

PERFORMANCE AUDIT REPORT

**Assessing How Effectively the Department of
Social and Rehabilitation Services Handles
Reports of Child Abuse and Neglect**

**A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
November 1990**

Legislative Post Audit Committee

Legislative Division of Post Audit

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PERFORMANCE AUDIT REPORT

ASSESSING HOW EFFECTIVELY THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES HANDLES REPORTS OF CHILD ABUSE AND NEGLECT

OBTAINING AUDIT INFORMATION

This audit was conducted by Mary Beth Green and Ellyn Rullestad, Senior Auditors, and Rick Riggs and Holly Zane, Auditors, of the Division's staff. If you need any additional information about the audit's findings, please contact Ms. Green or Ms. Rullestad at the Division's offices.

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ASSESSING HOW EFFECTIVELY THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES HANDLES REPORTS OF CHILD ABUSE AND NEGLECT

Summary of Legislative Post Audit's Findings

What have the trends been in the number and types of child abuse and neglect reports received by the Department? According to Department records, the number of child abuse or neglect investigations increased by about 34 percent between fiscal years 1980 and 1990. During that time, the number of investigations of child abuse allegations more than doubled while the number of investigations of child neglect allegations decreased. Much of the increase in investigations occurred in more populous areas of the State. Finally, the number and percentage of reports that were confirmed as child abuse or neglect has actually declined since a 1987 change in the standard of proof needed to confirm an allegation.

Is the Department effectively handling reports of child abuse and neglect? About 80 percent of the 133 Department investigations reviewed appeared to be timely and adequate to protect the children involved, given the nature of the allegations. However, about 20 percent of the investigations into allegations of suspected child abuse or neglect were not. Further, some reports that represented suspected abuse or neglect were not investigated at all, leaving children in potentially harmful situations without State intervention. In some cases, Department procedures and management controls for ensuring that investigations were timely and adequate were not effective or were not followed. Some Department procedures could be improved, especially those related to documentation of case actions and decisions. Finally, many of the Department staff surveyed indicated they do not always have adequate resources to do their jobs, which could have contributed to problems noted during the audit.

Have prevention services been effective in reducing the incidence of child abuse and neglect reports from at-risk families? Many families that were at risk of abusing or neglecting their children did not receive preventive family services from the Department. Family services were not always successful in preventing out-of-home placements or in reducing the risk of subsequent abuse or neglect, although there were some success stories. A significant number of family service cases appeared to be unsuccessful because the participating families were uncooperative. Finally, some procedures for providing family services could be improved.

The audit report makes numerous recommendations related to Department policies and procedures for ensuring that Kansas children are adequately protected from abuse and neglect. The findings are supported by detailed data on Department procedures, individual cases, and survey results, which may allow us to answer additional questions about the audit findings or to further clarify the issues raised. We would be happy to discuss the report with any legislative committees, individual legislators, or other State officials.



Meredith Williams
Legislative Post Auditor



ASSESSING HOW EFFECTIVELY THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES HANDLES REPORTS OF CHILD ABUSE AND NEGLECT

State law requires doctors, dentists, teachers, child care workers, law enforcement officials and others to report suspected instances of child abuse or neglect to the Department of Social and Rehabilitation Services. When Department offices are not open for business, reports can be made to the Kansas Child Abuse Hotline, which operates 24 hours a day, or to local law enforcement agencies. Department staff and law enforcement officials are responsible for investigating child abuse or neglect reports. Child abuse or neglect reports involving Department employees or occurring in institutions operated by the Department are handled by the Attorney General's Office.

Legislative concerns have been raised about how well the Department of Social and Rehabilitation Services is handling reports of suspected child abuse or neglect. Specific concerns relate to how adequately the Department's staff investigates and resolves child abuse and neglect reports. Other concerns have been raised about the effectiveness of the Department's family services designed to prevent removal of children from their homes. The Legislative Post Audit Committee directed the Legislative Division of Post Audit to conduct a performance audit examining the Department's handling of child abuse and neglect reports. This audit addresses the following questions:

- 1. What have the trends been in the number and types of child abuse and neglect reports received by the Department?**
- 2. Is the Department effectively handling reports of child abuse and neglect?**
- 3. Have prevention services been effective in reducing the incidence of child abuse and neglect reports from at-risk families?**

To answer these questions, we reviewed information maintained by Department staff concerning trends in the number and type of child abuse and neglect investigations conducted during the last decade. We examined the Department's procedures for receiving and investigating child abuse or neglect reports, as well as procedures for providing preventive family services. We also visited Department offices in eight counties across the State and reviewed actual case files for samples of child abuse or neglect investigations and preventive family services.

In addition, we surveyed individuals who are required to report suspected child abuse or neglect to the Department, and we surveyed current and former Department employees responsible for handling abuse or neglect reports or for providing preventive family services. Finally, we contacted the surrounding states to determine how they handle reports of suspected child abuse and neglect and preventive family services. In conducting this audit, we followed all applicable government auditing standards set forth by the U.S. General Accounting Office.

Between fiscal years 1980 and 1990, we found that the number of child abuse or neglect reports investigated by the Department of Social and Rehabilitation Services increased by about 34 percent. During that time, the number of investigations alleging child abuse more than doubled, while the number of investigations of neglect allegations actually declined. The number of allegations confirmed as child abuse or neglect have dropped by 50 percent since a 1987 change in the standard of proof needed to confirm an allegation.

Regarding the Department's handling of child abuse and neglect reports, we found that the majority of the investigations appeared to be adequate to ensure that children were not significantly at-risk of being abused or neglected. However, about 20 percent of the investigations were not adequate or timely enough to protect children from abuse or neglect. Further, some reports that alleged potential child abuse or neglect were not investigated at all because Department personnel were busy investigating reports with higher priority or did not consider the allegations to be serious enough.

Regarding the effectiveness of prevention services, we found that the Department was providing or arranging for preventive family services for only a small portion of the families who were at risk of abusing or neglecting their children. While these services were sometimes effective, they did not appear to be successful in the majority of cases we examined. Some families who received preventive services subsequently had their children placed in Department custody or had subsequent confirmed reports of abuse or neglect, while other families were uncooperative and did not successfully complete the program.

These and other findings are discussed in more detail after the following overview of the Department's procedures for conducting child abuse and neglect investigations.

Overview of Child Abuse and Neglect Investigations Conducted By the Department of Social and Rehabilitation Services

The Department of Social and Rehabilitation Services' Youth Services Division is responsible for administering child protective services, or investigations of child abuse or neglect reports. Members of the public, law enforcement officers, and professionals such as doctors and school officials may report suspected instances of child abuse or neglect to the Department's 105 county offices or to the Kansas Child Abuse Hotline.

Department social workers from the county offices then are charged with investigating the reports and determining whether the children have been abused or neglected. Depending on what they find during their investigations, Department staff may recommend that the county or district attorney and the courts take legal action to protect the child from further harm.

According to the Department's Kansas Manual of Youth Services, the investigation of child abuse or neglect reports is designed to perform two functions. The primary function is to determine whether a child has been abused or neglected, and what action is required to protect the child from further harm. In fiscal year 1990, the Department reported that it conducted about 23,400 such investigations.

A second function is to identify those persons who are more likely than not the perpetrators of the child's mistreatment. This information is then reported to the State's Central Registry, which is a central tracking system for victims and confirmed perpetrators of abuse or neglect. The Central Registry may be used by Department personnel to determine if a child or alleged perpetrator has been confirmed previously and State law requires the Department of Health and Environment to search the Registry for names of all persons who operate, are employed in, reside in, or volunteer in licensed or registered child care facilities.

The typical investigation process for child abuse and neglect reports, and the options available to the Department and the courts, is illustrated in the graphic on page five. As that graphic indicates, after Department staff receive a report of suspected abuse or neglect, they review the report to determine whether it should be investigated. Reports that may be "screened out" or not investigated include those that appear to be malicious, fictitious, or vague.

Reports may also be screened out if they appear to be frivolous. The Department defines a frivolous report as one that lacks substance and may involve poor parental judgment but that does not meet the definition of abuse or neglect. (The box on the next page describes how the Department defines the various kinds of child abuse and neglect.) According to the Kansas Manual of Youth Services, "Some examples of [frivolous] reports might be: the mother smokes while feeding the baby; the kids next door fight all the time; the children eat junk food all the time...the father is living with a woman to whom he is not married."

Types of Child Abuse and Neglect

The Kansas Manual of Youth Services defines the following types of child abuse and neglect:

Physical Abuse: Non-accidental or intentional action by a parent, custodian, or caregiver that results in bodily injury or that presents an imminent risk of death or of bodily injury. Such injuries include, but are not limited to, fractures, bruises, welts, cuts, abrasions, internal injuries, burns, poisoning, and congenital drug and alcohol addiction.

Emotional Abuse: Noticeable impairment of the child's social, emotional or intellectual functioning because of a parent, custodian or caregiver's pervasive negative behaviors. The most common forms of emotional abuse include belittling, rejecting, ignoring, terrorizing, isolating, and corrupting a child.

Sexual Abuse: Any contacts or interactions between a parent, custodian, or caregiver and the child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse includes permitting or

encouraging the child to engage in prostitution or to be depicted in obscene or pornographic material.

Physical Neglect: Failure of a parent, custodian or caregiver to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child. Neglect includes abandonment and the failure of a child to thrive because of inappropriate diet and lack of attention and care.

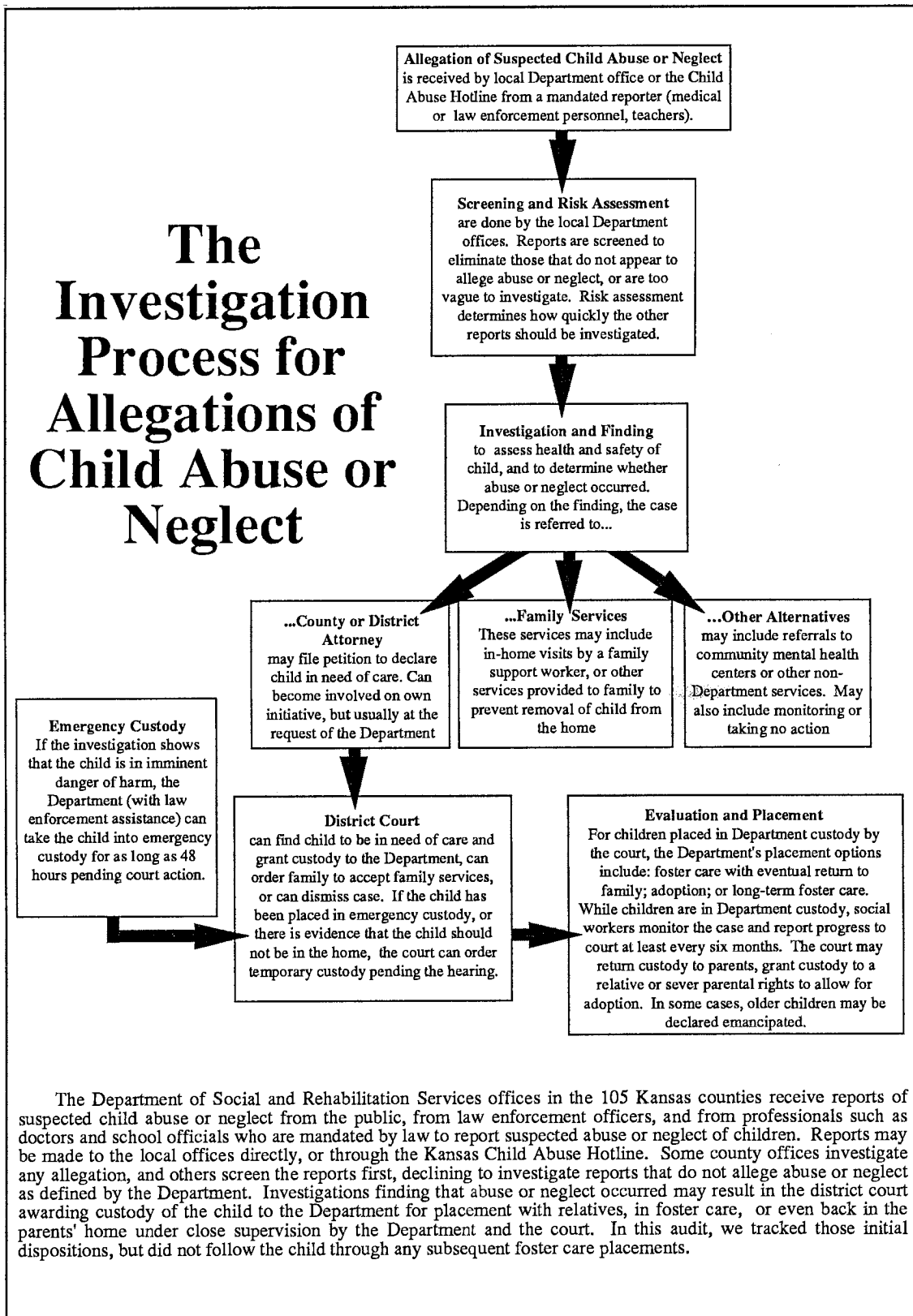
Lack of Supervision: Failure of a parent, custodian, or caregiver to provide adequate supervision of the child, or failure to remove a child from situations requiring judgment or actions beyond the child's level of maturity and abilities, resulting in harm or imminent risk of harm.

Medical Neglect: Failure of a parent, custodian, or caregiver to use available resources to treat a diagnosed condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, correct or substantially diminish a crippling condition, lengthen the life span, or prevent a condition from worsening.

After local Department employees screen out reports that allege poor parental judgment or other complaints that do not constitute abuse or neglect, a social worker investigates the situation. Depending on the nature of the allegation, the investigation may involve interviewing the child, parents, other family members, alleged perpetrator, and others. After completing the investigation, the social worker makes a finding. That finding, usually made in consultation with the social worker's supervisor, is to be made within 30 days of the initial report and should take one of the following forms:

- **Confirmed:** A report of suspected child abuse or neglect is confirmed when, in the social worker's opinion, a reasonable person would conclude that it is more likely than not that abuse or neglect occurred.
- **Unconfirmed but Eligible for Service:** When the social worker's conclusion is "no, a reasonable person would not believe that abuse or neglect occurred but [it] is likely to occur in the future without intervention," the appropriate finding is "unconfirmed/eligible for service." If the allegation involved a child-care facility rather than a family, the finding is to be "unconfirmed/corrective action needed."
- **Unfounded:** If the social worker concludes that a reasonable person would not believe that abuse or neglect occurred, the appropriate finding is "unfounded."

The Investigation Process for Allegations of Child Abuse or Neglect



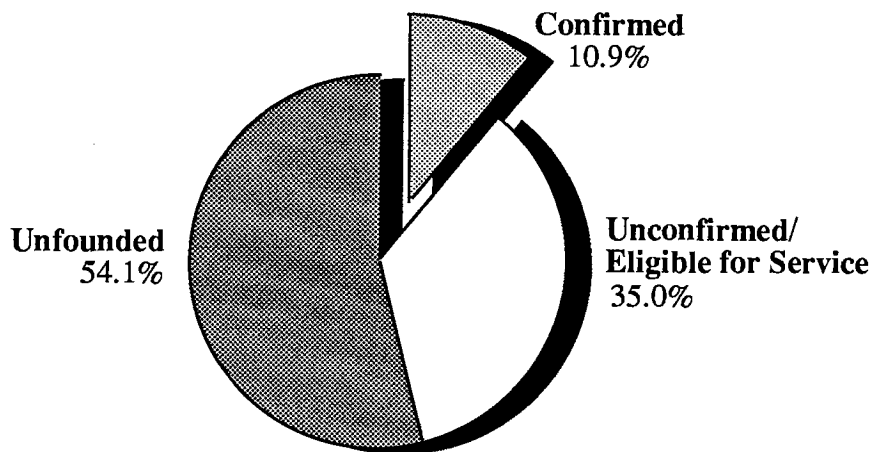
The Department of Social and Rehabilitation Services offices in the 105 Kansas counties receive reports of suspected child abuse or neglect from the public, from law enforcement officers, and from professionals such as doctors and school officials who are mandated by law to report suspected abuse or neglect of children. Reports may be made to the local offices directly, or through the Kansas Child Abuse Hotline. Some county offices investigate any allegation, and others screen the reports first, declining to investigate reports that do not allege abuse or neglect as defined by the Department. Investigations finding that abuse or neglect occurred may result in the district court awarding custody of the child to the Department for placement with relatives, in foster care, or even back in the parents' home under close supervision by the Department and the court. In this audit, we tracked those initial dispositions, but did not follow the child through any subsequent foster care placements.

Case findings for the Department's fiscal year 1990 investigations are summarized in the chart at the bottom of the page. Appendix A lists the fiscal year 1990 findings in more detail, such as the number of confirmed cases of physical abuse and the number of confirmed cases of emotional abuse.

When Department staff conclude that abuse or neglect has occurred or is likely to occur in the future without some kind of intervention, they may offer services to the family involved to prevent at-risk children from being removed from their homes or to decrease the children's risk of abuse or neglect. In those instances, the Department assigns one or more social workers or other employees to work with the family on such things as their parenting skills, hygiene, home management, or problem-solving skills.

Much of the work with these families may be done by family support workers who visit the family, often several times a week or even daily, showing the parents how to cook nourishing meals, clean the house, and discipline the children effectively. In addition, the Department may use family service funds to pay for counseling, daycare, pest extermination, and other services needed to provide a safe environment for at-risk children.

Findings Related to Investigations of Child Abuse or Neglect Fiscal Year 1990



In fiscal year 1990, the Department of Social and Rehabilitation Services conducted about 23,400 investigations into allegations of abuse or neglect. Of those, more than half (54.1 percent) were ruled as unfounded. Another 35 percent were ruled as unconfirmed but eligible for service, which means that the social worker found that abuse or neglect had not occurred, but might in the future without intervention. Only 10.9 percent were ruled as confirmed instances of abuse or neglect.

What Have the Trends Been in the Number and Type of Child Abuse and Neglect Reports Received By the Department of Social and Rehabilitation Services?

