

***State of New York
Office of the State Comptroller
Division of Management Audit
and State Financial Services***

**OFFICE OF CHILDREN AND FAMILY
SERVICES**

**CHILD PROTECTIVE SERVICES
PROGRAM**

REPORT 98-S-36



H. Carl McCall
Comptroller



State of New York Office of the State Comptroller

Division of Management Audit and State Financial Services

Report 98-S-36

Mr. John A. Johnson
Commissioner
Office of Children and Family Services
Capital View Office Park
52 Washington Street
Rensselaer, NY 12144

Dear Mr. Johnson:

The following is our audit report on the Office of Children and Family Services' Child Protective Services Program.

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

*Office of the State Comptroller
Division of Management Audit
and State Financial Services*

September 30, 1999

Executive Summary

Office of Children and Family Services Child Protective Services Program

Scope of Audit

The Office of Children and Family Services (OCFS) oversees the Child Protective Services (CPS) program, which is intended to safeguard children against abuse or maltreatment. The New York State Social Services Law (Law) requires that the State's 58 local social services districts (districts), which administer the CPS program, investigate reports of child abuse or maltreatment in their respective counties. OCFS receives such reports through the State Central Register of Child Abuse and Maltreatment, also called the toll-free child abuse hotline, and forwards them to the districts for investigation. The Law and OCFS regulations mandate specific time frames within which caseworkers must begin an investigation, do a preliminary safety assessment and make a determination as to whether a report of abuse or maltreatment is indicated (supported by credible evidence) or unfounded. Districts use OCFS' automated CONNECTIONS system for CPS operations, including transmitting reports and documenting investigation actions. Federal, State and local governments jointly fund CPS. For the year ended December 31, 1997 (the most current information at the time of our audit), OCFS reported CPS expenditures of more than \$210 million for the investigation of more than 141,000 reports.

Our audit addressed the following questions about the Child Protective Services program for the period January 1, 1997 through January 31, 1999:

- Does OCFS effectively oversee districts' investigation of reports of alleged child abuse or maltreatment?
- Do districts comply with the Law and regulations related to CPS activities?

Audit Observations and Conclusions

We found that OCFS needs to improve its oversight of districts' investigation of reports of alleged child abuse or maltreatment. We also found that districts do not always comply with the Law and regulations as to completing CPS-related actions, or completing them timely. For greater assurance that districts comply with mandated activities intended to safeguard children, OCFS should improve its oversight efforts, and work with districts to identify and correct the issues that cause noncompliance.

The Law requires OCFS to monitor districts' performance of CPS investigations and to provide them with necessary technical assistance. According to OCFS statistics, districts statewide were late in performing

40 percent of the preliminary safety assessments and 37 percent of the determinations for the six months ended June 30, 1998. OCFS relies on Comprehensive CPS Reviews for ensuring compliance. These reviews are so detailed and time-consuming that OCFS has completed just 17 such reviews (of which only 12 have been issued to date) over the last three years. There remains 41 districts that have not yet been reviewed. Further, OCFS does not maintain data about districts' caseload levels, a recommendation we made in a prior audit (Caseworker Deployment In Selected Child Welfare Programs, Report 96-S-52, issued February 10, 1998). We determined that the caseload levels at the four districts we visited were between 24 and 39 in December 1998, significantly higher than the national standard of 17 per caseworker. District personnel told us that the CONNECTIONS system is a cumbersome and sometimes unreliable tool, and one which, they feel, they have had insufficient training in using. District personnel also told us that there is insufficient oversight from OCFS officials, who do not regularly visit districts, review cases or discuss significant issues. We recommend that OCFS improve its oversight of districts' CPS practices by increasing communication with districts, by evaluating and improving its monitoring activities, including the CPS Review process, and by working with districts to maintain reasonable caseload levels. We also recommend that OCFS rectify CONNECTIONS problems that inhibit districts' use of the system, address district users' training needs and provide reference manuals. Some of these same issues were raised in a prior report on the development of the CONNECTIONS system (Report 97-S-68, issued November 17, 1998). (See pp. 5-12)

We visited four districts to test the extent to which caseworkers carry out the following mandated CPS actions upon receiving a report of alleged abuse or maltreatment: beginning an investigation within 24 hours; conducting a preliminary safety assessment within seven days; completing the investigation, and making a determination, within 60 days; and reviewing prior unfounded reports. We examined a total of 160 reports (40 at each district) and found that, out of a potential of two to three thousand investigation requirements, there were 172 instances in which requirements were not met, or were not completed timely. While this may represent a relatively low percentage of exceptions, given all the CPS actions needed, there is no tolerable error rate for child abuse or maltreatment investigations. CPS actions are required to be prompt and thorough to protect children from harm. Further, some of the exceptions were notable, such as assessments being performed almost a year late, and cases being closed without resolving issues that could pose serious risk of harm to children. We recommend that OCFS determine the reasons for noncompliance in the districts we visited, and work with districts officials to resolve these problems. (See pp. 15-20)

Comments of OCFS Officials

OCFS officials agreed with the recommendations in this report. They believe the recommendations support actions that they have already initiated, and said that they will incorporate our recommendations into ongoing plans for continuous improvement.

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Introduction

Background

The Department of Social Services (DSS) was the agency historically responsible for administering the State's child welfare programs, including Child Protective Services (CPS), a program intended to safeguard children against abuse or maltreatment. In 1997, legislation established a new Office of Children and Family Services (OCFS) to consolidate and improve programs and services to children, youth, vulnerable adults and families. Accordingly, OCFS now provides the State's 58 local social services districts (districts) that administer the CPS program with oversight, policy direction and operational support through its central office and its six regional offices (Albany, Buffalo, New York City, Rochester, Syracuse and Yonkers).

The New York State Social Services Law (Law) requires that districts investigate reports of child abuse or maltreatment in their county. District caseworkers investigate such allegations and plan necessary action if they determine that abuse or maltreatment has occurred. An abused child is a person under 18 years old whose parent or person otherwise legally responsible (caregiver) inflicts, or allows to be inflicted, a physical injury (resulting in death, disfigurement, impaired physical or emotional health or bodily function), or a substantial risk of such injury, by other than accidental means. An abused child is also one whose caregiver commits, or allows to be committed, a sex offense against the child, including incest; permits or encourages the child to engage in prostitution; or allows the child to engage in conduct that constitutes sexual performance. A maltreated child is a person under 18 years old whose caregiver fails to exercise a minimum degree of care, resulting in physical, mental or emotional impairment, or imminent danger of such impairment. Caregivers fail to provide minimum care when they do not supply the child with food, clothing, shelter, compulsory education or medical care, even though they are able to do so. Caregivers also fail to provide minimum care when they cause or allow harm, or a substantial risk of harm, to the child as a result of excessive corporal punishment, drug or alcohol abuse that causes the parent to lose self-control, or abandonment of the child.

