

THE WISEST INVESTMENT

New York City's Preventive Service System



CITIZENS' COMMITTEE for CHILDREN
OF NEW YORK INC

DEDICATED TO SISTER MARY PAUL JANCHILL, DSW



This report is dedicated to the life and legacy of Sister Mary Paul Janchill, DSW, CCC Board Member for 40 years and founder and director of the Center For Family Life in Sunset Park, Brooklyn. Sister Mary Paul dedicated her life to ensuring that the children and families of Sunset Park received the community-based support they needed to thrive. Sister Mary Paul's life's work continues to inspire CCC to work tirelessly to make New York City a better place for children and families.

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April 2010



ACKNOWLEDGEMENTS

CCC is thankful to the 24 CCC volunteers who made this report possible. Our data could not have been collected without their eagerness to learn about New York City's preventive service system or to travel throughout the city to meet with preventive service program directors. CCC is especially grateful to the Task Force Chairs, Chris Stern Hyman and Trudy Festinger, who graciously made themselves available at all times. Chris, we thank you for helping us focus and hone our research and our findings. Trudy, we thank you for your guidance and direction with the development of the survey and the interpretation of the data. Trudy and Chris, most of all, thank you for being yourselves- committed, goal driven professionals with great senses of humor and keen eyes for the details.

CCC is deeply grateful to the 31 preventive service program directors from throughout New York City who took time out of their extremely busy schedules to answer our survey questions and to share their thoughtful insights about their programs and the system as a whole. CCC is also indebted to the parents from the Child Welfare Organizing Project (CWOP) who were able to bring their real life experiences into our work and to be a voice for the families who receive preventive services. It is the collective wisdom and ideas of the program directors and the parents that enabled us to formulate the findings and recommendations in this report.

CCC is especially grateful to the staff at ACS for being both supportive and helpful to us in refining our findings and providing us with facts and data. In particular, we would like to thank Peggy Ellis, Nancy Martin, Lisa O'Connor, Judy Wolpoff, Levesia Rushing, Jackie Martin and Danielle Weisberg for their willingness to help regardless of how much data or information we needed. In addition, we thank Commissioner John Mattingly and Deputy Commissioner Elizabeth Roberts for their thoughtful insights, reality checks, openness to our suggestions, and most importantly for their relentless efforts to strengthen the preventive service system in New York City.

CCC appreciates all the hard-working professionals at the preventive service programs, the city's Administration for Children's Services, and the state's Office of Children and Family Services who work tirelessly, often with little recognition or compensation, to support and strengthen families while ensuring children are safe. And most of all, CCC has great appreciation for the children and families who have been touched by the child welfare system- their perseverance, frustrations, tears and laughter inspire us to continually work to make the system stronger.

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EXECUTIVE SUMMARY

Child welfare is a tripod comprised of child protective services, foster care services and preventive services—and like any tripod, for the system to be functioning well, all three legs must be strong and stable.

The child protective leg is responsible for investigating reports of abuse and neglect, determining whether to unfound or substantiate¹ the allegations in the reports, and making decisions about whether any identified level of risk to the children necessitates removing the children from their homes² or providing family support services to enable children to remain safely in their homes.³ The foster care leg is responsible for permanency planning and service planning for children and their parents so that children's needs are met while they are in foster care, appropriate services are provided to their parents, and the children can achieve permanency through reunification, adoption or another permanency plan as expeditiously as possible.

Preventive services that strengthen and support families in their communities, so children can remain in their homes without abuse, neglect, removal and/or placement in foster care, comprise the vital third leg of the child welfare tripod. While child protection and foster care often take center stage, this report sheds light on the less publicized, less funded and often less understood, yet equally important, leg of child welfare—the preventive service system.

In June 2009, 13,504 families, with 31,584 children,⁴ were receiving preventive services in New York City from approximately 150 preventive service programs operated by 75 agencies located throughout the five boroughs. The

system's utilization was operating at close to 100%.⁵ Families were receiving services such as substance abuse treatment, housing referrals, parent education classes, and counseling.

In addition to keeping children safe, strengthening and supporting families, and preventing the trauma often associated with removal, preventive services are also cost-effective. In New York City, the system-wide weighted average cost for foster care is \$36,000 per child per year,⁶ compared to \$9,000 annually per family for the most common preventive service slot and \$17,000 for the most expensive preventive service slot. Furthermore, child abuse itself is costly to society. Kids are Waiting, a project of the Pew Charitable Trusts, estimated that in 2007, the cost of child abuse to the United States was \$104 billion, including costs for foster care, the health care system, the judicial system, law enforcement and the estimated long-term economic impacts of the possible negative effects of foster care such as juvenile delinquency and teen pregnancy.⁷

The Wisest Investment is an analysis of New York City's preventive service system in the context of child welfare. Over the past three years, CCC has collected and analyzed the data and listened carefully to the plans, thoughts, and visions of families, preventive service providers, Administration for Children's Services officials, Office of Children and Family Services officials, umbrella organizations, advocacy organizations, city and state legislators, lawyers and social workers working with families, and community members.

The findings and recommendations are based on 31 survey interviews CCC conducted with preventive service program directors; a focus group of parents who had received preventive services in New York City; an analysis of state and city data; participation in various relevant workgroups, coalitions and formal meetings; and a review of relevant research and literature. We have taken all of this information and synthesized it into this report, *The Wisest Investment: New York City's Preventive Service System*. The preventive service system is complicated and each family and program is

¹ Child abuse and neglect reports are unfounded when child protective staff do not find credible evidence that the allegations in the report are true. Reports are substantiated, sometimes called indicated, when the child protective staff find credible evidence that the allegations are true.

² A Family Court Judge must approve all removals of children from their homes. Child welfare agencies are required to seek court orders prior to removing children, unless it is deemed to be an emergency. There must be imminent risk of harm to the child that cannot be alleviated through the provision of services for the court to sanction a child's removal and placement in foster care. Family Court Act §§ 1022, 1024 and 1027.

³ The New York City Administration for Children's Services (ACS) can refer families to preventive services and the families can participate voluntarily or ACS can seek a court order mandating that the family participate in services. Both types of cases are discussed more fully in this report.

⁴ New York City Administration for Children's Services. *ACS Monthly Update, June 2009, FY09*, at 4. <http://www.nyc.gov/html/acs/downloads/pdf/stats_monthly_update.pdf> (accessed 9/5/09).

⁵ NYC Children's Services Preventive Services Programs Quarterly Program Status Report Quarter 2, FY09. (October 2008-December 2008); New York City Administration for Children's Services. *July 2009 Monthly Flash*, at 9 (July 22, 2009). <http://www.nyc.gov/html/acs/downloads/pdf/stats_monthly_flash.pdf> (accessed 8/24/09).

⁶ Unpublished data provided to CCC by ACS. (February 5, 2009).

⁷ The Pew Charitable Trusts. *Time for Reform: Investing in Prevention: Keeping Children Safe at Home*. (2008). http://www.preventchildabuse.org/about_us/media_releases/pew_kaw_prevention_report_final.pdf

unique; we hope that our attempt to simplify and explain the systemic and familial needs reflects that diversity.

Preventing child abuse and neglect is actually broader than the child welfare system and needs to be a priority at the federal, state, city and community levels, using a variety of services and programs provided by a multitude of agencies and non-profits. Preventing child abuse and neglect before it ever occurs needs to be achieved by supporting communities and families by “strengthening protective factors and building family and social networks to reinforce the ability of parents⁸ to care for their children.”⁹ *The Wisest Investment* focuses solely on preventive services in the context of child welfare.¹⁰

CCC’s three years of analysis of NYC’s preventive service system has convinced us that the system is comprised of a diverse and deeply committed cadre of professionals seeking to prevent child abuse and neglect and foster care placements, as they strengthen and support families. While the New York State Office of Children and Family Services (OCFS),¹¹ the New York City Administration for Children’s Services (ACS),¹² the preventive service programs and the families themselves, face a variety of barriers, they are all seeking to continuously improve the system and the circumstances facing at-risk children and their parents. New York State, and New York City in particular, has one of the largest and most comprehensive preventive service systems in the country.

Much as public and political attention to child welfare waxes and wanes and state and city budgets are bright or gloomy, resources and attention for preventive services also fluctuate. After the tragic death of Nixxmary Brown in January 2006, there was tremendous attention paid to all aspects of child safety, at a time when New York City’s budget

had a surplus. Not only did the attention to child safety lead to an increased number of families identified as needing preventive services and an increased use and reliance on the preventive service system, there was also an influx of resources to the child welfare system, including for preventive services. ACS sought to strengthen the preventive service system by developing enhanced and intensified models, adding slots to serve more families, reducing caseloads at General Preventive and Medically Fragile programs,¹³ and providing \$9 million of performance based enhancement funding.

CCC administered its survey interview to preventive service program directors in April-June 2007. At that time, the child welfare system was no longer in the crisis it had been the prior year when the system was not yet prepared to manage the higher level of reports. In the spring of 2007 when CCC conducted its survey of preventive service programs, the preventive service system was operating at over 100% utilization, and with the much-needed preventive service enhancement funding and caseload reduction funds distributed. In addition, 1,000 new slots were due to be distributed beginning September 2007.

Both the economy and attention to child welfare have changed dramatically since the summer of 2007. Recently, tragic deaths of children known to ACS have not been heavily reported. In addition, the economic downturn has led to multi-billion dollar state and city budget deficits and preventive services have already begun to feel the impact of budget cuts.

Prior to the economic downturn, OCFS and ACS had devoted increasingly significant resources to this system. With the assistance of the state’s uncapped matching funds (which provided a 65% match for every dollar the city spent on preventive services), ACS developed new preventive service program models, provided additional funds to programs to use flexibly, began to institute a family team conferencing model, and developed a new tool to monitor their contracted preventive programs. Importantly, even at a time of greater resources, the system was in need of greater capacity, improved access to mental health services, enhanced language access and cultural competence, lower supervisory caseload ratios, and greater compensation for its workforce.

As the economic downturn has led to state and city budget shortages, OCFS and ACS have tried to maintain

⁸ Throughout this report, CCC uses the term “parent” to refer to the adults who are legally responsible for caring for children. Some of these “parents” may be kinship relatives, close family friends, guardians or other types of caregivers.

⁹ Stagner, M. & Lansing, J. *Progress Towards a Prevention Perspective*, Preventive Child Maltreatment, Vol. 19, No. 2 (Fall 2009), at 19.

¹⁰ To truly prevent child abuse and neglect, New York must also invest in supports and services outside of the child welfare system such as prenatal care, family planning services, home visiting programs, quality early care and education programs and after school programs, as well as supports and services that address risk factors such as poverty, social isolation, single parenthood, and the dearth of affordable housing options.

¹¹ The Office of Children and Family Services (OCFS) is the state agency responsible for child welfare services. New York State has a state supervised, county-administered system child welfare system.

¹² The Administration for Children’s Services (ACS) is New York City’s child welfare agency.

¹³ This was through the Child Safety Initiative funded by the City Council.

their core funding and programming for preventive services. At the state level, while uncapped 65% state and 35% local reimbursement to counties has been maintained, there has been a 2% decrease in the state's reimbursement to counties.¹⁴ At the city level, capacity has been reduced, and program enhancement funds and resources for the purchase of concrete goods for families have been reduced.

As we move deeper into the economic recession and budget cuts, and as more families lose their jobs, their housing, their child care and their children's after school programming, families are likely to experience more stress and depression. It is reasonable to expect that the city's preventive service system will become further taxed because more families will either seek support or be referred for services by ACS.

Furthermore, in May 2009, ACS issued a new Request for Proposals (RFP) for its preventive service contracts, a new Scope of Services and a new *Preventive Services Quality Assurance Standards and Indicators* manual, all of which are due to become effective with the new contracts in late 2010 (hereinafter the three documents and their seven addenda are referred to as "the new RFP").¹⁵ The enhancements, requirements and changes in this RFP, its Scope of Services, and new *Standards and Indicators* will likely guide policy and practice for the next decade. In short, as stated by ACS in the new RFP, ACS's goal for the next decade of preventive services is to "develop a more comprehensive array of effective preventive services to help families raise their children safely and further reduce the number of children who are separated from their families by placement into foster care."¹⁶

It is in the context of both an economic downturn leading to severe state and city budget shortfalls and ACS's release of an ambitious new RFP for new preventive service contracts that we are issuing this report.

At the heart of all the findings and recommendations in *The Wisest Investment* is the need for child welfare advocates, stakeholders and elected and appointed officials in Washington, DC, Albany and City Hall to more fully

embrace the value of preventive services in keeping children safe, strengthening families, preventing foster care, and improving child well-being. In doing so, scarce resources can be invested wisely, to both produce better outcomes for children and prevent the need for more costly interventions in the short and long term.

Report findings and recommendations are divided into the following twelve sections: 1) system capacity; 2) the initial 30 days after an ACS referral; 3) initial family engagement; 4) accessing services for families; 5) engaging men in preventive services; 6) language access and cultural competence in preventive services; 7) court ordered supervision cases; 8) identifying and addressing safety and risk; 9) training for preventive service caseworkers; 10) case closing; 11) the preventive services workforce; and 12) overarching findings and recommendations. The full list of Findings and Recommendations can be found in Appendix 1.

CCC's recommendations center around five themes: 1) increase the system's capacity to serve all families in need; 2) improve the collaboration and coordination among ACS, its preventive providers and other child welfare stakeholders; 3) enhance accountability and oversight and make the results of monitoring public; 4) strengthen case practice; and 5) increase federal, state and city resources available for ACS, preventive service providers, and other community-based supports.

The Wisest Investment details how New York City's preventive service system needs to be more fully supported at the federal, state and local levels in order to provide quality and timely services to all at-risk children and families in New York City. The system needs increased capacity, expanded options to meet the needs of non-English speaking families and those of various cultures, better access to mental health and housing services, and improved ability to hire and maintain an experienced and committed workforce. While the communication and collaboration on both the systemic and individual case levels between ACS and its contracted preventive providers has improved, our findings also reveal that these relationships can still be enhanced and strengthened, including in court ordered supervision cases.

In addition, CCC has concerns about the upcoming implementation of the new preventive service contracts (pursuant to the new RFP), which will lead to the system's loss of capacity (approximately 2,500-3,000 slots) and performance based funding linked to a shortened length of service provision.

¹⁴ The state is now reimbursing counties 98% of their 65% share, which is the equivalent of 63.7% state reimbursement.

¹⁵ The RFP, including the scope of services and the *Quality Assurance Standards* and all of the addenda, is an over 900 page document. Hereinafter this entire package of documents is referred to as the new RFP.

¹⁶ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 7. (May 20, 2009).

That said, *The Wisest Investment* also documents the innovations being carried out at both ACS and the preventive service programs, the dedication to protecting children and strengthening families found throughout the system, the extremely hard work being done by front line caseworkers, their supervisors, preventive services workers and ACS staff at all levels, and the benefits New York City's children and families are receiving from this invaluable component of the city's child welfare system.

There are already plans underway to address some of CCC's findings and recommendations. ACS's *Improved Outcomes for Children* model, which was rolled out system-wide in July 2009, will hopefully address some of the findings in this report if ACS and the contracted preventive programs have sufficient resources to implement the plan as

written. In addition, CCC anticipates that many of the new contract requirements, Scope of Services and updated *Preventive Services Quality Assurance Standards and Indicators* will also address some of our findings and recommendations, again if the preventive programs have the resources needed to implement them.

CCC is committed to advocating for the short-term and longer-term recommendations included in *The Wisest Investment*. We urge policymakers, elected and appointed officials, child welfare stakeholders and advocates to use the information in this report to protect the resources this system currently has, to improve oversight and monitoring, to improve and enhance practice at the program level, and to advocate for additional resources to strengthen the system.

CHAPTER 1: OVERVIEW OF THE PREVENTIVE SERVICE SYSTEM IN NEW YORK CITY

A) WHAT ARE CHILD WELFARE PREVENTIVE SERVICES AND HOW CAN A FAMILY RECEIVE THEM?

The literature describes three types of preventive services—primary, secondary and tertiary.¹⁷ Primary prevention targets the general population without any screening. Child safety public education campaigns and universal home visiting programs are examples of primary prevention. Secondary prevention is directed towards families deemed “at risk” of abusing or neglecting their children, but who have not yet done so. Finally, tertiary prevention is provided after abuse or neglect has occurred in an attempt to prevent it from happening again, and thus includes services for families with indicated child abuse and neglect reports and services after children reunify from foster care. New York has all three types of preventive services. CCC’s research and this report focus on secondary and tertiary prevention, or services for families at risk of abusing or neglecting their children and services for families where abuse or neglect has already occurred.

In New York City, the child welfare preventive service system is administered by the city’s local child welfare agency, the Administration for Children’s Services (ACS). ACS is charged with ensuring the safety of children and strengthening and supporting families in all five boroughs. In City Fiscal Year 2009, the average daily number of children receiving contract preventive services was 31,752, a 7.6% increase from CFY 2007.¹⁸

According to ACS’s preventive services brochure, preventive services fulfill the following purposes: “to provide services when a family is in need of help”; “to strengthen families”; and “to prevent child abuse and neglect.”¹⁹

New York is a state supervised, county administered system of child welfare. New York City ACS is supervised by the State Office of Children and Family Services (OCFS). State regulations define preventive services as “those supportive and rehabilitative services provided to children and their families . . . for the purpose of: averting a disruption of a family which will or could result in placement of a child in foster care; enabling a child who has been placed in foster care to return to his family at an earlier time than would otherwise be possible; or reducing the likelihood that a child who has been discharged from foster care would return to such care.”²⁰ Thus, for a family to be eligible to participate in preventive services, there must be documentation of the need for a child welfare intervention.

Specific services, that when provided for the purposes described in the state regulations,²¹ constitute preventive services include casework contacts, homemaking services, parent training, housing services, child care, provision of emergency cash or goods, and clinical services such as assessment and therapy.²²

According to ACS’s April 1998 *Preventive Services Quality Assurance Standards and Indicators and FRP Addendum* (hereinafter *1998 Standards and Indicators*),²³ which were in effect at the time of CCC’s survey administration, and will be in effect until new preventive service contracts are implemented in July-December 2010, the preventive service programs that contract with the city are required to provide the following services/interventions either directly or through referrals: child safety; clinical services (assessment, testing, treatment or therapy from an MSW, licensed psychologist, psychiatrist or therapist, which is distinct from casework

¹⁷ See e.g. Prevent Child Abuse New York. <http://preventchildabuseny.org/prevention.shtml>, visited 2/21/09; New Jersey Task Force on Child Abuse and Neglect, *Standards for Prevention Programs: Building Success through Family Support*, at 12. (2003). <http://www.nj.gov/dcf/about/commissions/njtfcan/StandardsPrevention.pdf> (accessed 2/21/09).

¹⁸ City of New York. *The Mayor’s Management Report, FY2009*, at 30. http://www.nyc.gov/html/ops/downloads/pdf/_mmr/acs.pdf (accessed December 14, 2009). The City Fiscal Year is from July 1st through June 30th. FY08 and FY09 were very consistent; the average daily number of children receiving contract preventive services was 31,875 in FY08 and 31,752 in FY09.

¹⁹ NYC Administration for Children’s Services, Division of Family Support Services. *Preventive Services: Helping Families in the Community*. (February 2008). http://www.nyc.gov/html/acs/downloads/pdf/preventive_brochure.pdf, (accessed 3/8/09).

²⁰ 18 NYCRR 423.2(b). The focus of CCC’s research and this report is on preventive services to prevent the need for foster care in the first place and not on services to expedite discharge from foster care or services provided after a child is discharged from foster care.

²¹ To be considered preventive services, and reimbursed as such, the services must be provided for the purposes of preventing foster care, expediting reunification from foster care, or reducing likelihood of foster care re-entry after reunification. 18 NYCRR 423.2(b).

²² Id.

²³ As of the writing of this report, the *ACS 1998 Standards and Indicators* remains the administrative guide for preventive programs contracting with ACS. There will be new Standards and Indicators for preventive services when ACS enters into new contracts. These Standards and Indicators were included in the new RFP issued in May 2009. The new contracts are due to be effective between July 1 and December 1, 2010, with most contracts starting October 1, 2010.

contacts); crisis respite for families affected by HIV/AIDS; day care referrals; homemakers; parent training; parent aid services; transportation; 24-hour emergency service access; alcohol and substance abuse counseling or treatment; parent-child interactions (i.e. the program promotes frequent and positive parent-child interactions, such as family counseling, recreational and social activities, etc.); medical and health services (i.e. educational and referrals for care); pre-natal/post-natal care or referrals; housing assistance; education-parent involvement in their children's education; education-training and employment for parents; child care to enable a parent to participate in services; and after-care for children leaving foster care.²⁴

When the new contracts are effective (some time between July and November 2010), required services will include: after-care/simultaneous provision of preventive and foster care services; chemical dependency treatment; child care; child safety assessment; crisis respite for families affected by HIV/AIDS; developmental services for children (such as screening, early intervention, home and community based waiver services, etc); domestic violence screening for all families and advocacy services where indicated; education-parental involvement in their children's education; education-training and employment for parents, caretakers and other adults or adolescents in the home; emergency service access (including cash or goods); health (education/assistance, educational materials, assistance in selecting a primary care physician, ensuring routine examinations and when necessary/appropriate assistance with applying for Medicaid/Child Health Plus); home attendant; homemaker; housekeeping services; housing assistance; mental health (assessment, diagnosis, testing, psychotherapy, and specialized therapies and interventions for families requiring them); promote parent-child interactions (examples: family counseling, parent/child homework groups, recreational activities); sexual health and pre/post-natal care; and transportation (for services).²⁵

In addition to the services preventive service programs are required to provide, offer or refer families to pursuant to their contracts with ACS, ACS also identifies *permitted* services, which are those services ACS encourages preventive providers to make a good-faith effort to offer to families eligible for the services if they are available, yet does not require programs to develop if resources are not available. According to the 1998 *Standards and Indicators*, permitted services (currently and at the time of CCC's survey administration) include crisis respite (for families that do not meet the HIV/AIDS criteria); emergency shelter; emergency cash or goods; entitlements; family planning; home management; housekeeper; independent living for youth 14 years of age or older; legal assistance; outreach (to alert families of the availability of preventive services); socialization; special therapy; therapeutic after-school programs; and vocational/rehabilitation training or counseling to improve a physical or mental condition that is a barrier to employment.²⁶

Pursuant to the *Standards and Indicators* that will become effective with the new contracts, permitted services will include crisis respite (for families that do not meet the HIV/AIDS criteria); day services for children; emergency shelter; entitlements; family planning; home management; housekeeper/housekeeping support (for families that do not fit the criteria for this as a required service); independent living for children 14 years of age and older; legal assistance; outreach to publicize the preventive program; parent education and support; sex education; socialization (for children); special therapy (such as speech therapy and physical therapy); therapeutic after-school program; vocational/rehabilitation education training or counseling; and youth-friendly sexual health services.²⁷

In addition to the services that a program can provide or to which it can refer a family, there is also a minimum number of casework contacts required when a family is receiving preventive services—meaning that preventive service caseworkers must assess a family's service needs, strengths and

²⁴ The City of New York Administration for Children's Services. *Preventive Services Quality Assurance Standards and Indicators and FRP Addendum*, at B1-B18. (April 1998).

²⁵ The City of New York Administration for Children's Services. *Preventive Services Quality Assurance Standards and Indicators*, at B14-B-37. (May 2009).

²⁶ The City of New York Administration for Children's Services. *Preventive Services Quality Assurance Standards and Indicators and FRP Addendum*, at C1-C3. (April 1998).

²⁷ The City of New York Administration for Children's Services. *Preventive Services Quality Assurance Standards and Indicators*, at C38-40. (May 2009).

ability to maintain their children safely in their homes through direct contact with the family and through home visits.²⁸

For a family to receive preventive services, the preventive service program and ACS must first determine that the family is eligible in that the “services are essential to improve family relationships and prevent the placement of the child into foster care”²⁹ or “the child is at risk of foster care” placement.³⁰ For the family to continue to receive services beyond the six-month eligibility period, the local social service district, which in New York City is ACS, must document in the case record that not all of the goals related to the reason for the family’s initial eligibility have been achieved (although they are being pursued) or that the removal of the services would lead to a deterioration of the progress made.³¹

There are two pathways for families to receive preventive services—ACS referrals and “walk-ins.” ACS can refer a family to a preventive service program during or after a child protective investigation or when a child is returned home from foster care. ACS caseworkers can refer families for services regardless of whether they substantiate or unfound the allegations in an abuse or neglect report.³² The parent’s participation in preventive services, even in an ACS referred case, is voluntary. Parents and caregivers can only be

mandated to participate in services if there is a court order requiring them to do so. The cases where parents or caregivers have been ordered to participate in preventive services are typically called court ordered supervision cases.

Families may also seek preventive services without an ACS referral. These cases are typically referred to as “walk-ins” and can be the result of a referral from a school, another community-based organization, another client, or the family can literally walk into the program and seek services.³³

B) CONTRACTED PREVENTIVE SERVICES IN NEW YORK CITY

ACS currently contracts with approximately 75 agencies operating approximately 150 community-based preventive service programs throughout New York City. These contracts are based on a Request for Proposals (RFP), Scope of Services and *Quality Assurance Standards and Indicators* issued in 1998. As indicated earlier, these contract requirements were in place at the time of CCC’s research and will remain in place until approximately July–November 2010. In May 2009, ACS issued a new RFP, along with a new Scope of Services and *Quality Assurance Standards and Indicators*, for almost all of its preventive service program contracts. When the RFP was issued, ACS anticipated that these new contracts and requirements would be effective in July 2010, which is the start of City Fiscal Year 2011.³⁴ Where applicable and feasible, this report addresses both the current preventive service system and the preventive service system outlined in the new RFP.

²⁸ New York State Regulations require a minimum of 12 casework contacts with a child and/or family receiving preventive services every 6 months. At least 6 of the 12 must be by the case planner; at least 4 must be face to face and at least 2 contacts must be in the child’s home. 18 NYCRR 423.4(c)(l)(ii)(d). New York City has more stringent requirements. For example, in General Preventive (GP) programs for families without an indicated case a minimum of 12 casework contacts per 6 months including 2 home visits (1 every 3 months) is also required, but at least 4 must be individual casework contacts (not group). In addition, NYC requires that for GP cases where there had been an indicated case of child abuse/neglect that 6 of the contacts be home visits (1 per month). Finally, NYC requires in GP cases that all 12 casework contacts be home visits for the first 6 months after a newborn enters the family. See Mattingly, J. Memorandum: Casework Contact Requirements for General Preventive Service Providers (Revised). March 8, 2007.

²⁹ 18 NYCRR 430.9(c), describing eligibility for mandated preventive services.

³⁰ 18 NYCRR 423.3(b), describing eligibility for non-mandated preventive services.

³¹ 18 NYCRR 430.9(h)(1). (Note: In ACS’s *Improved Outcomes for Children* (IOC) model described more fully on page 15, the case management function of reauthorizing a family for preventive services is delegated to the preventive service programs, although final approval by ACS is still required.)

³² Throughout this report, cases referred to preventive programs by ACS are called “ACS referred cases” regardless of whether ACS indicated or unfounded the child abuse/neglect report.

³³ There are other frequently used terms to describe preventive service cases—“advocate cases” and “mandated” preventive services. “Advocate” cases are those where the family does not have a substantiated/indicated case, or a sibling in foster care or referred for foster care. Advocate cases can be either walk-ins or ACS referred families. These Advocate cases still result in open ACS preventive service cases, but there are limitations on the transmission of case information to ACS regarding these families. In 1981, the Advocates who initiated the lawsuit, *Advocates for Children v. Barbara Blum*, sought to protect a family’s ability to seek services without fear of government reprisal. In addition, state regulations refer to “mandated” versus non-mandated preventive services. The mandate relates to the county’s obligation to provide services (and the state’s obligation to reimburse for them) and is not related to whether a parent is participating in the services voluntarily or pursuant to a court order.

³⁴ Since the New York City Fiscal Year runs from July 1st through June 30th, July 1, 2010 is the first day of City Fiscal Year 2011. On March 1, 2010 ACS indicated that pending approval from city oversight agencies, ACS is expecting to extend child welfare contracts. According to ACS, preventive contracts will be extended based on the transition plan for each program, such that these contracts will end between June 30 and November 30, 2010 with most contracts ending September 30, 2010.

There are several types of preventive service models in New York City, some of which are provided directly by ACS,³⁵ but most of which are provided through agency programs that contract with ACS. These contracted models currently include General Preventive (GP), the Family Rehabilitation Program (FRP), Medically Fragile services, PINS, Respite, Enhanced Preventive for Babies and Teens and Intensive Preventive for Teens. When the new contracts are awarded, the contracted models will be General Preventive (GP), Family Treatment/Rehabilitation (FT/R), Family-Based Respite Care Services,³⁶ and five specialized preventive program models (Special Medical and Developmental; Families with Children or Parents who are Deaf/Hearing Impaired; Families with Children with Sexual Problems and Youth who have Sexually Abusive Behaviors;³⁷ Families with Children who have been Sexually Exploited; and Center-Based Respite).³⁸

The city currently has the capacity to serve approximately 14,000 families at any one time³⁹ through its contracted programs, typically referred to as Purchased Preventive Services (PPRS). Most of ACS's preventive service contracts are for community-based preventive services, meaning the program's contract is for specific community districts. These programs are typically multi-service, strengths-based, culturally competent and part of the community in which they are located. Some of ACS's specialized preventive service programs are borough-wide or citywide contracts.

³⁵ Preventive services provided directly by ACS include the Family Preservation Program (FPP), homemaking only cases; Teen Age Service Act (TASA) services for parenting teens; and court ordered supervision/Family Services Unit (FSU) cases. The City's Fiscal Year 2010 Budget "reconfigures" the FPP model with "much of its current caseload [to be] served by the Family Services Unit or contracted preventive providers." The City of New York. *January 2009 Financial Plan Fiscal Years 2009-2013*. (January 30, 2009).

³⁶ Note: The Mayor's Preliminary Plan for the Fiscal Year 2011 Budget proposes eliminating the funding for family-based respite.

³⁷ Note: The Mayor's Preliminary Plan for the Fiscal Year 2011 Budget proposes eliminating the funding for this new specialized preventive program.

³⁸ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 13. (May 20, 2009).

³⁹ The City's preventive service capacity was 14,880 slots after 1,000 slots were added in the FY08 City Adopted Budget. These slots were not funded in the FY09 Budget (or FY10). ACS has indicated to CCC that its baselined preventive service slots for Fiscal Year 2009 was 14,687 slots. In March 2010, ACS provided information to CCC indicating that in FY10 there were 13,790 slots. The new RFP significantly reduces the number of slots for which ACS will contract; this is discussed in more detail in the section on System Capacity, which starts on page 22.

When ACS contracts with a preventive service program, the contract is for the program to serve a certain number of families, often referred to as "slots." Programs range in size from 30 slots to 250 slots. Given that ACS pays programs based on the number of slots they contract for (capacity) and not the number of families they are serving, a key indicator for ACS is a preventive service program's utilization rate, which is the percentage of a program's contracted slots that are being used to serve families (as opposed to being vacant).⁴⁰

In addition, the current contract includes a Model Budget, which in its inception in 1998 sought to standardize programs and enhance quality by imposing caseload ratios, minimum salaries, and costs per family. This Model Budget will no longer exist when the new contracts are awarded in late 2010, but the new contracts will include standardized program rates per family, as well as caseload and supervisory ratio standards specific to each program type.

The General Preventive (GP) program is the largest of the program types in terms of the number of families served and is essentially the basic preventive service package. The current average annual cost per slot is approximately \$9,000. Pursuant to the Model Budget, the caseload ratio was 15 families to 1 caseworker, but since July 2007 the caseload ratio has been lowered to 12 to 1 with City Council funding. ACS has adopted this lower caseload ratio in the new RFP, folding the agency's funds for the 12 to 1 caseload into the new GP rate.

The Family Rehabilitation Program (FRP)⁴¹ is currently for parents with substance abuse addictions who have young children. ACS pays a higher rate, of approximately \$16,000, for FRP programs. ACS's enhanced requirements for FRP include lower caseload ratios of 10 to 1, case aides and more frequent casework contacts.

While there are other preventive service program models, CCC's survey research focused only on General Preventive Programs (GP) and Family Rehabilitation Programs (FRP), and thus our findings and recommendations largely focus on these program models.

⁴⁰ ACS calculates utilization as the number of active cases plus the number of active pending cases divided by the program's capacity.

⁴¹ The Family Rehabilitation Program (FRP) is being replaced by the Family Treatment/Rehabilitation (FT/R) model in the new RFP. This new type of program expands eligible families to include those where a family member has a mental illness.