To answer this question, we reviewed statistics provided by the Department and interviewed Department officials. The information provided generally dealt only with the number of abuse or neglect reports actually investigated, and the results of those investigations. We had originally intended to gather information about the number of abuse or neglect reports received, but Department officials do not compile information for the number of reports received. Further, we did not verify the accuracy of the Department's information because that was outside the scope of our audit and Department staff did not maintain many of the original source documents for the historical information.

According to the Department's records, the number of child abuse or neglect investigations increased by about 34 percent between fiscal years 1980 and 1990. During that time, the number of investigations alleging child abuse more than doubled while the number alleging child neglect decreased. Further, much of the increase in investigations occurred in more populous areas of the State. Finally, the number and percent of reports that were confirmed as child abuse or neglect have actually declined since a 1987 change in the standard of proof needed to confirm an allegation.

Between Fiscal Years 1980 and 1990, the Number of Child Abuse and Neglect Investigations the Department Conducted Increased, While the Number of Confirmed Reports Decreased

According to Department records, reports of suspected child abuse or neglect investigated by Department social workers increased by about 40 percent between fiscal years 1980 and 1986. After 1986, however, the number of investigations leveled off and even declined slightly. Overall, the Department reports a 33.6 percent increase in investigations between 1980 and 1990. These changes are shown in the table at the top of page eight.

The table also shows that the number of reports confirmed increased during the early 1980s but started to decline in 1986 and 1987. The most significant drop occurred in fiscal year 1988. Department officials said that, in January 1987, the Department changed the criteria social workers were to use to determine whether abuse or neglect had occurred. Previous Department policy had been to make a finding of "confirmed" if the social worker had reason to believe abuse or neglect occurred. After January 1, 1987, because of concerns about the legal rights of confirmed perpetrators, the Department changed its policy to require a preponderance of evidence of abuse or neglect. In other words, a social worker had to find that it was more likely than not that abuse or neglect had occurred before confirming a report.

**Department of Social and Rehabilitation Services'
Child Abuse and Neglect Investigations
Fiscal Years 1980 through 1990**

<u>Fiscal Year</u>	<u>Number of Reports Investigated</u>	<u>Number of Reports Confirmed</u>	<u>Percent of Reports Confirmed</u>
1980	17,522	5,230	29.9%
1981	19,783	6,698	33.9
1982	18,661	6,272	33.6
1983	19,498	6,439	33.0
1984	22,450	7,647	34.1
1985	24,551	7,724	31.5
1986	24,655 (a)	5,174 (a)	21.0 (a)
1987	24,655 (a)	5,174 (a)	21.0 (a)
1988	24,372	2,896	11.9
1989	23,437	2,508	10.7
1990	23,416	2,552	10.9

(a) The data for these two fiscal years were combined and averaged because Department officials indicated the figures reported for fiscal year 1986 were artificially low and the 1987 figures were artificially high because of the Department's conversion to a computerized reporting system.

As the table shows, confirmations as a percentage of reports made fell by half after fiscal year 1987, from 21 percent in fiscal year 1987 to 11.9 percent the following year. The lowest percentage of confirmations was 10.7 percent in fiscal year 1989.

We had originally planned to compare the number of investigations conducted and confirmed in Kansas to statistics for other states, but found that other states' data are not necessarily comparable to Kansas' data because different states use different standards of proof and different resolution categories.

Investigations into allegations of child abuse have doubled in the last 11 years, while investigations into allegations of neglect have decreased. Child abuse generally refers to acts by a parent, custodian, or caregiver which result in non-accidental harm to a child, or in the substantial threat that harm will occur. Neglect refers to a parent, custodian, or caregiver's failure to provide a minimum level of care necessary to ensure the health and welfare of the child. Department records show that although the number of abuse or neglect investigations increased significantly between 1980 and 1990, the increase is attributable to a rise in abuse investigations. That trend is illustrated in the graph on page 10.

As the graph shows, abuse investigations rose from 6,322 in fiscal year 1980 to a 10-year high of 13,443 in fiscal year 1989. During the same period, neglect investigations fell from a high of 13,414 in fiscal year 1981 to a low of 9,994 in fiscal year 1989. Because the Department does not compile statistics for the number and type of

**A Sampling of Statistics on
Child Abuse and Neglect Investigations Conducted By
The Department of Social and Rehabilitation Services
Fiscal Year 1990**

In fiscal year 1990, the Department investigated 23,416 reports of suspected child abuse or neglect, of which 2,552, or 10.9 percent, resulted in a confirmed finding of abuse or neglect. These 23,416 investigations stemmed from reports made by physicians, teachers, law enforcement officers, social workers, relatives, and others. The boxes below provide some facts and figures about these investigations, and the children and families involved in them:

CHILD'S AGE

Of 2,552 confirmed reports:

38% involved children under 6 years of age
35% involved children ages 6-11
27% involved children ages 12-18

PARENTS' AGE

Of 2,552 confirmed reports:

4% involved parents under 20 years old
77% involved parents 20-39 years old
19% involved parents over 40 years

CHILD'S SEX

Of 2,552 confirmed reports:

44% involved boys
56% involved girls

PUBLIC ASSISTANCE STATUS

Of 2,552 confirmed reports:

37% involved families receiving public assistance
54% involved families not receiving public assistance
9% unknown

CHILD'S PHYSICAL CONDITION

Of 2,552 confirmed reports:

61% involved minor or no injuries
11% involved moderate injuries
24% involved sexual contact
3% involved major injuries
1% involved permanent injury or death

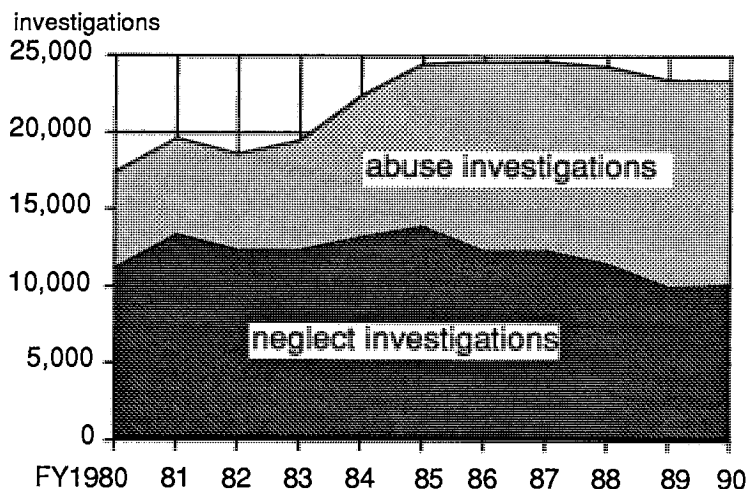
TYPE OF SETTING

Of 23,416 investigations conducted:

96% involved the parents' home or other family setting
4% involved schools or daycare facilities

reports received, we could not determine whether these changes occurred because the Department received more abuse reports and fewer neglect reports, or because Department personnel started investigating more abuse reports and fewer neglect reports. Appendix B lists the Department's reported numbers of abuse and neglect investigations conducted between 1980 and 1990, by year.

**Comparison of Investigation Rates
For Child Abuse and Neglect Reports
Fiscal Years 1980 Through 1990**

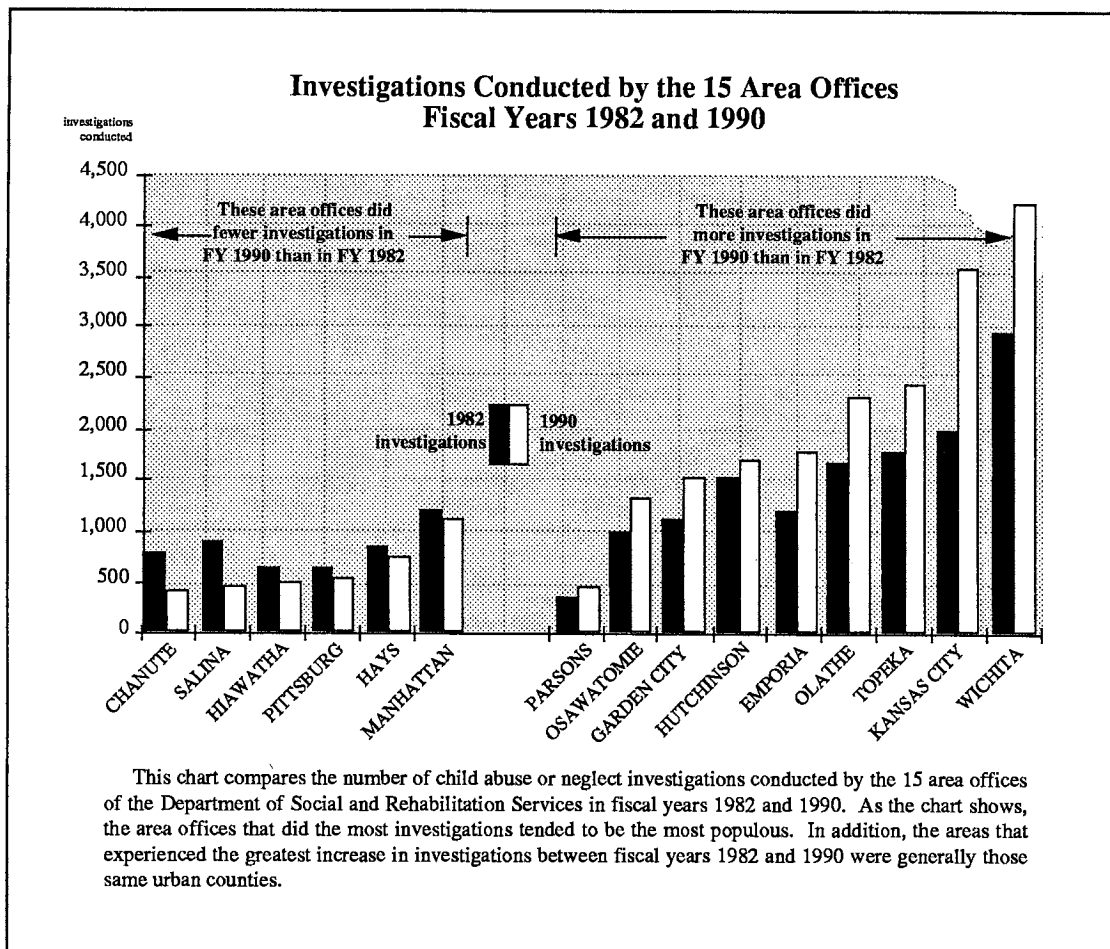


This chart shows that the number of total abuse and neglect investigations for the last 11 fiscal years has increased from 17,500 in fiscal year 1980 to about 23,400 in fiscal year 1990. Although the number of neglect investigations fell during that period from 11,200 in fiscal year 1980 to about 10,000 in fiscal year 1990, the overall total grew because of the sharp increase in the number of abuse investigations.

**The Most Significant Increases in
Child Abuse and Neglect Investigations
Have Occurred in More Populous Areas of the State**

In fiscal year 1990, the Department had 15 area offices established throughout the State. Each area office comprised one or more county offices. Using information provided by the Department for individual counties, we examined trends between fiscal years 1982 and 1990 in the number of investigations conducted by the 15 area offices in existence during fiscal year 1990. (In fiscal year 1991, the Department began a consolidation that will result in 12 area offices rather than 15.)

We found that the number of investigations conducted Statewide increased by about 25 percent between 1982 and 1990. However, nine of the Department's 15 area offices experienced increases, while six experienced decreases. Some of the most significant increases occurred in the more populous areas of the State. As shown in the chart below, area offices headquartered in Wichita, Kansas City, Topeka and Olathe experienced the sharpest increases, as did areas such as Emporia and Garden City. The actual number of investigations conducted in fiscal years 1982 and 1990, by area office, are listed in Appendix C.



The Department's Statistics for Child Abuse or Neglect Investigations Are Not Always Consistent

In reviewing the Department's records of child abuse and neglect investigations, we noted some inconsistencies. For example, the Department provided us with figures that showed 23,416 investigations were conducted Statewide in fiscal year 1990, while its figures for investigations conducted by the 105 counties totaled 23,233. These two figures should be the same. Similarly, the Department's computer records for fiscal year 1987 identified twice as many perpetrators of abuse or neglect as the total number of confirmed abuse or neglect cases that year.

In these instances, Department officials said that they were aware of the discrepancies but could not explain them. Although these inconsistencies would create problems for Department managers who rely on the data for making decisions, Department staff told us that they have a contract with data processing consultants to correct the problems, and should have the inconsistencies resolved in the near future.

Is the Department Effectively Handling Reports of Child Abuse and Neglect?

We reviewed a sample of 133 Department of Social and Rehabilitation Services' investigations of child abuse or neglect reports from across the State and found that more than 80 percent of those investigations appeared to be adequate and timely given the nature of the allegations. However, about 20 percent of the investigations reviewed during the audit—or one in five—did not appear to be adequate or timely enough to ensure that children were protected. Further, some reports that represented suspected abuse or neglect were not investigated at all, leaving children in potentially harmful situations without State intervention. In some cases, we found that Department procedures and management controls for ensuring that investigations were timely and adequate were not effective or were not followed.

We also found that some Department procedures could be improved, especially those related to documentation of investigation actions and decisions. Finally, many of the Department staff we surveyed indicated they do not always have adequate resources to do their jobs, which could have contributed to problems noted during the audit. Comments made by the survey respondents are scattered throughout the rest of this report, and additional information from the surveys is included in Appendices F through H.

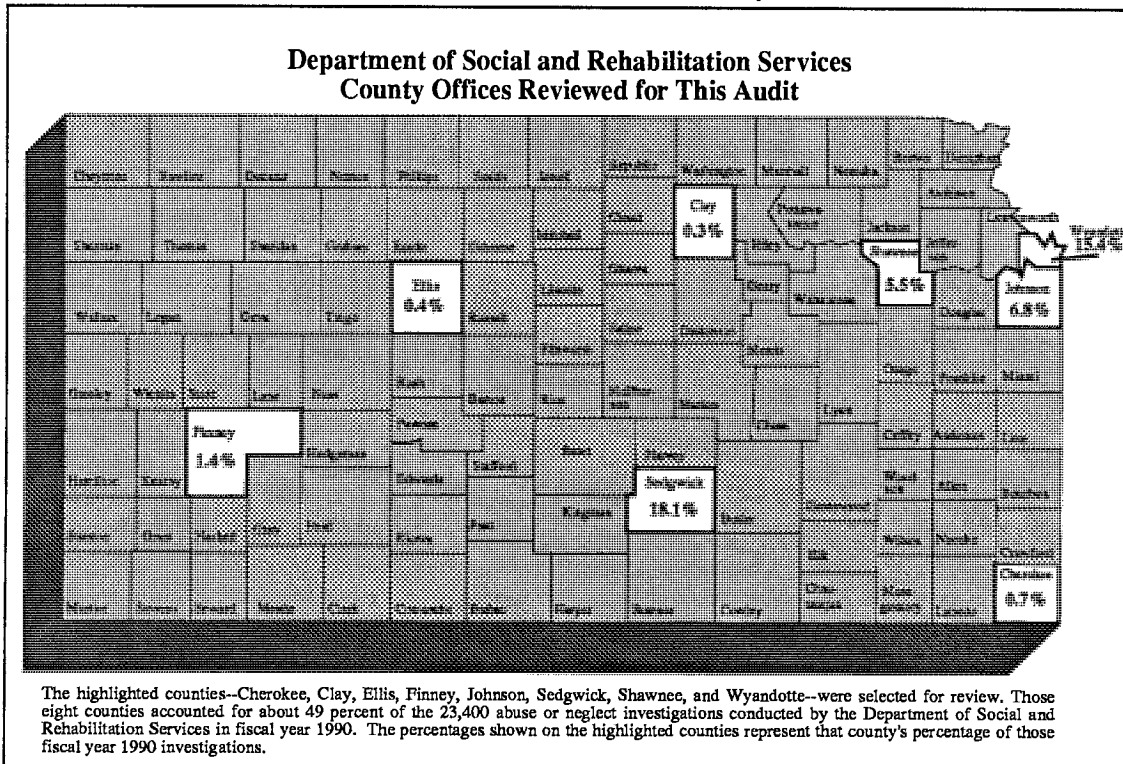
Many Investigations Conducted By Department Personnel Appeared To Be Adequate to Minimize Children's Risk of Abuse or Neglect

The Department of Social and Rehabilitation Services has established written procedures that guide all phases of investigations of suspected child abuse or neglect. Those procedures are listed in the Kansas Manual of Youth Services and include procedures for:

- receiving reports of suspected abuse or neglect from mandated and voluntary reporters
- screening reports to eliminate vague and frivolous reports or other allegations that do not represent abuse or neglect
- investigating reports that appear to represent potentially abusive or neglectful situations
- resolving reports by determining whether abuse or neglect occurred and notifying the people involved (such as the parents, alleged perpetrators of abuse or neglect, and the county or district attorneys)

We reviewed the Department's established procedures in these areas and concluded that they appeared to be adequately designed to ensure that investigations would be thorough and timely. Some written procedures could be improved, and they will be discussed later in this report.

To determine whether these procedures were being followed and had in fact minimized the risk of additional child abuse or neglect, we visited Department offices in eight counties and reviewed a random sample of 110 child abuse or neglect investigations conducted as the result of allegations received between July 1 and September 30, 1989. As shown in the map below, the eight counties we visited were: Cherokee, Clay, Ellis, Finney, Johnson, Sedgwick, Shawnee, and Wyandotte.



In addition to the random sample we selected, we also reviewed a Statewide sample of cases in which children were hospitalized, permanently injured, or fatally injured as the result of confirmed abuse or neglect. These cases included all children who, according to Department records, were permanently or fatally injured as the result of abuse or neglect during fiscal years 1989 and 1990. This sample originally included 28 cases but we determined that computer forms for five cases apparently had been coded incorrectly and the children were not hospitalized, permanently injured, or fatally injured. In all, then, we reviewed a sample of 133 investigations in the eight counties visited. Appendix D lists the number of child abuse or neglect investigations we examined in each of the eight counties.