The Law and OCFS regulations require caseworkers to begin an investigation within 24 hours of receiving a report of abuse or maltreatment, and to conduct a preliminary safety assessment within seven days. In a preliminary safety assessment, the caseworker evaluates safety factors to find out whether the child named in the report, and any other children in the household, may be in immediate danger of serious harm, a circumstance which may require an intervention. The Law and regulations also require that, within 60 days of receiving the report, the district make

a determination about whether the report (i.e., the reported or alleged maltreatment or abuse) is “indicated” or “unfounded.” A report is indicated when an investigation shows credible evidence that abuse or maltreatment exists; a report is unfounded when there is a lack of credible evidence.

An amendment to the Law, the use of OCFS’ statewide automated child welfare information system, and the availability of OCFS’ State Central Register of Child Abuse and Maltreatment are intended to help OCFS and district personnel improve efforts to safeguard children. For example, prior to February 12, 1996, reports determined to be unfounded were expunged from OCFS and district records. However, with the passage of “Elisa’s Law” (named after Elisa Izquierdo who was killed by an abusive parent in November 1995) on the above date, the Law was amended to require that unfounded reports no longer be expunged. They are legally sealed, but maintained by OCFS. Elisa’s Law authorizes disclosing such reports only if the subject requests access to the report within 90 days of notification that the report was unfounded, or if CPS receives a new report involving one or more children named in the sealed report. The district treats the unsealed report as a source of information in its investigation.

OCFS uses its automated CONNECTIONS system to manage CPS-related data. DSS began designing CONNECTIONS in 1995, and OCFS is continuing efforts to build CONNECTIONS into a single, integrated system for the recording and collection of child protective, preventive, foster care and adoption service information statewide. Currently, OCFS uses CONNECTIONS for managing and maintaining all aspects of its CPS.

OCFS’ State Central Register of Child Abuse and Maltreatment (SCR), also known as the toll-free child abuse hotline, receives reports of alleged child abuse or maltreatment. OCFS forwards the reports that warrant investigation to the districts via CONNECTIONS twenty-four hours a day, seven days a week. District CPS staff and local law enforcement agencies conduct the investigations. In 1997, the hotline received 386,378 calls, of which more than 141,000 (36 percent) were forwarded for investigation. The SCR also serves as a master database of indicated child abusers so employers (e.g., day care centers), and foster care and adoption agencies can screen out such persons as potential employees, or as foster or adoptive parents.

Federal, State and local governments jointly fund CPS. For the year ended December 31, 1997 (the most current information at the time of our audit), OCFS reported CPS expenditures of more than \$210 million, or

\$50 million more than the \$160 million expended in 1996. Districts investigated more than 140,000 reports of alleged child abuse or maltreatment in 1996 and more than 141,000 in 1997 and 1998.

Audit Scope, Objectives and Methodology

We audited OCFS' Child Protective Services program for the period January 1, 1997 through January 31, 1999. The objectives of our performance audit were to evaluate OCFS' oversight and monitoring of districts' investigation of reports of alleged child abuse or maltreatment, and districts' compliance with the Law and regulations for these activities. To accomplish these objectives, we interviewed OCFS central and regional office officials and CPS caseworkers and supervisors, and we visited district offices in Broome, Dutchess, Oneida and Suffolk counties. The districts we visited were among the top 15 statewide (excluding New York City) for the number of reports investigated during 1997. Of these 15 districts, we visited the two with the highest rate of compliance with investigation timeliness and the two with the lowest. We also reviewed applicable laws and regulations, reviewed OCFS policies and procedures, analyzed OCFS data from CONNECTIONS, and reviewed CPS investigation records and caseload documentation in counties.

We did not visit the Administration for Children's Services in New York City as part of this audit. Although we attempted to include this district in the scope of our audit, New York City officials declined to cooperate with our requests for access to their records. New York City accounts for about 40 percent of all reports annually. In addition, OCFS did not give us access to unfounded reports. Elisa's Law gives the State Comptroller the authority to access CPS information for audit purposes, given specific controls are in place to protect the confidentiality of client-identifiable information. However, OCFS officials claimed our legal authority did not allow us to access unfounded reports.

Except for the limitations cited above, 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 OCFS' internal control structure and compliance with those laws, rules and regulations that are relevant to the operations 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 such 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 to 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 Office of Children and Family Services Officials

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

While OCFS officials agreed with the recommendations contained in this report, they believe the report fails to recognize the changes that were ongoing at the time of the audit and which are continuing to be made. They also suggested several wording changes to the text of the report, which we have made.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Children and Family Services shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps they took to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Program Oversight

Section 421 of the Social Services Law requires OCFS to monitor and supervise the performance of local districts related to CPS and to provide regular, ongoing technical assistance regarding case planning, the provision of services, and the performance of other responsibilities. However, we found that districts are not completing significant numbers of assessments and determinations within mandated time frames which we attribute, in part, to inadequate monitoring of districts' activities, as well as to unresolved problems with CONNECTIONS. To help ensure districts comply with CPS laws and regulations intended to protect children, OCFS should do the following:

- increase communication with districts and evaluate OCFS monitoring activities, including the Comprehensive CPS Review process;
- determine the relationship between high caseloads and timely investigations; and
- rectify CONNECTIONS problems that inhibit districts' use of this system for CPS.

Monitoring Activities

We found that OCFS central and regional office staff need to improve their oversight of districts and review cases to ensure districts are completing all of the steps required for CPS investigations. Officials at the four districts we visited stated that there is insufficient oversight from OCFS, and specifically, from the regional offices. According to these officials, in past years DSS regional staff met regularly with the counties to discuss issues, concerns, and problems. District officials state that these meetings no longer take place, and that there is no other communication channel between the districts and OCFS. They indicated that they want increased interaction with OCFS officials to help them address significant issues, like caseworker understaffing and CONNECTIONS problems.

OCFS relies on the Comprehensive CPS Review (CPS Review) process to ensure local districts comply with CPS laws and regulations. This tool is reported as very time-consuming. During the three-year period January 1996 - December 1998, OCFS completed 17 reviews, an average of fewer than six per year. Moreover, districts like Dutchess, Oneida and Rensselaer counties, all of which ranked in the top fifteen statewide

(excluding New York City) in total reports received in 1997, have yet to have a CPS Review.