C) FUNDING FOR NYC'S PREVENTIVE SERVICES SYSTEM

New York City's preventive service system is supported by federal, state and city funding. The City's Adopted Budget for Fiscal Year 2010 provides \$201.8 million for preventive services, of which \$75.4 million are city funds (38%), \$94.7 million are state funds (47%) and \$31.7 million (16%) are federal funds.⁴²

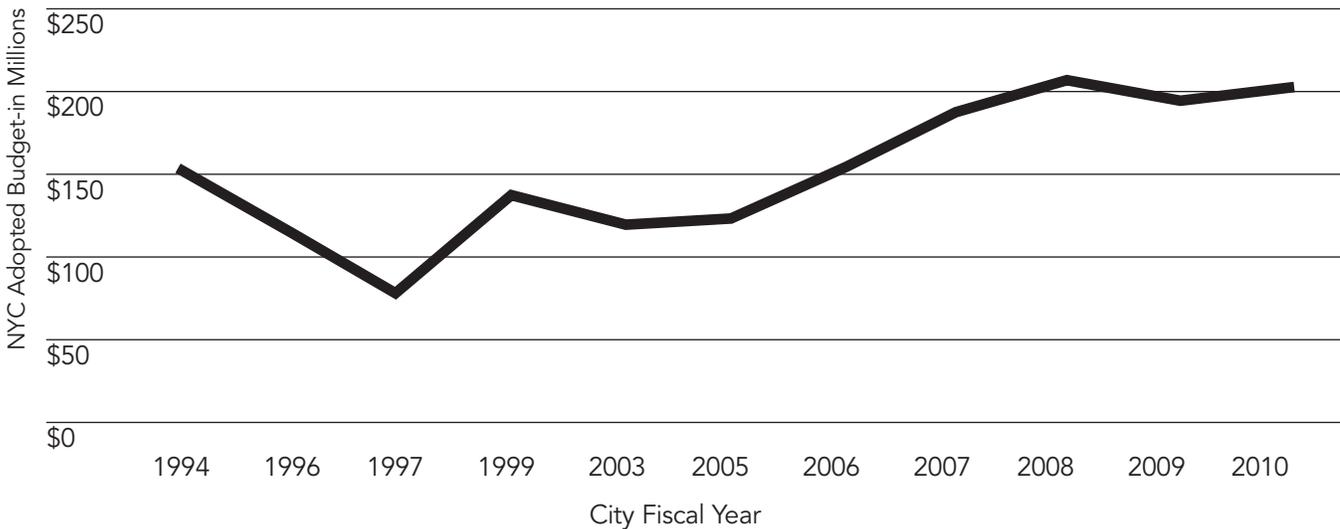
The New York State child welfare financing statute, Social Service Law §153-k, provides for uncapped 65% state reimbursement to counties for local expenditures after localities have used all their federal funds for preventive services and have met their maintenance of effort requirement.⁴³ In April 2010, two months before the statute would have sunset, these child welfare financing provisions were reauthorized for an additional three years, until June 2012.

i) Federal Funding for Preventive Services

While the fiscal benefits and more importantly the benefits to children and families are clear, and the federal government actually requires localities to make "reasonable efforts to prevent removal"⁴⁴ before any child can be placed into foster care, there is very limited federal funding available for services until AFTER a child is already in foster care. According to the Pew Charitable Trusts, in 2007, 90% of the \$7.2 billion in federal child welfare funds was dedicated to support children in foster care and children adopted from foster care and only 10% was for preventive services.⁴⁵

The dearth of federal support for New York City's preventive service system is seen clearly when federal support for foster care is compared to federal support for preventive services. The city projects that in Fiscal Year 2010, the federal government's support will be over \$163 million for foster care, which is almost 28% of total anticipated expenditures,

Figure 1: Funding for NYC Preventive Services Over Time



⁴² New York City Office of Management and Budget. *Budget Function Analysis June 2009 Adopted Budget, Fiscal Year 2010*, at 56. (June 29, 2009).

⁴³ The maintenance of effort (MOE) is the minimum amount of local dollars a county must spend under state law to be able to draw down state reimbursement. In New York City, local expenditures are referred to as city tax levy (CTL).

⁴⁴ Adoption and Safe Families Act, Pub. L. No. 105-89, 111 Stat. 2115 (codified as amended in scattered sections of 42 U.S.C.).

⁴⁵ The Pew Charitable Trusts. *Time for Reform: Investing in Prevention: Keeping Children Safe at Home*. (2007). This same concern was documented by the GAO in 1993. United States General Accounting Office, *Foster Care: Services to Prevent Out-of-Home Placements are Limited by Funding Barriers*. (June 1993).

but only \$31.7 million for preventive services, which is 16% of total anticipated expenditures.⁴⁶

Federal funding for preventive services is comprised of various statutory grants to New York State, which are then divided amongst the counties.⁴⁷ Specifically, federal funding for prevention is through the Child Abuse Prevention and Treatment Act (CAPTA), Title XX of the Social Security Act (the Social Services Block Grant⁴⁸), Title IV-E of the Social Security Act, Title IV-B Subpart 1 of the Social Security Act and Title IV-B Subpart 2 (Promoting Safe and Stable Families). These federal allocations are dependent on federal authorizations, reauthorizations and appropriations, which are not based on how many families are actually receiving preventive services. Furthermore, Congress has historically appropriated lower levels of funding for CAPTA and Promoting Safe and Stable Families than the authorization levels for these programs allow, leaving states and counties with limited federal support for preventive services.⁴⁹

ii) New York State Funding for Preventive Services

While federal support for prevention is through block grants, New York State reimburses counties for preventive services through a matching process that is open-ended, and often referred to as uncapped. The state child welfare financing scheme for preventive services is often referred to as

“the 65/35” because once a county uses its available federal funds and meets the county’s Maintenance of Effort requirement,⁵⁰ there is an uncapped state reimbursement match of 65% for every dollar the county spends on preventive services.⁵¹ Thus, counties receive a state match for every dollar spent on preventive services and that state match is almost two times the county expenditure.

The state’s financing of child welfare has not always been 65% state/35% local, uncapped reimbursement for preventive services. Prior to 1995, the state/local match for preventive services was 75% state/25% local. In 1995, New York State created the Family and Children’s Services Block Grant, which collapsed funding for protective, preventive and foster care services into a single block grant, and then reduced state funding by 26%, or \$151 million, \$131 million of which was shouldered by New York City.

The establishment of a capped block grant and initial funding decrease led localities, such as New York City, to decrease their expenditures for preventive services in order to ensure that they would have sufficient funds for more costly and mandated foster care. For example, in City Fiscal Year 1996, there was a \$38.3 million decrease in city funds for preventive services and then an additional \$35.6 million decrease in City Fiscal Year 1997.⁵²

In 2002, the state adopted Child Welfare Financing Legislation, which created uncapped 65% state reimbursement to localities for preventive, protective, adoption, aftercare and independent living services (after the use of federal funds and meeting the MOE) and a Foster Care Block Grant, which capped state reimbursement for foster care services. This financing structure greatly expanded state resources for preventive services and led to greater county investments as well. By 2007, New York City’s budget for preventive services was more than double what it had been in 1997.

⁴⁶ New York City Office of Management and Budget. *Budget Function Analysis June 2009 Adopted Budget, Fiscal Year 2010*, at 56. (June 29, 2009).

⁴⁷ This is different from foster care where federal support is an open-ended entitlement for all eligible foster children. Unfortunately, fewer and fewer children are eligible for federal foster care support because the income eligibility standard is based on being eligible for AFDC in 1996. Child Welfare League of America. *Ten Years of Leaving Foster Children Behind: The Long Decline in Federal Support for Abused and Neglected Children*. (July 2006). <<http://www.cwla.org/advocacy/childreninfostercarereport.pdf>>.

⁴⁸ New York City does not use the Social Services Block Grant for preventive services, but it is federally permissible.

⁴⁹ Several states have received federal IV-E waivers to conduct demonstration projects in which a capped amount of federal IV-E dollars (typically meant for foster care) are used flexibly for prevention, foster care, expediting permanency and after care services. Thus, in these waiver demonstration projects, federal dollars that typically can only be used for out-of-home-care can be used flexibly for preventive services. North Carolina, Indiana and Ohio had flexible IV-E waivers and had mixed results. Florida and California currently have flexible IV-E waiver demonstration projects. United States Department of Health and Human Services, Administration for Children and Families Children’s Bureau. *Summary of the Title IV-E Child Welfare Demonstration Waivers June 2008*. http://www.acf.hhs.gov/programs/cb/programs_fund/cwwaiver/2008/summary_demo2008.htm

⁵⁰ The Maintenance of Effort (MOE) is the minimum amount of county funds that need to be expended before the county can begin to draw down the uncapped state matching funds.

⁵¹ Social Services Law Section 153-k. As is discussed later in this report, the State’s FY08-09 and FY09-10 Budgets reduced reimbursement to 98%, which makes the state share equal to 63.7%. While reimbursement has been reduced, the statutory language remains unchanged.

⁵² Citizens’ Committee for Children. *Carrots and Sticks: The Impact of the New York State Family and Children’s Services Block Grant on Child Welfare Services in New York City*. (1998).

The 65/35 uncapped match for preventive services has remained in place statutorily since 2002. In the State Fiscal Year 2008-2009 budget,⁵³ due to budget shortfalls that led to across the board 2% cuts to social services, the state only provided reimbursement for 98% of its share (i.e. 98% of the 65% share). This translated into 63.7% state /36.3% local shares for preventive services. This 2% reduction was carried forward in the state's Fiscal Year 2009-2010 Budget, and remains in place at the time of this report's publication.

The state's child welfare financing scheme was due to sunset (expire) on June 30, 2009. As part of the State Fiscal Year 2009-2010 Budget, the state extended the child welfare financing provisions, including uncapped reimbursement for preventive services until June 30, 2012. The 2% reduction in reimbursement remains in place for SFY09-10, but was included only in the budget bill and not in the Social Service Law provisions that were extended for three years. As the state continues to have statutory authority to reimburse counties at 65%, the state will need to affirmatively cut preventive services in future fiscal years to carry forward the 2% reduction in reimbursement.

iii) New York City Funding for Preventive Services

After several years of decreased city funding following the 1995 State Block Grant, New York City steadily increased its investment in preventive services from fiscal years 1998 through 2008. For every dollar the city invested in preventive services, they received almost twice that amount from the state, due to 65/35 child welfare financing reimbursement.

A variety of new services and enhancements were added, many of which were funded through reinvesting savings from reducing the use of foster care. Some of the most recent of these preventive service investments include:

- **Foster Care Reinvestment FY06-FY10:** \$9.5 million city tax levy (\$27 million gross with the 65% state match) for Foster Care Reinvestment. Of the gross sum, \$9 million is for front-end enhanced preventive services for teens and babies and \$18 million is for aftercare (for children leaving foster care).⁵⁴

- **Preventive Service Enhancement Funding FY06-FY10:** In fiscal years FY06-FY08 this funding was \$3.15 million city funds (\$9 million gross with the state match) and in FY09-10, this funding was \$1.6 million city funds (\$4.5 million gross with the state match). In FY11, this funding is rolled into the new contracts and will not exist as a separate allocation. The preventive service enhancement funding is flexible funds, which preventive programs have been able to use to support their program's needs such as emergency goods and supplies for families, translation services, mental health consultants, etc. Over time the allocation has ranged from \$400-\$1,000 per slot.
- **Child Safety Initiative/Caseload Reduction Funding FY06-FY10:** In FY07 and FY08, the City Council allocated \$4.2 million in city funds (\$12 million gross with the state match) to reduce preventive service caseloads at general preventive and special medical programs down from 15 families per caseworker to 12 families per caseworker (referred to as the Child Safety Initiative). Due to budget cuts, the City Council only restored \$3.7 million in FY09 and FY10, which grossed \$9.9 million, so programs received 85% of the caseload reduction funding. Effective in FY11, with the new contracts, ACS has contractually lowered caseload ratios to 12 per worker, and has incorporated this ratio in the new rate.
- **1,000 Additional Preventive Service Slots FY08:** \$2.4 million city funds (\$6.8 million gross with the state match) were allocated to increase the capacity of the preventive service system by 1,000 additional slots/families. This capacity increase was only funded as a one-year addition and has not been budgeted to continue; however, since that time ACS has self-funded some of these slots by temporarily discontinuing its home-based preventive respite program.

City budget gaps have begun to impact the city's ability to maintain funding for preventive services. While most preventive service funding has been preserved, there have been cuts to the family based respite program, ACS's Family Preservation Program, enhancement funds and caseload reduction funds, as well as the number of slots in the system. The Mayor's Preliminary Budget Plan for Fiscal Year 2011 (which begins July 1, 2010) includes a proposal to cut another \$3.6 million in city funds from preventive services (almost \$10 million with the lost state match). This proposed cut would reduce

⁵³ The state fiscal year is from April 1st through March 31st. The State FY2008-2009 relevant Article VII budget bill for the FY08-09 Adopted Budget is Chapter 57 of the Laws of New York, S6807-C/A9807-C.

⁵⁴ The Enhanced Preventive programs are being phased out with ACS's new RFP.

the number of preventive service slots for families, eliminate the development of new specialized services, and lower the rates for the new Family Treatment/Rehabilitation model.

D) SYSTEMIC CHANGES CURRENTLY UNDERWAY⁵⁵

Amidst a continuing decline in the economy and fears of additional budget cuts, the preventive service system is also adjusting to substantial programmatic changes and bracing for others, including system-wide implementation of *Improved Outcomes for Children*, the Preventive Services Scorecard monitoring system, and the upcoming implementation of the new RFP's requirements.

Improved Outcomes for Children (IOC):

Improved Outcomes for Children (IOC) seeks to reform the way ACS works with its contracted preventive partners by enhancing ACS's monitoring of programs, requiring family team conferences every six months, and giving programs more authority to make decisions in individual cases by delegating case management from ACS to the programs. Five preventive service agencies (11 preventive service programs) in Brooklyn participated in Phase 1 starting in October 2007 and then another nine preventive agencies (21 programs) began participating in Phase 1A in June 2008. Unlike foster care agencies that received an annual allocation of \$50,000 per 150 children served to implement family team conferencing (which they have used to hire either conference facilitators or conference schedulers), preventive service programs received no additional funding to implement IOC. IOC was implemented citywide (for all preventive and foster programs) on July 15, 2009.

The New Request for Proposals (RFP):

On May 20, 2009, ACS released an RFP to enter into new contracts with preventive service providers for the next three years (with up to three renewals). According to the new RFP, ACS expected the new contracts to become effective in July 2010, which is the start of City Fiscal Year 2011. On March 1, 2010, ACS e-mailed its providers to inform them that nearly all current contracts will be extended beyond June 30, 2010. With regard to preventive contracts ACS explained, "Preventive contracts will be extended based on the transition plan for each program, such that these new

contracts will end between June 30 and November 30, 2010 with most contracts ending September 30, 2010" and new contracts pursuant to the RFP beginning October 1, 2010.⁵⁶

ACS describes their Goals and Objectives for Preventive Services in the new RFP, and thus for the next decade, in the following manner:

*"Preventive Services are designed to provide at-risk families with community-based services to ensure that children can remain safely in their homes and to avert the need for placements into foster care. This RFP provides support to broaden the scope of families served in General Preventive Programs, create greater efficiency in the use of preventive capacity, increase the capacity of preventive programs to assist families affected by mental illness, and increase the number of families who may be effectively served without removing their children from their homes. For children who have been placed into foster care programs, this RFP provides for the use of community-based assistance that will promote timely family reunification or adoption and prevent replacement."*⁵⁷

In essence, the new RFP seeks to intensify and strengthen the city's preventive service system by enhancing the existing service models, creating new specialized models, and increasing the rate ACS pays the programs, while also decreasing the length of service provision and the system's overall capacity (number of slots). In so doing, the new RFP makes some substantial changes to the preventive service system, some of which CCC feels will improve quality, access and outcomes, and some of which CCC is deeply concerned about. The most notable systemic changes outlined in the new RFP are described below:

KEY COMPONENTS OF ACS'S NEW RFP RELATED TO PREVENTIVE SERVICES:

- ACS indicates in the new RFP that General Preventive Programs (GP) will be "an enhanced version (e.g. higher service levels) of the existing General Preventive Program."⁵⁸ ACS anticipates funding approximately 7,600 GP slots through the RFP⁵⁹ (as compared to the current system's approximately 10,000 GP slots.)

⁵⁶ E-mail from ACS. March 1, 2010.

⁵⁷ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 34. (May 20, 2009).

⁵⁸ Id. at 38.

⁵⁹ Id., *Section II: Summary of RFP*, at 21. Note: The Mayor's Preliminary Budget for FY11 proposes to eliminate 343 of these General Preventive slots.

⁵⁵ A history of preventive services from 1995-2010 can be found in Appendix 2.

- The caseload ratio for General Preventive Programs has been reduced from 15 to 1 down to 12 to 1 and the supervisory ratio is to be 5 to 1.⁶⁰
- ACS is replacing the Family Rehabilitation Program (FRP) and the Enhanced Preventive models (for babies and teens) with the Family Treatment/Rehabilitation (FT/R) model. According to ACS, the model “builds upon the existing Family Rehabilitation Program and Enhanced Babies/Teen programs”⁶¹ and “is designed to support families whose children are at imminent risk of foster care placement or replacement because of prevalent effects of parental and/or child substance abuse and/or mental illness.”⁶² While the FRP program was limited to families with young children whose parents had a substance abuse/dependency issue, FT/R is expanded to include older children, youth with substance abuse/dependency issues, and families where a family member has a mental illness. ACS anticipates funding approximately 1,750 FT/R slots (as compared to the current system’s approximately 1,800 FRP and Enhanced Teens/Babies slots combined).⁶³
- ACS is expanding the types of specialized preventive service programs to include: Center-Based Respite (10-15 slots); Family-Based Respite (50 slots);⁶⁴ Special Medical and Developmental Preventive (348 slots); Families with children or parents who are deaf/hearing impaired (60 slots); families with children with sexual behavior problems and youth who have sexually abusive behaviors (60 slots);⁶⁵ and families with children who have been sexually exploited (60 slots).⁶⁶
- ACS is seeking to reduce the length of service provision to be an average of 12 months.⁶⁷
- As required by state law,⁶⁸ ACS is implementing performance based contracting for preventive services. ACS has chosen to use efficiency as the measure. For GP and FT/R contracts, 10% of the program’s funding will be contingent on meeting ACS’s performance expectations, which pursuant to the new RFP are based on length of service provision. Specifically ACS has set a target of 12 months as the average length of service and expects programs to serve a number of new families each year that is equal to the number of slots allocated to their program. (For example, if a provider were allocated 60 slots, the expectation would be to accept 15 new cases each quarter.)⁶⁹ In the new RFP, ACS explains that they are seeking GP and FT/R services “in which families receive timely assistance and supports to help them transition out of preventive services, with community resources in place where needed. Cases should not remain open for a prolonged period of time unless essential for safety or other reasons.”⁷⁰
- ACS is substantially reducing the system’s capacity by reducing the number of slots for families in the programs now called General Preventive, Family Rehabilitation, Enhanced Teens/Babies, Special Medical, and Deaf and Hearing Impaired from approximately 12,500 slots⁷¹ to 9,943 slots, a loss of over 2,500 slots. Thus, once the new contracts are awarded, ACS’s preventive providers will be able to serve 2,500 to 3,000 fewer families at any one time.⁷²

⁶⁰ Since FY07, the City Council’s Child Safety Initiative has been providing funding to reduce General Preventive caseloads from 15 to 1 down to 12 to 1. In fiscal years 2009 and 2010, the City Council was only able to provide a portion of this funding (\$3.7 million city funds as compared to \$4.2 million). No funds were ever added to ensure supervisory ratios remained at 5 to 1 after the new caseworkers were added. The new RFP codifies and funds 12 to 1 as the standard caseworker to family ratio and 5 to 1 as the standard supervisory ratio for General Preventive service programs. CCC is extremely pleased that the city has adopted and funded lower caseloads.

⁶¹ City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 38. (May 20, 2009).

⁶² Id. *Section III: Scope of Services*, at 50.

⁶³ Id. *Section II: Summary of RFP*, at 23. Note: The Mayor’s Preliminary Budget for FY11 proposes to eliminate 100 of the FT/R slots.

⁶⁴ Note: The Mayor’s Preliminary Budget for FY11 proposes that ACS would not contract for family-based respite.

⁶⁵ Note: The Mayor’s Preliminary Budget for FY11 proposes that ACS would not issue contracts for this new type of preventive program.

⁶⁶ Id. *Section III: Scope of Services*, at 27 and 38.

⁶⁷ Id. *Section II: Summary of RFP*, at 21-22 and 23-24.

⁶⁸ Chapter 57 of the Laws of 2007. 18 NYCRR 423.5 (2009).

⁶⁹ Id. *Section II: Summary of RFP*, at 21-22 and 23-24.

⁷⁰ Id. at 21 and 24.

⁷¹ The total capacity for the program types enumerated in the new RFP has changed over time. This capacity has ranged from 12,953 in FY08 to 12,055 in March 2010. More details of the Preventive Service System’s capacity by program type over time is available in Table 6 on page 26.

⁷² The decreased capacity ranges from 2,112 to 3,010 depending on what point in time the RFP’s proposed slot allocation is compared. In addition, the Mayor’s Preliminary Budget Plan for FY11 proposes to decrease the system’s capacity by an additional 463 slots. Finally, the Mayor has indicated that if the State’s FY10-11 Budget proposals are adopted as proposed, ACS will need to reduce the system’s GP capacity by an additional 30%, or another 2,584 slots.

- The rate per slot (for GP and FT/R programs) will be higher than the current rates for these slots if the decreased length of service provision measure is met. The rate per slot will vary by program size, with smaller programs having higher rates per slot due to larger overhead costs. The current average rate for a GP slot is now \$9,062 (taking into account the service enhancement, COLA and caseload reduction funds, which have been funded year to year and are therefore uncertain). In the new RFP, the rate per slot for GP programs will be \$9,340-\$10,586 (depending on program size) if the performance funds are earned for meeting the length of service requirements.⁷³ The current average rate for an FRP slot is \$16,256 (taking into account the service enhancement funds and COLA, which have been funded year to year). In the new RFP, the rate per slot for an FT/R slot will be \$15,764-\$17,202 (depending on program size) if performance funds are earned.⁷⁴
- ACS will be requiring preventive programs to address service termination and after care by developing programs that offer a range of intensity based on the level of risk and the “capacity to enable families to end their active enrollment with a program when their goals have been met, but retain a connection that enables them to sustain the relationship and return for support and guidance as needed.”⁷⁵ ACS is not providing additional funding for this type of after care service. ACS is also requiring that the FT/R programs offer two levels of intensity within the one program. According to ACS, “The contractor must incorporate into its FT/R a ‘step down’ component that offers services at a less intensive service level. The result is that case planners may have blended caseloads of more intense and less intensive cases. . . . eliminat[ing] the need for families to transfer to another program.”⁷⁶

- ACS is eliminating the use of the Model Budget for Preventive Services.
- ACS is mandating the use of family team conferencing.⁷⁷
- The new RFP contractually implements the IOC model by delegating case management and mandating family team conferences.

Enhanced Monitoring and Oversight of Preventive Service Programs

The quality of a preventive service program is often difficult to measure. While ACS has been able to evaluate, score and rank its foster care agencies for many years through the EQUIP system, there has been no similar monitoring tool for preventive service programs. Instead, much of ACS’s oversight had been with regard to a program’s compliance with the 1998 *Standards and Indicators*, rather than an assessment of the outcomes for children and families served by the program.

In 2008, ACS began a new system of preventive services monitoring and quality assurance, called Scorecard. Preventive Scorecard includes data reviews, case reviews, and interviews with parents participating in the program. This performance and outcome information is regularly shared with preventive service programs.

Careful monitoring and oversight is essential to ensure that children and families are receiving high quality services that effectively meet their needs. This enhanced monitoring is intended to provide both preventive service programs and ACS with critical information needed to strengthen individual programs and the system overall. Early stages of the enhanced monitoring of preventive service programs have already yielded concrete results; according to ACS over the past two years they have transferred approximately 1,000 preventive slots from poor performing programs to better performing programs.⁷⁸

To date, Scorecard results are not being released to the public. ACS decided not to release the Year One Scorecard results recognizing that the evaluation tools and measurements were still being refined and that the programs needed a chance to adjust to the model. ACS has not yet made a decision with regard to publicly releasing Year 2 results.

⁷³ City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 21. (May 20, 2009). The performance funding is 10% of the rate, so if the funds are not earned the range for a GP slot will be \$8,406-\$9,527, depending on the size of the program. Id.

⁷⁴ Id. at 24. If performance funds are not earned, the annual funding range for an FT/R slot is \$14,188-\$15,482 in the new RFP. Note: The Mayor’s Preliminary Budget for FY11 proposes to reduce the rate ACS intended to pay its FT/R providers by 5%.

⁷⁵ Id. *Section III: Scope of Services*, at 44.

⁷⁶ Id. at 51.

⁷⁷ Id. at 35.

⁷⁸ Personal communication with Elizabeth Roberts, Deputy Commissioner for Family Support Services at the Administration for Children’s Services, April 28, 2009.

E) EFFECTIVENESS

When testifying before the New York State Assembly and Senate at the State Fiscal Year 2009-2010 budget hearing, OCFS Commissioner Gladys Carrión was asked how the state's foster care population had decreased. Commissioner Carrión replied to the legislature that this was due to an investment in preventive service programs, particularly in New York City.⁷⁹

The effectiveness of preventive services is difficult to define, measure or demonstrate. As documented in the literature, evaluations of interventions designed to prevent abuse and neglect are still in the early stages of development.⁸⁰ It is generally understood that a successful preventive service intervention will reduce risk factors and promote protective factors.⁸¹

The ultimate goal of preventive services is to prevent abuse, neglect and the need for foster care, meaning that positive outcomes are achieved by the absence of certain bad events occurring. It is very difficult to demonstrate that a preventive service or a specific program successfully prevented abuse or neglect because it is impossible to know what would have occurred without the intervention. In addition, quality preventive service programs should be able to identify when preventive services are not sufficient to maintain children safely in their homes and/or when the actions of a parent warrant a new report of abuse or neglect. Thus, the absence of a foster care placement or a new abuse/neglect report cannot alone be used as a measure of success because it is critical that preventive service programs address child safety concerns when they arise.

While effectiveness is difficult to assess, a close look at recent child welfare trends in New York City suggests that preventive services have been a critical factor in enabling many of the city's children to remain safely in their homes, without the need for foster care, at a time when more abuse and neglect was being identified.

After the highly publicized death of 7-year old Nixzmary Brown in January 2006, the annual number of reports of child abuse and neglect in New York City dramatically increased by over 10,000 reports and has remained significantly elevated since that time. In addition, the indication or substantiation rate⁸² increased from about 33% to about 40%. The increased number of reports combined with the increased percentage of reports indicated means that the total number of families where ACS found abuse or neglect to have occurred increased substantially. Along with the increased number of reports and higher indication rate (and therefore more children found to be abused or neglected), there was also an increase in the number of children entering foster care and an increase in the number of families being served by preventive service programs.

Had it not been for the increased use of preventive services, we expect that there would have been an even larger increase in the number of children entering foster care. The data, listed in Table 1 and graphed in Figure 2, suggest that preventive services, particularly when targeted at families with indicated cases, seems to prevent foster care placement by offering child protective workers with an alternative to removing the child or simply closing the case without any continued involvement with the family.

⁷⁹ New York State Human Services Budget Hearing SFY09-10. (January 14, 2009).

⁸⁰ DePanfilis, D. & Dubowitz, H. *Family Connections: A Program for Preventing Child Neglect*. Child Maltreatment, Vol. 10, No. 2, at 109. Sage Publications. (May 2005).

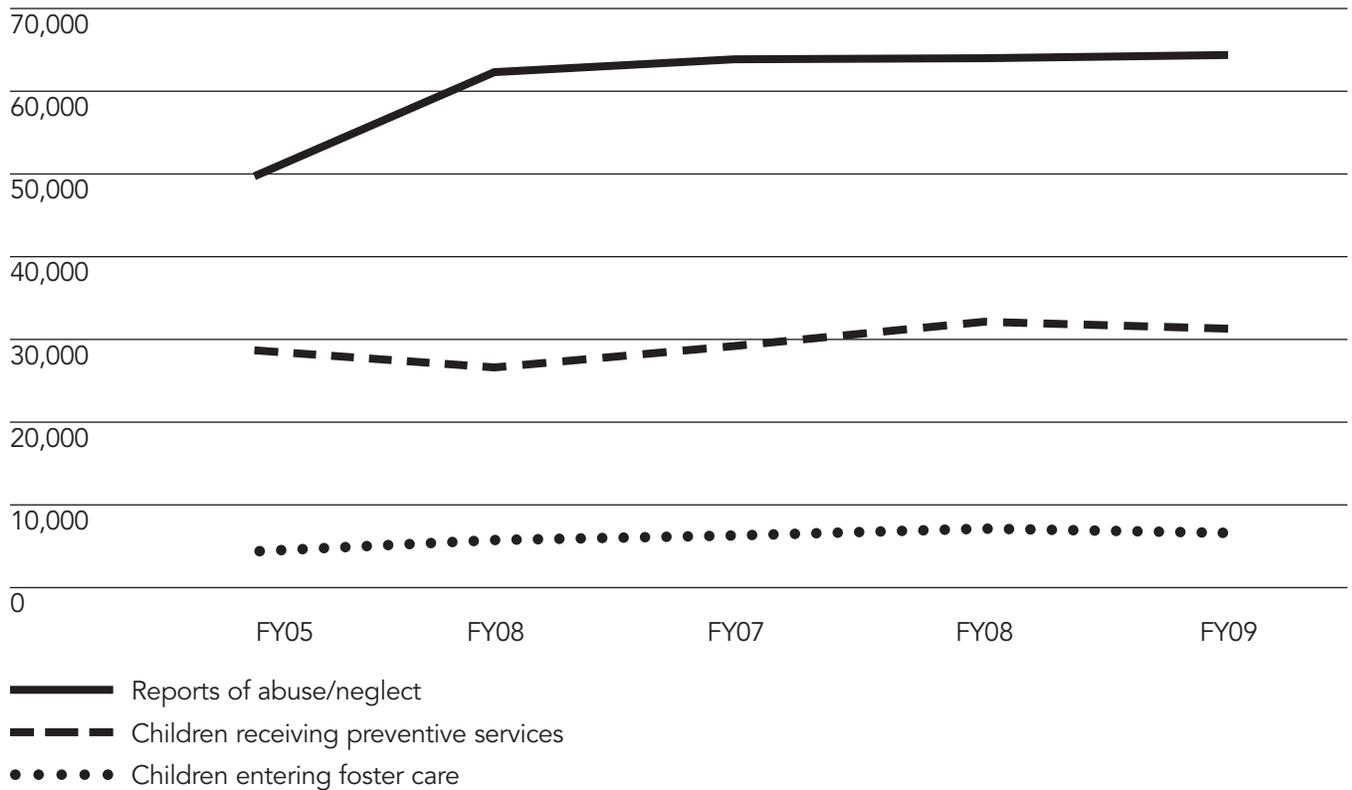
⁸¹ *Id.*

⁸² An indicated/substantiated report is one where ACS found credible evidence of abuse or neglect.

**Table 1: Data Trends Related to New York City Key Child Welfare Indicators;
City Fiscal Years 2005-2009⁸³**

	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007	Fiscal Year 2008	Fiscal Year 2009	% Change FY05 to FY09
Abuse and/or neglect reports	50,309	62,585	64,190	64,572	64,748	28.7%
Indication/Substantiation Rate	32.6%	36.7%	39.8%	39.9%	42.1%	29.3%
Number of reports ACS indicated as abused/neglected (Indication rate applied to # Reports)	16,400	22,969	25,548	25,764	27,259	66.2%
Children receiving contracted preventive services (average daily number)	28,781	27,304	29,506	31,872	31,752	10.3%
Number of children entering foster care	4,813	6,213	7,132	7,460	7,474	55.3%
Children in foster care (average daily number)	18,042	16,206	16,665	16,675	16,435	-8.9%

Figure 2: Child Welfare Indicators



⁸³ City of New York Administration for Children's Services. *ACS Update Five Year Trend (FY2005-FY2009)*. < http://www.nyc.gov/html/acs/downloads/pdf/stats_5_year_2009.pdf > (accessed 12/14/09).

CHAPTER 2: CCC'S INTERVIEW SURVEY, DATA AND POLICY ANALYSIS

A) CCC'S METHODOLOGY

With a longstanding commitment to child welfare and expanding resources for preventive services, Citizens' Committee for Children (CCC) created a "Preventive Services Task Force" in November 2006, led by CCC staff, two CCC Board Task Force Chairs, and comprised of 22 additional CCC volunteers. The Task Force sought to gather information about New York City's preventive service system to document what services were available to families, what barriers programs and families were facing when accessing services, and what additional steps needed to be taken to ensure that every family in need of preventive services could access high quality services in their community.

Prior to the official launch of the Task Force, CCC held ten background meetings with ACS and preventive service programs to learn more about the policies, finances, and day-to-day work of preventive service programs. In November 2006, CCC hosted a policy briefing, *Preventive and Aftercare Services: Keeping Children Safe and Strengthening Families*, which brought together ACS senior level staff responsible for administering preventive and after care services with provider agency managers responsible for their programs' delivery of services to families.⁸⁴

A 56-question survey was developed and finalized after testing draft versions with two preventive service programs. The Survey can be found in Appendix 3 of this Report. CCC volunteers were trained to administer the survey instrument through in-person on-site survey interviews of preventive service program directors at their programs. A total of 31 in-person surveys, consisting of 24 General Preventive (GP) and 7 Family Rehabilitation Program (FRP) interviews with program directors⁸⁵ were completed from April 2007-June 2007. After these 31 on-site survey interviews were conducted, all data was analyzed using SPSS.⁸⁶ All data reported from the survey is based on the answers the program

directors provided on the day of the survey interview.

In addition, in August 2007 a focus group was conducted with parents who had received preventive services in New York City. This focus group was invaluable to our research and the findings in this report because it provided information about how this system impacts the people it was designed to support. To build on this, CCC sponsored another policy briefing in November 2007 with three panelists chosen to speak about the strengths and challenges of New York City's preventive services from the perspectives of the parents and children who had received the services.⁸⁷

CCC developed draft findings and recommendations and vetted these with stakeholders from ACS, OCFS, the Mayor's Office and preventive service programs, to ensure that the findings and recommendations in this report would resonate with those in the field. We appreciate the thoughtfulness and guidance we received in those meetings and have incorporated much of the feedback into this report.

Finally, CCC has continued to stay abreast of the budget and policy changes at OCFS, ACS and the preventive service programs through ongoing and regular reviews of ACS's data, policies, practice guidelines and procedures, literature reviews, and participation in a variety of preventive service related meetings, workgroups and forums from July 2006 through the release of this report.

B) CCC'S SAMPLE

CCC decided to survey only General Preventive (GP) and Family Rehabilitation Programs (FRP), as these programs serve the most families, are community-based, and are long-standing programs that were not in the early stages of implementation at the time of CCC's survey development. While all programs were chosen randomly, we decided that to ensure a varied selection of programs our sample would include no more than one program per agency.⁸⁸

CCC decided to sample 25% of the GP and FRP programs. At the time of sample selection, there were 111 General Preventive Programs and 28 FRP Programs. A total of thirty-five preventive service programs, 28 GP and 7 FRP, were randomly selected to be part of the sample, as this represented 25% of the

⁸⁴ Policy Briefing speakers were Elizabeth Roberts, Deputy Commissioner, Family Support Services from ACS; Nancy Martin, Associate Commissioner, Office of Policy Development and Program Planning from ACS; Jane Golden, Director of Foster Care and Adoption at the Children's Aid Society; and Lew Zuchman, the Executive Director of the Supportive Children's Advocacy Network (SCAN) preventive service program.