We found that 108 of the 133 investigations we examined, or 81.2 percent, appeared to be thorough and timely enough to protect the children involved, given the nature of the allegations. In these cases, Department personnel generally conducted the investigations in a timely manner and took reasonable and necessary steps to protect the children involved. The box on the following page describes some of those investigations.

Examples of Adequate Investigations of Child Abuse or Neglect Reports

Example 1

The reporter indicated that a nine-year-old boy was being left unsupervised after school until 6 or 7 p.m. at least two days per week.

Department staff interviewed the child at school four days after receiving the report. The boy said that he was never left at home alone for more than about one hour. The child also said he had a phone number where a caregiver could be reached when he was left alone. Three days later the social worker interviewed the boy's mother and concluded that the report of neglect was unfounded.

Example 2

A hospital social worker reported that the mother of a newborn baby had admitted to using cocaine and marijuana throughout her pregnancy. The reporter said the mother had been released that day, but the baby would not be released for several days because of health problems and withdrawal symptoms.

Department staff notified the district attorney's office about the case and interviewed the mother at her home. The mother admitted to using cocaine the day before the child was born but denied any use of marijuana during the pregnancy. Medical tests confirmed that the child was born with cocaine in its system. Department staff confirmed that the mother had neglected the child due to drug use during pregnancy. The child was placed in the Department's legal custody and placed in its maternal grandmother's home. The child's mother voluntarily entered an in-patient drug treatment program.

Example 3

The reporter indicated that a mother had no food in the house for her three children, ages 4, 3, and 1, and that the mother's home was a party shack with lots of drug use and strange people going in and out.

Department staff made an unannounced visit to the home two days after the report was made. They found that the children had dirty feet and the home had sticky floors and smelled of urine, but there was food for the children to eat. The mother admitted having financial problems; the social worker said a family support worker would help her in this area. Six days later the social worker interviewed a law enforcement officer who had contacted several references about the mother. Those contacted indicated that the mother was a poor housekeeper, but they had no knowledge that she was using drugs. The case was then resolved as unconfirmed, eligible for service.

Example 4

A daycare center employee reported that a five-year-old girl had arrived at the center that day with bruises on her face, left leg, thigh, and buttocks. The reporter indicated that the child said her mother's live-in boyfriend hit her.

Department staff interviewed the child at the daycare center that same day. The child said the live-in boyfriend hit her. That day, the Department social worker tried to telephone the child's mother several times but no one answered the telephone. The investigating social worker interviewed the daycare employee again and interviewed the child's mother and the mother's live-in boyfriend five days after the report was received. The mother indicated that the boyfriend had spanked the child. The boyfriend admitted to spanking the child on the buttocks but claimed the child subsequently raised up from the bed and hit her face on his hand. Department staff confirmed the report as physical abuse with the boyfriend named as perpetrator.

About 20 Percent of the Child Abuse or Neglect Investigations We Reviewed Were Not Adequate or Timely Enough To Minimize the Risk of Abuse or Neglect

In all, 25 of the investigations we reviewed, or 18.8 percent, were not started soon enough, took too long to complete, or did not appear to be thorough. In these

Allowable Response Times for Child Abuse or Neglect Reports

After receiving reports of suspected abuse or neglect, Department staff determine how soon the investigation should occur by assessing the risk to the child, taking into consideration factors such as the child's age, the nature and severity of the alleged abuse or neglect, and whether the suspected perpetrator continues to have access to the child. According to the Department's Kansas Manual of Youth Services allowable response times are:

Immediate Response: When there is reason to believe a child is in immediate, serious physical danger, a social worker shall take immediate (same day) action necessary to protect the child or cause that action to be taken by emergency personnel such as law enforcement officers. For example, if a very young child is reported to have been severely abused by a parent who is still in the home, that child would probably be assessed as being in immediate danger.

72-Hour Response: When there is reason to believe that a child is not in immediate serious physical danger, but the report alleges critical neglect or physical/sexual abuse where the perpetrator continues to have access to the child, the worker shall respond within 72 hours.

5 to 30 Day Response: When there is reason to believe that a child is not in immediate serious physical danger and the report does not allege physical or sexual abuse in which the perpetrator has access to the child, the worker shall respond within five working days when possible, but no later than 30 calendar days.

According to the Manual, meeting the response time requirement does not mean that the investigation is completed. Rather, compliance with the response time requirement is met when the worker (in consultation with the supervisor or designee) determines the safety of the child or is unable to locate the child or parent/guardian after some reasonable effort. Reasonable effort is further defined as three well-documented attempts to have face-to-face contact with the child and family.

cases, the Department did not effectively minimize the children's risk of being abused or neglected. Department records indicate that some of the children involved were not subsequently harmed, to the Department's knowledge, but two of the children were fatally injured. Although it is impossible to determine whether additional Department action could have prevented any subsequent harm, Department staff did not take appropriate or timely actions to protect the children involved. These and other findings are discussed in the sections that follow.

Some investigations were not started soon enough to protect at-risk children. When a local Department office receives a report of suspected child abuse or neglect, the receiving social worker or supervisor is supposed to conduct a risk assessment based on the information given by the person making the report. Based on the age of the child, nature of the allegation, continued access of the perpetrator to the child, and so forth, Department personnel establish the maximum response time for the report.

Although the established response times for the investigations we reviewed generally appeared to be reasonable, we identified six investigations that were not started within the established response time. In one case, the Department established a maximum response time of 7 days for a report that indicated that a 10-year-old boy was being physically abused by his parents. Although the reporter could not provide all information about the child, such as his first name and where he attended school, the Department deter-

mined that enough information was provided to warrant an investigation. During the next two weeks, Department records indicated that the investigating social worker discussed the case with two other Department employees but made no attempt to locate the family until 15 days after the report was received.

In another example, a mother alleged that her 11-year-old son was being medically neglected by his father and stepmother. The son lived with his father and stepmother but the natural mother had noticed blood and pus coming out of his ear during a recent visit with the child. The mother indicated she took the child to a physician who told her the child needed to see a medical specialist.

The mother made an appointment for the child, but the child returned to stay at his father's and stepmother's home before the scheduled appointment. The mother reported that the father and stepmother did not keep the child's appointment with the specialist and were not getting medical treatment for the child. The social worker did not begin investigating the report until five weeks later.

Some investigations were not thorough enough to protect the children involved. In 13 cases we reviewed, it appeared that the reports were inadequately investigated, based on the documentation in the files. Superficial or incomplete investigations can result in children being kept at risk of potential harm. Conversely, they can also result in the confirmation of abuse or neglect when none actually occurred.

In the most serious example of an inadequate investigation we identified,

Our Surveys of Current and Former Department Staff, and People Required to Report Suspected Abuse or Neglect, Elicited Some Positive Comments

The survey respondents made a number of comments about the Department, sounding some positive themes. Following is a sample:

Good working relationships:

"We have an excellent rapport with the court system. We have several community resources to assist in accommodating our clients. This allows the Department's system to flow in a workable manner." (family support worker)

"I have had great response on serious cases. In 10 years I've worked with CPS, there is only one case I was unhappy with... Wonderful track record." (school personnel)

"...I work very closely with SRS. I find SRS personnel courteous, helpful, thorough, and most always there when needed." (law enforcement officer)

The Department does a good job with the available resources:

"...I am 100 percent dedicated to Youth Services at SRS and think we do an outstanding job considering our resources. With adequate staffing patterns, we could almost perform miracles." (social worker)

"They have a very difficult job and do the best job possible with all the limitations...I have been pleased with my contact." (school personnel)

"...SRS has a very difficult job that is often gone unnoticed for all the lives they save." (school personnel)

"They do an excellent (job) in an area which exerts a great deal of stress from all of those involved." (school personnel)

The Kansas system is a good one:

"Basically, our present system for receiving and investigating child abuse and neglect reports is a thorough and effective method." (social worker)

"After moving to another state, I realize how progressive Kansas is in its children's programs." (former social worker)

"Our Department has genuinely concerned, trained, and hard-working social workers and supervisors." (family support worker)

"Kansas SRS child abuse programs take a back seat to no one. For some children this is the only positive chance in their lives. Keep up the good work in child abuse and neglect reporting and care." (law enforcement officer)

**Survey Respondents
Were Critical of the Department In
Some Areas**

Current and former social workers, family support workers, and persons mandated to report abuse or neglect that we surveyed made a number of negative comments about the Department, many of which followed common themes. The comments below and on page 29 show a sample. More respondents' comments appear in Appendices E, F, G, and H.

Poor Department performance:

"I have had more than one instance where the SRS worker did not maintain confidentiality of person making the report—which can really cause havoc in a school where I am the only support staff personnel. Workers must be cautioned to say 'a report has been filed' without revealing where it came from as well as from whom!" (school personnel)

"I believe they are very slow and very neglectful on getting back to us after a report has been made...They are also very lax in doing anything about situations--does a child have to die before something is done?" (school personnel)

Excessive screening of allegations:

"We are responsible to report, but often feel that nothing is done as way too much time is taken to report. One quote we passed on that was heard from SRS - 'We won't do anything unless we see blood flowing under the door.'" (school personnel)

"I encountered a number of problems when contacting SRS to report child abuse. The staff here were informed by an SRS abuse/protection worker that 'unless a child was bloody', there wasn't much that could be done. Consequently, some staff members feel it is useless to even call SRS." (school personnel)

Too few staff or other resources:

"Social worker pay must be at a level to attract and keep quality people. Perhaps the legislature would relinquish a portion of their retirement package for that purpose." (school personnel)

"A very big weakness in the system is not having money available to operate with a full staff. Workers are expected to perform at 100%, which is almost impossible at full staff, let alone when units are operating with only 60 or 75 % of the positions filled." (former social worker)

Department staff received a report that a five-month-old boy was being physically abused, left alone, and not properly fed. The reporter alleged that the child's mother was the perpetrator. The reporter did not give a family address but did provide the parents' names and the father's place of employment.

Department staff did not attempt to locate the family until nine days later, when the reporter called back and provided an address. A social worker attempted to visit the family that day, but no one was home. Four days later the social worker interviewed the mother and observed the child. According to the social worker's case notes, the mother said the parents did not abuse the child, but she did not want the father notified of the report. During the visit, the social worker noted that the boy did not have any bruises or marks on his body but seemed very inactive and thin.

After this visit, the social worker's notes indicate that "my feeling is that though there is no physical evidence, something is going on with this baby." At that time, the social worker and the worker's supervisor decided that the social worker would attempt to contact the child's father and ask medical personnel to monitor the child's condition. Over the next 10 days, the social worker tried to telephone the father four times, all unsuccessfully. The social worker did not follow through with requesting medical personnel to monitor the child.

Department records for the case show no additional activity until one month later, when Department staff received another, somewhat unclear, report about the child. That report was not investigated. One and one-half months after that (or two and one-half months after the

last unsuccessful attempt to call the father), Department personnel were notified that the child (now eight months old) had been hospitalized with a ruptured stomach, a large amount of bruising, and bite marks on his body. The child died the next day. An autopsy report showed that the child's collar bone and a rib had been broken sometime before the fatal injuries. Department staff subsequently confirmed the case as child abuse, with the child's father named as perpetrator. The father eventually pleaded no contest to criminal charges of involuntary manslaughter and child abuse.

In another case we reviewed, a mother reported that she was concerned that her six-year-old daughter might have been sexually abused by a male, live-in babysitter. After making the report, the mother failed to bring the child to a scheduled interview with a Department social worker and a law enforcement officer. The social worker subsequently notified the county attorney that the mother was being uncooperative. One day after contacting the county attorney, the Department received an anonymous report that the child may have been sexually abused by the babysitter. Department records indicate that the county attorney subsequently told Department staff that nothing more needed to be done on the case because the mother was not cooperating. The mother also contacted the Department and indicated that she did not want the six-year-old to be interviewed and that a physician had told her the child showed no physical signs of sexual abuse. Because the county attorney had indicated that no further action was necessary, Department staff did not attempt to interview the child at school or verify the medical information with the physician.

Other examples of inadequate investigations conducted by Department staff are summarized in the box on page 20.

Finally, we found that none of the eight counties we visited during the audit routinely check with the Central Registry when they receive abuse or neglect reports. As noted earlier, this Registry is a central tracking system for victims and confirmed perpetrators of abuse or neglect. Department staff are not required to check the Registry for each abuse and neglect report, but doing so would help them determine whether an alleged perpetrator has ever had a confirmed report of child abuse or neglect. Department officials we talked with said they did not routinely check the Registry because it is too time-consuming; they must contact the Central Office in Topeka to have someone there search the Registry and report back to them.

In some investigations, the Department acted too slowly to help protect children from subsequent harm. For example, in one county a family was the subject of seven investigations of alleged neglect or sexual abuse over a one-

The Kansas Child Abuse Hotline

The Kansas Child Abuse Hotline was established in October 1989 as a toll-free number that could be called 24 hours a day, seven days a week to report suspected incidents of child abuse and neglect. The toll free number works from any location within the State, although the Hotline is physically located in rented space on the grounds of the Topeka State Hospital. The Hotline is currently advertised in the white pages of the telephone book and through posters. Approximately five calls are received on the Hotline each day.

The Hotline is staffed with social workers, social work students, and program technicians. Hotline staff immediately refer emergency reports to local law enforcement agencies. All other reports are referred to the appropriate Department area office to be investigated by the local social workers.

Examples of Inadequate Investigations of Child Abuse or Neglect Reports

Example 1

A landlord reported that some of his tenants neglected their children, age 3 years, 2 years, and 7 months. According to the landlord the home was filthy and had no furniture or gas utilities.

Department staff attempted to interview the family five days later but no one was home. That same day, the investigating social worker checked Department public assistance records for the parents and found no record. Also, that same day the investigating social worker attempted unsuccessfully to telephone the reporting landlord. No additional investigation actions were taken.

The investigation was inadequate because only minimal attempts were made to investigate the report. This investigation also did not comply with Department procedures requiring three attempts at face-to-face contacts with a family before an investigation can be closed.

Example 2

The reporter indicated that a nine-month old girl was brought to the hospital emergency room by her mother, who had noticed that the child's vaginal area was red and the child did not want to spread her legs when it came time to change her diaper. A medical examination of the child was inconclusive. The reporter further indicated that the child's grandmother had been babysitting with the child when the incident occurred. The child's uncle was also present during this time, but denied any abuse.

Department staff sent a letter to the mother the day after the report requesting a meeting. Four days later the social worker unsuccessfully tried to visit the mother at home. Three days later hospital staff informed the social worker that the child had a sexually transmitted disease. During the next two weeks, telephone messages were left and another letter was sent to the mother requesting contact. No further action was taken until almost three months later, when another letter was sent to the mother. Nearly two more months passed before the social worker sent another letter to the mother indicating that the case would be referred to the court system if she did not contact the social worker within seven days. The mother contacted the social worker two days later, and indicated that the child could have gotten the disease from the mother during her pregnancy. The mother said she would have a doctor send the social worker verification that the mother had the disease during her pregnancy. Over the next two days, the social worker again tried to contact the mother by phone and at home, but discovered that the mother had moved. The case was resolved as unconfirmed, eligible for service almost three months after the Department's last attempt to contact the mother.

The investigation was inadequate because the case was open for more than nine months, and there were three-month and two-month gaps in the investigation logs during which no activity was noted. In addition, the social worker did not make sufficient attempts to visit the mother's residence and did not receive verification from the doctor concerning the mother's statements about how the child could have contracted the disease. Finally, Department staff never interviewed the uncle.

Example 3

The reporter indicated that a 14-year-old boy had been physically abused by his father. The reporter also said that the living conditions in the family's home were horrible and that the boy and his 15-year-old brother needed to see a doctor; the older boy was overweight and the younger one smelled bad.

Department staff did not begin investigating the report until more than one month after they received it. The social worker sent the children's mother a letter informing her that the social worker would be visiting her in seven days. No one was home for the scheduled visit. A little more than two weeks later, the social worker interviewed the boys' school teacher. The teacher had talked with the mother and wanted to give her a little more time to see if things were going to change. Five days later, the school teacher indicated that things had improved, and that there was no need for the Department's involvement with the family.

The investigation was inadequate because Department staff did not investigate the report in a timely manner and did not interview either parent or the children. In addition, there was no indication that the allegations of abuse were ever pursued.

year period. For six of those seven investigations, the case finding was unconfirmed but eligible for services; one investigation resulted in a report of confirmed physical neglect. The county at one time was considering recommending that the county attorney seek legal custody of the four children in the family.

The family then moved to another county, where they were the subject of 11 additional investigations (most alleging neglect) in less than 15 months. Department records indicated that, again, one of these reports was confirmed as physical neglect. While these investigations were ongoing, the second county was not aware of the family's previous problems in the first county. Finally, after Department officials in the second county concluded that the youngest child—a two-and-a-half year old girl—had contracted gonorrhea after being sexually abused by the father, the children were removed from the home.

In another case, a five-week-old child had been placed in foster care in March 1989 because of injuries she received from a violent shaking. The Department confirmed that child abuse had occurred but had not named a perpetrator. After this child was placed in foster care, the parents moved to a neighboring county. In December 1989, a Department foster care social worker in the county with custody of the child asked a foster care worker in the county where the parents lived to conduct a home study to determine whether the child in foster care could be returned to her parents. At the time, foster care staff in both counties were aware that the couple was expecting a second child early in 1990. Both parents also were supposed to be participating in evaluation and counseling sessions.

At a January 1990 legal hearing, Department staff noted that one of the parents' therapists indicated that neither parent was ready to have a child. Also in January 1990, the foster care worker from the parents' county of residence conducted the requested home study. The results of that study were sent to the foster child's county around February 20, 1990. The study concluded that the child in foster care should not be returned to the parents' home.

The parents' second child was born on January 31, 1990. On February 23, the county with custody of the older child asked Department staff in the parents' county to supervise the family for the new baby's safety and well-being. At that time, foster care staff in the parents' county determined that the case should be transferred to the unit responsible for investigating abuse or neglect reports and providing preventive family services. The case was transferred on March 5, 1990. However, the parents' second child died on March 2 as the result of a confirmed case of abuse; the father was named as a perpetrator.

