
- promoting effective and appropriate use of community resources; and
- preparing a parent for eventual re-unification when substitute care has been used and assist when re-unification occurs.

**Therapeutic child care.** Therapeutic child care is a center-based intervention program providing educational, developmental, and emotional support services to abused, neglected, and at risk preschool children. The program goal is to provide these supportive treatment services to both children and their families enabling the child to remain safely in the home.

At the therapeutic child care center, children may receive health services such as vision and hearing testing, dental examinations, and referrals to additional health services when necessary. The program provides support for the children's families through parent education services. The program also acts as a referral resource for families with regard to nutritional and housing assistance, employment opportunities, and graduate equivalency diploma (GED) completion. Program staff also assist in meeting each child's developmental and emotional needs.

**Day treatment.** Day treatment is a mental health service for children needing intensive treatment while remaining in a family setting. This program is primarily designed for children who do not need 24-hour treatment, but require more than one or two hours of therapy a week.

Day treatment services may be provided before and after school or during an extended day program which includes some evening hours. Educational services may be offered as part of the program for children needing the most structure, or provided separately through other regular or special education programs. The core of day treatment is a structured and predictable daily environment.

All programs provide individual group and family therapy. The length of program participation varies from one to two years. Typically, children are judged ready to leave day treatment when they can return to a public school setting and family problems have been resolved to the point where the child can remain home without extensive day-to-day support.

Child guidance clinics. Child guidance clinics provide diagnostic and crisis counseling services and other psychiatric treatment services to children and their parents. Their primary goal is to decrease the incidence of mental illness, emotional disturbance, and social dysfunctioning.

Staffed by psychiatrists, psychologists, social workers, and other professionals and paraprofessionals, the clinics generally provide:

- screening and referral services;
- evaluation and diagnosis;
- individual, group, and family therapy;
- emergency crisis intervention; and
- community consultation.

Children are usually referred to clinics by public schools, their families, DCYS, other human service agencies, and health providers. On average, treatment services are based on seeing the child in the office for bi-weekly hour-long sessions, for about 12 months.

Child protection teams. Child protection teams emerged in Connecticut in the mid 1970's in response to the increasing number of referrals to DCYS, and the belief that abused and neglected children and their families required supportive services in their communities as well as a mandated child protection agency. DCYS defined a child protection team as a group of persons from a variety of disciplines, often representing different agencies, who work together for a well-defined purpose(s) such as child abuse and neglect prevention, identification, case consultation, service coordination, resource and service development, and community and professional education. The purpose of child protection teams is to provide a multi-disciplinary approach to child protection, and make it more a function of the entire service delivery network rather than the responsibility of one agency, like DCYS.

Child protection teams are mandated by both federal and state statutes. To receive federal grants, states must demonstrate that there are "multi-disciplinary programs and services" in effect. Connecticut statute mandates that DCYS make funds available to public or private organizations to develop and maintain programs for the treatment and prevention of child abuse and neglect, including, but not limited to, child protection teams.

The teams do not perform any child protection services. Once a case is referred, the team provides: oversight of the actions

taken on the case; consultation with experts in medical, psychological, social service, educational, and legal experts; service coordination; community education; and advocacy. Some have specialized teams such as child sexual abuse, substance abuse, adolescent teams, or focus on at risk cases that need community service but not protective service. Other teams focus on identifying the unmet needs of their community and assist in establishing new prevention and treatment programs.

The teams are staffed by volunteer professionals involved in the intervention of child abuse and neglect cases. The volunteers are from schools, DCYS, medical, law enforcement, and mental health fields, and a variety of agencies serving families and children.

### Program Usage

The program review committee analyzed DCYS usage of the six programs in treating abused, neglected, or abandoned children, and included foster care as the seventh program. The level of usage was measured by using: DCYS data on the number of children treated by the programs; data collected during the committee's case review; and interviews and day visits with DCYS social workers.

Usage statistics. Tables VI-1 and VI-2 represent case load during FY 89 and 90 for each of the seven programs. These data were provided by the DCYS management information system, which receives this information through community service programs' reporting procedures. However, some of the information is from estimates and projections because there is no automated data collection at either the DCYS or program level. In addition, these data are not uniformly collected or consistent between programs, and DCYS has had difficulty in gathering this information.

As shown in the tables, foster care is the most frequently used program for abused and neglected children. In FY 89, 4,157 children were placed in foster care homes or licensed relatives' homes, compared to 4,381 in FY 90. Child guidance clinics were the second most frequently used program during FY 89 and 90, with 2,517 and 4,737 DCYS clients respectively.

In some programs, a case consists of the family unit and in others it represents a single family member, either the child or parent. Cases referred to a program by DCYS may make up only part of that program's total case load, whereas some programs only serve DCYS-referred cases. Included in the tables are the percentages of the programs' total case load that are DCYS cases. The percentages range from a low of 19 percent to a high of 100 percent.

Only foster care and intensive family preservation programs' case loads are all DCYS cases. This is because foster care is

Table VI-1. Usage Data on DCYS-Funded Programs and Foster Care. State Fiscal Year 1988-89.

PROGRAM	CLIENTS AT START OF YR	NEW CLIENTS ADDED	TOTAL CASES CLOSED	YEAR END CASELOAD	TOTAL CLIENTS SERVED	TOTAL NUMBER OF CASES THAT ARE DCYS	% OF CASELOAD THAT ARE DCYS CASES	BUDGET BY DCYS FOR PROGRAM	# OF SERVICE PROVIDERS FOR PROGRAM
FOSTER CARE	2,475	1,808	1,328	2,664	4,157	4,157	100%	\$11,395,873	1,473
INTENSIVE FAMILY PRESERVATION	17	111	98	30	128	128	100%	\$524,000	2
PARENT AIDE	565	943	887	617	1,504	571	38% <sup>2</sup>	*	20
THERAPEUTIC CHILD CARE	436	557	481	512	993	566	57%	\$432,701	9
CHILD GUIDANCE CLINIC	6,371	6,880	6,520	6,728	13,248	2,517	19%	\$7,916,942	27
DAY TREATMENT	181	155	146	190	336	100	30%	\$900,495	10
CHILD PROTECTION TEAM <sup>1</sup>	294	243	356	336	537	279	52%	*	17

Source: Data provided by DCYS Management Info. System Division on 11/19/90.

Table VI-2. Usage Data on DCYS-Funded Programs and Foster Care. State Fiscal Year 1989-90.

PROGRAM	CLIENTS AT START OF YR	NEW CLIENTS ADDED	TOTAL CASES CLOSED	YEAR END CASELOAD	TOTAL CLIENTS SERVED	TOTAL NUMBER OF CASES THAT ARE DCYS	% OF CASELOAD THAT ARE DCYS CASES	BUDGET BY DCYS FOR PROGRAM	# OF SERVICE PROVIDERS FOR PROGRAM
FOSTER CARE	2,664	1,639	1,215	2,674	4,381	4,381	100%	\$13,166,698	1,636
INTENSIVE FAMILY PRESERVATION	30	198	192	31	228	228	100%	\$1,285,387	7
PARENT AIDE	612	1,052	772	759	1,531	612	40% <sup>2</sup>	*	20
THERAPEUTIC CHILD CARE	512	612	527	597	1,124	595	53%	\$447,207	9
CHILD GUIDANCE CLINIC	6,724	6,813	6,622	6,914	13,536	4,737	35%	\$8,211,163	27
DAY TREATMENT	191	168	114	245	359	125	35%	\$776,047	10
CHILD PROTECTION TEAMS <sup>1</sup>	335	259	269	256	594	139	52%	*	17

FOOTNOTES:

SOURCE: Data provided by DCYS Management Info. System Division on 11/19/90.

<sup>1</sup> Figures include estimates and projections.

<sup>2</sup> DCYS estimate for SFY89.

\* Expenditures for parent aide and child protection teams are combined as some programs provide both services. LPR&IC staff cannot determine budget with the expenditure information provided by DCYS.

administered by the department, and DCYS intervention must occur for a child to be removed from the home. Intensive family preservation program guidelines allow only those cases referred by DCYS to receive treatment.

Of those programs accepting non-DCYS cases, therapeutic child care has the highest percentage of DCYS clients-- 53 percent in FY 89, and 57 percent in FY 90. Fifty-two percent of the child protection teams' caseloads in both fiscal years were DCYS-referred cases.

Child guidance clinics had the lowest percentage of DCYS cases. In FY 89, only 19 percent of the case load was DCYS-referred, increasing to 35 percent in FY 90. This may be attributed to the fact that the grant process and fiscal administration has been transferred to the regions. Community service programs are finding that they must be more responsive to the needs of DCYS, through accepting more DCYS cases for treatment, to ensure continued funding.

Overall, child guidance clinics have the highest case load of all the programs analyzed. In FY 89, the clinics served 13,248 children, which increased to 13,536 the next year. The clinics also served the highest number of DCYS clients; 2,517 in FY 89 and 4,737 in FY 90. In fact, in FY 90 the number of DCYS clients accepted by child guidance clinics (4,737) surpassed the number of children in foster care (4,381). During FYs 89 and 90, foster care served 4,157 and 4,381 children respectively. All programs experienced a case load increase from FY 89 to 90.

**Budget.** Tables VI-1 and VI-2 show DCYS expenditures for each program. For the programs analyzed, DCYS funds represent only a portion of their total budgets, though it may be as high as 60 percent. Foster care and child guidance clinics received more than \$24 million and \$16 million respectively during the two years. DCYS was unable to provide separate expenditure amounts for parent aide programs and child protection teams. DCYS combined the expenditures for these programs because some facilities provide both services. During FY 89, DCYS expended \$1,188,488 for parent aides programs and child protection teams, and \$1,677,430 in FY 90.

**Case file review.** During the program review committee's review of 209 DCYS protective service cases, the number of referrals made, and the types of programs referred by the social worker, were compiled. The committee used this information to determine the frequency with which DCYS clients were referred to community programs.

The committee differentiated between a community service program and a foster care placement. Both are defined as treatment programs for abused and neglected children, but foster care is not considered a community service program -- it is a DCYS administered

program. However, the case file review revealed that a foster care placement could take place without any treatment from a community service program.

A child abuse, neglect, or abandonment case is very complex and may take many years to resolve to the point where the family can live together without DCYS intervention. It should also be remembered that there may be more than one source of tension in the home causing danger to the child. Since the causes of child abuse cases are multi-faceted, one community service program, many times, will not resolve a case.

The program review committee found it extremely troublesome that information on actual client participation in a community service program was not contained in the case files. In only 7 of the 90 cases where a DCYS-funded program was used did the committee locate information that the client participated on at least one occasion. This information was usually contained in a narrative document submitted during a court proceeding. Only one case file contained an official attendance record from a parent aide program, which was also part of a packet submitted to a court by the social worker.

Yet, as shown in Tables VI-1 and VI-2, case load data on program usage are available. However, DCYS relies on the community service programs to provide this information, rather than collecting it from individual client files. DCYS does not conduct follow-

Table VI-3. Number of DCYS-Funded Programs Referred Per Case.		
NUMBER OF PROGRAMS REFERRED PER CASE	NUMBER OF CASES	AS A PERCENT OF ALL CASES
NO PROGRAM	119*	57%
1 PROGRAM	40	19%
2 OR MORE PROGRAMS	50	24%
TOTALS	209	100%
*total includes 16 cases where only foster care placement was used.		
Source: LPR&IC staff analysis of DCYS case files.		

up studies on program participation or usage. All of the information, except for foster care, provided in Tables VI-1 and VI-2 was

submitted by program administrators to DCYS. While the data are maintained by the department they are not used to develop, evaluate, or fund the community service programs. In fact, DCYS found it difficult to provide this information in the format shown.