⁸⁵ At one program we interviewed the Supervisor because the Program Director was unable to keep the appointment. At several programs the Supervisor was also acting as the Program Director and at several other programs the Program Director was also acting as the Supervisor.

⁸⁶ SPSS is a computer program used for statistical analysis.

⁸⁷ The panelists included a parent from the Child Welfare Organizing Project, a Social Work Supervisor from the Legal Aid Society Juvenile Rights Practice and a Social Work Supervisor from the Center for Family Representation.

⁸⁸ In New York City, an agency can administer multiple programs located in different community districts in the city.

GP and FRP programs respectively. The distribution of randomly selected programs was chosen to roughly reflect the system-wide percentage of programs in each borough. (For example, 19% of the general preventive programs were in Queens so 19% of CCC's GP sample is from Queens.)⁸⁹

CCC then sent a letter to the 35 randomly selected programs explaining the intent of our survey, that their program had been randomly selected, and that all program and staff names would be kept confidential. We followed up with calls to the programs to schedule time for the in-person interview.

While thirty-one of the thirty-five selected programs agreed to participate, 4 GP programs did not agree to do so. Thus, CCC's sample is 31 programs, 24 GP and 7 FRP. The 24 GP programs represent 22% of the GP programs, as opposed to the intended 25%.

Table 2 (below) shows the CCC Sample's distribution by borough and program type.

The 31 programs in the sample served 39 of New York City's 59 Community Districts (CDs), or 66% of the CDs citywide. Taken together, the 31 programs accounted for 1,925 of the 10,965 General Preventive slots in the system (18%) and 220 of the 1150 (19%) FRP slots in the system at the time of the survey interviews.⁹⁰

The programs ranged in size from 30 slots⁹¹ to 260 slots, with a mean of 69 slots and a median of 60 slots. The GP

programs tended to be larger than the FRP programs. The GP programs ranged in size from 30 slots to 260 slots, with a mean of 80 slots and median of 75 slots. The FRP programs ranged in size from 30 slots to 40 slots, with a mean of 31 slots and a median of 30 slots.

In addition, the sample programs were with agencies that had a range of total preventive slots citywide; however, the size of the sample program did not correlate with the agency's total preventive slot capacity. In other words, small preventive programs in the sample were sometimes affiliated with agencies that had many preventive slots citywide. The agencies affiliated with the surveyed programs ranged in citywide capacity from 60 slots to 740 slots, with a mean of 210 slots and a median of 135 slots.

All 31 programs in CCC's sample were part of a community-based organization providing other services in a community such as mental health services, food pantries, after school programs, child care, tutoring, and foster care services. Some of the surveyed programs were part of agencies deeply embedded in the child welfare system and some were part of agencies where the preventive program was the only child welfare component in its range of services. Thirteen of the 31 programs (42%) were part of an agency that also provided foster care services and 18 (58%) were affiliated with agencies that did not provide foster care services.

Table 2: CCC Sample by Borough and Program Type (Percent is of the CCC Sample)

	Total CCC Sample	GP-CCC Sample	FRP-CCC Sample
Bronx	6 programs (19.4%)	5 programs (20.8%)	1 program (14.3%)
Brooklyn	11 programs (35.5%)	8 programs (33.3%)	3 programs (42.9%)
Manhattan	6 programs (19.4%)	5 programs (20.8%)	1 program (14.3%)
Queens	6 programs (19.4%)	5 programs (20.8%)	1 program (14.3%)
Staten Island	2 programs (6.5%)	1 program (4.2%)	1 program (14.3%)
TOTAL	31 programs (100%)	24 programs (100%)	7 programs (100%)

⁸⁹ For the 111 GP programs, 22% were in the Bronx, 34% were in Brooklyn, 23% were in Manhattan, 19% were in Queens and 3% were in Staten Island. For the 28 FRP programs, 21% were in the Bronx, 36% were in Brooklyn, 21% were in Manhattan, 18% were in Queens and 4% (1 program) was in Staten Island.

⁹⁰ The 1,000 slots added in FY08 had not been added at the time of CCC's survey.

⁹¹ A slot = a family.

CHAPTER 3: FINDINGS⁹² AND RECOMMENDATIONS⁹³

Through our on-site interviews of program directors at 31 preventive programs, a focus group with parents, and conversations with OCFS, ACS and other stakeholders, CCC is confident that New York City's preventive service system is one of the best in the country. It is within this context that we hope these findings and recommendations will be read and considered by ACS, OCFS, state and city elected officials, and the preventive service programs.

The findings and recommendations in *The Wisest Investment* document the need for the child welfare stakeholders and all elected and appointed government officials at the federal, state and local levels to more fully embrace the value of preventive services as an equal component of the child welfare tripod.

In doing so, scarce resources can be invested wisely, to both produce better outcomes for children and prevent the need for more costly interventions in the short and long term.

The findings and recommendations are divided into the following eleven sections: 1) system capacity; 2) the initial 30 days after an ACS referral; 3) initial family engagement; 4) accessing services for families; 5) engaging men in preventive services; 6) language access and cultural competence in preventive services; 7) court ordered supervision cases; 8) identifying and addressing safety and risk; 9) training for preventive service caseworkers; 10) case closing; and 11) the preventive services workforce.

The recommendations center around five critical themes: 1) increase the system's capacity to serve all families in need; 2) improve the collaboration and coordination between ACS, its preventive service providers, and other child welfare stakeholders; 3) enhance accountability and oversight and make the results of monitoring public; 4) strengthen case practice; and 5) increase federal, state and city resources available for ACS, preventive service providers, and other community based supports.

We urge city, state and federal elected and appointed officials, the preventive service providers, child welfare advocates and the families touched by the child welfare system, to use these findings and recommendations as they build on the strengths of the preventive service system to produce even better outcomes for New York City's children and families.

⁹² The findings are based on the survey interviews with the 31 preventive service program directors, ACS and OCFS data, interviews with parents, participation in workgroups and research. While CCC believes that 31 programs was a reasonable sample size, it is possible that some of our survey findings cannot be generalized to the entire system.

⁹³ The complete list of Findings and Recommendations is available in Appendix 1.

A) SYSTEM CAPACITY

FINDING: New York City's preventive service system has been, and continues to be, operating on overload and is therefore in need of increased capacity to meet the need and demand for services.

CCC's survey findings and a review of ACS data⁹⁴ document that New York City's preventive service system is in need of more capacity to be able to provide all families in need with high quality preventive services in their communities. This finding is based on a confluence of factors documented in detail below, including: 1) there has been an increase in child abuse and neglect reports, the percentage of reports indicated and thus the number of children ACS has found to be abused or neglected; 2) ACS has significantly reduced the number of cases closed without services following an indicated report of abuse or maltreatment, and is referring many more families for preventive services; 3) the preventive service system has been operating at approximately 100% utilization⁹⁵ for most of the past four years; 4) prior to ACS adding 1,000 additional slots to the system in 2007, programs were turning families away because their programs were full; 5) the percentage of families receiving preventive services that are ACS-referred has increased significantly (from roughly 50% to roughly 75%) impacting the number of slots available for walk-ins; 6) ACS is limited in its ability to collaborate with other city agencies because of its limited number of preventive service slots; and 7) ACS's new RFP intends to reduce the system's capacity by between 2,500 and 3,000 slots.⁹⁶

Prior to Nixzmary Brown's death in January 2006 (and thus before ACS instituted their child safety reforms) preventive service utilization had begun to decline, but within months after her death, preventive service utilization reached

⁹⁴ Relevant data reviewed includes ACS Quarterly Preventive Data; ACS Monthly Updates; the Mayor's Management Report and the NYC Children's Services Flash. Most of this data is available on ACS's web site, www.nyc.gov/acs.

⁹⁵ ACS and the programs define utilization to be the number of active cases plus the number of cases pending acceptance divided by the program's capacity. ACS gives programs up to 30 days to decide to accept a case—these are the cases pending acceptance.

⁹⁶ The Mayor's Preliminary Budget for FY11 proposes to further reduce the system's capacity by an additional 463 slots (343 General Preventive; 100 FT/R; 50 respite; and 60 for families with children with sexual behavior problems and youth who have sexually abusive behaviors).

100%⁹⁷ and has been operating at approximately 100% utilization for much of the time since. In calendar year 2004, the average daily number of active preventive service cases was 11,521 and in 2005 it was 11,309, but in 2006 the average daily number of active preventive cases was 13,152, then 13,247 in 2007, and up to 14,066 in 2008.⁹⁸

This increase has been due in part to the agency's focus on reducing the number of cases closed without services following an indicated report of child abuse or neglect. According to ACS, in January 2006, 44.9% of indicated cases were closed without services compared to just 16% in January 2007.⁹⁹ This change in practice remains in place today—about 13% of indicated cases were closed without services in 2008.¹⁰⁰

The increased use of preventive services is also due in part to the increased number of reports of abuse or neglect investigated by ACS as well as an increased indication rate—meaning that since 2006 ACS has been identifying more families where they believe abuse or neglect has occurred and thus more families they believe could benefit from preventive services. In fact, reports of abuse or neglect increased 22% from FY05 to FY06, with a 36% increase from January (the month of Nixzmary Brown's death) until the end of the 2006 fiscal year. In addition, the indication rate went up from 33% in December 2005 to over 41% in June 2006.¹⁰¹

In sum, the increased number of families identified by ACS to have abused or neglected their children (demonstrated by the increase in the number of reports and the higher indication rate) coupled with the decreased number of cases indicated and closed without services, appears to have led to the increased number of families ACS referred to preventive services. From January 2006–June 2007, ACS opened over 17,000 new preventive service cases, maintaining

approximately 13,000 active families at any one time.¹⁰² The spring of 2007 was the time period when CCC conducted its survey interviews of preventive service program directors.

The increased demand and utilization rate meant that families needing services (both those being referred from ACS and those seeking services on their own) were sometimes unable to access these services. Unlike the foster care system, which expands and contracts based on the number of children in foster care, ACS contracts with preventive service programs for a set number of families, typically referred to as slots.

CCC's survey findings confirm how taxed the preventive service system was in the spring of 2007, which was just prior to the addition of 1,000 new slots to the system. At that time, ACS had recognized the need for more preventive slots, and as part of the city budget adopted in June 2007, 1,000 additional slots were phased into the system starting in September 2007. While these slots were only funded in the city budget for one year, ACS has been able to maintain most of these slots by self-funding them. Even with the addition of these new slots, the system has continued to remain at close to 100% utilization. More details of system utilization over time by program type is in Table 3:

Table 3: Utilization by Program Type Over Time¹⁰³

	General Preventive (GP)	Family Rehabilitation Program (FRP)	Medically Fragile
FY 2005	92.8%	91.9%	95.3%
FY 2006	91.6%	91.7%	92.8%
FY 2007	99.1%	102.4%	105.7%
FY 2008	99.5%	99.2%	100.0%
FY 2009	96.4%	99.5%	91.3%

⁹⁷ In October 2005, preventive service utilization was at about 92% and by October 2006 it was over 100%. Administration for Children's Services. *Safeguarding Our Children- Safety Reforms Update November 2006*. http://www.nyc.gov/html/acs/downloads/pdf/pub_safety_reform_nov06.pdf.

⁹⁸ Administration for Children's Services. *Safeguarding our Children- Safety Reforms Update November 2007*, at 15; ACS Monthly Updates December 2008; June 2008 and June 2007 for 2007 and 2008 data.

⁹⁹ Administration for Children's Services. *Safeguarding our Children- Safety Reforms Update November 2008*, at 17.

¹⁰⁰ New York City Administration for Children's Services. *Child Welfare Indicators Annual Report 2008*. http://www.nyc.gov/html/acs/downloads/pdf/stats_annual_indicators.pdf

¹⁰¹ *New York City Administration for Children's Services. ACS June 2006 Update, FY06*, at 1.

¹⁰² Administration for Children's Services. *Safeguarding Our Children- Safety Reforms Update November 2007*. http://www.nyc.gov/html/acs/downloads/pdf/pub_safety_reform_sept07.pdf. This reflects the time period of CCC's interview survey, which was conducted in the spring of 2007.

¹⁰³ New York City Administration for Children's Services. *ACS Update Five Year Trend (FY2005- FY2009)*.

CCC's survey found that utilization was very high on the day the programs were surveyed.

In fact, 87% (27 out of 31 programs) reported being at or over 100% utilization on the day they were surveyed, with 11 programs (35.5%) reporting that were at 100% and 16 programs (51.6%) reporting being over 100% utilization. The 16 programs over 100% utilization reported being over 100% utilization from 0-30 months, with a mean of 9 months and a median of 7 months.

For more detail on the utilization rates on the day of CCC's survey interview, see Table 4 below.

Utilization was found to be high in all five boroughs. For more details please see Table 5 below.

CCC asked the program directors whether over the prior six months they needed to turn families away because their programs were filled to capacity. Eighty-three percent of the programs (26 of 31) reported that they had turned families away because their program was full (and that these were both ACS referrals and walk-ins).

CCC also asked programs to approximate the percentage

of their current cases that were families referred from ACS (as opposed to walk-ins). Historically, almost all FRP cases have been referred from ACS. This was also true in CCC's survey findings, with the 7 FRP programs reporting that 88%-100% of their cases were referred from ACS (mean was 96% and median was 98%).

General Preventive (GP) program directors reported that 70-75% of their GP cases were ACS referrals (as opposed to walk-ins). Specifically, CCC's survey found that an average of 70.2% (and a median of 74.5%) of the families in the GP programs had been referred from ACS. CCC's survey findings are consistent with ACS data, in documenting the shift from about half of GP families being ACS referred and half being walk-ins to about 70-75% of GP families being referred by ACS and less than a third being families who voluntarily sought services without an ACS referral.

The data clearly show the trend change regarding the proportion of walk-ins being served. In FY04, 50% of the GP cases were referred from ACS; in FY05 49% of the GP cases were referred from ACS, and in FY06 52% of the GP

Table 4: Utilization – Full CCC Sample and by Program Type¹⁰⁴

	Minimum	Maximum	Mean	Median
All 31 Programs	87%	113%	101.9%	101%
General Preventive (GP) (n=24)	87%	113%	101.3%	100.5%
Family Rehabilitation Programs (FRP) (n=7)	93%	110%	103.7%	106%

Table 5: Utilization by Borough

	Minimum	Maximum	Mean	Median
Bronx (n=6)	87%	103%	95.5%	96.5%
Brooklyn (n=11)	95%	110%	103.8%	104%
Manhattan (n=6)	100%	113%	105.3%	104%
Queens (n=6)	100%	103%	100.8%	100%
Staten Island (n=2)	100%	106%	103%	103%

¹⁰⁴All data in tables is based on the information provided by the program directors during the in-person survey interview conducted between April 2007 and June 2007.

cases were referred from ACS.¹⁰⁵ On the other hand, in FY07 68% of the GP cases were referred from ACS and in FY08 76% of the GP cases were referred from ACS.¹⁰⁶

This documents a systemic change for families, communities and providers in that both numerically and as a percentage of families receiving services, there are fewer families who have voluntarily sought services without first being investigated for abuse or neglect who are being served by the preventive service system. Effective with the new contracts pursuant to the new RFP, ACS will require that at least 65%¹⁰⁷ of the families served by General Preventive programs and 90%¹⁰⁸ of families served by FT/R programs (formerly referred to as FRP) be ACS-referred.

CCC also asked the program directors to select from a series of options the two most frequent ways “walk-ins” were referred to their programs. These options included child’s school, word of mouth in the community, referral from other community-based organization, referral from foster care agency, self-referral and other. We found that foster care agencies were not a referral source as often as CCC would have hoped.¹⁰⁹

Self-referral and the child’s school were the two most frequent options chosen, with 69% of programs selecting self-referral and 62% of the programs selecting the child’s school. With regard to the other options, 44.8% selected other community-based organizations, 13.8% selected word of mouth and 7% (2 programs) selected foster care agencies as one of the two most frequent ways “walk-ins” were referred to their programs.

As mentioned previously, the increased need for preventive service slots for families, which was also clearly documented during CCC’s survey interview, led to ACS receiving additional city funding in the City’s Fiscal Year 2008 Budget

to roll out 1,000 new preventive service slots for families.¹¹⁰ From September 2007 to April 2008, ACS distributed these additional 1,000 slots: 750 to General Preventive Programs (GP), 200 to Family Rehabilitation Programs (FRP) and 50 to Special Medical Programs. Two hundred of the additional GP slots were specifically allocated to programs that would be able to serve families with unmet or underserved language needs.

CCC’s survey was conducted just before the 1,000 new slots were gradually added to the system in Fiscal Year 2008. Throughout FY08, close to all 1,000 of these new slots were added to the system, but the utilization rate still remained at approximately 100% in both the GP and FRP programs. For example, from April 2008-June 2008, the average utilization at GP programs was 99.33% and the average utilization at FRP programs was 101.59% for a citywide average utilization of 99.56%.¹¹¹

This data confirms the experiences of the preventive programs. For example, when CCC vetted our draft findings and recommendations with preventive service program directors in September 2008, to ensure that what we were finding resonated with their experiences, a program director from Queens said, “In August we were given 15 new slots. They were filled in two days.”

While system utilization and demand for services remained high, the 1,000 slots were only funded in Fiscal Year 2008, so as of July 1, 2008 ACS technically no longer had the funding for these slots. ACS was able to maintain some of these slots in Fiscal Years 2009 and 2010 through savings resulting from closing their largely underutilized family-based respite programs and not redistributing slots when they terminated or reduced contracts with several poorly performing programs.

While the system continues to operate at almost full capacity,¹¹² ACS’s new RFP plans to reduce the number of slots in the system by approximately 2,500-3,000 slots. This means that even though reports of abuse or neglect have not decreased, the indication rate has not decreased (and in fact

¹⁰⁵ Center for New York City Affairs, The New School. *Child Welfare Watch*. Vol. 17 (Winter 2009), at 27. Administration for Children’s Services. *Preventive Services Programs Quarterly Status Reports*. (various).

¹⁰⁶ Id.

¹⁰⁷ City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Appendix D General Preventive Services Case Practice*, at D-42. (May 20, 2009).

¹⁰⁸ Id. *Section III: Scope of Services*, at 51. (May 20, 2009).

¹⁰⁹ CCC believes that even though children returning from foster care typically receive aftercare services from their foster care agency, that there are also many families that could also benefit from preventive services to ease with the transition. CCC was disappointed that the 167 pages of *Foster Care Quality Assurance Standards (Appendix F)* in the new RFP failed to address the benefits of linking families to preventive services when children transition out of foster care to reunification or adoption.

¹¹⁰ The 1,000 slots cost \$6.8 million, of which \$2.4 million was city funds and \$4.4 million was state funds (at the 65% match).

¹¹¹ NYC Children’s Services. *Preventive Services Programs Quarterly Program Status Report, Quarter 4, FY08* (April 2008-June 2008).

¹¹² During the last quarter of FY09, April-June 2009, the system was operating at approximately 98% utilization. NYC Children’s Services. *Preventive Services Programs Quarterly Program Status Report, Quarter 4, FY09* (April 2009-June 2009).

Table 6: Preventive Service System Capacity By Program Type Over Time

Program Type	# of Slots FY07 (Time of CCC's Survey) ¹¹³	# of Slots FY08 (after ACS added 1000 due to high demand) ¹¹⁴	# of Slots in May 2009 (as described in RFP) ¹¹⁵	Current # of slots (March 2010) ¹¹⁶	# of Slots Pursuant to New RFP ¹¹⁷	# of Slots if FY11 Preliminary Budget Cut to Preventive Services is adopted ¹¹⁸
General Preventive (GP)	9,945	10,695	10,625 ¹¹⁹	10,020	7,600	7,347
FRP or FT/R ¹²⁰	1,150	1,350	1,420	1,330	1,750	1,650
Enhanced Preventive (Teens and Babies)	470	470	N/A ¹²¹	410	0	0
Special Medical/Medically Fragile	225	275	240	225	348	348
Deaf/Hearing Impaired	60	60	45	60	60	60
Respite	103	103	103	10	65	15
New Specialized Programs	N/A	N/A	N/A	N/A	120	60
Total system capacity for program types impacted by RFP	11,953	12,953	12,433	12,055	9,943	9,480
Total preventive capacity with Beacons, intensive preventive and PINS (These three programs are not impacted by RFP. Another RFP for PINS is currently outstanding).¹²²	13,880	14,880	14,687¹²³	13,790	N/A*	N/A**

*(System total will be the 9,943 slots impacted by the RFP plus the PINS, Beacon and Intensive Preventive Slots)

***(System total will be the 9,480 slots impacted by the RFP plus the PINS, Beacon and Intensive Preventive Slots)

¹¹³Information provided to CCC from ACS in November 2007.

¹¹⁴Information provided to CCC from ACS in July 2008.

¹¹⁵In May 2009, ACS issued an RFP for GP, FT/R, and Specialized Preventive Programs. In the RFP, ACS enumerated the current number of slots (at that time) in those program types. This column reflects the number of slots per program type as indicated in the new RFP. City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 17-18. (May 20, 2009).

¹¹⁶Information provided to CCC by ACS in March 2010.

¹¹⁷City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 21,23 and 27. (May 20, 2009).

¹¹⁸The City of New York, Office of Management and Budget. *January 2010 Financial Plan*, at E-22. (January 28, 2010). According to the Mayor's Financial Plan, if the proposed State Budget is passed, ACS will need to reduce its preventive capacity by an additional 2,584 slots. This table does not reflect this additional potential cut.

¹¹⁹The RFP actually accounts for 11,645 GP slots; however, 1,020 of these slots are Beacon Preventive slots, which are not covered by this RFP. Thus, to compare the change in the number of GP slots before and after the RFP (which does not impact the number of Beacon slots), the 1,020 Beacon slots have been removed from the RFP GP count, by CCC.

¹²⁰The Family Rehabilitation Program (FRP) will be called Family Treatment/Rehabilitation (FT/R) in the new RFP. The program is being expanded from providing more intensive services to substance abusing parents with young children to families where a parent or child is abusing substances and families where a family member has a mental illness.

¹²¹ACS currently has Enhanced Preventive programs for teens and babies. The Enhanced Teens Program is an enhancement of GP and the Enhanced Babies Program is an enhancement of FRP. There will no longer be Enhanced Preventive after the new contracts are awarded pursuant to the new RFP. As such, ACS distributed the Enhanced Teens slots to GP and the Enhanced Babies slots to FRP when enumerating the current system capacity (as of May 2009) in the RFP.

¹²²ACS has separate RFPs for Beacon Preventive, PINS Preventive and Intensive Preventive and Aftercare programs. There currently are 1,020 Beacon slots (considered GP) and we do not anticipate this number changing based on information CCC has to date. ACS has another RFP pending with regard to PINS preventive services. ACS also has a separate RFP for intensive preventive. As of March 2010, ACS had 445 Intensive Preventive and Aftercare slots.

¹²³Information provided by ACS to CCC in August 2009.

has increased), and thus the number of families in need of preventive services has not decreased, when the new contracts are implemented in the fall of 2010, NYC's preventive service system will have about 2,500 fewer slots than currently exist in the system and when CCC conducted its survey.

According to the new RFP, there will be a citywide reduction of 22% for GP and FT/R slots; there will be a 16% reduction in slots in the Bronx; a 25% reduction in slots in Brooklyn; a 38% reduction in slots in Manhattan, a 19% reduction in slots in Queens; and a 40% increase in Staten Island. Appendix 4 provides the details of how the slot reduction is due to be distributed by community district.

As is shown in Table 6, the system's capacity has changed over time. Pursuant to the new RFP, the system will have 3,010 slots less than it did after the 1,000 slots were added in FY08; 2,490 slots less than it did when ACS issued its RFP in May 2009; and 2,112 slots less than it had in March 2010. In addition, the Mayor's Preliminary Budget for FY11 proposes to reduce the system's capacity by an additional 463 slots. Finally, the Mayor has indicated that if the State's FY10-11 Budget proposals are adopted, ACS will need to reduce its GP capacity by an additional 30%, or 2,584 slots.

ACS explained that the reduced capacity system in the new RFP should be able to serve the same number of families because the new RFP also looks to shorten the length of service delivery to an average of 12 months.¹²⁴ In the new RFP, ACS describes one of the goals for preventive services for the next decade to be to "provide an average 12-month service period to ensure the availability of preventive services to all families demonstrating a need for such services." Thus, the significant decrease in the system's capacity, whereby 2,500-3,000 fewer families will be able to be served at one time, is linked to the assumption that the programs can decrease the length of service provision.

CCC questions the ability of ACS to serve all of the families demonstrating a need for preventive services, even if the programs are able to achieve the shortened average length of service provision. In the most recent fiscal year 2009, ACS was serving approximately 14,000 families at any one time

and opened almost 12,000 new cases.¹²⁵ It seems unlikely that ACS could continue to serve 12,000 new families in just 10,000 slots, even if the programs maintained a 12-month average length of service provision. This finding is extremely troubling to CCC.

RECOMMENDATION: New York City needs to expand, not contract, the capacity of its preventive service system so it can accommodate every family in need of preventive services.

New York City's preventive service system must be able to accommodate every family that needs these services to enable their children to remain safely in their homes. This must apply for all families in need, regardless of whether they are voluntarily seeking services, being referred by ACS or being court-ordered to participate in preventive services. Unlike some community services that are understandably limited in capacity based on fiscal and other constraints, child welfare services must never have a shortage of supply.¹²⁶ Preventing child abuse, neglect, maltreatment and foster care can never be optional.

ACS has publicly made 5 commitments to New York City's children and families.¹²⁷ One of these is that "All families needing and wanting help to keep their children safe will receive the help they need."¹²⁸ CCC believes that for ACS to maintain this commitment, ACS must not only retract its plan to reduce the system's capacity, but must actually increase its preventive service slot capacity.

¹²⁴ E-mail from ACS, Oct. 7, 2008 in response to a question posed to an earlier version of the RFP that was repealed, but then reissued in May 2009. Both the 2008 repealed RFP and the May 2009 RFP have the same efficiency standards that are linked to a higher level of funding (12-month average length of service provision and turnover one quarter of families served each quarter).

¹²⁵ The cumulative number of preventive cases opened in FY09 is 11,924. New York City Administration for Children's Services. *ACS Monthly Update, June 2009, FY09*, at 4. <http://www.nyc.gov/html/acs/downloads/pdf/stats_monthly_update.pdf> (accessed 9/5/09).

¹²⁶ CCC is aware that at this time, particularly given the current budget constraints, the city's preventive service system is limited in capacity.

¹²⁷ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 6. (May 20, 2009).

¹²⁸ Id. The other 4 commitments are: All children coming into contact with the child welfare system will be protected from abuse and neglect; All children coming into contact with the child welfare system will receive the help they need to be healthy and achieve their full developmental and intellectual potential; All children in the child welfare system will leave our care with a caring, committed, and permanent family; Every team member at Children's Services and each of our partner agencies can expect guidance, respect, and emotional support to achieve our goals. Every child, family, community member and foster parent we come into contact with will be treated with the same concern and respect.

CCC was very concerned that at the time of our survey, 26 of the 31 programs (83%) reported they had turned away families in the prior 6-month period because their programs were full.¹²⁹ Since the additional 1,000 slots were added, the preventive service system has begun to stabilize in terms of utilization. CCC would hate to see this progress stymied by not only eliminating these 1,000 slots, but also eliminating 2,000-3,000 additional slots. Most importantly, CCC does not want preventive service programs to have to turn away eligible families seeking services.

In difficult economic times it is more important than ever that preventive services, which strengthen families and enhance child well-being by enabling children to remain safely in their homes, continue to be supported. The consequences of failing to do so will be more costly financially to the city, but more importantly, to the well-being of children.

CCC believes that the preventive service system must be able to accommodate not only the ACS referrals, but also the “walk-ins” who are found to be eligible for services. We worry that if the system is short of slots, that families voluntarily seeking services will not be able to be served. The new RFP will continue to require preventive programs to give priority to ACS referrals, FAP (Family Assessment Program for teens whose parents are considering Persons in Need of Supervision petitions), NYCHA (New York City Housing Authority), foster care providers and DHS homeless shelters.¹³⁰ While serving these families needs to be a priority, it is also critical that the preventive service system be able to accommodate the demand for services from walk-ins; providing services to strengthen and support an at-risk family that voluntarily seeks help before ACS involvement is the best-case scenario for children.

As one program director explained, “True prevention of child maltreatment, before investigations by ACS and before police and court involvement, is only possible if families can find community support when they recognize a problem and seek help. If preventive services are not available to community ‘walk-ins’ because of insufficient capacity, the risk increases

that those children and their families, who recognize that they need help but cannot get it, will suffer potentially grave consequences. This is not a matter of conjecture; it is a simple and predictable cause and effect.”¹³¹

In addition, there must be enough preventive service slots to serve families after children have been reunified or adopted from foster care, as well as enough slots so that families in court-ordered supervision cases are able to receive the services of a community-based preventive program when this is assessed to be beneficial.¹³²

At the same time, the child welfare system cannot be the default for families that need services that can be provided by other community-based organizations not affiliated with the child welfare system. Particularly in difficult budget and economic times, the child welfare system must be reserved for at-risk families needing services to maintain children safely in their homes. Preventive service programs must also close cases when families have been stabilized and children are no longer at risk so that other more needy families can be served in those slots.

CCC also believes that ACS should be expanding its collaboration with other city agencies that serve high-risk families and applauds the city’s formal collaboration between ACS and the New York City Housing Authority (NYCHA). Through this collaboration, families living in NYCHA public housing developments can be referred to a preventive service program by NYCHA and then receive priority for services when there is a need for services to maintain the children safely in the home.

Given that agencies, like NYCHA, that often come into contact with high-risk families, have developed relationships with such families, and can then identify families that could benefit from preventive services, CCC believes that ACS should be building on the NYCHA model and expanding it to other city agencies. Unfortunately, if ACS does not expand its capacity, and actually decreases its capacity, ACS will not be able to collaborate effectively with other city agencies also serving and identifying at-risk families.

Specifically, strategic collaboration with the City’s Department of Homeless Services (DHS), the Department of Education (DOE) and the Department of Health and

¹²⁹ CCC recognizes that this does not mean that all of the turned away families were unable to be served since hopefully the families were referred to other programs with openings; however, when a family is in crisis and seeks help, referring them elsewhere is far from best practice.

¹³⁰ City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Appendix D Preventive Service Quality Assurance Standards and Indicators*, at D-47. (May 20, 2009).

¹³¹ E-mail from Julia Jean-Francois, Co-Director of the Center for Family Life, to Stephanie Gendell, CCC Associate Executive Director. (August 8, 2008).

¹³² Court ordered supervision cases are discussed in more detail starting on page 60.

Mental Hygiene (DOHMH) would enable the preventive service system to reach out to families in need before abuse or neglect occurs. For instance, at any given time there are approximately 16,000 children from 9,000 families living in the city's homeless shelter system¹³³ and given the housing instability and the stress this causes, many of these families could benefit from preventive services.

In addition, in 2008, DOHMH conducted almost 8,000 newborn home visits to new mothers in seven high-need communities.¹³⁴ According to DOHMH, during a home visit the health worker: provides information on topics such as breastfeeding, safe sleep practices and health insurance; screens for potential health or socio-emotional problems such as post-partum depression, housing instability and domestic violence and then makes appropriate referrals as needed; assesses the home environment for hazards such as lead-based paint, missing or improperly installed window guards and missing smoke and/or carbon monoxide detectors and makes referrals for repairs; and arranges for a free crib for any family that needs one.¹³⁵ CCC believes that the lack of collaboration between DOHMH and ACS and its preventive providers, partly due to a capacity shortage, is a missed opportunity to link families to preventive services before any abuse or neglect occurs.¹³⁶

RECOMMENDATION: If ACS does significantly reduce the capacity of its preventive service system, ACS must very carefully and deliberately transition to the new contracts so as to ensure that families currently being served continue to have their needs met.

CCC is very concerned that the transition and implementation of ACS's new RFP will result in the discontinuity and/or discontinuation of services for many families who are currently receiving preventive services and continue to need services.

To transition from where the preventive service system is now (in terms of capacity) to where the preventive service system will be when all the new contracts become effective between July 1 and December 1, 2010, will mean shedding approximately 2,500 families from the system. In addition, due to this contraction and the new contract awards, many programs currently contracting with ACS will have new contracts for fewer slots, some programs will no longer have contracts with ACS at all, and presumably new programs will be awarded slots.

CCC is first and foremost concerned with how the system is going to very quickly and significantly downsize, while maintaining the ability to respond to new families identified to be in need of services. ACS has already spent several years working with its preventive providers on closing cases where families are no longer in need of services, and thus we have a hard time believing that there are 2,500 families with open cases whose cases will be able to be closed imminently.

Furthermore, we are concerned that the changes in program size and program existence will lead to disruptions in family engagement and service provision due to both changes in caseworkers and transfers of cases from one preventive program to another. Given that a key component of preventive services is parental engagement, these disruptions seem likely to have a very detrimental impact on the progress many families are currently making (and even more so for the families currently struggling to meet the goals in their service plans.)

While CCC would prefer that ACS not proceed with this downsizing and shuffling of slots, if these transitions are going to happen, ACS and its providers must proceed cautiously and must carefully and deliberately determine case by case whether the case should be closed and/or whether the family can be served by another program in their community. ACS must work with the Mayor's Office of Management and Budget (OMB) on a plan to meet the needs of the families in excess of their capacity who are found to still need services.

¹³³ The daily census for 12/8/09 was 8,938 families with 16,208 children. New York City Department of Homeless Services. *Daily Report 12/9/09*. < <http://www.nyc.gov/html/dhs/downloads/pdf/dailyreport.pdf>> (accessed 12/14/09).

¹³⁴ Personal communication with Tracy Agerton, Director of Newborn Home Visiting Program, NYC Department of Health and Mental Hygiene. November 2009.

¹³⁵ New York City Department of Health and Mental Hygiene web site. http://www.nyc.gov/html/doh/html/dpho/dpho_newborne.shtml?b=6, visited December 1, 2008.