Some investigations were not completed in a timely manner or were poorly documented. In nine cases we reviewed, the case logs indicated that the investigation were not completed in a very timely manner. For example, a mother reported that a step-grandfather had sexual intercourse with his 12-year-old step-granddaughter and had fondled his 10-year-old step-granddaughter. The same day the report was received, the investigating social worker interviewed the mother and both children.

The Exploited and Missing Children's Unit in Wichita

The Department's Wichita Area Office investigates reports of suspected sexual abuse of children differently than other reports of child abuse and neglect. While investigations of reports of non-sexual abuse or neglect may be the sole responsibility of Department social workers, sexual abuse reports are all investigated by Wichita's Exploited and Missing Children Unit. This Unit has several investigative teams consisting of a law enforcement officer and a social worker, that investigate all reports of sexual abuse and exploitation of children and all reports of missing children.

If the investigation produces sufficient evidence to indicate that prosecution of the perpetrator of the sexual abuse or exploitation of a child may be warranted, the Unit will send that information to the district attorney's office to begin criminal proceedings. If the evidence indicates that the child has been exploited or abused by a family member or that a parent has failed to adequately protect the child from abuse, the social worker will confirm abuse. The Unit will then send the evidence to the district attorney's office to request a Child In Need of Care petition.

The case logs, which are used to record all investigative actions, do not reflect any further investigative work until more than two months later, when the social worker interviewed the mother again. According to the investigating social worker, additional work was done on the case during that two-month period but was not recorded in the logs because he did not have time. From the available records, we could not determine whether additional work was done during the two-month gap.

In another investigation we examined, the initial report was made in July 1989. In the report, a mother stated that her husband told her he had been sexually molesting their children, a two-year-old boy and a two-month-old girl. The mother reported that she and the children had not been living with the father since he told the mother about the molestation. A Department social worker contacted the mother within four days and interviewed the mother and the two-year-old son on August 9, 1989. Department personnel,

however, did not do any additional work on the case until they interviewed the father on November 30, 1989. The supervisor said the reason for the delay was other more pressing cases needed investigation. Further, as of September 14, 1990, more than a year after the report was received, the case still had not been closed. Although Department records indicate the case may be confirmed with a perpetrator named, the perpetrator's identity has not been entered on the Central Registry, and the alleged perpetrator and family have not been formally notified of the outcome of the investigation.

Some Reports Alleging Suspected Child Abuse or Neglect Were Not Investigated At All

The Kansas Manual of Youth Services provides for Department personnel to screen out certain reports they receive. These reports are called "information and referral" reports and are defined as inquiries received that only result in providing information to the reporter or referring the reporter for assistance elsewhere. If a caller alleges, for example, that his ex-wife will not let him exercise his court-ordered visitation rights, the social worker taking the report might inform him that that is a matter for his attorney, not the Department. Depending on each county's procedures, the call might be recorded in some way, but it would not be investigated.

Information and referral reports generally should be matters that do not constitute suspected abuse or neglect, are too vague to be investigated, or are in some other way inappropriate for investigation.

During our visits to the eight county offices, we looked at a random sample of 90 reports received during fiscal year 1990 and classified as information and referral reports. Of those 90 reports, 12 (or 13.3 percent) included information that appeared to warrant further investigation or were at least questionable based on the available documentation. In Shawnee County alone, five of the 20 information and referral reports we reviewed appeared to represent potential abuse or neglect. The 12 cases included these examples:

- Two reports by neighbors alleged that they had heard sounds like bodies hitting the walls and floors in a neighboring apartment, and children could be heard pleading not to be hurt. In addition, the apartment manager expressed concerns about pit bull dogs living in the apartment. One reporter indicated that one of the children had bruises on his face a week earlier. Department staff told us they did not investigate the situation because the police had visited the apartment twice the day of the disturbance and had not removed the children or called the Department, and because the apartment manager had been concerned mostly about the presence of the dogs, not about the children's welfare. Department staff further indicated that such reports are not investigated because of a lack of resources.
- A caller reported that the neighbor children were being verbally abused. The caller alleged that the children's mother's boyfriend screamed at the children, belittled them, and shouted obscenities at them. The caller suspected physical abuse, but had never seen it, although according to the Department's intake form the children "do a lot of whimpering at night." The supervisor's log listed this report as "insufficient information" to investigate, although the report form gave the family's address. When questioned, the supervisor said he did not remember the case, but may have been remiss not to have had it investigated.
- A teacher phoned a local Department office to report a six-year-old girl who was exhibiting behaviors that often are signs of sexual abuse, including sexual precociousness and sexual play-acting with her classmates, and drawing pictures with violent themes. The intake supervisor labeled the report "frivolous...lacking in substance—not abuse or neglect." He subsequently explained that such reports are not investigated for two reasons. First, although the described behavior could have been caused by sexual abuse, it was more likely to have been caused by watching music videos or X-rated movies. Second, he said few cases of sexual abuse are ever discovered by investigating allegations of "acting-out" behavior, so the Department must put its resources into cases with a greater likelihood of proving abuse. He said he would have had the case investigated if the child had been bruised, or had shown signs of unexplained bleeding.

Although these reports were called "information and referral" reports by local Department staff, they do not appear to comply with the Department's definition of such reports. In these cases, it is possible that children were left in potentially harmful situations without State intervention even though someone reported the situation to the Department.

Some Department Procedures Could Be Improved, As Could the Department Staff's Adherence To Them

As part of our review of the Department's child abuse and neglect investigations, we examined the Department's Statewide guidelines in the Kansas Manual of Youth Services and the actual procedures established by the eight county offices we visited. While we concluded that the established procedures generally appeared to be adequate, we noted various areas in which procedures and compliance could be improved. Those areas are summarized in the following sections.

Department staff do not have access to complete historical information about children and families who are the subject of abuse or neglect reports. In determining how and when to investigate reports, Department staff search their local county files to see whether the county office has had previous contacts with the family. However, staff in the county offices do not have access to Statewide information about the families other than checking with the Central Registry. Thus, as noted in previous examples, if a family moves between counties in Kansas, Department staff in the new county will probably be unaware of any past investigations.

Information about a family's previous involvement with Department staff can impact how abuse or neglect investigations are handled. In one of our sample cases, a hospital social worker reported in July 1989 that a mother was possibly abusing or neglecting her 11-year-old son and 12-year-old daughter. The mother had recently admitted both children to the hospital—the son was physically violent and the daughter displayed signs of sexual abuse. The reporter indicated that the family had possibly been investigated by Department personnel in a neighboring county. Department staff subsequently contacted the neighboring county and determined that seven months earlier the neighboring county had confirmed that the mother abused the children. Consequently, while the children were still hospitalized Department staff in the second county recommended that the children be placed in Department custody.

Counties we visited handled the naming of perpetrators in abuse or neglect investigation inconsistently. According to the Department's Kansas Manual of Youth Services, one purpose of the child abuse or neglect investigation is to identify those persons who are more likely than not the perpetrator(s) of the child's mistreatment. We found, however, that counties' practices in naming a perpetrator varied, as the following examples show.

In one county in which a baby died from head injuries, the staff confirmed that the father had been the perpetrator because he was the caretaker of the child the day

she was injured and the injuries could not have been caused the way the father had reported. (The father was eventually sentenced in criminal court.)

In other cases, however, Department staff do not name perpetrators even when the perpetrator's identity is not in doubt. In one county, Department staff did not name a perpetrator in a case in which a child had been beaten several times by her mother's boyfriend, even though the boyfriend admitted to striking the child with a belt. In this case, the boyfriend apparently agreed to learn new methods of discipline and stopped beating the child. Department staff say that, by not naming a perpetrator, they are sometimes better able to work with people and change their behaviors.

In another county, a mother had allowed her two young daughters, ages eight and five, to go to a college football game alone. While at the game, the younger child fell and cut her head, resulting in the neglect allegations. The Department confirmed neglect on the younger child, but did not name a perpetrator, even though the case file clearly showed the mother, who was studying to be a nurse, was the neglectful party.

When questioned about why no perpetrator had been named, local Department staff told us that they had been instructed by the area office director to only identify a perpetrator under two circumstances: first, when identification of the perpetrator is necessary to protect the abused child or other children (if, for example, the perpetrator is likely to seek employment in a child-care facility). Second, staff could name a perpetrator who had been identified as such in a court of law: if a person had been found by a court to be the perpetrator, the available evidence should be enough for the Department to win an administrative appeal hearing, in the event the proposed finding was contested. Local staff said that the reason for this practice was to avoid the investment of staff time required by the Department's due process procedures.

Department staff obviously must make decisions given the information available to them and based on their best judgment at the time. However, practices in this area should be consistent across the State and should comply with Department requirements.

The Appeals Process for Confirmed Perpetrators

After investigating a child abuse or neglect report, Department of Social and Rehabilitation Services' staff in county offices, in consultation with supervisors, decide whether or not to name a perpetrator. Under the Department's standard, if a reasonable person would conclude that more likely than not abuse or neglect occurred, and that a particular person was responsible, the report is confirmed with that particular person named as a perpetrator.

Confirmed perpetrators are then notified in writing and have five calendar days to appeal the finding at the local level. The Department's area office director, or another employee who was not involved in making the initial determination, reviews any information provided by the alleged perpetrator and determines whether the finding should be changed. The county office then issues its final decision which the perpetrator may appeal to the Department's Fair Hearings Section in Topeka.

A hearing officer from the Department's Central Office then reviews the case and decides whether to uphold or change the county office's finding. Perpetrators who are still not satisfied may request the State appeals committee to review the decision and can subsequently appeal through the courts.

Risk assessments also are not handled uniformly across the State. The Department has developed a standard risk assessment form that acts as a guide for staff to determine how quickly they should respond to abuse or neglect reports. Because the Department does not require counties to use the form, some counties may not use it and others do not document their use of it. Consequently, it is sometimes impossible to determine the level of risk assigned to a case by Department staff. If the supervisor or worker does not document the basis upon which response times are decided, then Department management has no way to review those decisions. If response time decisions are not documented, it is impossible to determine if they were made correctly or were appropriate given the information available at the time.

Case findings are not always made in a timely manner and the written guidelines in this area are confusing. In one section of the Kansas Manual of Youth Services, the Department's written procedures require investigating social workers and supervisors to make a decision concerning the results of an investigation within 30 days of receiving the report. In another section, the written procedures indicate that workers may have up to 30 days to respond to abuse or neglect reports that appear to represent minimal risk to the children involved. Yet another section indicates that investigations shall be completed within 60 days after receiving the initial report. From these guidelines, it is not clear how quickly cases should be resolved. In reviewing actual investigations, we found that investigation decisions for 45 of the 110 random cases reviewed were not made and recorded within 30 days and 24 decisions were not made within 60 days. When case decisions are not made in a timely manner, the parties involved, such as parents and perpetrators, do not receive timely feedback and children may not be adequately protected.

Although Department procedures generally call for supervisory reviews of investigations and decisions, those reviews often do not occur or are not adequately documented in the case files. Without supervisory reviews, the supervisor has no assurance that social workers are following correct procedures. If those reviews are not documented properly, the Department has no assurance that the supervisor is exercising proper oversight of the investigations and decisionmaking that protect children from abuse or neglect. In our review, we found that supervisors were not always documenting their work. For example, in Finney County, none of the cases had any indication that the supervisor had approved the case to be closed. Supervisors are also supposed to be involved in making the initial risk assessment for a case; we often found that the risk assessment, if it was in the file at all, did not bear any evidence of who had prepared it. The absence of documentation indicating supervisory involvement may be simply a paperwork problem, or it may indicate that supervision is not taking place, which could result in inadequate investigations or case findings.

Department staff who are responsible for ensuring compliance with procedures have not been effective in the past because they have no way of enforcing their recommendations. The Program Assurance Unit was established within the Youth Service Division in 1987 in part to assist the Department's Central Office in

assessing area offices' compliance with laws, regulations, and policies. The Unit completed two rounds of compliance reviews between its inception and Fall 1989, and was working on a third compliance review during this audit. In all, the Unit staff looked at the area offices' compliance with a wide range of requirements for child abuse and neglect investigations, such as response time and fulfilling due process mandates.

We analyzed the Unit's findings for the area offices in which our sample counties were located and found that the areas' compliance actually declined between the first and second reviews. For abuse or neglect investigations and family services combined, county compliance with established procedures improved for 54 of the items assessed by the Unit, but went down for 78 items.

Program Assurance Unit officials told us that the reason for the seeming ineffectiveness of the review process is that the Youth Services Division had no direct authority over the area offices, and thus has no way to compel the area offices to improve their compliance rate. Two recent developments may improve these efforts. First, after the second round of compliance checks, each area office submitted a corrective action plan, detailing how each office planned to address the deficiencies noted in the reviews. Second, the Unit recently became part of the Department's Policy, Planning, and Management Analysis Unit which reports directly to the Department Secretary's Office rather than to the Commissioner of Youth Services.

Results From Survey Questions About Falsified Information

Because of newspaper reports that Department employees had falsified information to make it look as if Department policies and procedures had been adhered to, we surveyed current and former social workers about this issue.

None of the 33 former social workers responding to our survey said they had ever been asked by a supervisor or Department employee to back-date a child protective services' report, fabricate log entries, or otherwise provide false information, and none said they had ever done so.

Only five of the 167 current social workers who responded to our surveys said they had been asked to falsify information. One said that an "Area management person [had] instructed all personnel to 'make time-lines work' so we would not get penalized in [an] audit and end up losing staff." Another said that "policies and procedures were not always done timely because of the amount of reports received," but that reports [had] "never been messed with." A third social worker responded, "We get the job done—more so because of a moral or humanistic obligation than because of state mandates. Often you juggle to take care of clients and agency demands."

Seven of the 167 current social worker respondents said they actually had falsified information, although one respondent said he or she had done so simply to avoid confusing the client. Several said they had altered dates to comply with time-lines but that they had never done anything to jeopardize a child's well-being. One social worker said, "I have documented that parents have the right not to cooperate with [the Department] investigations when in fact the parents were not advised of this." Another said that after altering timeframes one time, "I concluded that I would not trust my supervisor and refused to back date." But another social worker said, "In general all my supervisors have been very good and I am not about to let them take any heat because I couldn't do everything the state demands."

These results indicate that falsifying information does not appear to be a big problem within the Department, although it does occur on occasion. Several of the comments suggest that employees were asked to falsify information or did so because they were unable to meet all the demands placed on them.

Department staff are not required to notify reporters of the Department's actions in an abuse or neglect investigation, even if the reporter requests such information. K.S.A. 38-1522 requires professionals such as doctors, dentists, teachers, child care workers, and law enforcement officers to report any suspected child abuse or neglect to the Department, or to an appropriate law enforcement agency if

the Department is not open for business. During the audit, we surveyed 1,702 of these mandated reporters in the eight counties we audited. About half the respondents who answered the question (52.4 percent) said the local Department office to which they reported their concerns did not provide any followup notification.

One respondent said, "It is hard to see any positive outcomes of any reports that we have made. Repeated requests for feedback have been ignored. It has created a barrier (hostility, anger, etc.) between the school and the parents. I would hope this could be corrected." Another respondent said, "Reporting seems so futile—never get any feedback—even a verification of contact would be reassuring." Other results from this survey of mandated reporters can be found in Appendix E. When mandated reporters request, but never receive, feedback from Department personnel, they may conclude that the Department took no action to address their concerns.

Department Employees Indicated They Do Not Always Have Adequate Resources To Do Their Jobs, Which Could Have Contributed to Problems Noted During the Audit

We surveyed all the Department social workers employed in the eight sampled counties as of July 1989, plus a random sample of 100 social workers employed in other counties across the State. In addition, we surveyed 84 former social workers who had discontinued their employment during the last year. The survey asked Department employees a series of questions about the adequacy of their physical, financial, and staff resources, as well as questions about their caseloads, in the areas of child abuse and neglect investigations and family services. This section only reports those responses related to child abuse and neglect investigations. Survey information related to family services will be discussed later in this report. Survey responses from the Department's current social workers included the following:

- More than half the social workers responding (55 percent) said their child abuse or neglect investigation caseloads were too high or much too high.
- More than three-fourths (78.3 percent) the respondents said that staff resources (social workers, drivers, clerical personnel) were somewhat inadequate or very inadequate. Only 20.3 percent of the respondents said that staff resources were adequate. Almost half the specific suggestions made expressed a need for more social workers. Other suggestions were made for drivers so that social workers did not need to spend so much time driving clients to counseling and other appointments, or for clerical staff to relieve some of the social workers' paperwork.
- Almost half (49 percent) of the respondents said their physical resources were somewhat inadequate or very inadequate to allow them to do their jobs. Of the 78 suggestions made, the physical resources most often mentioned were State cars (26 percent), better or more private office space (27 percent) and access to computer equipment (22 percent).