We are also concerned with the length of time that OCFS takes to release these reports. We noted that OCFS has not established timeframes for issuing reports. For 12 of the above 17 CPS Reviews, it took OCFS an average of nine months (ranging from 3 to 16 months) to release a report to the district from the time the CPS Review concluded. At the time our field work ended on January 31, 1999, OCFS had not issued reports for the last five districts reviewed, including a district reviewed in November 1997. Further, although districts are supposed to send OCFS a corrective action plan to address Review findings within 30 days of the report date, Nassau County had not submitted a plan to address a report issued in June 1998 by January 31, 1999.

CPS Reviews are very intensive and comprehensive. It takes a long time to conduct them and respond to them. Therefore, we believe OCFS should consider re-evaluating the review process. OCFS currently selects a statistical sample of 100 reports for each district it reviews, and reviewers must check each report for 58 different items. Compiling all this information, and analyzing, projecting and reporting complete review results takes an excessive amount of time. OCFS may be able to shorten the review process by reducing both the sample size and the number of items reviewed in each report.

OCFS should also consider developing alternative reporting mechanisms that can deliver review results to districts - and get their responses - more promptly. Regular monitoring is likely to improve compliance, and will definitely enhance two-way communication. Another alternative is to have regional office staff visit districts on a monthly or bi-monthly basis. On a one-day visit, the OCFS official could review 10 to 20 reports and give the district immediate oral feedback on its performance. District officials would also have the opportunity to explain CPS-related problems. OCFS could also consider using a risk-based approach to identify those districts which are in greater need of review.

In any case, OCFS needs to properly monitor the districts formally or informally, and require that corrective actions be implemented in a timely manner. Under the CPS Review process, a year passes before formal results are released and corrective actions are addressed. To improve and maintain monitoring effectiveness, OCFS should develop performance measures that show the number and timeliness of reviews OCFS has completed and the corrective actions districts have taken to resolve reported problems.

However, OCFS cannot rely on even an improved CPS Review process alone for monitoring the entire CPS caseload to determine whether districts statewide are meeting investigation requirements designed to protect children. OCFS has access to statewide compliance statistics, but it does not use this capability to assess the timeliness of required CPS activities or to work with districts to determine the reasons for non-compliance. We believe OCFS should do a periodic statewide statistical sample which it could use to project district compliance rates on a statewide basis.

OCFS data for the year ended December 31, 1997 showed that 45 percent of investigations statewide had taken more than 60 days to complete. We analyzed CONNECTIONS data for almost 27,000 indicated and undetermined (but not unfounded) reports received statewide from January 1, 1998 through June 30, 1998. A report is indicated when an investigation shows some credible evidence that abuse or maltreatment exists; a report is unfounded when there is a lack of credible evidence. As shown in *Table 1*, we found that, overall, more than 37 percent of CPS investigations took longer than the prescribed 60 days to complete, and more than 40 percent of preliminary safety assessments took more than seven days to complete. Therefore, our review shows continued problems with investigation timeliness.

**TABLE 1: Timeliness of Statewide Assessments and Determinations
January 1 - June 30, 1998**

	Safety Assess	Determinations		Safety Assess	Determinations
District	> 7 days	> 60 days	District	> 7 days	> 60 days
ALBANY	57%	32%	NIAGARA	46%	63%
ALLEGANY	74%	68%	ONEIDA	38%	50%
BROOME	56%	18%	ONONDAGA	49%	28%
CATTARAUGUS	44%	46%	ONTARIO	16%	31%
CAYUGA	57%	70%	ORANGE	30%	41%
CHAUTAUQUA	33%	48%	ORLEANS	21%	29%
CHEMUNG	27%	34%	OSWEGO	45%	36%
CHENANGO	8%	3%	OTSEGO	61%	47%
CLINTON	68%	66%	PUTNAM	71%	73%
COLUMBIA	32%	47%	RENSSELAER	75%	41%
CORTLAND	42%	24%	ROCKLAND	63%	32%
DELAWARE	73%	80%	ST. LAWRENCE	40%	25%
DUTCHESS	13%	19%	SARATOGA	73%	59%
ERIE	46%	35%	SCHENECTADY	45%	43%
ESSEX	61%	49%	SCHOHARIE	15%	12%
FRANKLIN	23%	18%	SCHUYLER	39%	21%
FULTON	50%	56%	SENECA	29%	42%
GENESEE	18%	16%	STEUBEN	34%	49%
GREENE	54%	54%	SUFFOLK	43%	61%
HAMILTON	100%	67%	SULLIVAN	50%	34%
HERKIMER	32%	63%	TIOGA	17%	10%
JEFFERSON	34%	44%	TOMPKINS	58%	48%
LEWIS	8%	12%	ULSTER	65%	26%
LIVINGSTON	34%	34%	WARREN	52%	51%
MADISON	37%	59%	WASHINGTON	53%	74%
MONROE	54%	36%	WAYNE	6%	10%
MONTGOMERY	0%	0%	WESTCHESTER	19%	38%
NASSAU	56%	43%	WYOMING	36%	29%
NEW YORK CITY	37%	34%	YATES	44%	52%
			STATEWIDE	40%	37%

Not completing CPS investigation requirements, or not completing them timely, could significantly affect child safety. We believe OCFS needs to improve communication with the districts and its overall monitoring of their performance, and require that they comply with CPS laws and regulations.

In responding to our preliminary findings, OCFS officials informed us of recent changes to their approach for monitoring local child protective services. In January 1999, OCFS implemented an additional district review process. This includes a desk review of district CPS data, caseload and staffing information and a case review survey.

OCFS expects that this process will be less labor intensive than the CPS Reviews and will allow them to conduct more reviews and have a better understanding of child protective services in all districts. The Comprehensive Case Reviews will continue to be conducted every other month.

Caseload Levels

Districts' lack of compliance with investigation requirements may also be attributable in part to relatively high caseloads. High caseload levels may make it more difficult for caseworkers to perform their duties effectively, thereby increasing the risks to children. The Child Welfare League of America (CWLA), a nationally recognized not-for-profit organization active in the area of child welfare, has published a standard of no more than 17 cases per CPS caseworker.

While we believe OCFS needs data such as district caseworker numbers and caseload levels to effectively oversee the program's implementation, OCFS could not provide us with this information. Thus, we determined caseworker and caseload information for the four counties we visited (Broome, Dutchess, Oneida, and Suffolk counties) as of December 31, 1998. As shown in *Table 2*, caseloads have risen significantly since January 1997 in Broome and Oneida counties while levels in Dutchess and Suffolk have remained steady.

