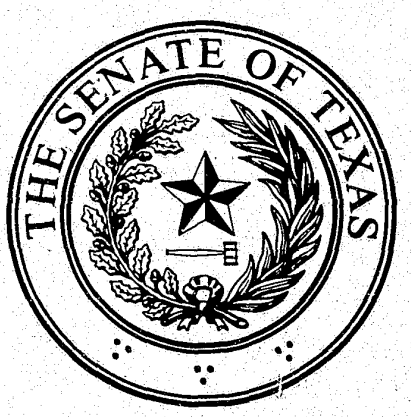

CHILD PROTECTIVE SERVICES IN TEXAS

Staff Report

to the

Senate Committee on Health and Human Services

FEBRUARY 1989

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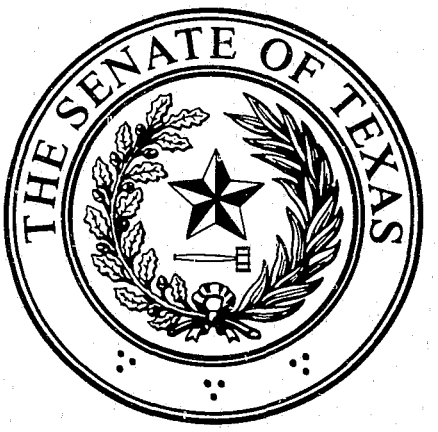

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"The children we fail to protect today will possibly be the adults we protect ourselves from tomorrow."

ACKNOWLEDGEMENTS

The Committee wishes to express its appreciation to the many witnesses who testified at our public hearings, to the individuals who shared very personal information with us in order to help identify and document weaknesses in our child protective services system, and to the community organizations and private citizens for ongoing encouragement and support for our efforts. We are especially grateful to the child protective services caseworkers, current and former, who offered valuable insight and suggestions with regard to problems within their own agency which impede and impair their ability to deal effectively with children and families experiencing abuse in their homes.

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INTRODUCTION AND OVERVIEW

INTRODUCTION AND OVERVIEW

The Child Protective Services (CPS) program administered by the Texas Department of Human Services has come under intense scrutiny over the past 18 months, including:

* A grand jury investigation involving the falsification of child protective services case records;

* An official investigation by the Texas Attorney General's Office regarding allegations that certain child abuse cases were handled inappropriately and inadequately;

* A class action lawsuit filed in federal court by adoptive parents claiming they were denied access to essential medical and psychological records of children adopted through the Department;

* Two legislative interim studies conducted by the House Select Committee on Child Abuse and Neglect and Child Pornography and the Senate Committee on Health and Human Services; and

* Two separate studies authorized by the Texas Board of Human Services: 1) an internal review of the way incoming reports of abuse and neglect are handled and 2) a comprehensive, statewide evaluation of the CPS program conducted by an independent entity through a contract with the agency.

In November 1987, the Senate Committee on Health and Human Services agreed to hold a public hearing in Houston on the Child Protective Services (CPS) program at the request of a group of concerned citizens. The tragic deaths of Harris County children with whom the agency had been or was presently involved caused many in the community to question the Department's ability to respond effectively to abused and neglected children.

On December 7, 1987, a Tom Green County grand jury issued a report citing evidence of false entries in child abuse records and other serious problems in the San Angelo Child Protective

Services Office. Although no indictments were returned, the grand jury recommended the Commissioner of the Department of Human Services take immediate corrective action to remedy the problems identified in the San Angelo office and determine whether record falsification "is occurring statewide at management and worker levels" (See pp. 78-80 and Appendix 1).

Approximately 10 days later, the Texas Board of Human Services approved two separate studies of the CPS program. The first consisted of a review by agency staff of the policies, procedures, qualifications and training of employees, and various other issues related to the "intake" system, the handling of incoming abuse and neglect reports.

Acknowledging the need for credibility, the Board contracted with an out-of-state organization recognized nationally for its expertise in the field of child abuse to perform a more comprehensive, statewide evaluation of the program. The American Association for Protecting Children (AAPC), based in Denver, Colorado, was selected to conduct the statewide examination.

Even though these two studies were prompted in part by the problems in San Angelo, neither of these efforts included a study of whether record falsification is a problem statewide.

In January 1988, El Paso County Attorney Joe Lucas asked the Texas Attorney General's Office to conduct an official investigation of several specific child abuse cases in El Paso which some local officials and members of the community believed were mishandled by the agency. In his letter to General Mattox requesting the investigation, Mr. Lucas cited the death of an

infant male as a result of "cerebral tissue softening." A previous report had been made to the Department on the same child approximately two months earlier regarding a "fractured skull and head and facial bruises" (See Appendix 2). Shortly after the agency's investigation of the first report confirmed the abuse, the child's case was closed administratively by a supervisor "due to staff shortages."

Although the Senate Committee initially intended to focus its review on the problems which had surfaced in Harris County, it quickly became evident that a statewide review of the CPS program was necessary. While the deterioration in effectiveness and credibility appears to be more pronounced in some regions of the state than others, the problems identified are present to some extent in all regions and will ultimately reach crisis levels everywhere if left unaddressed.

At its first public hearing in Houston on January 19, 1988, over 100 witnesses signed up to testify before the Committee. Due to the overwhelming response, a second public hearing in Houston was necessary to continue receiving testimony. The Committee held subsequent public hearings in Dallas, El Paso, and San Antonio. Overall, approximately 300 people signed up to testify and hundreds of others from across the state submitted written statements, sent personal correspondence, provided copies of actual case records and court documents, met privately with Committee staff in groups and as individuals, or contacted the Committee by telephone.

The information received was consistent, regardless of the source or the area of the state from which it came. Child protective services caseworkers and supervisors, attorneys, judges, law enforcement officers, doctors, nurses, teachers, social workers, foster parents, adoptive parents, biological parents and grandparents, psychologists, psychiatrists, child advocacy groups and numerous others communicated with the Committee. Although many praised the efforts of individual employees, they also expressed eroding confidence in the Department.

Every day, confirmed cases of child abuse are being closed leaving children in potentially dangerous homes without any further monitoring and without providing any services which could possibly alleviate the abusive or neglectful situation.

According to the Department's Regional Information and Performance Report (RIPR) for Fiscal Year 1988, an average of 2,360 cases of abuse and neglect were confirmed each month or 28,320 during the fiscal year. The agency estimates that 70% or 19,824 of the confirmed cases involved children who were left in their homes and who needed ongoing supervision and assistance from the Department. In reality, only about half of these cases were assigned to a caseworker. The remaining 49%, or 9,800 confirmed cases, were closed immediately after the investigation "due to staff shortages."

To put this in perspective, an average of 815 confirmed cases were closed each month or 27 CASES EVERY DAY OF THE YEAR. These are children whose abuse was reported as required by law,

whose abuse was confirmed by an investigation, and whose situation indicated a need for further monitoring and assistance. No caseworker was assigned, no one monitored the child, no services were provided to attempt to help the family, and nothing was done to address the resulting psychological damage to the child.

Testimony provided by a county child welfare board member at one of the Committee's public hearings suggests the problem is even more severe than the agency's statistics indicate. In a single month, this particular county alone closed 125 confirmed cases immediately following the investigation.

> "Since the board oversees the budget, I knew that most of those cases were being closed because of lack of funds. Of the 15 cases pulled, three were identified as Priority I (life-threatening), the rest were Priority II. With the possible exception of two of them, I felt all of the cases needed some follow-up services.
>
> "It gave me chills to think that in one of the Priority I cases, the mother moved to Houston taking her one-year-old and two-year-old; both...had just been hospitalized because of physical abuse. I read a notation in the file that said our staff up here had called the staff in Harris County and warned them she was coming and asked them to do some follow-up. But if their caseloads are anything like our caseloads up here, who knows what happened to that family?"

A child protective services caseworker in Harris County informed the Committee that not only were hundreds of confirmed cases being closed each month, but the situation was so critical that hundreds of incoming reports were not being investigated at all. Secretaries and receptionists were reassigned on an emergency basis to help staff field calls.

Clearly, Texas children are not being protected adequately when confirmed cases are closed in massive numbers and when

numerous others are never even investigated. For too many children, the consequences have been fatal.

The Committee recognizes the responsibility to protect children does not rest solely with the Texas Department of Human Services (TDHS). An effective child protective services "system" also includes judges, district and county attorneys, attorneys ad litem, law enforcement agencies, child advocates, a wide range of community service providers, and active citizen involvement. However, the Texas Family Code specifically places the principal statutory responsibility with the Department, and for this reason, the Committee focused largely on the deficiencies in the TDHS Child Protective Services (CPS) program.

A certain amount of criticism from the community has always been present and is expected when errors in judgment or the obvious incompetencies of particular employees result in tragedy. What the Committee did not anticipate was the tremendous level of dissatisfaction among the agency's own employees.

A considerable number of current and former CPS caseworkers communicated with the Committee. Many who are still employed with the agency contacted the Committee anonymously, expressing fear of reprisal for discussing or disclosing internal problems. Without the assistance of the frontline workers, those most knowledgeable about the deficiencies in the program, the Committee would not have been able to comprehend the magnitude of the problems.

In 1988, the turnover rate of CPS caseworkers was 31.1%, almost double the rate of 16.4% in FY 1986 and 17.7% in FY 1987.

Traditionally, the nature of the job has been the primary reason cited for turnover in caseworker positions, but today this factor no longer offers a plausible explanation for such a drastic increase. The Committee found extreme frustration with agency management to be a prominent factor in the significant increase in the turnover rate for frontline CPS positions.

Whether real or perceived, caseworkers believe state and regional administrators view frontline employees as expendable. Repeatedly, agency officials told the Committee more caseworkers are needed to prevent massive case closures, to investigate more reports, and to improve our monitoring of children. Yet, whenever budgetary constraints require reductions in staff, crucial caseworker positions are left vacant or eliminated, further exacerbating the already untenable conditions. This does not appear to be a responsible management decision and certainly lends credence to the caseworkers' concerns.

Routinely, the agency's effective use of existing staff resources was questioned throughout the Committee's examination of the program. This issue also was raised as a concern by the American Association for Protecting Children (AAPC) in its comprehensive evaluation of the program. The AAPC recommended an in-depth study of staffing ratios to determine whether the ratio of direct service employees to non-direct service staff is appropriate.

The Committee attempted to analyze staff ratios but could not obtain consistent, accurate data from any of the sources available. Based on the way the agency currently reports

information to the legislature, it is impossible to differentiate between state and regional office personnel and employees in local CPS offices across the state.

According to the Department's most recent Legislative Appropriations Request (LAR), approximately 52% of the 3,060 child protective services employees are classified as caseworkers. This figure is not intended to indicate the remaining 48% or 1,467 positions are administrative since a number of other employees provide direct supervision and support services to frontline caseworkers. Nonetheless, this information suggests the agency's use of resources warrants further examination.

With the enormous number of confirmed cases being closed "due to staff shortages" and with workers reporting excessive caseloads, it is clear adjustments in the front line must be made to rectify this indefensible situation. What is not clear is whether this should be accomplished through redirecting existing resources, appropriating additional funds for caseworker positions, or a combination of the two.

In addition to unreasonable caseload demands, caseworker morale is further undermined by overly bureaucratic policies and procedures which impede rather than promote good casework. Caseworkers estimate they spend 70% or more of their time on paperwork requirements, leaving very little time to devote to actually helping children and families. Although the agency has established special committees of caseworkers in the past to recommend changes in paperwork requirements, the workers have

seen no meaningful reductions. Some, in fact, reported paperwork has actually increased.

Since caseworkers' performance evaluations are based heavily on compliance with agency standards and time frames for completing paperwork, the good paper processor or "technocrat" is more likely to receive a favorable evaluation and to be considered for a promotion than the individual who places a higher priority on working with children and their families.

The opportunities for promotion are extremely limited for caseworkers. Under the existing classification scheme, there are no career ladder advancements available unless the worker leaves direct services for an administrative position. Several implied the few promotions which ARE available are granted based on favoritism instead of merit.

The agency has a poor record for terminating incompetent employees at all levels of responsibility within the CPS program, according to caseworkers and supervisors. Even though the incompetency of a CPS employee can actually endanger a child and pose a serious liability for the Department, it appears the agency fails to terminate incompetent employees because of an inordinate fear of liability resulting from potential lawsuits by employees.

In general, the principle problems the Committee identified can be attributed to ineffective management and inadequate resources. These two conditions combined have created a critical situation: children are not safe, the public is losing confidence

in the agency, and the agency is losing its most experienced and dedicated employees.

The Committee's findings are consistent with the findings from the various examinations and investigations conducted by other entities over the past 18 months. The following summary highlights several of the major areas of concern.

CASE DECISIONS. Inappropriate decisions affecting the health and safety of children are being made based on factors totally unrelated to their needs. For example, caseload levels may be the overriding factor in determining whether to investigate a report or whether to "open" a case after abuse has been confirmed. As a method of "managing" caseload levels, a supervisor may screen out cases at intake to limit investigations to only the more severe allegations. And as previously mentioned, almost half of cases confirmed last year were closed immediately after the investigation primarily because of "staff shortages."

According to the AAPC report, "The decision to close cases was at times made without judicious planning or thoughtful assessment. Instead, closure was sometimes based on factors unrelated to resolution of the problems causing the abuse and neglect, such as the unwillingness of the family to cooperate with the service plan or the unavailability of services." (AAPC, Section 3:24) Cases also are closed almost spontaneously when the alleged perpetrator is no longer in the home. Because no further protection is required, the agency closes the case even

though the child or the child's siblings exhibit trauma which should be addressed through professional counseling.

FOSTER CARE. Equally alarming is the fact the decision NOT to remove a child from a dangerous environment may be based on the lack of a suitable alternative placement, such as a foster home. One caseworker candidly remarked that in cases where the decision to remove a child is marginal, a worker might be tempted to leave a child in the home rather than fill out the reams of paperwork the agency requires for the removal of a child.

Only a relatively small number of abused children are removed from their homes, approximately 390 children each month or 4,700 in FY 1988. According to the Department's Legislative Appropriations Request (LAR), there were 103,088 alleged victims in the 65,966 child abuse and neglect reports investigated during the fiscal year. The total number of children in foster care has remained fairly constant over the past few years even though some agency officials have implied that an increasing number of the investigations involve far more severe abuse. This raises a troubling question about whether severely abused children are being left in their homes inappropriately.

The decline in the number of foster homes in Texas since 1987 may be the driving force behind these statistics. The AAPC report stated, "Without an increase in foster homes...fewer children can be placed and will remain in potentially explosive and dangerous situations...." (AAPC, Section 5:60) Some representatives of the Department attributed the decline in

foster homes to low daily reimbursement rates and the stress related to having foster children with more serious problems than in the past, but foster parents who communicated with the Committee emphasized the need to be treated professionally. Most suggested they would like to see the payments increased in addition to a change in the agency's attitude toward them.

Foster parents care for children on a 24-hour basis whereas the caseworker makes minimal contact with the child, usually once a month. Yet, the agency may not share essential background information which could help foster parents understand and seek appropriate treatment for a child's special medical or behavioral problems. Agency policy requires the foster parent to be notified of meetings to review the child's placement and progress; however, the AAPC report noted "...foster parents are not always involved in decision-making, depending on regional and worker attitudes." (AAPC, Section 3:48) A foster parent may learn the agency has decided to return a child home when a caseworker arrives to pick up the child and his or her belongings.

Foster parents from different parts of the state described incidents which they believed constituted retaliation by the agency for being too persistent in advocating for services for foster children or for openly discussing or complaining about problems with the agency. A caseworker validated their concerns by telling the Committee staff the best way to get foster parents

to be quiet is to "jerk" a child out of the home, and the rest of the foster parents will get the message.

Substandard foster homes may be allowed to continue operating because the agency cannot "afford" to close them due to a limited number of alternative placements available in the community. Several instances were cited where abuse in a foster home was known to the agency, but no action was taken because someone in a higher position of authority than the caseworker intervened.

CLIENT SERVICES. In a 1988 survey of CPS workers, the employees estimated that only 17% of the children left in their homes after abuse was confirmed and only 33% of the children in foster care would receive any professional counseling. According to the Department's Legislative Appropriations Request (LAR), approximately $12.2 million of the total CPS budget for FY 1988 was designated for purchasing services such as parenting classes, homemaker assistance, and counseling for child protective services clients. Protective day care is another service families may receive, but the expenditures for day care are included under a separate agency program and are not included as expenses in the $12.2 million.

Because the agency does not maintain data on the number of children and families needing or receiving a particular service or the duration and cost of the services delivered, there is no information available on which the effectiveness of the various kinds of services can be evaluated or on which to base the

estimated cost of providing appropriate services to all children and families in need.

Most services to clients of the CPS program are delivered through agency contracts with local providers. Sometimes, when a single provider is used, client access is limited because of long waiting lists for appointments or difficulties in arranging for transportation to and from the service provider. One foster parent reported having to take a child a considerable distance late at night to obtain medical treatment because the agency would only pay for medical services at a specific public hospital. Even though there was a local physician nearby who could see the child immediately, the foster parent and child were forced unnecessarily to drive many miles to the hospital and wait several hours in a crowded emergency room.

Families investigated by the agency believe limited contracts also result in less than objective evaluations. A particular psychologist or physician may be viewed as an "expert" by the agency, but the family may perceive the evaluation or examination to be influenced by the outcome the agency desires. In numerous cases brought to the Committee's attention, the child's regular pediatrician was never consulted to learn whether there was a history of special medical problems which could corroborate or invalidate the allegation of abuse.

CASE RECORDS. The integrity of the entire CPS program is at stake when evidence of record falsification is found. Falsification of any state record is a serious offense, but

falsifying child protective services records can actually jeopardize the health and safety of a child when, for example, a judge receives inaccurate or incomplete information on which to base a decision affecting the well-being of an abused or neglected child. (See pp. 78-80 and Appendix 1)

The Committee also found it inexcuseable for adoptive parents to be denied vital background information regarding the medical or psychological status of children adopted through the Department. Although the Texas Family Code and the agency's written policy provide for prospective parents to have access to all available information about the child, the Committee received letters and phone calls from adoptive parents across the state who were not permitted to review agency files and records regarding the children they adopted.

A similar problem exists with respect to persons investigated by the Department. The Family Code entitles the individual to review all records of the agency's investigation unless such review would jeopardize an ongoing criminal investigation. Yet, many people reported they were denied access to their records or only received portions of the information requested.

RECIDIVISM. Child protective services caseworkers estimated, in a 1988 survey conducted by the agency, that 32% of all child abuse reports involve families who have previously been investigated. However, in the Department's Legislative Appropriations Request submitted in 1986, the agency estimated

the rate of recidivism among child protective services cases to be 8% and projected the rate would remain the same in FY 1988. Apparently, the agency's effectiveness in preventing the recurrence of abuse has declined significantly or the data the Department reports is unreliable.

Over 1,000 caseworkers responded to the agency's survey which was designed specifically to identify what the employees believe to be the primary problems in the intake system. Although "repeat investigations" of the same families was identified as a major concern for caseworkers, the Department's recommendation was to conduct another "study" to determine whether recidivism is truly a problem.