More Critical Comments From Survey Respondents

No feedback for reporters:

"A social worker came and interviewed child in question. We never heard back as to follow-up on case. I know there is a procedure to follow, but this was handled very unprofessionally." (day care administrator)

"I find it very difficult that there is no feedback to the reporting person. ...whenever I ask for feedback it is always 'confidential information'. It is my job then to continue working with these families with no hint of what has happened with my referrals." (school personnel)

Weaknesses in the system:

"I see a much larger problem in the court system and laws of this State. It is becoming extremely difficult to assist children when you must fight your way through laws that make no sense, that protect parents and not children, and that mandate that nothing much happens until the child is damaged beyond repair." (school personnel)

"Our children deserve equal treatment under the law but are being abused and neglected by the system that is supposed to protect them." (school personnel)

"Because of the terrible reputation of the Department of Social Services in their brutal and unreasonable handling of child abuse cases, I would never report a suspected case to them, and would do so reluctantly in even obviously severe cases." (physician)

"Most of the problems [the Department faces are] a result of how the public perceives what we do. We are not in a position to defend ourselves when newspapers print stories that are not factual. We are not in a position to let people know what is going on, i.e. a school, so we are at times accused of not doing anything. I think we do a good job considering what we face on a daily basis." (social worker)

Inadequate Department training:

"I do not believe SRS workers have any training or any departmental encouragement as to how to effectively work with schools." (school personnel)

"The skills required to appropriately evaluate suspected child abuse are not provided by

bachelor's degree training. Master's degree training in social work provides the basic necessary interventional and counseling skills. SRS should only have MSW-level (or greater), workers for these positions and then provide them with ongoing specific training in child abuse." (physician)

Department administration:

"The primary problem I see is that we are so busy being accountable that there is no time left to provide services. When I came to work for SRS 17 years ago we spent about 75 percent of our time in the field and 25 percent documenting the services provided. Now this seems to be nearly reversed and the load of the paperwork is overwhelming." (social worker)

"SRS cannot expect to keep social workers or to employ quality social workers if they do not support them. Caseloads are historically high, but they offer no training, very little supervisory support, and the entire system is in chaos." (social worker)

"Too many chiefs and not enough Indians. Many supervisors sit around doing nothing or playing cards. If they have time on their hands they should carry a social worker caseload." (social worker)

Inefficient practices:

"Twenty to 30 percent of my job could be done better by support staff. That means for every five workers we're wasting one professional position that could be used if adequate staff were available." (social worker)

"Slowing us down is an early 20th century system of manually checking records, sharing information, etc., in a 21st century world. There are too many people and too much information to keep track of. GIVE US COMPUTERS!" (social worker)

"Social workers often were involved in tasks that could have been completed by other staff had they been available--such as a driver or program technician--to allow the social workers to spend more of their time completing professional rather than paperwork or transportation tasks." (former social worker)

—More than half the social workers (54 percent) said that the training they had received from the Department was somewhat inadequate or very inadequate, or that they had received no training. Of those who said their training was inadequate, the most frequent suggestions were for training in social work

professional practice (33 percent), training for new workers (13 percent), and training in Department procedures (11 percent). About 10 percent said they wanted training in legal issues, and 33 percent mentioned other training needs.

Other comments made by Department social workers are summarized in Appendix F. Responses and comments we received from the former social workers generally were consistent with those of the present staff; those comments are summarized in Appendix G. Although verification of these responses was outside the scope and timeframe allowed by this report, it appears that some of the problems noted during the audit could be aggravated by limited staff and other resources.

Summary

Although many of the investigations of suspected child abuse or neglect reviewed in this audit were adequate and timely, about one-fifth of the investigations were not. In addition, it appears that the Department of Social and Rehabilitation Services does not investigate some reports of suspected child abuse or neglect at all. In these situations, the Department is not taking appropriate actions to protect Kansas children from possible harm.

Have the Department's Prevention Services Been Effective in Reducing the Incidence of Child Abuse and Neglect In At-Risk Families?

The Kansas Code for the Care of Children (K.S.A. 38-1501 et. seq.) indicates that it is the State's policy to provide "preventive and rehabilitative services when appropriate to abused or neglected children and their families so that, if possible, the families can remain together without further threat to the children." During the last decade, the Department of Social and Rehabilitation Services' primary stated emphasis has been on family services and preventive services. Preventive services are aimed at maintaining children's own family units as safe environments and reducing the need for out-of-home, or foster care, placements.

We found that many families that were at risk of abusing or neglecting their children did not receive preventive family services from the Department. We also found that family services were not always successful in preventing out-of-home placements or in reducing the risk of subsequent abuse or neglect, although there were some success stories. A significant number of family service cases appeared to be unsuccessful because the participating families were uncooperative. Finally, we found that some procedures for providing preventive family services could be improved.

The Department Has Emphasized Preventive Family Services in Recent Years as a Way to Maintain a Child's Family Unit and Prevent the Need for Out-of-Home Placement

The Department's Family Services program is designed to keep families together and reduce the number of children placed in the Department's legal and physical custody. It includes four primary components:

Case management services: In this component, the social worker's primary responsibilities include planning the case, preparing reports, coordinating agency and community services, coordinating reviews and staffings, and referring families to community resources. Case management services involve only limited direct client contact.

Purchase of services: Under this program component, the Department purchases services from community agencies or private sources when such services cannot be obtained for a family at no cost or provided by Department staff. Purchased services include such things as counseling and treatment, protective daycare, and parenting classes. Transportation, utilities, and domestic cleaning supplies are also examples of items that could be purchased for families.

Family support worker services: In this component, paraprofessionals, in tandem with social workers, provide concrete services to families, such as

teaching, modeling appropriate behaviors, and demonstrating basic home-making and parenting skills, positive discipline techniques, and positive interaction and communication skills. Family support worker services have been offered Statewide since fiscal year 1983.

Family preservation services: This fourth component provides families with intensive in-home services that are time-limited and crisis-oriented. Family preservation social workers assess the family dynamics to identify strengths that may be developed in the family unit so parents can remain in control. Cases last an average of three to four months, and family preservation staff generally work with no more than 10 families at one time, and often fewer than that. This component began in 1987 through a three-year training program funded by the federal government. In 1990, the Legislature appropriated funds for family preservation services for 14 Kansas counties.

The Department does not maintain comprehensive data for the funds allocated only to preventive family services. For fiscal year 1990, the Department budgeted approximately \$2.7 million for family services, but that figure includes funds to pay for both preventive and reintegration family services. (Reintegration services are provided to families after a child has been placed in foster care. They are provided to try to address the problems that led to the out-of-home placement so that the child can be reunited with his or her family.) The figure would also include only salaries for social workers in the special family preservation units and family support workers. Salaries for social workers outside the family preservation units, such as those that provide case management services, would not be included in the figure.

The Department's general steps in providing family services are the following:

- A social worker investigating a child abuse or neglect report determines that a family is eligible for services because of a confirmed report or a report that indicates the children are at-risk of being abused or neglected.
- A family assessment is conducted to determine the family's history, needs, problems, and the like.
- After the family agrees to services (acceptance of services is voluntary), a social service plan is drawn up that sets out the family's tasks and responsibilities, identifies the Department's and social worker's responsibilities, states the consequences of not fulfilling the agreement, and establishes the duration of the plan.
- The plan is signed by the family and appropriate Department staff and serves as documentation of the family's agreement to services and of the Department's reasonable efforts to keep the family together.

Many Families That Were At Risk of Abusing or Neglecting Their Children Did Not Receive Preventive Family Services

One of the Department's stated objectives for family services is to provide preventive family services to 85 percent of the families that have confirmed abuse or ne-

Family Preservation Services

The Kansas Family Preservation Project was initiated in 1987 to safely maintain children in their own homes whenever possible. It is a Department project of home-based family services, and is targeted to families with children at immediate risk of out-of-home placement. The program was established to shift funds traditionally spent on foster care to family preservation services. A team comprising a social worker and a family support worker is used with most families, and provides counseling, skill building, and concrete services in combinations that fit the needs of each individual family.

Staff in all Department management areas have received intensive training in family systems and crisis intervention skills. In fiscal year 1990, funding was provided for family preservation services in 14 Kansas counties.

Family preservation services are generally limited to 90 days, although some extensions are allowed. Social workers are assigned a maximum of ten families which enable them to be available as needed to have personal contact with the family from five to twenty hours a week. To target families that will benefit most from family preservation services the Department has developed guidelines for determining which families are eligible for the program. Generally, the Department does not offer family preservation services to the following types of families:

- where parents have chronic psychosis which has not responded to medication or mental health services in the past
- with parents who are mentally retarded to the extent that they cannot fully care for themselves or the children
- where there is a continued pattern of a high level of physical violence
- where a parent is a chronic substance abuser who has failed several attempts at treatment or refuses treatment
- where parents have previously killed a child or have been criminally convicted of aggravated child abuse

The types of services provided by the family preservation units vary, depending on the needs of the families involved. For example, in one case examined during the audit, law enforcement officials had taken two children into temporary custody (ages 2 and 5 years) because the family's home was not safe for the children. The children were returned to their home, with Family Preservation staff working with the parents to improve personal hygiene, housekeeping skills, parenting skills, nutrition, and household safety. During the case, a family support worker met with the family three or four times a week to work on these areas.

glect reports and that are in imminent risk of having their children removed from the home as a result.

In reviewing our sample of abuse or neglect investigations, the case documentation generally did not indicate whether children were about to be removed from their homes. Consequently, we could not verify whether the Department was meeting this objective for family services. As an alternative, we identified 66 families from our random sample of 110 abuse or neglect investigations that appeared to be at risk of abusing or neglecting their children. In all, 19 of those families had confirmed findings of child abuse or neglect, and 47 had unconfirmed-eligible for service findings. We examined the family services provided or offered to these families and found that a relatively small portion of those at-risk families actually received preventive family services.

Of 19 families with confirmed findings of child abuse or neglect, only 11 families (58 percent) received services from the Department or another source. The Department provided family services for five of these 11 families, while six

families received services from another source, such as counseling from a mental health center. Of the remaining eight families that had confirmed findings of child abuse or neglect, three were offered services but refused, and five were not offered any services. Reasons families were not offered services included the children had been removed from the unsafe environment, the family moved out of the county, or the alleged perpetrator was not identified.

Of 47 families with a finding of unconfirmed but eligible for service, only seven families actually received family services. A finding of unconfirmed-eligible for service means the social worker concluded that abuse or neglect had not occurred in the specific instance investigated, but was likely to occur in the future without intervention.

From our sample of abuse or neglect investigations, it appears that the Department offered family services to only 18 families (38 percent) with findings of unconfirmed-eligible for service; only seven of those 18 families actually agreed to take services. These seven families represent about 15 percent of the 47 families that were eligible for service. One reason for this low rate of acceptance is that preventive family services are generally voluntary (although a court may order such services). Thus, even if the Department offers services to a family, the family can choose to decline them.

Another 18 of these 47 families with children at risk were told about community resources (such as counseling that they might be able to get at a local community mental health center), took corrective action that eliminated the problem, or were already in counseling at the time of the investigation and finding. In nine of these 18 cases, Department staff did not monitor the families or follow-up to ensure that they participated and completed any recommended counseling or therapy. In three cases, Department staff ensured that the corrective action had been taken by the family to eliminate the problem. In the other six cases, Department staff verified that the family was actually in counseling or getting some other service, but did no further follow-up or monitoring to ensure that the family continued its participation. Finally, Department records show no services being offered, arranged for, or mentioned to the 11 remaining families with at-risk children (23.4 percent).

Family Preventive Services Did Not Always Prevent Out-of-Home Placements, But There Were Some Success Stories

From our sample of 110 child abuse or neglect investigations, we were able to identify a total of only 10 cases in which preventive family services were offered and documented in Department records. Because this sample was too small to draw any conclusions about the effectiveness of the program, we supplemented those cases with 35 additional cases opened between July 1 and September 30, 1989. Altogether, we reviewed a total of 45 preventive family service cases involving 73 children in the eight counties we visited during the audit. (Shawnee and Sedgwick Counties have

family preservation units, so our sampled cases were selected from those units. The other six counties did not have family preservation units, so our sampled cases from these counties were family services cases that are generally less intensive than those offered through family preservation units.)

The sample included only those cases that involved preventive family services aimed at preventing out-of-home placements for the children involved. We did not consider whether family services were effective for reintegrating families whose children had been removed from their homes and placed in foster care.

Of the 45 cases we reviewed, we concluded that 25 were unsuccessful, 16 were successful, and four were either ongoing or we could not make a determination based on the Department's records.

In all, 25 of 45 preventive family service cases (55.6 percent of the sample) were unsuccessful, either because children were later removed from the home or because the families did not complete the services offered. Seven families subsequently had their children removed from their homes. A total of 13 children were involved. Five of these seven families also had a subsequent report of child abuse or neglect or child in need of care filed against them after they received family services, although these generally were not confirmed.

In 18 cases, services were terminated early by the family, the parents were uncooperative in meeting their responsibilities as outlined by the social service plan, or the family moved before completing the services. In one case, for example, a finding of unconfirmed neglect-eligible for service was made against a father. Family services were offered and the father completed an application for service. Department staff determined that the father needed to improve his disciplining skills, needed to obtain adequate food and housing, and needed someone to talk to about family problems. The Department paid one month's rent and a security deposit for the family. The father never followed up after completing the application, and no additional services were provided to the family. As this example shows, the lack of success is not always within the Department's control.

A total of 16 cases, or 35.6 percent, could be classified as successful, including four cases in which the families regained full custody of their children. These four families had children who were in the Department's legal custody or were under informal court supervision, even though their children remained at home. All four families successfully completed the family services offered, and subsequently regained legal custody of their children.

One of these four cases appeared to be very successful. In this case, the Department had received legal custody of an infant because of allegations that the child was emotionally abused by the parents' fighting. A family support worker provided support and encouragement to the parents, helped develop parenting and stress management skills, and assisted with meal planning and preparation. During the first two months of the social service plan, the parents regained full custody of their child but

Department Staff We Surveyed Were Generally Supportive of the Family Support Program

The family support workers and social workers we surveyed made a number of comments about the family support and family preservation programs. Following is a sample:

Positive Comments:

"The State of Kansas SRS has a better than usual system for providing services to families." (family support worker)

"We do all that is possible to work, teaching skills, setting guidelines, and etc. for families, trying to prevent the Department from taking the children into custody." (family support worker)

"...many of our most successful interventions were with the use of family support workers - they did the real nitty gritty front-line services and became important models, 'grandmothers,' and teachers to families." (social worker)

"Our Family Support program is quite successful. Families continually express their gratitude and satisfaction with this service. Repeat occurrences of abuse/neglect are minimal. Families remain intact!!" (social worker)

Negative Comments:

"We're not receiving much training at the present. We're told that there's no money for training." (family support worker)

"I finally received training for becoming a family support worker after I had been doing it for six months." (family support worker)

"There is not enough money to assist our clients with a lot of necessary items such as toilet paper, toothbrushes, toothpaste, school supplies." (family support worker)

"It is sad a State worker (family support work) is eligible for ADC and food stamps when we try to show them (client families) an honest job and self-support is the best way to go in life." (family support worker)

"...family preservation services is the only positive direction the Department is moving in. However, the implementation of that program—because of protected number in caseload—has hopelessly overloaded the workers in other units." (social worker)

continued services. At the end of six months, the social service plan was extended and two months later, the services were terminated at the mother's request. Department records noted that the family had made real progress.

In the remaining 12 cases, the social service plan goals were fulfilled or progress was being made towards fulfilling them, and no subsequent child abuse or neglect reports had been filed against the families. One of these cases appeared to be very successful as well. In that case, an infant was not being fed properly. After a few months of a social worker and family support worker teaching the parents how to take care of their child, the child was healthy and well-nourished.

The Department Does Not Have the Basic Information It Needs to Manage the Family Services Program Or Determine How Well It Works

During the last decade, the Department of Social and Rehabilitation Services' primary stated emphasis has been on family services and preventive services. Preventive services are aimed at maintaining children's own family units as safe environments and reducing the need for out-of-home, or foster care, placements.

We found that the Department does not do an adequate job of evaluating and monitoring the family services program. The only information routinely maintained by the Central Office about the family services program is information collected on a computer form, which is completed when family services cases are opened and closed. The Department has not used this data to date to analyze the program and determine how well it is working, perhaps in part because, until recently, the Depart-

ment has only been able to analyze the data manually. Within the last few months, the Department has computerized the information about the family services program. This improved capability should increase the management information available to staff about the family services program.

Despite the Department's improved analytical capability, the information that is collected about the program is relatively limited. Most of the information collected could be termed work load measures (such as number of families, broad categories of services, and the like). Only a very few measures related to effectiveness (primarily, the reason services were terminated) are collected. Other basic types of information the Department would need to manage the program, set priorities, and have a basis for allocating dollars to areas where they would do the most good include such things as the numbers of families contacted who need services, the number of families accepting or rejecting an offer of services, the specific services provided and the way the services were delivered, the numbers of subsequent abuse or neglect reports, and the length of time that children remained out of Department custody.

Several Procedures for Documenting Family Service Needs and Decisions Should Be Improved

In addition to examining the effectiveness of the family services program in meeting its goals, we also examined the Department guidelines for delivering family services as well as the actual practices followed at the eight county offices. In general, we found that various Department procedures could be improved at both the State and the local levels.

Current procedures are inadequate for recording referrals to family services and for recording the results of the screening process. During this audit, we had great difficulty selecting our sample of family services cases. Neither the Department's Central Office nor our sample counties had systematic procedures for recording which families were referred for preventive family services or whether services were actually provided. Further, statistics generally were not kept on the numbers of families who are offered services but decline them. The absence of systematic procedures and records in these areas limits the Department's ability to gather management information about the program. It also limits the local Department office's ability to offer services to a family at a later date, because the office may not know which families were referred for services but did not receive them. Improved procedures in this area would improve the information available to the Department and help it to more effectively manage the family services program.

Department procedures do not require that a family assessment be conducted and documented. Although most files we reviewed contained something that could be considered a family assessment summary, the form of the assessments and the information contained in them varied tremendously. This lack of consistency makes it difficult to ensure that all the important elements have been considered in

designing a family's social service plan, and makes it difficult to document which elements were considered in making a decision.

The Department does not impose any specific documentation requirements for supervisory reviews. Supervisory reviews help ensure that cases were handled appropriately. All the sample counties had some requirements for supervisory reviews, but their documentation requirements varied. Most required supervisory reviews at the close of a case, but not all required some type of supervisory sign-off to document that this review took place. Our review also showed that some counties did not consistently follow their own procedures. For instance, 8 of 11 closed cases in Sedgwick County had supervisory sign-offs in the logs, while three did not. In Shawnee County, four cases had indications in the logs that a supervisor had staffed the case, but none of the cases had supervisory sign-offs at case closure.

We also found some compliance problems at the county offices. For instance, all counties are required to complete a data collection document for family services showing things like the name of the family being served, the numbers of children in the family, the purpose of the services, and the general type of services for each case. However, this data collection document was not consistently in the files in six of the eight counties we visited.