Of the 209 cases reviewed in the sample, Table VI-3 shows that 57 percent (119 cases) did not contain any referral to a community service program. Of the remaining cases, 19 percent were referred to only one program, and 24 percent to two or more programs. In effect, more than half of the abuse, neglect, and at risk cases reviewed were closed without receiving any treatment from DCYS.

The program review committee concluded that the current level of treatment offered through DCYS case management is mostly from a single program. The use of a single community service program often serves as a temporary solution to a crisis. It addresses the serious problem immediately while the peripheral issues are ignored.

One reason why cases are not referred to treatment programs is that social workers are unaware of all the treatment options available. DCYS does not maintain any type of a central data base on community service programs. Social workers have no resource to identify program options needed to treat clients. Another reason is a lack of programs in a particular region. Regional directors stressed that some areas have more community resources than others.

Table VI-4. Number of Referrals Per Program Type.		
Program type	Number of Referrals	Percent
Foster care	48	53.9%
* along with program referral	32	35.9%
* without program referral	16	17.9%
Parent aide	20	22.4%
Child guidance clinic	18	20.2%
Intensive family preservation	2	2.2%
Day treatment	1	1.1%
Therapeutic child care	0	0
Child protection team	0	0
Source: LPR&IC staff analysis of DCYS case file.		

The committee examined the frequency of client referrals to programs. Foster care, included in this analysis, was divided into two categories: foster care along with referral(s) to a community service program, and foster care without other referrals. Table VI-4 shows the number of referrals to a particular program in the case sample.

The most frequently used program was foster care, representing more than half of the referrals. Parent aide programs were the next most frequently used (22%), closely followed by child guidance clinics (20%). The case sample information is further supported by the FY 89 and 90 usage data provided by DCYS shown in Table VI-5.

In both samples reviewed, the majority of children in treatment were placed in foster care. Child guidance clinics and parent aide programs were the next most frequently used, with slight differences shown between the case sample review and DCYS usage data. The remaining four programs show a drastic decrease in the number of DCYS clients treated.

**Table VI-5. Number of DCYS Cases Per Program. Usage Data.**

Program	FY 89		FY 90	
	Total Number of DCYS Cases Per Program	Percent of Total Cases	Total Number of DCYS cases	Percent of Total Cases
Foster Care	4,157	49.9%	4,381	40.5%
Parent Aide	571	6.8%	612	5.6%
Child Guidance Clinics	2,517	30.2%	4,737	43.7%
Intensive Family Preservation	128	1.5%	228	2.1%
Day Treatment	100	1.2%	125	1.1%
Therapeutic Child Care	566	6.8%	595	5.5%
Child Protection Team	279	3.3%	139	1.2%
Total Cases	8,318	100%	10,817	100%

Source: DCYS Management Information System.

**Interviews and visits.** Through interviews with protective services social workers and their supervisors, and field visits with the workers, the committee learned that use of community programs depends on availability. The number of available slots in community service programs is limited and, therefore, a DCYS social worker may have to refer a client to a program which is not ideally suited to that client's needs. This is done to get the client into some type of treatment rather than none at all.

Thus, adequate or appropriate treatment for DCYS clients from department-funded, community-based programs is weak. Social workers, in an effort to provide a minimal level of service, have resorted to using other types of service and treatment programs. Many of these programs are not funded by DCYS, but rather provided by charitable and non-profit organizations. The DCYS-funded programs are used for two reasons: (1) availability; and (2) historically, DCYS funded and depended on these programs to treat clients. The program review committee did not determine that these programs were used because they were successful in treating clients.

During the field visits with social workers, clients were seen who were participating in intensive family preservation, parent aide, child guidance clinics, respite day care, and therapeutic and traditional foster care homes. Committee staff learned during these visits that social workers generally develop their own network of information and contacts concerning community programs. There is no central data base or directory of programs readily available to them. DCYS does not conduct outcome evaluations or measures the effectiveness of community programs to provide social workers information on what works and what does not. Social workers rely on past experience, trial and error, and discussions with colleagues when determining where to refer a client. Information about the community programs that social workers have developed on their own is a valuable, yet untapped, resource that the department does not use.

There were only two areas where the program review committee found DCYS conducting oversight of community service programs-- the grant process, and the central office monitoring a programs' compliance with professional standards. The following section details the grant process procedure and the monitoring operations of the program review and evaluation unit.

#### **Community Programs: Evaluation and the Grants Process**

Originally administered through the central office, the responsibility for allocating grants was recently shifted to the regional offices. As discussed in the department management and organization chapter, the intent of regionalization was to strengthen the involvement of each regional office in the adminis-

tration and evaluation of community programs. Regions were to base funding decisions through the evaluations. In general, the grant process begins with a spending plan for each region, including expenditures for each type of program, developed by the DCYS central office. The expenditures are based on the legislative appropriation and on the assumption that existing programs will continue to receive funding.

Once a region receives its spending plan, applications are sought from the existing funded programs. The application requires information regarding budget, resources, personnel, policies, and data relevant to the particular program.

Returned applications are reviewed for eligibility. Eligibility standards are based on the program's target population, case load data including the DCYS cases served, program employee qualifications, the project's goals and objectives, and budget documentation identifying the program's fee schedule. If the program is eligible and the expenditures are within the DCYS spending plan, funding is awarded.

An applicant not meeting the requirements may be requested to revise and resubmit the application until it meets the standards. If the program cannot or will not meet the requirements of the contracted services, funding is discontinued.

**Program evaluation unit.** The Department of Children and Youth Services is mandated by law to monitor and evaluate programs funded by it. The mandate states the department shall, "evaluate a comprehensive and integrated statewide program of services ... for children and youth" and shall also, "conduct studies of any program, service or facility operated, contracted for or supported by the Department in order to evaluate its effectiveness". Many of the programs funded by DCYS also receive funds from the federal government under Title XX of the Social Security Act. The grants awarded under this act also require that programs be evaluated annually.

To meet the state and federal mandates, DCYS created the Division of Quality Assurance within its central office. This division, described in an earlier chapter, includes a Program Review and Evaluation Unit responsible for monitoring and evaluating DCYS-funded community service programs.

Charged with performing program evaluations of eight different types of community services, the unit monitors: child guidance clinics; temporary shelters; child protection teams; parent aide programs; residential group treatment homes; group homes; alcohol and substance abuse treatment programs; and day treatment programs.

**Operation.** Program evaluations are done annually with the rigor changing each year of a three-year schedule. The cycle is renewed the fourth year, after:

- year 1: intensive review;
- year 2: follow-up visit; and
- year 3: summative review.

**Intensive review.** The intensive review is an inventory of practices and policies to ensure the program is meeting minimum DCYS standards. A monitoring inventory scores the program's compliance with standards in administration and organization, human resources, physical environment, quality of services, and direct services management.

The intensive review takes three to five days, depending on the size of the program. The unit lists programmatic and administrative problems and weaknesses, along with a score from the monitoring form, and makes recommendations.

**Follow-up visit.** The second year includes a follow-up visit to determine progress made toward meeting the recommendations issued during the intensive review. In addition, any programmatic or administrative changes are reviewed. The follow-up visit takes two to three days to complete.

The monitoring inventory is used again, and the program's score is compared to the first year ratings. The difference between the first and second year evaluations is the focus away from identifying problems to measuring compliance. The second year visit is not as intensive as the first.

**Summative review.** The third-year review is even less intensive than second, and is a summary of the first two year's evaluations and recommendations. During this review, any significant changes to the program are reported and reviewed. The summative review is completed in one to two days.

**Reporting.** The Program Review and Evaluation Unit reports on each program every year. The reports are forwarded to the program being evaluated and the region in which it operates. The unit can forward its report to the Division of Quality Assurance or the Licensing Unit if a persistent problem area has been identified. However, the only sanction available to DCYS for noncompliance is to issue the program a provisional license instead of relicensing. A program receiving a provisional license is then monitored on a monthly basis rather than annually.

The purpose of regionalization is to strengthen regional involvement in the administration and evaluation of community

programs. The grant process is to be based on an on-going process of program evaluation and needs assessment. Funding would be proportionate to the program's success or discontinued. However, the department has provided regions with procedures for collecting fiscal and program information as it relates to the grant renewal process, but has not provided uniform guidelines for evaluating a program's success. As noted previously, the only formal evaluation done reviews programs to ensure that minimal standards of service are provided, not whether they have successfully treated clients. The Program Review and Evaluation Unit does not evaluate client outcomes or effectiveness of the community service programs.

To ensure that the grant process has all the necessary information to make fair and responsible funding decisions, the regions should have an evaluation process that takes into consideration the effectiveness and DCYS client use of the program. The program review committee concluded that despite the lack of useful evaluation information, the regions do have some latitude in deciding which programs to accept or reject. The regional directors stated that the grant process did give them some leverage to request changes or to bargain for services. However, this process is still an informal one which is dependent upon the relationship between the regional director and the community service providers.



## CHAPTER VII

### FINDINGS AND RECOMMENDATIONS

The Legislative Program Review and Investigations Committee findings lead to the conclusion that the Department of Children and Youth Services is in need of major changes. The changes are proposed as recommendations that will have a significant impact on the operations of Connecticut's child protective services system. The emphasis of these recommendations is on strengthening the role of the social worker in managing cases of child abuse and neglect. The program review committee found that if there is to be any improvement in the handling of cases, it can only be achieved by enhancing the social work function, the first line of defense against child abuse and neglect. Ultimately, it is the social worker, much like a teacher, who will make the difference in a child's life.

The legislative program review committee propose recommendations in four areas: 1) management and regional operations; 2) staff training and development; 3) case management and evaluation; and 4) the operations of DCYS and community programs. It is these areas where the greatest benefit can come for improving the agency's effectiveness and ability to prevent child abuse and neglect cases.

#### Management and Regional Operations

**Communication.** To achieve many of following recommendations proposed by the program review committee, a strong communications network needs to be in place before new policies can be implemented.

As the survey results show, both managers and direct service workers within DCYS have an extremely poor view of how information is communicated to staff, particularly from the management team and central office. The department has a management structure that should facilitate communication throughout the organization, but as the survey indicates, it is not working. The commissioner should aggressively establish an effective communication network between and among all levels within the department.

**Organizational changes.** As part of the review of DCYS, the program review committee examined the responsibilities and functions of the central office, the six regions, and the management team. The program review committee believe that the department's management team concept is an important vehicle in implementing policy and that the team needs to become further involved in reviewing information on how the department operates. Through-

out these recommendations it is implicit that the management team be involved in the evaluation and implementation of policy.

Currently, the Quality Assurance Division conducts program evaluations that review a program for conformance to accepted professional standards. However, there is no evaluation of program success in treating abuse and neglect. Furthermore, the grant application material submitted by the program each year, contains only productivity data rather than an assessment of program effectiveness. Evaluation of client outcomes is not done by anyone in the department. Specifically, the program review committee found that the department does not:

- evaluate community programs in terms of their effectiveness in treating abuse and neglect;
- distribute grant monies based upon the evaluation of a program's success;
- conduct client-outcome evaluations to determine what is effective in treating abuse and neglect;
- know if outcomes differ based upon interventions undertaken; or
- examine interventions that are more likely to result in a case not being reopened.

The department must also focus resources on determining if the programs funded are successful in treating clients and couple those findings with funding. Currently, no entity within the central office conducts this function. Given the finding that half the cases are closed without any program referral, as well as the fact that a third of the cases are reopened within a year, attests to the need for examining the interventions taken by DCYS social workers who are providing assistance and treatment.