One caseworker cited the masssive closure of cases without ever providing any services as the reason families constantly recycle through the system. The caseworker described investigating the same family in May, August and December of 1988. After each investigation confirmed abuse, the case was transferred to a separate unit of workers for ongoing monitoring and services. Each time, the case was closed by a supervisor immediately upon receipt "due to staff shortages." While there is no data to prove it would be less costly to address the family's problems after the initial investigation rather than investigating three times, there is sufficient evidence to show abuse tends to escalate to more dangerous levels in subsequent reports.

In this particular case, there were other unintended negative outcomes. The teacher who reported the abuse questioned

why the worker even investigated the reports and expressed an intent to call someone else in the future who could take action. The family warned the caseworker to stop interfering with their lives since the worker was powerless to intervene and obviously unwilling to help.

CASELOADS. Repeatedly, the Committee heard that caseloads are far too high to permit prompt, thorough and professional investigations of all reports and to adequately monitor children who are left in their homes, placed in foster care or returned to previously abusive homes. Several individuals disputed whether caseloads are excessive.

The Committee was unable to resolve this disagreement because the agency does not maintain accurate data on the actual caseload levels of its employees. The data used to arrive at average caseloads counts employees who do not even handle cases and caseworker positions which are vacant. Therefore, agency statistics are distorted and one would assume caseload levels are probably much higher than the figures indicate.

The AAPC report pointed out substantial variances in caseload levels among the agency's 10 regions, with some regions having caseloads of up to 100 per worker. The AAPC further reported that "... caseload size seems to be defined differently across regions, some including only family cases and others opening cases on individual children." (AAPC, Section 4:20) In other words, some local offices open cases on every child in the family and others open only one case for the entire family. Thus,

no statewide comparisons of actual caseload levels can be performed.

The AAPC determined, however, that caseloads are inappropriately high for some regions and for some individual workers, and "Until caseloads are brought to a manageable level, it is statistically inevitable that children will continue to die even though there is agency involvement." (AAPC, Section 3:68)

CONCLUSION. The Child Protective Services program represents only 5% of the approximately $3.3 billion total annual budget for the Texas Department of Human Services. Since the Department administers several of the state's largest public assistance programs such as Food Stamps, Aid to Families with Dependent Children (AFDC), and Medicaid, it appears the CPS program has not received the priority attention it deserves.

While almost all other programs the agency administers have been automated for several years, many local CPS offices still do not have even the most basic computer equipment to enable employees to immediately check the statewide computer system for vital information about previous abuse reports involving a particular child or alleged perpetrator.

The overall organizational structure and management philosophy of the agency may be well-suited for determining income eligibility for medical services, financial assistance or nutrition benefits, but the nature of the CPS program is entirely different and cannot be expected to operate effectively under the same bureaucratic system. Furthermore, the diffusion of

responsibility resulting from the agency's decentralized management structure makes it virtually impossible to hold any particular division or individual accountable for program deficiencies.

The problems in the Child Protective Services program are immense. Regrettably, an infusion of resources alone will not be sufficient to address these problems. Judgment, ethics and attitude cannot be purchased or legislated. Money cannot buy common sense and it cannot change institutionalized ideas and practices. Texas children deserve better. They deserve the full commitment of the legislature, the Board of Human Services, agency administrators at state and regional levels, and caseworkers and supervisors in local offices across the state. Judges, attorneys, doctors, teachers, other community professionals, child advocates and individual citizens also must fulfill their obligations if we are to be successful. It is imperative to recognize that the damage caused by child abuse affects not only individual children or families but all of society.

A caseworker who wrote an anonymous letter to the Committee suggested looking at the relationship between child abuse and the present overcrowding problem in Texas prisons and county jails. To illustrate the "corrections connection," a private citizen offered the following case history involving a man just recently released from the state penitentiary. He was incarcerated for brutally beating and sexually abusing his infant daughter.

His criminal history began as a juvenile when he was placed in and out of detention facilities numerous times. He and the child's mother became parents as teenagers. And like so many teen pregnancies, this one was unintended and the young parents were unprepared financially and emotionally. By the age of 18, he entered the adult prison system, first on a felony theft conviction and then for injury to his child.

This cycle of violence started when he was beaten and sexually molested in his home at a very early age. He also witnessed numerous other violent episodes against his siblings and his mother. Some of the injuries were severe enough to require medical attention and some were even reported to the Department of Human Services. No one ever stopped the abuse and no one ever attempted to repair the disastrous effects it had on this young child.

The consequences of child abuse reach far beyond the private doors of a family's home and into the gates of the Texas prison system. The children we fail to protect today will possibly be the adults we protect ourselves FROM tomorrow.

S U M M A R Y

O F

R E C O M M E N D A T I O N S

CHILD PROTECTIVE SERVICES (CPS)
Senate Committee on Health and Human Services

R E C O M M E N D A T I O N S

1. THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES SHALL CONTINUE TO MONITOR AND EVALUATE THE CHILD PROTECTIVE SERVICES PROGRAM ADMINISTERED BY THE TEXAS DEPARTMENT OF HUMAN SERVICES AND SHALL RESEARCH ANY ADDITIONAL ISSUES WHICH WARRANT FURTHER EXAMINATION.

   THE COMMITTEE SHALL SUBMIT A PROGRESS REPORT AND ANY NECESSARY RECOMMENDATIONS TO THE 72ND TEXAS LEGISLATURE. IF SUBSTANTIAL IMPROVEMENTS IN THE OVERALL MANAGEMENT AND EFFECTIVENESS OF THE CPS PROGRAM ARE NOT ACHIEVED, THE COMMITTEE SHALL DEVELOP A PROPOSAL TO TRANSFER THE STATUTORY RESPONSIBILITIES FOR PROTECTING CHILDREN TO ANOTHER EXISTING STATE AGENCY OR TO ESTABLISH A SEPARATE AGENCY AND BOARD TO ADMINISTER THIS CRITICAL PROGRAM. (PAGE 28)

2. THE LEGISLATURE SHOULD REQUIRE AN IN-DEPTH MANAGEMENT AUDIT OF THE CPS PROGRAM AT THE STATE, REGIONAL AND LOCAL LEVELS TO BE CONDUCTED BY THE STATE AUDITOR'S OFFICE, THE GOVERNOR'S MANAGEMENT EFFECTIVENESS DIVISION, OR THROUGH A CONTRACT WITH A QUALIFIED PRIVATE ENTITY WITH EXPERTISE IN MANAGEMENT AUDITS. (PAGE 30)

3. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL SUBMIT THE FOLLOWING INFORMATION TO THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES AND TO THE LEGISLATIVE BUDGET OFFICE NO LATER THAN MARCH 31, 1989: (PAGE 32)

   1) THE TOTAL NUMBER OF STATE OFFICE POSITIONS AUTHORIZED AND BUDGETED FOR FY 1989, AND THE TOTAL NUMBER OF POSITIONS FILLED ON FEBRUARY 1, 1989. ANY EMPLOYEE WHOSE POSITION IS PAID UNDER THE CPS LINE ITEM BUT WHOSE PRINCIPAL HEADQUARTERS IS IN THE STATE OFFICE SHOULD BE INCLUDED EVEN THOUGH THE EMPLOYEE'S DUTIES MAY INVOLVE FIELD ASSISTANCE;

   2) THE TOTAL NUMBER OF REGIONAL OFFICE POSITIONS, BY REGION, AUTHORIZED AND BUDGETED FOR FY 1989, AND THE TOTAL NUMBER OF POSITIONS FILLED ON FEBRUARY 1, 1989. ANY EMPLOYEE WHOSE SALARY IS PAID UNDER THE CPS LINE ITEM BUT WHOSE PRINCIPAL HEADQUARTERS IS IN A REGIONAL OFFICE SHOULD BE INCLUDED EVEN THOUGH THE EMPLOYEE'S RESPONSIBILITIES MAY INVOLVE ASSISTANCE TO OR SUPERVISION OF A LOCAL CPS OFFICE; AND

3) THE TOTAL ESTIMATED EXPENDITURES FOR SALARIES FOR FY 1989 TO MAINTAIN THE STAFFING LEVELS REPORTED ABOVE FOR STATE AND REGIONAL OFFICE PERSONNEL.

4. THE LEGISLATURE SHOULD REQUIRE THE TEXAS DEPARTMENT OF HUMAN SERVICES TO REPORT ALL SALARIES, TRAVEL AND OTHER EXPENDITURES FOR STATE AND REGIONAL OFFICE CPS ACTIVITIES UNDER "PROGRAM SUPPORT" IN ITS LEGISLATIVE APPROPRIATIONS REQUEST FOR THE 1992-1993 BIENNIUM. THE DEPARTMENT SHALL CONTINUE REPORTING IN THIS MANNER UNTIL OTHERWISE DIRECTED BY THE LEGISLATURE.

   THE LEGISLATURE SHOULD ADD A RIDER TO THE APPROPRIATIONS ACT WHICH EXPRESSLY PROHIBITS THE AGENCY FROM EXPENDING ANY FUNDS APPROPRIATED UNDER THE "CHILD PROTECTIVE SERVICES" LINE ITEM FOR ANY STATE OR REGIONAL OFFICE ACTIVITY, INCLUDING SALARIES, TRAVEL, OVERHEAD, OR ANY OTHER EXPENSE. (PAGE 34)

5. THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES, AS PART OF ITS ONGOING EVALUATION, SHALL PERIODICALLY SURVEY CPS SUPERVISORS TO OBTAIN ACCURATE INFORMATION ON THE ACTUAL STAFFING AND CASELOAD LEVELS IN LOCAL OFFICES ACROSS THE STATE. THE DEPARTMENT SHALL NOT INTERFERE WITH THE SUPERVISORS' ABILITY TO RESPOND ACCURATELY TO THE COMMITTEE'S SURVEY AND SHALL PERMIT SUPERVISORS TO RETURN THE SURVEYS DIRECTLY TO THE COMMITTEE WITHOUT REVISIONS. (PAGE 35)

6. THE LEGISLATURE SHOULD AUTHORIZE AND FUND TWO ADDITIONAL CLASSIFICATION LEVELS FOR CPS SPECIALISTS (CASEWORKERS) AND ONE ADDITIONAL LEVEL FOR CPS SUPERVISORS TO PROVIDE A TRUE CAREER LADDER FOR DIRECT DELIVERY STAFF. (PAGE 37)

7. THE LEGISLATURE SHOULD APPROPRIATE SUFFICIENT FUNDING TO PROVIDE ADEQUATE COMPUTER EQUIPMENT FOR ALL LOCAL CPS OFFICES TO PERMIT EMPLOYEES TO HAVE IMMEDIATE ACCESS TO THE STATEWIDE COMPUTER CONTAINING VITAL INFORMATION ON PREVIOUS ABUSE REPORTS ON PARTICULAR CHILDREN AND PERPETRATORS. THE DEPARTMENT SHALL EXPEDITE THE ACQUISITION AND INSTALLATION OF THE EQUIPMENT AND SHALL PROVIDE "ACCESS CODES" TO ALL CASEWORKERS TO ENABLE THEM TO RETRIEVE INFORMATION IN THE STATEWIDE COMPUTER SYSTEM. (PAGE 39)

8. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL INCORPORATE THE USE OF EXPERTS FROM OUTSIDE THE AGENCY IN ITS BASIC AND ADVANCED TRAINING AND IN THE CONTINUING EDUCATION OPPORTUNITIES FOR CPS WORKERS. THE CURRENT METHOD OF DELIVERING TRAINING SHOULD BE RESTRUCTURED TO ENSURE MORE DIRECT

AND TIMELY CASEWORKER TRAINING. THE DEPARTMENT SHOULD PROVIDE EVERY CASEWORKER WITH A COPY OF THE CPS HANDBOOK OF PROGRAM POLICIES. (PAGE 42)

9. THE PERSONNEL POLICIES FOR THE CPS PROGRAM SHOULD BE REVISED TO PERMIT CPS SUPERVISORS TO REVIEW APPLICATIONS, INTERVIEW SELECTED APPLICANTS, AND HIRE APPROPRIATE EMPLOYEES FOR LOCAL CPS OFFICES. (PAGE 44)

10. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL REVIEW ITS CURRENT PAPERWORK REQUIREMENTS FOR THE CPS PROGRAM AND SHALL ELIMINATE ALL DUPLICATIVE AND UNNECESSARY DOCUMENTATION. THIS INITIATIVE SHOULD INCLUDE INPUT FROM CASEWORKERS AND SUPERVISORS AND A FOLLOW-UP SURVEY OF STAFF TO DETERMINE IF MEANINGFUL REDUCTIONS WERE ACHIEVED. (PAGE 46)

11. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD IMMEDIATELY BEGIN TO ADDRESS THE EXCESSIVE STAFF TURNOVER BASED ON FACTORS ALREADY IDENTIFIED. EFFORTS TO ALLEVIATE THESE PROBLEMS SHOULD NOT BE DELAYED PENDING THE COMPLETION OF THE AGENCY'S TWO-YEAR BURNOUT AND TURNOVER PROJECT. (PAGE 47)

12. THE LEGISLATURE SHOULD APPROPRIATE SUFFICIENT FUNDS TO ENABLE THE DEPARTMENT TO EXPAND SERVICES TO HELP MORE ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES AND SHOULD ESTABLISH A SEPARATE LINE ITEM IN THE APPROPRIATIONS ACT TO CLEARLY DIFFERENTIATE BETWEEN THE FUNDING AUTHORIZED FOR STAFF AND THE FUNDING FOR "CLIENT SERVICES." (PAGE 49)

13. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL SUBMIT A DETAILED ANNUAL ACCOUNTING OF EXPENDITURES FOR "CLIENT SERVICES" BY REGION TO THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES AND TO THE LEGISLATIVE BUDGET OFFICE. THIS ACCOUNTING SHALL SPECIFY THE TOTAL AMOUNTS EXPENDED FOR AND THE TOTAL NUMBER OF CHILDREN AND FAMILIES NEEDING AND RECEIVING THE FOLLOWING: (PAGE 49)

    A) PSYCHOLOGICAL OR PSYCHIATRIC EVALUATIONS;
    B) PROFESSIONAL COUNSELING;
    C) MEDICAL EXAMINATIONS;
    D) MEDICAL TREATMENT;
    E) PARENTING CLASSES;
    F) HOMEMAKER ASSISTANCE;
    G) PROTECTIVE DAY CARE; AND
    H) ANY OTHER SERVICE DELIVERED.

THE DATA PROVIDED SHOULD REFLECT WHETHER THE SERVICES WERE PROVIDED TO CHILDREN LIVING AT HOME OR IN SUBSTITUTE LIVING ARRANGEMENTS.

14. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD DEVELOP POLICIES WHICH DISCOURAGE THE USE OF MULTIPLE MEDICAL AND PSYCHOLOGICAL EVALUATIONS IN CPS INVESTIGATIONS AND WHICH PROMOTE SENSITIVITY IN SITUATIONS WHERE CASEWORKERS MUST PHYSICALLY INSPECT CHILDREN FOR INJURIES. (PAGE 54)

15. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL IDENTIFY AND CHANGE POLICIES WHICH LIMIT LOCAL LEVEL CONTRACTS FOR SERVICES AND SHALL CONSIDER A SYSTEM OF "OPEN ENROLLMENT" WHICH ALLOWS ALL QUALIFIED PROVIDERS OF SERVICES TO CPS CLIENTS TO PARTICIPATE IN THE PROGRAM IF THEY ARE WILLING TO ACCEPT THE AGENCY'S REIMBURSEMENT RATE. (PAGE 55)

16. THE LEGISLATURE SHOULD INCREASE THE APPROPRIATIONS FOR SEXUAL ASSAULT CENTERS (TEXAS DEPARTMENT OF HEALTH) AND SHELTERS FOR BATTERED WOMEN (TEXAS DEPARTMENT OF HUMAN SERVICES) AS A COST-EFFECTIVE WAY TO SERVE MORE ABUSED CHILDREN AND THEIR FAMILIES. CHILD PROTECTIVE SERVICES EMPLOYEES SHOULD BE ENCOURAGED TO WORK WITH THESE NON-PROFIT ORGANIZATIONS IN THEIR LOCAL AREAS.

    THE DEPARTMENT OF HUMAN SERVICES SHOULD REVIEW, AND TO THE EXTENT POSSIBLE, IMPLEMENT PROTOCOLS FOR COORDINATION AND COOPERATION BETWEEN SHELTERS FOR BATTERED WOMEN AND CPS AS RECOMMENDED BY THE NATIONAL WOMAN ABUSE PREVENTION PROJECT FUNDED BY THE U.S. DEPARTMENT OF JUSTICE. (PAGE 58)

17. THE LEGISLATURE SHOULD APPROPRIATE FUNDING TO ENHANCE COMMUNITY EFFORTS TO PROVIDE COURT-APPOINTED SPECIAL ADVOCATES FOR ABUSED AND NEGLECT CHILDREN UNDER THE COURT'S JURISDICTION. GRANTS SHOULD BE PROVIDED TO THOSE NON-PROFIT ORGANIZATIONS WHICH HAVE DEMONSTRATED LOCAL FINANCIAL SUPPORT AND MEET ESTABLISHED GUIDELINES AND STANDARDS. (PAGE 62)

18. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD INSTITUTE LEVELS OF SUPERVISION FOR CASES INVOLVING ABUSED OR NEGLECTED CHILDREN WHO REMAIN IN THEIR HOMES. THESE LEVELS OF SUPERVISION SHOULD BE BASED ON THE RESULTS OF A RISK ASSESSMENT INDICATING THE ACTUAL NEEDS OF EACH CHILD AND FAMILY. (PAGE 64)

19. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD REINSTATE MINIMUM SERVICES TO PRIORITY III CASES BY ASSIGNING THEM TO THE NEWLY HIRED AND LEAST EXPERIENCED CASEWORKERS. (PAGE 67)

20. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD CLARIFY POLICIES RELATING TO "PARENT-AGENCY AGREEMENTS." AGENCY

POLICIES SHOULD PROHIBIT THE INCLUSION OF UNREALISTIC DEMANDS ON PARENTS, MANDATE ACTUAL PARENT INVOLVEMENT IN THE DEVELOPMENT OF THE AGREEMENT, AND PROHIBIT PRESSURING AN INDIVIDUAL TO SIGN AN AGREEMENT WHICH CONTAINS A STATEMENT OF GUILT. (PAGE 70)

21. THE TEXAS FAMILY CODE SHOULD BE AMENDED TO CLEARLY ALLOW COURTS TO REQUIRE A FAMILIES TO COMPLY AND COOPERATE WITH CPS SERVICE PLANS IN ABUSE AND NEGLECT CASES WHERE CHILDREN REMAIN IN THE HOME. (PAGE 72)

22. THE TEXAS FAMILY CODE SHOULD BE AMENDED TO INCLUDE A DEFINITION OF CHILD ABUSE UNDER THE PROTECTIVE ORDER STATUTE WHICH IS CONSISTENT WITH THE EXISTING DEFINITIONS PROVIDED IN SECTION 34.02(1)(C), (E), AND (G).