¹³⁶ CCC has spoken to both ACS and DOHMH about trying to formalize this type of linkage by providing DOHMH home visitors/health workers with preventive service referral information for the communities they are serving. To date, this effort has been stymied by capacity restraints.

B) THE BEGINNING OF A PREVENTIVE SERVICE CASE: REFERRALS FROM ACS TO PREVENTIVE SERVICE PROGRAMS

FINDING: There was significant disparity among surveyed programs with regard to how cases were handled when they were first referred from ACS. Some programs did not begin working with families in a timely or expeditious manner.

The 1998 *Standards and Indicators*,¹³⁷ in effect at the time of CCC's survey and in effect until ACS awards new preventive service contracts, provides little guidance and issues few requirements to programs regarding the initial stages of engagement or service provision for families referred for preventive services by ACS. The only exceptions are a) ACS referrals take priority;¹³⁸ b) waitlists for families seeking services are prohibited;¹³⁹ and c) programs must determine within 30 days whether or not they will accept a case for services, and must attempt a home visit prior to making this determination.¹⁴⁰

Typically, when an ACS child protective worker (in conjunction with his/her supervisor and manager) has conducted an investigation and believes preventive services would be beneficial to strengthen and support the family and enable the child to remain safely in the home, the child protective worker refers the case to the ACS Preventive Service Liaison who works in the ACS child protective unit. The ACS Preventive Service Liaison (typically referred to as the PPRS Liaison) then refers the case to a preventive service program in the family's community that ACS believes can meet the family's needs. The program accepts the referral if they have slots available and if they feel they can meet the language, cultural and service needs of the family.

Once a program accepts a referral, the program contacts the family (by letter, phone and/or home visit) to try to engage the family in services, as family participation is

typically voluntary.¹⁴¹ As per the 1998 *Standards and Indicators*, the program has 30 days to inform ACS whether or not the program is accepting or rejecting the case. When a parent agrees to participate in preventive services, he/she signs an agreement form, referred to as a "2921."

ACS provides guidance to the preventive service programs on a timeline to follow during the 30 day engagement period in the CS-842, which is a form used by preventive service programs to notify ACS of the disposition of ACS referrals. The form tells programs that their contract allows 30 days for the agency to engage the ACS-referred client and then gives the following guidance:

- Within 48 hours of the ACS referral the preventive service program is to contact the client.
- Within 10 days of the ACS referral, the caseworker and referring ACS caseworker are to meet with the client face to face, if possible in the client's home.
- Between 10 and 30 days, the preventive service program is to have successful weekly contacts with clients.¹⁴²

From approximately 2001 until September 2008, ACS encouraged preventive service caseworkers and ACS child protective workers to complete a "joint home visit" when cases were transferred from a child protective field office to a preventive service program. The purpose of this joint home visit was to transfer the case from ACS to the provider more seamlessly so that the family understood the process and critical information was shared among ACS, the program and the family.

In July 2008, ACS Commissioner John Mattingly issued a memorandum stating that effective September 2, 2008, preventive service programs and ACS child protective workers would be required to have a "transition meeting" for all families referred from ACS to a preventive service program as a result of an indicated child abuse or maltreatment report. As per the memorandum, the transition meeting can either be a joint home visit, a family team conference or a family meeting, and it can be held at ACS, at the preventive program or in another location in the community. In addition, the Commissioner stated that ACS expects the

¹³⁷ The City of New York Administration for Children's Services. *Preventive Services Quality Assurance Standards and Indicators and FRP Addendum*. (April 1998).

¹³⁸ *Id.* at D4.

¹³⁹ *Id.* at D5.

¹⁴⁰ *Id.* at D6.

¹⁴¹ The exception to this is when the court orders the family to participate in preventive services, which typically happens either in a Court Ordered Supervision case or when preventive services are ordered as a condition of a child's reunification from foster care. Court Ordered Supervision cases are discussed in more detail on page 60.

¹⁴² E-mail from ACS Deputy Commissioner Elizabeth Roberts to Stephanie Gendell, May 7, 2009.

preventive service program to reach out to the family within 48 hours of receiving the referral and for the transition meeting to be held within 7 days of the referral; however, if the meeting cannot be held within 7 days, the program needs to work to engage the family independently and the meeting must be held before the end of the 30 day engagement period.¹⁴³ CCC conducted its survey interview prior to the issuance of this July 2008 memorandum (and the subsequent May 12, 2009 memorandum issuing minor revisions).

The *Preventive Service Quality Assurance Standards and Indicators* that are included in the new RFP, and thus will become part of the contracts between ACS and providers, also address timelines and requirements for the initial engagement of families. Pursuant to these new contracts, programs will still be given 30 days to accept or reject the referral and be required to employ appropriate outreach and engagement strategies that include at least two attempted home visits at different times of the day before rejecting an ACS referral.¹⁴⁴ The new *Standards and Indicators* will also contractually codify the need to begin outreach to families within 48 hours of receiving a referral¹⁴⁵ and hold a transition meeting (with ACS child protective staff) within 7 days of the referral for ACS referrals of indicated cases.¹⁴⁶ Finally, the new *Standards and Indicators* clearly require programs to monitor safety and risk throughout the life of the case.¹⁴⁷

During CCC's survey interview, we asked program directors how many days typically elapse between the time their program received a referral from ACS and the occurrence of several events related to engaging and serving families. While CCC asked for the typical number of days, some programs provided ranges or other open-ended responses that could not be quantified. This section summarizes these findings numerically where possible and quoting program responses where informative.

¹⁴³ Mattingly, J. *Memorandum: Improving the referral process from protective services to preventive services*. (July 18, 2008). This Memorandum was reissued on May 12, 2009 with minor revisions. Mattingly, J. *Memorandum: Improving the referral process from protective services to preventive services*. (May 12, 2009).

¹⁴⁴ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Appendix D Preventive Service Quality Assurance Standards and Indicators*, at D-47. (May 20, 2009).

¹⁴⁵ *Id.*

¹⁴⁶ *Id.* at D-48.

¹⁴⁷ *Id.* at D-52.

According to the surveyed programs, the number of days that typically elapse between the time their program receives a referral from ACS and the following events occurred is as follows:

- **First contact with family:** The time between the ACS referral and the first contact¹⁴⁸ with the family ranged from immediately to 3 weeks. Only about half of the programs self-reported meeting ACS's 48-hour contact rule.
 - 52% of programs (16 of the 31) said the first contact was made between immediately and 2 days after the ACS referral.
 - 32% of programs (10 of the 31) said the first contact was typically between 3-5 days after the ACS referral.
 - 16% (5 of the 31) said the first contact was typically made in more than 5 days after the ACS referral.
- **Home visit:** The time between the ACS referral and the first home visit also varied widely. Several programs indicated that in the cases requiring a joint home visit with ACS, it takes them longer to make the first home visit. ACS's rule at the time of survey administration was that in ACS referred cases, the preventive service worker and the ACS worker were supposed to meet with the client together within 10 days of the referral, preferably in the family's home. Eighty percent of the responses that could be quantified indicated that there was typically a home visit within 10 days of the referral from ACS.
 - Only 29 of the 31 responses could be quantified. For the two that cannot, one reported that the home visit occurred within 3 days of when the family signs the "2921", which is the form indicating that they are accepting services (this could be up to 33 days after the referral) and the other responded that it varies too widely to estimate.
 - 34% (10 of 29) reported that they made a home visit within 6 days or less from the day they receive the referral from ACS.
 - 45% (13 of 29) reported that the home visit typically happens 1 week to 10 days after they receive the referral from ACS.
 - 20% (6 of 29) reported that the first home visit is typically more than 10 days after they receive the referral from ACS.

¹⁴⁸ The first contact can be by phone, letter, or in-person meeting (in the office or the family's home).

- **Provide a service to address the family’s presenting need(s):** Program director responses included a range from “immediately if there is a crisis” to “30 days after the family signs the 2921” form. While the responses were difficult to quantify because they were often ranges, for the most part, the responses seem to indicate that surveyed programs were providing a service to address a family’s presenting service need between 7 to 30 days after a referral is made.
- **Program does a safety assessment:** While CCC feels that every preventive program’s interaction with a family should be assessing the safety of the children, programs gave varying responses when asked how many days elapse from an ACS referral until their program does a safety assessment, ranging from immediately to 45 days to not at all. Several program director responses are provided below:
 - “Immediate and ongoing”
 - 45 days
 - 30 days after the family signs the ACS form
 - Within 10 days- at the joint home visit with ACS
 - At first home visit
 - At point of first contact
 - “Not in ACS cases”¹⁴⁹
 - 3 weeks- in the context of a thorough intake
 - 20 business days
- **The family receives emergency cash or other emergency assistance (such as food, clothing, cribs, etc.) if needed:**¹⁵⁰ Program directors gave various responses, which ranged from immediately to not at all. Several responses are listed below:
 - “Almost not applicable. We rarely turn to petty cash.”
 - Immediately (10 programs gave this response)
 - “No budget allowance, so rarely. We may send the family to our food pantry.”
 - Same day as family signs 2921 agreement form to work with program
 - “After ACS is out of the picture.”
 - “ACS has to do this.”

- **The program tells ACS whether or not the case is accepted or rejected:**
 - 74% of the programs (23 of 31) said that they typically use the full 30 days provided by ACS policy.
 - 26% of the programs (8 of 31) said that they typically respond in less than 30 days. For these programs, they reported telling ACS whether or not the case was accepted or rejected within 2 weeks to 20 days after they received the referral.

FINDING: According to the surveyed programs, when ACS referred cases to them they typically received an assessment of the family, but the information was not as helpful with regard to the family’s service needs, the risk to the children and the family’s history, as they would have liked.

CCC asked the program directors how often ACS provided their program with an assessment of the family when ACS referred families to them. The programs reported that they typically receive an assessment.

- 77.4% of programs (24 of 31) reported that they almost always (15 programs) or sometimes (9 programs) received an initial assessment from ACS when cases were referred.
- 22.6% of programs (7 of 31) reported that they rarely (3 programs) or never (4 programs) received an initial assessment from ACS when cases were referred.

Several programs did note, however, that what they received was actually “just a paragraph” from ACS and that they would not necessarily describe it as “an assessment,” which was the term used in the CCC question. For example, one program director from an FRP program said, “ACS gives us a paragraph that is a case description with the presenting problem- it is not an assessment. All families in FRP programs have a drug problem- so we start knowing that, which helps.”

CCC also asked the program directors how helpful the information they received from ACS was with regard to a family’s service needs, the risk to the children, and a family’s history. While information on a family’s service needs and the risk to the children was typically somewhat helpful, 64.5% of the programs reported that the information about a family’s history was “not too helpful.” Table 7 provides more details of the program directors’ responses to this series of questions:

¹⁴⁹ This report addresses issues related to preventive programs understanding their role in identifying safety issues in Section H, starting on page 64.

¹⁵⁰ It is important to remember that this finding comes from a survey interview conducted prior to the economic downturn. Currently, families are more in need of this type of assistance and programs have fewer resources to obtain them.

Table 7: Helpfulness of ACS’s assessment in telling the programs the family’s service needs, risk to the children and family’s history N=31

	Very Helpful	Somewhat Helpful	Not Too Helpful
Family’s Service Needs	6.5% (2)	71% (22)	22.6% (7)
Risk to the Children	12.9% (4)	64.5% (20)	22.6% (7)
Family’s History	6.5% (2)	29% (9)	64.5% (20)

It is important to note several policy and procedure changes have taken place since CCC conducted its survey interview. First, since October 2007, ACS has been providing preventive service programs with access to ACS’s case investigation progress notes and findings on indicated cases (i.e. the CONNECTIONS case record). This should provide programs with more case information, particularly related to a family’s history and service needs. Second, in 2009, ACS revised their referral forms and procedures such that they now use the Family Service Intake Form (a state-developed tool in the CONNECTIONS system) as the primary source of information about the family’s needs and the basis for the referral to preventive services. Third, ACS recently delivered a training to their Preventive Service Liaisons (some of whom were new to the role due to staffing changes created by ACS layoffs and subsequent civil service bumping), which emphasized the policy and practice expectations regarding referrals and transition meetings.

RECOMMENDATION: To ensure more timely contact and engagement with families in crisis, ACS should intensely monitor preventive service program compliance with timeframes when cases are first referred and consider adding a deadline for the first home visit.

As demonstrated by the data obtained through CCC’s survey interviews, timeframes for the initial contact, home visit, safety assessment, provision of services to meet a family’s presenting need and the provision of emergency cash or goods, varied widely from program to program. On the other hand, where there was a clear requirement to accept or reject a case within 30 days, programs were very consistent in their self-reported timeframes, indicating a clear understanding of the mandated timeframe.

Families referred from ACS are in the midst of a crisis. At a minimum, they have just been the subject of a child abuse or maltreatment report and endured a child protective investigation for allegedly abusing or neglecting their children. In addition, familial circumstances or needs have led ACS to refer the family to a preventive service program for services to strengthen and support their family. Some of these families may be on the brink of a tragedy. These families cannot wait and should not have to wait for the preventive service program to contact them, to begin assessing their needs, or to start providing them with services. While building a relationship and engaging a family takes time, making contact, assessing safety, making a home visit, providing a service to address an identified need and providing emergency cash or goods can and should be done in significantly shorter timeframes than many of those that were reported to CCC.

CCC concurs with ACS’s requirement that preventive service programs initiate outreach to the family within 48 hours of the referral and that a home visit or family conference be held within seven days of the referral.¹⁵¹ This requirement is codified in the new RFP, which states, “A face-to-face transition meeting should occur within the first seven days after the referral to the provider. Concurrently, the provider shall initiate outreach to the family within forty-eight (48) hours. Should the meeting not occur within the first seven (7) days, the provider shall continue the engagement process independently, while working with the Child Protective Specialist to schedule the transition meeting.”¹⁵² CCC recommends that ACS make the requirement for the transition meeting to be held within seven days stronger and issue a mandated deadline for the first home visit.

CCC appreciates that the requirements for preventive service providers are taking into account the fact that ACS child protective staff are not always able to attend a transition meeting within seven days of the referral; however, CCC encourages ACS to strengthen this requirement for both its own staff and its contracted providers.

¹⁵¹ Mattingly, J. *Memorandum: Improving the referral process from protective services to preventive services.* (July 18, 2008).

¹⁵² City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Appendix D Preventive Service Quality Assurance Standards and Indicators*, at D-48. (May 20, 2009).

Furthermore, the new RFP still does not include a timeframe for the first home visit. CCC believes that it is critical for the preventive service caseworker to make a home visit within the first ten days after the referral, to ensure the safety of the children and to further the engagement process.¹⁵³ CCC recommends that ACS consider implementing a policy that would require this deadline be met.

Finally, the current guidelines and new RFP guidelines are only effective for families if they are in fact implemented. CCC appreciates that ACS's monitoring tool, Preventive Scorecard, evaluates providers' family engagement efforts. CCC encourages ACS to closely monitor compliance and effective engagement, hold programs accountable for meeting the timeframes, and make the results publicly available.

RECOMMENDATION: To ensure transmission of critical information from ACS to preventive service programs, ACS should monitor the implementation of their new policies intended to improve information-flow between the ACS child protective units and the preventive service programs and OCFS should simplify the ability to print a family's prior case record from the CONNECTIONS system of record.

It is to the benefit of ACS, the preventive programs, and the families, that critical information be shared when families are referred for services. Information sharing helps programs better understand a family's strengths and needs in less time, ensures that ACS and the preventive service programs have consistent information, and helps manage everyone's expectations about the risk factors that led to the referral and the service needs of the family.

CCC recommends that ACS monitor the implementation of three of its relatively new policies, all of which are aimed at improving the transmission of information from ACS to the preventive programs, to ensure that the policies are being consistently implemented system-wide and that they are effective at providing preventive programs with the critical information they need.

The first policy, effective 10/1/07, provides preventive service programs with access to the CONNECTIONS case record in indicated cases. Access to this case history should provide programs with more information earlier in cases if the caseworkers and supervisors are accessing and reading these records. The safety and risk assessment requirements in the new RFP's *Preventive Service Quality Assurance Standards and Indicators* require the provider to review the investigation that led to the services referral during intake.¹⁵⁴ It is important to note, however, that accessing a family's history in CONNECTIONS, which is the state system of record, is a time-consuming task due to the limitations of this computer system. As OCFS looks to improve the CONNECTIONS system, CCC urges the state to add a feature to a family's case record that would enable staff to click one icon to print a family's case history.

The second policy, effective 9/2/08 (and incorporated into the new RFP), requires "transition meetings" for every indicated case referred from ACS to a preventive service program. One meeting that includes the ACS caseworker, the preventive services caseworker and the parents should provide an opportunity for a full discussion of the expectations of all parties, the safety and risk factors ACS identified, the family's strengths and needs, and the family's perception of what services they need. If the transition meetings are found to be effective, CCC recommends that they also be required for unfounded ACS-referred cases, meaning all ACS referred cases would have such a transition meeting.¹⁵⁵

The third policy change is with regard to the referral form used by ACS Preventive Service Liaisons. Unlike at the time of CCC's survey administration, ACS is now using the state-developed Family Service Intake as the tool for referrals. CCC suggests that ACS seek feedback from their providers with regard to whether they believe they are now receiving more comprehensive information about the family's service needs, the safety and risk to the children, and the family's history. Based on this feedback, ACS can determine whether more training is needed for their staff.

¹⁵³ This seems especially imperative given ACS's new 12-month average length of service provision expectation. If programs are going to be able to close cases that expeditiously, they must make a home visit within 10 days of the referral.

¹⁵⁴ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Appendix D Preventive Service Quality Assurance Standards and Indicators*, at D-52. (May 20, 2009).

¹⁵⁵ Unfounded abuse and neglect report information cannot legally be shared, so while CCC is recommending a transition meeting in these cases, CCC is not recommending that the case record history (CONNECTIONS investigation) be expanded to unfounded cases.

RECOMMENDATION: ACS should implement a more streamlined process for providing emergency cash or goods to families and/or establish a fund for preventive programs to use to obtain these critical items.

As described in Maslow's hierarchy of needs,¹⁵⁶ it is very difficult for parents and caregivers to focus on attending drug treatment, counseling sessions or parent training programs if they do not know whether they will have food, clothing or a roof to sleep under with their children that night. Emergency cash or goods, such as money for rent, beds, cribs, clothing, food and diapers, are critical to decreasing stress and stabilizing a family. It is only when these basic physiological needs are met, that family members can begin to address the other safety and risk issues that led to their need for preventive services. The economic downturn is causing more families to be in need of these types of basic goods at the same time that budget cuts have led ACS to reduce its fiscal support for these items.

ACS has a program, within its Administrative Services Division, called Day Program, which distributes items to families, which are literally meant to help them through the day. The undated "Day Program Services Guide Book" distributed in 2006 lists the types of goods and services then available through Day Program, which included clothing, school supplies, furniture (such as beds, strollers and play pens), special handling items (such as major appliances, heavy duty cleaning services, extermination services and school uniforms) and safety related items (such as cribs, car seats, smoke detectors, window locks and gates and window guards).¹⁵⁷

When cases are still open in ACS child protective field offices, preventive service programs were previously able to access emergency goods and services through ACS Day Program. This explains why some programs responded to CCC's survey question saying they either only provided emergency goods after the case was officially transferred from

ACS to the preventive program (because ACS provided the items beforehand) or that they only provided emergency goods to families when ACS was still involved (because ACS was providing the item through Day Program and the preventive program did not supply emergency cash or goods.)

On July 16, 2008, the ACS Deputy Commissioner for Family Support Service issued a memorandum to all Preventive Service Program Executive Directors and Program Directors changing the policy regarding ACS's provision of goods and services through Day Program. First she stated that "unfortunately, due to current budget restraints, [ACS is] no longer able to provide the same level of service."¹⁵⁸ The memo then explains that Day Program will only be able to provide beds, cribs and extermination services and will explore requests for heavy duty cleaning on a case-by-case basis. In addition, ACS will require that providers explore a minimum of two alternative resources for the needed item before requesting it from ACS Day Program. The Memo explains that the request to ACS will need to include the names and phone numbers of these two explored resources, an explanation of how the item/service will prevent foster care placement, ensure child safety and/or stabilize the family, and why the family lacks the resources to obtain the item/service.¹⁵⁹

In addition, on November 18, 2008, also due to ACS budget reductions, ACS issued a new policy for ACS housing subsidy, which states that applicants receiving preventive services "will no longer be able to use the ACS Housing Subsidy special grant to purchase furniture" and directs preventive programs to the July 2008 Day Program policy memorandum.¹⁶⁰

Compounding the restricted ability to obtain cash or goods for families in need, is the fact that several program directors told CCC that they had been purchasing these concrete goods/items for families with the flexible \$9 million enhancement funds provided by ACS in fiscal years 2006-2008. In fiscal years 2009-2010, this funding was reduced in half to \$4.5 million. Starting in Fiscal Year 2011, when the new contracts are awarded, this funding will no longer be a separate allocation. These enhancement funds will be rolled into the rate ACS will pay its providers. Since there will be no Model Budget nor separate allocation, providers will have the flexibility to

¹⁵⁶In 1943, Abraham Maslow developed a hierarchy of needs, often depicted in a pyramid, and theorized that higher needs could only be met when lower level needs were met. Physiological needs are the lowest level of the pyramid, followed by safety, love/belonging, esteem and then self-actualization. See A.H. Maslow, *A Theory of Human Motivation*, Psychological Review 50 (1943): 370-96 and Maslow, Abraham (1954). *Motivation and Personality*. New York: Harper.

¹⁵⁷New York City Administration for Children's Services, *Day Program Services Guide Book*.

¹⁵⁸Roberts, E. Memo dated July 16, 2008.

¹⁵⁹Id.

¹⁶⁰Mattingly, J., November 18, 2008 Memorandum, *Revised Foster Care and Preventive Housing Subsidy Application and Approval Process*.

determine what portion of their new budgets to use for this type of assistance. CCC urges preventive providers to ensure that they maintain their current allocations for obtaining concrete goods when the new contracts are implemented.

The *Standards and Indicators* in the new RFP require programs to provide “Emergency Service Access.” The Standard states, “The provider will arrange or provide for emergency services when necessary, including cash or the equivalent thereto, goods, and shelter when a child is at risk of foster care placement and such services may prevent placement.”¹⁶¹ This required service reads quite narrowly, as it is linked specifically to risk of foster care and not to strengthening, supporting or stabilizing a family; however, the Indicator in the new RFP is that “All families have access to Emergency Service Access services as necessary and appropriate to achieve family goals and maintain the health and safety of the children and parents.”¹⁶²

The two 2008 policies, and the decrease in the \$9 million enhancement funding (to \$4.5 million) at a time of shrinking non-profit budgets has made it even more difficult for programs to purchase basic goods such as food, clothing, and beds for their families than when CCC conducted its survey interviews. While CCC is sensitive to current budget realities, we expect that ACS’s new policies and budgetary cutbacks will significantly hamper the provision of basic and necessary goods to families, at a time when the economic downturn is increasing this need. Furthermore, CCC is unsure that the Indicator in the new RFP will be able to be met when programs receive their new rates, which have the enhancement funding folded into them.

When these concrete goods are purchased for families as a preventive service, there is a 63.7% state match, which alleviates some of the burden for the city. CCC suggests that ACS reconsider its new policies; develop a more streamlined policy for obtaining emergency goods/services; create a fund that preventive programs can access to obtain these critical goods and services; consider other options for purchasing these items through 65/35 preventive funding; ensure that the new rates (that will be effective with the new RFP) are sufficient to enable programs to purchase these items without receiving the enhancement funds; and develop relationships with private industries that can donate these types of items.

C) INITIAL FAMILY ENGAGEMENT

FINDING: The relationship between the family members and the caseworker is critical to successful engagement and ultimately the success of the intervention itself.

Family engagement is critical to the success of a preventive service program’s interventions. Since preventive services are typically voluntary, the relationship developed between the family members, the caseworker(s) and other program staff is critical to the family’s continuation in services and thus the impact the program can have on strengthening and supporting the family.

All parents in the focus group conducted by CCC noted that the relationship they had with their caseworker was the most critical factor to the success of their work with their preventive service program. This relationship was more important to many of the parents than the strength of the program itself. Some parents reported that when they had a change of caseworker this resulted in a decision to end their participation in services at that program. Parents spoke of the need for the caseworker “to get them.” Below are some examples of what parents who participated in preventive services said about the importance of their relationship with their caseworker:

- “It just depends on the person you are dealing with and what they are working with. That’s where it starts- what they are working with is where it starts and the relationship you build with your worker is where it ends and it continues.”
- “When I got my kids back, the preventive was good. What was good about it was the worker- she was really good.”
- “Being able to communicate with the counselor I was with—that was the best part. To be able to have someone recognize the needs that my family had- and she met them. She was decent. My children liked her which made it that much easier- because if they didn’t like her, I would have had to drag them out the house.”

¹⁶¹ The City of New York Administration for Children’s Services. *Preventive Services Quality Assurance Standards and Indicators*, at B25. (May 2009).

¹⁶² Id.

FINDING: According to the surveyed programs, parents referred from ACS typically fear that ACS will remove their children, which has an impact on engagement.

While the surveyed programs typically felt that it was very common for families referred from ACS to fear that ACS would remove their children, they were mixed about the impact this fear has on a family's participation in services. Seventy-four percent of the program directors (23 of 31) felt that it was "very common" that the families referred from ACS feared ACS would remove their children, but differed on whether this fear of removal affected the family's participation in services.

When CCC asked program directors what impact the fear of removal had on a family's participation in services, we received the following responses:

- 26.7% (8 of 30) felt that families are usually more receptive to participating in services
- 33.3% (10 of 30) felt that the families were less receptive to participating in services (Note: These 10 were all GP programs)
- 40% (12 of 30) felt that there was roughly an even split of families who were more receptive and families who were less receptive
- 0 programs felt that the fear of ACS removing the children had no impact on a family's participation in services.

FINDING: Program directors identified the most critical factors for encouraging family participation as having hours of operation that meet the needs of working parents and school-age children; having skilled staff to counsel families; having caseworkers who speak languages besides English; and meeting a short term need and building on it.

CCC interviewers explained to program directors that we were interested in understanding how preventive service programs encourage families to work with them when their cases are first referred. We then asked the program directors to rank how critical several factors were for encouraging families to participate in their program. Program directors reported all eight of CCC's factors as critical to encouraging family participation, with the program days/hours meeting the needs of working parents and school-age children, having skilled staff to counsel families, having caseworkers speak languages besides English and meeting a short term need and building on it as the most critical.

- 87% of the programs (27 of 31) reported that the days/hours of their program meeting the needs of working parents and school-age children was "very critical" to encouraging family participation.
 - 87% of the programs (27 of 31) reported that having skilled staff to counsel families into wanting to participate was "very critical" to encouraging family participation.
 - 84% of the programs (26 of 31) reported that having caseworkers who can speak languages besides English was "very critical" to encouraging family participation.
 - 84% of the programs (26 of 31) reported that meeting a short-term need of the family and then building on this success was "very critical" to encouraging family participation.
- For more details of program director responses please see Table 8.

FINDING: Program directors identified the most frequent barriers they encountered when trying to encourage family participation in their program to be resistance from parents and youth and long waiting lists for services.

CCC explained to the program directors that we were also interested in understanding what barriers their programs most frequently encountered when trying to engage families. We asked program directors to think of the families that their program had served during that past year and then to tell us how often they encountered certain listed barriers when trying to encourage families to participate in their program.

Program directors indicated that the most frequent barriers to encouraging family participation were caregivers not being fully committed to working on their issues; children/youth being resistant to working with the program and long waiting lists for services inhibiting programs from meeting the family's immediate needs. Specifically, the percent of program directors that responded that those three items were barriers in *almost every case/many cases* is as follows:

- 58%: A parent or caregiver is not fully committed to working on their issues
- 48%: The child/youth is resistant to working with the program
- 48%: When the program refers the family to services, long waiting lists inhibit the ability to meet the family's immediate needs.

Table 9 provides more details of the program directors responses to this question.

Table 8: Factors Critical to Family Engagement When Cases First Referred
N=31

How critical is it that...	Very critical	Moderately critical	Not too critical	Not at all critical
The days/hours of the program meet the needs of the working parents and school-age children	87.1% (27)	12.9% (4)	0	0
The program has skilled staff who can counsel families into wanting to participate	87.1% (27)	12.9% (4)	0	0
When necessary, the program's caseworkers speak languages besides English	83.9% (26)	16.1% (5)	0	0
The program can meet an immediate short-term need of the family and then build on this success	83.9% (26)	16.1% (5)	0	0
The program provides reimbursement for the family's transportation costs to and from services	64.5% (20)	25.8% (8)	9.7% (3)	0
The family feels the program is part of their community	64.5% (20)	19.4% (6)	12.9% (4)	3.2% (1)
The program site appears and feels welcoming to families	58.1% (18)	38.7% (12)	3.2% (1)	0
The family knows other families who had positive experiences with the program	51.6% (16)	32.3% (10)	12.9% (4)	3.2% (1)

Table 9: Barriers to Encouraging Family Participation:
N=31 but N/A responses have been removed from the base when calculating percentages:¹⁶³

	Almost every case	Many Cases	Some cases	A few cases or no cases	N/A
When families are referred for services, long waiting lists inhibit the program's ability to meet the family's immediate needs	8% (2)	40% (10)	40% (10)	12% (3)	6 (N=25)
A parent/caregiver is not fully committed to working on their issues	3% (1)	55% (16)	41% (12)	7% (2)	0 (N=31)
The child/youth is resistant to working with your program	3% (1)	45% (14)	48% (15)	3% (1)	0 (N=31)
Parent(s)/caregiver(s)' working hours conflict with times when the services are offered	3% (1)	28% (8)	34% (10)	34% (10)	2 (N=29)
The program and/or the services the programs refer the families to are not conveniently located for the family	4% (1)	11% (3)	43% (12)	43% (12)	3 (N=28)
The family's fears due to their immigration status	0	7% (2)	45% (13)	48% (14)	2 (N=29)
Language differences between the program's staff and the family	0	4% (1)	32% (8)	64% (16)	6 (N=25)
Cultural differences between the program's staff and the family	0	0	33% (9)	67% (18)	4 (N=27)

¹⁶³ If the program director did not think the item was a barrier they were told to select N/A and then N/A selections were removed from the base when calculating percentages.

DATA LIMITATION:

It should be noted that program director responses to questions about encouraging family participation and barriers to family engagement are based on the families their programs are serving and not the families for whom the program would not accept the ACS referral. So for example, the data does not reflect the fact that programs typically will not accept referrals from ACS when they do not have a staff member who can meet the language needs of the family.

RECOMMENDATION: To successfully engage family members in preventive services, ACS and preventive service programs must ensure there are skilled and dedicated staff at preventive service programs that can meet the language, cultural and service needs of families in their communities at hours that meet the needs of working families and school-age children.

Engaging family members in preventive services is critical for the intervention to be successful. In addition, the sooner family members are engaged, the quicker family members can receive the support and services they need, which can then lead to shortened lengths of service provision.

CCC's findings related to initial parent engagement reaffirm the need to have well-trained, skilled, diverse casework staff who understand the dynamics between caregivers and ACS, and are able to encourage family participation through developing quality relationships with family members. In addition, the data reiterate the need to obtain services for families that meet their language and cultural needs in a timely manner without long waiting lists. Recommendations related to workforce development and training, accessing services for families, and meeting the cultural and language needs of families are discussed in more detail throughout this report.

D) ACCESSING SERVICES FOR FAMILIES

FINDING: Every program reported providing or referring families to almost all of the services that are required or optional in the state regulations¹⁶⁴ and ACS Scope of Services that accompanied the contract requirements that were in effect at the time of CCC's survey administration.

In addition to engaging families, developing relationships with family members and conducting home visits, the other critical component of a successful preventive intervention is the services programs provide directly or to which they refer families. If preventive service programs are unable to access and/or provide the services families need, they will not be able to strengthen and support families, keep children safe and/or prevent abuse, neglect and foster care.

Table 10, which was included in CCC's survey instrument, details the services required in state regulations and in the ACS Scope of Services, and how many of the surveyed programs reported providing the service on site, through referral or not at all.¹⁶⁵

FINDING: According to program directors, caseworkers frequently face a number of barriers when trying to access services for families. The most frequent barriers reported were long waiting lists for services and the need for child care for parents to be able to participate in services.

CCC asked program directors to think about the families their program had served during the past year and then report how often caseworkers faced certain barriers when trying to access services for families. The program directors reported that the most frequent barriers encountered by their caseworkers when they were trying to access services were long waiting lists and the parents' need for child care while participating in services.

Specifically, the percent of program directors who responded that items were barriers in *almost every case or many cases* is as follows:¹⁶⁶

- **62%—There were long waiting lists for services needed**
- **54%—Parent needs child care to participate in services**
- 36%—Services in family's primary language difficult to locate
- 35%—Service only provided when parent working
- 33%—Service not provided in the community
- 30%—Immigration status impacted ability to access and/or pay
- 27%—Cost of service not covered by Medicaid

¹⁶⁵ CCC used the Scope of Services in effect at the time of survey administration. This Scope of Services will remain in effect until the new contracts are in place. The changes to service requirements made by the new RFP are described on page 9 of this report.

¹⁶⁶ N/A responses (meaning that the program director did not believe the item was a barrier) have been removed from the base when calculating percentages.

¹⁶⁴ 18 NYCRR 423.2(b).