TABLE 2: Caseload Levels in Districts Visited				
	December 1998		January 1997	
District	Average Caseload	Highest Individual Caseload	Average Caseload	Highest Individual Caseload
Broome	24	68	16	34
Dutchess	26	39	25	40
Oneida	39	70	20	34
Suffolk	29	n/a	29*	n/a

* as of 12/96

n/a = not available

In our prior audit, entitled "Caseworker Deployment in Selected Child Welfare Programs," (Report 96-S-52, issued February 10, 1998), we found that DSS, the predecessor agency in administering this program,

could not calculate caseload numbers because it did not know the number of CPS caseworkers in each district. Therefore, based on a survey we sent to all 58 districts, we computed caseload ratios for 55 districts (three did not respond) and found that the ratios in many districts exceeded CWLA standards. We recommended that DSS develop caseload standards, monitor caseloads against those standards, and identify reasons for significant caseload variances. DSS disagreed with this recommendation, stating that the Law prevented its enforcement of caseload standards. Enforcement capability notwithstanding, we restate our recommendation to maintain caseworker and caseload statistics, using the data we developed as a benchmark. OCFS can then determine whether there is a relationship between noncompliance and high caseloads levels. Where a relationship exists, OCFS should work with districts to manage and reduce caseloads to reasonable levels.

OCFS officials indicated that several changes occurred in 1999 that were designed to improve oversight and supervision of local CPS operations. These include the establishment of a separate regional office in New York City, hiring additional staff and new legislation that will impact the investigation and review of child fatality cases.

Use of the CONNECTIONS System

CONNECTIONS is critical to CPS functions such as: recording reports received from the public via a telephone hotline; transmitting reports to local districts for investigation; documenting investigation actions, safety assessments and determinations; recording supervisory review and approval; monitoring caseloads; producing monthly management reports; maintaining the sealed unfounded report inventory; and capturing data used to assess district performance. However, at each of the four districts we visited, CPS caseworkers and supervisors consistently stated that CONNECTIONS is causing significant problems. Caseworkers said that they find CONNECTIONS very time-consuming and cumbersome to use because it requires so many screens to document CPS investigation actions. For example, whereas the prior information system required caseworkers to fill out one page of information for a report of alleged child abuse or maltreatment, CONNECTIONS requires that they complete approximately six pages of details and family information for each report. As a result, caseworkers state, they have less time to spend with families.

In addition, CPS staff believe the Person Search function in CONNECTIONS is unreliable as a tool for conducting investigations. Caseworkers are required to use CONNECTIONS' Person Search capability to identify any prior reports of alleged child abuse or maltreatment when investigating current reports. We tested the Person Search function and observed that it requires very specific and accurate search criteria (i.e., the correct

spelling of a person's name, address, or case number) to return reliable data. When even a slight spelling error is made, CONNECTIONS may not return all possible matches. Therefore, given the limitations of Person Search, caseworkers may not be able to identify all the matches that actually exist. The failure to identify a prior report could result in serious harm to children with a history of being abused or mistreated.

Caseworkers also told us that, in many cases, they maintain duplicate hard copy records because they lack faith in the reliability of CONNECTIONS data, and think manual records are easier to access than those maintained on the system. Local social services officials have voiced similar concerns before, as we reported in a prior report on the development of the CONNECTIONS system (Report 97-S-68, issued November 17, 1998). In that audit, we surveyed local officials and found that 69 percent of them consider CONNECTIONS unreliable. Many of them reported maintaining duplicate records. That audit also found that, in certain instances, erroneous information about child abuse or maltreatment cannot be corrected on the system, and that child abuse hotline information is sometimes lost. Although OCFS responded at that time that related technical and quality assurance issues had been (or would shortly be) addressed to resolve these problems, we found in this audit that the problems still persist.

CONNECTIONS has the potential to be a useful tool for districts to use to manage their caseloads, carry out and document CPS investigations and achieve compliance with mandated time frames. However, OCFS must take steps to refine this tool in response to feedback from caseworkers and supervisors, and to adequately train district personnel in using it.

We found that OCFS has not established effective communication between CONNECTIONS system developers and district users so that system personnel can make changes in response to user needs. In response to our preliminary findings, OCFS officials told us that throughout 1998, they held extensive design review sessions with CONNECTIONS users. These sessions resulted in a prioritized plan of proposed system changes. Several changes are in process and the remainder await approval.

District caseworkers and supervisors told us that OCFS has not provided them with sufficient CONNECTIONS training or given them an adequate reference manual to use. While we recognize that OCFS has provided significant CONNECTIONS training, district caseworkers and supervisors consistently told us that it was insufficient or inadequate. Many told us that they had never received CONNECTIONS training.

Recommendations

1. Enhance oversight of district operations to ensure caseworkers take all necessary actions to meet CPS laws and regulations intended to protect children. To do this, OCFS should:
 - reestablish regular communication between OCFS and the districts to facilitate the discussion of issues, concerns and problems;
 - evaluate the CPS Review process; if it is retained, establish measurable performance indicators and desired outcomes (e.g., reviews per year);
 - consider alternatives or modifications to CPS Reviews to provide more timely oversight and monitoring of CPS activities;
 - monitor CPS caseload levels; identify reasons for high caseworker caseloads and work with districts to establish reasonable caseload levels; and
 - use available statewide data to identify districts that are not in compliance, and work with them to identify and correct the reasons for the noncompliance.

(OCFS officials stated that they had identified oversight of local CPS operations as an area for improvement prior to this audit. A review of the comprehensive CPS process is underway with a goal of streamlining the process. Timeframes for Comprehensive CPS Reviews have been shortened. Officials believe these changes have strengthened their oversight role and stated that they will continue to refine the system.)

2. Solicit feedback from CONNECTIONS users regarding system problems which affect their ability to effectively meet CPS investigation requirements.

(OCFS officials stated that they have already made users a cornerstone of overall system improvement. Continuing implementation of CONNECTIONS is designed to address user-identified training and system changes.)

Recommendations (Cont'd)

3. Modify the CONNECTIONS Person Search function to enable users to identify prior reports more efficiently and effectively.

(OCFS officials responded that meetings with users resulted in a proposal for a long-term redesign of Person Search, as well as identification of some shorter-term enhancements that would significantly improve CONNECTIONS consistency and reliability. They state that some of these short-term improvements were implemented in April 1999.)

4. Solicit feedback from caseworkers and supervisors concerning CONNECTIONS training needs and address those needs in future training efforts. Develop and distribute a user-friendly CONNECTIONS reference manual.

(OCFS officials said that they have recently engaged in a comprehensive needs assessment process designed to assess the training needs of local district staff. This has included visits to local districts, user interviews, and the development of draft training options.)