    EVERY CPS WORKER SHOULD RECEIVE TRAINING REGARDING THE PROTECTIVE ORDERS AND THE MANNER IN WHICH THEY CAN BE USED TO PROTECT CHILDREN WHO HAVE BEEN PHYSICALLY OR SEXUALLY ABUSED. WHEN A WORKER IS AWARE THAT A CHILD ABUSER IS ALSO ABUSING THE OTHER PARENT OF THE CHILD, THE WORKER SHOULD ENCOURAGE THE NON-ABUSING PARENT TO PETITION FOR A PROTECTIVE ORDER. (PAGE 74)

23. PRIOR TO PLACING AN ABUSED OR NEGLECTED CHILD WITH A RELATIVE, THE AGENCY SHOULD CONDUCT A FULL HOME EVALUATION WHICH INCLUDES A CANRIS CHECK ON ALL ADULTS IN THE HOME. RELATIVE PLACEMENTS SHOULD NEVER BE MADE INVOLUNTARILY. WHENEVER A RELATIVE PLACEMENT IS MADE, CPS SHOULD MAINTAIN AN OPEN CASE ON THE CHILD INVOLVED. (PAGE 77)

24. THE FAMILY CODE SHOULD BE AMENDED TO CLEARLY MANDATE THAT THE TEXAS DEPARTMENT OF HUMAN SERVICES AND ANY PRIVATE AGENCY WHICH PLACES CHILDREN FOR ADOPTION PROVIDE ADOPTIVE PARENTS FULL ACCESS TO ALL RECORDS AVAILABLE ON CHILDREN THEY ARE CONSIDERING FOR ADOPTION, EXCLUDING INFORMATION WHICH WOULD REVEAL THE IDENTITY OF THE BIRTH PARENT OR ANY OTHER PERSON WHOSE IDENTITY IS PROTECTED. (PAGE 82)

25. FOSTER PARENTS SHOULD RECEIVE A COPY OF THE CPS INTAKE STUDY FOR EACH CHILD PLACED IN THEIR HOMES. (PAGE 84)

26. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD TAKE EVERY MEASURE TO RESPOND AS SOON AS POSSIBLE WITH DIRECT ASSISTANCE OR REFERRAL TO CONTRACTED SERVICES WHEN FOSTER PARENTS IDENTIFY THE NEED AND REQUEST SERVICES FOR CHILDREN IN THEIR CARE. (PAGE 88)

27. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL DEVELOP AND IMPLEMENT CLEAR POLICIES REGARDING REVERIFICATION OF FOSTER HOMES WHICH INCLUDES A FORMAL MEETING BETWEEN THE FOSTER PARENT AND THE FOSTER HOME DEVELOPMENT WORKER AND WHICH PROVIDES OFFICIAL DOCUMENTATION OF THE HOME'S STRENGTHS AND WEAKNESSES. (PAGE 91)

28. THE AGENCY'S EFFORTS TO RECRUIT FOSTER PARENTS SHOULD ALSO INCLUDE RECRUITMENT OF PERSONS WILLING TO PROVIDE RESPITE CARE OR DAY CARE TO PROVIDE RELIEF FOR FULL-TIME FOSTER PARENTS. (PAGE 93)

29. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL COLLECT DATA ON RECIDIVISM RATES OF CPS CASES AND SHALL REPORT THESE STATISTICS IN ITS ANNUAL REPORT ON THE CPS PROGRAM. THE AGENCY SHALL ANALYZE A REPRESENTATIVE SAMPLE OF THE CASE RECORDS TO DETERMINE THE FOLLOWING: (PAGE 94)

    (A) IF THE REPORT WAS INVESTIGATED OR THE REASON THE CASE WAS CLOSED WITHOUT INVESTIGATION;
    (B) THE RESULTS OF THE INVESTIGATION; AND
    (C) IF AND WHEN ANY SERVICES WERE PROVIDED, THE SPECIFIC KIND OF SERVICE(S) DELIVERED, AND THE DURATION AND COST OF THE SERVICE(S).

30. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL INCLUDE THE FOLLOWING DATA IN ITS ANNUAL REPORT ON THE CPS PROGRAM, AND THE LEGISLATIVE BUDGET OFFICE SHOULD CONSIDER INCLUDING THESE STATISTICS IN THE DEPARTMENT'S PERFORMANCE MEASURES: (PAGE 96)

    (A) THE TOTAL NUMBER OF ABUSE AND NEGLECT REPORTS MADE TO THE AGENCY;
    (B) THE TOTAL NUMBER WHICH WERE ASSIGNED FOR INVESTIGATION;
    (C) THE NUMBER OF REPORTS WHICH WERE CLOSED ADMINISTRATIVELY AFTER THE INVESTIGATION CONFIRMED ABUSE;
    (D) THE NUMBER OF REPORTS RECEIVED ALLEGING ABUSE OR NEGLECT IN FOSTER HOMES;
    (E) THE NUMBER OF FOSTER HOMES CLOSED AS A RESULT OF ABUSE/NEGLECT; AND
    (F) THE ACCURATE AVERAGE CASELOAD OF EMPLOYEES BY AREA OF SPECIALIZATION: TELEPHONE INTAKE, INVESTIGATIONS, INTAKE AND INVESTIGATIONS, IN-HOME SERVICES, SUBSTITUTE CARE, FAMILY SERVICES, AND GENERIC (NO SPECIALIZATION).

31. THE LEGISLATURE SHOULD INCREASE FUNDING FOR THE OFFICE OF YOUTH CARE INVESTIGATIONS (OYCI) UNDER THE ATTORNEY GENERAL'S OFFICE TO PERMIT THE OFFICE TO CARRY OUT ITS STATUTORY

RESPONSIBILITIES OF REVIEWING STATE AGENCY INVESTIGATIONS OF CHILD ABUSE AND NEGLECT.

THE TEXAS FAMILY CODE SHOULD BE AMENDED TO REQUIRE STATE AGENCIES TO NOTIFY THE OYCI WITHIN 10 WORKING DAYS OF THE RECEIPT OF AN ABUSE OR NEGLECT REPORT AND TO REQUIRE THE AGENCIES TO SUBMIT A COPY OF THE INVESTIGATIVE REPORT TO THE OYCI WITHIN 10 WORKING DAYS OF ITS COMPLETION. (PAGE 98)

32. THE TEXAS DEPARTMENT OF HEALTH'S BUREAU OF VITAL STATISTICS SHOULD REQUEST A CANRIS CHECK ON ALL DEATH CERTIFICATES RECEIVED ON PERSONS UNDER AGE 17. IF THE CHILD IS LISTED IN CANRIS, THE BUREAU SHOULD FORWARD THE INFORMATION ON THE DEATH CERTIFICATE TO THE TEXAS DEPARTMENT OF HUMAN SERVICES AND TO THE OFFICE OF YOUTH CARE INVESTIGATIONS (OYCI).

THE DEPARTMENT OF HUMAN SERVICES SHOULD FORWARD THE INFORMATION TO THE CHAIR OF THE APPROPRIATE REGIONAL CHILD DEATH REVIEW COMMITTEE FOR REVIEW AND FOLLOW-UP INVESTIGATION, IF WARRANTED. THE REVIEW COMMITTEE SHOULD FORWARD ITS REPORT TO THE OYCI. THE OYCI SHOULD REVIEW EACH CHILD DEATH REPORT AND SHOULD MAINTAIN AND REPORT STATISTICAL INFORMATION BASED ON DATA PROVIDED. (PAGE 101)

33. THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD CONDUCT A PILOT PROJECT TO TEST THE EFFECTIVENESS OF STATIONING A CPS CASEWORKER IN A LOCAL LAW ENFORCEMENT OFFICE TO WORK AS A TEAM IN INVESTIGATING CHILD ABUSE REPORTS IN THAT PARTICULAR JURISDICTION. (PAGE 103)

NOTE: TWO ISSUES IDENTIFIED BY THE COMMITTEE COULD NOT BE RESOLVED THROUGH STATUTORY OR FUNDING CHANGES: RECORD FALSIFICATION (PAGE 79) AND RETALIATORY ACTIONS AGAINST AND AGENCY ATTITUDES TOWARD FOSTER PARENTS (PAGE 85).

RECOMMENDATIONS

ISSUE: Based on the magnitude of the problems identified in the Child Protective Services (CPS) program by various independent examinations and investigations over the past 18 months, continued legislative oversight is essential to monitor the agency's progress. Furthermore, many aspects of the program cannot even be evaluated until consistent, reliable data is obtained.

R E C O M M E N D A T I O N #1:

THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES SHALL CONTINUE TO MONITOR AND EVALUATE THE CPS PROGRAM ADMINISTERED BY THE TEXAS DEPARTMENT OF HUMAN SERVICES AND SHALL RESEARCH ANY ADDITIONAL ISSUES RELATED TO CHILD PROTECTION WHICH WARRANT FURTHER EXAMINATION.

THE COMMITTEE SHALL SUBMIT A PROGRESS REPORT AND ANY NECESSARY RECOMMENDATIONS TO THE 72ND TEXAS LEGISLATURE. IF SUBSTANTIAL IMPROVEMENTS IN THE OVERALL MANAGEMENT AND EFFECTIVENESS OF THE CPS PROGRAM ARE NOT ACHIEVED, THE COMMITTEE SHALL DEVELOP A PROPOSAL TO TRANSFER THE STATUTORY RESPONSIBILITIES FOR PROTECTING CHILDREN TO ANOTHER EXISTING STATE AGENCY OR TO ESTABLISH A NEW AGENCY AND BOARD TO ADMINISTER THIS CRITICAL PROGRAM.

RATIONALE: The Texas Department of Human Services has begun implementing changes in the CPS program to address some of the weaknesses identified in the agency's internal study of the "intake" system and in the comprehensive evaluation conducted by the American Association for Protecting Children (AAPC). The AAPC report alone contained 72 recommendations for improvement, and the agency has not developed initiatives to address all of them. Additionally, the investigation conducted by the Texas Attorney General's Office was just completed in January 1989, and although it focused specifically on the El Paso office, this report may offer insight for resolving similar problems which appear to be affecting the program statewide.

A number of aspects of the CPS program, such as staffing ratios and caseload levels, still cannot be evaluated until consistent, reliable data is obtained. Several of the Committee's recommendations are designed to extract precise information so a valid analysis of the agency's use of resources can be performed.

Because the problems in the CPS program are immense and will require substantial improvements, the Committee may want to establish an advisory committee comprised of caseworkers to assist in the ongoing evaluation. Since these employees ultimately will implement any statutory, policy, or procedural changes, their input and consultation would be valuable in assessing the quality and effectiveness of changes in the program.

The Board and the Department of Human Services have tremendous responsibilities in administering the state's largest public assistance programs in addition to a multitude of smaller health and human services programs. Like CPS, these programs can get lost in a large bureaucracy and not receive the level of attention they deserve. It is possible the problems in the CPS program cannot be resolved realistically by a board and agency with so many other priority responsibilities.

ISSUE: The agency's use of funds appropriated for the Child Protective Services (CPS) program was questioned repeatedly by caseworkers and numerous others. Due to insufficient data and the diffusion of management responsibilities at state, regional and local levels, it was virtually impossible for the Committee to account for and analyze all program expenditures and to establish clear responsibility for certain management decisions involving CPS policies and personnel issues.

R E C O M M E N D A T I O N #2:

THE LEGISLATURE SHOULD REQUIRE AN IN-DEPTH MANAGEMENT AUDIT OF THE CPS PROGRAM AT THE STATE, REGIONAL AND LOCAL LEVELS TO BE CONDUCTED BY THE STATE AUDITOR'S OFFICE, THE GOVERNOR'S MANAGEMENT EFFECTIVENESS DIVISION, OR THROUGH A CONTRACT WITH A QUALIFIED, PRIVATE AGENCY WITH EXPERTISE IN MANAGEMENT AUDITS.

RATIONALE: A comprehensive, professional audit of expenditures for the Child Protective Services (CPS) program over the past few years is needed to analyze the agency's use of funds appropriated by the legislature for staff, client services, travel, and other program activities.

Although the Committee was frequently reminded of the autonomy of regional management as an explanation for inconsistencies in staffing ratios, caseload levels, and policy implementation, it appears the diffusion of administrative responsibilities at the state level also contributes to these problems. At least two different state level divisions of the Department have management responsibilities for CPS: 1) the Office of Field Management and 2) the Protective Services for Families and Children Branch. Therefore, the audit must examine all appropriate state office divisions as well as regional and local office program management.

An in-depth management audit should determine the overall administrative costs for the program and should produce data which will permit a comparison of expenditures and staffing levels among the 10 regions of the state. Special attention should be focused on the intensely troubled regions of the state to determine whether the severity of the problems in those areas is a direct result of poor program management or other conditions unique to the particular region. The Committee has identified these regions as El Paso, Houston, and Abilene.

The audit also should include a review of overhead costs and agency expenditures for special projects, contracts with consultants, and contracts with service providers such as psychologists, psychiatrists, physicians, and private adoption agencies.

The results of the management audit should be shared with county child welfare boards and commissioner's courts. Since many Texas counties contribute substantial funds to assist the state in its efforts to protect children, counties should be assured these resources are being spent wisely.

ISSUE: It is essential for the Legislature to have access to accurate information regarding state and regional office Child Protective Services (CPS) staffing levels prior to determining the agency's level of funding for "Program Support" for the 1990-1991 biennium.

R E C O M M E N D A T I O N #3:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL SUBMIT THE FOLLOWING INFORMATION TO THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES AND TO THE LEGISLATIVE BUDGET OFFICE NO LATER THAN MARCH 31, 1989:

1) THE TOTAL NUMBER OF STATE OFFICE POSITIONS AUTHORIZED AND BUDGETED FOR FY 1989, AND THE TOTAL NUMBER OF POSITIONS FILLED ON FEBRUARY 1, 1989. ANY EMPLOYEE WHOSE POSITION IS PAID UNDER THE CPS LINE ITEM BUT WHOSE PRINCIPAL HEADQUARTERS IS IN THE STATE OFFICE SHOULD BE INCLUDED EVEN THOUGH THE EMPLOYEE'S DUTIES MAY INVOLVE FIELD ASSISTANCE.

2) THE TOTAL NUMBER OF REGIONAL OFFICE POSITIONS, BY REGION, AUTHORIZED AND BUDGETED FOR FY 1989, AND THE TOTAL NUMBER OF POSITIONS FILLED ON FEBRUARY 1, 1989. ANY EMPLOYEE WHOSE SALARY IS PAID UNDER THE CPS LINE ITEM BUT WHOSE HEADQUARTERS IS IN A REGIONAL OFFICE SHOULD BE INCLUDED AS A REGIONAL OFFICE EMPLOYEE EVEN THOUGH THE EMPLOYEE'S RESPONSIBILITIES MAY INVOLVE ASSISTANCE TO OR SUPERVISION OF A LOCAL CPS OFFICE.

3) THE TOTAL ESTIMATED EXPENDITURES FOR SALARIES FOR FY 1989 TO MAINTAIN THE STAFFING LEVELS REPORTED ABOVE FOR STATE AND REGIONAL OFFICE PERSONNEL.

RATIONALE: The Legislature appropriates funding for child protective services staff under two separate line items in the appropriations act: 1) Program Support and 2) Child Protective Services.

Program Support, as defined by the agency, includes funding for ALL state and regional office employees, travel for

administrative employees and other costs associated with operating state and regional offices. The Child Protective Services (CPS) line item is intended to reflect the staff, travel, client services, and other expenditures necessary to deliver services at the local level.

In reviewing the agency's Legislative Appropriations Request (LAR) for the 1990-1991 biennium, several state and regional office positions were identified as expenditures under the CPS line item for local office program delivery and were included in the agency's request for funding for the next two years. These positions included a state office "section director," a regional director, administrative assistants and bookkeepers for regional directors, and case analysts in each of the 10 regional offices. The Committee was not able to identify the total number of positions and the total amount of expenditures for salaries which were inappropriately reported under the line item designated for local offfice CPS activities.

ISSUE: The manner in which the Texas Department of Human Services currently reports staffing and expenditures for the Child Protective Services (CPS) program makes it impossible to determine the total overall administrative costs for regional and state office activities.

R E C O M M E N D A T I O N #4:

THE LEGISLATURE SHOULD REQUIRE THE TEXAS DEPARTMENT OF HUMAN SERVICES TO REPORT ALL SALARIES, TRAVEL, AND OTHER EXPENDITURES FOR STATE AND REGIONAL OFFICE CPS ACTIVITIES UNDER "PROGRAM SUPPORT" IN ITS LEGISLATIVE APPROPRIATIONS REQUEST FOR THE 1992-1993 BIENNIUM. TDHS SHALL CONTINUE REPORTING IN THIS MANNER UNTIL OTHERWISE DIRECTED BY THE LEGISLATURE.

THE LEGISLATURE SHOULD ADD A RIDER TO THE APPROPRIATIONS ACT WHICH EXPRESSLY PROHIBITS THE AGENCY FROM EXPENDING ANY FUNDS APPROPRIATED UNDER THE "CHILD PROTECTIVE SERVICES" LINE ITEM FOR ANY STATE OR REGIONAL OFFICE ACTIVITY, INCLUDING SALARIES, TRAVEL, OVERHEAD OR ANY OTHER EXPENSE.

RATIONALE: Since the Legislature specifically separates the funding for state and regional office CPS activities (Program Support) and local office direct service delivery (Child Protective Services) in the appropriations act, the agency should be required to report its expenditures and requests for funding accordingly.

The Department appears to be circumventing the Legislature's intended level of funding for state and regional office personnel by using some of the funds provided for local office staff to finance additional administrative positions. Although some positions in local offices also could be considered administrative in nature, requiring strict adherence to the above reporting requirements will at least provide a more accurate accounting of administrative costs for the program.

ISSUE: Inadequate staffing for local Child Protective Services (CPS) offices was identified as the primary reason for the agency's inability to investigate all child abuse reports and for the massive closures of confirmed child abuse cases which indicated a need for further monitoring. In order to determine adequate staffing and caseload levels, the Legislature must have access to accurate information.

R E C O M M E N D A T I O N #5:

AS PART OF ITS ONGOING EVALUATION, THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES SHALL PERIODICALLY SURVEY ALL CHILD PROTECTIVE SERVICES SUPERVISORS TO OBTAIN ACCURATE INFORMATION ON THE ACTUAL STAFFING AND CASELOAD LEVELS IN LOCAL CPS OFFICES ACROSS THE STATE. THE DEPARTMENT SHALL NOT INTERFERE WITH THE SUPERVISORS' ABILITY TO RESPOND ACCURATELY TO THE COMMITTEE'S SURVEY AND SHALL PERMIT SUPERVISORS TO RETURN THE SURVEYS DIRECTLY TO THE COMMITTEE WITHOUT REVISIONS.

RATIONALE: In FY 1988, almost half of the confirmed child abuse cases where the victim was not removed from the home were closed "due to staff shortages." Although the number of reports which were never even investigated is not known, information received by the Committee suggests a substantial number of cases may have been closed inappropriately solely because of staff shortages.

Clearly, the number of frontline employees must be increased. The Committee attempted to review staffing levels to estimate how many additional caseworkers are needed but could not ascertain from the documents available precisely how many employees presently carry active caseloads. Unfortunately, accurate data on caseload levels and local office staffing patterns is not accessible at the state level. This information must be obtained from individual supervisors in local CPS offices.