Table 10: Services Provided (N=31)

SERVICE	Service Provided On-site	Refer Families Off-site for This Service	Service Not Provided
Homemaking	0	100% (31)	0
Parent training/parent education	93.5% (29)	6.5% (2)	0
Child care	16.1% (5)	77.4% (24)	6.5% (2)
Respite	3.2% (1)	93.5% (29)	3.2% (1)
Housing services	22.6% (7)	77.4% (24)	0
Educational counseling and training	51.6% (16)	45.2% (14)	3.2% (1)
Vocational training	12.9% (4)	83.9% (26)	6.5% (2)
Employment counseling	54.8% (17)	38.7% (12)	6.5% (2)
Preventive medical care and treatment	3.2% (1)	96.8% (30)	0
Speech therapy	9.7% (3)	83.9% (26)	6.5% (2)
Legal services	19.4% (6)	77.4% (24)	3.2% (1)
Immigration services	25.8% (8)	71% (22)	3.2% (1)
Educational advocacy for the children	90.3% (28)	9.7%(3)	0
Emergency cash or goods	93.5% (29)	3.2% (1)	3.2% (1)
Family Planning	35.5% (11)	61.3% (19)	3.2% (1)
Independent living for youth 14 and older	19.4% (6)	67.7% (21)	12.9% (4)
Alcohol and substance abuse treatment	12.9% (4)	80.6% (25)	6.5% (2)
Family counseling/therapy	74.2% (23)	25.8% (8)	0
Substance abuse counseling	29% (9)	64.5% (20)	6.5% (2)
Individual counseling/therapy – for parents/caregivers	71% (22)	29% (9)	0
Recreational activities for parents	48.4% (15)	38.7% (12)	12.9% (4)
Mental health services for adolescents	25.8% (8)	74.2% (23)	0
Recreational activities for children	48.4% (15)	48.4% (15)	3.2% (1)
Groups for parents	77.4% (24)	16.1% (5)	6.5% (2)
Groups for children/youth	74.2% (23)	16.1% (5)	9.7% (3)
Domestic violence counseling (for victim)	61.3% (19)	38.7% (12)	0
Tutoring	32.3% (10)	67.7% (21)	0
Batterer’s treatment	16.1% (5)	83.9% (26)	0
Anger Management	35.5% (11)	64.5% (20)	0

- 25%—Services not culturally competent
- 25%—No ability to pay for non-related adults in the home
- 11%—Family lacks transportation

Table 11 provides more detailed data of program directors' responses regarding barriers encountered by their caseworkers when trying to access services for families.

FINDING: Program directors reported that Mental Health Services and Housing Assistance were the services families most often needed and also the services most difficult to access.

CCC asked program directors to name the three services that the families served by their program most often needed. Almost two-thirds of the program directors (20 out of 31) named mental health services of varying types such as individual counseling, family therapy, and therapy for teens as one of their three responses. Almost half (15 out of 31) named housing assistance. One program director's gut response to this question was, "Housing, housing and housing."

In addition, almost one third of the programs (10 out of 31) named both mental health services and housing assistance as two of the top three services families served by their program most often need.

Table 11: Barriers to Accessing Services N=31¹⁶⁷

	Almost every case	Many cases	Some cases	A few cases/ no cases	N/A Not a barrier to accessing services
Services in the family's primary language were difficult to locate or could not be located.	0	36% (10)	29% (8)	36% (10)	3 (N=28)
There were long waiting lists for the services needed	7% (2)	55% (16)	28% (8)	10% (3)	2 (N=29)
The family lacked transportation	4% (1)	7% (2)	48% (13)	41% (11)	4 (N=27)
The parents' immigration status impacted the ability to access and/or pay for services	0	30% (9)	43% (13)	27% (8)	1 (N=30)
The cost of the service was not covered by Medicaid (ex. Batterer's treatment)	0	27% (8)	50% (15)	20% (6)	1 (N=29) ¹⁶⁸
The service needed was not available in the family's community	3% (1)	30% (9)	40% (12)	27% (8)	1 (N=30)
The service was only available at times when the parent(s) was working	3% (1)	32% (10)	39% (12)	25% (8)	0 (N=31)
The services were not culturally competent	4% (1)	21% (6)	32% (10)	39% (11)	3 (N=28)
The parent/caregiver needed child care to participate in services	7% (2)	47% (14)	43% (13)	3% (1)	1 (N=30)
There was no ability to pay for services for the non-related adults living in the home	0	25% (6)	50% (12)	25% (6)	7 (N=24)

¹⁶⁷ N/A responses have been removed from the base when calculating percentages so percentages show of those who thought the item was a barrier, how often was it a barrier.

¹⁶⁸ One program director did not answer this question, feeling unable to approximate a number.

Below is a list of most needed services, as reported by the program directors. (Note: Percentages do not add up to 100% because each program director was asked to choose three services.)

Services Families Most Often Need: N=31

- **Mental Health Service—64.5% (20)**
- **Housing Assistance—48.4% (15)**
- Parenting skills/Parent Education- 32.3% (10)
- Educational Services for Children- 29.9% (9)
- Assistance Accessing Entitlements- 25.8% (8)
- Substance Abuse Services- 22.6% (7)
- Other services named: domestic violence services; financial/employment assistance; emergency cash/goods/transportation; services for teens; medical services; homemaking; child care; anger management

CCC also asked the program directors to name the three services they felt were most difficult for their program to access for families. Interestingly, the program directors again mentioned mental health services and housing assistance. This time, almost two thirds of the programs responded that housing assistance was one of the three most difficult services to access and over half responded that mental health services were one of the three most difficult to access.

Following is a list of the services program directors reported as most difficult for their programs to access for families. (Note: Percentages do not add up to 100% because each program director was asked to choose three services.)

Services Most Difficult to Access: N=31

- **Housing Assistance—64.5% (20)**
- **Mental Health Services—58.1% (18)**
- Services non-citizens can access/pay for- 25.8% (8)
(Note: The question asked program directors to name a service and this is not actually a service but a factor for accessing services; however 8 programs provided this as a response.)
- Educational services for children- 19.4% (6)
- Financial Assistance/employment- 16.1% (5)
- Other services mentioned: legal services; domestic violence services; homemaking; services in languages that meet the family’s needs; immigration services; services for teens; programs with child care provided while the parent participates; entitlements; medical services; respite; and batterer’s treatment)

It is troubling that the services families most often need are also the services that are most difficult for programs to access. Given this, CCC took a closer look at the data and analyzed it by program type and borough.

The data by program type reveal that both mental health services and housing assistance are not only major issues for General Preventive (GP) Programs but also for the Family Rehabilitation Programs (FRP) working with families dealing with substance abuse issues. The need for housing assistance for families in FRP programs is particularly interesting given that caregivers in FRP programs are working to address their addictions. Table 12 below compares program director

**Table 12: Need for and accessing housing, mental health and substance abuse services by program type
N=31**

	GP (N=24)	FRP (N=7)
Need Housing	41.7% (10/24)	71.4% (5/7)
Housing Most Difficult to Access	58.3% (14/24)	85.7% (6/7)
Need Mental Health Services	58.3% (14/24)	85.7% (6/7)
Mental Health Services Difficult to Access	54.2% (13/24)	71.4% (5/7)
Need Substance Abuse Services/Treatment	8% (2/24)	71.4% (5/7)
Substance Abuse Services/Treatment Difficult to Access	8% (2/24)	0% (0/7)

responses regarding the need for and difficulty in accessing housing assistance, mental health services and substance abuse treatment/services by program type.¹⁶⁹

Looking at housing assistance and mental health services by borough is also interesting, although the data cannot be generalized because the borough sample sizes are quite small. As shown below, in CCC's sample we found that the Brooklyn programs named housing assistance as one of the most difficult services to access more often than mental health services, but that this was not the case in the other boroughs.

Table 13: Difficulty Accessing Housing and Mental Health Services by Borough
N=31

Services	Housing	Mental Health
Bronx (N=6)	50% (3/6)	83.3% (5/6)
Brooklyn (N=11)	72.7% (8/11)	18.2% (2/11)
Manhattan (N=6)	66.7% (4/6)	83.3% (5/6)
Queens (N=6)	66.7% (4/6)	66.7% (4/6)
Staten Island (N=2)	50% (1/2)	100% (2/2)

After analyzing the survey findings and clearly seeing that families in preventive service programs needed access to mental health services, but that these were difficult to access, CCC sought to deepen our understanding of this issue through conversations with additional preventive service program directors.

We learned that many programs sought the services of consultants who did on-site mental health evaluations so that clients did not have to wait on long waiting lists to be evaluated. Once found in need of services, however, there were barriers to accessing services for children and their parents.

¹⁶⁹The sample size of 7 for FRPs is quite small and so CCC is not attempting to over-generalize from this sample. That said, 7 programs were 25% of the system's total FRP programs.

A number of factors appear to be contributing to the difficulties programs are having when they seek to access mental health services for their preventive service clients. Some of the barriers we learned about include:

- Shortage of child psychiatrists¹⁷⁰
- Outpatient mental health clinics are not properly reimbursed through managed care
- Home and community based waiver services¹⁷¹ slots are not sufficient to meet the demand in New York City
- Clients often need family therapy in the evenings.

FINDING: Program directors felt that when families move in or out of the homeless shelter system it negatively impacts the continuity of services for families.

CCC asked the program directors about the impact of families entering or leaving the homeless shelter system on the continuity of services. Specifically, we asked programs to think about the families they had served during the past year who had entered or left the shelter system and then to tell us how often the change in home address made it more difficult for their program to continue to provide services to the families. Over three-quarters of the program directors (22 of the 29 who responded) felt that moving in or out of the shelter system almost always or often had a negative impact on their ability to continue to provide services. This is an important finding because moving in or out of the shelter system is in and of itself stressful, and thus a critical time for families receiving preventive services to have the support and assistance of their preventive programs.

¹⁷⁰According to the American Academy of Child and Adolescent Psychiatrists, almost 30,000 child and adolescent psychiatrists are needed in the United States, but there are fewer than 7,500. American Academy of Child and Adolescent Psychiatry. *Annual Report 2006*, at 8.

¹⁷¹Home and Community Based Waiver Services is a state Office of Mental Health (OMH) initiative to provide six core services to children who have been diagnosed with a severe mental illness so as to prevent the need for out-of-home placement. The core services are individualized care coordination, intensive in-home services, respite care, family support services, crisis response services and skill building services. Office of Mental Health. Home and Community Based Services Waiver. http://www.omh.state.ny.us/omhweb/ebp/children_hcbs.htm#What, accessed 3/8/09.

Specific details of the responses to this question are provided below:

Shelter Impact on the Continuity of Preventive Services (N=29)

Question: Think about the families your program has served this past year who had entered or left the shelter system and were then living in a different CD.¹⁷² How often did this change in home address make it more difficult for your program to continue to provide services to the family?

- Almost always- 37.9% (11/29)
- Often- 37.9% (11/29)
- Sometimes- 13.8% (4/29)
- Rarely- 6.9% (2/29)
- Almost never- 3.2% (1/29)

FINDING: Program directors reported that it was difficult to access services for families when family members were not citizens, partially due to payment-related issues.

As mentioned previously, CCC asked program directors to name the three most difficult services for their preventive program to access for families. Over a quarter of the programs (8 of 31) chose as one of their three items, services non-citizens could access and/or pay for. This is particularly interesting since unlike housing and mental health services, services for non-citizens are not, in and of themselves, an actual service in the sense that the question had been conceived.

Table 11 (on page 41) provided detailed data of program directors' responses regarding how often their caseworkers encountered a series of barriers to accessing services. While the large majority of families receiving preventive services are legal citizens, 73% of the directors believed "the parents' immigration status impacted the ability to access and/or pay for services," in many¹⁷³ or some¹⁷⁴ of their cases that year, with only 27%¹⁷⁵ feeling this was a barrier in a few or no cases.¹⁷⁶

¹⁷² CD is shorthand for Community District. There are 59 Community Districts in New York City.

¹⁷³ 9 programs, or 30%, responded that the parents' immigration status impacted the ability to access and/or pay for services in "many" cases.

¹⁷⁴ 13 programs, or 43%, responded that the parents' immigration status impacted the ability to access and/or pay for services in "some" cases.

¹⁷⁵ 27% equals 8 programs.

¹⁷⁶ The N=30 for this question as one program director answered N/A, meaning that he/she did not believe the parent's immigration status was a barrier to accessing services.

When CCC discussed its draft findings and recommendations with preventive service program directors there was consensus regarding the difficulties in accessing services for undocumented immigrants. One explained that the only way to access mental health services for such a family would be to go to court and get an order for ACS to pay for it. Another explained that having on-site psychological evaluations for undocumented clients was helpful, but that programs need access to ACS funds to purchase medications for undocumented clients because Medicaid does not cover this and it could cost hundreds or thousands of dollars.

FINDING: Program directors reported difficulties in accessing and providing services for teens and in working with the Department of Education (DOE).

Throughout the survey interviews and during the meeting CCC had with the preventive service program directors,¹⁷⁷ issues related to serving teens and addressing the educational needs of children were raised on numerous occasions.

When CCC asked program directors what services were most needed by their clients, and what services were most difficult to access, they often qualified their responses regarding counseling, therapy, or educational services, indicating that it was particularly so for teens. Ten of the 31 programs (32%) qualified at least one of their responses by specifying youth as the target for the service. One program director's first response to the question, "What are the three most difficult services for your preventive programs to access for families?" was "Any services for adolescents."

In addition, programs identified many issues regarding meeting the educational needs of the children in the families they served. Nine programs cited this as one of the top three most needed services and six programs cited it as one of the top three most difficult to access.

Program directors spoke of the difficulties they faced addressing truancy and advocating to the Department of Education on behalf of the children. One program director described the difficulty with truancy saying, "We can't seem to do anything to get them back to school. It is a big problem. The teens come and talk but do not go to school." Several programs directors also spoke of the difficulties they

¹⁷⁷ CCC presented draft findings and recommendations at a COFCCA Preventive Service Director's Meeting on December 19, 2007. COFCCA is the umbrella organization to which many of the programs belong.

(and the parents had) in advocating to the DOE to address the issues related to the child's truancy, be it the need for additional assistance, a change in class or a change in schools.

The program directors also expressed concerns about how far behind in school they found many of the children to be. One program director explained that many of the children in their program need tutoring and educational advocacy because they were already so far behind, their parents had not encouraged them to excel in school, and this cycle led the youth to become disinterested in school.

FINDING: Programs face a range of barriers when trying to access services for families, some of which are outside of the control of the child welfare system.

The survey questions and program director responses related to service provision reveal many of the difficulties programs face when trying to access the services that strengthen and support families. Specifically, they encounter long waiting lists for services; a dearth of child care options particularly when child care is needed for the parent to participate in services; and difficulties accessing housing, mental health services, and services for their non-citizen clients. The table detailing what services programs generally provide on-site and what services they generally refer clients to (Table 10 on page 40), demonstrates that programs have tried to accommodate the needs of families on-site whenever possible, which helps to avoid long waiting lists and payment issues.

Agencies and programs have tried to be creative by providing services on-site, co-locating preventive service programs at multi-service community organizations, and hiring mental health and educational consultants to provide mental health evaluations and services on-site. Yet the survey interview responses indicate that programs still face barriers when trying to access services for families.

The program directors collectively cited mental health services and services to stabilize or secure a family's housing situation as both the services most needed and the services most difficult to access for their clients—and these are services that programs cannot typically provide on-site to make up for the shortage in the community.

Program directors indicated that the problem of accessing services is further exacerbated when the caregivers are not legal citizens and thus do not have Medicaid or other insurance to cover costs. In addition, preventive programs are also trying to address the needs of youth and the educational

needs of the children in the families they are serving.

These findings are troubling. First, the range of services (housing, mental health, child care, education, youth, immigration, legal, domestic violence substance abuse, etc.) that these preventive programs are struggling to address are numerous and complex. And second, many of these challenges, such as the shortage of affordable housing, child care, and mental health services for adults and children in New York City, are larger in scope than child welfare preventive services, making them difficult to resolve for individual families.

i) RECOMMENDATIONS – ACCESSING SERVICES

RECOMMENDATION: New York City should ensure that the rate paid to preventive service programs is sufficient to enable programs to pay for the services families need, be they provided on-site or through referrals.

The new preventive service contracts that will take effect between July 1 and December 1, 2010 will require preventive service programs to provide or refer families to services such as chemical dependency treatment; child care; crisis respite for families affected by HIV/AIDS; domestic violence screening for all families and advocacy services where indicated; emergency service access (including cash or goods); mental health (assessment, diagnosis, testing, psychotherapy, and specialized therapies and interventions for families requiring them); and transportation (for services).¹⁷⁸ In addition, programs will be

¹⁷⁸ The full list of required services in the new RFP is: after-care/simultaneous provision of preventive and foster care services; chemical dependency treatment; child care; child safety assessment; crisis respite for families affected by HIV/AIDS; developmental services for children (such as screening, early intervention, home and community based waiver services, etc); domestic violence screening for all families and advocacy services where indicated; education-parental involvement in their children's education; education-training and employment for parents, caretakers and other adults or adolescents in the home; emergency service access (including cash or goods); health (education/assistance, educational materials, assistance in selecting a primary care physician, ensuring routine examinations and when necessary/appropriate assistance with applying for Medicaid/Child Health Plus); home attendant; homemaker; housekeeping services; housing assistance; mental health (assessment, diagnosis, testing, psychotherapy, and specialized therapies and interventions for families requiring them); promote parent-child interactions (examples: family counseling, parent/child homework groups, recreational activities); sexual health and pre/post-natal care; and transportation (for services). The City of New York Administration for Children's Services. *Preventive Services Quality Assurance Standards and Indicators*, at B14-B-37. (May 2009).

expected to maintain a 12-month average length of service provision.¹⁷⁹ The critical question that cannot be answered until after the new RFP is in effect is whether the rate ACS is going to pay preventive service programs will be sufficient to ensure timely access to services for families, lower caseloads, and reduce the length of service provision.

In 2006, ACS began providing preventive service programs with \$9 million of what has been referred to as “preventive service enhancement funding,” of which \$3.2 million was city funding and \$5.8 million was state funding. Programs that met certain criteria, such as a high utilization rate, were provided \$800-\$1,000 per slot to use flexibly to meet the needs of the families in their programs. Some of the programs used this funding to hire on-site consultants to conduct mental health evaluations of parents and children, which obviated the very long waiting lists families usually faced for evaluations (although did not resolve the waiting lists for treatment). Other programs used this funding to hire on-site educational consultants to address children’s educational needs and still others used the funds to sporadically pay for services that were not reimbursable through Medicaid. Unfortunately, due to budget shortfalls, ACS was only able to distribute \$4.5 million in enhancement funding in city fiscal years 2009 and 2010, but still programs that met utilization and casework contact standards received \$400 per slot and those that did not received \$200 per slot. ACS has stated that starting in Fiscal Year 2011, this funding is folded into the new preventive service rates.¹⁸⁰

To date, the enhancement funding has been effective for programs because it is flexible funds that they can use to provide more on-site service delivery, which enables families to avoid long waiting lists at programs they would otherwise be referred to and enables undocumented immigrant families to receive services for which they would otherwise be unable to pay. It is essential that with the implementation of the new RFP, the city and the programs maintain their commitment to using flexible funding for these items, even when the programs are no longer receiving a separate allocation for this purpose.

The city must continue to assess whether the rates being

provided to preventive service programs are sufficient to enable programs to provide the services required by the new RFP and when the new contracts go into effect, ACS must ensure that programs maintain the services they had previously obtained with the enhancement funds. In addition, CCC urges the state to restore the 2% reimbursement cut to the uncapped 65% reimbursement for preventive services so that when the city invests in preventive services, there is a more adequate state match.

RECOMMENDATION: ACS should explore options for creating a fund that would be available to pay for services when traditional payment options are not available.

ACS should consider having funds available that could then be provided to families on a case-by-case basis when a family and a preventive service program have no other way to access or pay for a service. The ACS Preventive Services Technical Assistance Unit could first try to assist the program in identifying alternatives, but then approve the payment from the fund when deemed necessary to meet a family’s needs. OCFS and ACS might consider ways to engage foundations and other donors to help fund this type of an initiative. This would be invaluable for undocumented immigrants who do not have Medicaid and thus typically have no way to pay for substance abuse treatment, medications or specialized mental health services that cannot be provided on-site such as sex offender/victim treatment. In addition, it would alleviate the need to litigate these issues in Family Court, a process that further burdens the overwhelmed court system and often results in court orders for ACS to pay.

RECOMMENDATION: ACS should expand the tasks of their Community Partnership Initiative (CPI) to better implement the stated goals of expanding child welfare linkages and ACS should continue to monitor the effectiveness of CPI. If CPI is found to be effective at improving access to services in the 11 CPIs, then ACS should expand CPI to all of NYC’s high-risk communities. If CPI is not found to be an effective mechanism for creating community coalitions that expand child welfare linkages, then ACS should reinvest the CPI funding into another initiative that improves access to services.

¹⁷⁹ Id. at *Section II: Summary of RFP*, at 21-22 and 23-24. This new requirement is discussed in more detail in the Case Closing section starting on page 70.

¹⁸⁰ Personal communication with Elizabeth Roberts, Deputy Commissioner for Family Support Services at the Administration for Children’s Services, September 4, 2009.

For preventive service programs to better access services in their communities, they need to know what services are available and how to access them. As part of ACS's new RFP, ACS will not only enter into contracts with preventive, foster care and residential programs, but will also enter into contracts with eleven community based organizations serving as fiscal agents for eleven community partnership initiatives. According to the new RFP, one of the goals of the Community Partnership Initiative (CPI) is to "create an integrated, coordinated local community and citywide system of comprehensive services through a network of Community Partnerships."¹⁸¹ "The Community Partnerships work to develop and support holistic, seamless local networks of service providers, community members and families, and other stakeholders with the goal of assisting families and offering safety and support where they reside."¹⁸²

In the initial 2006 pilot of four community partnerships, and now with all eleven CPIs, the charge has been to focus on four tasks: coordinate service delivery between child care/Head Start and preventive service programs; participate in family team conferences; support foster and adoptive parents and recruit new ones; and promote and provide support for family visiting. As recommended in a Chapin Hall Evaluation of the Community Partnership Initiative,¹⁸³ in the new RFP ACS expands the tasks of the CPI to include creating linkages with local schools.¹⁸⁴

When ACS describes the mission and guiding principles of the CPI they describe building "coalitions that are family focused and provide integrated services that will strengthen the community's ability to keep children safe."¹⁸⁵ "Each coalition is designed to improve the well-being of children and families in the child welfare system and decrease the use of foster care in their community. The coalitions will be

forums where members share resources, ideas, information and referrals."¹⁸⁶

As explained by many of the existing CPIs in a survey they completed as part of Chapin Hall's evaluation of the implementation of the Community Partnership Initiative, consideration should be given to expanding the "current child welfare focus to a more cross-systems approach."¹⁸⁷ CCC believes that it is a missed opportunity if the community partners in the CPIs do not have the opportunity to work together on strategies to access community-based services, such as mental health services and housing assistance. CCC is extremely pleased to see that the new RFP expands CPI to include linkages with local schools.

CCC supports the principles and goals of the Community Partnership Initiative, whereby communities come together to identify service gaps and barriers and ways to address them so that accessing services can be more seamless and timely. It is unclear, however, how communities will resolve barriers such as long waiting lists, shortages of services, and the lack of child care for parents while they participate in services, or how the preventive programs awarded the new contracts with ACS will provide easier and faster access to services. CCC urges ACS to continuously monitor the effectiveness of the Community Partnership Initiative.

RECOMMENDATION: Preventive programs should continue to provide services on-site, expand on-site service provision when possible and develop additional linkages to other service providers that can give priority to families receiving preventive services. ACS should closely monitor this and provide assistance to programs lacking effective service linkages.

The 1998 Preventive Services Scope of Services,¹⁸⁸ in effect at the time of CCC's survey administration specified that "if the agency does not have the expertise or capacity to directly provide all services necessary to assist and support

¹⁸¹ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 8. (May 20, 2009).

¹⁸² Id. at Section III: *Community Partnership Contractor*, at 163.

¹⁸³ Wulczyn, F., Rosenblum, R., Roy, A., Rowe, M. *New York City Administration for Children's Services Community Partnership Initiative Implementation Report*. Chapin Hall Center for Children, University of Chicago. (August 2008).

¹⁸⁴ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Community Partnership Contractor*, at 164. (May 20, 2009).

¹⁸⁵ ACS web site visited 3/1/09. http://www.nyc.gov/html/acs/html/support_families/services.shtml

¹⁸⁶ Id.

¹⁸⁷ Wulczyn, F., Rosenblum, R., Roy, A., Rowe, M. *New York City Administration for Children's Services Community Partnership Initiative Implementation Report* at 54. Chapin Hall Center for Children, University of Chicago. (August 2008).

¹⁸⁸ The Scope of Services is part of the contract between ACS and its preventive service provider agencies.

clients, the agency shall meet the full range of client needs through linkages with other neighborhood-based service providers.”¹⁸⁹ The 1998 Scope of Services goes on to say, “In this instance, the agency shall establish linkages including, but not limited to, service provider contracts, formal service agreements, ‘letters of linkage,’ and ‘memoranda of understanding.’”¹⁹⁰ The new Scope of Services, effective when the new contracts are in place, has similar language.¹⁹¹

As a general matter, the more services that a program can provide directly on-site, the less frequently the program will have to resolve barriers such as long waiting lists, the inability of undocumented immigrants to pay for the services, or the need to find child care for the parent to participate (assuming someone at the program can care for the child while the parent is participating.) To the extent possible, preventive programs should provide on-site services and programs should be housed within agencies that provide other services that the families can access.

In addition, the current and future contracts between ACS and the programs clearly require that preventive service providers have relationships with other providers in the community who should be accepting their referrals. It is clear from the responses to the survey questions that preventive programs, with the assistance of ACS when needed, need to develop additional relationships with more service providers and where possible these linkages should enable a priority slot for preventive service families. CCC is pleased that ACS is planning to provide technical assistance and support to its new contractors around the development of strong service linkages, and that one of ACS’s goals for the new FT/R model is that these programs develop strong linkages with mental health clinics. It is critical that ACS closely monitor these linkages, provide technical assistance where needed, continue to collaborate with state and city agencies such as the Department of Health, and to do this throughout the entire life of the new contracts.

¹⁸⁹ City of New York Administration for Children’s Services. *Preventive Services Scope of Services*. 1998.

¹⁹⁰ *Id.*

¹⁹¹ City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 34. (May 20, 2009).

RECOMMENDATION: ACS, OCFS and the preventive service programs should work to develop a child care model, in which child care would be available to parents while they are participating in services.

While the preventive service program directors themselves identified child care for parents while they participate in services as a common barrier, the 1998 Scope of Services, in effect at the time of CCC’s survey administration, required the programs to “assist each parent in obtaining appropriately supervised child care services where such services are needed to enable the parent to participate in on-site services and programs, such as parenting skills training, individual counseling or support group activities.”¹⁹²

ACS also administers the city’s subsidized child care program, but most of those slots are for parents on public assistance and low income parents who are working or going to school full time. Parents who need child care to participate in preventive services typically only need child care for a few hours each week. The child care model that would best serve these families is more akin to the family court “court care” model, where parents can leave their children in the court’s child care center while they attend court appearances.

Consideration should be given to developing specially designated child care facilities in various high-needs communities throughout the city where the children of families engaged in preventive services could receive temporary child care while their parents were receiving services. Alternatively, this type of shorter-term, community-based child care, could be a project coordinated by the Community Partnership Initiatives, if ACS expanded the CPI mission. Finally, as ACS implements Project Full Enrollment and other child care budget related initiatives that are leaving empty classrooms in child care centers,¹⁹³ ACS could consider

¹⁹² City of New York Administration for Children’s Services. *Preventive Services Scope of Services*. 1998. The new Scope of Services has similar language. See City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 42. (May 20, 2009).

¹⁹³ Project Full Enrollment is an ACS child care initiative that will result in ACS paying centers based on the number of children enrolled in the centers as opposed to the center’s capacity. In addition, ACS child care centers already have empty classrooms from when afterschool/Out-of-School Time was moved from ACS programs to the Department of Youth and Community Development (DYCD).

converting some of the empty classrooms in these centers into this model of child care.¹⁹⁴

ii) RECOMMENDATIONS – HOUSING ASSISTANCE

RECOMMENDATION: New York State and New York City should increase the \$300 preventive services housing subsidy to an amount that is sufficient to stabilize a family’s housing situation.

It is very difficult for parents and children to be able to focus on strengthening their relationships when they are worried about their basic needs for food, shelter and clothing. Given the affordable housing crisis in New York City, it is not surprising that many of the at-risk families served by preventive service programs are struggling to pay their rent or find housing.

Since 1988, the New York State Social Service Law, and corresponding regulations, have authorized a housing subsidy aimed at preventing homelessness for at-risk families receiving preventive services.¹⁹⁵ Families with an open mandated preventive services case¹⁹⁶ and limited income are eligible for a housing subsidy of up to \$300 per month for up to 3 years (or up to \$10,800, whichever is reached first). Families can also receive a payment of up to \$1,800 (up to two times during the 3 year period) to help pay for rent arrears or other moving costs; however, this amount is then subtracted from the \$10,800, decreasing the length of subsidy eligibility.

Given that the \$300 subsidy amount has not been changed since 1988, has not been adjusted for inflation, and does not reflect Fair Market Rents in New York City, it is no longer a significant enough rent assistance mechanism to secure and stabilize housing for many families receiving preventive services.

Housing subsidy should be adjusted to keep up with inflation. According to the United States Department of Labor Consumer Price Index (CPI) inflation calculator, \$300

in 1988 had the same buying power as \$547.68 in 2009.¹⁹⁷

In addition, the preventive services housing subsidy should account for the New York City housing market. The high rents in New York City and the disparity in what \$300 could buy in 1988 versus 2009 can be dramatically illustrated when comparing the 1991 and 2005 New York City Housing Vacancy Survey results.¹⁹⁸ In 1991, 64.5% of renter households had rents less than \$600 per month. By 2008, only 12.5% of renter households had rents less than \$600 per month.¹⁹⁹ Thus, it would now be very difficult for a family to find an apartment where \$300 would make a significant contribution to the rent.

Furthermore, according to the federal Department of Housing and Urban Development (HUD), the 2008 Fair Market Rents for the New York City Metro area²⁰⁰ are \$1,095 for a studio, \$1,185 for a 1-bedroom, \$1,318 for a 2-bedroom, \$1,621 for a 3-bedroom and \$1,823 for a 4-bedroom.²⁰¹ Clearly \$300 would have minimal impact for a family struggling to pay any of these Fair Market Rents.

At a minimum, the housing subsidy should be adjusted to \$547.58 to account for inflation and the state law should be amended so that the housing subsidy amount would be adjusted annually to account for inflation. This increased cost would be borne by the state and city, as the housing subsidy is a preventive service paid for through the 65/35 state/local funding stream.

RECOMMENDATION: ACS should provide preventive service programs with resources to have access to Housing Specialists.

Navigating the real estate market in New York City, while understanding housing programs such as ACS housing subsidy,

¹⁹⁴ In addition, the city could receive additional state funding for this type of child care. Currently, state and federal child care funds are distributed to counties through the capped Child Care Block Grant. Since these classrooms would be used for preventive services, the state match would be 63.7% from the uncapped preventive services “65/35” funding stream.

¹⁹⁵ Social Service Law 409-a(5)(c) 18 NYCRR 423.4(b)(ii); 18NYCRR 423.4 (l).

¹⁹⁶ The housing subsidy is also available when children reunify from foster care and for youth ages 18-21 who have aged out of foster care.

¹⁹⁷ U.S. Department of Labor, Bureau of Labor Statistics. *CPI Inflation Calculator*. http://www.bls.gov/data/inflation_calculator.htm

¹⁹⁸ The Housing and Vacancy Survey is conducted every three years by the US Bureau of the Census. 1991 data is used for this analysis (as opposed to 1988 when the \$300 housing subsidy was first enacted) because 1991 is the first year of publicly available information and 2008 data is being used because this is the most recent Survey.

¹⁹⁹ U.S. Bureau of the Census. New York City Housing and Vacancy Survey 1991; U.S. Bureau of the Census. New York City Housing and Vacancy Survey 2008.

²⁰⁰ This includes the five boroughs of New York City, Putnam County and Rockland County.

²⁰¹ US Department of Housing and Urban Development. *Final FY08 Fair Market Rent Documentation System*. http://www.huduser.org/datasets/fmr/fmrs/2008summary.odn?inputname=METRO35620MM5600*New+York%2C+NY+HUD+Metro+FMR+Area&data=2008&fmrtype=Final

the Department of Homeless Services Advantage Programs, the New York City Housing Authority's Section 8 Program and Public Housing Program, and the various supportive housing services available is complicated, ever-changing and very time-consuming. Preventive service caseworkers are not housing experts nor are they realtors and often they do not have the time it takes to secure housing for a family in New York City because they are tending to the other needs of the families on their caseloads.

Many foster care agencies have addressed this issue by hiring a housing specialist to alleviate this burden from falling onto foster care caseworkers. CCC recommends that funding be made available for preventive service programs to have access to housing specialists. There does not, however, need to be a housing specialist at all 150 preventive programs. For example, each of the 75 agencies operating a preventive service program could have one housing specialist or perhaps each Community Partnership Initiative could have access to one housing specialist who would be shared by all the preventive programs in that community.

RECOMMENDATION: The state and the city should expand child welfare housing initiatives to include families receiving preventive services.

Both New York State and New York City, with some help from the federal government, have developed a variety of affordable housing options that meet the needs of high needs families and individuals. Several of these initiatives are already aimed at child welfare, but are targeted at children reunifying from foster care, families with open child protective cases, and/or youth aging out of foster care. CCC urges the state and the city to expand these affordable housing initiatives to include families receiving preventive services.

These initiatives include: the Family Unification Program (FUP), which is a priority code for Section 8 vouchers; the child welfare priority for NYCHA public housing; and the Children's Advantage program through the Department of Homeless Services where families in shelter with open ACS cases (but not currently preventive) receive priority for Section 8 vouchers.²⁰²

²⁰² In December 2009, New York City officials announced that due to limited funding, they would no longer be issuing Section 8 vouchers and that they were terminating 3,000 vouchers for families who were issued vouchers but had not found apartments yet. See New York Times. *Thousands Lose Rent Vouchers in Cutback*. Dec. 17, 2009, <http://www.nytimes.com/2009/12/18/nyregion/18vouchers.html>. It is still unclear how this will impact the continuation of the Children's Advantage program and the Family Unification Program (FUP), two housing programs that provide priority Section 8 vouchers to families involved with the child welfare system.

CCC believes that including families receiving preventive services (i.e. families for whom there is a risk that the children will be placed in foster care) in the eligibility for these housing programs could help stabilize the housing situations for many of the families receiving preventive services who are also struggling with housing insecurity.