Districts' Compliance With Investigation Requirements

Section 424 of the Social Services Law and OCFS regulations prescribe the activities districts must perform during a CPS investigation from the time the report of alleged abuse or maltreatment is received until the case is closed and CPS ends its involvement with the family. Districts are required to carry out these activities according to specific steps and time frames to ensure the safety of the child or children involved.

We visited four districts (Broome, Dutchess, Oneida and Suffolk) to assess compliance with CPS investigation requirements. To do this, we examined a total of 160 reports (40 at each district) to test compliance with mandated steps and time frames and to identify reasons for any noncompliance noted. At each district, we randomly selected from a CONNECTIONS database a sample of 30 reports from among those received during the six-month period ended June 30, 1998. The database totaled almost 27,000 indicated or undetermined (but not unfounded) reports. We also tested a sample of 10 reports, judgementally selected from each district's manual report intake log, for which investigations were still ongoing at the time of our audit.

For the 160 reports we reviewed, we noted 172 instances in which CPS investigation requirements were not met for the initial 24-hour investigation, the preliminary safety assessment, the completion of investigations and determinations, and the review of prior reports. Our review included as many as 20 investigation requirements for each report. Depending on the circumstances, these 160 reports could have had a total of two to three thousand investigation requirements. Therefore, the number of exceptions we noted was not large. However, we believe there is no tolerable error rate for investigations of child abuse or maltreatment. It is essential that OCFS work with districts to help eliminate all such exceptions that can compromise child safety.

Initial 24-Hour Investigations

Within 24 hours of receiving a report of alleged child abuse or maltreatment, the CPS unit must begin an investigation. A caseworker must meet in person, or contact by telephone, the alleged abuser and/or the child or any individuals named in the allegation (or other persons able to provide information) to assess the risk of immediate danger to the child.

As shown in *Table 3*, we noted 13 instances in which these requirements were not met during initial 24-hour investigations.

TABLE 3: Initial 24-Hour Investigation Requirement					
Compliance Item Not Met	Broome	Dutchess	Oneida	Suffolk	Total
An investigation was not started within 24 hours after the report was received	1	2	2	3	8
An assessment of the risk of immediate danger to the child was not made within 24 hours of receiving the report	1	0	1	3	5
Total	2	2	3	6	13

Of the 13 exceptions we noted, the following represent three instances in which there were excessive days in making this initial contact with the family. District officials were unable to provide specific reasons for the delays noted in these instances.

- In Oneida County, initial contact took seven days for a report alleging that a stepfather choked his stepson; the child’s mother was not contacted for eleven days.
- In Suffolk County, initial contact on a report alleging educational neglect, inadequate guardianship and parent’s drug/alcohol misuse took seven days.
- In another instance in Oneida County, initial caseworker contact on a report alleging educational neglect and inadequate guardianship took eight days.

Preliminary Safety Assessments

Within seven days of receiving a report, a caseworker must complete a preliminary safety assessment for all children in the home, even if they were not included in the allegations made in the report. If the assessment indicates that any child in the household is unsafe, the caseworker must pursue immediate and appropriate controlling interventions (e.g., removing the child from the home) to protect the child.

As shown in *Table 4*, we noted 55 instances in which the requirement or required timeframes for preliminary safety assessments was not met.

TABLE 4: Preliminary Safety Assessments					
Compliance Item Not Met	Broome	Dutchess	Oneida	Suffolk	Total
Preliminary safety assessment was due, but not completed, by end of audit work	2	0	0	1	3
Preliminary safety assessment was completed, but not within 7 days	18	3	17	14	52
Total	20	3	17	15	55

In the three instances in which a preliminary safety assessment was not completed by the end of our audit field work, the assessments were overdue by 258, 286 and 380 days. The cases for which these assessments had yet to be done included reports of serious allegations, including sexual abuse, excessive corporal punishment, lack of medical care, and lacerations, bruises and welts. In the remaining 52 instances, the preliminary safety assessments were done, but were completed late. Some assessments were just a day or two late, but others were several months late.

Completed Investigations and Determinations

Within 60 days of receiving a report, the district CPS unit must complete its investigation, and address each allegation that was made in the report, as well as any other abuse or maltreatment that was found during the investigation. A complete CPS investigation requires the following elements: a review of prior reports of alleged child abuse or maltreatment; a home visit to evaluate the household environment; face-to-face contact with all children in the household and the alleged abuser, as named in the report; and a medical exam for the children, if necessary. After completing the investigation, the caseworker must determine whether the report is indicated or unfounded.

If the report is indicated, the caseworker must assess whether the children are at risk of future abuse or maltreatment. If the caseworker determines that the risk of future abuse or maltreatment is low, the case may be closed even if abuse or maltreatment occurred. However, if the caseworker assesses the risk of future abuse or maltreatment as sufficiently high, the case must generally be kept open. The district should provide rehabilitative services to reduce that risk, unless there is appropriate justification for closing the case despite the higher risk rating.

As described in *Table 5*, we found 75 instances in which caseworkers either did not complete the required elements of the investigation or did not complete determinations timely. This includes two instances in which caseworkers appear to have inappropriately closed cases.

TABLE 5: Investigations and Determinations					
Compliance Item Not Met	Broome	Dutchess	Oneida	Suffolk	Total
A home visit was not conducted during the investigation	0	1	0	0	1
Face-to-face contact with all children and alleged subject(s) did not take place	0	0	5	0	5
A determination was not completed by the end of our audit field work	8	0	9	9	26
A determination was not completed within 60 days	11	6	10	13	40
Child did not receive a medical exam	0	1	0	0	1
Case closing did not appear appropriate	0	0	2	0	2
Total	19	8	26	22	75

At the time of our site visits, districts had not completed determinations for 24 open investigations between 64 to 83 days old. The two remaining cases for which determinations were not completed at the end of our field work involve a Broome County report received May 8, 1998 alleging sexual abuse (265 days old) and an Oneida County report received on June 30, 1998 alleging inadequate guardianship and lack of supervision (169 days old). In 40 instances in which districts completed determinations, but did not complete them timely, they took from 62 to 230 days to complete the determinations.

We also found two instances in Oneida County in which cases appear to have been inappropriately closed. The first case involved the allegation that a man had choked his 16-year old stepson, the same report for which the initial contact was made after 8 days, rather than within 24 hours. The household, consisting of a family of two parents and four children, was already the source of eight unrelated indicated reports during the prior three-year period. Despite a history of indicated reports in this family, the caseworker reported this was an isolated incident. The caseworker then closed the case, despite the potential for a pattern of abuse, as well as conflicting stories from the stepson, family members and others as to what transpired.