The method the state office uses to determine caseload levels counts employees who do not actually carry caseloads and caseworker positions which are vacant. Both caseworkers and supervisors indicated that frontline caseworker positions may be left vacant for extended periods of time causing caseload levels for the remaining employees to escalate to inappropriate, unreasonable levels.

In its Legislative Appropriations Request (LAR) for the 1990-1991 Biennium, the agency reported there are approximately 1,593 caseworker positions or 52% of the total 3,060 CPS employees in state, regional and local offices. To ensure any additional funding appropriated by the Legislature for staff is used to hire more direct service employees, the Committee will survey supervisors in local CPS offices periodically throughout the interim to obtain accurate data.

ISSUE: Presently, there are no career ladder opportunities available for Child Protective Services (CPS) caseworkers. Promotions are extremely limited and any potential career advancement forces the caseworker to move out of direct service delivery and into an administrative position.

R E C O M M E N D A T I O N #6:

THE LEGISLATURE SHOULD AUTHORIZE AND FUND TWO ADDITIONAL CLASSIFICATION LEVELS FOR CPS SPECIALISTS (CASEWORKERS) AND ONE ADDITIONAL LEVEL FOR CPS SUPERVISORS.

RATIONALE: Under the present state employee classification system there are only two classification levels authorized for caseworkers, Child Protective Services Specialist I and II. Only one classification level is authorized for supervisors of caseworkers, Child Protective Services Supervisor I.

Ironically, there are several career ladder opportunities provided for upper management positions in CPS. Four levels are authorized for Regional Directors (Social Services Administrator I, II, III, and IV), and three for Program Directors (Child Placement Director I, II, and II). Even support staff have more classification levels than caseworkers and supervisors: Clerical Supervisor I, II, III, and IV and Clerk I, II, and III.

The comprehensive evaluation conducted by the American Association for Protecting Children (AAPC) revealed that 77% of CPS caseworkers are currently paid at step 1 and 2 out of the eight steps available within their classification levels even though 34% have over five years of experience and 29% have two to five years of experience with the program. Although 83% of the supervisors have over five years of experience, 55% are paid at

steps 1, 2, and 3 out of the eight steps available within the single classification level authorized for supervisors.

In the AAPC's 1988 survey of Texas caseworkers and supervisors, the lack of promotional opportunties was cited as the number one barrier to job satisfaction. Several years ago the Department received authorization to establish a Human Services Specialist position to provide career mobility for caseworkers. Unfortunately, the information the Committee received indicated these employees are being used in many cases to perform administrative functions and do not offer promotions within the direct service field.

Retention of these experienced employees must be a priority for the legislature. By providing adequate career ladder opportunities, these employees can be rewarded for outstanding job performance and would be able to remain in direct service positions where they are most needed.

Ideally, establishing four levels of caseworker positions would enable case assignments to be based on the level of experience and expertise of the worker. For example, Priority I cases involving life-threatening situations could be handled by a senior caseworker or Child Protective Services Specialist IV. This level of employee also could assist the supervisor in consulting with other workers on difficult assignments. Cases involving children at risk of abuse could be handled by the least experienced employee or Child Protective Services Specialist I. This range of direct services positions would prevent sending a totally inexperienced employee out to investigate a high priority, dangerous and complex case.

ISSUE: Many local Child Protective Services (CPS) offices do not even have the basic computer equipment necessary to permit caseworkers to immediately check for vital information about previous abuse reports on children and perpetrators in the agency's statwide Child Abuse and Neglect Reporting and Inquiry System (CANRIS).

R E C O M M E N D A T I O N #7:

THE TEXAS LEGISLATURE SHOULD APPROPRIATE SUFFICIENT FUNDING TO PROVIDE ADEQUATE COMPUTER EQUIPMENT FOR ALL LOCAL CPS OFFICES. THE CPS PROGRAM SHOULD BE A PRIORITY FOR THE LEGISLATURE IN CONSIDERING THE DEPARTMENT'S TOTAL BUDGET REQUEST FOR "INFORMATION SYSTEMS" FUNDING.

IF FUNDING IS APPROPRIATED, THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL EXPEDITE THE ACQUISITION AND INSTALLATION OF THE EQUIPMENT TO MAKE THE COMPUTERS AVAILABLE TO CASEWORKERS AS SOON AS POSSIBLE. THE AGENCY SHALL PROVIDE "ACCESS CODES" TO ALL CASEWORKERS TO ENABLE THEM TO DIRECTLY RETRIEVE INFORMATION CONTAINED IN CANRIS.

RATIONALE: The Child Abuse and Neglect Reporting and Inquiry System (CANRIS) is the statewide computer bank which stores information on previous child abuse reports. The purpose of collecting the information and maintaining a statewide data bank is to provide caseworkers immediate access to this vital information. Agency policy directs the employee to check local records and CANRIS as soon as an incoming report of abuse is received to see if there have been any previous reports involving the child or alleged perpetrator.

Local offices which do not have computer equipment may have to rely on a telephone call to a regional office or other local office to request a CANRIS check. In at least one instance described to the Committee, a CANRIS check was not performed because the worker tried unsuccesfully several times to complete

a call to the regional office. Later, after the child died from physical abuse, a CANRIS check was completed and revealed three previous incidents involving injury to a child by the same perpetrator.

Even in offices where computer equipment is available, there may be only one terminal or only one employee who has an "access code" to retrieve information. A group of caseworkers told Committee staff only one employee in their local office was given an access code to protect the confidentiality of information contained in CANRIS. These employees investigate reports and have firsthand knowledge of very personal and confidential information but are not trusted to have access to the computer.

Some offices do not have basic word processing equipment to handle the tremendous volume of paperwork, including extensive case record documentation and preparation of official court documents. Multiple forms must be completed on every report, and these are still being processed manually and transferred to regional and state offices via mail. Computer equipment also would permit better tracking of children in foster care placements so at any given time the child could be located immediately and the child's caseworker easily identified.

The CPS program is one of the few remaining programs the agency administers which still is not automated. The agency has included funding for CPS computer equipment in its overall budget request for "Information Systems" for 1990-1991. Although improvements in the computer capacity of other programs such as

Food Stamps and AFDC are probably warranted, automation of the CPS program should be considered the top priority for the legislature and the agency.

ISSUE: Presently, the basic and advanced training provided to Child Protective Services (CPS) employees is conducted almost exclusively by agency-employed trainers in state and regional offices. This method of delivering training is inefficient and fails to provide professional, comprehensive skills development.

R E C O M M E N D A T I O N #8:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL INCORPORATE THE USE OF EXPERTS OUTSIDE THE AGENCY IN ITS BASIC AND ADVANCED TRAINING AND CONTINUING EDUCATION OPPORTUNITIES FOR CPS WORKERS. THE CURRENT METHOD OF DELIVERING TRAINING SHOULD BE RESTRUCTURED TO ENSURE MORE DIRECT, PROFESSIONAL, AND TIMELY TRAINING OF CPS EMPLOYEES. ADDITIONALLY, THE AGENCY SHOULD PROVIDE EVERY CASEWORKER WITH A CPS HANDBOOK CONTAINING PROGRAM POLICIES AND PROCEDURES.

RATIONALE: Using agency employees as "special trainers" may be effective for providing standardized training on departmental policies and procedures, but it does not allow for comprehensive skills training and development of expertise. In some instances, the special trainers train the CPS supervisors who, in turn, are then responsible for training the employees they supervise. Not only does this indirect method of training result in inconsistencies across the state, it is inefficient and consumes a significant amount of the supervisor's time which should be spent consulting with workers and reviewing case records.

In a survey conducted by the AAPC, caseworkers and supervisors rated the training currently provided as "average." Twenty-one percent of caseworkers and 28% of supervisors rated satisfaction with the training as low to very low. Most described the training as too heavily concentrated on agency policies and procedures with very little emphasis placed on the

special skills needed for conducting thorough, professional investigations and working effectively with families.

Some of the specific deficiencies identified by caseworkers include: 1) legal training in civil and criminal law; 2) preparing for and presenting courtroom testimony; 3) investigating sexual and emotional abuse cases; 3) conducting professional videotaped interviews with children; and 5) making better case decisions, especially when the employee is faced with deciding whether return a child to a previously abusive home.

Experts are available in most communities or could be brought in to local areas on occasion to assist with these special training needs: judges, county and district attorneys, attorneys ad litem, law enforcement officers, physicians, psychiatrists, psychologists, and experts in family violence, sexual assault, and substance abuse. In addition to improving the profesionalism of the CPS staff, employees would be able to develop direct and cooperative relationships with individuals in the community who can serve as valuable resources to the caseworker.

And finally, the Committee learned that caseworkers are not provided a copy of the CPS Handbook which contains all of the policies and procedures the employees are required to follow. The massive amount of information contained in the handbook cannot be learned in a 2-week basic training course. Caseworkers cannot be expected to follow agency policy if they are not even provided with a handbook to study and guide them.

ISSUE: In an attempt to "regionalize" agency personnel policies, the responsibility for hiring Child Protective Services (CPS) caseworkers has been transferred from local offices to regional personnel departments. This employment practice may be efficient for other agency programs, but it is not conducive to selecting individuals with the special skills necessary for handling child abuse cases.

R E C O M M E N D A T I O N #9:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD REVISE ITS PERSONNEL POLICIES TO PERMIT CPS SUPERVISORS TO REVIEW APPLICATIONS, INTERVIEW SELECTED APPLICANTS, AND HIRE EMPLOYEES WHO ARE APPROPRIATE FOR THE PARTICULAR LOCAL CPS OFFICE.

RATIONALE: Child protective services caseworkers must be able to work well with children, families, law enforcement, district and county attorneys, judges, foster parents, and numerous other individuals. Except for a few very small TDHS offices where there may be only one or two CPS employees, the majority of caseworkers work in "units" as a team. It is very important for the employees to be compatible and for their individual skills to complement the other members of the unit. In addition to special casework skills, a potential employee's judgment, reason, ethics, and personality must be taken into consideration.

The current method of hiring CPS employees also causes unnecessary delays in filling critical frontline positions. Leaving direct service positions vacant for extended periods of time substantially increases the caseload for the remaining employees, reduces the quality of investigations and decreases the amount of time available to monitor the safety of children.

One supervisor told the Committee she never knows a position has been filled until the new employee appears at the local office. Because the agency does not have a good record of terminating incompetent employees, it is imperative to carefully select appropriate and qualified employees initially.

ISSUE: Child Protective Services (CPS) caseworkers estimate as much as 70% of their time is spent filling out forms and other paperwork required by the agency, leaving minimal time to devote to actual client casework and monitoring the safety of children.

R E C O M M E N D A T I O N #10:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL REVIEW ITS CURRENT PAPERWORK REQUIREMENTS FOR THE CPS PROGRAM AND SHALL ELIMINATE ALL DUPLICATIVE AND UNNECESSARY DOCUMENTATION. THIS INITIATIVE SHOULD INCLUDE INPUT FROM CASEWORKERS AND SUPERVISORS IN ADDITION TO A FOLLOW-UP SURVEY OF DIRECT DELIVERY STAFF TO DETERMINE IF MEANINGFUL REDUCTIONS WERE ACHIEVED.

RATIONALE: "(A) review of case records indicated an inordinate and duplicative amount of documentation. While the intent of state and/or regional policy was to ensure good recordkeeping...the system is no longer coordinated because of the layers added over time. Ironically, much of the documentation is not useful." (AAPC, Section 3:59)

In the past, the agency has established committees of caseworkers to recommend reasonable reductions in paperwork requirements, but CPS employees report there have been no meaningful reductions, and in fact, paperwork has actually increased.

A regional director for CPS was quoted in the AAPC report as saying the good caseworkers get frustrated and leave the agency, whereas the good technicians or paper processors remain. Not only do they remain, they may be more likely to receive promotions since the agency's performance evaluations place undue emphasis on compliance with paperwork requirements.

ISSUE: In FY 1988, the turnover rate for Child Protective Services caseworkers was 31.1%, almost double the turnover rate in 1986. The reasons for turnover in caseworker positions have been identified repeatedly in the past. However, the Department began a two-year study in September 1988 to "identify the factors contributing to burnout and turnover, to develop and test methods of reducing turnover and to select successful methods and implement them statewide."

R E C O M M E N D A T I O N #11:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD IMMEDIATELY BEGIN TO ADDRESS THE EXCESSIVE CASEWORKER TURNOVER RATES BASED ON THE FACTORS ALREADY IDENTIFIED. EFFORTS TO ALLEVIATE THESE PROBLEMS SHOULD NOT BE DELAYED PENDING THE COMPLETION OF THE AGENCY'S TWO-YEAR BURNOUT AND TURNOVER PROJECT.

RATIONALE: Although the agency's two-year "Reduction of Staff Burnout and Turnover (RSBT)" project is financed through a federal grant, the resources and staff time devoted to this project are unnecessary. The factors contributing to burnout and turnover have been identified repeatedly, and delaying essential improvements will only result in the loss of even more experienced employees.

"Acknowledging that turnover in CPS was a problem, TDHS (has) implemented a number of initiatives over the past few years to reduce turnover. These initiatives included...developing a Human Services Specialist position to create a career ladder for staff, offering flextime, developing a Workload Management System...and establishing a respite worker pilot to test the effectiveness of providing a 'floating' caseworker to cover respite assignments." (AAPC, Section 4:12).

With respect to the Human Services Specialist position, there are only 23 of these positions available on a statewide

basis and this does not provide a true career ladder for caseworkers. Most of the caseworkers who contacted the Committee expressed support for "flextime" and "respite" workers but stated they are not being used in their particular local offices or regions.

In response to a 1988 statewide survey conducted by the American Association for Protecting Children (AAPC), Texas caseworkers rated the following factors according to their impact on job satisfication: 1) limited opportunities for career advancements, 2) job pressures, 3) lack of support from agency administration, 4) salaries; 5) excessive paperwork requirements, 6) unreasonable workloads; and 7) community expectations.

In addition to these factors, caseworkers cited a number of other reasons for job dissatisfaction: inadequate support staff including clerical assistance and case aides; the agency's inability to terminate incompetent and unprofessional caseworkers, supervisors, program directors and other administrative personnel; and the inability to really help families as a result of extremely limited funding for client services. Moreover, there is deep dissatisfaction with the agency for leaving caseworker positions vacant for extended periods of time, creating additional burdens on the remaining staff.

Some of these problems will require additional resources, but many others are management-related and immediate action could be taken without funding increase and <u>certainly</u> without additional research.

ISSUE: The appropriations act does not specifiy the amount of funding intended to provide services to clients of the Child Protective Services (CPS) program. The current funding level allocated by the agency is insufficient to provide appropriate services to all children and families in need. Additionally, the agency does not maintain data on the number of persons needing or receiving services, the kinds of services delivered, or the cost of providing the services.

R E C O M M E N D A T I O N #12:

THE TEXAS LEGISLATURE SHOULD: 1) APPROPRIATE SUFFICIENT FUNDS TO ENABLE THE DEPARTMENT TO EXPAND SERVICES TO HELP MORE ABUSED AND NEGLECTED CHILDREN AND THEIR FAMILIES; AND 2) ESTABLISH A SEPARATE LINE ITEM IN THE APPROPRIATIONS ACT UNDER THE CPS PROGRAM TO CLEARLY DIFFERENTIATE BETWEEN FUNDING AUTHORIZED FOR STAFF AND THE FUNDING INTENDED TO PROVIDE "CLIENT SERVICES."

R E C O M M E N D A T I O N #13:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL SUBMIT A DETAILED ANNUAL ACCOUNTING OF EXPENDITURES FOR CLIENT SERVICES ON A REGIONAL BASIS TO THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES AND THE LEGISLATIVE BUDGET OFFICE. THE ANNUAL ACCOUNTING SHALL SPECIFIY THE TOTAL AMOUNTS EXPENDED FOR AND THE TOTAL NUMBER OF CHILDREN AND FAMILIES NEEDING AND RECEIVING THE FOLLOWING:

A) PSYCHOLOGICAL OR PSYCHIATRIC EVALUATIONS;
B) PROFESSIONAL COUNSELING;
C) MEDICAL EXAMINATIONS;
D) MEDICAL TREATMENT;
E) PARENTING CLASSES;
F) HOMEMAKER ASSISTANCE;
G) PROTECTIVE DAY CARE; AND
H) ANY OTHER SERVICES DELIVERED.

THE DATA SHOULD REFLECT WHETHER THE SERVICES WERE PROVIDED TO CHILDREN LIVING AT HOME OR IN A SUBSTITUTE LIVING ARRANGEMENT SUCH AS FOSTER CARE.

RATIONALE: A caseworker's response to a survey conducted by the Texas State Employees Union was read into the record at the Committee's public hearing in Dallas on March 3, 1988, as follows:

"I can live with the long hours and I can live with the low pay, but just give me some services to give to my families: housing that is habitable and not three months away, food, job sources, transportation, mental health services--available NOW when needed. Day care tomorrow so the family can look for a job. Health care where they don't have to sit at the hospital over six hours and be treated like dirt. Maybe then our families will be able to listen and learn about being better families."

In comparing previous appropriations requests submitted to the legislature by TDHS, the estimated and actual expenditures for 1987 show the agency budgeted $13.3 million for client services and spent only $11 million. It was difficult to comprehend why the program actually spent less than was budgetd since the Committee repeatedly was told cases must be closed because of insufficient funds to provide services and that local offices routinely run out of money for services before the fiscal year ends.

According to the agency's FY 87 annual report, an estimated 63,073 children in confirmed reports of abuse or neglect needed services after investigation, but only 42% actually received services. The remaining 36,832 abused children received nothing--no caseworker assigned, no monitoring, no services to alleviate the abuse, and no services to address the resulting psychological damage to the child.

The definition of "services" varies greatly, from cursory monitoring by a caseworker who makes monthly contact with the child and/or family, to extensive treatment in a residential facility. In response to a 1988 inquiry from the Senate Select Committee on Juvenile Justice, the agency surveyed its employees

to determine approximately how many children would receive professional counseling during the fiscal year. The results revealed that only 17% of the children who were left in their homes after abuse was confirmed and only 33% of children in foster care would receive such services. The agency had to survey its employees for the information because there is no accounting from the direct delivery level to the state office level of which services the agency provided, how many received the particular service, and the cost of delivering the service.

"In Texas, a family is eligible for in-home services when a report of child abuse or neglect is confirmed or adjudicated." (AAPC, Section 3:17) However, eligibility is not the only criteria used in determining whether a family will receive services. It appears the decision whether to open a case often hinges on the availability of staff rather than the perilous situation in the home. One might question why the agency's 1987 annual report indicates "lack of staff" as the only reason for excluding the provision of services when insufficient funding for purchasing services is surely the most significant factor. Unfortunately, the Committee staff has determined the agency generally defines "services" as opening a case and assigning a caseworker.

The agency reports that an estimated 70% of the families in which child abuse or neglect has been determined to have occurred actually need services to PREVENT future abuse or neglect or removal of children. "The rationale is that the remaining 30% of the families do not require services because the risk to the

child has been alleviated or the perpetrator is no longer in the home. In some cases, the family has moved and cannot be located." (AAPC, Section 3:17). These situations include women and children in family violence shelters who often eventually return, divorced parents with court-established visitation rights, or situations where the perpetrator is in jail and may eventually bond out.

