

State of New York
Office of the State Comptroller
Division of Management Audit

DEPARTMENT OF SOCIAL SERVICES

**SELECTED ASPECTS OF THE
FOSTER CARE PROGRAM**

REPORT 95-S-94



H. Carl McCall
Comptroller



State of New York Office of the State Comptroller

Division of Management Audit

Report 95-S-94

Mr. Brian J. Wing
Acting Commissioner
Department of Social Services
40 North Pearl Street
Albany, NY 12243

Dear Mr. Wing:

The following is our report on selected aspects of the New York State Department of Social Services' Child Protective Services, Preventive Services and Foster Care Programs.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. Major contributors to this report are listed in Appendix A.

*Office of the State Comptroller
Division of Management Audit*

Executive Summary

Department of Social Services Selected Aspects of the Foster Care Program

Scope of Audit

The Department of Social Services (Department) supervises New York State's child welfare system, including its Child Protective Services, Preventive Services, and Foster Care programs. Jointly supported by Federal, State and local government funds, these programs are intended to protect neglected and abandoned children through investigations of allegations of child abuse, and preventive services aimed at reducing the number of children placed in foster homes or child-caring facilities.

Local social services districts (districts) operate the programs, for which the Department reported expenditures of nearly \$1.7 billion for the year ended December 31, 1994. In 1992, the Legislature had set a maximum limit or CAP on the amount the Department could reimburse the districts for Foster Care. If a district reduced its costs, it could apply the savings to new initiatives. However, the CAP was discontinued in 1995-96 and was replaced with a block grant that, according to the Department, provided less overall funds for child protection.

Our audit addressed the following questions:

- ! Are the Department and the districts managing the size of the Foster Care caseload while continuing to protect children from abuse and neglect?
- ! How did districts perform under the CAP reduction targets?

Audit Observations and Conclusions

Allegations of child abuse reported to the Department's telephone hotline are forwarded to the district, where a Child Protective Services (CPS) unit conducts an investigation. If CPS staff find a child in imminent danger, they can immediately take the child into protective custody, e.g., an emergency Foster Care placement. If CPS staff believe there is a likelihood that a child, not in imminent danger, may be abused or maltreated in the future, they can petition the Family Court for a determination that the child be placed in Foster Care. The Social Services Law and Department regulations specify the steps and related time frames that the districts must follow in order to ensure a child's safety. For example, the investigation must begin within 24 hours after an allegation has been received, districts must make a Preliminary Assessment of Safety within seven days after that date and "mandatory reporters" — physicians, school officials and police officers — must also report suspected child abuse, and submit a written report to the district on an official form, DSS-2221A.

Although we noted numerous instances where the specific requirements were not met, we found that, for the vast majority of cases tested, the seven districts we visited are not leaving children in unsafe households. However, our review of 281 case folders at the seven districts we visited identified seven cases in which the child's safety could have been ensured more effectively. For example, in one case it was alleged that the mother in a one-parent household was working outside the home as a prostitute during the night, leaving her four young children unsupervised. The caseworker made two visits after the allegation was received and determined the allegation was unfounded because the mother was present and the children were safe. However, the visits were made during the daytime rather than in the evening when it was alleged that the mother was not at home, and over seven months elapsed between two visits. (see p. 8)

At the seven districts visited, we identified numerous instances where officials did not always comply with Department time frame requirements. District officials told us that they are not always able to meet certain compliance requirements because of their workloads. They also contended that some of the requirements were actually met, but were not documented in the case folders. In addition, we noted that the districts were not consistently receiving the DSS-2221A forms from the mandatory reporters. While district staff have little control over whether mandatory reporters submit the form, this form was not available in 60 of the 166 cases where a mandatory reporter was the source of the allegation of abuse. To achieve its mandated goal of protecting children, we recommended that the Department monitor district operations periodically, identify instances of noncompliance, and work with districts to correct the situation. We also recommended that the Department reiterate to mandatory reporters their responsibility to complete the DSS-2221A form. (see pp. 8-11)

During the three-year period ended March 31, 1995, as allowed by the Foster Care CAP legislation, the Department authorized the expenditure of \$20.1 million in initiatives to reduce the Foster Care caseload. However, neither the Department nor the districts were required to evaluate the impact of these initiatives or to demonstrate that they were accomplishing their intended purpose. In 1995-96, the Legislature created a block grant that covers several local programs serving families and children and reduces the State's share of reimbursement for these programs. We recommended that performance measures be developed to help districts identify the best way to achieve their mandate within current financial constraints. (see pp. 13-14)

**Comments of
Department of
Social Services
Officials**

Department officials indicated that they have procedures in place or will develop procedures to implement our recommendations.