In the second case, a hospital reported to the SCR that the newborn child of a single 21-year old woman had tested positive for marijuana at birth. In the hospital, this mother of two very young children

informed the caseworker that she had been using drugs since she was 14 and did not realize they were harmful. Case notes show the caseworker made a home visit four days after the report, at which time the mother told the caseworker she would continue substance abuse treatment. In this instance, the district closed the case without determining whether the mother actually received the drug counseling she needed. In addition, there was a discrepancy between CONNECTIONS data and district records concerning the report's status. Although CONNECTIONS indicates the report is open for voluntary services, district records indicate the case is closed.

Review of Prior CPS Reports

According to Elisa's Law, all reports received on or after February 12, 1996 that are subsequently determined to be unfounded must be legally sealed, but maintained by OCFS. Elisa's Law authorizes the disclosure of information in legally sealed reports for investigation purposes if CPS receives a new report involving one or more children named in the sealed report. District caseworkers should review these prior unfounded reports, just as they would any indicated reports, because they may be relevant to the new report. It is possible that this information, combined with current information, may show evidence of a pattern of behavior that could indicate abuse or maltreatment.

Since OCFS would not give us access to unfounded reports during our audit, our compliance review was limited to district actions regarding indicated and undetermined reports. However, based on our observations of caseworker activities at the districts we visited, it appears that caseworkers generally do review prior CPS reports for pertinent information when investigating new reports. However, as a result of our review of caseworker documentation for CPS investigation activities, we identified 29 instances in Oneida County which showed no evidence that prior CPS reports were reviewed during the investigation of new reports. By not examining these prior reports which are now available for review, the district could have missed the opportunity to identify a pattern of behavior that may indicate child abuse or maltreatment.

Recommendation

5. Investigate the reasons for noncompliance in the districts we visited, and work with the districts to resolve these problems.

(OCFS officials indicated that they have completed Comprehensive CPS Reviews at two of the districts we visited and have scheduled reviews for the other two. They stated that regional offices are working with these districts to complete corrective action plans, and are conducting ongoing monitoring and technical assistance.)

Major Contributors to This Report

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**New York State
Office of
Children & Family
Services**

George E. Pataki
Governor

John A. Johnson
Commissioner

September 7, 1999

FAX AND MAIL

William P. Challice, Audit Director
NYS Office of the State Comptroller
Division of Management Audit
270 Broadway, 19th Floor
New York, New York 10007

Re: OSC Audit #98-S-36
Child Protective Services

Dear Mr. Challice:

Capital View Office Park

52 Washington Street
Rensselaer, NY 12144-2796

The Office of Children and Family Services (OCFS) believes the recommendations contained within the above-cited audit report are supportive of actions already initiated by the agency to strengthen oversight of the Child Protective Services (CPS) program. Promoting the well-being and safety of our children, families and communities represents this Agency's public mission to the State of New York. The audit report has been a useful tool and will continue to be as we strengthen and refine current efforts.

The CPS program will continue to be an area of focus for this agency, and the recommendations contained in the audit report will be incorporated into ongoing plans for continuous improvement in this important area.

Sincerely,

John A. Johnson



An Equal Opportunity Employer

Response to OSC Draft Report #98-S-36: Child Protective Services

General Comments

At the outset, it should be noted that the body of this report on Child Protective Services (CPS) fails to acknowledge the actions that the Office of Children and Family Services (OCFS) which became operational on January 8, 1998, has taken to improve its monitoring of local social services districts in general or to acknowledge steps taken to improve the CPS case review process, in particular. The OSC comment that "We considered their response in preparing this report" is a woefully inadequate and unfair response to the information that OCFS provided to OSC. The CPS report is truly a "point in time" study that fails to reflect the changes that were ongoing at the time of the study, and which are continuing to be made.

The report refers to "abuse" throughout. However, the State Central Register (SCR) reports and subsequent CPS investigations may involve allegations of maltreatment which do not rise to the level of abuse. The report should be revised to reflect this.

On Page 1 in the Background section of the report, the second paragraph of this section should include references to "person otherwise legally responsible" as potential subjects (i.e., alleged abusers). The word "financially" should be deleted from the penultimate sentence in this paragraph; parents may be able to provide food, shelter, clothing, education or medical care even if "financially" unable to do so [Family Court Act Section 1012(f)(1)(A)].

On Page 2 in the Background section of the report the last sentence of penultimate paragraph should be revised to read as follows:

The SCR also serves as a master database of indicated [familial] child abusers or maltreaters so employers (e.g., day care centers) and foster care and adoption agencies can screen out such persons as potential employees, or foster or adoptive parents.

On Page 6 (last paragraph) and Page 8 (first full paragraph), OCFS objects to the use of the term "ensure" in these two paragraphs. Although statutorily required to monitor and supervise the districts child protective services activities, OCFS does not have a statutory responsibility to "ensure" (i.e., guarantee) that certain actions are taken by the districts.

On Page 7 the statutory standard for initial indication of cases of child abuse and maltreatment is "some credible evidence." [Social Services Law Section 312(13)].

On Page 13 in the Initial 24-Hour Investigations section of the report, the applicable regulation, 18 NYCRR 432.2(b)(3) requires that an investigation be commenced within 24 hours of receipt of a report. A telephone or face-to-face interview with the alleged perpetrator and/or the child or other persons named in the report must occur within 24 hours of receipt of the report. There is no absolute requirement that the alleged perpetrator, child and witnesses all be contacted within the initial 24-hour period.

On Page 14 in the Preliminary Safety Assessments section of the report, the last sentence should be revised to read "As shown in Table 4, we noted 55 instances in which the requirement or required time frames for preliminary safety assessments was not met." This change will clarify that untimely assessments were nonetheless completed.

On Page 17 in the Review of Prior CPS Reports section of the report the first sentence should be revised to indicate that reports received on or after February 12, 1996 and subsequently unfounded are legally sealed.

Following is the remainder of the OCFS response, which is organized to parallel that of the OSC draft report:

Recommendation #1: Enhance oversight of district operations to ensure caseworkers take all necessary actions to meet CPS laws and regulations intended to protect children.

OCFS had already identified oversight of local district CPS operations as an area for improvement prior to issuance to the audit report. The agency's previous response to an earlier draft of this report informed OSC of the "new two-pronged approach implemented by OCFS to monitor local child protective services..." This new process, which the Division of Development and Prevention Services has initiated, was developed precisely because OCFS concluded, prior to the OSC study, that the then system of CPS monitoring reviews was too detailed and time consuming. Thus, in January of 1999 OCFS initiated the "Ongoing Monitoring and Assessment" (OMA) in review process to provide OCFS the capacity to review all districts statewide in a manner that was more frequent, less detailed, and less time consuming. Use of the OMA process will also allow OCFS to better target the districts that require the more comprehensive case review of their CPS practices.