"In most of the states reviewed, even if a case is unfounded or invalid, a family may still need some services and can be offered such." (AAPC, Section 2:13). Services should not be provided only to PREVENT recurrence of abuse but also as a treatment response. In Texas, we do not even offer services routinely when a case of abuse or neglect is verified.

> "The inconsistent use of the term (services) contributes to a lack of clarity about the underlying purpose of in-home services. The community and to some extent CPS staff are not always clear if the primary goal of in-home services is to alleviate the risk of abuse or neglect, improve individual and family functioning or prevent placement of a child into substitute care." (AAPC, Section 3:21-22)

If we fail to address the emotional and physical effects of child abuse, we cannot possibly begin to end violence in future generations of families. Clearly, more employees are needed to prevent closure of confirmed cases, and additional funding for services must be appropriated if active treatment is desired.

The manner in which the agency currently reports the numbers of children and families needing and receiving services is inadequate for determining the actual needs of CPS clients. Establishing a separate line item for "Client Services" in future

appropriations bills and requiring the agency to account for expenditures under this line item will not only help the legislature track where and how money is spent, but will enable us to begin evaluating which services truly help remedy or alleviate abuse and aid the victim in coping with and recovering from traumatic experiences.

ISSUE: Multiple medical and psychological evaluations of children are not only costly but they can actually increase the trauma to a child and contribute to conflicting and inaccurate information for case decision-making.

R E C O M M E N D A T I O N #14:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD DEVELOP POLICIES WHICH DISCOURAGE THE USE OF MULTIPLE MEDICAL AND PSYCHOLOGICAL EVALUATIONS IN CPS INVESTIGATIONS AND WHICH PROMOTE SENSITIVITY IN SITUATIONS WHERE CASEWORKERS MUST PHYSICALLY INSPECT CHILDREN FOR INJURIES.

RATIONALE: The Committee reviewed numerous cases in which repeated medical examinations or psychological evaluations were performed. For the children, these evaluations involved describing extremely horrible and embarrassing experiences, intrusive vaginal and anal exams, and hours of interrogation by many people who are virtual strangers to the child. Children who have experienced abuse in the hands of their caretakers should be handled with sensitivity and should not be subjected to further unnecessary probing in the hands of the very system which is supposed to protect them from harm.

Caseworkers frequently must physically inspect children for injuries as part of the investigation, but this, too, can be handled with sensitivity. For example, a 13-year-old boy was required to expose his lower body so a female caseworker and school nurse could examine him for alleged injuries. Although he had not been abused, the process of invalidating the accusation caused unnecessary trauma and humiliation. Providing an adult male to inspect the child would have been more appropriate and could have prevented this unfortunate experience.

ISSUE: Access to services for Child Protective Services (CPS) clients is severely restricted in areas of the state where the agency contracts exclusively with only one service provider or with a very limited number of selected providers.

R E C O M M E N D A T I O N #15:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL IDENTIFY AND CHANGE POLICIES WHICH LIMIT CONTRACTS FOR SERVICES FOR CPS CLIENTS AND SHALL CONSIDER A SYSTEM OF "OPEN ENROLLMENT" TO ALLOW ALL QUALIFIED SERVICE PROVIDERS TO PARTICIPATE IN THE PROGRAM IF THEY ARE WILLING TO ACCEPT THE AGENCY'S REIMBURSEMENT RATE.

RATIONALE: The method by which CPS delivers services to clients is through a limited number of contracts with private providers in the community. This method unnecessarily restricts client access due to long waiting lists, inflexible provider schedules, excessive client travel to reach service providers, and other unnecessary barriers to services.

> "Limitations imposed by the contracting process appear to be a significant factor contributing to the unavailability of resources for families receiving in-home services. For example, a number of regions limit contracts to a few providers....As a result, other community providers that might be more appropriate for particular families cannot be used." (AAPC, Section 3:26)

Access to services is one of the most essential components for caseworkers in their efforts to help the child or family. "Our staff see themselves as case managers not as practitioners...we can identify signs of abuse and neglect but depend on contracted services to deal with them." (AAPC, Section 3:24) It is unfair for a child to linger in foster care unnecessarily because services have not been made available to

the family in a timely manner, and it is unfair for families who "fail" to comply with the agency's requirement to participate in counseling or parenting classes solely because services are inaccessible.

Additionally, testimony in public hearings indicated an erosion of confidence in contracting with providers whose primary source of income is from an agency contract. This prompts the criticism that some providers base their evaluations on the outcome desired by the agency, a common perception among those accused of abusing or neglecting their children.

Often the agency "experts" are seeing the child for the first time when it would seem logical to allow the child's regular pediatrician to perform the examination, or at a minimum, for the agency to consult with the professional who is most knowledgeable about the child's medical history. These problems could possibly be solved by a more expansive use of the resources already present in the community. An "open enrollment" system would allow an unlimited number of qualified providers to be approved by the agency and thereby expand the choices available to caseworkers, abused and neglected children and their families. Freedom to choose from the qualified providers participating in the program can help restore a sense of objectivity to the agency's work.

According to the AAPC report, "Statewide policies and procedures governing formal contracting relationships between the Department and service providers are reported to limit the flexibility of the regions in establishing case-by-case service

agreements with providers." (AAPC, Section 5:6) TDHS should identify and change the specific policies which create these limitations.

Furthermore, contracts with private providers should be evaluated annually for the quality of their services. These assessments should be documented clearly in agency records and should be considered in the process of enrolling or approving subsequent contracts. Feedback from children, families, community advocates, and CPS staff must be an integral part of the evaluation.

ISSUE: Non-profit organizations operating sexual assault centers and shelters for battered women serve many abused and neglected children in a cost-effective manner through their existing programs.

R E C O M M E N D A T I O N #16:

THE TEXAS LEGISLATURE SHOULD INCREASE THE APPROPRIATIONS FOR SEXUAL ASSAULT CENTERS (TEXAS DEPARTMENT OF HEALTH) AND SHELTERS FOR BATTERED WOMEN (TEXAS DEPARTMENT OF HUMAN SERVICES) AS A COST-EFFECTIVE WAY TO SERVE MORE ABUSED CHILDREN AND THEIR FAMILIES. CHILD PROTECTIVE SERVICES EMPLOYEES SHOULD BE ENCOURAGED TO WORK WITH THESE NON-PROFIT ORGANIZATIONS IN THEIR LOCAL AREAS.

THE DEPARTMENT OF HUMAN SERVICES SHOULD REVIEW, AND TO THE EXTENT POSSIBLE, IMPLEMENT PROTOCOLS FOR COORDINATION AND COOPERATION BETWEEN SHELTERS FOR BATTERED WOMEN AND CPS AS RECOMMENDED BY THE NATIONAL WOMAN ABUSE PREVENTION PROJECT FUNDED BY THE U.S. DEPARTMENT OF JUSTICE.

RATIONALE: SEXUAL ASSAULT CENTERS are non-profit organizations which provide services to persons who have been sexually abused, including many children whose abuse has been reported to CPS. Currently, eligible centers receive minimal state funding through grants from the Texas Department of Health (TDH). They receive no special state funding for the services they provide to CPS children.

In FY 1987, the 40 sexual assault centers receiving state grants served 3,391 children who had been sexuallv assaulted. This community resource obviously provides significant support to children who are sexually abused and can enhance the services CPS children receive.

The types of service provided by these centers include: 24-hour hotlines; crisis and follow-up counseling; support

groups; referrals to and coordination with other community services; accompaniment for medical, law enforcement, and court procedures; education/prevention programs for all age groups and special populations; training for professionals working with survivors of sexual assault; emergency shelter and transportation. These centers can provide support services at minimal cost to the state through the use of trained volunteers and substantial funding from local government and private sources (87% in FY 1987).

In FY 1988, funding for the centers statewide was approximately $370,000. State general revenues accounted for only $150,676 and federal block grants provided the balance of $219,273. The average allocation to a sexual assault center was $7,600.

In recognition of the valuable treatment these programs provide to sexually abused children, the legislature should increase the appropriations to sexual assault centers in the TDH budget. Furthermore, local CPS programs should actively work with the centers in their communities by making referrals, particularly when the agency is unable to provide treatment services for the child.

SHELTERS FOR BATTERED WOMEN not only provide protective housing for women who have been abused by their spouses or partners but for their children as well. According to FY 1987 statewide statistics, the 50 shelters receiving state funding provided temporary protective housing for 9,169 women and 13,555

children. Due to lack of space, the shelters were forced to turn away 9,641 women and their 11,331 children needing protection from violence in their homes.

Many shelters have special programs designed to help children with the trauma experienced from living in a violent home. The shelter setting provides an excellent environment for counseling services for children. For many of them, the shelter is their first experience of living without the fear of unpredictable violent attacks against themselves or their mothers.

These programs offer extensive, cost-effective services through the use of volunteer and community resources. Financial support from local governments and private sources accounts for an average of 72% of the shelters' funding. Although many shelters have been developed through grass roots community efforts across the state, it would take an estimated 135 shelters to meet the needs of victims of family violence.

In FY 1987, the state allocated $2.5 million to the 50 eligible shelters in Texas. Providing additional state appropriations in FY 1990-1991 would expand the number of shelters receiving funding and would significantly enhance essential community-based resources for abused children whose mothers are also victims of abuse.

The extent of cooperation between local CPS offices and local shelters appears to vary, and there is no statewide policy recognizing the presence of abuse of the mother as a high risk indicator for child abuse. When CPS investigations reveal the

mother of the abused child also is being abused, referral to a local shelter can provide a safe place without having to separate children from their siblings and their non-abusing parent.

During the past year, the National Woman Abuse Prevention Project (NWAPP), a task force of family violence experts from around the country, funded by the Office of Victims of Crime in the U.S. Department of Justice, has developed a protocol for CPS workers to intervene more effectively in cases of child abuse when the child's mother is also a victim of abuse. The project also has developed an advocate's guide for shelter workers designed to assist them in understanding the CPS system, to approach the system effectively as advocates for women, and to increase their awareness of child abuse intervention techniques. The project has been completed and should be available in March 1989.

The Texas Department of Human Services (TDHS) has formally agreed to apply for a technical assistance grant if federal funding becomes available for intensive training projects to implement the protocol in piloted areas. The NWAPP is required to publish their report and transmit it to the 50 states, so even if federal funding for this project is not approved, TDHS can use the NWAPP materials as guidelines for enhancing cooperation between CPS and shelter centers.

ISSUE: Court-appointed special advocates provide independent, objective reviews of children who are under the managing conservatorship of the state. These advocates sometimes are the only individuals who focus solely on the best interests of the child.

R E C O M M E N D A T I O N #17:

THE LEGISLATURE SHOULD APPROPRIATE FUNDING TO ENHANCE COMMUNITY EFFORTS TO PROVIDE COURT-APPOINTED SPECIAL ADVOCATES FOR ABUSED CHILDREN WHO ARE UNDER THE COURT'S JURISDICTION. GRANTS SHOULD BE PROVIDED TO NON-PROFIT ORGANIZATIONS WHICH HAVE DEMONSTRATED LOCAL FINANCIAL SUPPORT AND MEET ESTABLISHED GUIDELINES AND STANDARDS.

RATIONALE: Court-appointed special advocate programs throughout the nation have proven to provide effective support for children and CPS workers. The members of these non-profit organizations are trained volunteers who are appointed by judges presiding over cases involving abused or neglected children who are under the managing conservatorship of the state.

These volunteers serve as independent child advocates who are not tied to the court, CPS, or parents. Their responsibility is to add objective oversight of the needs of children in substitute care. This oversight can reduce the time children spend unnecessarily out of the home and can relieve some of the burdens on caseworkers by providing more frequent contacts with these children.

The AAPC report acknowledged that although these programs already exist in some parts of the state and TDHS is generally supportive, the department has "failed to provide sufficient encouragement at the state or regional level to broadly stimulate

the effective use and expansion" of court-appointed advocates (AAPC, Section 5:21). The report further states the agency could provide guidance to workers on the effective use of these volunteers and thereby expand the services available to abused and neglected children (AAPC, Section 5:21). "Court appointed special advocates should be utilized by the court at the earliest stage of the court proces, where necessary, to communicate the best interests of an abused or neglected child." (Deprived Children: A Judicial Response, 1986 Metropolitan Court Judges Committee Report, p. 15)

The Committee found court-appointed child advocacy programs usually have a very cooperative relationship with the courts and CPS staff, but financial constraints limit the availability of their services to only a small number of cases. Increasing the availability of these programs could substantially expand resources for abused children in a cost-effective manner. The estimated average cost of training a volunteer is $360. After training is completed, a volunteer is able to contribute to the management of a case or to the assessment of the needs of abused and neglected children at no further cost to the state.

ISSUE: Families have varying degrees of problems which may require a range of services from intensive case management to simple monitoring. Current policy provides minimum guidance to workers regarding the level of involvement required to more effectively prevent future abuse.

R E C O M M E N D A T I O N #18:

THE AGENCY SHOULD INSTITUTE LEVELS OF SUPERVISION FOR CASES INVOLVING ABUSED OR NEGLECTED CHILDREN WHO REMAIN IN THEIR HOMES. THESE LEVELS OF SUPERVISION SHOULD BE BASED ON THE RESULTS OF A RISK ASSESSMENT INDICATING THE ACTUAL NEEDS OF EACH FAMILY.

RATIONALE: The CPS Handbook establishes few expectations for the provision of in-home services and provides minimal definition of services. "Even when purchased providers are used, the caseworker usually maintains responsibility for monitoring the provision of services and the family's progress toward specified goals requiring continual coordination of efforts between the caseworker and the service provider." (AAPC, Section 3: 20-22).

The "Program Standard" for worker contact with a family is to have "monthly face-to-face contacts..." The handbook further states that "Contacts with the family are related to the problems identified in the service plan and are used to observe and monitor the effects of problemsolving efforts on the children." (CPS Handbook Section 3400) While workers often have more frequent contact with families, this minimum standard does not require the frequency of contacts to be based on the actual needs of the particular child and family. The CPS handbook does include a Management Policy for establishing "each in-home and substitute care case an ongoing service priority of A, B. or C,"

but this appears to be used as a tool for supervisors when assigning cases rather than as guidance for workers regarding the management of their caseloads (CPS Handbook Section 1492).

Creating "levels of supervision" for families receiving in-home services could more appropriately address the needs of the family and provide more direction for workers regarding expected activities. A risk assessment document should be used which reflects the specific home situation. For example, if two children have sustained similar injuries, but one comes from a family with a multitude of problems such as substance abuse, wife abuse, and poverty, then that family may require more intensive monitoring by the department and more extensive services.

The levels of supervision could be established as follows:

INTENSIVE SUPERVISION: One face-to-face contact with the child per week and two home visits with the family per month. All children being returned home from substitute care should be at this level. A short-term intensive supervision program could also satisfy this level of supervision.

MODERATE SUPERVISION: Two face-to-face contacts with the child and parent(s) per month.

MINIMAL SUPERVISION: One face-to-face contact with the child and parent(s) per month.

MONITORING: One contact with the family per month which can be face-to-face or by telephone (for Priority III cases).

Once a level of supervision is established, it should not be considered rigid, that is, based on a particular home situation a family could move from one level to another. Regardless of the level, caseworkers should respond to specific requests for assistance from the child or parent(s).

Removal of a child due to abuse or neglect does not necessarily mean every child in the home also will be removed. Whenever this occurs, the agency should at least open a case on the siblings in the home and designate a level of supervision for those children. It is anticiapted the monitoring level may be most frequently used in these cases, but any other level also could be appropriate.

ISSUE: Currently, the Texas Department of Human Services (TDHS) only investigates Priority I and II cases and no longer responds to what was once referred to as a Priority III situation, cases involving "at risk" children who may be in potentially dangerous home environments.

R E C O M M E N D A T I O N #19:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD REINSTATE MINIMUM SERVICES TO PRIORITY III CASES BY ASSIGNING THEM TO THE NEWLY HIRED AND LEAST EXPERIENCED CASEWORKERS.

RATIONALE: Failure to address the problems of child abuse and neglect at an early stage only increases the likelihood of escalated violence in the future. For children in these situations, direct intervention at a relatively low cost can have a significant impact on preventing future child abuse or neglect.

TDHS prioritizes reports of abuse or neglect in an effort to identify those cases which present imminent danger to the life and safety of children. Chapter 34 of the Texas Family Code provides the framework for assessing reports received by CPS.

In reality, prioritization of cases is truly a triage exercise where the determination of whether a child receives services is directly related to a comparison of that child's situation with other more seriously abused children. Thus, if the amount of money available to a CPS office does not even cover Priority I and II cases, there surely is nothing left to provide services to children in Priority III cases for whom the danger is considered to be less imminent.

Priority I cases are those involving children who face an immediate threat of death or serious harm as a result of the

alleged abuse or neglect, and workers are required to begin the investigation of these cases within 24-hours after receiving the report.

Priority II reports represent allegations of abuse or neglect in which there is no immediate threat of death or serious harm and investigation of these cases must begin within 10 days. The agency is currently requesting funding to reduce the timeframe for responding to Priority II reports from 10 to 5 days according to its Legislative Appropriations Request for FY 1990-1991.

In the past, the agency used a Priority III classification for reports which alleged abuse or neglect but more closely represented "at risk" situations in which childrens' living situations are not optimal for their growth and development. Examples of such cases could include truancy, runaway, reasonable physical discipline, latchkey children, inadequate supervision or physical care, and parent-child conflict. The worker may refer the case to volunteer programs or other community services, however, "...none of the regions reported having a formal system to track whether these families actually received services (cases not opened but referred)." (AAPC, Section 3:14)

The agency identifies only 1.6% in FY 87 and .03% in FY 88 as Priority III cases. However, these percentages reflect cases at intake only, while AFTER investigation, 22.6% are identified as Priority III's. Although it is doubtful whether the practice is statewide, one intake/investigation supervisor told Committee staff the current philosophy of the agency is to label what used

to be called a Priority III case as Priority II at intake in order to provide a safety net for those marginal situations. Therefore, CPS may not necessarily screen out all Priority III's at the intake and investigation stage, but at some point after investigation these families are referred to community resources and CPS ceases to be involved.

Priority III or "at risk" cases offer the greatest opportunity to handle family problems before they escalate and should be reinstated. They also would provide excellent training ground for new, inexperienced workers to learn about the CPS system, community resources, risk assessment and how to interact with families in a helpful manner. The Committee was told repeatedly about new workers who were sent out to handle potentially serious cases after only two weeks of basic training. Since the Committee is recommending a career ladder for workers by adding two additional categories for the more experienced workers, the delivery of services in Priority III cases may be most appropriately handled by CPS I workers (See Recommendation #6, pp. 37-38).

In general, the activities in these cases would involve assignment to a CPS I worker who would serve as a "case manager" by assessing the situation and the community resources available, referring the family to those resources and providing limited follow-up contacts. This would not be limited to traditional resources used by CPS, but may include a wide array of resources for food, housing, job assistance, etc. The worker's goal would be to FACILITATE access to these services for families who have been identified as at risk for future abuse.

ISSUE: Parent-agency agreements are intended to identify family problems and develop a constructive plan of action to prevent recurrence of abuse or neglect.