Therefore, the Legislative Program Review and Investigations Committee recommends that the Program Development Division should be reorganized to incorporate the function of case evaluation. The new division would become the Program Development and Evaluation Division. This new division shall also be responsible for evaluating client outcomes to determine the most effective methods in preventing and treating child abuse and neglect. The existing program evaluation unit within the Quality Assurance Division should be transferred to this division and, in addition to monitoring programs, shall also conduct evaluations that measure

program effectiveness. Information collected shall be submitted for review to the management team. This division would also be responsible for developing a grant processing system, as proposed in a later recommendation, linking program evaluations with the distribution of grant monies. This recommendation should also be implemented with a later recommendation on the department's management information system.

This recommendation would place responsibility for program evaluations and monitoring client outcomes within a single division in the central office. The information gathered by these evaluations will allow the management team to determine which programs are successful and which are not.

**Quality assurance.** Given the confidentiality of DCYS cases, the program review committee found that there is a need for an independent review of the handling of DCYS cases. This function is necessary because case oversight generally does not extend beyond the social worker's immediate supervisor. The program review committee found that there is no random audit of cases for compliance with DCYS promulgated policies. As part of the audit function, a mechanism to track individual clients who have been placed needs to be developed and follow-up of problems identified by the Quality Assurance Division.

The Legislative Program Review and Investigations Committee recommends that the department develop an independent case audit unit that will monitor each region's compliance with DCYS promulgated procedures and standards. The Quality Assurance Division within the central office of DCYS shall be responsible for the unit's operations.

The audit function would be an independent examination of cases by a staff trained to assess the manner in which cases have been handled. The cases should be audited on a regular basis, chosen randomly from the regions throughout the state. Also, specific cases could be referred to the audit unit at the discretion of the commissioner of DCYS.

In addition, the program review committee found broad variations in the way that cases are managed from region to region. The absence of uniform standards is the major reason for this variation. The department is not fully aware of the difference in the length of time cases have remained open, the percentage of cases that are transferred from intake to treatment, worker case load, and the percentage of cases that are reopened from office to office.

To ensure more equitable treatment between regional offices, the Legislative Program Review and Investigations Committee recommends that the department develop standards for regional performance. At a minimum, these standards should address the

appropriate case load for social workers, and under what circumstances a case should be opened, closed, and reopened. (Case load will be addressed further in a separate recommendation).

The program review committee found that there is no follow-up by quality assurance staff to make sure recommendations have been implemented until the next administrative review is done six months later. Without such a reporting mechanism, it is feasible that a child could "fall through the cracks" and linger in an inappropriate placement indefinitely.

The Legislation Program Review and Investigations Committee recommends that the Quality Assurance Division issue monthly reports listing any recommendations that arose as a result of the administrative case reviews or investigations of out-of-home abuse. Each region should report back to the division once the recommendation has been implemented. The division shall maintain a record that includes the child's name, the region in which the review or investigation occurred, and the recommendations and date issued, on a monthly basis until the region has implemented the recommendation.

Although the committee believe that the place for resolution of problems should remain at the regional level, this recommendation provides a mechanism that allows feedback to quality assurance. Reports produced by the quality assurance division fail to follow-up on recommendations made as a result of the administrative case review and therefore, it is possible that implementation never occurs. This recommendation ensures regions are held accountable by allowing the division to track individual problems and ensure their correction. In addition, specific case outcomes can be measured at the next case review.

Training division. The Staff Development and Training Unit is currently located within the Child Protective Services Division. The program review committee found that training is not a top priority of the department and, as the survey indicated, the majority of managers and direct service workers evaluated the training provided by the department as inadequate. In addition, the committee found that although the overwhelming majority of social workers do not hold advanced degrees in social work, continuing education is sporadic. Furthermore, social worker trainees, many who have no educational background in social work, can actually be assigned a case load prior to receiving any department training. Several recommendations concerning training are made in the next section. To implement these recommendations program review committee staff believes that the department needs to give training a high priority.

The Legislative Program Review and Investigations Committee recommends the department create a Staff Development and Training Division. This division shall be responsible for assessing

training needs, and providing and coordinating all training requirements.

Staff Development and Training. Successful case resolutions are dependent to a large extent on the ability and resources of the social worker. Half the cases reviewed in the program review committee's sample involved intervention by only the social worker. No outside programs were used and, in all of the cases staff reviewed, it was evident that the social worker's case management skills are crucial. Child abuse and neglect cases are difficult, but the probability of success is greatly enhanced by a well-trained social worker.

The Legislative Program Review and Investigations Committee found that an educational background in social work is not required by the department for a social worker trainee position. As a result, 83 percent of all child protection service social workers have no formal educational background in social work; 86 percent of all child protection service trainees have a bachelor's degree with no social work credentials.

The department's mandatory training for new social workers is not a pre-service program. Given this fact, program review staff found that new social workers, the majority without backgrounds in social work, may be handling cases without any prior training. In addition, the department requires only 20 days of mandatory training. Any additional in-service training is voluntary.

The results of program review's DCYS employee survey indicates the majority of the respondents believe that training provided by the department is inadequate or poor. The department has not conducted a formal evaluation of the current training program nor a needs assessment for statewide training.

The Legislative Program Review and Investigations Committee, therefore, recommends that no social worker trainee be assigned a case load prior to completing 20 days of structured training.

In addition, the department should expand its current training requirement to include an additional 20 days of in-service training to be completed within the first two years of employment.

All child protective service social workers shall, within the first 10 years of employment, obtain a master's degree in social work or closely related academic field. The department shall provide 100 percent reimbursement for the cost of tuition. The social worker's educational program requires approval by the commissioner. The 10 year requirement shall begin on the hire date or the date upon passage of the legislation, which ever comes later. At the completion of the masters of social work degree, the social worker shall remain employed by DCYS for a period of 2 years, at the option of the department.

The department shall recruit applicants for the social worker position who possess a bachelor or masters' degree in social work or a closely related field, as determined by the commissioner.

In an effort to reduce staff turnover and caseworker "burn-out", the department shall develop a program that allows social workers to obtain the necessary skills to become trainers. As trainers, the workers would be allowed a temporary respite from managing cases while providing the department with an important resource needed to fulfill these new training mandates.

The newly created Staff Development and Training Division should conduct a formal evaluation of the current training curriculum and an assessment of training needs of the department's social workers. The results of the evaluation and needs assessment should be reported to the management team.

These new training requirements shall become effective January 1, 1992.

Child protective service workers carry many responsibilities requiring special skills. These responsibilities would be best fulfilled by staff who have social work education.

#### Case Management and Evaluations

Case loads. Even the best trained worker would find it difficult to achieve better case management when faced with too many clients. Understanding the client, investigating a referral, proposing treatment, visiting children and families, and following up on client activities are time consuming. To meet performance standards, such as investigating cases within a limited number of days, reducing the number of cases that are reopened, and preventing expensive residential and emergency placements, workers simply need the time to devote to case management and intervention. This can only be achieved by reducing the amount of time a worker must spend on paperwork and reducing the worker's case load.

The Legislative Program Review and Investigations Committee recommends that the department should, as a department-wide goal, limit workers to 25 ongoing cases at any point in time. It is also recommended that social worker trainees be limited to a case load that is, on average, half that of the permanent social worker. Funds shall be provided in the budget to achieve this goal by July 1, 1994.

The program review committee developed a model to estimate the number of workers needed given a constant case load size. To achieve the recommended goal, the department would need to increase staff resources according to the numbers presented in Table VII-1 on the next page. As was noted earlier, an estimate of the current

case load-to-worker ratio lies somewhere between the measure of cases served and cases open at the end of given month. The model also accounts for the recommendation that trainees be limited to a workload that is 50 percent of the social worker's average case load.

Table VII-1. Caseload Ratios for DCYS Offices: July '89 to July '90.					
Office	Cases Served <sup>1</sup>	Cases Opened <sup>2</sup>	Case Ratio Goal	Served: Workers Needed	Opened: Workers Needed
Hartford	41	38	25	37	31
New Britain	40	38	25	16	14
Hamden	40	36	25	32	24
Meriden	40	33	25	6	4
Danbury	39	35	25	8	7
Rockville	38	33	25	14	9
Stamford	33	28	25	4	2
Norwich	32	28	25	15	8
Willimantic	29	26	25	4	2
Waterbury	27	24	25	2	0
Bridgeport	26	22	25	5	-1
Middletown	23	20	25	-1	-3
Torrington	21	18	25	-2	-3
Average	34	30	25	136	91
<p>1 Cases Served are all cases that are part of the DCYS caseload even if they were closed before the end of the month.</p> <p>2 Cases Open are only cases that are open on the last day of the month.</p>					

The table gives a range of 91 to 136 social workers needed to reduce the case load to 25. Given a three-year phase-in, it is estimated that one-third of the social workers would be hired in each year. Program review reported earlier that the supervisor to

social worker ratio was one to five. If the supervisor-to-worker ratio was raised to one to seven, then the program review committee estimates that there would be a need for between 68 and 75 supervisors. There are currently 73 supervisors and, therefore, no additional supervisory staff would be required.

**Case management and evaluation.** The Legislative Program Review and Investigations Committee found a number of deficiencies in the management of cases. As noted earlier, the problems of case management are evident in the differences that were found in regional operations. They were also evident in the amount of duplicative paper work that the committee found in reviewing files as well as the lack of information on program usage, out-of-home placement, and case tracking. There is no evaluation of cases within the regions, or state wide, as to what is effective in treating abuse and neglect. There is also no understanding of whether cases are handled in similar ways or if outcomes differ based upon interventions undertaken.

The Department of Children and Youth Services needs to develop a comprehensive system for managing cases and evaluating client outcomes. Coupled with a reduction in case load, a new case management system would greatly improve the operations of the child protective services and allow the social worker more time to spend on intervention.

**The Legislative Program Review and Investigations Committee recommends that the Department of Children and Youth Services; 1) revamp its current case management system and replace it with an on-line computer system with 24-hour access; and 2) design a process for evaluating the effectiveness of client interventions.**

This recommendation involves two separate but closely related activities. First, the department needs to assess the inadequacies of its current computerized information system. Some of those inadequacies have been documented in this report. It must then design a comprehensive client information system that captures the appropriate personal and demographic information as well as a complete history of case events such as:

- risk assessment decisions;
- referrals and investigations;
- interviews and narratives;
- abuse and neglect confirmations;
- family relationships;
- out-of-home placement decisions; and

- treatment plans and goals.

It is estimated that the new computer system can become operational within two years.

The second area to be addressed deals with the evaluation of case and client outcomes. The system should allow the social workers to access resources needed for case intervention, given the case profile. In other words, the client information system must be linked with two other important sources of information, foster care availability and community program resources.

The system should also be able to produce performance reports vital to the effective operations of child protective services. For example, the department should be able to monitor how long investigations are taking, what services are most in demand, or the current social worker case load.

The benefits of a comprehensive client information system are needed to improve case management operations. Social workers need on-line access to case information to make informed decisions regarding critical areas based on timely, accurate and complete client details. Workers' time can be more effectively used in monitoring and treating clients rather than having to keep up with unnecessary paperwork that results in the duplicative information being processed. The key benefit is that cases of child abuse and neglect can be responded to quickly and with the best information on file.

**The Legislative Program Review and Investigations Committee recommends that the newly created Program Development and Evaluation Division design and implement a case evaluation system that measures client outcomes throughout the case history to better determine the progress being made by the social worker.**

Service effectiveness can only be achieved through the systematic evaluation of case outcomes resulting from social worker interventions. There is currently no measurement of the protective services program's success other than that of the so-called "case-goal achieved" criteria which is only minimally related to a successful outcome of an abuse and neglect case. Currently one-third of the cases closed between 1987 and 1990 were cases that had been previously opened. While this does not necessarily mean that interventions in these cases failed, there is no examination by the department as to what interventions would more likely result in a case not being reopened.