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Exhibit A	Foster Care CAP District Performance
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Appendix A	Major Contributors to This Report
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Appendix B	Comments of Department of Social Services Officials
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The comments of Agency Officials are not available in an electronic format. Please contact our Office if you would like us to mail you a copy of the report that contains their comments.

Introduction

Background

The State Department of Social Services (Department) supervises New York State's child welfare system. This system includes Child Protective Services, Preventive Services, and Foster Care programs. Federal, State and local governments jointly fund these programs. The purpose of these programs includes protecting neglected and abandoned children by investigating allegations of child abuse and providing families with preventive services that will help reduce the need to remove children from their homes. If removal is necessary, the children are placed either with foster parents or in child-caring facilities.

The Department's Division of Services and Community Development (formerly the Division of Family and Children Services) oversees these programs, which are administered through the local social service districts (districts). For the year ended December 31, 1994, the Department reported nearly \$1.7 billion in expenditures for these programs, as follows:

Child Protective Services	\$ 191,881,155
Preventive Services	252,666,258
Foster Care	<u>1,242,861,856</u>
Total	<u>\$1,687,409,269</u>

According to State policy, the care and raising of children are primarily the right and responsibility of parents, and if parents are unable or unwilling to carry out this role, and child abuse or maltreatment does occur, the community must intervene for the protection of the children. This role of the community is defined in the Federal Social Security Act, the New York State Family Court Act and the New York State Social Services Law.

New York State law defines an abused child as one who is less than 18 years of age and has a parent who inflicts upon the child or allows to be inflicted a physical injury or a substantial risk of such injury by other than accidental means that causes or creates a substantial risk of death, serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the functions of a bodily organ. An abused child also is one whose parent commits with the child or allows to be committed with the child, a sex offense against the child as defined in Article 130 of the Penal Law; commits incest; allows, permits or encourages such child to engage in prostitution; or allows such child to engage in acts or conduct that constitute a sexual performance.

A maltreated child is one who is less than 18 years old whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired because of the parent's failure to exercise a minimum degree of care. Parents are considered to be failing to provide care when they do not supply the child with food, clothing, shelter or compulsory education;

or medical, dental, optometrical or surgical care, even though they are financially able to do so. Parents are also considered to be failing if they do not provide the child with proper supervision by unreasonably inflicting on the child or allowing to be inflicted on the child harm or a substantial risk of harm. Such harm would include the use of excessive corporal punishment, or a level of drug or alcohol abuse that causes the parent to lose self-control, or abandonment of the child.

The Department operates a telephone hotline 24 hours per day, 7 days per week to receive allegations of child abuse and maltreatment. Reports arising from these allegations are forwarded electronically via the State Central Register (SCR) to the appropriate district. District Child Protective Services (CPS) units are responsible for investigating the allegations. If an investigation identifies some credible evidence that alleged abuse or maltreatment has occurred, the report is considered "indicated." CPS investigations which conclude that such evidence exists are major sources of referrals to Foster Care. Allegations which after investigation are determined to be "unfounded" are expunged from the SCR along with all related information maintained at the district office.

District Foster Care caseloads have soared during recent years, nearly tripling between 1985 and 1994 to about 59,000 children as of December 31, 1994. To contain the growing costs of this program, the Legislature, in 1992, set a maximum limit or CAP on the amount local districts could obtain in State reimbursement for Foster Care. Chapters 53 and 793 of the Laws of 1992, Chapter 259 of the Laws of 1993 and Chapter 53 of the Laws of 1994 defined this limit and the conditions under which districts could spend the funds. Districts that expected to spend less than the maximum allowed could request Department approval to spend the anticipated savings on new initiatives.

The Foster Care CAP was discontinued in the 1995-96 State budget. Instead, the Legislature created a block grant that covers several local programs serving families and children. The block grant provides less funding than the districts have previously received for these programs, but greater flexibility to administer these programs. However, managing the size of the Foster Care caseload while still providing mandated services continues to be a Department goal.