The Comprehensive CPS Reviews are conducted in a specific district on a periodic basis. Selection of districts for the comprehensive review will be based upon input from the Regional Office Directors incorporating the information obtained from the OMAs. Moreover, any district that requests that a

comprehensive review be done will be scheduled for one. The comprehensive review will look at 100 reports received by the districts within the past year, and the decisions made during key points of the investigation.

Both review processes are aimed at assessing the delivery of child protective services in New York State. They are not fiscal audits, but rather they are program reviews intended to promote consistency in child protective services, and to identify ways to improve and enhance services to families in New York State.

In the past 3 years, the Office has conducted comprehensive CPS reviews in 18 local districts. In addition, a review of the Comprehensive CPS process is currently underway with a goal of streamlining the process. Timeframes for the process have also been shortened. OCFS Regional Offices are now assigned the responsibility of writing the sections of the report. The last two (2) reviews which were conducted under the new approach showed improved response time, reducing the timeframes for the entire process including issuance of a final report, by 3-6 months.

In the first eight (8) months of 1999 the Office conducted OMA's in 15 local districts.

The establishment of the OMA process, announced to local districts in January 1999, has substantially increased communication between OCFS and local districts. While not the only venue of communication with districts, the OMA process has strengthened the OCFS oversight role and provided a structured forum to identify issues and concerns, identify needed corrective action and focus technical assistance.

While OCFS will continue to refine the system, we have seen positive results of our efforts to date. The following examples, all from different counties, are illustrative of corrective action plans prepared by local districts:

- The findings from one OMA were substandard, including inadequate 24 hour and 7 day assessments. The Regional Office presented the findings and worked with the local district to develop better ways to conduct investigations and standardize case practice. As a result of their corrective action plan, the district has instituted a quality assurance record review. Checklists have been used as prompts for both supervision and staff to keep the investigation focused and complete all 6 elements of a thorough investigation. Regional Office staff meet with the district on a bi-weekly basis to review records, and debrief supervision. As a result of this activity the district reorganized it's Children's Services Unit to increase the focus on CPS investigations. The Regional Office has also arranged follow-up training for the fall.

- In yet another district, a formal case review questionnaire was initiated for supervisory conferences. Caseworkers will receive training on Risk Assessment. In addition, a specialized unit to investigate sexual abuse and serious physical abuse was established. The district also initiated a group administrative review of a sample of cases.
- As a result of a review, a local district immediately devised a "checklist" for caseworkers that incorporated the six required activities to ensure the safety of children in their district. The checklist was subject to supervisory approval prior to closing any case investigation. If a particular activity was not completed, an explanation was required.
- Another district implemented a case record review of cases by line supervisors to ensure documentation of case information and practices. A subsequent review is done on 30% of the cases on a weekly basis by the Grade A supervisor. Since the implementation of the weekly review, the district reports significant progress in their compliance with State Standards. (State Report in 1997 showed compliance of 70%, in April of 1999, the district reports a compliance of 93%, based on their own internal audits).
- As a result of a review in yet another district, one of the review findings indicated that there was a lack of supervisory oversight of casework activities in: contact with the family (ies), timely determinations, contact with collateral sources and contacts with other individuals named in the report. As a result of the review findings and the required actions noted in the report, the county has developed a "face sheet" to be attached to each case record to aid in monitoring CPS contacts and activities. The CPS supervisors are scheduling weekly meetings with the caseworkers based on "Office Day" schedules. The Regional Office is supporting this effort through the assistance of the CPS Specialist who will be reviewing CPS investigation requirements with all NCDSS CPS staff and will provide a half-day training for staff on the CPS investigative standards.
- **New York City:** With the recent creation of the New York City Regional Office (NYCRO), OCFS has embarked on a number of steps to more effectively supervise the Administration for Children's Services (ACS), including quarterly meetings between NYCRO and ACS to discuss corrective action plan implementation concerning the outcomes of child fatality reviews, case reviews of child welfare cases, including a commitment for a large review of CPS cases to occur in January 2000; and review of the current CPS training provided by ACS.

Additional Improvements

The OSC report acknowledges that OCFS cannot rely on a CPS review process alone. However, the report fails to acknowledge other avenues for monitoring local districts that are conducted routinely by OCFS, primarily through the work of the Regional Offices. These activities include complaint investigations, integrated County Planning and Comprehensive Services plan, routine site visits and response to technical assistance requests. In addition, contrary to the assertions in the report, Regional Office staff do have regularly scheduled regional meetings for district representatives.

During 1999, OCFS instituted several other changes designed to improve the State's presence and supervision of child protective case practices in New York State. The creation of a separate Regional Office in NYC (NYCRO) not only allows one office to focus specifically on NYC child welfare but also has resulted in an additional Regional Office. The new Yonkers Regional Office will focus its resources on oversight of districts in the lower Hudson region and Long Island.

It is worthy of note that on June 30, 1999, Governor George E. Pataki signed into law legislation that made major improvements to the State child protection system. This legislation will have a significant impact on New York State on the investigation and review of child fatality cases.

As a corollary to our efforts to monitor local CPS performance, OCFS plans to take steps to encourage and support local district self-assessments or self-monitoring. OCFS, in the near future, will be sharing both the OMA and Comprehensive CPS case record review instruments with the local districts to encourage district supervisors and managers to routinely utilize these instruments in conducting their own case record reviews.

Finally, OCFS has distributed the 1997 and 1998 Child Fatalities, Annual Cumulative Reports to every local social services commissioner in the State. Further, the OCFS Regional Offices will meet with all the local Directors of Services in their region to review these reports, facilitate discussion and solicit input about steps both social services districts and OCFS should be taking to prevent future child fatalities.

Recommendation #2: Solicit feedback from CONNECTIONS users regarding system problems which affect their ability to effectively meet CPS investigation requirements.

Recommendation #3: Modify the CONNECTIONS Person Search function to enable users to identify prior reports more efficiently and effectively.

Recommendation #4: Solicit feedback from caseworkers and supervisors concerning CONNECTIONS training needs and address those needs in future training efforts. Develop and distribute user-friendly CONNECTIONS reference manual.

While user input is the common theme of all three (3) recommendations, OCFS has already made users a cornerstone of overall system improvement. Continuing implementation under CONNECTIONS project management is specifically designed to address user-identified training and system changes, especially where such changes pertain to compliance with CPS investigation requirements as noted in the audit. The following details how OCFS has reflected and will continue to reflect the importance of users in its management of CONNECTIONS implementation.