## Programs: Evaluations and Grant Process

The Child Protection Division of the American Humane Association has stated that, "treatment in child protective services is the weakest link in the case work process". This is a startling conclusion because, without treatment, the mission and goal of a child protective service organization can not be accomplished. Therefore, the effective management and funding of community service treatment programs should be of the highest priority for both the regions and central office of DCYS.

DCYS relies on, and funds more than, 350 community service programs state-wide to provide treatment to abused and neglected children and their families. The system currently in place to develop, fund, utilize, and evaluate these programs is not sufficient given the enormous responsibility DCYS has placed on the social workers and programs. DCYS does not assist in bringing the two most vital components of protective services, the social worker and treatment programs, together. The department needs to improve the working relationship between the social worker and community service programs and needs to ensure that it is resulting in the most effective treatment of children and families.

The Legislative Program Review and Investigations Committee found that DCYS is deficient in administering and funding community programs in the following areas:

- current evaluations done by DCYS are simply an inventory of the programs' policies and practices , and there are no measures of case outcome or effectiveness of treatment;
- there is no link between the grant process and the program monitoring inventories;
- DCYS has no authority to impose sanctions against community service programs that are not in compliance with standards or are consistently inadequate in providing treatment;
- DCYS does not collect performance data from the community service programs in a consistent and uniform process, nor does it utilize social workers as an information resource regarding the programs; and

- DCYS does not provide a resource directory of community service programs as a tool for its social workers.

Therefore, Legislative Program Review and Investigations Committee recommends that the Department of Children and Youth Services design a grants processing system that funds community service programs proportionate to their success in treating clients, and be allowed to impose a reduction in funds against those programs found to be ineffective.

This sanction would require that funding be phased out over a three-year probationary period. During the first year a program is on probation, it will receive 75 percent of the total grant expenditures from the previous fiscal year. If the program fails to satisfactorily comply with the department's recommendations for improving service, funding will be decreased to 50 percent during the second year. Funding will cease at the end of the third year if the program is unable to comply with the departments requirements.

The success of the program will be measured based on the following:

- evaluating a program's effectiveness in treating clients, including analysis of case outcomes;
- assessing the regions' needs for treatment services;
- rating of the programs by protective services social workers; and
- analyzing performance data consistently and uniformly collected from each program, including availability to DCYS clients.

The committee further recommends that the newly created Program Development and Evaluation Division collect, maintain, analyze, and provide the evaluation data to be used in the grants process. This recommendation shall apply to all grants made in fiscal year 1991-92 and the evaluation and resulting sanctions would take effect in fiscal year 1992-93.

Grants process. In addition to reviewing the grant applications submitted annually by the community programs, the recommended grants process requires that every department-funded program be evaluated by the Division of Program Development and Evaluation.

The division will evaluate the program based on standards and guidelines that it develops.

The division should produce a report that includes analysis of the data, findings, and recommendations based on the areas of evaluation. The division shall determine if the program is successful and operating within the standards previously set by the division. The programs receiving a favorable report from the division of program development and evaluation will proceed through the grants process procedure and appropriate funding will be awarded. Those programs that the division rates as failing to perform will be placed on a probationary status.

The probationary status automatically puts the program in a three year evaluation cycle that could eventually result in no funding by DCYS. During the first year a program is on probation, it will receive 75 percent of the total grant expenditures from the previous fiscal year. The program will be required to implement all recommendations made by the division of program development and evaluation and the DCYS director of the region in which the program operates.

The program will be evaluated during its probationary year to determine its compliance with DCYS recommendations. Again, the program will either receive a pass or fail rating from the division. If the program passes, funding will be reinstated. However, if the program fails, funding will be decreased to 50 percent.

During the third evaluation of a probationary program, the division must review the program with a specific focus, in that, a determination is made as to whether or not the program can be brought into compliance as well as a region's need for the program as a treatment resource is assessed. The division may determine there is a need for such a treatment resource, however, the particular program under evaluation may not be the one to provide that service. If the program again receives a poor rating from the division then funding ends after the third year.

Regions and social workers will be informed of all programs placed on probationary status. This provides the social workers with information that the program is not currently successful in treating clients and may ultimately be discontinued as a DCYS-funded resource. The social workers would then have the option to refrain from referring clients until the probationary status is lifted or to make other arrangements for those clients currently within the program.

**Program evaluation.** The program review committee found that social workers are an untapped resource in the evaluation of community service programs. Social workers, through their use of the programs in treating DCYS clients, know which are successful,

the type of services each offers, and have identified which accommodate DCYS clients. They can distinguish between those that provide useful and necessary services and those that do not.

**As part of the evaluation process conducted by the Program Development and Evaluation Division, the Legislative Program Review and Investigations Committee recommends that the protective services social workers and their supervisors be routinely surveyed regarding their opinions of the operations of community programs, and asked to rate the effectiveness of each program according to predetermined standards and performance measures.**

The benefit of this survey is two-fold. First, it would provide the division with practical information and first-hand knowledge of the actual working relationship between DCYS and community programs. It would allow DCYS to identify those programs that are actually used and those that, while receiving funding, are not used by social workers. In addition, the social workers can relate why they do not use some of the programs.

Secondly, the survey would allow DCYS to refocus its attention on the social workers. The alliance between the department and its workers should be strengthened, and making the social workers part of the process of determining what community programs are funded would begin to develop the relationship. This would give the social workers a voice in determining which resources and tools they have available to them in treating children and families.

Another area that DCYS must reinvest some of its resources toward the social workers is in the creation of a directory of community service programs. **The Legislative Program Review and Investigations Committee further recommends that the Program Development and Evaluation Division, in conjunction with other divisions of DCYS, develop and maintain a computerized data base listing all available community service programs. The data base would provide information on the following:**

- a listing by region of all DCYS-funded community service programs;
- a description of the program's operation and the treatment services it provides;
- the name of the program's contact person (DCYS liaison), address, and telephone number;
- the cost per client;

- an updated availability assessment (how many DCYS clients the program can accommodate);
- brief outline of the program's evaluation rating from the division and what areas the program is most successful in treating; and
- identify those programs which have been placed on probation by the grants process, and the level of funding they are receiving from DCYS.

The data base would be developed and maintained by the division of program development and evaluation and the department's management information system (computer division), the division of protective services, and its regional directors. Also, as discussed in the training recommendation section, social workers on respite can be assigned to compile and update the database.

The community program database would also assist in providing better treatment to DCYS clients, in that, the social workers would have one resource tool to use in locating program options to treat clients. All current programs and necessary information would be readily available to social workers. In fact some of the time previously spent networking or simply locating an appropriate outside program could now be spent more effectively managing cases.

Programs have been funded for many years and are continually funded because they have been considered to be the mainstay of social service treatment. DCYS has not required that a program document its success at providing treatment nor has it reviewed the continued need for certain types of programs. The department does not even monitor to ensure programs are accommodating DCYS clients. It is simply not enough to operate within established guidelines, a program should demonstrate measurable success for funding to continue.

A more responsive network of community service programs will result in the following:

- more cases referred and accepted for treatment;
- improved treatment services;
- an increase in the number of programs providing treatment per case;

- a decrease in the length of time a case remains open and the number of cases subsequently re-opened;
- easier case management for social workers; and
- fewer children removed from their homes.

The recommended grants process would redirect the efforts of the department into funding successful programs. The new process would ensure that the resources of DCYS are distributed in proportion to the needs of the regions and clients being served.

# **APPENDICES**

**APPENDIX A  
EMPLOYEE SURVEY RESULTS**

As part of the review of DCYS, program review committee staff conducted a survey of the entire DCYS work force. Employee views on department performance in such areas as department management, policies, communication, and resources were solicited. Of particular interest to committee staff were responses from central and regional office managers and direct service workers.

DCYS staff in all six regions and DCYS-operated institutions, as well as central office employees, were surveyed. Surveys were distributed to a total of 1,822 employees. Completed questionnaires were submitted by 636 employees, for a response rate of 35 percent.

Table A-1 gives the rate of response for each work location by comparing the number of employees who answered the survey to the total number of employees at each location. DCYS-operated institutions had the lowest response rate at only 19 percent and, because of the poor response, will be excluded from the rest of the analysis. When institutions are eliminated from the analysis, the response rate, as depicted in the subtotal in Table A-1, increases significantly. The remaining analyses will focus on the central office of DCYS and it's regions.

Table A-1. Response Rate by Work Location.			
Location	# Employees Responding to Survey	Total Employees	Response Rate
Regions	339	636	53%
Central Office	109	232	47%
SUBTOTAL	448	868	52%
Institutions	188	1,005	19%
TOTAL	636	1,822	35%

The table above includes 77 survey responses that failed to identify the employment location, however program review committee staff apportioned these responses at a rate consistent with the return rate from each location. As shown in table A-1, the regional response rate was 53 percent, slightly higher than the

central office, for a total response rate from these locations of 52 percent.

Program review committee staff also examined the response rate from central office or regional managers and direct service workers. Table A-2 shows the number of respondents who identified themselves as either central office or regional managers and direct service staff, as well as the total number of managerial or direct service employees at those locations. Among the 636 surveys received by program review staff, a total of 45 respondents failed to identify their function within the department. These responses were also apportioned consistent with the return rate by each function.

As the table depicts, 224 surveys were received from direct service workers out of a total of 507 direct service workers employed in the central office and the six regions. The rate of response from this group was 44 percent. Managers accounted for a response rate in excess of 62 percent, with 76 out of a total of 123 central and regional office managers responding.

Table A-2. Response Rate by Function.		
*As of 7/31/90	Direct Service Employees	Managers
# of Survey Respondents	224	76
Total # of Employees	507	123
Response Rate	44%	62%

Program review committee staff compared the survey responses of managers in the central office and six regions to direct service worker's views on department operations. Committee staff found that in most areas responses were similar, and indeed, often the manager's were more negative on how the management team, central office and the regions were performing than the social workers. Overall, responses were positive when evaluating unit performance and gradually became more negative when evaluating the central office and management team. Program review staff collapsed responses of excellent, good, and fair into a positive rating and considered poor to be a negative rating for analytical purposes.

Direct service workers were asked to rate the management team, the primary policy-making body in DCYS, in communicating information necessary to achieve the agency's goals and objectives. As

noted earlier in this report, the team received a particularly poor rating in the area of communication, with 63 percent responding unfavorably. Similarly, even a higher percentage -- a full 80 percent -- of central and regional office managers negatively evaluated the management team in communicating information.

Employees also were asked to evaluate how well the central office, the region and the unit where the employee worked communicated information. Table A-3 shows 85 percent of direct service workers and 79 percent of managers positively rated communications within their units.

Table A-3. Rating of Communication by Location										
Location	Managers					Direct Service				
	1	2	3	4	5	1	2	3	4	5
Central Office	1%	9%	24%	62%	4%	0%	9%	28%	55%	8%
Region	2%	26%	43%	13%	15%	4%	28%	33%	33%	3%
Unit	13%	44%	22%	19%	2%	14%	42%	29%	13%	2%
1=Excellent    2=Good    3=Fair    4=Poor    5=Don't Know										

Although the majority of both direct service workers and managers felt that the central office did a good job at establishing statewide goals and objectives, 45 percent of direct service workers and 51 percent of managers felt that the central office did poorly in achieving the goals established. Ratings were much higher on the regional level -- only 25 percent of direct service workers and 13 percent of managers thought that the regions were not achieving the goals it had established. At the unit level only 12 percent of direct service and 6 percent of managers believed that the unit's were not achieving set goals.