Audit Scope, Objectives and Methodology

The objective of our performance audit was to evaluate selected aspects of the Department's oversight of Child Protective Services, Preventive Services and Foster Care programs for the period April 1, 1992 to September 30, 1995. Our audit focused on the ability of both the Department and the districts to control the size of Foster Care caseloads while continuing to protect children from abuse and neglect. To accomplish these objectives, along with auditors from the State Comptroller's Division of Municipal Affairs, we reviewed Department and Federal procedures and regulations, interviewed responsible Department managers and examined case records in the seven districts in Broome, Erie, Monroe, Onondaga, Orange, Suffolk and Westchester counties. In addition, we assessed how the districts performed under the CAP reduction targets. As part of this audit we did not visit the New York City district. For the most part, New York City's Foster Care caseload is carried out through the Kinship program, which is the subject of a separate audit. Also, the New York City district reported no CAP savings in any of the three years of our audit scope. Furthermore, the New York State Office of the Special Deputy Comptroller recently issued an audit report (Report number A-18-92, issued May 24, 1994) that addressed New York City's Foster Care program.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations which are included within the audit scope. Further, these standards require that we understand the internal control structure and compliance with those laws, rules and regulations that are relevant to the operations which are included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments, and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach to select activities for audit. We therefore focus our audit efforts on those activities we have identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. We devote little audit effort reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit reports on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Department Officials to Audit

Draft copies of this report were provided to Department officials for their review and comment. Their comments have been considered in preparing this report and are included as Appendix B.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Social Services shall report to the Governor, the State Comptroller, and the leaders of the Legislative and fiscal committees, advising what steps were taken to implement

the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Child Protective Services

Safety of Children

Section 424 of the Social Services Law and Part 432 of the Department's regulations establish the requirements that districts must follow in processing allegations of child abuse. These mandates set forth specific steps and time frames that the districts must meet; these steps are intended to ensure the safety of the child. We audited CPS reports to determine whether the districts are leaving children in unsafe households, rather than placing them in Foster Care. We found many instances where mandated steps and/or time frame requirements were not met. However, for the vast majority of the cases we tested, the districts did not leave children in unsafe households. We reviewed 281 cases at the seven districts we visited. We identified seven cases where it appeared the district could have improved its efforts to ensure the safety of a child.

In the assessment reports for each of the seven cases, the district made a safety decision that, in our opinion, was not consistent with the evidence documented in the case file. The following is a summary of each report:

Case 1

Maltreatment was alleged in a one-parent family with three children aged 14, 13, and 6. The allegation was that the children had missed more than 32 days of school and the mother was not cooperating with efforts to improve their attendance rates. When the caseworker visited the mother's apartment, she observed a Notice of Eviction attached to the door. The landlord showed her the apartment, which contained a few dirty mattresses, broken tables and a dirty sofa. According to the landlord, the mother was spending her money on drugs, often left the children alone and was engaging in prostitution in the apartment. In addition, case record information showed that the children were not attending school, but were wandering the streets when the caseworker visited the household. The Preliminary Assessment of Safety showed that the CPS worker had concluded that the children were safe. However, the case file contained no documentation showing how the caseworker reached this conclusion. This is of vital importance since, in our opinion, the documentation contained in the case file indicates the district should have considered immediate intervention to protect the children from harm. (Erie)

Case 2

Maltreatment was alleged in a two-parent household with four children aged 14, 13, 11, and 18 months. The parents were alcoholics and crack addicts, and did not supervise the children adequately. The youngest child reportedly played in the street in front of the house. Case notes indicated that the family had been reported to the district on previous occasions. The notes stated that the children had been neglected between 1990 and 1993, that their medical needs were not always met, and that two other drug addicts had lived in the home. Despite the findings, the Preliminary Assessment of Safety and caseworker notes neither mentioned the youngest child, nor explained the district's decision to allow the children to remain in the house during the two-month period between the report date and the date the mother entered rehabilitation. (Onondaga)

Case 3

Maltreatment was alleged in a two-parent household with three children aged 15, 13, 12. Both parents and the 15-year old boy admitted to hitting the 12-year old girl in the face on more than one occasion. The allegation stated that the child also had welts on her buttocks from being struck with a belt. The case was ultimately classified as unfounded. However, the case file contained no verification by the caseworker regarding the presence of welts. Furthermore, there was no documentation in the case file which set forth the reasons why the case was classified as "unfounded." (Onondaga)

Case 4

Maltreatment was alleged in the household of a single parent with an 11-year old daughter and two foster children. The mother admitted to whipping her daughter with a clothesline, stating that the child was too young to understand non-physical discipline. She expressed the belief that hitting an 11-year old was more effective than trying to reason with her or depriving her of privileges. The district could not provide us with its Preliminary Assessment of Safety. Case notes stated that the two foster children were removed from the household. However, the case notes did not document why the 11-year old daughter was allowed to remain in the household. (Onondaga)

In response to our draft report, Department officials disagreed with our conclusions related to the safety of the children mentioned in one Erie county case and two Onondaga county cases. According to these officials, personnel from their regional office re-examined these three cases and concluded from their review that case files contained sufficient data to substantiate the caseworkers' assessment that the children were safe.