Three counties (Johnson, Sedgwick, and Shawnee) did not complete family service plans for all their cases, as required. In fact, Johnson County did not require that a formal family service plan be completed for cases unless there was a court order. Cherokee County staff said they followed the same practice as Johnson County. This practice would appear to be in conflict with the Kansas Manual for Youth Services, which requires that a social service plan be prepared within 20 days of a verbal agreement with the family that wants services.

Department Staff Indicated They Do Not Always Have Adequate Resources To Do Preventive Family Services Work, Which Could Have Contributed To Some of the Problems Noted With This Program

In our surveys of current social workers, we also asked a number of questions about their experiences with the Department's family services program. In addition, we surveyed 100 family support workers throughout the State. (Family support workers, many of whom are part-time employees, are paraprofessionals who work with families under the supervision of the social workers.) The surveys asked the social workers and family support workers a series of questions about the adequacy of their physical, financial, and staff resources, as well as questions about their caseloads. In all, 66 family support workers responded to the survey. In addition, 57 of the current social workers said that they spent significant time in providing or supervising family services. Responses from these groups included the following:

- About two-thirds of the family support workers (69 percent) and more than one-half of the social workers who dealt with family services (57 percent) said their preventive family services caseloads were about right.

--More than 58 percent of the family support workers indicated their training was adequate to allow them to do their jobs. They suggested additional training in recognizing sexual abuse, techniques for dealing with families, and general family support worker training.

A total of 63.8 percent of the social workers who deal with family services said their family services training was adequate. Half of those who said their training was inadequate wanted more training in social work.

--Family support workers were split on the adequacy of their physical resources: 41.7 percent found them adequate, while 40 percent found them somewhat inadequate. A total of 30.6 percent of the respondents indicated a need for more State cars and 24.2 percent said they needed better office space and visitation rooms.

A slightly higher percentage of social workers thought their physical resources were adequate (43.5 percent); nearly 20 percent thought their physical resources were very inadequate. Again, better office space and more State cars were the most frequently mentioned improvements needed.

--Family support workers were also split on the adequacy of their financial resources. In all, 42.6 percent said they were adequate, while 52.4 percent found them to be somewhat or very inadequate. The specific resources they identified as being needed included funds to buy household goods for clients (32.7 percent), more daycare funds (10.2 percent), and more transportation funds (10.2 percent).

Social workers followed the same pattern with 39.6 percent finding their financial resources adequate and 56.2 percent finding them somewhat or very inadequate. They most often cited a need for funds to purchase client services or community resources (42.5 percent) and funds for client items and family support services (12.5 percent each).

--Nearly two-thirds of the family support workers (66.1 percent) said that staff resources were adequate or more than adequate. On the other hand, 70.2 percent of the social workers found staff resources to be somewhat or very inadequate. They said they needed more social workers (48.2 percent), more drivers (17.9 percent), more clerical staff (16.1 percent), and more family support workers (10.7 percent).

Other survey results are described in profiles in the report; a summary of the responses can be found in Appendices F through H. Although verification of these responses was outside the scope and timeframe allowed by this audit, it appears that some of the problems noted with the family services program (such as not offering services to all eligible families) could be exacerbated by limited staff and other resources.

Conclusion

The effectiveness of the family services program is mixed. Many eligible families are not provided with services, and few families either accepted the voluntary services when offered or completed them once started. We considered many of the family services cases we reviewed to be unsuccessful, but the reasons why often involved circumstances beyond the Department's control. However, the Department does not have the type of information it would need to adequately monitor and evaluate the effectiveness of the family services program.

Taken together, the results we noted here with the family services program and those we identified earlier with child abuse or neglect investigations—that one in five investigations reviewed during the audit were in some way inadequate and that not all reports of suspected child abuse or neglect were investigated—point out that the current programs may be failing a number of children.

In carrying out these programs, Department staff must exercise considerable judgment, and they may regularly face competing demands and crisis situations that require them to set priorities and make hard decisions. To do their jobs well, they need adequate training, clear and consistent direction, adequate information, sufficient time and resources to carry out their responsibilities, and proper supervision.

During this audit, we were not able to identify the specific causes of many of the problems we noted. However, we did find that Department employees working in the local offices did not always have access to critical information they needed to make decisions, that supervision was sometimes inadequate or undocumented, that policies and practices were sometimes inconsistent, and that the Department's own evaluations and oversight efforts were inadequate. Further, many employees we surveyed said their caseloads were too high, the training they received was inadequate or nonexistent, or the staff and physical resources available to carry out their jobs were insufficient.

Within the timeframe for this audit, we were unable to examine the issue of how efficiently the Department is using its existing staff resources to investigate child abuse or neglect reports or to provide preventive family services, but it does seem apparent that resources are insufficient to address all the needs that exist for these programs. In addition, all the factors mentioned here could be contributing to the Department's failure or inability, on some occasions, to take appropriate actions to protect Kansas children that have been abused or neglected from further harm.

The recommendations presented below are primarily for strengthening procedures, communication, and oversight of the child abuse and neglect reporting system and the family services program. While they should help address some of the problems and issues we have identified, the longer-term solutions will be much more far-reaching and difficult to achieve, because they will involve balancing the competing resource needs of these and other important programs and agencies in light of budget constraints. As a first step, the long-term solutions for these two programs will require a thorough review of the Department's existing resources in this area and an assessment of the resources that would be needed to effectively carry out both programs.

Recommendations

1. To ensure that Department of Social and Rehabilitation Services' personnel are conducting adequate and timely investigations into allegations of suspected child abuse or neglect, the Department should do the following:
 - a. *Ensure that Department staff are adequately trained to do their jobs.* Employees who have not received adequate training should not be put into positions where they will have to conduct investigations or make decisions about such reports without close supervision.
 - b. *Ensure that all child abuse and neglect investigations and decisions are adequately supervised, and that supervisory reviews are properly documented.* Areas that need proper supervision include risk assessments on abuse or neglect reports, confirmations, and the naming of perpetrators.
 - c. *Ensure that all procedures are being carried out uniformly, and review practices in such areas as the naming of perpetrators and risk assessments to ensure they are in line with Department policies.* If those policies are unclear or do not represent the Department's current position, they should be clarified or changed as needed.
 - d. *Ensure that the findings of the Department's internal program review staff about the local offices' compliance with policies and procedures are taken seriously, and that corrective actions are submitted and carried out as planned.*
 - e. *Clarify the requirement in the Kansas Manual of Youth Services dealing with deadlines for investigations to be completed.* The

Manual appears to give conflicting instructions on whether certain investigations are to be completed within 30 days or 60 days.

2. To ensure that children are protected from chronic abuse or neglect situations, the Department should review and revise its policies related to the “unconfirmed, eligible for service” finding. In this audit, we found cases in which this finding was made many times on the same family. In one case, a family had more than a dozen unconfirmed, eligible for service” findings before the children were finally removed from the home. Multiple “unconfirmed, eligible for service” findings imply that the family has repeatedly refused services or has failed to benefit from them. In either event, the children continue to be at risk, sometimes for years. The Department should reevaluate whether children should be allowed to remain in such situations indefinitely.
3. To ensure that children who are at risk of being abused or neglected are protected even though an abuse or neglect report is not received, the Department should review and revise its policies related to identifying and assisting such children in a timely manner. In this audit we found that a sibling of a child in the Department's custody died as a result of confirmed abuse under circumstances similar to those that led to the older sibling being placed in custody. In this case, Department personnel were aware of the family circumstance, but did not act promptly.
4. To ensure that the Department and its staff have the kinds of information needed to adequately manage the investigation and family services programs, determine how effective those programs have been in meeting their goals, decide how to best allocate resources, and make appropriate decisions regarding families and children, the Department should explore options for keeping track of and compiling the following information Statewide:
 - a. *Families against whom allegations of child abuse or neglect have been made.* A Statewide tracking system would give Department social workers access to historical information on such families that is currently not available to them. This information would allow social workers to readily determine whether a family or individual alleged to be abusive or neglectful had ever been confirmed as such, or had ever been found to be eligible for service, in any other Kansas county. Options could include on-line computer access to a central database, a list periodically updated and sent to each area or county office, or the like.
 - b. *Complete information about child abuse and neglect reports, from receipt of the initial allegation to the final resolution.* During our

review, we found that local offices had no standard system for logging incoming abuse or neglect reports, recording to whom they were assigned, or ensuring that deadlines were met. The systems in place varied in their adequacy and effectiveness. Having this information recorded and kept systematically would allow local supervisors to know when a case came in and the results of the screening, risk assessment, investigation, and so forth. Summaries of this information (for example, the number of reports received, the number screened out without investigation, the reasons why reports are not investigated--such as a report was frivolous or there was a lack of staff resources to investigate it--and the number of confirmations) would help the Department assess how well the program is working and help identify possible unwanted inconsistencies among local offices.

- c. *Complete information about families that are referred for services, including whether they accepted the services offered, what services were provided, whether they completed the services offered, whether their children subsequently were removed from the home or were returned to parents' legal custody, and the like.* Such management information can help the Department evaluate whether family services are effective at meeting the goals of keeping families together without further risk to the children.

In determining how best to collect and compile such information, the Department should consider the types of management reports it needs so that it can use the data collected to better manage the program and allocate resources.

5. To ensure that people who are most likely to observe abused and neglected children continue to report their observations, the Department should re-evaluate its policy for notifying people who report suspected instances of child abuse or neglect that their reports have been checked out. Although confidentiality requirements prohibit detailed feedback, people who make such reports are more likely to continue doing so if they know their allegations are taken seriously and are checked out, when appropriate. Such feedback, through a form letter or phone call, would not violate the family's right to privacy and could encourage mandated reporters to keep making reports.
6. To ensure that decisions about family services are consistent and supportable, and that proper supervision is provided in this area, the Department should do the following:

- a. Consider requiring Department employees to complete a standard family assessment form for all families being referred for family services.
- b. Direct its local offices to require consistent documentation of supervisory reviews of family services cases and case files.

APPENDIX A

Department of Social and Rehabilitation Services Summary of Child Abuse and Neglect Investigations, By Case Finding Fiscal Year 1990

Case Finding	Fiscal Year 1990		
	Total	Percent of Subtotal	Percent of Total
<i>Unfounded (a)</i>	12,657	100.0%	54.1%
<i>Unconfirmed, Eligible for Services (b)</i>			
Eligible for Services--Physical Abuse	2,185	26.6%	9.3%
Eligible for Services--Sexual Abuse	805	9.8%	3.4%
Eligible for Services--Emotional Abuse	541	6.6%	2.3%
Eligible for Services--Physical Neglect	2,878	35.0%	12.3%
Eligible for Services--Medical Neglect	246	3.0%	1.1%
Eligible for Services--Child in Need of Supervision	1,268	15.5%	5.4%
Not Confirmed--Corrective Action Recommended	284	3.5%	1.2%
<i>Subtotal--Eligible for Services</i>	<i>8,207</i>	<i>100.0%</i>	<i>35.0%</i>
<i>Confirmed (c)</i>			
Confirmed Physical Abuse	611	23.9%	2.6%
Confirmed Sexual Abuse	826	32.4%	3.5%
Confirmed Emotional Abuse	112	4.4%	0.5%
Confirmed Physical Neglect	562	22.0%	2.4%
Confirmed Medical Neglect	69	2.7%	0.3%
Confirmed Child in Need of Supervision	372	14.6%	1.6%
<i>Subtotal--Confirmed</i>	<i>2,552</i>	<i>100.0%</i>	<i>10.9%</i>
<i>Total</i>	<i>23,416</i>	<i>--</i>	<i>100.0%</i>

- (a) An allegation is "unfounded" when the social worker concludes that a reasonable person would not believe abuse or neglect occurred.
- (b) An "unconfirmed, eligible for service" finding is made when the social worker concludes that a reasonable person would not believe that abuse or neglect occurred, but it is likely to occur in the future without intervention.
- (c) A "confirmed" finding is made when the social worker determines that a reasonable person would conclude that it is more likely than not that abuse or neglect occurred.



APPENDIX B

Department of Social and Rehabilitation Services Summary of Child Abuse and Neglect Investigations, By Type Fiscal Years 1980 Through 1990

<u>Fiscal Year</u>	<u>Abuse Reports (a)</u>		<u>Neglect Reports (b)</u>		<u>Total Reports Investigated</u>
	<u>Number Investigated</u>	<u>Percent of Total</u>	<u>Number Investigated</u>	<u>Percent Of Total</u>	
1980	6,322	36.1%	11,200	63.9%	17,522
1981	6,369	32.2	13,414	67.8	19,783
1982	6,379	34.2	12,282	65.8	18,661
1983	7,145	36.6	12,353	63.4	19,498
1984	9,258	41.2	13,192	58.8	22,450
1985	10,736	43.7	13,815	56.3	24,551
1986	12,349(c)	50.1(c)	12,306(c)	49.9 (c)	24,655(c)
1987	12,349(c)	50.1(c)	12,306(c)	49.9 (c)	24,655(c)
1988	12,965	53.2	11,407	46.8	24,372
1989	13,443	57.4	9,994	42.6	23,437
1990	13,321	56.9	10,095	43.1	23,416

- (a) Child abuse refers to acts by a parent, custodian, or caregiver which result in non-accidental harm to a child, or in the substantial threat that harm will occur.
- (b) Child neglect refers to a parent, custodian, or caregiver's failure to provide a minimum level of care necessary to ensure the health and welfare of a child.
- (c) The data for these two fiscal years were combined and averaged because Department officials indicated the figures reported for fiscal year 1986 were artificially low and the 1987 figures were artificially high because of the Department's conversion to a computerized reporting system.

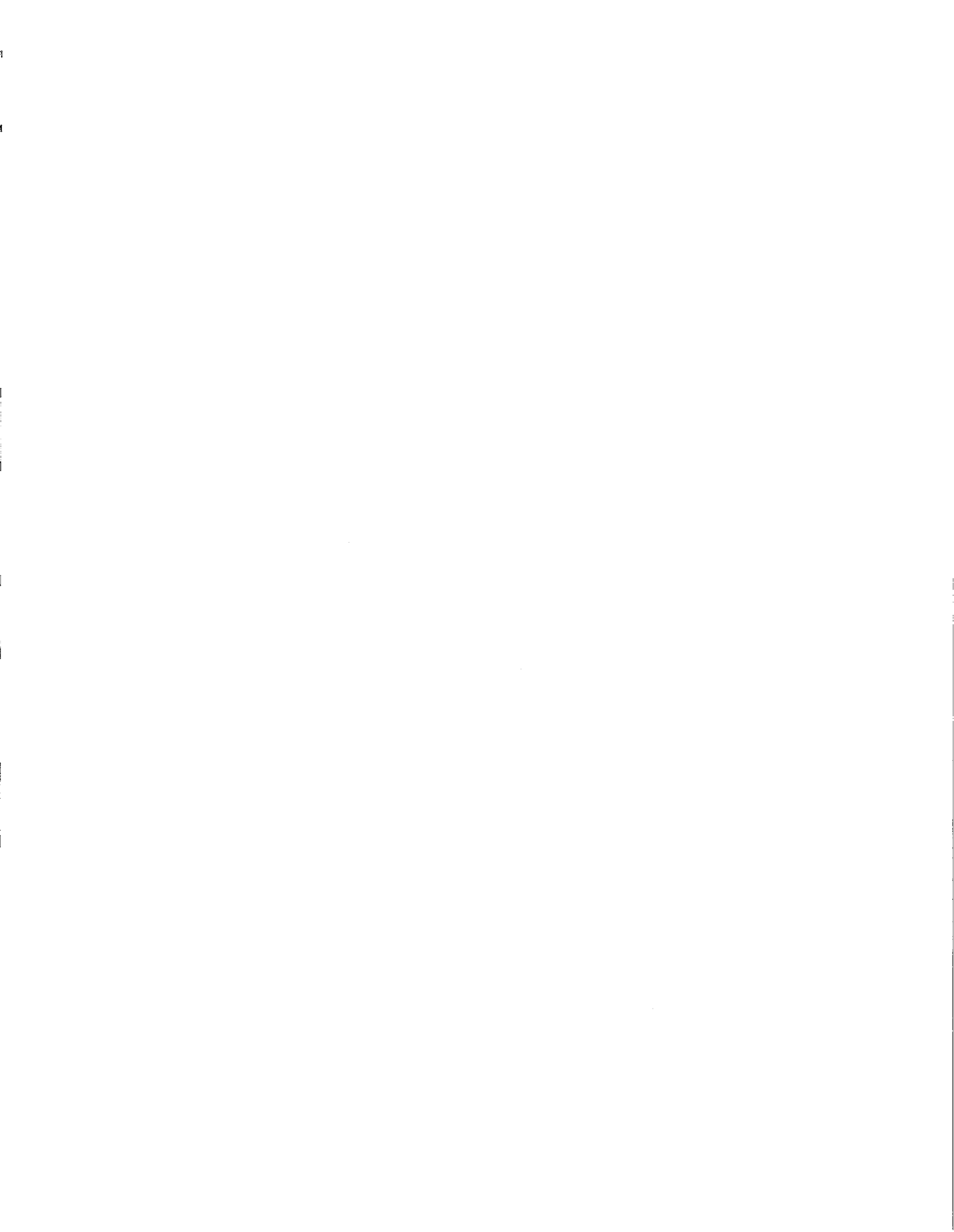


APPENDIX C

Department of Social and Rehabilitation Services Changes in the Number of Investigations, By Area Office Fiscal Years 1982 and 1990

<u>Area Office (a)</u>	<u>Abuse or Neglect Investigations Conducted in Fiscal Year....</u>		<u>Percent Change</u>
	<u>1982</u>	<u>1990</u>	
Kansas City	1,987	3,595	80.9%
Emporia	1,218	1,789	46.9%
Wichita	2,969	4,241	42.8%
Olathe	1,669	2,316	38.8%
Garden City	1,111	1,529	37.6%
Topeka	1,783	2,436	36.6%
Parsons	350	465	32.9%
Osawatomie	1,014	1,324	30.6%
Hutchinson	1,527	1,706	11.7%
Manhattan	1,207	1,113	-7.8%
Hays	855	758	-11.3%
Pittsburg	654	548	-16.2%
Hiawatha	648	502	-22.5%
Salina	882	482	-45.4%
Chanute	787	429	-45.5%
Totals	18,661	23,233	24.5%

(a) Represents the Department of Social and Rehabilitation Services' area office configuration as of fiscal year 1990.