Table A-4 shows how direct service workers rated the central office in identifying and meeting client needs. Over 50 percent of these employees thought that the central office was performing poorly in meeting clients needs compared to 44 percent of the managers. However, at the regional level, 71 percent of the direct service workers responded positively, and 70 percent of the managers.

Table A-4. Identifying and Meeting Clients Needs.										
Location	Managers					Direct Service				
	1	2	3	4	5	1	2	3	4	5
Central Office	3%	7%	38%	44%	9%	1%	8%	32%	52%	8%
Region	4%	40%	26%	17%	13%	6%	28%	37%	26%	3%
Unit	16%	34%	33%	9%	8%	20%	39%	26%	15%	1%
1=Excellent 2=Good 3=Fair 4=Poor 5=Don't Know										

The ratings given for the adequacy of resources by both managers and direct service workers is shown in Table A-5. As presented, 66 percent of direct service workers judged the department's resources to be inadequate compared to 69 percent of the managers.

Table A-5. Adequacy of Resources.		
Employees	Positive Response	Negative Response
Managers	31%	69%
Direct Service	34%	66%

Survey respondents were also asked to evaluate the overall training provided by DCYS. Table A-6 shows both managers and direct service workers response. Managers overwhelmingly rated the training given by the department as poor, while the majority of direct service workers rated the training as either fair (39 percent) or poor (35 percent).

Table A-6. Adequacy of Training.				
	1	2	3	4
Managers	1%	16%	21%	61%
Direct Service	5%	21%	39%	35%
1=Excellent 2=Good 3=Fair 4=Poor				

In summary, program review committee staff found that the management team and central office received the most negative

responses from managers and direct service workers. One area -- communication -- fared particularly poor in the survey responses. As department employees were asked to rate their region or unit the replies were more positive. For example, managers and direct service workers were similar in their negative responses toward the Management Team's ability to communicate, but were overwhelmingly positive in evaluating their units' abilities to communicate. The same trend in responses were shown in evaluating the various offices in achieving established goals. In general, the responses to the survey indicate that there is a consensus among both managers and direct service workers that the department is resource-poor and training is inadequate.

SURVEY OF DEPARTMENT OF CHILDREN AND YOUTH SERVICES PERSONNEL

Below are the complete survey responses from managers and direct service workers who are employed in either the central or regional offices.

- 1) In your opinion, how well does DCYS's **Management Team** plan, coordinate, and communicate to achieve the agency's goals and objectives?

PLAN

	Excellent   1	2	Adequate   3	4	Poor   5	Don't Know 6
MGR	4%	10%	20%	20%	31%	16%
DS	5%	13%	25%	19%	23%	16%

COORDINATE

	Excellent   1	2	Adequate   3	4	Poor   5	Don't Know 6
MGR	0%	10%	13%	27%	41%	9%
DS	2%	10%	24%	26%	25%	12%

COMMUNICATE

	Excellent   1	2	Adequate   3	4	Poor   5	Don't Know 6
MGR	0%	4%	13%	24%	56%	3%
DS	3%	9%	18%	27%	36%	7%

2) How would you rate the central office in:

Excellent    Good    Fair    Poor    Don't Know

	FUNCTION	1	2	3	4	5
Establishing state-wide goals and objectives for the agency	MGR	1%	28%	31%	32%	7%
	DS	3%	21%	34%	33%	9%
Achieving its goals and objectives	MGR	0%	11%	30%	51%	9%
	DS	1%	10%	31%	45%	14%
Planning activities	MGR	3%	11%	30%	42%	14%
	DS	1%	11%	29%	45%	15%
Coordinating activities	MGR	0%	7%	27%	59%	7%
	DS	1%	8%	28%	49%	15%
Setting standards for performance	MGR	1%	11%	32%	47%	9%
	DS	1%	18%	28%	46%	7%
Responding to unusual work demands	MGR	4%	13%	24%	54%	6%
	DS	2%	6%	22%	57%	15%
Identifying and meeting clients needs	MGR	3%	7%	38%	44%	9%
	DS	1%	8%	32%	52%	8%
Communicating information you need to do your job well	MGR	1%	9%	24%	62%	4%
	DS	0%	9%	28%	55%	8%

3) How would you rate your regional office/facility in:

	FUNCTION	1	2	3	4	5
Establishing goals and objectives	MGR	4%	49%	19%	13%	15%
	DS	5%	41%	32%	16%	6%
Achieving its goals and objectives	MGR	0%	36%	36%	13%	15%
	DS	3%	29%	38%	25%	7%
Planning activities	MGR	4%	42%	21%	17%	15%
	DS	7%	27%	37%	25%	5%
Coordinating activities	MGR	4%	40%	28%	13%	15%
	DS	5%	28%	36%	28%	4%
Setting standards for performance	MGR	2%	40%	30%	11%	17%
	DS	5%	30%	30%	32%	4%
Responding to unusual work demands	MGR	10%	33%	27%	15%	15%
	DS	10%	23%	28%	37%	4%
Identifying and meeting clients needs	MGR	4%	40%	26%	17%	13%
	DS	6%	28%	37%	26%	3%
Communicating information you need to do your job well	MGR	2%	26%	43%	13%	15%
	DS	4%	28%	33%	33%	3%

4) How would you rate your division/unit's success in:

Excellent      Good      Fair      Poor      Don't Know

	FUNCTION	1	2	3	4	5
Achieving its goals and objectives	MGR	19%	41%	33%	6%	1%
	DS	14%	48%	26%	12%	1%
Coordinating and planning activities	MGR	13%	50%	25%	10%	2%
	DS	15%	42%	31%	12%	1%
Setting standards for performance	MGR	12%	26%	29%	12%	1%
	DS	17%	41%	27%	15%	1%
Responding to unusual work demands	MGR	30%	38%	19%	12%	1%
	DS	29%	30%	22%	17%	2%
Identifying and meeting clients needs	MGR	16%	34%	33%	9%	8%
	DS	19%	39%	26%	15%	1%
Communicating information you need to do your job well	MGR	13%	44%	22%	19%	2%
	DS	14%	42%	29%	13%	2%

5) How well is your division/unit staffed to perform the functions it is assigned?

Excellent      Good      Adequate      Inadequate      Poor

FUNCTION	1	2	3	4	5
MANAGER	4%	13%	14%	56%	13%
DIRECT SERVICE	5%	17%	21%	35%	22%

6) How would you describe the resources you have to work with?

Excellent      Good      Adequate      Inadequate      Poor

FUNCTION	1	2	3	4	5
MANAGER	1%	14%	16%	55%	14%
DIRECT SERVICE	1%	10%	23%	42%	24%

7) Overall, how would you characterize the morale within your division/unit?

	Excellent	Good	Adequate	Inadequate	Poor
FUNCTION	1	2	3	4	5
MANAGER	4%	21%	25%	14%	35%
DIRECT SERVICE	5%	24%	25%	20%	25%

8) Do you believe DCYS' current policies relating to Risk Assessment are:

FUNCTION	CLEAR	SOMEWHAT CLEAR	NOT CLEAR	NO INVOLVE-MENT
MANAGERS	31%	29%	13%	27%
DIRECT SERVICE	22%	53%	19%	7%

Do you believe DCYS' current procedures relating to Risk Assessment are:

FUNCTION	CLEAR	SOMEWHAT CLEAR	NOT CLEAR	NO INVOLVE-MENT
MANAGERS	27%	30%	18%	25%
DIRECT SERVICE	20%	46%	24%	10%

9) How would you rate DCYS's Risk Assessment policy for protecting a child's welfare?

FUNCTION	EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE	NO INVOLVE-MENT
MANAGERS	18%	38%	15%	29%
DIRECT SERVICE	10%	54%	31%	5%

10) Please use the scale below to rate the training provided by DCYS for your job.

FUNCTION	Excellent	Good	Fair	Poor
MANAGERS	1%	16%	21%	61%
DIRECT SERVICE	5%	21%	39%	35%

11) How would you rate the services directly provided by your office to children and families:

FUNCTION	Excellent	Good	Fair	Poor	Not Applicable
MANAGERS	6%	35%	23%	7%	30%
DIRECT SERVICE	7%	45%	37%	10%	1%

12) Overall, how would you rate the services provided to clients by agencies under contract to DCYS:

FUNCTION	Excellent	Good	Fair	Poor	Don't Know
MANAGERS	1%	30%	45%	4%	20%
DIRECT SERVICE	0%	30%	48%	17%	5%



APPENDIX B

DCYS-FUNDED PROGRAMS MATRIX: LEVELS I, II, III, IV BY REGIONS I, II, III.

	REGION I	REGION II	REGION III
LEVEL I	YOUTH AND COMMUNITY	DEVELOPMENT SERVICES	
Parent Ed. and Support Centers	Save the Children Stratford Community Services New Futures-Univ. of Bridgeport	Catholic Family Services Hamden Mental Health Services (Town of Hamden)	Community Health Center Old Saybrook Youth & Family Services
School-Home Liaison Center Projects	Catholic Family & Social Services of the Diocese of Bridgeport Norwalk Board of Ed. Unv. of Bridgeport	Community Consultation Board Farnam Neighborhood House	
Early Childhood Programs			
Youth Drug & Alcohol Abuse Prevention	Southfield Village		Child Guidance clinic of Southeastern Ct. Lyme Youth Services
Student Drug & Alcohol Abuse Prevention	Norwalk Dept. of Youth Services	Child Guidance Clinic of Central Ct. Community Consultation Board Lower Naugatuck Valley Council on Alcohol & Drug Abuse	

42

Drug Free Schools & Communities (Federal)	Norwalk Coalition for Children and Youth Southfield Community Organization	Clifford Beers Guidance Clinic West Haven Community House	YMCA of SE Ct. Child Guidance Clinic of SE Ct.
Prevention Neighborhood Project		City of New Haven	
New Haven Youth Program		City of New Haven	
<b>LEVEL II</b>	<b>SUPPORT SERVICES</b>		
		<b>COMMUNITY CHILD PROTECTIVE</b>	<b>SERVICES</b>
Intensive Family Preservation	Hall Neighborhood House	Milford Mental Health Clinic Yale Child Studies center	Child & Family Agency of SE Ct.
Parent Aide	Child Guidance Greater Bridgeport Family & Children's Services of Stamford Greater Norwalk Coalition	Child Guidance Central Ct. Coordination Council for Children in Crisis Lower Naugatuck Valley Parent -Children Resource Center	Community Health Center Family Services Assoc. Serving New London County
Child Protection Team	Greater Nowalk Coalition Stamford Hospital YWCA of Greater Bolton	Child Guidance of Central Ct. Coordination Council for Children in Crisis	Middlesex Memorial Hospital Lawrence Memorial Hospital
Therapeutic Child Care	ABCD Hall Neighborhood House	Community Consultation Board New Haven Public School St. Francis Home for Children	SE Ct. Child Protection Council

Stress Management				
Family Violence	YWCA of Greater Bridgeport Inc.	Coordinating Council for Children Crisis, Inc.	Child & Family Agency of SE Ct., Inc.	
Perinatal	Stamford Hospital			
Parent Education				
Clinical Intervention		Clifford Beers Child Guidance		
		<b>COMMUNITY CHILD PSYCHIA</b>	<b>TRIC SERVICES</b>	
Child Guidance Clinics	Bridgeport Norwalk Stamford	Clifford Beers Hamden Hill Health Meriden Milford Valley PCRC West Haven Yale	Middletown New London (C & F) New London (CGC) Norwich	
Emergency Psychiatric Services	Bridgeport Mid-Fairfield (Norwalk) Stamford	Acute/CPES	Lawrence Memorial Hospital	
		<b>COMMUNITY LIVING</b>		
Juvenile Criminal Diversion				
Health & Community Services		City of New Haven		