Documentation we gathered during our audit contradicts the Department's position. In Case 1, seven months after the caseworker's investigation and four months after our fieldwork, the caseworker added a note supporting the caseworker's decision that the children were safe. The fact that the contents of the note are not documented in the case file and the fact that the note was added seven months after the caseworker's investigation should cause the Department serious concern.

In its response to Case 2, the Department stated that the district had been unable to obtain information that substantiated the fact that the mother had a drug/alcohol problem. However, case file documents contradict this assertion. The caseworker's first and second assessment of safety both specifically identified behaviors or conditions that may be associated with a child being in immediate danger or harm. In both assessments, the caseworker indicated that the caretaker has not or will not provide sufficient supervision to protect a child from potentially serious harm. The caseworker also indicated that the caretaker's drug/alcohol abuse affected their ability to supervise, protect or care for the child.

In responding to Case 4, Department officials stated that the children were safe and that the mother did not abusively discipline the children. Case file documents indicate otherwise. Caseworker notes show that a child was whipped with an extension cord on several occasions and that these punishments resulted in body markings on the child's upper back and right buttock. The notes also document other beatings with a belt.

Case 5

Maltreatment was alleged in a two-parent household with two children aged 6 and 2. The father had made an allegation to the SCR that the mother was getting high on crack cocaine in the presence of the children on a daily basis. The Preliminary Assessment of Safety, completed the next day, concluded that the children were safe. However, information gathered after that date contradicts this decision. For example, the father said he bought just enough food for one day because the mother would sell the food for drugs. The caseworker also learned that one of the mother's two children had been born with a positive toxology for cocaine. In addition, when the mother learned that the father had filed the report against her, she threatened, in the presence of the caseworker, to kill him. Despite this additional information, the children continued to reside in the household. The caseworker did not document in the case file how this new information was considered relative to the future safety of the children. (Westchester)

Case 6

Maltreatment was alleged in a two-parent household with an eight-month old baby. The allegation was that the father, under the influence of alcohol, struck the mother while she was holding the baby. Although he aimed the blow at the mother, he also hit the baby on the head so hard that a lump was formed. The police were called to intervene. The Preliminary Assessment of Safety showed that the CPS caseworker, without obtaining a copy of the police report, had decided that the child was safe. In addition, the caseworker had not followed up on a prior allegation against the father from another district. (Westchester)

Case 7

Maltreatment was alleged in a one-parent household with four children aged 8, 3, 2, and 1. The allegation was that the mother was working outside the home as a prostitute during the night and leaving the children unsupervised; the 8-year old was expected to take care of the younger children. When the caseworker made an unannounced daytime visit about three weeks after the report date, it was determined that the mother was present and that the children were safe. A second unannounced day time visit was made 221 days later. Again, the caseworker determined that the mother was present and that the children were safe. The district then determined that the report was unfounded, despite the facts that: a visit was not made during the evening hours when it was alleged that the parent was outside the home, and no case notes or contacts between the two visits had been recorded. In total, the district was 188 days late in determining this report, i.e., deciding whether the case is indicated or unfounded. (Westchester)

Compliance Requirements

The Social Services Law and the Department's regulations require that the following steps be taken to ensure the safety of a child:

- ! Within 24 hours after receiving a report of suspected child abuse or maltreatment, the CPS unit must commence an investigation.
- ! Within 24 hours after receiving the report, the CPS unit must meet in person, or contact by telephone, the alleged abuser, the child and other individuals named in the allegation; or other persons able to provide information about whether the child may be in immediate danger of serious harm.
- ! Within seven days after the report is received, the CPS unit is to conduct a Preliminary Assessment of Safety to determine whether the

child named in the report and any other children in the household may be in immediate danger of serious harm. If the assessment indicates that the child is unsafe, CPS staff are to undertake immediate and appropriate controlling interventions to protect the child.