RECOMMENDATION: New York State and New York City should create and implement short-term and long-term strategies to address the city's affordable housing crisis.

The affordable housing crisis is a New York City issue well beyond the scope of the preventive service system. That said, housing instability is often a family stressor when children are found to be neglected. New York State and New York City need short and long-term strategies to truly address the affordable housing shortage.

These plans should address options and opportunities to support public housing, to create incentives to develop more affordable housing units in New York City (for renters as well as owners), to develop additional housing subsidy programs akin to Section 8, and to maintain and preserve existing affordable housing stock. New York City should also continually monitor and apply for additional federal resources, such as more Section 8 vouchers or to become one of the Obama Administration's "Choice Neighborhoods," which would expand urban revitalization.²⁰³

In addition, state and city affordable housing plans should make efforts to ease rent-burdens for families. While 63% of NYC households and 41% of New York State households are renters,²⁰⁴ they are not eligible for any property tax relief. A renter's tax credit would provide equitable tax relief and help offset the rent burdens for the nearly half of all renters who are spending more than 30% of their income on rent.

Finally, federal, state and city officials should consider modifying some of their housing assistance programs to allow for roommates. In a city where rents are so high and having another adult available to assist with rent and child-rearing would be helpful, it is unfortunate that many housing assistance programs preclude roommates.

²⁰³ Choice Neighborhoods are an initiative in President Obama's FY10 Budget, which would provide \$250 million to ten neighborhoods. More information is available in Secretary Donovan's July 14, 2009 press release. <http://www.hud.gov/news/release.cfm?content=pr09-119.cfm>.

²⁰⁴ U.S. Census Bureau. *American Community Survey*. 2008.

RECOMMENDATION: ACS and the city's Department of Homeless Services (DHS) should work together to enhance their coordination and collaboration on behalf of families in both the preventive service system and the homeless shelter system.

CCC's survey found that the continuity of services is hampered when families enter or exit the shelter system. This is unfortunate because both of these moves are stressors on already at-risk families and thus a time when the support of a preventive service program would be invaluable.

To address this gap, DHS should be required to place families already receiving preventive services in the same community district where they are receiving services. This would prevent service disruption. Currently, when families apply for shelter they are screened at the DHS intake facility (PATH) by an ACS caseworker to see if there is any ACS history, so DHS staff know when a family with an open preventive service case is entering the shelter system.

DHS already tracks and monitors the rate at which they place families in a shelter that is in the youngest child's school district of origin. While this is an important indicator, many of the children in families receiving preventive services are not school-age, as 20% of the children receiving preventive services in June 2007 were younger than 4 years old.²⁰⁵ These families with young children are often most in need of continuity of services so that their children can remain safe. CCC is concerned that the DHS policy of focusing on school-age children might lead to families with younger children being placed in shelters out of their neighborhoods more often.

CCC believes that if DHS were to also track, monitor and report on community placement for families receiving preventive services, the percentage of these families who remain in their community of origin when they enter a homeless shelter would increase and in turn more homeless families would continue to receive services from the same community-based preventive program.

In addition, better coordination between ACS, preventive service programs and DHS would be beneficial for many homeless families. CCC recommends that ACS and DHS enhance their collaboration to improve services for the at-risk families they are jointly serving. For example, ACS's

preventive programs and DHS's shelters could create formal linkages, whereby families in a shelter could more seamlessly be able to access preventive services if they were interested.

iii) RECOMMENDATIONS – MENTAL HEALTH SERVICES

RECOMMENDATION: Maintain and enhance the ability of preventive programs to access on-site mental health services such as MSW caseworkers, mental health consultants and on-site therapists.

The shortage of child psychiatrists, the inadequate reimbursement for outpatient services, and the long waiting lists for mental health services, such as individual and family therapy, are not unique challenges to the preventive service system. That said, many of the children and their families who are receiving preventive services also need mental health services, ranging from psychiatric treatment for mental illnesses, to family therapy to repair damaged relationships, to individual therapy to process the trauma of prior abuse or neglect, to counseling on how to nurture and care for children while dealing with life's stressors.

When preventive service programs provide on-site mental health services, waiting lists and reimbursement issues are no longer barriers to accessing services. The benefit of on-site and easy to access services can be seen in CCC's findings related to the FRP programs, which serve families with substance abuse problems and typically have on-site substance abuse services. While families in these FRP programs all need substance abuse related services, none of the FRP programs we interviewed cited substance abuse treatment services as a service that was difficult to access.

Many of the surveyed programs explained how they circumvented the waiting lists and other mental health service barriers by using the flexible enhancement money they were receiving from ACS to hire on-site consultants to do mental health assessments. Unfortunately, preventive service programs are now only receiving half of this enhancement funding. Furthermore, according to ACS, these funds have been rolled over into the new rate they will pay providers when the new contracts go into effect,²⁰⁶ and thus there will

²⁰⁵ Unpublished data provided by ACS to CCC in 2007.

²⁰⁶ According to a March 1, 2010 e-mail from ACS, the new preventive contracts will start between July 1 and December 1, 2010, with most of the new contracts starting October 1, 2010.

no longer be a separate pot of money carved out for programs to use in a flexible manner. CCC urges the preventive programs to continue to use a portion of their budgets for this purpose because the new contracts provide them with more flexibility with regard to their funding.

As will be discussed in more detail in the workforce section of this report starting on page 77, many preventive service programs hire Masters of Social Work (MSW) level caseworkers to provide counseling services on-site to the families on their caseloads, often in a family-focused context. ACS has indicated that the FT/R funding and staffing requirements are intended to support access to high quality mental health services, including funding to contract for on-site mental health consultants and to hire MSW-level caseworkers to counsel families. As the new contract requirements are implemented, ACS must ensure that both the FT/R rates and the GP rates are sufficient for programs to be able to provide and/or access mental health services for families.

RECOMMENDATION: Expand the functions of the ACS Mental Health Technical Assistance Unit to include providing support to preventive service providers.

As part of Improved Outcomes for Children (IOC), ACS created a Mental Health Technical Assistance Unit, which provides assistance to foster care providers and residential placement providers when they confront barriers to accessing mental health services for children and parents. CCC recommends that ACS expand this unit so it can provide this type of assistance to preventive service providers.

The Mental Health TA unit is currently staffed by two MSWs who have significant knowledge of the mental health services available in various communities. While CCC appreciates ACS's staffing and budget limitations, we urge the city to expand the resources available to this unit, so that the staff can also provide technical assistance to preventive service providers. Notably, if the city provides additional resources as a preventive service, the funds are eligible for a 65% match from the state.

RECOMMENDATION: Expand partnerships between preventive service programs and mental health clinics to improve timely access to quality mental health services and ensure preventive programs and mental health clinics are adequately reimbursed for their services.

Partnerships and collaborations between mental health providers and preventive service providers are critical to improving timely access to mental health services for families engaged in preventive services. In 2006, the State Office of Mental Health (OMH) developed a model, Child and Family Clinic-Plus, that formally developed these partnerships and CCC encourages the state and the city to replicate the philosophy behind this model, which is aimed at providing timely access to assessment and treatment in natural settings.

Specifically, OMH developed Child and Family Clinic-Plus to improve children's emotional well-being by providing early identification and treatment services.²⁰⁷ Child and Family Clinic-Plus consists of three major components, which all require parental consent: screening, assessment and treatment. Screenings are free, voluntary, and conducted in natural settings such as schools, early childhood centers, and preventive service programs. If mental health needs are identified in the screening and the parent consents, a Child and Family Clinic-Plus provider will do a comprehensive assessment to develop a treatment plan based on the child's individual needs. Treatment plans can include in-home treatment, easier access to clinic-based treatment and/or evidence-based treatment. Child and Family Clinic-Plus is a preventive model in that it seeks to identify children's mental health needs early, intervene quickly and then have a positive impact on the child's emotional growth and development.

In 2006, an RFP was issued for providers interested in participating as screening and/or treatment sites. These participating Clinic-Plus Agencies were required to partner with schools, early childhood centers and/or preventive service programs. OMH selected 21 Clinic-Plus Agencies, six of which partner with preventive service programs. As of the winter of 2008, 32 preventive agencies, encompassing 41 preventive service programs, were partnered with Clinic-Plus agencies.²⁰⁸

Children at these participating preventive service programs are able to be screened at intake (if their parents consent) and then comprehensively assessed to see if mental health services are indicated. These children are then supposed to gain immediate access to treatment services, which can be provided at the preventive service program, at the child's school or home, or at the mental health clinic. Child and Family Clinic-Plus can also address the mental health service

²⁰⁷ New York State Office of Mental Health. *Clinic Plus Home Page*. <http://bi.omh.state.ny.us/clinicplus/index>. (Accessed April 1, 2009).

²⁰⁸ Unpublished data provided to CCC by OMH.

needs of parents, if the agency is licensed to treat adults. While Clinic-Plus is still relatively new, it is believed to be beneficial for the children in the participating preventive service programs. Notably, when a child is assessed to benefit from treatment services, the child is supposed to have immediate access to services, without needing to be on a waiting list. In addition, with Clinic-Plus, treatment can be offered in the child's home for up to nine sessions a year, which assists with family engagement, alleviates transportation issues, and enables the clinician to see the children in a natural setting and see the familial context more fully.

The partnerships between preventive service programs and the Clinic-Plus agencies, and the ability to provide in-home services have been critical. The New York State Office of Mental Health is in the process of finalizing and implementing clinic rate restructuring/refinancing. OMH has indicated the desire for this rate restructuring to lead to clinic development in high needs communities, as well as funding for the services that now are provided through Child and Family Clinic-Plus (such as the ability to bill for providing services in a child's home.) CCC has concerns about whether the new rates and the consistent applicability of these rates to Medicaid Fee-for-Service, Medicaid Managed Care and commercial insurance will be sufficient to support clinics, regardless of which insurance coverage the clients served have. CCC would be pleased if this initiative leads to the development of more mental health clinics in high needs communities.

In addition, ACS's new preventive service model, Family Treatment/Rehabilitation (FT/R), is specifically designed for families where children are at risk of foster care placement due to the prevalent effects of parental or child substance abuse or mental illness. According to ACS's new RFP, this model will require the contractor to provide more casework contacts than the General Preventive model, and to provide counseling services to address presenting mental health issues; conduct mental health assessments in the office or client's home; provide short-term interventions, counseling and supportive services while awaiting pending referrals for long-term mental health services; and establish formal referral and treatment agreements to coordinate service delivery with child and adult mental health treatment programs licensed by OMH and the city Department of Health and Mental Hygiene (DOHMH).²⁰⁹

CCC recommends whether through Child and Family Clinic-Plus, clinic rate restructuring, the implementation of ACS's new FT/R preventive service model, and/or additional initiatives, that every preventive service program be partnered with a mental health clinic to ensure more timely access to mental health services for children and their parents, and that these partnerships replicate the Clinic-Plus model of providing reimbursement for services in natural settings, such as the child's home. In addition, CCC urges OMH, DOHMH and ACS to ensure that the Child and Family Clinic-Plus rate, the preventive service provider rates and the rates established through clinic rate restructuring are all sufficient to enable programs and clinics to be viable and provide quality services to all children and families in need.

iv) RECOMMENDATION – YOUTH

RECOMMENDATION: Revive the Enhanced Preventive Services For Teens model.

From Fiscal Year 2007 through Fiscal Year 2010, ACS has contracted with 17 preventive programs to provide "Enhanced Preventive Services" for teens and babies.²¹⁰ The Enhanced Program for Teens is an enhancement of the General Preventive (GP) program, meaning that the participating preventive service programs receive an enhanced GP rate and are therefore required to provide additional services. There are 13 preventive service programs, serving up to 390 families, that currently have Enhanced Teens contracts. The program enhancements include lower caseload ratios, additional on-site programming and case aides.

One of the program directors from an Enhanced Teens program explained to CCC how beneficial the program had been for their youth because they were able to use the enhanced resources to hire educational consultants and case aides, as well as fund recreational activities to engage youth in their program.

CCC is disappointed that the new RFP no longer includes the Enhanced Babies or Teens models. According to ACS, these models are being replaced by the new FT/R (Family Treatment/Rehabilitation) model, which according to ACS builds on the lessons learned from the Enhanced programs.²¹¹

²⁰⁹ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 53. (May 20, 2009).

²¹⁰ The Enhanced program for babies is an enhancement of the FRP program at 3 preventive programs, serving 80 families where there is a baby with a substance-abusing parent.

²¹¹ Personal communication with ACS Deputy Commissioner, Elizabeth Roberts. Aug. 24, 2009.

According to the new RFP, however, the purpose of FT/R is to “support families whose children are at imminent risk of foster care placement or replacement because of the prevalent effects of parental and/or child substance abuse and/or mental illness.”²¹² This description leads CCC to believe that unless the youth has a mental illness or is abusing substances, he/she will not be able to participate in the higher level of services offered by the FT/R program, and thus FT/R is not a full replacement for the Enhanced Teens model.

CCC urges ACS to reassess the progress of youth who participated in the Enhanced Teens model and consider retaining it as a viable model in their system after the new contracts are awarded. Regardless of whether the Enhanced Teen model is a part of New York City’s preventive service system of the future, ACS must ensure that its providers have enough slots and services to engage teens and meet their needs, so that they remain safely in their homes and out of foster care (or worse, the juvenile justice system).

v) RECOMMENDATION – EDUCATION

RECOMMENDATION: Improve coordination and collaboration among ACS, preventive service programs and the Department of Education (DOE) by improving DOE’s access to social service supports, truancy prevention programs and school based mental health services and by fully integrating DOE into the Community Partnership Initiative (CPI).

Another system that preventive service programs identified as challenging to work with was the Department of Education (DOE). Program directors also indicated that many of their children and youth were facing educational challenges.

CCC understands that ACS and DOE have worked much more closely over the past few years to strengthen their partnership. DOE personnel can refer families for preventive services, Beacon programs have preventive programs located in them, ACS’s Education Unit has provided training and support to help child welfare professionals navigate the school system, and the ACS Division of Child Protection has been engaged in an ongoing dialogue with school administrators

regarding improved collaboration and strategies to offer preventive services prior to making an SCR report.²¹³

A continuous effort is needed to strengthen the coordination between the broader social service system (beyond ACS) and the education system. As documented in a 2008 Report by the Center for New York City Affairs, “In many neighborhoods the challenges of child and family poverty are immense and problems in school overlap directly with problems at home.”²¹⁴ The Center for NYC Affairs’ 2008 data analysis of chronic elementary school absenteeism (defined as missing over 20 days of school) found that in south and central Bronx, central Harlem, and portions of central Brooklyn, 30% or more of the children were chronically absent in the 2007-2008 school year, compared to 5.2% in Bayside, Queens. Similarly, CCC’s 2008 status report on the well-being of children, which catalogues over 400 indicators, found that risks to child well-being were concentrated in these same communities.²¹⁵

It is not surprising that children who are chronically absent from elementary school have lower levels of academic success, as they become teenagers. The city’s preventive service programs, whose contracts are typically to serve the families in these same high-risk neighborhoods, are therefore interacting with these same children, be they in kindergarten or high school. The struggles that led their parents to the child welfare system and the academic troubles of the children and youth are often inter-related. The solution for improving the educational outcomes of these children must therefore be better coordination and collaboration between the social service systems, early care and education programs, the Department of Education, and the individual schools themselves.

It is critical that New York City’s schools, particularly in the high-risk neighborhoods, have better access to social services for families and truancy prevention programs for youth outside of the child welfare system. CCC believes that many attendance-related issues could be resolved without a child welfare intervention (such as a report alleging educational neglect) if

²¹³ Personal communication with ACS Deputy Commissioner Elizabeth Roberts, January 19, 2010.

²¹⁴ Nauer, K., White, A. & Yerneni, R. *Strengthening Schools by Strengthening Families: Community Strategies to Reverse Chronic Absenteeism in the Early Grades and Improve Supports for Children and Families*, at 3. Center for New York City Affairs, Milano the New School for Management and Urban Policy. (October 2008).

²¹⁵ Citizens’ Committee for Children. *Keeping Track of New York City’s Children 2008*, at 3 and 24.

²¹² City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 50. (May 20, 2009).

schools and families could access the services they need in their communities and if schools had more programs and services that engaged families and improved educational outcomes. These services include those within the child welfare system such as preventive services, but also services outside the child welfare system such as counseling, housing assistance, child care, and after school programs. In addition, schools need access to programs and supports that prevent children from coming into contact with the child welfare system.

These include programs that better engage youth in school and assist youth who are already behind in school, such as the Center for Court Innovation’s “attendance court;” evidence-based models currently used by the child welfare system such as MST and FFT;²¹⁶ classes that meet the needs of youth who are significantly behind in school be it due to language barriers, past absenteeism, or learning delays; expanded access to school based mental health services (such as on-site clinics) and school social workers; expansion of the Multiple Pathways program; and an increased number of transfer schools and alternative schools.

CCC also believes that the city’s borough-wide Integrated Service Centers need more staff to help school principals investigate the causes of child specific absenteeism and to locate needed social service supports for families. Finally, CCC thinks that it would be beneficial to children and their families if DOE created a centralized division to work with families if DOE created a centralized division to work with families where children are truant because they are refusing to go to school (as opposed to an educational neglect situation). Specifically, CCC would like DOE to hold family team conferences led by a neutral DOE conference facilitator from the centralized unit who convenes the youth, the family, the teacher and others whom the family would like to have participate, to discuss and understand why the young person is not attending school and then to create a plan that addresses the young person’s needs (including but not limited to a school transfer that the centralized DOE unit would facilitate).

CCC commends ACS for adding education to their Community Partnership Initiative (CPI). CCC suggests that DOE staff from schools be required community coalition partners. This would give the child welfare community an opportunity to regularly interact with the community’s school leadership and collaboratively determine how they can better leverage one another’s resources, and thus better serve children and families.

²¹⁶FFT and MST are evidence-based, family-based prevention interventions for youth and their families, aimed at decreasing anti-social behavior and strengthening families.

E) ENGAGING MEN IN PREVENTIVE SERVICES

FINDING: Preventive service programs do not always require caseworkers to work with men/fathers even when they are living in the home.

CCC asked program directors whether in cases where their caseworkers were working with a mother,²¹⁷ they were also *required* to work with the child’s father living in the home, the child’s father living outside the home, and/or the mother’s boyfriend when he was an unrelated male living in the home. CCC’s survey findings of self-reported program director responses revealed that while many acknowledged it was best practice, working with the men/fathers was not a requirement at all surveyed programs.

Table 14: Do programs require caseworkers to work with fathers/men?
N=31

	Father Living in the Home	Father Living outside of the Home	Boyfriend/ Unrelated Male Living in the Home
Yes	80.6% (25)	48.4% (15)	71% (22)
No	19.4% (6)	51.6% (16)	29% (9)

FINDING: While research shows that fathers play a critical role in parenting children and that unrelated adults living in the home may have an increased likelihood of abusing the children, parent education programs and preventive programs do not always engage men and other unrelated adults in the home in preventive services.

The literature is clear that fathers play a critical role in their children’s development.²¹⁸ In addition, the data on the effects of a father’s presence or absence in the home is staggering:

²¹⁷This caveat was an attempt to eliminate the father-only cases from conflating the responses to the question.

²¹⁸Lundahl, Tollefson, Risser and Lovejoy. *A Meta-analysis of Father Involvement in Parent Training*. (March 2008).

when compared to children living with both parents, children living with single mothers are five times more likely to be poor and children living with single parents are twice as likely to suffer physical, emotional or educational neglect.²¹⁹

A troubling study published by the American Academy of Pediatrics in 2005 found that children residing in households with unrelated adults were almost 50 times more likely to die of intentionally inflicted injuries than children living with two biological parents. In this study of 149 injury-inflicted deaths of children under age five in Missouri over an eight year period, 71.2% of the perpetrators who could be identified were male—and 34.9% were the child’s father and 24.2% were the mother’s boyfriend. Furthermore, in homes where there was an unrelated household member living in the home, 83.9% of the perpetrators were the unrelated household member.²²⁰

Unfortunately, this sad trend reported nationally,²²¹ that when a child’s death is a homicide it too often is perpetrated by the mother’s boyfriend, holds true in many child fatalities reported in New York City.²²²

Yet a literature review, discussions with ACS and preventive programs, and the CCC survey findings indicate that fathers and men in children’s homes are not always engaged in services, such as parent education programs. In fact, fathers are noticeably absent in parent education programs, with several reviews indicating that only 20% of parent education programs even include fathers.²²³

RECOMMENDATION: Fathers and unrelated household members need to be more engaged in preventive services. ACS should directly mandate the inclusion of fathers in assessments and service provision (where appropriate) and strictly monitor programs’ effectiveness in engaging fathers.

Fathers and unrelated adults living in the home can either be stabilizing or destabilizing factors for families. In addition, even when the mother and father are living separately, the father and his extended family can be important resources for the family. When preventive service programs assess families for strengths, safety and risk factors, and service needs, the assessments must include fathers and any other unrelated adult living in the home, as they are critical members of the child’s household. Fathers and men in the home should be assessed for their service needs, and when appropriate, included in parent education programs (either in fathering programs, co-parenting classes with the mother, or in a separate co-ed parenting class).

CCC believes ACS should be more direct in issuing a mandate that preventive service programs do more to engage and serve men living in the household. The Scope of Services in the new RFP addresses this issue of fathers/unrelated men in the home in three places:

- “The contractor, as part of case planning responsibility, shall ensure that children and parents/primary caretakers participate in the design of their service plans and goals.”²²⁴
- “During the initial stages of a family’s participation in the program, staff must have frequent and regular casework contact, including extensive home-based casework contact with the child and family members in the home. Caseworkers must have regular contact with non-resident family members to the extent appropriate to achieve the family’s service plan goals.”²²⁵
- “The contractor must perform outreach and engage non-custodial and/or incarcerated parents to the extent necessary to successfully implement the child’s and family’s service plan, while taking into account any history of domestic violence prior to such outreach.”²²⁶

²¹⁹ National Fatherhood Initiative: The Father Factor in Child Well-Being. www.fatherhood.org/father_factor.asp

²²⁰ Schnitzer and Ewgiman, *Child Deaths Resulting From Inflicted Injuries: Household Factors and Perpetrator Characteristics*. Pediatrics. Vol. 116 No. 5. (November 2005).

²²¹ See Pittsburgh Post Gazette, Child Abuse Often Linked to Unrelated Live-in Lovers,” April 26, 2001. www.post-gazette.com/regionstate/20010426-boyfriend2.asp; *Recent Child Abuse Deaths Blamed on Mom’s Boyfriend*. The Associated Press. (November 17, 2007). www.abcnews.go.com/US/wirestory?id=3880984;

²²² Examples include the tragedies of Nixzmary Brown killed by her stepfather on January 11, 2006; Quachuan Browne killed by his mother’s companion on January 30, 2006, Sharlene Morillo who died on July 29, 2006 from injuries inflicted by her mother’s companion; and Jaysa Brown killed by his mother’s companion on August 18, 2008.

²²³ Lundahl, Tollefson, Risser and Lovejoy. *A Meta-analysis of Father Involvement in Parent Training*. (March 2008).

²²⁴ City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 43. (May 20, 2009).

²²⁵ Id.

²²⁶ Id. at 44.

While CCC appreciates that the intent of these requirements is to include fathers, unrelated men living in the home and other adult household members, CCC thinks that given the history of case practice and CCC’s findings in this area, that ACS should issue more direct requirements. In the short term, ACS should issue a policy memorandum, typically referred to as a “Child Safety Alert,” that clearly states that working with fathers and other adult men in the household is not only best practice, but is mandatory unless an assessment indicates the person presents a safety concern. Furthermore, when ACS evaluates and monitors its preventive programs through their Scorecard system, a program’s efforts to assess and engage all household members should be an item measured and monitored. Finally, CCC recommends that the state Office of Children and Family Services (OCFS) assess its safety and risk assessment tools, which New York City is required to use, to ensure fathers, men in the home, and all other adult household members are fully integrated into all safety and risk assessment tools and service planning templates.

F) LANGUAGE ACCESS AND CULTURAL COMPETENCE

FINDING: Language access and cultural competence are critical for NYC’s preventive service programs to be able to meet the needs of New York City’s diverse population. ACS and preventive programs have taken steps to improve the system’s ability to meet the language needs of families and the city’s cultural diversity, but there is still a need for more bilingual and culturally competent staff.

“She was Hispanic... you know they try to match you. She lived in Queens, I lived in the Bronx- we came from two different backgrounds. She tried to counsel me but you can’t do that if you don’t know anything that is going on.” As described by one of the parents in the CCC focus group, both cultural competence and the ability to speak to parents in their primary language are critical to the effectiveness of preventive services.

CCC asked the 31 preventive program directors in what languages their program was able to provide services to families, and what languages they were finding families were speaking but were hard for their program to serve.

We found that programs were able to provide services in a variety of languages, based on the caseworkers employed at their program at the time of the survey interview. Program directors reported that 100% of their programs could serve English-speaking families; almost 40% could serve Haitian/Creole speaking families; and about a quarter could serve Spanish-speaking families. Table 15 provides more details:

Table 15: Languages Programs Were Able to Serve
N=31

Language Programs	Percent (Number of Programs)
English	100% (31)
Haitian/Creole	38.7% (12)
Spanish	22.6% (7)
Chinese/Mandarin	12.9% (4)
Mexteco	6.5% (2)
Sign Language	3.2% (1)
Urdu	3.2% (1)
Russian	0% (0)
Hindi	0% (0)
Other:	22.6% (7)
Japanese	1 program
French	3 programs
Jamaican/Guyanese	1 program
Arabic	1 program
Italian	1 program
Portuguese	1 program
Garifino (from Honduras)	1 program
Korean	1 program

We also found that based on the needs of families referred to the programs, and the families served by the programs, there were additional languages that program directors reported families were speaking that were difficult for their program to serve. Notably, over a quarter of programs reported Spanish. Table 16 provides more details:

**Table 16: Languages Difficult to Serve
LN=31**

Language Programs)	Percent (Number of
Spanish	25.8% (8)
Mexteco	12.9% (4)
Russian	9.7% (3)
Chinese/Mandarin	6.5% (2)
Haitian/Creole	6.5% (2)
Hindi	6.5% (2)
Urdu	3.1% (1)
Sign Language	3.2% (1)
English	0% (0)
Other:	29% (9)
Korean	2 programs
African dialects	2 programs
Pakistani	1 program
Bengali	1 program
Cambodian	1 program
Arab dialects	2 programs
Bangladeshi	1 program
Portuguese	1 program
Non-mainstream Chinese	
Dialects	1 program
Wolof (West Africa)	1 program

It may be that CCC's findings actually underestimate the language access needs of families needing preventive services. As one program director explained, "it may be that ACS is not referring families that speak the other languages because they know [our program] cannot serve them." Responses to other questions in CCC's survey reinforce this finding. Program directors were asked to rank the "top three most frequent reasons cases are rejected by your program" and were given options including "the family's primary language is one that your program cannot serve." Five of the 31 programs (26%) chose the language barrier as one of the top three reasons they reject cases, but another 4 programs explained that they would not accept a referral where this was an issue so they would never be in a position to reject it. If these types of cases do not even count as rejections, then it is very difficult for the preventive service programs to be able to quantify the language access needs in their communities.

Recent reports by the Coalition for Asian American Children and Families and the Committee for Hispanic Children and Families, Inc. specifically address the need for culturally competent preventive services in the languages that their constituencies speak.

In their March 2007 *Connecting the Dots* report, the Coalition for Asian American Children and Families (CACF) found that the Asian American community, representing 11% of New York City's population, comes from China, Japan, Taiwan, Korea, India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, Vietnam, Indonesia, the Philippines, Cambodia, Laos, Burma, Malaysia, Singapore, Guam and the Samoas. New York City's Asian Americans speak over 50 dialects and languages, and are largely an immigrant population with 78% foreign born.²²⁷ CACF reports that there are only five agencies that ACS contracted with at that time that could provide linguistically and culturally appropriate preventive services to Asian American families, and that these programs mainly served the Chinese population, leaving a gap for families needing services in languages such as Korean, Urdu, Bengali and Vietnamese.²²⁸ In 2008, ACS specifically awarded preventive slots to help serve Urdu and Bengali speaking families.

The Committee for Hispanic Children and Families found similar cultural and linguist challenges for the 28% of New York City residents who are of Hispanic background. In their study of thirty-eight families receiving preventive services and thirty-four preventive workers they found that both clients and caseworkers indicated that being able to speak to one another in Spanish was critical to their relationship and the engagement process.²²⁹

ACS has taken steps to improve language access for families needing preventive services. When ACS makes referrals, the PROMIS system lists the languages spoken by agency staff. If the liaison making the referral is unable to find a program for the family, the liaison can receive assistance from the ACS Office of Preventive Technical Assistance, the Community Partnership Initiative, or engage CBOs serving immigrant communities.

²²⁷ Coalition for Asian American Children and Families, *Connecting the Dots: Improving the Neighborhood-Based Child Welfare Services for Asian Pacific American Families*, at 7. March 2007.

²²⁸ Id at 9.

²²⁹ Phillips, M. *Voices of Preventive Services: Perspectives of Clients and Workers*, at 18-20. Fordham University and the Committee for Hispanic Children and Families. September 2007.

In 2007-2008, ACS used data on languages spoken by families who were the subject of SCR reports, languages for which ACS used interpreter services in the Division of Child Protection, DOE data regarding the number of households with a public school enrolled child in each CD speaking specific languages, and a survey of ACS and preventive agency staff to identify underserved languages. ACS then awarded 200 special language slots to GP providers in FY08. These slots are still in place, and have reduced the difficulties ACS has had when referring families to preventive services. In addition, ACS has made interpreter services available for families who cannot be served by a bilingual case planner, and ACS has issued a memo stating a clear expectation that providers take such cases when there is no other suitable alternative available to the family.²³⁰

To address this issue in the future, ACS's new RFP recognizes how critical cultural competence, language access and diversity are to a successful preventive service system, and includes several new provisions to try to strengthen the system's ability to meet the diverse cultural and language needs in New York City.

In the RFP Summary Section "Cultural Competency and Diversity" is identified as an area where ACS is reinforcing its expectations. In addition, this language is reiterated in the ACS Preventive Services Scope of Services. Specifically, ACS says:

"Throughout the child welfare system, ACS seeks providers whose leadership and mission show an active commitment to diversity in all forms. ACS expects contractors to employ strategies that support sound culturally competent practice, promote diversity, and contribute to ending racial and ethnic disparity and racial disproportionality. This commitment should be borne out through staff hiring, training, and development and culturally competent practice. Providers should have strong ties to their communities through leadership, staff and advisory boards."²³¹

The Preventive Services Scope of Services section of the new RFP goes on to require, "Professional staff who are

qualified and trained, and who provide services that support racial equity, are culturally competent and linguistically accessible and reflect the diversity of the communities they serve."²³²

ACS attempts to accomplish these goals through two staffing mandates. First, the contractor must make "diligent efforts to recruit and hire qualified staff that reflect the race/ethnicity and language spoken by the families in their community."²³³ Then ACS provides clear minimum requirements for achieving language access by requiring contractors to "hire a bilingual staff person for every 5,000 or 10% of parents of public school students that speak a language other than English in the community district served by the contractor."²³⁴ While ACS on one hand issues this mandate, the new RFP also provides some flexibility for community districts where more than one language (not including English) meets the 10% or 5,000 person threshold by saying that in these community districts if "it is not feasible to hire bilingual/bicultural staff from each different immigrant community group [meeting the 5,000 person or 10% threshold], the contractor, through written agreements, must establish relationships with community-based organizations or have contractual arrangements with interpretation and translation services needed to serve non-English speaking children and family members."²³⁵ According to ACS, this flexibility was put in place because most Community Districts are served by several preventive providers, making it appropriate and desirable for different providers in the same CD to specialize in serving different cultural groups, allowing the needs of the CD to be met by the providers as a group, rather than by each provider individually.²³⁶

²³² Id. *Section III: Scope of Services*, at 39.

²³³ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Addendum #2*, at 3. (June 8, 2009).

²³⁴ ACS provided the programs with the Department of Education's Language Data to be used to develop proposals that meet this requirement. ACS further explains that at a minimum the contractor may satisfy the requirement by the lesser of the 5,000 or 10% threshold; however if the number of families exceeds 5,000 or is above 10% but not both, the contractor must have at least one bilingual case planner for the language.

²³⁵ Id.

²³⁶ Personal Communication with ACS Deputy Commissioner Elizabeth Roberts, February 12, 2010.

²³⁰ Personal Communication with ACS Deputy Commissioner Elizabeth Roberts, February 12, 2010.

²³¹ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 9. (May 20, 2009). Id. *Section III: Scope of Services*, at 35.

RECOMMENDATION: Increase the number of preventive service slots available to families at preventive service programs specifically designed to meet language and cultural needs of immigrant families and families not proficient in English, and ensure that preventive service programs are funded to hire trained, qualified, bilingual, culturally competent staff.

In a city as diverse as New York City, it is very difficult for any social service system to be able to meet the needs of families speaking hundreds of languages and dialects and representing hundreds of cultures. On the other hand, the high levels of poverty among immigrant families, the cultural differences in child-rearing, and the difficulties in accessing city services and entitlements when there are language barriers, make preventive services an invaluable tool to strengthen these families and to keep children safe and supported in their homes.

To address this need, ACS contracts with several community-based organizations that specialize in serving immigrants, non-English proficient and culturally diverse families, including those specializing in serving Puerto Rican, Dominican, Chinese, Arab, and Haitian families. Looking at the current slots for which ACS contracts, about 10% of its preventive service slots are with programs that have a cultural specialty.²³⁷ CCC urges ACS to ensure that its new contracts for preventive services increase the number of slots available at these types of programs by increasing the number of slots available at these existing programs and/or contracting with additional service providers with these cultural and language specialties.²³⁸

For culturally competent programs that meet the language, cultural and racial needs of families to exist and for preventive programs to be able to make referrals to other service providers, there must be a cadre of skilled and dedicated bilingual staff who enter this field and remain in it. As is discussed in the workforce section of this report, there is much work to be done to make child welfare a field that is sought after by professionals seeking to use their skills to improve the lives of children and families. CCC urges ACS to ensure that

the preventive service programs are sufficiently funded to be able to hire these qualified staff and to be able to access translation and interpretation services when necessary.