Youth At Risk	Bridgeport Youth At Risk, Inc.	New Haven Youth At Risk, Inc.	
Aftercare for Children		Children's Center, Inc.	
Independent Living	Domus Foundation Hall Neighborhood	Family Services Assoc. of Central Ct. St. Francis Home	Northern Middlesex YMCA Thames Valley Council For Community Action
		<b>YOUTH SERVICE BUREAUS</b>	
Youth Service Bureaus	Bridgeport Darien Fairfield New Canaan Norwalk Stamford Stratford Trumbull Weston Westport	Branford Cheshire East Haven Guilford Hamden Madison Meriden Milford New Haven North haven Orange Shelton Wallingford West Haven	Colchester Cromwell East Haddam (new bureau) East Hampton East Lyme Essex Groton Ledyard Middletown Montville New London Norwich Old Lyme Old Saybrook Portland Stonington
<b>LEVEL III</b>	<b>SUPPLEMENTARY SERVICES</b>		
Day Treatment	Stamford Board of Ed. Vitam	Boys Village Children's Center Curtis Home Highland Heights	Community Health Center Connecticut College Rushford

LEVEL IV	SUBSTITUTE SERVICES		
Residential Treatment	Quaezar Vitam Center University Residential Facility Maryglenn	APT Foundation Boys Village Children's Center Curtis Home Highland Heights Grove School Greenshire School	Children's Home Founders School Mt. St. John Waterford Co. Sch. RFD 1 Lake Grove-Durham
Group Homes	Aequus House Domus Foundation Mohonk House Project Return University Residential Facility Hall Neighborhood House	Youth Continuum/TRI-RYC	Noank Baptist Grp. Home N.E. Adolescent Trmt.Ctr. Thames House TVCCA
Emergency Shelters	Janus house Youth Shelter	Douglas House Northern Middlesex YMCA	
Alcohol & Drug Treatment	Vitam Center	Children's Center	
Community Services			
Transitional Living			
Maternity Homes	Mary Glenn		
Residential EducationalProgram		Grove School	

Temporary Shelters	Greenwich Youth Shelter Janus House Council of Churches	Douglas House Youth Continuum/TRI-RYC	No. Middlesex YMCA
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DCYS-FUNDED PROGRAMS MATRIX: LEVELS I, II, III, IV BY REGIONS IV, V, VI.

	REGION IV	REGION V	REGION VI
LEVEL I	YOUTH AND COMMUNITY	DEVELOPMENT SERVICES	
Parent Ed. and Support Centers	Family Services, Inc. Town of Canton Town of Windsor	McCall Foundation Waterbury Youth Services	
School-Home Liaison Center Projects	Catholic Charities/Family Services Child & Family Services Hispanic Health Council Town of Wethersfield	Danbury Board of Ed.	
Early childhood Programs	CREC	Easter Seals	East Conn
Youth Drug & Alcohol Abuse Prevention	Artist Collective Hispanic Health Council	McCall Foundation Waterbury Youth Services	Windham Youth Services Bureau United Social & Mental Health
Student Drug & Alcohol Abuse Prevention	Hispanic Health Council	Danbury Youth Services	New Directions Quinebaug Valley Youth Services

Drug Free Schools & Communities (Federal)	Touch of Granby Town of Simsbury Public Schools Suffield Board of Ed Urban League of Greater Hartford	New Opportunities for Waterbury United Way of North Fairfield County	Quinebaug Valley Youth Services No. Central Ct. Mental Health System, Inc. New Hope Manor Windham Heights
Prevention Neighborhood Project			
New Haven Youth Program			
<b>LEVEL II</b>	<b>SUPPORT SERVICES</b>	<b>COMMUNITY CHILD</b>	<b>PROTECTIVE SERVICES</b>
Intensive Family Preservation	Klingberg Family Centers	New Opportunities for Waterbury, Inc.	Quinebaug Valley Youth Services Bureau
Parent Aide	Bristol Hospital City of Hartford Health Dept. Hispanic Health Council St. Francis Hospital & Medical Center VNA Home Care of New Britain	Danbury Reg. Comm. on Child Care, Rights, Abuse Housatonic Center for Mental Health St. Mary's Hospital	Exchange Clubs Center of Rockville No. Central Coalition for Children Quinebaug Valley Youth Services Bureau United Services

Child Protection Team	Central Ct. Community Mental Health Affiliates New Britain General Hospital UCONN Health Center	Danbury Reg. Comm. on Child Care, Rights, Abuse Torrington Area Youth Services Breau	Exchange Clubs Center of Rockville No. Central Coalition for children Town of South Windsor United Services
Therapeutic Child Care	YWCA of the Hartford Region YWCA of New Britain	Family Services Assoc. of Waterbury	
Stress Management			Exchange Clubs Center of Rockville
Family Violence	Catholic charities/Catholic Family Services	Family Services Assoc. of Watertown, Inc.	Hockanum Valley Community Council, Inc. United Services, Inc.
Perinatal			
Parent Education	Manchester Memorial Hospital		
Clinical Intervention	Catholic Family Services/ Catholic Charities		East Hartford Youth Services Bureau
		<b>COMMUNITY CHILD PSYCHIA</b>	<b>TRIC SERVICES</b>
Child Guidance Clinics	C & F S Institute for the Hispanic Family Institute of Living New Britain Wheeler Clinic	Charlotte Hungerford Hospital Danbury Housatonic Waterbury	Enfield Manchester U.S.M.H.S.

Emergency Psychiatric Services	Hartford Hospital	Charlotte Hungerford Danbury Hospital	
		<b>COMMUNITY LIVING</b>	
Juvenile Criminal Diversion	City of Hartford Conn. Jr. Republic		
Health & Community Services			
Youth At Risk			
Aftercare for Children	Shelter for Women, Inc.		
Independent Living	Hartford Youth Service Bureau New Britain Youth Service Bureau	Danbury Youth Service Bureau LISA Inc. Torrington Youth Service Bureau	Educational Resources Inc.
		<b>YOUTH SERVICE BUREAUS</b>	
Youth Service Bureaus	Berlin Bloomfield Bristol Hartford New Britain Newington Plainville Rocky Hill Southington West Hartford Wethersfield Windsor	Danbury Naugatuck New Milford Newtown Ridgefield Southbury Torrington Waterbury Winchester	Coventry East Hartford Enfield Glastonbury Hebron Manchester Mansfield South Windsor Stafford Thompson Tolland Windham

<b>LEVEL III</b>	<b>SUPPLEMENTARY SERVICES</b>			
Day Treatment	Child & Family Services CREC Extended Day CREC- PIP Hartford Substance Abuse Institute for Living	Danbury Hospital	EastConn Quinebaug Valley ARC	
<b>LEVEL IV</b>	<b>SUBSTITUTE SERVICES</b>			
Residential Treatment	CREC Gray Lodge Klingberg Wheeler Child & Family Services	Alpha House Ct. Junior Republic Glenholme	New Hope Manor	
Group Homes	Child & Family Services LISA, Inc. Ct. Acc./Residential	Ct. Junior Republic LISA, Inc.	Windham Area Community Action Program, Inc. TLC Foundation Hawkins House	
Emergency Shelters	Hartford YMCA Junction 1019 Marshall House	Salvation Army- Waterbury		
Alcohol & Drug Treatment		Alpha House	New Hope Manor	
Community Services Emergency Services		Waterbury Youth Services Bureau	Quinebaug Youth Services Bureau Windham Youth Services Bureau	

Transitional Living	Gray Lodge			
Maternity Homes				
Residential Educational Programs			The Learning Clinic	
Temporary Shelters	Junction 1019 Hartford YMCA Shelter Salvation Army Shelter The Bridge Ct. Assc./Residential Fac.	Salvation Army Waterbury Youth Services System	Quinebaug Vally YSB Windham Regional Comm	

SOURCE: LPR&IC staff analysis of DCYS information.

APPENDIX B (continued)  
 DCYS-FUNDED PROGRAMS MATRIX: LEVELS I, II, III, IV BY REGIONS IV, V, VI.

	REGION IV	REGION V	REGION VI
LEVEL I	YOUTH AND COMMUNITY	DEVELOPMENT SERVICES	
Parent Ed. and Support Centers	Family Services, Inc. Town of Canton Town of Windsor	McCall Foundation Waterbury Youth Services	
School-Home Liaison Center Projects	Catholic Charities/Family Services Child & Family Services Hispanic Health Council Town of Wethersfield	Danbury Board of Ed.	
Early childhood Programs	CREC	Easter Seals	East Conn
Youth Drug & Alcohol Abuse Prevention	Artist Collective Hispanic Health Council	McCall Foundation Waterbury Youth Services	Windham Youth Services Bureau United Social & Mental Health
Student Drug & Alcohol Abuse Prevention	Hispanic Health Council	Danbury Youth Services	New Directions Quinebaug Valley Youth Services
Drug Free Schools & Communities (Federal)	Touch of Granby Town of Simsbury Public Schools Suffield Board of Ed Urban League of Greater Hartford	New Opportunities for Waterbury United Way of North Fairfield County	Quinebaug Valley Youth Services No. Central Ct. Mental Health System, Inc. New Hope Manor Windham Heights

Prevention Neighborhood Project				
New Haven Youth Program				
<b>LEVEL II</b>	<b>SUPPORT SERVICES</b>	<b>COMMUNITY CHILD</b>	<b>PROTECTIVE SERVICES</b>	
Intensive Family Preservation	Klingberg Family Centers	New Opportunities for Waterbury, Inc.	Quinebaug Valley Youth Services Bureau	
Parent Aide	Bristol Hospital City of Hartford Health Dept. Hispanic Health Council St. Francis Hospital & Medical Center VNA Home Care of New Britain	Danbury Reg. Comm. on Child Care, Rights, Abuse Housatonic Center for Mental Health St. Mary's Hospital	Exchange Clubs Center of Rockville No. Central Coalition for Children Quinebaug Valley Youth Services Bureau United Services	
Child Protection Team	Central Ct. Community Mental Health Affiliates New Britain General Hospital UCONN Health Center	Danbury Reg. Comm. on Child Care, Rights, Abuse Torrington Area Youth Services Breau	Exchange Clubs Center of Rockville No. Central Coalition for children Town of South Windsor United Services	
Therapeutic Child Care	YWCA of the Hartford Region YWCA of New Britain	Family Services Assoc. of Waterbury		
Stress Management			Exchange Clubs Center of Rockville	

Family Violence	Catholic Charities/Catholic Family Services	Family Services Assoc. of Watertown, Inc.	Hockanum Valley Community Council, Inc. United Services, Inc.
Perinatal			
Parent Education	Manchester Memorial Hospital		
Clinical Intervention	Catholic Family Services/ Catholic Charities		East Hartford Youth Services Bureau
		<b>COMMUNITY CHILD PSYCHIA</b>	<b>TRIC SERVICES</b>
Child Guidance Clinics	C & F S Institute for the Hispanic Family Institute of Living New Britain Wheeler Clinic	Charlotte Hungerford Hospital Danbury Housatonic Waterbury	Enfield Manchester U.S.M.H.S.
Emergency Psychiatric Services	Hartford Hospital	Charlotte Hungerford Danbury Hospital	
		<b>COMMUNITY LIVING</b>	
Juvenile Criminal Diversion	City of Hartford Conn. Jr. Republic		
Health & Community Services			
Youth At Risk			