- ! Within 60 days after receiving the report, the CPS unit has sole responsibility for determining whether there is some credible evidence of child abuse and/or maltreatment to justify an indicated report of child abuse or maltreatment. This investigation shall include, but shall not be limited to:
 - One home visit, involving face-to-face contact with the subjects and others named in the report, to evaluate the environment of the child named in the report as well as other children in the same home.
 - An assessment of the current level of safety in the home and of the risk of future abuse and maltreatment to the children living there, and documentation of such assessment.
 - A determination of the nature, extent and cause of any condition enumerated in the report.
- ! A CPS unit supervisor must review and approve the decision to categorize the allegation as indicated or unfounded.
- ! Mandatory reporters must file a written report within 48 hours of their oral report. Mandatory reporters are those individuals, e.g., physicians, school officials and police officers, who must report whenever they have reasonable cause to suspect that a child coming before them in their professional or official capacity has been abused or maltreated.
- ! The CPS unit is responsible for providing and coordinating rehabilitative and Foster Care services, where appropriate, to any child and family named in an indicated child abuse or maltreatment report. The services are intended to safeguard the child's well-being and development and to preserve and stabilize the family, when appropriate.

For the seven districts we tested, we noted 158 instances where the requirements were not met within the 281 reports we reviewed. These instances are shown in Table 1. We also noted that statewide Department statistics show that almost 40 percent of the CPS investigations conducted during the year ended December 31, 1994, took more than 60 days to complete.

Table 1

	Broome	Erie	Monroe	Orange	Onondaga	Suffolk	Westchester	Total
Number of Reports Tested	46	45	37	30	48	35	40	281
Compliance Item Not Met:								
An investigation was not started within 24 hours after the report was received.	3	0	2	0	2	0	0	7
An assessment of immediate danger was not conducted within 24 hours after the report was received.	2	1	2	0	0	2	0	7
The question of whether other children were in the household was not resolved.	2	0	0	0	0	1	0	3
A preliminary assessment of safety was not completed within 7 days.	5	11	8	2	2	5	0	33
A preliminary assessment of safety was not completed.	1	5	2	0	8	4	2	22
A home visit was not conducted during the investigation.	1	0	0	0	0	0	0	1
The investigation took longer than 60 days to complete.	7	10	16	11	6	21	4	75
A service plan was not prepared for an indicated and opened report.	0	1	0	0	0	0	9	10
Total	21	28	30	13	18	33	15	158

District officials stated that they are not always able to meet requirements. They said that in prioritizing their workloads, some of these requirements receive lower priority. For example, the immediate start of a new abuse allegation would take priority over finishing an ongoing investigation. In addition, district staff stated that they comply with the mandated requirements, but do not always document their compliance.

The Department's regional offices are responsible for supervising the district operations. However, we found that regional office staff do not routinely review cases to ensure that the districts are completing all of the steps required in CPS investigations.

In response to our draft report, Department officials told us that regional offices will review a case when they receive a complaint about the outcome of the investigation. They also stated that they performed statewide reviews when the CPS Risk Assessment Model was implemented in 1992. Finally, they stated

that the 153d sanctioning process for Foster Care and preventive cases provides oversight of district compliance for CPS-related cases.

We recognize that staff from the regional offices do investigate complaints related to CPS outcomes. However, we believe that this alone does not provide adequate coverage of the entire CPS caseload. We also believe statewide reviews, similar to those conducted in 1992 should be continued on a periodic basis. Finally, 153d monitoring does not cover CPS processing. It does not begin until after the CPS investigation has been completed and either preventive service or Foster Care is provided.

Not completing these requirements, or not completing them in a timely manner, could impact the child's safety. Thus, the districts need to improve their compliance with State CPS regulations.

We also noted that the districts were not consistently receiving the DSS-2221A mandatory reporter form. During our review, we noted that this form was not documented in 60 of the 166 case files in which a mandatory reporter was the source of the allegation. District staff stated that they did not have control over whether the mandatory reporter submits the form. They stated the districts are responsible only for educating the mandatory reporters about their responsibilities.

Recommendations

1. Monitor district operations periodically to ensure that caseworkers take all necessary action to meet Child Protective Services regulations intended to protect children.
2. Besides the districts we cited in this report, identify those districts that do not meet Child Protective Services regulations and work with all districts to identify and correct the reasons for the noncompliance.
3. Reiterate to mandatory reporters their responsibility to complete and submit a DSS-2221A form within 48 hours of their oral report.

Foster Care CAP Savings

Under the Foster Care CAP, at the start of the fiscal year, districts that anticipated spending less than their appropriation could request Departmental approval to use the anticipated savings on new initiatives in the subsequent fiscal year. The law required these new initiatives to focus on developing better ways to prevent Foster Care placements or to accelerate Foster Care discharges to either the birth parents or adoptive homes. Success in either case would result in a smaller Foster Care caseload.