RECOMMENDATION: Educate the child welfare community on various cultures and their customs related to child-rearing in an effort to provide for more culturally competent interventions.

To be able to engage and serve families, particularly immigrant families who may have different values and expectations for child-rearing, it is critical that service providers be trained in understanding and recognizing cultural differences and how to then provide culturally sensitive interventions. To this end, the Community Partnership Initiative (CPI) could include a role for the community coalitions in providing or locating training for workers, as well as assistance in accessing culturally competent, community-based services.

G) COURT ORDERED SUPERVISION (COS)

FINDING: There has been a very large increase in the number of Court Ordered Supervision cases and a decrease in ACS's ability to make the required two home visits per month in these cases.

Court ordered supervision cases are those where the city's child welfare agency (ACS) has filed a petition alleging abuse or neglect against the child's caregiver(s) and the court has ordered that the child can remain at home, with the ongoing supervision of the child welfare agency. This means that the court has the authority to order ACS to provide certain services and the authority to order parents to participate in services—this is the only time when preventive services are not voluntary. Court ordered supervision can occur when ACS first files a case and the children may never have entered foster care, or supervision can be court ordered when a child returns home from foster care.

In court ordered supervision cases, an ACS child protective worker from the Family Services Unit (FSU) supervises the family through a minimum of bi-weekly home visits. In addition, this FSU worker refers the family to services and reports to the court on the family's progress. Thus, in some ways, the FSU worker, who is an ACS child protective worker working in an ACS field office, is acting like a preventive

²³⁷ Estimate based on unpublished data provided by ACS to CCC in October 2006.

²³⁸ CCC's recommendation is for these slots to be additional slots and not substitutes for existing slots. Unfortunately, ACS's intention to reduce the system's capacity by over 2,500 slots makes this unlikely.

service worker by providing referrals, but is not affiliated with a community-based program in the family's community. As part of the court ordered supervision case, the ACS FSU worker can refer the family to a preventive service program.

Often times, the level of risk to the children is higher in a court ordered supervision case than in a typical preventive service case. Heightened risk is demonstrated by the fact that ACS believed it necessary to file a case in Family Court in order to mandate the family's participation in services, and that there was sufficient evidence of prior abuse or neglect to enable the court to grant ACS's request. On the other hand, these cases typically receive less in the way of preventive services because the ACS worker makes referrals and supervises the home, but is not able to offer the full panoply of services that comes with having an open preventive service case. Notably, the ACS FSU worker has an office in an ACS field office, which does not offer the same neutral setting as a preventive service program.

As Table 17 shows, there was a 67% increase in the number of court ordered supervision cases from May 2005-May 2008 and a significant drop in ACS meeting the two visits per month requirement. From May 2008-May 2009, there was a slight decrease in the number of cases and a slight increase in the percent of cases receiving the required number of home visits; yet, still almost 30% of the families were not receiving the required two home visits per month.

Thus, families in court ordered supervision cases are often the most high risk, but these families may be receiving less in

the way of services. Although they are receiving service referrals and assistance from ACS (such as referrals for substance abuse treatment, housing subsidy, assistance with entitlement applications and the provision of emergency goods), they are not receiving the full package of caseworker counseling in a community-based/non-governmental environment that families voluntarily seeking services receive. In addition, ACS is only making bi-weekly home visits in 60-70% of these cases.

ACS has made efforts to both decrease Family Service Unit (FSU) caseloads²⁴⁰ and increase the percent of cases where workers are making the required 2 home visits per month. While ACS appears to have achieved the 15 to 1 caseload ratio, more work is needed to ensure these families are receiving the required home visits and needed services.

Table 17: Dramatic Increase in Court Ordered Supervision Cases (COS); Decrease in Home Visits- May 2005-May 2009;²³⁹

	Number of COS Cases	Percent of Cases with 2 ACS Home Visits Per Month
May 2005	2264	95%
May 2006	2281	86%
May 2007	3556	57%
May 2008	3779	65%
May 2009	3430	71.3%

²³⁹ Administration for Children's Services. *ACS Monthly Updates: May 2009; May 2008, FY08; June 2007, FY07; June 2006, FY06 and June 2005, FY05.*

Table 18: Family Service Unit Caseloads and Percent of Cases Meeting Home Visit Requirements by Month-2008

	Average FSU worker caseload ²⁴¹	Percent of Cases with 2 ACS Home Visits Per Month ²⁴²
January 2008	17.4	60%
February 2008	17.1	60%
March 2008	16.7	62%
April 2008	15.9	66.2%
May 2008	15.8	64.6%
June 2008	15.3	70%
July 2008	15.0	67.9%
August 2008		67%
September 2008		67.5%
October 2008		69.8%
November 2008		68.1%
December 2008		71.1%

²⁴⁰ Family Service Unit (FSU) caseworker caseloads are comprised of Court Ordered Supervision (COS) cases.

²⁴¹ Administration for Children's Services. *Safeguarding Our Children: Safety Reforms Update November 2008*, at 15. Caseload data only provided up through July 2008.

²⁴² Administration for Children's Services. *ACS Monthly Update December 2008, FY09.*

FINDING: Although there has been a dramatic increase in the number of court ordered supervision cases since 2005, preventive service program directors did *not* report that a high percentage of their preventive cases had court ordered supervision. In addition, less than one third of the program directors had noticed a substantial increase in the number of COS cases in their programs.

Through CCC’s survey interview, we sought to understand how often families in court ordered supervision cases were being referred for services at preventive service programs. We believed this was important because of both the tremendous increase in the number of these cases and the high level of risk factors often identified in these cases.

CCC asked the program directors a series of questions about their court ordered supervision cases, which we defined as cases where the court had ordered ACS to supervise and the family was also receiving services at their preventive program. One program director did not respond to this section of the survey even though the definition of court ordered supervision was provided in the survey instrument because the director maintained that no case with court involvement would be open in his/her preventive program.

CCC asked the preventive program directors a) whether when ACS refers a case to their program that already has court ordered supervision ACS alerts the program of this at the time of referral; and b) whether ACS alerts them timely (within a month) of cases that become court ordered supervision while the case is already open for services in their program.

In both scenarios, program directors generally felt that ACS did alert them to the court ordered supervision cases, although this seemed more likely if the case was a COS case at the time it was referred to the preventive program (as opposed to a case that was already open in the preventive program and later became a COS case). That said, several program directors did think this practice could be improved upon. One program director reported that ACS does not call them but they can learn about COS through reading the progress notes entered by ACS into the computerized case management system (CONNECTIONS). Another program director said that one of her workers learned a case had court ordered supervision because she ran into the ACS caseworker when she was doing a home visit. More details about responses to these questions can be found in Table 19 and Table 20.

Table 19: Programs learn about COS cases at time of referral:

N=30

Almost Always	40% (12)
Frequently	13.3% (4)
Sometimes	33.3% (10)
Rarely	6.7% (2)
Never	6.7% (2)

Table 20: Programs learn about COS in a timely fashion (within a month) if case becomes COS after referral to the preventive program:

N=30

Almost Always	10% (3)
Frequently	22.6% (7)
Sometimes	51.6% (16)
Rarely	10% (3)
Never	3.2% (1)

CCC also asked the program directors whether they knew approximately what percent of their programs’ currently open cases had court ordered supervision. Seventy-one percent (22/31) of the surveyed programs reported knowing the approximate percentage of court ordered supervision cases in their program.²⁴³ CCC then asked those 22 programs what percent of their cases were in fact COS cases. Responses ranged from 0% to 40%, with a mean of 7.7% and a median of 5%. More detail by program type is provided in Table 21.

Given that at the time of survey administration (April-June 2007) there had been a substantial increase in the number of court ordered supervision cases open in ACS, CCC asked the program directors whether in the past year their program had seen a substantial increase in the number of court ordered supervision cases open in their programs. Only 31% (9 of the 29 programs that responded) reported seeing a substantial increase in COS cases over that year.

²⁴³ CCC counted the program that claimed it would never have a COS case as knowing the percent. We calculated the percent as 0%.

Table 21: Reported percent of COS cases at the preventive programs (N=22)

	All 22 Programs	GP (N=18)	FRP (N=4)
Minimum:	0%	.5%	0%
Maximum:	40%	40%	15%
Mean:	7.7%	7.9%	6.5%
Median:	5%	5%	5.5%

CCC is unsure whether these findings, which hinge on a program’s awareness that there is court ordered supervision in particular cases, are based on ACS not referring many court ordered supervision cases to preventive programs, or preventive programs not being aware that the families they are serving have a court case, or both. To try to untangle this, CCC requested data from ACS as to how many cases they have open both in preventive programs and in their Family Service Units at the same time, but ACS was unable to provide this data to CCC. ACS explained that this is because they use two different computer systems to track these cases: PROMIS tracks preventive service cases and CONNECTIONS tracks FSU cases.

Finally, CCC asked the program directors what impact they felt the court’s involvement had on a family’s participation in their program in an attempt to understand the impact of mandating a parent’s participation in a program that is otherwise voluntary. While responses varied, the program directors typically believed that the court had an impact on family participation. Just over half of the programs (16 out of the 30 that responded) felt that the families were more willing to participate when they were being court ordered to do so. Thus, the program directors did not seem to feel that the mandate was negatively impacting family engagement or that families were not participating. For more details, please see Table 22.

RECOMMENDATION: ACS should assess whether there should be an increase in the number of court ordered supervision cases that are referred to preventive service programs.

While many families in court ordered supervision cases could benefit from referrals to preventive services programs, there are

Table 22: Impact of court involvement on family’s participation in preventive services (N=30)

Families are <i>more</i> willing to participate	53.3% (16)
Families are <i>less</i> willing to participate	6.7% (2)
Approximately <i>equal</i> number of families are more and less willing to participate	33.3% (10)
Court orders seem to have <i>no impact</i> on a family’s willingness to participate	6.7% (2)

also several downsides to referring COS cases to preventive service programs. First, in this time of budget shortages and limited capacity at preventive service programs,²⁴⁴ it is critical not to duplicate services and to be efficient wherever possible. Second, it is possibly confusing and overwhelming to families to have both ACS and a preventive service program engaged with them at the same time around the same service plan. Finally, if the case is open both with ACS and a preventive program, the two caseworkers need to coordinate with one another.

CCC thinks it is likely that about 50% of the court ordered supervision cases should also be referred to preventive service programs because we believe that for a family, the difference between receiving assistance from an ACS government office versus a preventive service program in the family’s community cannot be understated.

However, because of the potential downsides and because we do not know what percent of these cases are currently referred to preventive service programs, we are recommending that ACS do further analysis of these cases to determine which court ordered supervision cases should be referred to preventive service programs and which should be served solely by ACS. Specifically, we are recommending that ACS review and compare court ordered supervision cases open only in the ACS Family Services Unit with those cases also open in a preventive service program to better understand the impact on the families and effectiveness of the interventions. ACS should then issue guidance to its staff and preventive service staff regarding when court ordered supervision cases should also be referred to preventive service programs.

²⁴⁴ This will be even more so after ACS eliminates over 2,500 preventive service slots when the new contracts are effective in July-December 2010.

RECOMMENDATION: OCFS and ACS should improve their data collection systems so that data on the number of cases open in both ACS Family Service Units (Court Ordered Supervision units) and preventive service programs can be readily accessible.

To understand the true dynamics of court ordered supervision, ACS and its preventive providers need better information and data regarding the overlap between court ordered supervision at ACS and preventive service programs. This will require using the newly developed common case identifiers in CONNECTIONS and PROMIS²⁴⁵ to run regular management reports regarding these cases. Ultimately, this should be captured by one data system that can track all aspects of preventive service cases.

While it seems that the court ordered supervision cases are not getting referred to preventive service programs at a high rate, it is possible that the preventive service programs do not know that they are serving a family with ongoing court review and ACS supervision. The latter, if true, is another issue that would need to be addressed.

RECOMMENDATION: ACS and the preventive service programs should improve their coordination and collaboration in shared court ordered supervision cases.

CCC recommends that ACS take additional measures to increase coordination and collaboration between the ACS Family Service Unit caseworker, the ACS legal division handling the case in court,²⁴⁶ and the preventive service program in court ordered supervision cases. Both caseworkers and lawyers involved need to know the status of court orders, safety and risk factors identified, and updates on the family's participation in services. It would not serve ACS, the preventive program or the family well if ACS and the preventive program were merely duplicating each other's efforts instead of collaborating to support one another.

CCC suggests that ACS create a workgroup or steering committee on court ordered supervision that includes ACS child protective and legal staff, preventive service program

directors and legal service organizations that represent children and parents.²⁴⁷ This would enable discussion about the current processes, policies, strengths and weaknesses in the system, and brainstorming on how coordination and collaboration could be improved.

H) IDENTIFYING AND ADDRESSING SAFETY AND RISK FACTORS IN FAMILIES

FINDING: Preventive service programs do not all have the same understanding of their role with regard to assessing safety and risk.

The role of preventive service caseworkers in assessing safety has not always been clear or consistent. Program directors, both in CCC survey interviews and in other conversations with CCC, have spoken about what many believe to be their changing and heightened role with regard to assessing safety as part of the supportive work they are doing with families.

This lack of uniformity was seen in answers to some of CCC's survey questions. For example, the program directors gave varying responses when CCC asked how long after a case was referred from ACS until their program did an initial safety assessment. Ten programs responded saying that this was done immediately, at the point of first contact, or at the first home visit. On the other hand, the remaining programs responded with significantly longer lengths of time including three weeks, 45 days, 10 days after the family signs the form agreeing to participate in services, and not at all.²⁴⁸

In addition, as will be discussed more fully in Section I on Training starting on page 68, when CCC asked the program directors what training their caseworkers were required to complete before they started working with families, we learned that none of the 31 programs required their caseworkers to receive training on assessing safety or risk prior to working with families.

FINDING: ACS's new RFP more clearly articulates the role of preventive service providers in assessing safety and risk.

²⁴⁵ CONNECTIONS is the state administered system of record. PROMIS is a preventive service management information system created by ACS. New York City uses both systems.

²⁴⁶ This division is called Family Court Legal Services.

²⁴⁷ Citizens' Committee for Children is interested in participating in this workgroup if ACS thinks our participation would be helpful.

²⁴⁸ This was discussed in more detail on page 30.

ACS's new RFP infuses the need to assess, monitor and address safety and risk throughout all aspects of the RFP. ACS addresses safety and risk in the list of system-wide goals for NYC's child welfare system, in the list of future expectations and support for all of their child welfare contracted services, and then throughout the Summary and Scope of Services.

ACS lays out four system-wide goals for NYC's child welfare system for the next decade, one of which is to "Reinforce the importance of on-going safety assessment of immediate and impending danger of serious harm to children throughout the life of a case."²⁴⁹ Then ACS goes on to say that to achieve this (and the other goals), they are reinforcing their expectations and support for their provider agencies in a number of key areas, one of which is Safety and Risk Assessment.²⁵⁰ In the Summary section of the new RFP, ACS states that they have "created standards that encourage preventive service and family foster care providers to monitor safety and risk throughout the life of the case for all children and families they serve."²⁵¹ ACS suggests this can be done through information gathering (including a review of the initial investigation), casework contacts (of the requisite quality and frequency), effective supervision, and the "expectation that all staff, case planners, supervisors and conference facilitators will identify unresolved safety and risk concerns and seek interventions to address these concerns."²⁵² Then in the Scope of Services, in the very first item, ACS requires, "Through an integrated neighborhood-based service model, General Preventive (GP) services are provided to families at risk of foster care placement in order to ensure the safety of their child(ren), to reduce risks to children, and to preserve, support, and strengthen the family, when appropriate."²⁵³

FINDING: Preventive service programs regularly make reports to the State Central Register (SCR).

CCC's survey interview asked program directors approximately how often they needed to make a report of abuse or neglect to the State Central Register (SCR) during the prior

²⁴⁹ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 7. (May 20, 2009).

²⁵⁰ Id. at 8-9.

²⁵¹ Id. at 9.

²⁵² Id. at 10.

²⁵³ Id., *Section III: Scope of Services*, at 40.

six months. For the 29 of 31 programs able to answer this question, responses ranged from 0 (1 program) to 15 (1 program), with a mean of 4.3 reports and a median of 3 reports during the prior six months.

Due to the differences in the types of cases handled by GP programs versus FRP programs (where parents of young children have abused substances), we analyzed the data for GP and FRP separately. As shown in Table 23, and as expected, FRP programs tended to make SCR reports somewhat more frequently than the GP programs.

Table 23: SCR Reporting During the Past 6 months, by program type

	FRP (N=6)	GP (N=23)
Minimum	3	0
Maximum	10	15
Mean	5.7	4
Median	5	3

While the FRP programs were generally the same size (all 6 that responded had 30 slots), the GP programs ranged in size from 60 to 260 slots, with a mean of 80 and a median of 75. Given that larger programs serve more families, CCC hypothesized that the larger programs would make significantly more SCR reports. Upon further examination of the data for the GP programs, CCC found a moderate positive correlation between program size and the number of SCR abuse/neglect reports made.²⁵⁴

While this correlation did exist, it was not as strong as we would have anticipated. When we distributed the GP programs by size, into small and large based on whether they were at the median or smaller (75 slots or less) versus greater than the median (larger than 75 slots), and looked to see whether they were lower reporters (at the median of 3 reports or lower) or higher reporters (over the median of 3), we found that 38% of the smaller programs were higher reporters while 57% of the larger programs were higher reporters. These data also show that the 10 programs that made the most reports were from both small and large programs. For more details, see Table 24.

²⁵⁴ The Pearson correlation is .403.

Table 24: Impact of Program Size on Reporting for GP Programs (N=23)

	Larger programs (over the median of 75 slots)	Smaller programs (at or under the median of 75 slots)
Higher reporters (over the median of 3 reports)	4 (57%)	6 (38%)
Lower Reporters (at or under the median of 3 reports)	3 (43%)	10 (62%)

CCC also reviewed the SCR reporting data by borough and as is shown in Table 25, there are borough differences among GP programs, with a higher proportion of Bronx and Brooklyn programs tending to be higher reporters and a higher proportion of Queens and Manhattan programs tending to be lower reporters. Given the small numbers here, caution is required with respect to any generalizations.

FINDING: Programs reported that they work differently with high-risk families, including making more home visits, providing additional services, holding more case conferences, and intensifying services.

CCC’s survey interview asked program directors whether their programs worked with high-risk families differently than families where there was a lower level of risk. A large majority, or 93.5% (29 of 31), responded that they do work differently with families with a higher level of risk. CCC then asked those 29 programs how typical it was that the following would be done differently: more home visits, additional services provided, more case conferences, and services intensified. Ninety-three percent of the programs responded that there would almost always or usually be more home visits and intensified services

for high-risk families. Interestingly, while ACS’s Improved Outcomes for Children (IOC) model encourages holding case conferences to address heightened risk, in CCC’s pre-IOC survey, this was not used as often as the other interventions.

For more details see Tables 26-29 on the following page.

FINDING: When program directors were asked how their programs measure or assess a family’s progress with services, most of the directors focused on tools and casework tasks rather than changes in behaviors.

CCC asked the program directors whether they measure or assess a family’s progress with services, and if so, how. Two of the thirty-one programs responded that they did not do this.

Twenty of the 29 program directors that reported assessing a family’s progress answered this question by enumerating tasks or tools for caseworkers and their supervisors. They mentioned weekly or bi-weekly supervision, administrative reviews and the completion of the Family Assessment and Service Plan (FASP) tool every 6 months.²⁵⁵

Only eight of the programs (28%) mentioned the family’s participation, behavioral changes or progress, as opposed to caseworker tasks and processes and/or tools. Below are examples of how these eight programs said they measured or assessed the family’s progress with services:

- “Look at whether the parents are attending their drug program; whether their urine is clean; look at education records and see if child is going to school and whether medical appointments are kept. Look at whether the client is reaching out for services and accepting them. Observe interactions between children and caregivers.”
- “Look for improvement in the parents’ behaviors, specifically the targeted behavior. Look at the parent’s participation in services. Look at the client’s attitudes.”
- “Observe interactions at home visits and look for changes and whether goals achieved.”

Table 25: Borough Distribution of High and Low Reporters for GP Programs (N=23)

	Bronx (N=5)	Brooklyn (N=7)	Manhattan (N=5)	Queens (N=4)	Staten Island (N=1)
Higher reporters (over the median of 3)	5 (100%)	4 (57.1%)	1 (20%)	0 (0%)	0 (0%)
Lower Reporters (at or under the median of 3)	0 (0%)	3 (42.9%)	4 (80%)	4 (100%)	1 (100%)

²⁵⁵ The Family Assessment and Service Plan (FASP) is a statewide assessment and service planning tool required to be completed every six months.

Table 26: More Home Visits (N=29)

Almost always	69% (20)
Usually	24% (7)
Sometimes	7% (2)
Rarely	0%
Never	0%

Table 27: Services are intensified (N=29)

Almost always	55% (16)
Usually	38% (11)
Sometimes	3% (1)
Rarely	0%
Never	3% (1)

Table 28: Additional services provided (N=29)

Almost always	59% (17)
Usually	17% (5)
Sometimes	21% (6)
Rarely	0%
Never	3% (1)

Table 29: Hold more case conferences (N=29)

Almost always	45% (13)
Usually	34% (10)
Sometimes	10% (3)
Rarely	10% (3)
Never	0%

RECOMMENDATION: ACS should ensure that all preventive programs are always aware of their expectations regarding assessing safety and risk.

CCC believes that identifying safety and risk factors is a critical component of preventive services. While the goal of prevention is to strengthen and support families, the paramount concern must be ensuring that children remaining in their own homes are safe. Assessing, identifying and addressing safety and risk are what differentiate child welfare preventive services from other voluntary community services. Similarly, ACS also believes that assessing safety and risk factors is a fundamental component of the work of preventive service programs, and is clear about this expectation in their new RFP.

CCC understands that as part of IOC implementation, ACS did a great deal of work with its preventive providers with regard to assessing safety and risk. Notably, ACS worked with OCFS to provide safety and risk training to preventive caseworkers and supervisors, issued a safety and risk desk aid, and has been providing technical assistance to programs through its Office of Preventive Technical Assistance and a contract with the Hunter School of Social Work. CCC urges ACS and the providers to ensure that this type of training and attention is ongoing, long after IOC and the new contracts have been implemented.

CCC is also aware that several preventive service providers have expressed concern that ACS's expectations and requirements (current and future) are too focused on safety and risk, and no longer sufficiently focused on strengthening and supporting families- making them feel like an arm of child protection rather than a neighborhood-based support. CCC appreciates this concern and urges ACS and the programs to continually monitor this balance throughout the life of the new RFP. While CCC believes that preventive services are a child welfare intervention and therefore child safety must be paramount, we are also equally aware that the intervention will not be as successful if neutrality and support are no longer felt by family members. CCC thinks that a critical component to maintaining preventive programs as places families can turn to in their communities when they need help, is ensuring that programs have enough capacity to continue to serve the families that voluntarily walk-in seeking services.

RECOMMENDATION: ACS should share system-wide and individual program results from their monitoring efforts, with regard to how well programs assess safety and risk and measure family progress with services, so that their findings can be used to develop targeted training curricula and policies where necessary.

After many years of careful development, ACS began implementing its Preventive Service Scorecard Monitoring Tool in 2008. ACS's enhanced monitoring of preventive programs includes case reviews, a data review, and interviews with parents who received services from the program. Assessing, identifying and addressing safety and risk is an important piece of Preventive Scorecard and ACS's enhanced monitoring of preventive service programs.

CCC's findings about safety and risk and measuring a family's progress with services are self-reported and not case specific. ACS's results should be able to better assess whether suspected abuse or neglect is reported to the SCR appropriately, whether programs are assessing safety and risk throughout the life of the case, and whether programs address increased risk through case conferences, intensified services, additional services or more home visits when appropriate. Similarly, ACS's results should show whether programs are able to adequately assess a family's progress in services, either through the tools programs cited or through meaningful assessments of family members' behaviors.

Given the range of responses CCC received to our questions regarding safety and risk and the reliance on tools and tasks for measuring or assessing a family's progress with services, CCC recommends that ACS review its safety and risk findings very carefully. It seems likely that there are programs that are not assessing safety and risk when cases are referred, programs that are not adequately addressing heightened risk, as well as programs that do not know how to best assess a family's progress with services.

CCC recommends that ACS consider using their Preventive Scorecard results to aggregate data, make the data public, and then develop quality improvement initiatives, such as training curricula, policies and required timelines, to inform practice and policy at preventive service programs. This will be particularly critical as ACS and its providers seek to implement ACS's new 12-month average length of service requirement, in a manner that ensures appropriate and safe decisions about whether cases can be safely closed within a year.

RECOMMENDATION: When preventive service programs hire new caseworkers or supervisors, they should be required to receive training or refresher training on identifying, assessing and addressing safety and risk before they begin working with families.

Preventive service caseworkers and their supervisors are critical components of the child welfare system, which is designed to maintain children safely in their homes by strengthening and supporting their parents whenever possible, but also by removing children and placing them into foster care when their homes are not safe. Preventive service workers make home visits, assess service needs, coordinate service provision and assess the needs of the children and their parents. Every interaction between a preventive program and a family is through the dual lenses of supporting families and keeping children safe, making this work challenging and nuanced. CCC believes that every new preventive services worker needs to receive training on how to assess and address safety and risk before they begin to work with families. CCC recommends that OCFS and ACS mandate this training and assist in both curriculum development and the provision of the training.

RECOMMENDATION: ACS and OCFS should provide safety and risk training for preventive service staff at least annually.

As part of ACS's 2006 Child Safety Plan, ACS and OCFS developed and administered a Safety and Risk Refresher Course for all caseworkers. Then, as part of the roll-out of IOC, safety and risk training was offered in 2008 and 2009. Given the high turnover, there surely will be caseworkers, supervisors and program directors that have not received this training (or other safety/risk training). In light of the important role preventive programs play in keeping children safe in their homes, CCC recommends that ACS and OCFS provide this training at least annually.

I) TRAINING

FINDING: Preventive service caseworkers seem to receive little, if any, training before they start working with families.

CCC asked the program directors what training was required for their caseworkers before they started working with families. We learned that little, if any, training was required before caseworkers began interacting with families. Specifically, the program directors gave the following responses:²⁵⁶

- 45.2% (14 of 31): “On the job” or no training
- 38.7% (12 of 31): ACS Common Core²⁵⁷
- 35.5% (11/31): Computer systems training (CONNECTIONS and/or PROMIS)²⁵⁸
- 29% (9/31): New workers receive extra attention from their supervisor when they first start
- 19.4% (6/31): Only hire workers with prior child welfare experience so they do not need training.

FINDING: The 1998 *Standards and Indicators* and the *Standards and Indicators* in the new RFP both require training for preventive service caseworkers.

While the program directors reported to CCC that essentially preventive service caseworkers were assigned caseloads before receiving any formalized training, both the 1998 *Standards and Indicators* that were in effect at the time of CCC’s survey administration and the new *Standards and Indicators* that will be in effective when the new contracts are in place, require training for preventive service caseworkers.

The 1998 *Standards and Indicators* require preventive programs to “have and implement a written staff development and training plan for each City Fiscal year” and that the “contractor provide at least the minimum required training for new staff and update incumbents as needed.”²⁵⁹ While the training was required for new caseworkers, there was no written requirement that the training take place before the new caseworker began working with families.

With regard to the actual substance of the training, the 1998 *Standards and Indicators* require that at a minimum, the

training plan include the following items: basic interviewing and communications skills; client family outreach; engagement and retention skills; confidentiality; mandated reporting of abuse/neglect; cultural awareness issues; HIV/AIDS; substance and alcohol abuse; the concept of self-help/12-step groups; domestic/family violence (including spousal abuse, teen relationship violence and elder abuse); recognizing indicators of developmental delays; stress management; application procedures for public assistance programs, Medicaid and/or Medicare; working with families/ family members affected by physical and developmental disabilities; indicators of mental health issues and appropriate actions to take in response to such indication; and the range of crisis intervention services available to address client families’ needs.²⁶⁰

According to the 1998 *Standards and Indicators*, ACS would monitor these training requirements by looking at documentation such as the training plan for the year, curricula, lesson plans, attendance sheets and evaluation forms.

The training requirements in the new RFP are similar; however, the required topics have been updated. The *Standards and Indicators* effective in July-December 2010 require training in the following topics: assessment and monitoring of child safety and risk; child and adolescent development; client outreach, engagement and retention skills; crisis intervention; culturally competent practice; FASP: Assessment, service planning and goal setting; Family Team Conferencing; How a parent’s history of trauma, or the current presence of violence or other traumas in the household or community, may impact parenting and the acquisition of new parenting skills; identification and reporting of child abuse; interviewing and communication skills; new caseworker child welfare core trainings; progress note documentation; PROMIS training; recognizing indicators of developmental delays and actions to take upon documentation; recognizing indicators of chemical dependency/use, and mental illness, and actions to take upon identification; and the ACS Domestic Violence Practice Guidelines, recognizing indicators of domestic violence (including teen relationship violence and elder abuse) and actions to take upon identification.²⁶¹ While the Scope of

²⁵⁶ Percentages add up to over 100% (and numbers total more than 31) because some programs provided more than one response.

²⁵⁷ CCC’s understanding is that the ACS Common Core is a training offered by ACS that is about casework practice generally and not specific to preventive services. In addition, while preventive service caseworkers can participate in this training, it is not actually provided before caseworkers work with families.

²⁵⁸ CONNECTIONS is the official system of record and is a state administered system. PROMIS is a New York City developed system.

²⁵⁹ The City of New York Administration for Children’s Services. *Preventive Services Quality Assurance Standards & Indicators and FRP Addendum*, at E-8. (April 1998).

²⁶⁰ *Id.*

²⁶¹ City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Appendix D: Preventive Services Quality Assurance Standards and Indicators, Part II*, at E-91. (May 20, 2009).

Services requires the contractor have a plan for initial and ongoing staff training and development,²⁶² the new RFP does not specifically require certain types of training prior to a caseworker beginning to work with families.

RECOMMENDATION: OCFS and ACS should mandate that all preventive service caseworkers receive a basic child welfare training before they start working with families.

Child welfare, and preventive services in particular, is very complicated and requires professional staff with a variety of skills. Preventive service caseworkers need to be able to assess whether there are conditions placing a child at risk, identify what if any services could alleviate that risk, develop a relationship with the parents and children, and be able to access a wide range of services. Before a caseworker is assigned to work with families, the caseworker should receive a basic training that at a minimum includes how to assess safety and risk, engage parents and children, conduct home visits, and both identify and access services for families. CCC urges OCFS and ACS to make such training mandatory.

RECOMMENDATION: OCFS and ACS should develop curricula and assist programs in providing the training to the preventive service caseworkers. The federal government should provide funding for training preventive service caseworkers.

If training were to be mandatory for caseworkers before they began working with families, then CCC believes that OCFS and ACS should support the preventive programs by developing a general curriculum that each program could then adapt to fit its own program model and by assisting with the provision of the training.

OCFS and ACS have the skills and staff to develop curricula, while many preventive programs do not have staff trained in curriculum development. In addition, a state or city developed training would ensure some level of consistency among programs and be more efficient than requiring each program to develop its own.

Preventive services programs are also generally small, consisting of a program director, 1-3 supervisors and 4-15

caseworkers. It would be very difficult for a program to run a training course every time a new caseworker started. In addition, it is important to the programs that the caseworkers be able to start working with families as soon as possible to alleviate caseload issues for the other workers. Thus, CCC recommends that OCFS or ACS staff provide the training to the preventive service caseworkers, either on-site at the programs or in a central location with caseworkers from various programs trained together. This would be a more efficient way to ensure the preventive service workforce received training prior to working with families.

Finally, CCC urges the federal government to broaden the scope of training for which it will pay. In 2008, the Fostering Connections to Success and Increasing Adoptions Act expanded federal reimbursement for training to go beyond just those who work for the state or city agency and now includes foster care caseworkers and court staff; however, these training funds are not large sums of money and they are limited to IV-E eligible activities.²⁶³ CCC is hopeful that the federal government can either amend the regulations or expand the scope of the statute to include training for preventive workers, as this would ease some of the burden created by mandating training for preventive service workers before they begin working with families.

J) CLOSING CASES

FINDING: A review of ACS data, policies and the new RFP shows that even though ACS has been encouraging programs to shorten their length of service provision, many preventive service cases are open for over 18 months.

Within the field, and in the research done by CCC, there seems to be no definitive answer as to how long a preventive service case should be open for a family to receive services. On one hand, preventive services are intended to be a time-limited intervention that mitigates safety and risk factors while strengthening the family and the parent's ability to parent. On the other hand, there is some evidence that short-

²⁶²Id. Section III: Scope of Services, at 47.

²⁶³Fostering Connections to Success and Increasing Adoptions Act of 2008, Pub. L. No. 110-351 (codified as amended in scattered sections of 42 U.S.C.).

term interventions do not typically stick and that there needs to be reinforcement of learning.²⁶⁴

For example, Nurse-Family Partnership (NFP), which is an evidence-based model of primary preventive services that has been successful at preventing abuse and neglect,²⁶⁵ is provided for two and a half years. NFP is an intensive home visiting program for low income, first time mothers where nurses make weekly visits from the time the mother is approximately 16 weeks pregnant until the child is typically two years old.²⁶⁶ On the other hand, ACS's Family Preservation Program (FPP) is an example of a program that is short-term and intensive. FPP provides 8-12 weeks of crisis intervention by a child protective worker with a caseload of only four cases who is on-call for the family 24-hours per day.²⁶⁷

The intensity and duration of the community-based preventive services provided by the GP and FRP programs are different from both of these other types of preventive services. New York State Regulations and ACS policy essentially require bi-weekly contact and monthly or bi-monthly home visits depending on the case circumstances.²⁶⁸ New York State Regulations do not limit the duration of preventive service provision, but do require recertification every six months. This means that programs need to document every six months that preventive services are still necessary because without the

provision of preventive services, it would be reasonable to believe that the child would enter foster care.²⁶⁹

In 2007, after the increase in demand for preventive service slots led to a system-wide utilization rate of over 100%, ACS encouraged programs to review all of their cases that had been open for over 18 months to see if any could be safely closed. While this did result in some additional case closings, it was not as effective as ACS would have hoped. It should be noted that ACS staff members were involved in some of the individual case reviews and thus also saw the need for many families to continue receiving services beyond 18 months.