R E C O M M E N D A T I O N #20:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD CLARIFY POLICIES RELATING TO PARENT-AGENCY AGREEMENTS. AGENCY POLICIES SHOULD PROHIBIT THE INCLUSION OF UNREALISTIC DEMANDS ON PARENTS, MANDATE ACTUAL PARENT INVOLVEMENT IN THE DEVELOPMENT OF THE AGREEMENT, AND PROHIBIT PRESSURING AN INDIVIDUAL TO SIGN AN AGREEMENT WHICH CONTAINS A STATEMENT OF GUILT.

RATIONALE: The CPS Handbook states by agency rule and program standard that workers "must establish a written family service plan for children and families who receive in-home protective services." The handbook further requires the plan to be completed within 45 days, to be developed with the parents' active participation, to identify the family's problems and the effects of the problems, and to identify possible solutions to the problems. The parents must be given a copy of the plan (CPS Handbook Section 3310).

The Committee received numerous copies of these service plans from parents who are or were clients of CPS, and several problems were identified. First, there often seems to be a lack of true involvement of the parents in the development of the plan. Since this service plan is really an "agreement" which must be signed by the parents, then it must reflect their input.

Second, some service plans reviewed by the Committee included a statement which indicated the abuse was a fact rather than an allegation. Many parents had problems with this

statement, especially in light of their legal rights if the case ever went to court. They believed signing such an would in effect constitute an admission of guilt. If the service plan is truly to be used as a tool to attempt to identify problems and outline activities to reduce the risk of further abuse or neglect, then it should not be necessary to include such a statement.

Finally, these plans often include unrealistic conditions for the family to meet. One single mother who worked a night shift in a convenience store was told she would have to find daytime employment and get a three-bedroom house so there would be sufficient space for each individual child.

It also is the worker's responsibility to facilitate a family's ability to meet these conditions; for example, if the plan includes completing a parenting class, then the agency is responsible for ensuring timely access to these services.

ISSUE: Currently, TDHS closes some confirmed abuse and neglect cases which are identified as needing in-home services solely because the family refuses to cooperate. The ability to seek court-ordered participation would help CPS in attempting to prevent further abuse.

R E C O M M E N D A T I O N #21:

THE TEXAS FAMILY CODE SHOULD BE AMENDED TO CLEARLY ALLOW COURTS TO ORDER FAMILIES TO COMPLY AND COOPERATE WITH A CPS SERVICE PLAN WHILE THE CHILD REMAINS IN THE HOME.

RATIONALE: Only a very small percentage of confirmed abuse cases end up in the courts. These are generally serious abuse or neglect cases involving children who have been removed from their homes and for whom the agency is seeking conservatorship. Child protective services is a social service agency and, as discussed previously should make reasonable efforts to prevent removal of a child from the home by providing support and direct services to families to prevent further abuse. Court involvement should be and is reserved for serious cases and is the exception rather than the rule.

The AAPC report identified limitations in the Texas Family Code with regard to court involvement in child abuse and neglect cases. The report indicates "Texas law and policy differs from the national norm" in that "court intervention in Texas is structured toward having TDHS seek conservatorship, not toward an adjudication of abuse or neglect as defined by law. TDHS is typically seeking 'custody' of a child rather than court-ordered protective services (in cases where such services are needed but

the parents are uncooperative)..." Because of the "national trend toward encouraging home-based family preservation, it is important for the Texas judicial process to readily permit (and for THDS policy to encourage) a court's ordering a family to comply with a service plan without TDHS having to be given managing conservatorship." (AAPC, Section 5:13) Although the AAPC report did not include a specific recommendation, the Committee believes such adjustments in the Family Code should be made. Court-ordered participation in services also could be achieved through the use of a protective order.

ISSUE: Protective orders can serve as useful tools for the protection of abused and neglected children without the separation of the child from his or her siblings and from the non-abusing parent.

R E C O M M E N D A T I O N #22:

SECTION 71.01 OF THE TEXAS FAMILY CODE RELATING TO PROTECTIVE ORDERS SHOULD BE AMENDED TO INCLUDE A DEFINITION OF CHILD ABUSE CONSISTENT WITH THE DEFINITIONS CONTAINED UNDER SECTION 34.012(1)(C), (E) AND (G) OF THE FAMILY CODE.

EVERY CPS WORKER SHOULD RECEIVE TRAINING REGARDING PROTECTIVE ORDERS AND THE MANNER IN WHICH THEY CAN BE USED TO PROTECT CHILDREN WHO HAVE BEEN PHYSICALLY OR SEXUALLY ABUSED. WHEN A WORKER IS AWARE THAT A CHILD ABUSER IS ALSO ABUSING THE OTHER PARENT OF THE CHILD, THE WORKER SHOULD ENCOURAGE THE NON-ABUSING PARENTS TO PETITION FOR A PROTECTIVE ORDER.

RATIONALE: When a child has been abused by a parent, the act of separating the child from the family is devastating and traumatic. "The alleged offender, rather than the child, should be removed from the home, whenever appropriate" (Deprived Children: A Judicial Response, 1986 Metropolitan Court Judges Committee Report, p. 22).

In 1979, the Texas Legislature established the use of protective orders in cases of family violence as a mechanism to protect family members who are being physically abused in the home. Although the issuance of a protective order does not necessarily guarantee safety of a child, the perpetrator is subject to arrest if the order is violated and vigorous enforcement of these violations will send a clear message that abuse of a child is a crime which results in legal penalties.

Chapter 71 of the Family Code authorizes the issuance of protective orders and basically allows applications for orders to

be filed by adult family members for their protection from abuse by another family member; by any related or unrelated adult for the protection of a child; or by prosecuting attorneys who represent the state in district or county courts. The application must contain specific information regarding the facts and circumstances of the alleged abuse as well as identifying information about the applicant and persons to be protected.

The law requires a hearing in which the court must find that family violence occurred prior to issuing the protective order. The law allows temporary orders to be issued immediately where clear and present danger exists. The court is quite flexible in the conditions it may order, such as prohibiting an abusive person from removing a child member of the family; disposing of community property; directing the person to vacate the residence; prohibiting the person from going to or near the residence, place of employment, school, or child care facility; requiring payment of support; requiring counseling; and prohibiting the person from engaging in specific acts.

The intent of this law has always been to include protection of children, but in practice the orders have primarily been used by battered women. Frequently the children of these women are included in the order. Specifically adding the definition of physical and sexual abuse of a child in the protective order statute should clear up any questions persons may have about the intent of this law.

The AAPC report recommended CPS caseworkers be trained

regarding the use of protective orders as "a possible alternative to conservatorship petition/removal petition when such an action is an appropriate choice and in the child's best interest." (AAPC, Section 2:27) Rarely have protective orders been used by CPS when an abused child remains at home with both parents or when the perpetrator is no longer in the home but may be in the area.

Although the statute allows a protective order application to be filed by "any adult for the protection of a child member of a family or household," the agency's informal policy reportedly is to prohibit CPS staff from personally filing an application. A few workers advised the Committee they were aware of protective orders and they encouraged non-abusing parents to file applications in cases where those parents also were being abused. The agency's written "formal" policy should require caseworkers to directly assist non-abusing parents or other family members or concerned adults in seeking court protection of children. If the agency has concerns about whether caseworkers qualify as "any adult" under this statute because of their employment by a state agency, then they should adopt a policy which clearly allows caseworkers to initiate protective orders through prosecuting attorneys' offices.

Since the conditions of protective orders can vary greatly, these orders are effective tools for addressing the specific problems individual cases may present. Protective orders should be used to enhance the agency's work, and under no circumstances should the acquisition of a protective order be used as the sole reason for closing a case.

ISSUE: Whenever it becomes necessary to remove a child, the agency often looks to other relatives for placement options. However, precautions are not always taken to ensure the prevention of further abuse of these children in relative placements.

R E C O M M E N D A T I O N #23:

PRIOR TO PLACING AN ABUSED OR NEGLECTED CHILD WITH A RELATIVE, THE AGENCY SHOULD CONDUCT A FULL HOME EVALUATION WHICH INCLUDES A CANRIS CHECK ON ALL ADULTS IN THE HOME. RELATIVE PLACEMENTS SHOULD NEVER BE MADE INVOLUNTARILY AND WHENEVER SUCH A PLACEMENT IS MADE, CPS SHOULD MAINTAIN AN OPEN CASE ON THE CHILD.

RATIONALE: Current agency policy requires a written assessment of the relatives which must be approved by a supervisor and must include an assessment of the family's plans for protecting the child from exposure to the conditions from which the child was removed. The policy further states that if an assessment of the relatives cannot be done due to the emergency status of the situation, the worker should put the child in a temporary emergency placement and, as soon as possible, complete the necessary work for a relative placement (CPS Handbook, 6431).

> "...placing with a relative as an out-of-home placement decision can occur even when the presenting evidence, past experience, family history, or present case information indicate the relative cannot or will not provide adequate protection of the child from the parent. Even though policy requires a 'written assessment of the relatives' plan for protecting the child...' and approval of the worker's supervisor, many case records reviewed were not clear on how or if the relative could protect the child." (AAPC, Section 3:45-46)

During the course of the Committee's study, a case involving a relative placement resulted in the tragic death of a child. In

this particular case, the agency policy was not followed. A full home evaluation should always be completed prior to placement with relatives and should be done as soon as possible in order to minimize trauma to the child. Also, prior to such placement, a CANRIS check should be run on each adult in the home as well as a criminal background check--the same precautionary measures the agency requires for a foster family.

Whenever a relative placement is made, the agency should open a case on the children to monitor the adequacy of the placement. A level of supervision based on the particular case should be determined (See Recommendation #18, pp. 64-66:) and will indicate the regularity of contacts required.

Relative placements should never be made involuntarily. Pressure from the agency on relatives to accept responsibility for these children only invites further problems. If relatives agree to care for the children on a short-term basis, then the agency should immediately begin planning for the alternative placement and should not pressure the relatives to do more than they are willing. Also, if the relative requests services to meet the child's needs, the agency should respond to these requests.

ISSUE: Falsification of ANY state record is a serious offense, but falsifying child protective services records can actually jeopardize the health and safety of children in addition to destroying the integrity of the CPS program.

NOTE: THIS ISSUE CANNOT BE RESOLVED BY THE LEGISLATURE THROUGH STATUTORY CHANGES. FALSIFICATION OF STATE DOCUMENTS IS ALREADY AN OFFENSE UNDER TEXAS LAW AND A "WHISTLEBLOWER" STATUTE ALSO IS IN PLACE TO PROTECT STATE EMPLOYEES. THE DEPARTMENT OF HUMAN SERVICES MUST TAKE FULL RESPONSIBILITY FOR ADDRESSING THIS PROBLEM.

RATIONALE: In December 1987, a Tom Green County grand jury (119th Judicial District) found evidence of false entries in child protective services records in the San Angelo office. The grand jury recommended the Commissioner of the Department of Human Services determine whether inaccurate or false recordkeeping is practiced statewide at management and worker levels.

No attempt was made by the agency to determine to what extent child protective services records are being falsified statewide. Only a review of case records in the San Angelo office was conducted, and the agency's review team found no further evidence of false recordkeeping. This finding is entirely plausible since a completely new case record can be prepared after information has been deleted or revised. Logically, there would be no remaining evidence unless the original copies had been preserved and kept in the file with the altered records.

According to current and former employees in the San Angelo office, the caseworkers themselves had provided local authorities

with the information about record falsification. The agency responded to this problem by hiring security guards and forbidding employees from taking records home at night, even though it is common practice for caseworkers to complete paperwork at home. An employee also was assigned to monitor the use of the copy machine. It is ironic the agency determined there was no further evidence of record falsification in the San Angelo office but found it necessary to take the above mentioned extreme measures.

The agency's actions had a demoralizing effect on staff. The employees interpreted the response as an attempt to protect the agency by keeping further information from reaching authorities rather than to protect the integrity of case records. One worker described management's actions as "concealing or containing the problem rather than correcting it." There has been a total turnover in frontline caseworker positions in the San Angelo office, resulting in the loss of well over 100 years of combined employee experience.

Sufficient information was provided to Committee staff by workers in other parts of the state to warrant concern about the extent of record falsification. Some indicated falsification is likely to occur when there is a child death and the agency's records are publicly scrutinized. Others told the Committee that records are changed by, or at the direction or encouragement of, administrative personnel.

The most common examples of record falsification described to the Committee involved backdating forms to be in compliance

with agency timeframes or documenting that a required follow-up contact with a family or complainant had been made when it had not. Whether worker-initiated or management-directed, falsification of records jeopardizes the integrity of the child protective services program. It presents a formidable conflict when an employee fears losing his or her job for not following management's directions. But even more importantly, it presents a formidable danger to the health and safety of children when inaccurate, incomplete, or intentionally false information is provided to a judge on which to base a decision about an abused or neglected child.

The Committee did not arrive at a recommendation for resolving this problem, but considers the issue to be very serious. Agency administrators should take the corrective measures necessary to eliminate this unethical practice at all levels of employment within the program, including management.

ISSUE: Although the Department's written policy is to provide adoptive parents with essential health, social, educational, and genetic information about children being placed for adoption, many adoptive parents have been denied access to vital information in psychiatric and medical records and have received only summaries of the child's status prepared by agency staff.

R E C O M M E N D A T I O N #24:

THE LEGISLATURE SHOULD AMEND THE TEXAS FAMILY CODE TO CLEARLY MANDATE THAT THE DEPARTMENT AND PRIVATE AGENCIES WHICH PLACE CHILDREN FOR ADOPTION PROVIDE ADOPTIVE PARENTS FULL ACCESS TO ALL AVAILABLE RECORDS ON CHILDREN THEY ARE CONSIDERING FOR ADOPTION, EXCLUDING ANY INFORMATION WHICH WOULD REVEAL THE IDENTITY OF THE BIRTH PARENTS OR ANY OTHER PERSON WHOSE IDENTITY IS PROTECTED.

RATIONALE: In May 1988, seven adoptive couples filed a lawsuit in a federal court in Dallas alleging they were denied access to essential records the agency maintained on their adopted children. The Committee received a substantial number of telephone calls and letters from other adoptive parents across the state describing similar experiences.

Although the Department now requires both the caseworker and the adoptive parents to sign a form which acknowledges the information was offered, provided and received, the Family Code should be amended to clearly mandate full disclosure so adoptive parents are not dependent solely on agency personnel to follow policy. Because the Texas Family Code currently requires that a "summary" of the information be provided, many of the adoptive families received very general information on the child prepared by agency staff.

There is a major difference between knowing a child has exhibited some behavioral problems and reading a psychiatrist's evaluation concluding that the child will require long-term therapeutic treatment, possibly in a residential facility. Families may not have the financial resources necessary to provide such intensive and expensive care and should be able to consider this level of commitment before consummating the adoption.

Additionally, the Family Code should require the agency to provide financial information regarding the child's birth parents since this may form the basis for determining whether the adoptive child is eligible for a state or federal adoption subsidy. Many adoptive parents stated they were not aware of the child's potential eligibility for financial assistance which could have helped offset the cost of therapeutic treatment services.

ISSUE: Foster parents who provide 24-hour care to children who have been removed from their homes frequently have minimal information regarding these children.

R E C O M M E N D A T I O N #25:

FOSTER PARENTS SHOULD RECEIVE A COPY OF THE CPS INTAKE STUDY FOR EACH CHILD PLACED IN THEIR CARE.

RATIONALE: Foster parents should be provided adequate information regarding the children in their care if they are to be expected to respond appropriately to their needs. Simply telling them the child was abused is not enough. The CPS handbook requires staff to complete an "Intake Study" for each child placed in substitute care (CPS Handbook Section 6510 and Appendix I/6510).

This study includes information about the child's developmental and medical history; personality; behavior; interests; school history; previous placement experiences; legal status; assessment of the child's needs; background information about the child's family; and information about the need for placement. Providing this document to the foster parents for children in their care would more adequately inform them about their special needs.

ISSUE: Since 1987, the number of foster homes in Texas has declined. Although agency representatives attribute the decline to low daily reimbursement rates and stress associated with caring for children with more difficult problems, foster parents blamed agency attitudes and actions for the reduction in foster homes.

NOTE: THIS ISSUE CANNOT BE RESOLVED BY THE LEGISLATURE THROUGH STATUTORY CHANGES OR ADDITIONAL REVENUES. THE DEPARTMENT MUST TAKE FULL RESPONSIBILITY FOR ELIMINATING RETALIATORY ACTIONS, IMPROVING AGENCY ATTITUDES, AND IMPLEMENTING POLICIES IN A FAIR AND OBJECTIVE MANNER.

RATIONALE: "Foster parents state a need for 'a change in attitude' by the Department. They expressed a desire to be treated as valued professionals and to be allowed to be advocates for children without fear of retaliation for speaking out publicly." (AAPC, Section 3:39).

The process of placing children in foster care is often conducted under emergency conditions and by nature is a traumatic and stressful situation for all persons involved. In addition to these inherent stresses, a prevalent factor in the retention and recruitment of foster parents is the agency's attitude toward them. In public, the agency professes a great respect for them, but based on testimony and the agency's response to inquiries by Committee staff about specific situations, an underlying attitude of disregard toward the needs and concerns of foster parents exists in many areas of the state.

Although some problems with foster care recruitment and retention can be attributed to funding constraints, most can be best resolved by clear, directive policies which are carried out fairly, consistently and ALWAYS with consideration of the effects

on the children involved. If only a handful of complaints had been received by the Committee, the incidents might be considered anecdotal. But due to the volume of specific examples, the Committee concluded the agency will never be able to successfully recruit or retain foster parents without addressing fundamental management issues on a statewide level. The following examples offer a clear illustration of some of the problems:

* "There appears to be a lack of trust in some places between foster...parents and TDHS evidenced by allegations of withholding of information upon referral and a fear by some foster parents of retaliation for public disclosures of agency difficulties." (AAPC, Section 3:57) Examples of retaliatory action include: refusing to place any children in a particular foster home for a period of time; removing children from a foster home based on a disagreement or personality conflict rather than the best interest of the child; refusing to allow contact between foster parents and their foster home development worker; reproaching foster parents for becoming too involved with the children; and in some instances even going as far as making allegations of abuse and neglect against the foster parents or interfering with adoption procedures.

* Foster parents reported the agency often places undue pressure on them to take children they may feel they cannot handle. An integral part of the agency-foster parent relationship must be to honor the foster parents wishes regarding the kinds of children they care for in their homes. For example, if a foster parent wishes to care for infants, they should not be pressured to accept teenagers.

* Inconsistencies in the removal of children from particular foster homes can lead to unfair and biased treatment of foster parents. For example, in one region a family with six foster children was alleged to have spanked the children. A team of workers went to the home, interviewed the children involved and determined the children were not in danger. Two days later, however, CPS staff returned to the home at dinnertime and removed all of the children, causing extreme disruption and trauma for the foster children and the family's natural children. Some of the foster children had been in the home for a long period of time and siblings were separated from each other in the subsequent placement. In the same region, CPS staff identified repeated abuse in another home where the

children were found to have new and old scars from being hit with an extension cord. This home reportedly was allowed to continue to operate and was being considered as a potential adoptive home for these children.