During the three years ended March 31, 1995, 33 of the 58 districts, on average, spent less than their maximum limit. However, in two of the three years the CAP was in place, the 25 districts that exceeded their appropriations overspent in total more than the total amount the other 33 districts had saved. Exhibit A shows the CAP, expenditures and related savings by the 33 districts for each of the three years ended March 31, 1995. During this period, the Department authorized these districts to reinvest the total savings of \$20.1 million in further initiatives to reduce the Foster Care caseload. Each of the seven districts we audited reported CAP savings in at least one of the three State fiscal years during the three-year period ended March 31, 1995. They reported savings of nearly \$10.4 million, or 51 percent of total reported savings.

The law, however, did not require either the Department or the districts to evaluate the impact of the initiatives or to demonstrate that they were accomplishing their intended purpose, i.e., to reduce the number of Foster Care placements or to accelerate the number of Foster Care discharges to birth parents or adoptive homes. Furthermore, neither the Department nor the districts we visited set up systems to accumulate data to accomplish these objectives. As a result, the Department and the districts did not determine which of the initiatives were effective. Such analysis would identify successful initiatives of one district that could be duplicated in other districts, thus enhancing the benefit to the State. The districts we visited relied on their overall performance statistics to determine the effectiveness of their current array of services, but did not have sufficient specific data for each service or initiative. Officials at these districts advised us that they did not have enough time and resources to formally evaluate the success of each initiative at the same time they were providing mandated services.

The Foster Care CAP was discontinued in the 1995-96 State budget. Instead, the Legislature created a block grant that covers several local programs serving families and children. Specifically, the block grant reduces the State's share of reimbursement for the Child Protective Services, Preventive Services and Foster Care programs by \$158 million compared to the prior fiscal year. The block grant legislation provides flexibility about how the districts staff their

Child Protective Services units. To determine how well districts are meeting the Department's objective of protecting children, we believe both the districts and the Department need to develop performance measures that will make it possible to identify the most effective and efficient practices. Such measures are particularly important in an environment of declining resources, since they allow managers to target resources to those initiatives that are most successful, thereby making the most effective use of scarce tax dollars.

Recommendations

4. Develop performance measures, in conjunction with the districts, for all initiatives and evaluate the effectiveness of these initiatives in continuing to meet the mandate of protecting children.
5. Disseminate information about successful initiatives, and encourage other districts to consider similar initiatives to allow them to benefit from the initiatives.

Major Contributors to This Report

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DEPARTMENT OF SOCIAL SERVICES
 FOSTER CARE CAP
 DISTRICT PERFORMANCE
 APRIL 1, 1992 TO MARCH 31, 1993

EXHIBIT A
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DISTRICT	DISTRICT CAP	AMOUNT CLAIMED	AMOUNT OVER (UNDER)	APPROVED CAP SAVINGS
Albany	\$2,200,919	\$2,200,919	\$0	
Allegany	221,636	208,079	(13,557)	
Broome	2,395,130	2,018,737	(376,393)	376,393
Cattaraugus	696,336	692,470	(3,866)	
Cayuga	345,113	345,113	0	
Chautauqua	892,939	924,976	32,037	
Chemung	622,395	701,968	79,573	
Chenango	268,535	203,201	(65,334)	65,334
Clinton	477,439	492,889	15,450	
Columbia	483,478	483,478	0	
Cortland	507,154	385,610	(121,544)	121,544
Delaware	338,958	338,958	0	
Dutchess	2,341,062	2,463,066	122,004	
Erie	5,778,287	5,602,865	(175,422)	175,422
Essex	140,600	121,619	(18,981)	18,981
Franklin	142,767	133,745	(9,022)	9,022
Fulton	335,548	335,548	0	
Genesee	238,701	162,282	(76,419)	76,419
Greene	354,359	354,359	0	
Hamilton	2,391	1,123	(1,268)	
Herkimer	288,710	288,710	0	
Jefferson	528,661	528,661	0	
Lewis	196,568	168,733	(27,835)	
Livingston	477,730	362,727	(115,003)	115,003
Madison	413,880	434,341	20,461	
Monroe	8,437,946	8,437,946	0	
Montgomery	193,705	147,827	(45,878)	45,878
Nassau	5,371,950	4,541,169	(830,781)	830,781
Niagara	1,789,576	1,789,576	0	
Oneida	2,105,387	2,105,387	0	
Onondaga	5,028,859	5,028,859	0	
Ontario	396,298	396,298	0	
Orange	4,035,881	3,707,959	(327,922)	327,922
Orleans	168,525	138,681	(29,844)	
Oswego	699,547	793,848	94,301	
Otsego	540,226	315,430	(224,796)	224,796
Putnam	561,022	456,712	(104,310)	104,310
Rensselaer	818,883	590,374	(228,509)	228,509
Rockland	3,526,220	3,353,188	(173,032)	173,032
St Lawrence	574,743	535,539	(39,204)	39,204
Saratoga	385,587	336,515	(49,072)	49,072
Schenectady	2,216,258	2,204,224	(12,034)	
Schoharie	255,756	196,361	(59,395)	
Schuyler	75,787	59,170	(16,617)	16,617
Seneca	271,966	334,804	62,838	
Steuben	383,624	332,740	(50,884)	
Suffolk	7,219,780	5,249,090	(1,970,690)	1,970,690
Sullivan	783,894	898,359	114,465	
Tioga	235,850	187,482	(48,368)	48,368
Tompkins	838,836	838,836	0	
Ulster	2,403,619	2,110,917	(292,702)	292,702
Warren	237,649	127,498	(110,151)	110,151
Washington	353,920	251,889	(102,031)	102,031
Wayne	129,302	129,302	0	
Westchester	11,593,360	10,909,669	(683,691)	683,691
Wyoming	136,227	144,346	8,119	
Yates	71,764	49,936	(21,828)	21,828
TOTAL UPSTATE	82,531,243	76,654,108	(5,877,135)	6,227,700
New York City	258,792,083	266,396,297	7,604,214	0
STATEWIDE	\$341,323,326	\$343,050,405	\$1,727,079	\$6,227,700