Aftercare for Children	Shelter for Women, Inc.			
Independent Living	Hartford Youth Service Bureau New Britain Youth Service Bureau	Danbury Youth Service Bureau LISA Inc. Torrington Youth Service Bureau	Educational Resources Inc.	
		<b>YOUTH SERVICE BUREAUS</b>		
Youth Service Bureaus	Berlin Bloomfield Bristol Hartford New Britain Newington Plainville Rocky Hill Southington West Hartford Wethersfield Windsor	Danbury Naugatuck New Milford Newtown Ridgefield Southbury Torrington Waterbury Winchester	Coventry East Hartford Enfield Glastonbury Hebron Manchester Mansfield South Windsor Stafford Thompson Tolland Windham	
<b>LEVEL III</b>	<b>SUPPLEMENTARY SERVICES</b>			
Day Treatment	Child & Family Services CREC Extended Day CREC- PIP Hartford Substance Abuse Institute for Living	Danbury Hospital	EastConn Quinebaug Valley ARC	
<b>LEVEL IV</b>	<b>SUBSTITUTE SERVICES</b>			

Residential Treatment	CREC Gray Lodge Klingberg Wheeler Child & Family Services	Alpha House Ct. Junior Republic Glenholme	New Hope Manor
Group Homes	Child & Family Services LISA, Inc. Ct. Acc./Residential	Ct. Junior Republic LISA, Inc.	Windham Area Community Action Program, Inc. TLC Foundation Hawkins House
Emergency Shelters	Hartford YMCA Junction 1019 Marshall House	Salvation Army- Waterbury	
Alcohol & Drug Treatment		Alpha House	New Hope Manor
Community Emergency Services		Waterbury Youth Services Bureau	Quinebaug Youth Services Bureau Windham Youth Services Bureau
Transitional Living	Gray Lodge		
Maternity Homes			
Residential Educational Programs			The Learning Clinic
Temporary Shelters	Junction 1019 Hartford YMCA Shelter Salvation Army Shelter The Bridge Ct. Assc./Residential Fac.	Salvation Army Waterbury Youth Services System	Quinebaug Vally YSB Windham Regional Comm

## **AGENCY RESPONSE**





# STATE OF CONNECTICUT

DEPARTMENT OF CHILDREN AND YOUTH SERVICES



LOWELL P. WEICKER JR.  
GOVERNOR

ROSE ALMA SENATORE  
COMMISSIONER

January 15, 1991

Mr. Spencer Cain  
Chief Analyst  
Legislative Program Review  
& Investigations Committee  
State Capitol - Room 506  
Hartford, CT 06106

Dear Mr. Cain:

Thank you for giving the agency an opportunity to respond to the final report, **Performance Audit: Child Protective Services in Connecticut**. The response is enclosed.

Sincerely,

Rose Alma Senatore  
Commissioner

RAS/el  
Encl.

RECEIVED

JAN 16 1991

DEPARTMENT OF CHILDREN AND YOUTH SERVICES RESPONSES TO THE  
PERFORMANCE AUDIT: CHILD PROTECTIVE SERVICES IN CONNECTICUT

Overall, the Department of Children and Youth Services agrees with the Legislative Program Review and Investigation Committee that more resources must be allocated to the department in order to continue improvements made in services to children, youth and their families and to remedy various problem areas identified in the report.

This response to the report, and the recommendations contained therein, must be viewed within the following contextual parameters:

There will not be major improvement in services without additional staff to reduce case loads and to provide essential support functions, as well as increased funding for the development of appropriate community resources;

Decisions for increased funding for protective services and related programs must be made with the realization that DCYS is more than a child protection agency, and that the funding levels for its other functions is as insufficient as it is for child protection;

Some of the findings within the report are quite general and/or based on incomplete or inaccurate assumptions and information. For example the department has in place policy/guidelines/procedures in the areas of protective services intake and treatment, and evaluation of contracted programs and client progress;

Several of the recommendations make specific reference as to where in the organization certain functions should be performed; in all of these instances, it is the agency's view that such organizational detail should be within the purview of the department's administrators; and

It must be emphasized that all decisions made about these recommendations should be deliberated in the context of the Juan F. v. O'Neill Consent Decree and the various requirements within that document.

The following are the individual responses to each of the report's eighteen recommendations:

**Recommendation 1.....that the Program Development Division be reorganized to incorporate the function of case evaluation. The new division would become the Program Development and Evaluation Division.**

Response:

- o The agency agrees that efforts should be made to continue to improve the evaluation of services provided to clients from contractual programs.
- o The technology of evaluation of human service delivery is not sufficiently developed to perform effective client outcome evaluation in the short term. Longer term, longitudinal studies may be desirable, but are expensive, labor intensive and would be difficult for a state agency to perform. With reduced case loads, workers will be able to monitor more closely client progress in meeting objectives outlined in individual treatment plans.
- o Decisions regarding where in the organization the evaluation function should be placed is more properly left to the agency administration. Further, the staffing recommended for these evaluation functions does not appear to be sufficient in number or appropriate in terms of job titles and requisite experience.

**Recommendation 2.....that the department develop an independent case audit unit that will monitor each region's compliance with DCYS promulgated procedures and standards.**

Response:

- o The department agrees that an automated tracking system that monitors client progress as well as compliance with agency policy and procedure is desirable. This will require a substantial investment in computer hardware and software.
- o It should be pointed out, however, that contrary to the findings of the report, there are several individuals and groups, both within and outside of the agency, that provide casework decisions. Program Supervisors, Child Protection Administrators and Regional Directors all perform case review functions. Additionally, child protection teams, clinical consultants and the courts also have a great deal of input into the casework process.

Recommendation 3.....that the department develop standards for regional performance.

Response:

- o As stated above, the department does have standards for regional performance in the case management process.
- o The department agrees, however, that efforts must be made to increase the degree of conformity to these standards among offices and sub offices without eliminating necessary flexibility from a social work perspective.
- o Improved automation of case management information as well as enhanced training and communication of standards are important factors in increasing the level of regional conformity to standards.

Recommendation 4.....issue monthly reports listing any recommendations that arose as a result of the administrative case reviews or investigations of out-of-home abuse.

Response:

- o The department does provide for follow-up on administrative review recommendations that become part of the case treatment plan through the case supervision and management process.
- o The department agrees, though, that a more tangible method of follow-up, based on an automated processing system, is desirable in order to complete the information loop and maximize the effectiveness of the administrative review process.
- o The department also believes that the quality of the reviews must improve, primarily by increasing the number of facilitators so that more time can be given to each review.

Recommendation 5.....create a Staff Development and Training Division.

Response:

- o The department agrees that the agency training function must be enhanced. Such enhancement must take into consideration that the agency is more than a child protection agency, and that resources devoted to the

training of social workers, supervisors and managers in that area should not be increased at the expense of staff development in other areas such as mental health and juvenile justice staff in the department's institutions.

- o It must be pointed out that recommendations in the area of training must be seen in the context of the Juan F. v O'Neill Consent Decree and various requirements within that document.

Recommendation 6.....that no social worker trainee be assigned a caseload prior to completing 20 days of structured training. And

Recommendation 7 - In addition, the department should expand its current training requirement to include an additional 20 days of in-service training to be completed within the first two years of employment.

Response:

The department believes that specific numbers of training hours should be determined by a broad based agency needs assessment and a formal method of determining individual training needs.

Recommendation 8 - All child protective service workers shall, within the first ten years of employment, obtain a Master's Degree in social work or closely related academic field. The department shall provide 100 percent reimbursement for the cost of tuition.

Response:

- o This recommendation should be studied further to determine:

Whether course work and field placements in Connecticut's schools of social work provide relevant training for child protection social workers;

Whether retention of trained staff will become a problem when Master's Degrees are required; and

Whether requirements for master's degrees and/or differential tuition reimbursement payments for part of a bargaining unit conflict with collective bargaining agreements.

- o Presently, child protective services social workers and supervisors are entitled to 100% reimbursement of 18 credit hours per year (up to a maximum of \$110 per credit) for graduate level course work.

Recommendation 9.....that the department recruit applicants for the social worker position who possess a bachelor or master's degree in social work or a closely related field, as determined by the Commissioner.

Response:

The department actively recruits candidates with bachelor or master's degrees in social work or closely related fields for social work positions. However, the numbers of trained social workers willing to work in child protection is far short of what is required by the agency to keep vacancies filled. Further, the department believes that with proper training, candidates with educational backgrounds in other than social work can and do become effective child protection social workers.

Recommendation 10.....that the department develop a program that allows social workers to obtain the necessary skills to become trainers. As trainers the workers would be allowed a temporary respite from managing cases.....

Response:

The department believes that workers who are qualified and interested in training should be utilized as trainers. However, skill in providing social work services does not, in all cases, translate to skill in the training of social work, and a general program of assigning all experienced social workers to the training division would not enhance the training function.

Recommendation 11.....that the newly created Staff Development and Training Division conduct a formal evaluation of the current training curriculum and an assessment of training needs.....

Response:

It is the department's view that some additional training resources should be devoted to completing a comprehensive needs assessment and training plan. Formal evaluation of training efforts should be completed by independent sources.

Recommendation 12.....that the department should as a department-wide goal limit workers to 25 ongoing cases at any point in time. ....that social worker trainees be limited to a caseload that is, on average, half that of the permanent social worker. ....by July 1, 1994.

Response:

- o This recommendation must be considered in the context of the Juan F. v O'Neill Consent Decree which contains requirements regarding reduction of social work caseloads.
- o The recommended goal of 25 cases per worker does not take into consideration the different requirements of intake/investigation casework and treatment casework. The former caseloads should be much smaller than the latter according to nationally recognized standards.
- o With regard to trainee caseloads, it is not clear whether the recommendation refers to the employee class of Social Worker Trainee or workers in a training period. The department agrees that workers who are in training ought to have a sharply reduced caseload, but would point out that Social Work Trainees stay in that official classification for up to two years, far longer than what would be considered an orientation or initial training period.

Recommendation 13.....that the Department of Children and Youth Services: 1) revamp its current case management system and replace it with an online computer system with 24-hour access; and 2) design a process for evaluating the effectiveness of client interventions.

Response:

The department agrees, as pointed out in responses to other recommendations in this document, that such an online case management system is highly desirable. Such a system would provide immediate case status information for workers, supervisors, managers and administrators as well as reducing the amount of time devoted to repetitive paperwork.

Recommendation 14.....that the newly created Program Development and Evaluation Division design and implement a case evaluation system that measures client outcomes throughout the case history to better determine the progress being made by the social worker.

Response:

While the department agrees, as outlined above, with the intent of improving the process of evaluating its services and those of its contractors, it does not agree that the design of such evaluation should be the sole responsibility of the proposed Program Development and Evaluation Division. Decisions as to where specific functions of overall agency operations are best left to the agency administration and made in the context of the overall agency mission. Additionally, the caveat regarding the extreme difficulty of measuring individual client outcomes in the short run must be noted with regard to this recommendation.

Recommendation 15.....that the Department of Children and Youth Services design a grants processing system that funds community service programs proportionate to their success in treating clients, and be allowed to impose a reduction in funds against those programs found to be ineffective. This sanction would require that funding be phased out over a three-year probationary period.

Response:

- o The department disagrees with the implication that it has a significant number of ineffective programs that if funding of such programs were reduced, funds could be reallocated to support more effective services.
- o The department already has the ability to discontinue funding for poor performance on the part of contractors. This ability is used with many programs as an incentive to improve services to children served by the department. Many of the programs which are under contract with the department are new types of services which require time to mature into maximum effectiveness. If the department were to have an inflexible policy of reducing funding for less than full satisfactory service, many of the programs affected would be unable to stay in business long enough to improve. The department believes that its present practice of working with contractors to build effective programs is the most practical approach in the long run. The department agrees with the report that better evaluation procedures will enhance its ability to make specific requests for improvement on the part of its contractors.