* In some areas of the state CPS encourages adoption after a child has been in a particular foster home for a lengthy period of time and a good relationship has been established. In other areas, the agency is reported to strictly prohibit it. "Texas does not appear to be as supportive of foster parent adoptions as other states. Only 13% of adoptive placements in Texas in 1984 were with foster parents compared to a national level of 27%." (AAPC, Section 3:52) Foster parents expressed frustration with the agency which expects and demands them to treat their foster children as part of the family but on the other hand criticizes them for "loving too much." Families who are able to establish a close bond with their foster children are natural candidates for adoption.

* Foster parents are with these children every day and obviously have significant insight into the needs of the children. They should be active participants in decisions about the well-being of foster children. "...foster parents are not always involved in decision making depending on regional and worker attitudes." (AAPC, Section 3:48) Several foster parents indicated the agency only wants "babysitters" and fails to treat them as members of the "team" who are knowledgeable about the needs of abused and neglected children.

The AAPC evaluation team recommended addressing retaliation by establishing "a mechanism to accept foster parents grievances against the Department which can be made without fear of reprisal" and which also includes "a mechanism to employ sanctions against staff who violate the impartial review process or otherwise exercise inappropriate influence on the placement process." (AAPC, Section 7:4) This recommendation would be a first step toward improving the agency's relationship with foster parents. Continuing to punish foster parents by refusing to place children in their homes and consequently loading down other homes will only exacerbate the current foster care crisis.

ISSUE: Children have been moved unnecessarily from foster home to foster home or to a more costly therapeutic setting because services to address the child's problems were not provided.

R E C O M M E N D A T I O N #26:

THE AGENCY SHOULD TAKE EVERY MEASURE TO RESPOND AS SOON AS POSSIBLE WITH DIRECT ASSISTANCE OR REFERRAL TO CONTRACTED SERVICES WHEN FOSTER PARENTS IDENTIFY THE NEED AND REQUEST SERVICES FOR CHILDREN IN THEIR CARE.

RATIONALE: The agency reports children requiring substitute care today have more serious and complicated psychological problems than those 20 years ago due to more severely abusive situations. If this is true, all children in foster care need more substantive services than simply a supportive and nurturing family environment. However, TDHS reports a 1988 survey of CPS employees revealed an estimated 67% of the children in foster care received no professional counseling services.

When foster parents identify particular problems a child is experiencing, the agency should respond with services or at least constructive assistance toward resolution of the problem. The services need to be delivered when requested, not months later. Instead, a number of foster parents reported being told a child's behavior was "normal" or the agency had "run out of money" for services. They were left to do the best they could on their own.

Adequate provision of services to children in foster care can reduce the number of times a child is moved while in the custody of CPS. Based on the Committee's findings and the AAPC findings, "multiple placements" is a critical problem in Texas.

> "Statistics for 1984 show a high proportion of children in substitute care who have had two or more previous placements (49%). Fifteen percent have had at least five previous placements....48% of children nationwide who were in substitute care were in their first placement compared to 25% in Texas. The biggest gap appears in the number of children in two to four additional placements with Texas 62% higher than the national average.
>
> "Proportionately, Texas again has over twice the national average of children placed six or more times (7% nationally and 15% in Texas). Clearly this indicates a critical problem." (AAPC, Section 3:33,53)

Although these statistics are five years old, current feedback from foster parents and other sources indicates a continued trend towards multiple placements of children in substitute care, often due to lack of services to the children and support services for foster parents. If a child is exhibiting extreme behavioral problems and the foster parents' requests for help from CPS are met with unresponsiveness, they often have no other choice but to ask for the child to be removed from their home.

Failure to provide services to foster children also can lead to a more expensive placement later. One example provided to the Committee involved a foster home caring for a young child with disablities who required a great deal of attention and rehabilitative services. The child was in the home for approximately one year during which the child greatly improved and established a strong bond with the foster family. However, when the child began displaying bizarre behavior and having seizures, the foster parents asked the agency for a professional evaluation and special day care services. The agency denied the request, and when the foster parents persisted, the agency began

questioning their performance as foster parents. Without the requested services, the foster parents advised CPS they were unable to meet the child's needs and the child was moved to another foster home. This second placement lasted six weeks after which the child was moved to a residential treatment facility in another part of the state. Instead of providing specialized day care which had been located by the family for $20/day, the child was moved two more times and the agency is now paying significantly more than the $31/day it would have cost to keep the child in the first foster home with day care. The child has now been evaluated and the original foster family has been involuntarily closed by the agency.

The AAPC report identifies Texas as second in the nation with regard to the proportion of our foster children who have "special needs" (45%, more than double the national average of 22%). In the interest of these children and in light of skyrocketing costs of residential treatment facilities, it is essential for CPS to do everything within its power to keep special needs children in foster care settings when possible.

If the agency cannot provide adequate services to children in foster care because of lack of funding or other resources, then budget priorities may need to be re-arranged or the agency needs to take a more active approach in expanding community resources.

ISSUE: Current law requires reverification of foster homes every two years or when changes in the home affect the conditions of the verification certificate. Information provided to the Committee indicates the reverification process is not used as a standard mechanism to identify and correct problems in foster homes.

R E C O M M E N D A T I O N #27:

THE AGENCY SHOULD DEVELOP AND IMPLEMENT CLEAR POLICIES REGARDING REVERIFICATION OF FOSTER HOMES WHICH INCLUDE A FORMAL MEETING BETWEEN THE FOSTER HOME DEVELOPMENT WORKER AND THE FOSTER PARENTS AND WHICH PRODUCES OFFICIAL DOCUMENTATION OF THE HOME'S STRENGTHS AND WEAKNESSES.

RATIONALE: The AAPC report identified the reverification process as "the state's strongest quality assurance mechanism for substitute care." The report also stated the reverification process is inconsistent within regions "and results in the potential for compromises in the selection and use of homes. This opens the Department to potential liability, creates unsafe environments for children, and undermines attempts to provide quality control." (AAPC, Section 3:56,61).

The Committee heard testimony at its public hearings alleging substandard conditions in some active foster homes which were not being addressed by the agency. Substandard care typically was described as inappropriate disciplinary actions by foster parents, failure to meet nutritional needs of children, or unsanitary conditions in the home. The reverification process offers an excellent opportunity to improve foster care and to enhance the relationship between workers and foster parents, but it does not appear to be used for such purposes in all regions of the state.

The agency handbook states the foster home development worker must prepare a re-evaluation summary for the foster home record but does not require any specific communication between the worker and the foster parents during this process (CPS Handbook, Section 7140). In order for this reverification to have any meaning other than for recordkeeping purposes, such interaction is necessary.

In addition to the statutorily mandated evaluations, the agency should initiate such reviews when it believes a foster home is providing substandard care. Reverification should include a formal meeting between the foster home development worker and the foster parents during which the parties should identify and discuss the strengths and weaknesses of the home as well as any problems the home has experienced with the agency. The information should be written on a standard evaluation form and included in the foster home's records. Follow-up reports relating to the home's progress should be included in the records and foster parents should receive copies of all reverification documents. Any weaknesses identified should be followed by written goals to be completed within a given timeframe.

The agency should facilitate or provide direct assistance to foster parents in meeting these goals. The agency should make every effort to avoid reaching the point of having to move children or close a foster home. If corrective actions are not completed in a timely manner and the CPS worker concludes further placement of children in the home would put them in danger, the foster home should be closed.

ISSUE: Due to the decline in the number of foster homes in Texas, the agency must make every effort to retain good foster homes. These parents need periodic relief from the awesome responsibilities of providing 24-hour care to abused and neglected children.

R E C O M M E N D A T I O N #28:

THE AGENCY'S EFFORTS TO RECRUIT FOSTER PARENTS SHOULD ALSO INCLUDE THE RECRUITMENT OF PERSONS WILLING TO PROVIDE RESPITE CARE OR DAY CARE TO PROVIDE PERIODIC RELIEF FOR FULL-TIME FOSTER PARENTS.

RATIONALE: Full-time, 24-hour foster care involves a significant commitment of people who are willing to dedicate extraordinary time and energy caring for abused children. However, they are human beings who need an occasional break from this commitment. The agency's foster care recruitment efforts should also include an attempt to recruit families who are willing to care for foster children for a weekend every month or several weeks during the summer. When these families are recruited, the commitment they are willing to make should be clearly delineated and honored so there is no undue pressure on them to take children for longer periods of time.

Another source of respite homes for full-time foster parents are long-time foster parents who are being involuntarily closed for reasons other than abuse or neglect. For example, some foster parents who have served the agency well for many years may have difficulty handling seriously disturbed children over long periods of time due to their age or burnout. Rather than completely eliminating this home, the agency should explore other options for them, such as using the home for temporary, short-term placements as respite homes.

ISSUE: Child Protective Services (CPS) caseworkers estimate that 32% or more of all child abuse reports involve families who have previously been reported to the agency. It is not possible to determine how many individual Texas children are victims each year since the agency reports only aggregate numbers which may count the same children several times. Furthermore, there is no information compiled on these families to evaluate the specific services provided which were intended to prevent the recurrence of abuse.

R E C O M M E N D A T I O N #29:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL COLLECT DATA ON RECIDIVISM RATES OF CPS CASES AND SHALL REPORT THESE STATISTICS IN ITS ANNUAL REPORT ON THE PROGRAM. ADDITIONALLY, THE DEPARTMENT SHALL ANALYZE A REPRESENTATIVE SAMPLE OF THE CASE RECORDS TO DETERMINE:

1) WHETHER THE REPORTS WERE INVESTIGATED;
2) THE RESULTS OF THE INVESTIGATION OR THE REASON THE CASE WAS CLOSED WITHOUT AN INVESTIGATION; AND
3) IF AND WHEN ANY SERVICES WERE PROVIDED, THE SPECIFIC KIND OF SERVICE(S) DELIVERED, AND THE DURATION AND COST OF THE SERVICE(S).

RATIONALE: In 1988, the Department of Human Services conducted a statewide study to identify major problems in the "intake" system, the system for handling incoming reports of abuse and neglect. The agency surveyed CPS employees who are assigned intake responsibilities in local offices across the state. Among the primary problems identified by the 1,028 employees who responded was the high rate of recidivism of child protective services cases. Supervisors of intake units estimated that 26% of the reports received by the agency involve families who have been reported before; caseworkers estimated the recidivism rate to be even higher, at around 32%.

On March 1, 1988, the Department reported the findings from its intake study to the Board of Human Services and proposed

recommendations to address the problems identified. Even though its employees identified repeat calls involving the same families and children as one of the PRIMARY problems, the Department recommended another "study" to determine if the current level of recidivism is truly a problem.

Apparently, accurate statistics on recidivism among child protective services cases are not collected. In its Legislative Appropriations Request (LAR) submitted in 1986, the agency estimated recidivism rates to be 8% in 1987 and projected the rate to remain the same in 1988. These estimates differ substantially from the 32% estimated by the employees who actually handle incoming abuse and neglect reports.

Because accurate data is not available, it is not possible to determine how many individual Texas families and children are victims of child abuse each year and how many Texas families are involved. Furthermore, in order to evaluate the effectiveness of services which are provided to prevent the recurrence of abuse/neglect and to measure the progress of changes in the program, recidivism data must be collected and the case records of families who have been reported repeatedly must be analyzed.

ISSUE: The statistical information generated by the Texas Department of Human Services on the Child Protective Services (CPS) program lacks pertinent data which would allow a more comprehensive assessment of the program's strengths and weaknesses.

R E C O M M E N D A T I O N #30:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHALL INCLUDE THE FOLLOWING DATA IN ITS ANNUAL REPORT ON THE CPS PROGRAM AND THE LEGISLATIVE BUDGET OFFICE SHOULD CONSIDER INCLUDING THESE STATISTICS IN THE PERFORMANCE MEASURES FOR THE PROGRAM:

1) THE TOTAL NUMBER OF ABUSE AND NEGLECT REPORTS MADE TO THE AGENCY;
2) THE NUMBER OF REPORTS WHICH WERE ASSIGNED FOR INVESTIGATION;
3) THE NUMBER OF REPORTS WHICH WERE CLOSED AFTER THE INVESTIGATION CONFIRMED ABUSE;
4) THE NUMBER OF REPORTS RECEIVED ALLEGING ABUSE OR NEGLECT IN FOSTER HOMES;
5) THE NUMBER OF FOSTER HOMES CLOSED AS A RESULT OF ABUSE/NEGLECT; AND
6) THE ACCURATE CASELOAD LEVELS OF EMPLOYEES BY AREAS OF SPECIALIZATION--TELEPHONE INTAKE, INVESTIGATIONS, INTAKE AND INVESTIGATIONS, IN-HOME SERVICES, SUBSTITUTE CARE, FAMILY SERVICES, AND GENERIC (NO SPECIALIZATION).

RATIONALE: The Department collects and reports data on several major aspects of the CPS program such as the total number of investigations, the number of investigations which confirmed abuse/neglect, the total number of victims in confirmed reports, and the average number of foster homes. However, statistics are not available on the number of cases that are closed administratively without an investigation and the number closed after the investigation confirmed abuse. The Committee staff also had questions regarding abuse in foster care and the number of homes closed as a result. None of this information is contained in the agency's reports on the program.

Additionally, the agency does not know the accurate caseload levels of its employees. The method used to arrive at statewide average caseloads counts employees who are not carrying caseloads and vacant caseworker positions. Although fairly sophisticated workload measures have been established according the employee's area of specialization, e.g., intake, sexual abuse investigations or substitute care, the agency still does not know the actual workload of its employees.

ISSUE: The Office of Youth Care Investigations (OYCI) in the Attorney General's Office is responsible for "independent oversight of investigations of child abuse and neglect in facilities operated, licensed, certified or registered by the state." (Section 34.21(b), Family Code) The current level of staff and resources is inadequate to handle statutory responsibilities and requests for assistance received by OYCI. Additionally, reports to OYCI from state agencies are not always made in a timely manner.

R E C O M M E N D A T I O N #31:

THE LEGISLATURE SHOULD INCREASE FUNDING FOR THE OFFICE OF YOUTH CARE INVESTIGATIONS (OYCI) UNDER THE ATTORNEY GENERAL'S OFFICE TO PERMIT THE OFFICE TO CARRY OUT ITS STATUTORY RESPONSIBILITIES OF REVIEWING STATE AGENCY INVESTIGATIONS OF ABUSE AND NEGLECT.

THE TEXAS FAMILY CODE SHOULD BE AMENDED TO REQUIRE STATE AGENCIES TO NOTIFY THE OYCI WITHIN 10 WORKING DAYS OF THE RECEIPT OF AN ABUSE OR NEGLECT REPORT AND TO REQUIRE AGENCIES TO SUBMIT A COPY OF THE INVESTIGATIVE REPORT TO THE OYCI WITHIN 10 WORKING DAYS OF ITS COMPLETION.

RATIONALE: When child abuse or neglect is alleged to have occurred in a facility under the state's jurisdiction, the agency responsible for the facility conducts an "in-house" investigation of the allegation. When such allegations are made, the responsible agency is required by law to notify the OYCI at the time of the initial report of abuse or neglect. Following completion of the in-house investigation, agencies are required to report their findings to the OYCI.

The OYCI staff reviews each report for compliance with investigation standards. If the OYCI finds an investigation was not conducted properly, the office must conduct its own

investigation and report its findings and recommendations to the policymaking body of the appropriate agency.

One problem identified by the OYCI staff is the timely reporting of abuse allegations and timely receipt of the agencies' investigative reports. According to staff, the initial allegation report sometimes comes in two months after the incident occurred. Establishing statutory deadlines in Sections 34.22(b) and 34.23(b) of the Texas Family Code for these reports to be sent to OYCI should resolve this problem.

During its first year of operation, the OYCI also attempted to identify systemic problems which may exist in the overall investigation processes used by state agencies. The office's 1988 annual report recommends the formation of an interagency committee to develop uniform standards which would improve the quality of investigative practices by state agencies.

The OYCI also is required to review complaints relating to investigations of abuse or neglect conducted by TDHS that could not be resolved through the department's administrative review process. Such complaints would come from a person under investigation by TDHS for abuse or neglect of a child. Requests for reviews by OYCI can also come from a source with knowledge of a specific case, such as a district or county attorney. For example, in 1988 the El Paso County Attorney requested an investigation of the handling of several cases by the local CPS office, some involving children who were killed. The extensive OYCI investigation which ensued took almost a year to complete.

Complaints referred to the OYCI which are unresolved in the TDHS administrative review process also offer OYCI an opportunity to evaluate the overall manner in which these reviews are conducted. These evaluations should lead to suggestions for improving agency practices in an effort to afford persons under investigation of child abuse and neglect full due process rights.

For the entire year of 1988, the Committee staff spent an incredible amount of time responding to complaints from citizens regarding the CPS investigation process. The requests came in steadily throughout the year from numerous sources across the state and indicated a need for an oversight function by an independent governmental entity.

The 1988-89 biennial appropriation for the OYCI was $50,000. The current staff consists of two employees whose duties "are almost exclusively dedicated to the OYCI" and two investigators and an attorney who "devote substantial work to the office." (OYCI 1988 Annual Report) The Attorney General has obviously pieced together a staff for OYCI within existing resources in an attempt to respond to the statutory duties prescribed. Based on the Committee's experience with the quantity of complaints about the CPS program and the additional responsibilities the Committee would like to see the OYCI assume, expansion of the staff and additional operating expenses for follow-up investigations will be necessary.

ISSUE: Currently TDHS conducts special reviews of child deaths which are a result of abuse and neglect ONLY if the child had previously been brought to the attention of the agency. Accurate statewide information regarding all child deaths due to abuse and neglect is unavailable.

R E C O M M E N D A T I O N #32:

THE TEXAS DEPARTMENT OF HEALTH'S BUREAU OF VITAL STATISTICS SHOULD REQUEST A CANRIS CHECK ON ALL DEATH CERTIFICATES RECEIVED ON PERSONS UNDER AGE 17. IF THE CHILD IS LISTED IN CANRIS, THE BUREAU SHOULD FORWARD THE INFORMATION ON THE DEATH CERTIFICATE TO THE TEXAS DEPARTMENT OF HUMAN SERVICES' PROTECTIVE SERVICES FOR FAMILIES AND CHILDREN BRANCH AND TO THE OFFICE OF YOUTH CARE INVESTIGATIONS (OYCI) IN THE ATTORNEY GENERAL'S OFFICE.

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD FORWARD THE INFORMATION TO THE CHAIR OF THE APPROPRIATE REGIONAL CHILD DEATH REVIEW COMMITTEE FOR REVIEW AND FOLLOW-UP INVESTIGATION, IF WARRANTED. UPON COMPLETION, THE REVIEW AND INVESTIGATIVE REPORT SHOULD BE FORWARDED TO THE OYCI.

THE OYCI SHOULD REVIEW EACH REPORT RELATING TO CHILD ABUSE-RELATED DEATHS AND SHOULD MAINTAIN AND REPORT STATISTICAL INFORMATION BASED ON DATA PROVIDED.

RATIONALE: The AAPC report includes an extensive review of the current TDHS policies on investigation of child fatalities and makes numerous recommendations for the agency to improve existing Regional Child Fatality Review Committeees by creating uniform procedures; involving persons other than TDHS employees; including representatives from other state agencies; and evaluating deaths of ALL children due to abuse or neglect (AAPC, Section 3:64-76). The AACP recommendations are a first step toward identifying the true scope of child abuse-related deaths in Texas and the circumstances under which the deaths occurred.