APPENDIX D

Number and Types of Cases Reviewed, By County

We reviewed child protective services and family services cases in eight sample counties. We picked our sample so that large and small counties in several areas of the State would be represented. We also reviewed special cases (those involving children who were hospitalized, permanently injured, or fatally injured) in our eight sample counties and a sample of special cases from other counties. The numbers of cases we included in our sample from each county are displayed below.

<u>County</u>	<u>Child Protective Service Investigations</u>			<u>Family Services Cases</u>
	<u>Random Sample (a)</u>	<u>Special Cases (b)</u>	<u>Total</u>	
Cherokee	5	1	6	1
Clay	7	0	7	3
Ellis	9	1	10	2
Finney	9	1	10	4
Johnson	20	2	22	12
Sedgwick	20	5	25	12
Shawnee	20	2	22	4
Wyandotte	20	3	23	7
Other Counties	<u>0</u>	<u>8</u>	<u>8</u>	<u>0</u>
Totals	110	23	133	45

- (a) These cases were selected from all abuse or neglect investigations in the counties we visited that were started in July, August, or September 1989.
- (b) These are cases that were investigated in fiscal years 1989 or 1990 in which children were hospitalized, permanently injured, or killed as the result of confirmed child abuse or neglect. The cases included all children in the State who were permanently injured or killed as well as a sample of children who were hospitalized.



APPENDIX E

Survey of Professionals Required to Report Suspected Child Abuse or Neglect

K.S.A. 38-1522 requires professionals such as doctors, dentists, teachers, child care workers, and law enforcement officers to report suspected instances of child abuse or neglect to the Department of Social and Rehabilitation Services, or to the appropriate law enforcement agency if the Department is not open for business. To determine how these mandated reporters view the effectiveness of the Department of Social and Rehabilitation Services' system for handling reports of suspected child abuse and neglect, we sent 1,702 surveys to a sample of doctors, hospital personnel, law enforcement officials, school staff, and daycare administrators. A total of 1,114 surveys were returned, for a response rate of about 65 percent. Here is who responded:

Survey of Mandated Reporters of Abuse or Neglect Summary of Respondent's Professions

	<u>number</u>	<u>percent</u>
a. Private Practice Physician	226	20.3
b. Hospital Personnel	18	1.6
c. Law Enforcement Officer	39	3.5
d. School Personnel	776	69.7
e. Day Care Administrator	50	4.5
f. unspecified	5	0.4
Totals:	1,114	100.0%

In all, 60 percent of the respondents said that they had personally reported suspected child abuse or neglect to the Department.

We asked the respondents how they were treated when they called the Department to report suspected abuse or neglect. Only about four percent of them said that they had not been treated courteously, but about 30 percent said the workers they dealt with were not thorough in taking their information. About 23 percent said that they did not find the workers supportive.

We also asked this question: "If you reported any cases of suspected child abuse or neglect to the Department of Social and Rehabilitation Services and requested that the Department notify you after it investigated your report, did you receive such notification?" About 52 percent of the respondents who answered that question said that they had not.

Finally, we offered space for respondents to make any other comments about their experiences with the Department. Following are a sample of those comments. A full summary of the survey results is available for review at our offices.

Sample of Mandated Reporters' Positive Comments

School personnel: "My experiences to date have been very positive. I believe sometimes those filing reports expect a quick/immediate resolution to the situation. As professionals, we need to remember that this quick resolution is not generally possible."

School personnel: "In the past 20 years...I have been pleased with follow-up and results. At times I have not been impressed with investigators working someone else's referral, more over-zealous than not doing a thorough job."

School personnel: "Excellent rapport...but so understaffed the reports they couldn't deal with were too numerous."

School personnel: "I make many referrals each school year. Most are handled effectively and promptly. We rarely get feedback, however. SRS is so busy that I rarely ask."

School personnel: "I've had contact with a few excellent workers who responded promptly and returned my calls, but I've also had some who didn't care at all and I never heard from them."

School personnel: "In general, I have been pleased with the response time. I have been concerned with the concern that 'older' (13 - 15) children are given. It seems that when they are older abuse is tolerated at a more alarming rate."

School personnel: "The...County Social Services were extremely cooperative and helpful. It was the difficulty after the parental notification that caused a great deal of pain and pressure."

Sample of Mandated Reporters' Negative Comments

School personnel: "It is hard to see any positive outcomes of any reports that we have made. Repeated requests for feedback have been ignored."

School personnel: "Although I know case workers are over-loaded I have real concerns about the emotional welfare of children when reports are made. They are usually very frightened of retaliation from parents...Kids may be sent home within 24 hours and parents threaten them never to talk to the counselor or teacher again. They withdraw and lose an important support system."

Private practice physician: "The parents of several families found out that I had reported them...is there some sort of protection for those of us that do report and are involved in these situations more frequently than others?"

School personnel: "I have not been very pleased with the way in which the case I reported was handled. It first took approximately two weeks for anyone to check on the child, then no one seemed to know who the case worker was in charge. They gave us the "run-around." Not until the child attempted to seriously injure himself did they actually step in and take action."

School personnel: "I filed a report regarding physical abuse in which there was visual evidence and verbal confirmation. A short time later the abuse was repeated and the student indicated no one had talked to him from SRS. I filed another report and indicated it to be the second report with no response. I received a call from (the social worker)...requesting that I not file any more reports on this student because she was working with the mother and when I filed a report it meant someone had to go out and investigate and this made the mother mad. These behaviors certainly do not enhance my view of SRS as an effective agency."

Hospital personnel: "I have practiced Emergency Medicine .. for 17 years and....have had many occasions that I have had to report the suspicion of child abuse...We have gone from a 24-hour response team to the present where I seldom ever see an SRS person in the Emergency Department. Much of this is due to understaffing (not enough dollars). Even worse have been a couple of instances in which the response was inappropriate to where I now have second thoughts about reporting."

School personnel: "The local SRS office, in my experience, screens CPS referrals carefully in order to keep investigations to a minimum--because caseloads are so big. It's a question of not having the resources (personnel, money), etc., to do the job. Inevitably, some children suffer in the process. The legislature needs to better fund Youth Services so that they may give due attention to all CPS referrals and not just the 'worst cases'."

School personnel: "It is very frustrating to plead for the help ofchildren who evidence signs of ...abuse. By reporting to SRS and never seeing the results of our efforts, never knowing outcomes, also. I'm angry that SRS ignores truancy issues brought about by negligent parents of elementary age school children."

School personnel: "Response was not always prompt. Follow up is not always thorough. I sometimes feel that we leave the child in a worse situation than existed previously to reporting. The parent is often angry and verbally abuse to the child and no one appears to be working actively with the family. This probably assures the child won't report incidents in the future..."

School personnel: "No follow through. Often times worker has not come to school when called. Have talked to one or two workers who made me feel guilty for taking up their time."

School personnel: "I always fear for the safety of the child after reporting suspected abuse. So often it takes so much time for the investigation and the child returns home in the midst of everything, gets abused more and our credibility is totally destroyed."

Law enforcement officer: "...County SRS has different procedures than any other area of the State. Police officers that have joined our force from other counties are disappointed at the lack of after hours and week-end cooperation and communication."

Law enforcement officer: "I have been contacted by a social worker on some cases. I have not asked to be notified as a rule except on the serious cases; the life-threatening cases we have worked our own investigations."

Law enforcement officer: "We report several cases each month; a lot of the time the phone rings several times, 10-15, before it is answered. Sometimes no one answers after several minutes of rings. I have also been transferred several times and always wondered how many people who were trying to report would hang up. People tell us when they call SRS about problems (family) with their children they are told to call the police."

School personnel: "Children continue to be victimized because judges trust SRS over other professionals when because of lack of good pay and conditions on the job, I know they get some of the least-qualified people to do the job."

School personnel: "It seems that cases of suspected sexual abuse get the most immediate attention, whereas suspected neglect cases take much longer to be investigated."

School personnel: "The SRS does fairly well with what they have. They are understaffed and

underfinanced. I see a much larger problem in the court system and laws of this State. It is becoming extremely difficult to assist children when you must fight your way through laws that make no sense, that protect parents and not children, and that mandate that nothing much happens until the child is damaged beyond repair."

School personnel: "Is it necessary to send a uniformed, gun-toting police officer to interview young children? In a recent sexual molestation case, a male police officer came along with the female case worker to interview the 12-year-old female child. The male's presence was not needed."

School personnel: "...County staff is understaffed. Cases that I believe are urgent are put off because of lack of staff."

School personnel: "The system is failing or SRS needs help."

School personnel: "We find that two factors inhibit investigations: (1) increased number of complaints and (2) inadequate numbers of personnel with SRS to investigate complaints in a timely manner."

Law enforcement officer: "Problem is high turnover in child protection staff and too few child protection workers...Present staffing indicates child protection is not a priority for SRS."

Private practice physician: "SRS in...County is understaffed by order of magnitude to investigate suspected abuse and neglect and frankly acknowledges to me that really only the most severe, e.g., life-threatening, cases get more than cursory investigation. Cooperation between counties is, in the few cases I've seen very poor."

School personnel: "My observation is that the parents generally move to another area of the city, to another city, or to another state once the first investigative inquiry is made of them. Then the child must suffer more until the next report is made. Such a sad situation and not a result of poor follow-up. I believe they take their jobs very seriously and probably have a large caseload."

Day care administrator: "Department was very courteous but I felt not as thorough as they could have been. I was told to keep observing and in a couple of weeks to call back if I was still concerned."

School personnel: "I find that after reporting, parental contact takes too long, especially if a report is made on a Friday or prior to a school holiday."

Private practice physician: "The problem is lack of support for the system. You cannot expect overburdened social workers with insufficient funds and resources to do a good job of investigating cases and providing assistance to families that are willing to accept rehabilitative support."

School personnel: "I have reported some cases where the follow-up was terrible. They visited on time and said - 'no problem'. SRS needs to investigate more thoroughly when an incidence occurs."

School personnel: "Reporting seems so futile--never get any feedback--even a verification of contact would be reassuring."

Private practice physician: "It was difficult to find the number to call the hotline. I would appreciate the number be sent on an adhesive strip to attach to a phone."

Law enforcement officer: "It is very clear that the...Area SRS/Child Protection Unit is severely understaffed, both in investigators and support services people. It is imperative that the Legislature

fund sufficiently to correct this."

School personnel: "The local SRS office does not respond to persons making neglect reports. A severe case may be checked out if we keep after the agency to do so. Follow-up is poor! We must continue to inquire if we want follow-up information. Confidentiality is not maintained. Parents are informed as to the source of the referral."

Private practice physician: "Thoroughness is very spotty. Some investigations are handled well. Some do not seem to be taken seriously and investigated completely."

School personnel: "It would be good to send information to all of us explaining what we should do. I've taught 15 years and have never received any information from SRS."

School personnel: "I have reported more than four cases last year that had nothing done on them. If I were not required by law to report, I would stop for nothing is done when it is a report of sexual abuse. It did not used to be this way."

Private practice physician: "The overreporting of child abuse (reporting on very slim hunches) can be harmful to families. The over-zealous follow-up and even persecution by agency personnel of innocent families is a tragedy."

Hospital personnel: "SRS workers ...are not always prompt in their actions. Children have stayed in the hospital past medical necessity due to SRS not having the discharge plans ready. It seems they need many calls before they will act on a case. It should be their responsibility to handle cases effectively without reminders and then keep hospital personnel informed if needed."

School personnel: "SRS is understaffed. There are too many cases reported, that deserve attention, but case workers don't have the time."

School personnel: "Families need more preventive help...and children may need temporary removal more often than is occurring due to money and lack of foster care."

School personnel: "It is the most frustrating experience of my job. We are told by law to report and what to report, however when we have called in reports of serious physical abuse...we are told there is not enough evidence. Most of the time a case is not even open."

School personnel: "The Department is slow to act on cases; you have to make three to five reports per child to even begin to get their attention."

School personnel: "In two recent situations where another agency filed/made the report, we (the school) were asked to investigate and assess the severity of the situation. It is my understand that we are to report and SRS/Police are to investigate, right? I certainly hope we are never put in that situation again."

Law enforcement officer: "In many instances, the SRS office is notified of an abuse/neglect case and forwards it to the police department for investigation without any follow up from their office. Police reports are used to complete their own reports."

School personnel: "The phone intake person was supportive and concerned. The children case worker was short-tempered, non-understanding, and did not want to work with the school."

School personnel: "SRS by its own admission is overwhelmed and is unable to thoroughly follow up on all reported cases. A real Catch-22--require a report of suspected abuse and little

follow-through."

School personnel: "In the last five to seven years...I've seen a gradual but insidious retrenchment by the Department of SRS to investigate suspected cases of neglect or abuse where there was not beyond a reasonable shadow of doubt that the child in question was abused or neglected. The reporting parties must now do some preliminary investigation of our own before a suspected neglect or abuse case is seriously followed-up on by SRS."

Private practice physician: "It is important that a child has to have easily recognized injuries before SRS gets concerned. I feel my duty is to identify a potential problem before hard comes to a child, report my concern, and then have it investigated."

School personnel: "I have had more than one problem with SRS picking children up at school and assuring me they would notify parents, then having parents calling me after school wanting to know why their children aren't home."

Day care administrator: "I would like to see the establishment of some form of an 'advice' hotline for caregivers to call and propose their problem, dilemma, situation, etc. about a child and have a professional help you determine if you have something 'real' to report or just suspicions that cannot be acted upon."

APPENDIX F

Survey of Social Workers Employed by the Department of Social and Rehabilitation Services As of July 1990

To determine how current Department social workers viewed the effectiveness of the Department's system for handling reports of suspected child abuse or neglect and its provision of family services, we surveyed all 307 social workers in the eight counties we visited (Cherokee, Clay, Ellis, Finney, Johnson, Sedgwick, Shawnee, and Wyandotte). In addition, we surveyed a random sample of 100 other social workers from the remaining 97 counties. Of the 407 surveys sent, we received 167 responses, for a response rate of 41.0 percent.

Among other things, we asked Department social workers how long they had been performing child protective services for the Department. Even though one often hears that turnover among social workers is high, we found that about 63 percent of the social workers in our sample who worked in protective services had been doing it more than five years.

We also asked respondents to rate their county office's child protection policies and procedures for clarity and completeness. In all, about three-quarters of the respondents who answered the question said that those policies and procedures were generally or very clear, and very or generally complete.

In addition to the specific questions, we asked social workers to provide open comments regarding the Department's programs in these areas. About a fifth of the comments were primarily positive, and the remainder were primarily negative, focusing on weaknesses within these systems. Many of the comments received addressed not only Department programs, but also the courts, funding levels, public perceptions, and other issues. Following are some representative comments from the survey. Other comments appear in the boxes on pages 17, 18, and 29. A full summary of the survey results is available for review at our offices.

Sample of Social Workers' Positive Comments

"I feel, based on 18 years of CPS work with SRS...that Kansas currently has a good program/philosophy and many of the social workers I know are trying very hard to apply both. My concern is that SRS has taken a lot of "heat' for things that are beyond our control and that the Department does not explain that many things are beyond our control and/or the Department is made to look responsible for things (decisions of a court made against SRS recommendations)..."

"I am dedicated to seeing that the children of Kansas are not the victim of abuse/neglect. I believe that the Department shares that concern. I further believe that those who are attempting to make political gain from the issues that they have helped create (i.e. the lack of staffing, funding) have made it virtually impossible for the agency to say 'yes, there are problems.' No one seems to really want to know what it really takes to do our job and how often we do it well."

Sample of Social Workers' Negative Comments

"The agency is called upon to respond to an enormous number of marginal CPS referrals which in the past could have been addressed by private resources. As the system of private charities has dwindled, the public agency has been called upon to take up the slack."

"It is a complete mystery to me why state governments will invest multiple times more taxpayer money into remedial services when it is documented nationwide that prevention--in-home, intensives services to families--can prevent placements and save money, and protect children. We need more social workers doing prevention instead of foster care and permanency planning"

"At some point the Legislature will have to come to terms with the needs of the Department. If the public desires social work intervention every time a report is made, staff must be available to respond and that will require financial expenditures."

"At this time it appears that 'prevention' is a wish with no time to pursue it to reality."

"Staff promotion is done on an obedience scale not a professional competency scale. Individuals that confront the system get backlash with employee evaluations, daily treatment, sabotage of case files, and various deceptions."

"I think SRS has been given the insurmountable task of solving the child abuse/neglect problem in this State and it's impossible! Child abuse/neglect is a societal problem that one lone State agency can't solve. I think SRS, in general, ends up feeling responsible for solving society's problems when in effect all they really do it put 'band aids' on many problems and let them fester."

"I really enjoy my job. However, it is very easy to burn out on this job because of the stress."

"I feel that workers are usually hesitant to confirm a report or perpetrator, which makes them less likely to refer that client for Family Preservation services. Because of this, many families do not receive help soon enough to make changes."

"I feel strongly that the SRS bureaucracy is out of control. Our supervisors/chiefs are there to make sure we meet the State's mandates and complete paperwork to justify all our jobs. Who is there to see that services are provided? No one, because the State doesn't allow enough dollars to fund staff."

"SRS's scope of investigation should be narrower and the politicians should quit using SRS to do all and be all especially now in a money crunch with positions frozen."

"With the increase of gang and drug-related activities in our city, it's become more and more dangerous to make home visits alone. I've had several police officers and a detective tell me they wouldn't even go to some of the places that I go alone."

"Because of the shortage of workers, the supervisors and intake workers attempt to screen referrals too much on the front end - won't open for investigation - therefore, missing some possibly serious cases and alienating schools, doctors, other professionals who try to get SRS to take action."

"I feel we have very little supervision. Our current leader is very intelligent and philosophical but we need reality-based help and support. We do 'band aid' surgery, not neuropsychiatry. SRS is not the answer for every catastrophe invented by modern man."