DEPARTMENT OF SOCIAL SERVICES
 FOSTER CARE CAP
 DISTRICT PERFORMANCE
 APRIL 1, 1993 TO MARCH 31, 1994

DISTRICT	DISTRICT CAP	AMOUNT CLAIMED	AMOUNT OVER (UNDER)	APPROVED CAP SAVINGS
Albany	\$2,522,945	\$2,482,063	(\$40,882)	\$40,882
Allegany	224,475	301,178	76,703	
Broome	2,352,728	2,318,852	(33,876)	33,876
Cattaraugus	710,414	652,076	(58,338)	
Cayuga	354,360	372,556	18,196	
Chautauqua	964,443	830,254	(134,189)	134,189
Chemung	732,507	723,644	(8,863)	8,863
Chenango	252,798	205,613	(47,185)	47,185
Clinton	510,164	671,070	160,906	
Columbia	438,204	522,436	84,232	
Cortland	511,262	355,137	(156,125)	156,125
Delaware	343,926	342,286	(1,640)	
Dutchess	2,542,676	2,413,930	(128,746)	128,746
Erie	6,388,864	6,865,948	477,084	
Essex	131,855	80,698	(51,157)	51,157
Franklin	128,960	151,845	22,885	
Fulton	313,080	380,469	67,389	
Genesee	198,082	142,310	(55,772)	55,772
Greene	350,291	409,505	59,214	
Hamilton	1,148	2,560	1,412	
Herkimer	325,114	235,184	(89,930)	89,930
Jefferson	525,529	702,200	176,671	
Lewis	209,184	181,189	(27,995)	
Livingston	415,247	287,542	(127,705)	127,705
Madison	468,575	449,215	(19,360)	19,360
Monroe	8,371,003	8,691,364	320,361	
Montgomery	184,043	206,937	22,894	
Nassau	5,297,174	4,612,771	(684,403)	684,403
Niagara	1,861,265	1,534,924	(326,341)	326,341
Oneida	2,402,644	2,865,086	462,442	
Onondaga	5,006,966	5,316,887	309,921	
Ontario	384,003	336,837	(47,166)	47,166
Orange	4,101,112	3,549,174	(551,938)	551,938
Orleans	152,829	117,228	(35,601)	35,601
Oswego	834,766	1,426,925	592,159	
Otsego	535,989	466,184	(69,805)	69,805
Putnam	597,491	376,136	(221,355)	221,355
Rensselaer	824,005	819,330	(4,675)	4,675
Rockland	3,582,724	3,127,997	(454,727)	454,727
St Lawrence	574,077	664,590	90,513	
Saratoga	343,384	288,994	(54,390)	54,390
Schenectady	2,181,551	2,181,551	0	
Schoharie	244,539	278,269	33,730	
Schuyler	70,643	41,881	(28,762)	28,762
Seneca	354,806	402,471	47,665	
Steuben	350,816	270,298	(80,518)	80,518
Suffolk	6,809,725	5,279,917	(1,529,808)	1,529,808
Sullivan	903,831	818,181	(85,650)	85,650
Tioga	212,857	158,625	(54,232)	54,232
Tompkins	883,488	979,349	95,861	
Ulster	2,524,807	2,147,095	(377,712)	377,712
Warren	204,252	185,426	(18,826)	18,826
Washington	359,976	313,508	(46,468)	46,468
Wayne	131,791	145,040	13,249	
Westchester	11,831,424	10,169,709	(1,661,715)	1,661,715
Wyoming	147,732	179,280	31,548	
Yates	54,100	64,326	10,226	
TOTAL UPSTATE	84,236,644	80,096,050	(4,140,594)	7,227,882
New York City	262,737,117	264,655,931	1,918,814	0
STATEWIDE	\$346,973,761	\$344,751,981	(\$2,221,780)	\$7,227,882