Nationally "25-50% of child maltreatment fatalities will have had prior contact with protective services." (AAPC, Section

3:73) About 40% of Texas child abuse-related deaths reported from 1984-86 were previously known to CPS (AAPC, Section 3:64). Thus, the current CPS policy of only investigating those children with previous CPS contact provides a misleading portrayal of the problem.

"Child abuse related fatalities in Texas have remained relatively constant with 121 deaths report in 1984, 113 in 1985, and 129 in 1986." (AAPC, Section 3:64) On the other hand, a review of the Texas Department of Health's Bureau of VItal Statistics data indicates only 31 of the 7,890 deaths of children under the age of 9 in Texas in 1985 and 1986 were abuse related. Thus, the only central statewide depository of data relating to deaths of all children, sheds even less light on the number of children who have died due to abuse, and emphasizes the need for the state to establish a method which will begin to compile accurate data.

As indicated in the above recommendation, an interagency effort is necessary. Providing a reliable cross check between child death certificates at TDH and the CANRIS system at TDHS will accurately identify those children or families who have previously been reported to any CPS office in the state. Further examination of these cases by the Regional Child Fatality Review Committees will more accurately identify the number of Texas children who died due to abuse. These committees should record the results of their examinations in a standardized format and forward the information to the Office of Youth Care Investigations (OYCI) for review and compilation of statewide data.

ISSUE: Cooperation between local law enforcement agencies and child protective services offices is essential for an effective protective services system. In an effort to improve investigations and prosecution of cases, some states require the agencies to conduct joint investigations of child abuse reports.

R E C O M M E N D A T I O N #33:

THE TEXAS DEPARTMENT OF HUMAN SERVICES SHOULD CONDUCT A PILOT PROJECT TO TEST THE EFFECTIVENESS OF STATIONING A CHILD PROTECTIVE SERVICES CASEWORKER IN A LOCAL LAW ENFORCEMENT OFFICE TO WORK JOINTLY AS A TEAM IN RESPONDING TO AND INVESTIGATING CHILD ABUSE REPORTS IN THAT PARTICULAR JURISDICTION.

RATIONALE: Unlike some other states, Texas law does not require the Department of Human Services and local law enforcement agencies to conduct joint investigations of child abuse reports. In some jurisdictions the agencies work very well together, but in others there is very little cooperation. Throughout the Committee's examination of the Child Protective Services (CPS) program, a number of witnesses identified the need to improve the working relationship between local law enforcement agencies and CPS offices.

At least a few CPS offices in the state have addressed this problem by either employing a police officer to serve as a liaison or by having a police officer stationed on the premises to assist caseworkers with investigations, particularly when the circumstances appear to be dangerous. A law enforcement officer who testified at one of the Committee's public hearings suggested testing the reverse arrangement where a CPS worker would be stationed at a local police department. The officer explained that each time a child abuse case is reported directly

to the police department, he initiates an investigation and notifies the local CPS office. Ideally, a caseworker also will be sent to the child's home. Or, in instances where the officer has already removed the child, the caseworker will come to the police department, hospital or wherever the child is located since it is the responsibility of TDHS to make temporary substitute living arrangements for the child.

The officer's testimony indicated that the caseworker must travel approximately 30 miles to reach the officer's jurisdiction. Because of the volume of reports received by the police department, the travel time and expenses of the caseworker could possible be reduced substantially by being housed with the juvenile police officer.

APPENDIX 1

GRAND JURY REPORT

DATE: DECEMBER 7, 1987

TO: JOHN SUTTON, District Judge, 119th Judicial District
Marlin Johnston, Commissionar, Department of Human Services, Austin, Texas
Ray Dunavant, Regional Administrator, Department of Human Services, Abilene, Texas
David Mayberry, Assistant Regional Director, Department of Human Services, Abilene, Texas
David Marsh, Regional Director, Department of Human Services, Abilene, Texas
Mark Hoover, Regional Attorney, Department of Human Services, Abilene, Texas
Ernest Haynes, Sheriff, Tom Green County, Texas
Travis Johnson, Chief of Police, San Angelo, Texas

The Grand Jurors for the County of Tom Green, duly selected, impaneled, sworn, charged and organized as such at the November, A.D. 1987, of the 119th District Court of said County, upon their oaths present and resolve, from the evidence heard:

1. That serious problems exist at the Department of Human Services (DHS), Child Protective Services Division in San Angelo, Texas, which impair the investigation of child abuse and neglect;

2. That false entries into records at DHS have been made in violation of the law;

3. That there appears to be more concern by management at DHS Abilene with burreaucratic requirements and potential civil legal liability rather than the welfare of abused and neglected children;

4. That the system that exists appears to encourage inaccurate or false recordkeeping with no system of verification;

5. That management at DHS Abilene has failed to correct inadequacies in the San Angelo office, although they have been aware that problems have existed for two to three years;

6. Though made aware of the problem by a prior Grand Jury report, DHS management has failed to adequately develop an appropriate and meaningful working relationship with law enforcement agencies in San Angelo for the purpose of investigation of abuse and neglect;

7. That the system of having the Child Protective Services Unit in San Angelo governed by DHS Abilene management is questionable in light of past and recent problems and the volume of abuse and neglect cases in San Angelo;

THEREFORE, based on these findings, the Grand Jury recommends in the interest of abused and neglected children:

1. That the Commissioner of DHS determine whether inaccurate or false recordkeeping, though in violation of law and policy, is nevertheless being practiced statewide, at worker and management levels, because of the pressures of heavy caseloads or for whatever other reasons;

2. That a verification system be implemented to insure that appropriate investigative contacts in abuse and neglect cases are being made;

3. That the Commissioner of DHS take appropriate and meaningful measures to correct the unstable and unsatisfactory situation in San Angelo that has existed for two to three years.

4. That the Commissioner of DHS appear before this Grand Jury at its next scheduled meeting (in approximately sixty days) to report corrective actions taken and to testify as to his findings, if any, regarding violations of the criminal law in this county pertaining to DHS.

Bill D. Collins
FOREMAN OF THE GRAND JURY.

APPENDIX 2

JOE LUCAS
COUNTY ATTORNEY
EL PASO COUNTY, TEXAS
ROOM 201, CITY-COUNTY BUILDING
EL PASO, TEXAS 79901

(915) 546-2050

January 11, 1988

Attorney General Jim Mattox
P.O. Box 12548
Austin, TX 78711

Dear General Mattox:

As I am sure you are well aware, the Texas Department of Human Services recently announced that it would be requesting an internal investigation of its Child Protective Services (CPS) Program. The department indicated this action was partially in response to a number of cases which have surfaced recently across the State wherein the decisions made by CPS workers have been seriously questioned by the general public. You may not be aware of the fact that an inordinate number of these cases have occurred in El Paso County and it is for this reason that I am now writing you personally.

In the past 13 months, 3 children have died in El Paso who had been or should have been under the care of DHS. Christmas of 1986 resulted in the tragic death of 2 boys who were burned to death at the hands of their father shortly after DHS returned the boys to his custody. Since then, cases continue to flow into my office with clear evidence of abuse or neglect with the full knowledge of DHS but little or no action on their part other than documenting the problems.

Other noteworthy cases include; a child sleeping in ditches and abandoned cars to avoid beatings by his father which beatings had been documented by DHS (but resulted in no action by DHS); a child shooting his sister in the head while the two were alone in the house after DHS had clear evidence of neglect (but no services rendered since "no real danger"); and another child who had been supplied with heroin by her mother by her mother's reported admission (no action by DHS).

Many more cases of child abuse and neglect concerning lack of action or concern by DHS have come to my attention but have not ended with the dramatic results as the above stated cases. Nonetheless, they are equally important because they evidence a continuing pattern of negligence and incompetence which clearly borders on criminal.

The most recent case to come to light includes the death of an infant male from cerebral tissue softening apparently from physical abuse. This is most shocking since an allegation of child abuse was reported concerning head and facial bruises and a fractured skull incurred by this infant only 2 months earlier. After the first report of abuse, the case was recommended for ongoing services but was subsequently closed by a supervisor administratively due to "staff shortages". I have since learned that this supervisor was merely "reprimanded" (whatever that might be).

It is this type of irresponsibility which shocks and offends me. A baby boy is beaten to death because DHS failed in performing its duty and a supervisor is "reprimanded". If such is the value of a baby boy's life, this world is indeed in a sad state. This is exactly why we cannot be satisfied with DHS investigating itself. Documenting and reprimanding does not save and protect the lives of our children. Both as attorneys and citizens of this great state, we cannot allow this corruption or incompetence to continue. Children are dying in El Paso.

For the sake of the abused and neglected children who are subsequently neglected by the Department created to protect them, I respectfully request that your office undertake a thorough investigation of the Department of Human Services to determine whether the problem is mere incompetence or criminal in nature. As County Attorney and as a concerned citizen, I anxiously await your reply.

Sincerely,

Joe Lucas,
County Attorney

JL/cc

APPENDIX 3

Texas Department of Human Services

John H. Winters Human Services Center • 701 West 51st Street
Mailing Address: P.O. Box 2960 • Austin, Texas 78769

COMMISSIONER
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ROB MOSBACHER
Houston

March 15, 1989

The Honorable Chet Brooks, Chairman
Senate Committee on Health and
Human Services
P. O. Box 12068 - Capitol Station
Austin, Texas 78711-2068

Dear Senator Brooks:

We have reviewed the draft of the staff report of the Child Protective Services (CPS) program, dated February 20, 1989. We were most gratified to see that the report recognizes the need for adequate funding in order to enhance service delivery to CPS clients and that a number of the recommendations pertain to increased funding for the program, as well as funding for sexual assault centers and family violence shelters. We were also pleased to note that Recommendation 21 proposes an amendment to the Family Code which was also suggested by the American Association for Protecting Children (AAPC).

Following is a list of comments offered to assist you in clarifying statements made in the report:

Page 4, Paragraph 3. Confirmed cases are closed for reasons other than staff shortages. These include: no services needed, needed services provided during investigation, needed services refused by client, and needed services unavailable because of lack of appropriate resources.

Page 5, Paragraph 3. Child welfare boards oversee only the county CPS budget, not the total budget.

Page 5, Paragraph 5. A sample of 126 intake reports read in Harris County in August, 1988 for the months of September, 1987 through April, 1988, did not support the contention that "hundreds of incoming reports were not being investigated at all." With very few exceptions, those calls that were not assigned for investigation were those that did not meet the criteria for abuse/neglect reports.

Page 8, Paragraph 4. CPS time study data calculated by caseworkers for October, 1987, indicate that they spend 25%-30% of their time on paperwork requirements, including case documentation, forms completion, workload planning, and miscellaneous activity. Staff in headquarters, however, are not confident about the accuracy of those findings.

Page 10, Paragraph 3. CPS Handbook policy does not allow supervisors to "screen out cases at intake to limit investigations to only the more severe allegations." Policy requires supervisors to assign for investigation all reports which appear to involve the statutory definitions of abuse/neglect. Only program directors may approve an administrative closure of a report of abuse or neglect prior to completion of the investigation.

Page 11, Paragraph 3. 65,966 child abuse and neglect reports were investigated in FY 1988 rather than 65,065 as cited.

Page 14, Paragraph 2. Unless a foster child is covered through private insurance, which is relatively rare, Medicaid providers are used for the child's medical care. Many physicians do not participate in the Medicaid program, so foster parents and CPS staff must often transport children some distance for medical appointments.

Page 15, Paragraph 3. Item 1453 of the CPS Handbook states that a CPS client "may review all information in the client's case record except the identity of the complainant, information exempted from disclosure under the Open Records Act, and information exempted under other state laws." Because of this rule, clients sometimes do not receive portions of the information requested.

Page 16, Paragraph 1. The recidivism rate of 8% cited in the LAR is defined as the percentage of families whose cases were closed after receiving in-home services and then were subsequently re-opened for in-home services within 12 months as a result of the recurrence of abuse or neglect. Conversely, the 32% recidivism rate cited in the 1988 intake study relates to workers' estimates of families who are reported to the agency more than once, regardless of whether the allegations are confirmed or unfounded.

Page 17, Paragraph 4. CPS Management Information Reports do not reflect caseloads of 100 in any region. In December, 1988, caseloads ranged from a high of 26.9 (Region 11) to a low of 16.9 (Region 08). In December, 1987, caseloads ranged from 24.1 (Region 07) to 15.9 (Region 08). We are examining the issue of caseload size to determine where the problem of excessively large caseloads exists.

The inconsistency in counting cases (opening one case for the entire family versus opening cases on every child in the family) relates only to conservatorship or out of home care case records, not to investigation or in-home cases.

The following is offered in relation to the recommendations and supporting material to recommendations:

#5, Page 35, Paragraph 4. Data on caseload levels and office staffing patterns at the local level are not routinely available in the state office but can be obtained upon request.

Page 36, Paragraph 1. The method that state office uses to determine caseload levels counts only employees who carry caseloads. Vacant caseworker positions are not included.

#7, Page 40, Paragraph 3. The Department has a tracking system for children in foster care, the Foster Care, Adoption, and Conservatorship Tracking System (FACTS). Paragraph 4: Income Assistance programs are the only ones fully

automated. Funding requested for the FY 1990-91 biennium would complete automation of Child Protective Services, Day Care Licensing, Family Services and Services to the Aged and Disabled.

#8, Page 41. The program uses experts in various fields (medical, legal, law enforcement, etc.) whenever possible to train CPS staff. Page 42: A paper copy of the CPS Handbook is accessible to every caseworker since each supervisory unit has at least one copy. Supervisors may request additional copies, if workers desire them.

#10, Page 45. The citation from the AAPC study (Section 3:59) pertains to substitute care case records, not to all CPS case records.

#11, Page 46. The Reduction of Staff Burnout and Turnover project did not begin in September 1988. Turnover data has been gathered to the unit level, and data collection will continue when a project director is hired. A variety of efforts are already underway to reduce burnout and turnover, including worker support groups, quality circles, and morale committees. Regions will be provided a small amount of money to support these activities as part of the Reduction of Staff Burnout and Turnover project.

Page 50, Paragraph 1. The Department's response to the 1988 inquiry from the Senate Select Committee on Juvenile Justice, dated June 24, 1988, estimated that 38% of children in foster care received professional counseling services, not 33% as cited. In a subsequent letter to the Senate Select Committee, dated August 19, 1988, the Department estimated that 33% of children receiving in-home services and 48% of children in foster care were receiving "coping skills training," which was defined as any type of therapeutic service provided to assist children in coping with their victimization or life skills training for adolescents.

Page 50, Paragraph 2. In order for a family to receive services through direct delivery or purchase, a worker must be assigned the case.

#14, Page 53. DHS often does not control situations in which children are subjected to repeated medical examinations or psychological evaluations. These most commonly occur during custody disputes to which DHS is not a party, when parents are trying to prove or refute allegations, typically involving sexual abuse. The problem of DHS requiring multiple examinations has not been identified to us previously, and we would be particularly interested in the situations which led to it.

#19, Page 66. The purpose of the priority system is to establish response times, not to determine "whether a child receives services..." Page 67, Paragraph 3: The Priority III classification was not used "for reports which alleged abuse or neglect..." Priority III was a designation for reports about children who are in situations that are not optimal for their growth and development, but which do not appear to involve abuse or neglect. The agency discontinued the Priority III designation in October, 1988. Page 67, Paragraph 4: It is not correct that "current philosophy of the agency is to label what used to be called a Priority III case as Priority II at intake..."

Page 68, Paragraph 3. Resources routinely used by CPS include the wide array of community resources for food, housing, job assistance, etc., as well as services such as psychological counseling.

#20, Page 69, Paragraph 5. At the time a parent-agency agreement is completed, there is at least some credible evidence to support the finding that abuse or neglect occurred. Parental acknowledgment of problems which resulted in abuse or neglect is necessary for successful treatment and is an important factor in determining a child's safety.

#22, Page 75, Paragraph 2. We agree that CPS staff need to be better informed about protective orders (Chapter 71, Family Code). However, we do not agree that it is appropriate for CPS staff to initiate protective orders. These orders cannot be effectively used in CPS cases if the non-abusive parent is unable or unwilling to take action to protect the child. The parent's willingness and ability to apply for a protective order, with CPS assistance if necessary, is an important indicator of his or her ability to provide adequate protection.

#23, Page 77. If DHS is the managing conservator of a child placed with a relative, CPS would maintain an open case for the length of the placement or until conservatorship is transferred to the relative. Many relative placements are made with the parent's agreement, in situations in which DHS has not been appointed managing conservator. In those instances, it is appropriate for DHS to maintain an open case while working with the parents to return the child home or until the placement stabilizes, if the plan is for the child to remain with the relative on a permanent basis.

We strongly concur that relative placements should never be made involuntarily. Exerting pressure on a relative to accept placement is counter-productive and does not serve the best interest of the child.

#24, Page 82, Paragraph 2. The Human Resources Code (21.012) and the Texas Administrative Code (71.1, 71.3) prohibit the Department from releasing financial information about birth parents to adoptive parents.

(NO RECOMMENDATION) - Page 79, Paragraph 1. It is not accepted practice for caseworkers to take case records home at night. Item 1440 of the CPS Handbook states that staff "must ensure the security of case records as required by DHS licensing standards." Section 1400 of the Minimum Standards for Child-Placing Agencies states, "The agency shall ensure that case records are kept confidential and inaccessible to unauthorized persons."

Page 79, Paragraph 3. The allegation that administrative staff direct or encourage falsification of records is extremely serious. If the Committee has specific information about any DHS administrative staff, we request that you provide such information to us so that we may investigate the charges.

#25, Page 83. Item 6811 of the CPS Handbook requires staff to share information from the child's intake study with the foster parents and to document on the intake study the date that the information was shared.

#27, Page 90. Item 6812 of the CPS Handbook requires foster home staff to make quarterly home visits to each foster family to "...help them assume their role and to ensure quality care for children." During these visits staff discuss "any specific concerns the foster parents have..." They also identify training needs, discuss options for managing children's behavior, and assist foster parents in identifying successes.

#28, Page 92. The Department's 1990-91 LAR includes funds to provide day care and respite care for foster children.

#30, Page 95. Statistics are currently available on the number of cases closed after investigation confirmed abuse. The number of completed investigations is also available, and this number should closely approximate the number of reports received since all reports alleging abuse or neglect by a person responsible for a child's care, custody, or welfare must be investigated unless a program director approves an administrative closure.

#31, Page 97. CPS staff are required to report abuse/neglect in agency foster or adoptive homes to Licensing Branch within one workday after receiving the initial report (CPS Handbook, Section 2620). Licensing Branch forwards the report to OYCI. CPS staff must send a report of the completed investigation to Licensing Branch within 30 days after receiving the initial report or 10 days after completing the investigation, whichever is longer (CPS Handbook, Section 2620). Licensing Branch sends the completed report to OYCI. In FY 1988, 27 foster fathers and 39 foster mothers were identified as alleged perpetrators of abuse or neglect in confirmed cases.

We appreciate the opportunity to review the report and would be happy to meet with you or your staff to discuss it in more detail.

Sincerely,

Charles Stevenson
Acting Commissioner