Recommendation 16.....that the newly created Program Development and Evaluation Division collect, maintain, analyze, and provide the evaluation data to be used in the grants process.

Response:

While the department has agreed that enhanced evaluation data be developed, the placement of specific functions within the agency should be the responsibility of department's administration.

Recommendation 17.....that the protective services social workers and their supervisors be routinely surveyed regarding their opinions of the operations of community programs and asked to rate the effectiveness of each program.....

Response:

The department does not agree with the premise that workers are not used as a resource in program evaluation. However, the department does agree that a more formal method of obtaining worker input should be made a part of the overall mechanized evaluation system.

Recommendation 18.....that the Program Development and Evaluation Division in conjunction with other divisions of DCYS, develop and maintain a computerized database listing all available community service programs.

Response:

With regard to a resource directory of community resources, the department agrees that, in principle, this is a highly desirable goal. However, such an undertaking is extremely labor intensive, and the continued updating of such a directory is crucial to its usefulness. The department suggests that the development of such a directory ought to include resources already in place, (e.g., Infoline), and be a multi-agency effort including all types of human services in an interactive computerized format.

The following are various comments on the technical data and informational content in the body of the report. These comments are presented in two sections: (A) Overall Assessment and (B) Detailed Comments.

**A. Overall Assessment**

It would be difficult not to be impressed by the depth of understanding evinced by the data and information collected by the Legislative Program Review and Investigations Committee when comparing the needs of children and their families with the legislative mandate and the resources available to fulfill that mandate. The review was, on the whole, both thorough and fair.

There are, however, a few areas in which there appears to be some confusion: distinction between protective services and child welfare; being accepted as a DCYS case and transfer to treatment; distinction between caseload standards for intake and treatment workers; best measure for caseload; availability of automated resource directory and referral history; and distinction between family and individual case.

On occasion LPRIC used child welfare and protective service information interchangeably. In addition to protective services, the regional offices provide for the following services; adoption, probate court studies, non-committed treatment program, interstate courtesy supervision, unwed parent, and committed child. Some figures used in the report were specified as protective services but in reality represented child welfare services.

There was some misunderstanding of the progress of a case from allegation to screening to assessment to treatment. LPRIC analysis did not clearly reflect that acceptance for assessment is a DCYS service. When a case is referred to a regional office for alleged abuse or neglect, a screening is done to determine if the case should be accepted for assessment. If it is determined that the referral is to be investigated, the case is considered a DCYS case to which services are being provided regardless of whether the allegations are confirmed. When allegations are not confirmed, by law the case is closed and the record of that case is expunged from the computer system. Cases confirmed may be transferred to a treatment unit. The database provided to the LPRIC did not contain the records of those cases which were not confirmed as most had been expunged.

LPRIC did not compute caseloads by intake and treatment cases though national caseload standards are based on whether the case is in intake (generally investigation though some short term treatment services may be provided) or treatment. The standard suggested by the Child Welfare League of America is intake 12 cases per worker and treatment 17 cases per worker. The Massachusetts consent decree was 12 cases per worker in intake and 20 per worker in treatment. Also to be considered is the type of case being served as for instance, in home supervision will require much more worker effort than a probate court study.

There were two measures used to determine the number of cases being served, case population on the last day of the month and cases served at any time during the month. The LPRIC stated that the best measure is somewhere in between those measures. From a measurement point of view, the measure which best represents the worker's actual workload is the average daily caseload which is best approximated by the average of the caseload on the last day of the month.

LPRIC stated that there was no automated community resource file. However, a community resource file currently exists on the mainframe. This file with its location search capabilities can be made available to each regional office. It's usefulness would depend upon constant updating by each region. LPRIC also stated that no historical file on referrals exists. However, it is part of the Case Management System (automated system containing information on all child welfare cases). The file extract requested by LPRIC contained only the most current transaction in each area, i.e., last referral, investigation, placement, court record. This was stated in the memo of agreement relating to the file.

LPRIC seemed unclear as to the difference between family and individual cases. Comparisons were made between measures for family cases and those for individual children. This can lead to error as generally each family has more than one child being served. DCYS has defined two types of cases, family and individual. Cases referred for protective services are almost always family cases. These cases consist of the family unit, one or more adult caretaker(s) and one or more children. Children in out of home placement are individual cases and consist solely of one child. By these definitions, a family could have many related cases. For instance, a family with three children could have four active cases, three individual children in out of home placement and the parents with whom the social worker is working in order to prepare for reunification. This also makes the definition of caseload difficult as some states count the entire family, regardless of placements, as one case.

**B. Detailed Comments:**

**Pg. 3, Paragraph 2**

LPRIC states that the remaining 2,564 children referred for non-abuse and neglect reasons were referred for delinquency etc. Few of the department's delinquency

referrals are included in this number. The higher number of referrals in this category were for Probate Court services and the next highest number was for the Non-committed Treatment Program.

**Pg. 3, Paragraph 4**

LPRIC states that the 11,385 newly opened and 4,454 reopened cases were abuse and neglect cases, however the cases also include child welfare cases (please refer to overall assessment).

**Pg. 3, Paragraph 5**

The like problem exists for number of cases closed representing all child welfare cases not just abuse and neglect.

**Pg. 4, Paragraph 1**

The report states "Although DCYS receives numerous referrals, not all become DCYS". It is more accurate to state that each allegation is screened and if accepted for assessment does become a DCYS case. (please refer to overall assessment).

**Pg. 30, Paragraph 3**

Conclusion that almost three times as many cases are closed in Torrington within 45 days than in Middletown (based on percent closed) is not valid unless total number of cases are equal. Middletown caseload is approximately 150% of that of Torrington. General intent of paragraph however, is valid.

**Pg. 30, Paragraph 4**

It should be noted that the length of time between referral and investigation is measured on completed investigations and those confirmed. All referrals found not confirmed must by law be expunged from the database. The use of only completed investigations makes the statistics look more favorable. There are approximately 10% of referrals with no confirmation reflected three months after the close of the fiscal year.

**Pg. 32, Paragraph 2**

The percentage of cases closed at intake may actually be higher than the numbers presented in the report as those cases found not valid were expunged and therefore not part of the database used. However, since this database

was on closed cases only, the data is not complete as cases transferred to treatment would tend to remain open longer. A study completed on all children confirmed found that less than 40% were transferred to treatment.

**Pg. 33, Paragraph 1**

LPRIC uses as its definition of reopened cases, reopened within a year of closing. In practice the year parameter was not universally used. The percentage of reopened cases changes somewhat when all cases opened (instead of closed) is used as the database.

**Pg. 43, Paragraph 2**

LPRIC again reflects the view that services begin at intake (see Pg. 44 chart)

**Pg. 44, Chart**

The chart reflects an incorrect view of when case is open. It is shown here following investigation, substantiation and risk assessment. It should be at entrance to intake. It is important to note that an unsubstantiated case still requires the time and attention of a worker and forms part of the Worker Caseload computation (see overall assessment).

**Pg. 51, Paragraph 1**

LPRIC states "Careline responds to all reports or referrals of child abuse, neglect .....". This is not technically true. Careline responds to these calls only after regular working hours. Referrers calling during working hours are asked to call their regional DCYS office or sub-office.

**Pg. 51, Paragraph 5**

LPRIC implies that a listing of cases is kept by Careline in order to respond to requests from physicians to treat DCYS clients. Actually Careline is on line with the Case Management System and therefore has access to the latest information recorded in the system. Careline also has access to a computerized resource directory through which one can locate services geographically.

**Pg. 51, Paragraph 6**

LPRIC makes a comparison of calls from 1973 through 1989. This comparison should be made from 1984 through 1989 as the operation and focus of Careline has changed considerably from the 1970's to now. In the 70's, it was staffed by volunteers except during the night. It was administered by a private agency and the focus was heavily counselling of parents.

**Pg. 55, Paragraph 1**

LPRIC collapses the disposition into five categories. However, this categorization seems not to reflect the diversity of the dispositions. For example grouping permission to treat, closed records requests, Central Registry inquiries and information given reflect very different concepts in that some are services to agency employees, others to the general public and yet others to professionals who serve children.

**Pg. 55, Paragraph 2**

LPRIC states that a call can have more than one disposition, however that was changed in SFY 89 so that there is just one disposition per call which is reflected in Table III - 3.

**Pg. 58, Paragraph 3 and Paragraph 5**

There seems to be conflicting statements about the cost of clothing being included in foster care rates. Paragraph 3 states that it is, Paragraph 5 states it is not. A child entering placement receives an initial clothing allowance. Clothing replacement costs are included in the monthly rate.

**Pg. 82, Paragraph 3**

LPRIC states that the true caseload ratio lies between the number served per month and the last day of the month census. From a statistical point of view, the method which more reflects the workers responsibilities is the daily census best represented by last day of the month. (please refer to overall assessment).

**Pg. 82, Paragraph 4**

LPRIC calculates worker caseload without discrimination as to whether the case be intake or treatment. The type of case, i.e., protective service reviews or probate court study is also not addressed. Both these factors need to be addressed to determine a valid caseload. (please refer to overall assessment)

**Pg. 83, Paragraph 2**

LPRIC compares caseload to the National Association of Social Workers suggested caseload. Most National suggested caseloads are established separately for intake and treatment (please refer to overall assessment)

**Pg. 84, Paragraph 4**

LPRIC states that a complete history on referrals is not available. This is a misunderstanding as the agreement made for the database extract LPRIC requested was for most current data only. All founder referrals are available historically. It is true however, that no history is available on openings and closings.

**Pg. 85, Paragraph 3**

It is important to note that the time between referral and investigation that has been calculated by LPRIC is only for founded cases as unfounded cases have been expunged. Also the calculations, of necessity, were done only on cases with completed investigations and therefore the 9 to 10% incomplete investigations are not part of these statistics.

**Pg. 96, Paragraph 3**

The matrix of programs reflecting the four levels of care by region (Appendix B) developed by LPRIC does not include all agencies. Also, the location or type of service provided varies with departmental information in some instances.

**Pg. 101, Paragraph 5**

LPRIC include foster care (here referring to just foster family care) in the same section with LEVEL 2 community programs. It should be noted that it is a DCYS administered program and the data is obtained from the

DCYS Case Management System. It is a LEVEL 4 program and the extent of care and differences in the degree of need should be recognized. It is also possible that a child may be served by both foster family care and community program(s).

**Pg. 102, Table**

There are errors for both SFY 89 and SFY 90 in columns 6 and 7, line 5. These were due to transcription errors on the source document. The percent of DCYS cases in Child Guidance Clinics should be 18% in SFY 89 and 20% in SFY 90. This result is the change of number of DCYS cases served to 2,384 and 2,707 respectively. Also client data is presented for Child Guidance Clinics, however, cost data also reflects emergency psychiatric funding. Likewise with day treatment and preschool intervention programs.

**Pg. 103, Paragraph 3**

The error noted in the Tables is reflected in the conclusion that regionalization may have had a large impact upon Child Guidance Clinics service to DCYS children.

**Pg. 103, Paragraph 4**

LPRIC compares Child Guidance Clinic caseloads with foster care. The programs and services are so different that it is difficult to see the relevance of this comparison.

**Pg. 105, Paragraph 4**

LPRIC states that DCYS does not have a central database on community service programs. This is in error as an automated resource location system is available at Careline. This can be made available at any office. Likewise there is a contract system located in central office from which listings can be obtained. (please refer to overall assessment)

**Pg. 106, Table**

The transcription errors on the source document regarding Child Guidance Clinics from the Table on page 102 are repeated here.