Since continuing efforts began in the winter of 1998, OCFS has convened operational workgroups with users to review specific system issues (person search, intake/IRI Reports) as well as general design issues. The Person Search effort consisted of district site visits in early 1998, development of a preliminary proposal shared with districts in the fall of 1998, joint district/state workgroup meetings in November and December of 1998, and a prototype of early improvements in February of 1999. The intake/IRI Report Improvement workgroup met via conference call in October of 1998 and January of 1999. A prototype of the revised reports was supported in June of 1999. Design documentation and meeting minutes were shared throughout the development periods for both items. A general design user workgroup met for two, 2-day sessions in both June and August of 1999, and a follow-up with the same group is scheduled for September of 1999. Additionally, users from the SCR and OCFS Regional Offices met on July 15, 1999 to discuss system issues, proposed resolutions, and prioritization for implementation.

Meetings with users, as described above, resulted in a proposal for a long-term redesign of Person Search, as well as identification of some shorter term improvements that would significantly improve the consistency and reliability of the phonetic Person Search. The latter improvements were implemented with build 11.1 on April 12, 1999, and included: scoring modifications to return better matches to the top of the list, improved filters to reduce the impact of search limits when very common names are searched, edit list improvements and consistency in results for identical searches.

Planned modifications to CONNECTIONS include: elimination of search limits, window usability improvements, improved address searching, increased accuracy when searches include hyphenated-names, multi-word names or nicknames, redefined rules and clear messages relative to results returned, resolution of some data quality issues that impact Person Search, and an output

to support offline review and comparison to other systems. Valuable federal resources to be had could have been jeopardized by undertaking improvements without federal action on the State's planning document which was submitted on July 1st for their consideration.

Over the past two (2) months OCFS has also been engaged in a comprehensive needs assessment process designed to assess the training needs of local district staff. In this process, staff has visited upstate local districts of varying sizes, as well as New York City management and training staff, interviewed CONNECTIONS users at different levels in each site, and developed a set of draft training options based on the results of these sessions. In addition, we have used the information gathered in these visits to develop a formal, statewide needs assessment document that will elicit feedback from every social services district in the state regarding their CONNECTIONS related training needs for CPS workers. This document has been released. Our overall training strategy for CPS workers will be based in large part on the results of these efforts.

Notwithstanding the information to be obtained through the use of the needs assessment document, we have already begun to plan and deliver training based upon initial feedback from the users. In June, we began offering a one-day course "Building Blocks" which provides instructor-led "hands-on" training at the computer to all new CONNECTIONS workers. This one-day training course is part of an ongoing initiative to provide lab based "hands on" computer training and on-site post implementation training in the use of the CONNECTIONS system to enable child welfare caseworkers to use CONNECTIONS to accomplish all aspects of their jobs. The course is being scheduled as needed throughout upstate and in New York City.

In addition, we have a wide range of training materials and system documentation to convey CONNECTIONS requirements to local users. Below is a listing of several of these training areas. All of these materials and aids will be reviewed as part of the needs assessment and future changes to the application.

1. **On-line Help:** The CONNECTIONS system contains an extensive on line help feature that can be accessed by users in several ways.
2. **Desk Aids:** A series of desk aids for users which provide a step by step guide to the completion of important processes paired with corresponding CONNECTIONS screens.
- 3 **Job Aids:** These Aids provide a combination of step by step guidance and more general instructions and information regarding particular issues or system components.

4. **Release Notes:** A Set of "Release Notes" has been issued with every major CONNECTIONS build. These documents contain extensive documentation explaining each feature of the new build as well as how the system has changed as a result of the build.

5. **Training Materials:** A variety of training curricula and supportive materials have been downloaded to each users hard drive so that they are available to be accessed by every user in the state.

6. **Reference Manual:** We have developed and are continuing to develop training materials that are available for CPS workers and can be accessed via the Intranet.

7. **Intranet Site:** In order to facilitate access to many of these materials, OCFS has established a training site on its intranet which contains job aides, desk aids, and other training materials.

Our current training efforts are an extension as well as continuation of our past efforts to satisfy CONNECTIONS training needs.

Past Training

Our multi-pronged approach to training that utilized instructor-led training, Computer Based Training (CBT), teleconference training, job aids and desk aids is ongoing. We have also developed, and are designing plans to improve and refine, on-line help, which is available to every worker on her/his PC.

Our training database (TDB) that remains available to CPS workers and supervisors to help prepare them for work in CONNECTIONS. The TDB creates a simulated CONNECTIONS environment in which staff practice business functions on CPS cases. The TDB is available to workers on their PCs. We have continued to improve the training database to become a more effective tool for training CONNECTIONS users.

Instructor-led training, although not necessarily at the computer, is provided to all CONNECTIONS users. Pre-implementation Training was offered to every worker, administrator and supervisor. This training provided an introduction to CONNECTIONS and an overview of the functionality included in each of the releases. Participants learned how existing practices would be impacted by CONNECTIONS and were given time to plan for the transitions. A Supervisory Skills Course was developed specifically for all CPS supervisors. The training provided an opportunity for trainees to gain experience using system functionality to manage, review and modify unit workloads. Other instructor led training include; Application Security Training for security coordinators and a hands-on

computer training course, Preparing to Help, to train selected staff to help colleagues utilize CONNECTIONS.

Recommendation #5: Investigate the reasons for non-compliance in the districts we visited, and work with the districts to resolve these problems.

Concerning the four (4) districts included in this audit, OCFS completed Comprehensive CPS reviews in Broome and Suffolk and has scheduled Comprehensive CPS Reviews in Oneida and Dutchess. In the two (2) districts where the comprehensive CPS case reviews have been completed, the Regional Offices are working with the districts to complete plans of corrective action. The Regional Offices are also conducting ongoing monitoring and technical assistance efforts.

Other steps have been taken to improve OCFS' capacity to both monitor and supervise local districts. The 1998-99 budget included 15 new positions in upstate Regional Offices. In addition, 17 new positions were added to the existing resources in New York City. As noted in our response to Recommendation #1, the NYCRO has been created with additional staffing resources to supervise New York City only. The former Metropolitan Regional Office (MRO) was responsible for supervising child welfare practice in New York City and in nine (9) other districts in the lower Hudson Valley and Long Island. Now, since the beginning of January 1999, there are two (2) Regional Offices – one for the five (5) boroughs of New York City (the NYC Regional Office [NYCRO]) and another office for the remaining nine counties (The Yonkers Regional Office [YRO]). The Central Office has also added additional staff to the Monitoring and Compliance Unit.