"In most situations, the social worker who investigates child abuse and neglect cases is the same person who then offers and provides services to the family...a lot of time their relationship could be strained and be less trustful of the social worker because he or she had investigated their abuse or neglect case. This is a weakness of the system."

APPENDIX G

Survey of Social Workers Formerly Employed by the Department of Social and Rehabilitation Services

To determine how former Department social workers viewed the effectiveness of the Department's system for handling reports of suspected child abuse or neglect and its provision of family services, we surveyed the 84 social workers who terminated their employment with the Department of Social and Rehabilitation Services between July 1989 and July 1990. In all, 38 of these former workers had been employed in the eight counties we visited (Cherokee, Clay, Ellis, Finney, Johnson, Sedgwick, Shawnee, and Wyandotte). The other 46 former social workers were from the remaining 97 counties. Of the 84 surveys sent, we received 33 responses, for a response rate of 39.3 percent.

A total of 14 former social workers responded to our question on the adequacy of the Department's training. Most of those respondents were divided: six said that their training had been adequate or more than adequate; eight said that their training had been somewhat or very inadequate. In another question, we asked about the adequacy of the physical resources (office space and office equipment, vehicles, supplies, and the like) available to the former social workers. Of 16 who responded, only four said that their resources were adequate or more than adequate. Eleven others said the physical resources available to them had been inadequate or very inadequate (one person had no opinion).

In addition to more specific questions, we asked former social workers to provide open comments regarding the Department's programs in these areas. The respondents provided both positive and negative comments. About a fourth of the comments were primarily positive, and the remainder were primarily negative, focusing on weaknesses within these systems. Many of the comments received addressed not only Department programs, but also the courts, funding levels, public perceptions, and other areas. Following are some representative comments from the survey. A full summary of the survey results is available for review at our offices.

Sample of Former Social Workers' Positive Comments

"Being able to screen intake reports that were vague, malicious, etc. helped workers to better spend their time investigating CPS reports."

"The family preservation program provided the workers with competent training and competent consultation on a weekly basis. Caseloads were small and manageable. SRS supervision was excellent!"

"I feel that our office did everything we could to prevent custody of children and I feel more and more money needs to be put forth on this program because in the long run everyone saves money and the children are better off than in foster care - in most cases."

"The family preservation services allows workers to have low caseloads and to really work to save families."

Sample of Former Social Workers' Negative Comments

"I think that one of the weaknesses was not with SRS policies and procedures as much as it was with the court system. Our court ignored statutes designed to keep children out of the court system and SRS custody unless the situation was an emergency or family services had been provided."

"In referring a protective service concern to one large area office, we were told by the supervisor that since they were shortstaffed, it would be at least two weeks before the investigation could be assigned. When asked how they could do that she informed the worker that she would just wait until right before she assigned it to do the risk assessment since the response time did not start until after the risk assessment was completed."

"(Preventive family services) is the most unclear and controversial area in SRS. No clear definition of who receives services-everyone has their own opinion - very frustrating."

"I believe the workers in my office were very dedicated and professional but the constant pressure of doing more and more work affected the morale of the unit."

"The most frustrating cases were the teenagers. SRS should not be involved in families with out-of-control teenagers. That should be a function of court services."

"Family service training was helpful but there needed to be follow-up to implement the policy into program."

"The State Department of SRS is a much neglected system. People (staff) are given many tasks and very few tools to complete the tasks."

"I was assigned CPS cases my first day. I did not receive any training in that area until I was on the job for 6 months to one year."

"It (the caseload) is far too high now due to the lack of social workers...my caseload was too overwhelming at all times. 65-70 cases is three times what a good social worker can handle."

"Regulations are generally clear, but overwhelming for rural workers who handle "all case types" and are responsible for all youth programs."

"If you want professional work from experienced people, start at range 25 and double the social work staff."

"The area office workers could get services we couldn't - closer to the decision-makers."

"Do something about the licensing issue. I had great difficulty obtaining mine and left Kansas because of it. CPS loses productive staff that way."

"The biggest weaknesses I see are (1) the limited family preservation services available in Kansas, (2) the push to try to push family preservation responsibilities off on family service workers who already have too large of caseloads instead of setting up units to handle family preservation cases, and (3) the feeling that family preservation is being separated out from other services can cause inter-departmental problems."

"Too much paperwork and too many forms. SRS is not client-centered - the emphasis is on completing paperwork timely."

"There were not enough resources for the family. All the resources had waiting lists. By the time the family got services, the kids were usually placed in foster care, as the situation had exploded."

"The less serious cases, where it is possible that services before the kids were placed in care would be effective, were either closed due to lack of resources and time, or never assigned (rejected) because of more serious cases being handled."

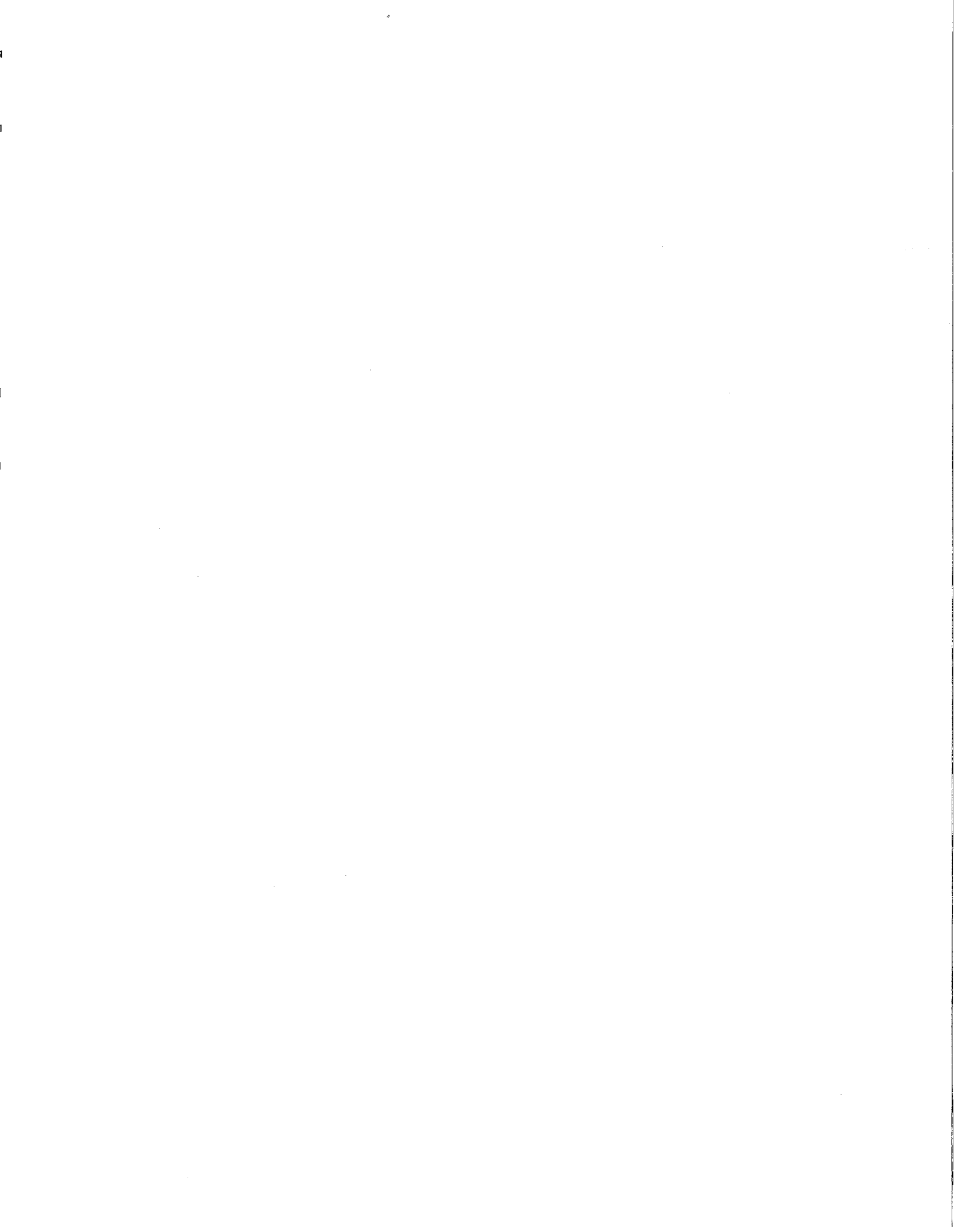
"Parental rights are being terminated and we have no resources for children who have been left in the agency's 'cracks' for five to six years and probably would have been better off left in the abusive home."

"The local supervisory staff was so overburdened by administrative minutiae that there was little time for training. Large uncovered case loads had to be covered by new staff without any training."

"Safety of staff in the field and office was of great concern."

"Staff was required to transport children and adults with undetermined illnesses and flea-infested belongings. Therefore their personal automobiles were many times infested with fleas."

"If more staff and staff support is not given to the front line workers, they will continue to do a minimal job at the expense of one of those we were hired to protect and serve."



APPENDIX H

Survey of Family Support Workers Employed by the Department of Social and Rehabilitation Services As of July 1990

To determine how Department family support workers viewed the Department's provision of preventive family services, we surveyed 100 family support workers employed by the Department as of August 1990. Of the 100 surveys sent, we received 66 responses, for a response rate of 66.0 percent.

Among the questions on the survey, we asked family support workers to rate the supervision and management support they had received from the personnel in their county offices. About 80 percent rated their supervision and management support as good or very good. About two-thirds said that their training had been adequate or more than adequate.

In addition to the specific questions, we asked family support workers to provide open comments regarding the Department's family services program. About 34 percent of the comments were positive, and the remainder were primarily negative, focusing on weaknesses in the program. Following are some representative comments from the survey. Other comments appear in the boxes on pages 17, 18, and 29. A full summary of the survey results is available for review at our offices.

Sample of Family Support Workers' Positive Comments

"[This] office has provided professional consultation through the Family Preservation Program for family support workers."

"Communication with social workers, supervisors in local office...also with law enforcement and health people. Cooperation between those same people to help our families."

Sample of Family Support Workers' Negative Comments

"We haven't been allowed to transport clients to services the past year-and-a-half. Since we live in a very rural area this does create some problems. Many families have no transportation and are often referred for counseling or to medical specialists."

"I feel prevention is a joke. Many times our clients are sifted down through other agencies. Our successes are so minimal. Failures come back and come back."

"In previous years...family services did preventive work. Due to high caseloads, they no longer provide preventive services."

"The pay range is far too low for family support workers. They are a valuable tool for preventative services."

"Weakness: not locating families before they are at the point of 'no return'."

"More trained investigative personnel and more cooperating in the legal system would improve the system."

"As family support workers, we are not acknowledged enough. I enjoy my job, but because of this we have to work hard on keeping morale high."

"Theoretical system is well thought out. In application there are too few workers attempting to stem the tide of a deluge of cases - workers can respond to only most needy of cases."

"There are times when family support workers need more hours to provide in-home service when families are in crisis. We have to work within 83 hours (PTI) and in rural areas a lot of time is spent traveling."

APPENDIX I

Agency Response

On October 26, 1990, we provided a copy of the draft audit report to the Department of Social and Rehabilitation Services. Its response is included as this Appendix.



STATE OF KANSAS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

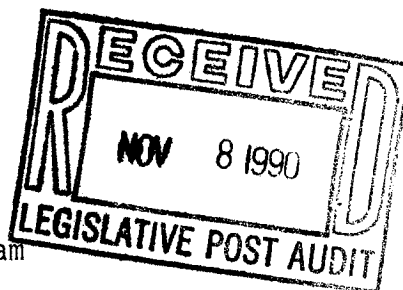
915 S.W. Harrison, Docking State Office Building, Topeka, Kansas 66612-1570

MIKE HAYDEN
Governor

DENNIS TAYLOR
Acting Secretary

November 8, 1990

Meredith Williams
Legislative Post Auditor
109 West 9th, Suite 301
Topeka, KS 66612-1285



Re: The Kansas Child Protective Services Program

Dear Mr. Williams:

Thank you for the opportunity to review and comment on a draft copy of "Assessing How Effectively the Department of Social and Rehabilitation Services Handles Reports of Child Abuse or Neglect."

In the audit overview, Legislative Post Audit sampled two distinctly different types of cases. The first sample was a random selection of 110 cases in eight of 105 counties for a three-month period (7/1 to 9/30/89). The second sample of 23 cases included the total population of all death and permanent injury cases, along with some hospitalization cases for FY 89 and FY 90. The audit findings are based on combining these two different sample populations. Consequently, drawing conclusions based on the sampling is misleading in that the audit sample is not statistically valid for the whole state.

SRS has initiated several steps to address the effectiveness of the department's response to reports of abuse or neglect; service delivery; staff training; dissemination of policy and procedure manuals; and information systems.

Based on audit findings, SRS will immediately implement a written response to mandated reporters. This procedure will help ensure that these individuals, who are most likely to observe abused and neglected children, will continue to report their observations.

Since 1988 the Youth Services Program Assurance Unit (PAU) has audited area offices for compliance with state and federal policies and Youth Services procedures. These audits help assure that services are provided in accordance with established policy. In the past two years PAU has audited more than 7,000 cases in six different Youth Services programs. This included 2,400 child abuse/neglect and family services case audits.

Mr. Williams, November 8, 1990

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Based on the PAU case audits, issues have been identified and improvements made in the service delivery of Child Protective Services (CPS), Family Services, Foster Care Services and Adoption Services. In particular, program specialists are providing technical assistance to area offices using a revised Child Protective Service and Family Services Manual. This manual was distributed to all field offices (105 counties) in June, 1990 and is currently in effect.

Over the past few months, a new core curriculum for Youth Services staff has been field tested in several area offices. This curriculum addresses generic skill development, such as team building, empowering families, testifying in court, case planning, interviewing and implementing services. This core curriculum will be distributed and implemented statewide in December.

All new staff will be required to complete the core curriculum (using printed materials, video tapes, and written assignments) with supervisory review, pretest and post tests effective January 1, 1991 to achieve permanent status in the civil service system. Staff not achieving an 80% score will be required to repeat training. Mandatory training for current staff on the core curriculum will become effective June 1, 1991.

Recent organizational changes within SRS have led to the creation of a Policy, Planning and Management Analysis Unit (PPMA), to develop short- and long-range policy for SRS. PPMA, working in conjunction with Youth Services and Staff Development, is expanding program specific training using a performance based approach. Specifically, this group is responsible for:

- * Immediate development of a case reading guide which will outline key policy and procedure requirements. This guide will be distributed January, 1991 to the field for all CPS case openings. In each case the guide, used as a procedural checklist, will be completed by the social worker and signed by the supervisor. We believe this process sets the standards for supervisor accountability and documents joint decision making for the agency.
- * Provision of technical assistance by program specialists at least twice a year in each of the 12 management areas. Attendance will be mandated for all staff with Youth Services responsibilities.
- * Review of sample cases and survey of clients in each management area six months after technical assistance training. The PAU will measure the impact of training and corrective action will be implemented as needed.

In addition each of the 12 management areas will establish regional training positions. These trainers will be responsible for core curriculum training and specialized training as needed. Training will be supplemented by peer trainers and field social workers who are skilled in such areas as sexual abuse investigations, documentation, permanency planning, and family preservation. We believe this training system will maximize the department's existing resources while providing consistent delivery of service to clients.

A social worker assessment team has been developed within PPMA. Each of these team members is thoroughly trained in CPS issues and is available to provide

assistance and practical hands-on training to staff throughout the state.

In addition, the PPMA unit is working with Youth Services staff to develop two new resources: a Child Protective Services Policy and Procedural Manual and a Child Protective Services Handbook. These materials will be completed by October, 1991 and will provide protective service staff with clear, concise information covering all applicable federal and state policies.

The Child Protective Services Policy and Procedural Manual will include such information as:

- * Agency philosophy and mission
- * Specific policies and laws pertaining to child abuse/neglect
- * Mandatory timelines for investigations
- * Instructions for reports, record maintenance, and statistical input documents
- * Requirements for utilizing the risk assessment

The Child Protective Services Handbook is intended to be a hands-on reference for staff, containing examples of child protective service issues. This handbook will include such topics as:

- * Techniques to structure staff's investigation and decision making
- * An overview of the investigation process, investigation techniques, and guidelines for preparing testimony for court hearings
- * A "how to" guide for observing physical and mental indications of abuse/neglect in children
- * Guidelines for interviewing the child, family, and collaterals
- * Involvement of law enforcement and community contacts
- * Gathering evidence and guidelines for testifying in court

In general the audit overview identified the need for a comprehensive data system to ensure that SRS and staff have sufficient information to manage child protection and family services issues in a consistent and timely manner. To provide an accurate integrated information system SRS was recently authorized to establish an Information Resource Management System and hire an Information Resource Manager II. This new section, which includes the former Audit Unit, will plan and coordinate an agency-wide integrated information resource system. The Information Resource Management Team is working with PPMA to evaluate the reporting system. In particular staff are assigned the following tasks:

- * Correct existing reports to assure headings, labels and programming are accurate.
- * Monitor child protection, children in need of care, and family service reporting to correct and maintain accurate data in these systems.

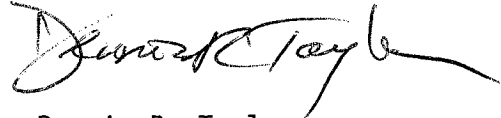
The long range goal of SRS is to design an integrated information system that provides appropriate information for managers and field staff. Ideally, an integrated system will collect data on the following programs:

- * Child abuse registry
- * Child in need of care statistics
- * Family service information
- * Foster care
- * Adoption
- * Financial eligibility

Mr. Williams, November 8, 1990
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I believe that the initiatives outlined in this letter will lead to improvements in the effectiveness of SRS services for Kansas children and families. Please contact me if you need additional information.

Sincerely,

A handwritten signature in cursive script, appearing to read "Dennis R. Taylor", with a long horizontal flourish extending to the right.

Dennis R. Taylor
Acting Secretary

DT:cr