DEPARTMENT OF SOCIAL SERVICES
 FOSTER CARE CAP
 DISTRICT PERFORMANCE
 APRIL 1, 1994 TO MARCH 31, 1995

DISTRICT	DISTRICT CAP	AMOUNT CLAIMED	AMOUNT OVER (UNDER)	APPROVED CAP SAVINGS
Albany	\$2,689,386	\$2,731,045	\$41,659	
Allegany	339,859	400,056	60,197	
Broome	2,415,397	2,158,774	(256,623)	146,895
Cattaraugus	719,811	719,811	0	
Cayuga	424,163	438,134	13,971	
Chautauqua	959,100	775,924	(183,176)	178,428
Chemung	867,009	867,009	0	
Chenango	235,619	195,007	(40,612)	
Clinton	753,421	780,625	27,204	
Columbia	595,773	595,773	0	
Cortland	415,941	312,676	(103,265)	87,076
Delaware	414,656	414,656	0	
Dutchess	2,530,594	1,937,819	(592,775)	519,509
Erie	7,783,979	8,511,484	727,505	
Essex	140,234	103,610	(36,624)	22,275
Franklin	170,614	140,113	(30,501)	18,521
Fulton	421,339	446,969	25,630	
Genesee	174,601	161,751	(12,850)	9,186
Greene	456,169	574,597	118,428	
Hamilton	5,579	5,579	0	
Herkimer	329,978	286,352	(43,626)	19,304
Jefferson	802,503	802,503	0	
Lewis	203,516	223,612	20,096	
Livingston	378,183	287,797	(90,386)	
Madison	475,573	429,499	(46,074)	26,568
Monroe	8,970,351	8,595,590	(374,761)	244,183
Montgomery	270,457	300,384	29,927	
Nassau	5,268,558	4,367,785	(900,773)	885,656
Niagara	1,877,709	1,756,730	(120,979)	46,560
Oneida	3,258,812	3,718,451	459,639	
Onondaga	5,364,819	4,677,485	(687,334)	767,616
Ontario	381,876	357,164	(24,712)	
Orange	3,776,523	3,652,245	(124,278)	
Orleans	150,809	133,570	(17,239)	17,227
Oswego	1,294,472	1,719,072	424,600	
Otsego	481,615	578,851	97,236	
Putnam	472,368	392,517	(79,851)	77,250
Rensselaer	998,085	998,085	0	
Rockland	3,600,831	2,823,652	(777,179)	555,215
St Lawrence	687,287	660,647	(26,640)	4,887
Saratoga	385,738	302,191	(83,547)	49,616
Schenectady	2,620,483	2,913,379	292,896	
Schoharie	279,137	101,698	(177,439)	124,583
Schuyler	72,174	46,275	(25,899)	25,141
Seneca	352,840	210,376	(142,464)	142,464
Steuben	336,215	320,211	(16,004)	6,595
Suffolk	5,929,845	4,900,239	(1,029,606)	639,390
Sullivan	913,191	678,565	(234,626)	204,633
Tioga	216,153	144,510	(71,643)	55,214
Tompkins	1,005,163	752,256	(252,907)	220,454
Ulster	2,371,438	1,984,201	(387,237)	281,134
Warren	254,324	200,930	(53,394)	50,543
Washington	336,290	344,448	8,158	
Wayne	158,744	158,744	0	
Westchester	11,906,735	10,317,017	(1,589,718)	1,250,385
Wyoming	207,722	207,722	0	
Yates	64,218	64,218	0	
TOTAL UPSTATE	88,967,979	82,680,383	(6,287,596)	6,676,508
New York City	267,501,167	292,317,281	24,816,114	0
STATEWIDE	\$356,469,146	\$374,997,664	\$18,528,518	\$6,676,508