ACS continued to encourage programs to ensure that families with open cases were still in need of services and to close cases more timely when risk had been alleviated. In September 2008, ACS released an RFP for Preventive Services that was subsequently cancelled in November 2008. In that now repealed RFP, ACS set a standard average length of service provision of 12 months and ACS planned to provide incentive payments to programs that maintained an average of 12 months of service provision for their families and were able to turn over one quarter of their families each quarter.²⁷⁰ While the length of service provision was intended to be shorter, the services were supposed to be more intensive, all with the goal of reducing the number of slots ACS needed to have in the system. Prior to repealing the RFP, ACS was asked questions about the decreased number of slots and the decreased length of service provision. ACS responded saying, "ACS is funding fewer preventive slots but anticipates the same number of families being served due to a decrease in the average length of service by preventive programs. In addition, we have increased the rates per slot to support more intensive services."²⁷¹

While this RFP was cancelled, the preventive service programs were clearly put on notice that when ACS entered new contracts with preventive programs, their vision was for a shorter length of service provision. In March 2009, ACS

²⁶⁴ Family Support America. *Standards for Prevention Programs: Building Success through Family Support*, at 37. Developed by the New Jersey Task Force on Child Abuse and Neglect. 2003.

²⁶⁵ Outcomes from Nurse-Family Partnership include a 48% reduction in child abuse and neglect, a 56% reduction in emergency room visits for accidents and poisonings, and a 67% reduction in behavioral and intellectual problems for the child at age six. Nurse-Family Partnership. *Overview*. June 2008. http://www.nursefamilypartnership.org/resources/files/PDF/Fact_Sheets/NFP_Overview.pdf; Nurse-Family Partnership. *Benefits and Costs: A Program with Proven and Measurable Results*. June 2008. http://www.nursefamilypartnership.org/resources/files/PDF/Fact_Sheets/NFP_Benefits&Cost.pdf.

²⁶⁶ First time mothers must sign-up for the program before they are 28 weeks pregnant. In New York City, this program is administered by the Department of Health and Mental Hygiene (DOHMH) and not the child welfare agency (ACS).

²⁶⁷ As a result of the city's 2010 Adopted Budget, ACS has been "reorganizing" the FPP program. Specific details of the reorganization are not yet available to CCC.

²⁶⁸ FRP (and soon FT/R) have more casework contact requirements.

²⁶⁹ 18 NYCRR 423.4(b) Length of Service: "Preventive services shall continue only if a new determination is made every six months after the initial application for services that the child will be placed or continued in foster care unless such services are provide and that is reasonable to believe that by providing such services, the child will be able to remain with or be returned to his family." The case management function of recertifying families has been delegated to preventive providers as part of IOC.

²⁷⁰ It is important to note that the base rate per slot without the incentive payment was significantly lower than the current rate per slot.

²⁷¹ E-mail from ACS, October 7, 2008.

issued a Discussion Paper regarding what was then an upcoming RFP, which stated that the RFP will “Establish an average 12-month service period to ensure the availability of preventive services to all high-need families. The new contracts will codify this expectation for General Preventive and Family Rehabilitation/Treatment programs.”²⁷²

When the new RFP was issued in May 2009, ACS’s intent to shorten the length of preventive service provision and link this expectation to funding was laid out very clearly. In fact, one of the goals of Preventive Services, as described in the new RFP, is to “Provide an average 12-month service period to ensure the availability of preventive services to all families demonstrating a need for such services.”²⁷³

The new RFP goes on to explain how length of service will be linked to performance-based funding for General Preventive (GP) and Family Treatment/Rehabilitation (FT/R) services. “ACS is seeking to fund GP [FT/R] services in which families receive timely assistance and the supports to help them transition out of preventive services, with community resources in place where needed. Cases should not remain open for a prolonged period of time unless essential for safety or other reasons. To reinforce this practice expectation, ACS is setting a target for the *average* length of service, which is twelve months. GP [FT/R] contractors will be expected to serve, each year, a number of new families that is equal to the number of slots allocated to their program and to maintain a twelve month average length of service for the caseload overall.”²⁷⁴ After an initial transition period of two to three quarters, 10% of the payments to the programs “will be performance-based and contingent upon achievement of these performance results.”²⁷⁵ In response to numerous questions about this requirement, ACS made it clear that when programs apply pursuant to the new RFP, they should develop their proposals anticipating they will receive the full

funding even though many programs expressed concern about being able to meet these requirements.²⁷⁶

In response to these new expectations, the link between length of service provision and funding levels, and the concern that the shortened length of service (which may not be met) is also tied to a dramatic reduction to the system’s capacity, several advocacy organizations, including Citizens’ Committee for Children, expressed concern to ACS.²⁷⁷ On July 27, 2009 ACS Deputy Commissioner Elizabeth Roberts issued a letter that explains ACS’s decision calling for shortened length of service for families receiving preventive services and cites to literature ACS believes supports their decision. On November 2, 2009, the Preventive Services Action Network (PSAN), wrote to ACS, expressing concerns with the studies cited by ACS, including that the models in the studies were not comparable to ACS General Preventive programs, that the caseloads were significantly smaller in the studies, that in some instances the study families did not have child protective histories, and that in many studies families received additional services after the service that was the subject of the study.

Given the ongoing debate about length of service provision in preventive service cases, as well as our concerns about the 12-month average being implemented safely and the severe shortage of slots that will occur if programs are unable to implement this requirement, CCC reviewed ACS’s data to try to gain a better understanding of how long families are currently receiving preventive services in New York City.

In the most recent quarter for which CCC has ACS data, July 2009-September 2009, 18% of General Preventive (GP) and 14.7% of Family Rehabilitation Program (FRP) cases were open receiving services for over 18 months, which is a total of 1,975 of the 11,321 families receiving GP or FRP services.²⁷⁸ This is indeed showing fewer families with cases open longer than 18 months than the October 2008-December 2008 quarter, when 21.63% of General Preventive (GP) and 16.44% of Family Rehabilitation Program (FRP) cases were open

²⁷²New York City Children’s Services. *Child Welfare Services with Community Coalitions II: Upcoming Request for Proposals- Discussion Paper*. (March 3, 2009). Note: In the new RFP, the Family Rehabilitation Program (FRP) is renamed Family Treatment/Rehabilitation (FRT) and will build on the current FRP model but serve both families with substance abuse issues and families in which a family member has a mental illness.

²⁷³City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 7. (May 20, 2009).

²⁷⁴City of New York Administration for Children’s Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section II: Summary of RFP*, at 21 for GP and at 24 for FT/R. (May 20, 2009).

²⁷⁵Id.

²⁷⁶ACS Pre-Proposal Bidder’s Conference. 6/10/09.

²⁷⁷These include a letter to Commissioner Mattingly from Citizens’ Committee for Children, Legal Aid Juvenile Rights Practice and Lawyers for Children and letters from the Preventive Service Action Network (PSAN). Letters on file with CCC.

²⁷⁸Administration for Children’s Services Preventive Service Programs Quarterly Program Status Report (Quarter 1, FY10). (July 09-Sept 09).

receiving services for over 18 months.²⁷⁹ And this is slightly lower than the percent of cases open for over 18 months in the same quarter in 2007 when almost 23.59% of GP cases and 16.9% of FRP cases were open for over 18 months.²⁸⁰

While this may seem like a small improvement in reducing the length of service provision, the gradual addition of 1,000 new slots to the system in FY08 created a window of time when there was an increased ability to serve many more new families, who are probably pulling down the system-wide average since they could not have been receiving services for much more than 18 months. Notably, *almost 2,000* of the families currently receiving preventive services have been receiving services for *over 18 months*, yet ACS is going to be expecting a *12-month length of service average*. ACS has not made public, or released to CCC, any numbers with regard to how many families are currently receiving preventive services for longer than 12 months, nor what the

current system-wide average length of service provision is.

ACS did provide CCC with case opening cohort data that shows how long families who entered the system during the same six month period of time received services.²⁸¹ While this data does not reveal the current system-wide average length of service, and thus cannot be compared with the upcoming 12-month expectation,²⁸² it does show that over half of the families had been receiving services for over 12 months and over a third of families had been receiving services for over 18 months.²⁸³ Details are in Tables 30 and 31.

Finally, with regard to CCC's review of length of service provision data, we find that there are a significant number of cases at the extremes of the continuum, which can significantly impact a program's mean length of service provision, especially since many programs are so small that any one case could have a dramatic impact on the mean.²⁸⁴ In Fiscal Year 2008, 11,857 new preventive cases were opened (and 11,280

Table 30: Length of Service Provision for Entry Cohorts- General Preventive (GP)

	Percent 12 Months or Less	Percent Over 12 months
Jan. 2006-June 2006 Entry Cohort	40.4%	59.8% (41.3% over 18 months)
July 2006-December 2006 Entry Cohort	40.17%	59.83% (39.8% over 18 months)
January 2007-June 2007 Entry Cohort	38.84%	61.16% (36.88% over 18 months)
July 2007-December 2007 Entry Cohort	41.39%	58.61%

Table 31: Length of Service Provision for Entry Cohorts- Family Rehabilitation Program (FRP)

	Percent 12 Months or Less	Percent Over 12 months
Jan. 2006- June 2006 Entry Cohort	43.7%	56.3% (37.7% over 18 months)
July 2006-December 2006 Entry Cohort	43.01%	56.99% (36.2% over 18 months)
January 2007-June 2007 Entry Cohort	40.67%	59.33% (34.67% over 18 months)
July 2007-December 2007 Entry Cohort	48.11%	51.89%

²⁷⁹ Administration for Children's Services Preventive Service Programs Quarterly Program Status Report (Quarter 2, FY09). (October 2008-December 2008). The total GP and FRP cases open over 18 months was 21.1%.

²⁸⁰ Administration for Children's Services Preventive Service Programs Quarterly Program Status Report (Quarter 2, FY08). (October 2007-December 2007). The total GP and FRP cases open over 18 months was 23%.

²⁸¹ Entry cohort data shows the experiences (here length of service provision) for families that enter the system at the same time.

²⁸² CCC requested the system-wide mean and median length of service provision data from ACS, but ACS did not provide it.

²⁸³ Unpublished entry cohort data length of service data provided by ACS to CCC on March 13, 2009.

²⁸⁴ In CCC's randomly selected sample, the mean program size was 69 and the median was 60.

closed)²⁸⁵ in a system that at that time had a capacity of 14,880. This means that many new cases with a short length of service exist in the system at any given point in time, as almost 12,000 cases were opened in the year. At the other extreme, in January 2008 there were 3,119 cases open for over 18 months, 730 of which had been open for over three years.²⁸⁶

FINDING: Preventive service program directors generally believed that there are cases that should be open for longer than two years.

As part of the interview survey, CCC asked program directors several questions related to closing cases. First we asked whether they believed that a preventive service case should ever be open longer than two years. Approximately 90%, or 28 of the 31 program directors, said they believed there were instances where this would be appropriate.

We then asked those 28 program directors what they believed were the two main reasons that a case might stay open for longer than two years. Essentially the program directors believed that cases need to remain open in the following circumstances: when there has been a delay in accessing services; when a family's conditions are chronic, such as a health condition, mental illness or developmental disability; when the family has multiple issues to address; or when the case involves issues (such as substance abuse) that they felt took longer to resolve. For more details about the program directors' responses, please see Table 32.

FINDING: After the surveyed programs closed cases, families did not return to their preventive service programs for additional support or services very often.

CCC asked the program directors how often they found that after they closed a case, the family came back to their programs seeking additional support or services. The responses seem to indicate that this does not occur as frequently as one might expect given that the program had been a safety net for these families. In fact, about one third, or 10 program directors, responded that families rarely come back seeking additional support or services. For more details, please see Table 33.

²⁸⁵ New York City Administration for Children's Services. ACS Monthly Update, June 2008, FY08.

²⁸⁶ Unpublished data provided by ACS.

Table 32: Reasons Program Directors Felt Cases Might Be Open Longer Than 2 Years²⁸⁷

N=28	
Safety/risk factors still exist	30% (8 programs)
Chronic Condition (medical or mental health)	26% (7 programs)
Delays accessing services	19% (5 programs)
Family has multiple issues to address	19% (5 programs)
Family needs more services	19% (5 programs)
Substance abuse case/relapse	11% (3 programs)
Mental health case	11% (3 programs)
Chronic neglect	7% (2 programs)
Housing instability	7% (2 programs)
Additional child born	7% (2 programs)
Reunification cases	4% (1 program)

Table 33: How often do families come back to the program seeking additional support or services after the case is closed? N=31

Almost always	0% (0)
Often	10% (3)
Sometimes	58% (18)
Rarely	32% (10)

FINDING: Many of the surveyed program directors believed that aftercare for preventive services would enable them to close cases more quickly.

We asked the program directors the following question: *"If there was a way for your program to receive resources to provide ongoing support or assistance to families when it was needed, without having to re-open a preventive case, how often would this lead your program to close cases more quickly?"*

²⁸⁷ Seven programs (26%) responded to this question by saying that housing subsidy and homemaking cases typically remain open longer than two years. By definition these cases are typically open for over 2 years. For example, families may receive housing subsidy for up to three years, and their preventive case will need to remain open throughout this three-year period. ACS has committed to developing a policy to address these cases in a manner that will not negatively impact a provider's length of service data.

Essentially, we were asking whether a tapering off period where families could still receive services or have a place to turn in an emergency, would enable the programs to close cases more quickly, as is the case in a foster care trial discharge or aftercare period. CCC had hypothesized that caseworkers, supervisors and families might feel more comfortable closing cases if it did not totally cut the family off from the support and services the programs had been providing.

As shown in Table 34, we found that many of the programs (68%), felt that this would almost always or often lead their program to close cases more quickly.

Table 34: “Aftercare/trial discharge” for Preventive Services would lead to closing cases more quickly²⁸⁸

N=28

Almost always	29% (8 programs)
Usually	39% (11 programs)
Sometimes	18% (5 programs)
Rarely	14% (4 programs)

RECOMMENDATION: ACS must very closely monitor the programs and cases to ensure that children will be safe when the cases are closed because ACS is providing incentives to reduce the length of service provision, instituting a 12 month average length of service provision, and delegating the decision to close cases to programs.

CCC believes the length of service provision needs to be flexible, responsive and tailored to each family and their needs. It is important that programs begin to work with families intensively soon after the referral and that once the families are stabilized and safety and risk factors have been mitigated, cases be closed. It is also critical to CCC that families continue to receive preventive services when safety and risk factors continue to exist, regardless of how long the family has already been engaged in services.

²⁸⁸ 3 program directors chose not to answer this question, feeling that “aftercare” with resources was not possible.

ACS has indicated that the agency is not issuing a 12-month *limit* in individual cases, but rather instituting a 12-month program *average/mean*; however, CCC is concerned that this nuance will not trickle down in individual cases with individual workers. In fact, CCC has already heard high-level preventive program staff refer to this upcoming expectation as the “12-month rule.” For individual caseworkers, and even their supervisors, it will be difficult to implement an average length of service provision, particularly when the length of service will be measured and monitored by ACS and then the program will be funded based upon whether the average is achieved. CCC is very concerned that this could result in cases being closed at 12-months, even when this is contrary to the child’s best interests.

CCC’s survey interview findings, as well as additional conversations CCC has had with directors and ACS, reveal a tension between ACS and the programs regarding length of service provision. CCC believes that earlier engagement and the new family team conferencing model (that is part of IOC) could lead to a more efficient preventive service system. Particularly in these difficult budget times, it is critical that families be strengthened and stabilized as quickly as possible so that there can be open slots for other families. At the same time, CCC feels that preventive service programs must have latitude, and not be penalized, for ensuring that families still at risk continue to receive services so that children can remain safely in their homes.

At the same time that ACS is providing incentives for shortened length of service provision, ACS is delegating the case management function of closing cases to preventive programs (as part of IOC). While CCC supports the goals of IOC and believes that programs that have been working with the families are in a better place to determine when a case should be closed than someone from ACS doing a paper review, we are concerned that instituting incentives and enhanced monitoring for shortened length of service provision at the same time as delegating case closing decisions, could lead some programs to close cases when it is not in the children’s best interests to do so. Furthermore, because many of the preventive service programs are so small, having just one case open for over three years would greatly skew a program’s mean (and thus Scorecard performance and funding rate), and therefore some programs may be unwilling to continue to serve these families, regardless of their needs.

Given CCC's concerns about child safety, CCC urges ACS to very closely monitor the programs and cases as they implement these new timeframes and payment structures, to ensure that children in the cases being closed will be safe and ensure that neither the programs nor ACS are overly focused on case closing. CCC is also urging ACS to make the results of this monitoring publicly available so that programs, advocates and the public know whether the 12-month average length of service provision and financing scheme are jeopardizing child safety.

RECOMMENDATION: ACS should conduct an analysis of the cases that have been open for longer than three years to gain a better understanding of the issues facing these families and to determine whether there is another system that could better serve these families, whether there is another type of preventive service needed for these families, and/or whether there are certain types of cases that need long-term preventive services.

CCC believes that it is critical, for system planning and development, for those working in this field to have a better understanding of the families who are engaged in preventive services for longer lengths of time. An ideal place to start this analysis would be with the families whose cases have been open for over three years.

A better understanding of family circumstances in cases with longer lengths of service provision might help preventive service providers, advocates and government officials to better plan for these families. In CCC's survey, program directors identified families with chronic conditions that will not go away with the provision of preventive services (such as chronic health conditions and mental illness), families with multiple risk factors to work on, families where new babies are born, and families with substance abuse issues as cases that they believed could lead to a case being open for more than two years. In addition, program directors indicated that delays in accessing services for families might lead to longer lengths of service provision.

An analysis of the cases open the longest could help us to better understand whether there are certain family and case profiles, such as the ones offered by the program directors, that lead to longer durations of service and/or how often delays accessing other services lead to keeping cases open for longer timeframes. Depending on the results, it may be that

some of the families should be receiving services outside the child welfare system (such as the Office of Mental Health's community based waiver program, the Office of Mental Retardation and Rehabilitation services for children or parents, HIV services through the state or city health departments, or other community based organizations). The analysis could also identify service access issues that might be leading to longer lengths of service provision. If this type of circumstance is prevalent, it might be more efficient and less costly for ACS to work with other city and state agencies to address the service access issues identified.

The analysis could also show that families with certain characteristics (such as families with young parents, families with young children, families with adolescents, families reuniting from foster care, etc.) require a model of long-term preventive services that needs to be formally developed.

RECOMMENDATION: ACS should implement a funded "aftercare" period for preventive services.

CCC thinks it might be difficult, for both families and caseworkers, to close cases because families have become dependent on preventive service programs for help during crises and in managing day-to-day family life. While good casework and social work includes addressing closure, the abrupt withdrawal of support and services when a preventive service case is closed, is possibly related to keeping cases open. While preventive service programs should be linking families to other community programs, the relationship between the parents and caseworkers at the programs has been identified by parents as one of the most critical components of these services, and this is lost when a case is closed.

ACS's new RFP does add an aftercare requirement to preventive services, but provides programs with limited guidance and no additional funding. In the overview of preventive services, ACS states that one of the elements of the programs must be "Support for families leaving preventive services when some level of contact is warranted."²⁸⁹ ACS goes on to explain in the "Service Termination and Aftercare" section in the Scope of Services that, "The contractor must have the capacity to enable families to end their active involvement with a program when their goals have been met,

²⁸⁹ City of New York Administration for Children's Services. *Child Welfare Services Including Community Partnerships Request for Proposals, Section III: Scope of Services*, at 39. (May 20, 2009).

but retain a connection that enables them to sustain the relationship and return for support and guidance as needed. ACS recognizes the value of continued connections to families after the formal closing of their cases. Preventive programs can play a critical role in offering support to families in their communities, keeping an eye on the families' well-being and that of their children, and responding should additional services or help be needed. For this reason we encourage and seek creative approaches to sustaining relationships with families in formal as well as informal ways.”²⁹⁰

Given the very small number of programs that responded to CCC's survey question by saying that families came back to their programs for additional support or services after cases were closed, this new requirement will be a significant change to the preventive service delivery system. While CCC applauds ACS for including an aftercare component in their new RFP, we are concerned about how effective this will be given that the programs have received limited guidance and no additional funding to implement aftercare.

CCC urges ACS to provide more guidance, as well as funding, for the “aftercare” period to enable programs to develop meaningful aftercare components that ease the transition out of preventive services.

RECOMMENDATION: Given concerns about child safety and having enough slots to meet the needs of NYC's families, ACS must reassess whether the elimination of over 2,500 slots, the implementation of a 12-month average length of service provision linked to funding, and the delegation of case closing decisions are feasible and safe.

CCC appreciates ACS's efforts to make its preventive service system more intensive and efficient. CCC has also heard the concerns expressed by preventive program directors that believe that 12 months is not long enough to meet the needs of many of the families they are serving. We do not know what the correct system-wide or program-wide average length of service provision should be, but we do know that decisions about closing cases should be made on a case-by-case basis, based on the needs of the children and their families.

We urge ACS to continuously assess the 12-month mean length of service provision expectation to ensure that it is sufficient to strengthen families and keep children safe. In

addition, we ask ACS to a) measure a program's median length of service provision rather than their mean to get a better sense of how long cases are open in a program; b) use an analysis of preventive service cases open for longer than three years to create a family profile for long-term preventive services whose cases would be excluded from the 12-month mean/median calculation; c) consider developing a new model of preventive service for families needing long-term preventive services (which may be either very high intensity for some families and a lower level of intensity for other families depending on what is learned in the analysis); d) rigorously monitor case closing to ensure that safety is not being jeopardized in an attempt to meet the 12-month average expectation; and e) preserve at least a portion of the slots that are due to be eliminated in anticipation of the shortened length of service provision.

K) PREVENTIVE SERVICES WORKFORCE

FINDING: The child welfare workforce faces high caseloads, high turnover and low salaries.

In the spring of 2006, the New York State Legislature passed a law requiring the state Office of Children and Family Services (OCFS) to contract with a national child welfare expert for a child welfare workload study. On December 1, 2006, a workload study was issued recommending that preventive service caseworker caseloads be no more than “12-16 families per caseworker per month, compared to the current estimated caseload (based on time spent per case) of 27 cases per month for ACS and its voluntary agencies.”²⁹¹ Notably they felt that lowering preventive caseloads would enable a preventive caseworker to on average “spend 7.9 to 10.5 hours per family per month compared to the current estimate of 4.6 hours per family per month for ACS and its voluntary agencies.”²⁹²

In 2006, the National Association of Social Workers (NASW) released two relevant reports that were based on their survey of a random sample of 10,000 social workers from 48 states, which they conducted in 2004. In *Assuring*

²⁹⁰Id. at 44.

²⁹¹Walter R. McDonald & Associates and American Humane Association. *New York State Child Welfare Workload Study Final Report*, at xi. (November 2006).

²⁹²Id.

the *Sufficiency of a Frontline Workforce*, the NASW concluded that they anticipate an increased demand in the need for social workers, but “given the serious challenges regarding recruitment, retention and replacement of retiring social workers that the profession now faces, there is no certainty that the educational pipeline is sufficient to fully meet future demands for new licensed social workers.”²⁹³

The NASW used their data to put together a special report on social work specifically related to children and families. They note that social workers providing services to children and/or adolescents are slightly younger than licensed social workers overall,²⁹⁴ yet while the profession has successfully recruited new graduates, “retention is a paramount concern.”²⁹⁵ Social workers working with children reported increases in paperwork (74%), severity of client problems (73%), caseload size (68%), and waiting lists for services (60%). Social workers in the child welfare practice area were more likely than other social workers to report that oversight had increased, that families were court-ordered to participate in services, and that social work staffing had decreased.²⁹⁶ Notably the NASW wrote, “social workers in the practice areas of Child Welfare/Family and Adolescents earn less than other social workers regardless of degree”²⁹⁷ and “the practice area of Child Welfare/Family appears the most vulnerable to both the number of staff vacancies and the difficulty of filling vacancies.”²⁹⁸

In 2007, after organizing the Human Services Workforce Initiative, the Children’s Defense Fund and Children’s Rights, Inc. released a report highlighting child welfare workforce issues. They indicated that in child welfare, high caseloads get

in the way of effective work with children and families, staff turnover hurts children and families, and staff turnover costs money. They proposed lower caseloads, enhanced training and professional development, and loan forgiveness programs as ways to address the recruitment, preparation, support and retention of child welfare staff working with abused and neglected children and their families.²⁹⁹

New York City’s child welfare workforce, and specifically the preventive service caseworkers, supervisors and program directors, face the same challenges as those reported nationally by the NASW, Children’s Rights, Inc. and Children’s Defense Fund. High caseloads, high staff turnover, young caseworkers, insufficient training, burdensome paperwork requirements and low salaries are all issues that have been cited by ACS and preventive service programs.

FINDING: FRP caseworker caseload ratios tended to be 10 to 1, which is consistent with how the programs are funded.

While CCC’s FRP sample size of 7 is very small, we found that the FRP Programs tended to be at a 10 to 1 caseworker to family caseload ratio. In fact, 6 of the 7 programs reported a caseload ratio of 10 to 1. One FRP program reported being at 13 to 1 and explained that their program commingled its FRP cases with its GP cases to try to ease all caseworker caseload ratios.³⁰⁰ For more details about the FRP caseworker to family ratios in CCC’s survey sample, please see Table 35.

Table 35: FRP Caseload Ratios

	Minimum	Maximum	Mean	Median
Family Rehabilitation Program (FRP) (ACS mandate was 10 to 1) N=7	10 to 1	13 to 1	10.4 to 1	10 to 1

²⁹³ National Association of Social Workers. *Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers Executive Summary*, at 33. (2006).

²⁹⁴ National Association for Social Workers. *Assuring the Sufficiency of a Frontline Workforce: A national Study of Licensed Social Workers. Special Report: Social Work Services for Children and Families*, at 15. (2006).

²⁹⁵ Id. at 23.

²⁹⁶ Id. at 23-24.

²⁹⁷ Id. at 24.

²⁹⁸ Id. at 26.

²⁹⁹ Cornerstones for Kids. *Promoting Child Welfare Workforce Improvements Through Federal Policy Changes*, at 5. (2007).

³⁰⁰ CCC is aware that this is a violation of the program’s contract with ACS.

FINDING: GP caseworker caseload ratios tended to be higher than 12 to 1, which is the ratio for which they were funded.

In 2006, New York City began taking measures to improve the child welfare system's ability to address child safety issues. CCC and other advocates worked with the New York City Council to obtain funding (through the city budget negotiation process) to lower preventive service caseloads down from 15 families per worker to no more than 12 families per worker. This City Council Initiative, known as the Child Safety Initiative, secured \$4.2 million in city funds (\$12 million with the state 65% match) for fiscal years 2006 and 2007. This allocation was reduced to \$3.75 million city funds for fiscal years 2008 through 2010. ACS's new RFP sets 12 to 1 as the benchmark caseload ratio, and will fund the programs accordingly (without City Council funding) when the new contracts are effective (some time between July 1 and December 1, 2010).

CCC found that in the summer of 2007, even though caseload reduction funds had been provided for a year, not all General Preventive programs were maintaining caseloads of 12 to 1. Details of General Preventive caseloads at the surveyed programs are in Table 36 on the next page.

Looking more closely at the GP programs, we found that only 10 of the 24 programs (41%) were at a caseload ratio of 12 to 1 or less and that 25% of the programs (6/24) actually had caseload ratios of 15 to 1 or higher (even though they had received funding to lower caseloads to 12).

CCC took a closer look at the GP programs that had caseload ratios higher than 12 to 1 to see if there was a relationship between being over 100% utilization and having higher caseloads. This seemed like a plausible explanation since caseworker caseload ratios at programs are based on being at 100% utilization and not higher.³⁰¹ Of the 16 programs that were over 100% utilization, 12 of them were GP programs. We compared the 12 GP programs over 100% utilization to the 12 GP programs at or under 100% utilization and we found that contrary to our hypothesis, caseloads were actually lower at the programs with higher utilization:

- GP Programs over 100% utilization (n=12): mean caseload was 12.8 to 1

³⁰¹ For example, when ACS contracts for a 60 slot program the Model Budget provides funding for 4 caseworkers with 15 cases each. Council funds to lower caseloads to 12 would have paid for one additional caseworker- 5 caseworkers with 12 cases each.

- GP Programs at or under 100% utilization (n=12): mean caseload was 13.6 to 1

Since higher utilization did not explain the higher than expected caseload ratios at the General Preventive programs, CCC sought to understand this finding better by speaking with program directors at a COFCCA Preventive Service Directors³⁰² meeting. Various possible explanations were provided such as attrition; difficulty hiring bilingual workers (which was encouraged by ACS and desired by programs to meet family needs); lack of space for additional workers; and difficulty hiring given the salary offered.

FINDING: Preventive service program directors generally believed that caseloads should be lower.

CCC asked the preventive service program directors what they believed the caseworker to family caseload ratio should ideally be. Notably only 3 of the 24 GP programs and 2 of the 7 FRP programs felt that their own caseworker to family ratio (on the day of the survey interview) was the ideal ratio. The mean and median for ideal GP caseloads was approximately 10 to 1.³⁰³ The mean and median for ideal FRP caseloads was reported to be approximately 8 to 1.

For more details about the ideal caseload ratios reported by the program directors in CCC's sample, please see Table 37.

FINDING: The percentage of caseworkers with a Master's in Social Work (MSWs) or an equivalent Master's Level Degree varied widely.

CCC asked the program directors both how many full-time equivalent caseworkers were employed by their programs and how many of those workers had MSWs (or an equivalent master's level degree).³⁰⁴ Based on this information, CCC calculated the percentage of MSW level caseworkers at each program. Responses varied widely,

³⁰² COFCCA (Council of Child Caring Agencies) is an umbrella organization in which most preventive services providers are members.

³⁰³ ACS's Model Budget, in place as of 1998, funded programs for a 15 to 1 caseworker to family ratio. From Fiscal Year 2008-Fiscal Year 2010, the City Council provided funding to reduce preventive service caseloads from 15 families per worker down to 12 families per worker. ACS's new RFP includes the funding for the 12 to 1 caseload ratio going forward.

³⁰⁴ Some programs explained that their Master's Level caseworkers included those with Masters in Psychology, Play Therapy or Art Therapy.

ranging from 0% to 100% and everything in between (e.g. 11%, 25%, 33%, 40%, 60%, 80%). Program type (GP versus FRP) did not appear to make a difference with respect to the percent of MSWs. Table 38 provides more details.

FINDING: Preventive Service Program Directors generally believed supervisory caseload ratios should be lower than they were.

CCC asked the preventive service program directors what their supervisor to caseworker ratio was at the time of the survey and what they believed it should be. It should be noted that there were several instances where the program director was also acting as the supervisor, as well as the opposite where the supervisor was also acting as the program director.³⁰⁵ Generally we found that the supervisory ratios were 5 to 1 on average in General Preventive programs and somewhat lower on average in

the FRP programs, and that in both instances the program directors felt the ratios should be lower than they were.

In the General Preventive programs, the data showed some supervisory ratios to be higher than the recommended 5 to 1 due to the caseload reduction funding that lowered caseworker caseloads from 15 to 1 to 12 to 1 without providing funding for additional supervisors. ACS's new RFP affirmatively establishes 12 to 1 as the caseload ratio in General Preventive programs and 5 to 1 as the supervisor to caseworker ratio.

Details of CCC's survey interview findings with regard to supervisory ratios are presented in Table 39 on the next page.

FINDING: The preventive programs surveyed were generally offering salaries slightly higher than the minimum requirements, yet these salaries were still fairly low.

Table 36: GP Caseloads

	Minimum	Maximum	Mean	Median
General Preventive (GP) (ACS mandate was 15 to 1 and Council Initiative funded 12 to 1) N=24	11 to 1	16.5 to 1	13.2 to 1	13 to 1

Table 37: Ideal Caseworker Caseload Ratios- as reported by the Program Directors

	Minimum	Maximum	Mean	Median
GP Programs (Currently 12 to 1 with Council funding; no more than 15 to 1 as per ACS Contract)	6 to 1	12 to 1	10.4 to 1	10 to 1
FRP (10 to 1 per ACS contract)	7 to 1	10 to 1	8.3 to 1	8 to 1

Table 38: Percent of Caseworkers with MSWs- by Program Type (N=31)

	Minimum	Maximum	Mean	Median
All 31 Programs	0% (8 programs)	100% (2 programs)	35.6%	33%
GP Programs (N=24)	0% (6 programs)	100% (1 program)	35.2%	29%
FRP Programs (N=7)	0% (2 programs)	100% (1 program)	37.1%	33%

³⁰⁵ One program did not feel comfortable answering the current supervisory ratio question because the program director was acting as the supervisor.

The ACS Model Budget for Preventive Services establishes minimum salary requirements for caseworkers (with and without MSW degrees), supervisors and program directors, which are currently in effect. All of these salaries are subject to any state or city Cost of Living Adjustments (COLAs) that go into effect.

In the State's FY08-09 Adopted Budget, there was a 3% COLA for preventive service workers,³⁰⁶ but the state funding for this COLA was reduced by 2% in the April 2008 adopted budget, an additional 50% in August 2008, and was then eliminated in the state's Adopted Budget in April 2009. Unfortunately, at the state level, a COLA for preventive service workers was not included in the COLA for other social service workers (including foster care caseworkers) and was instead a legislative line item addition. This oversight leads future COLAs for preventive service workers more vulnerable than COLAs for other social service workers.

In addition, there was also a New York City COLA secured by the Human Services Council in City Fiscal Year 2009, which did include the preventive service workforce. The implementation of this COLA is on hold due to the economic downturn.

Table 40 shows the mean salaries CCC found in its June 2007 survey compared to the FY08 Preventive Standard minimum salaries and the FY08 salary with the 3% city COLA. Table 41 provides more details about the salary findings in CCC's survey.

Notably, CCC's survey findings show mean salaries slightly higher than the Model Budget's minimum salaries (with or without the COLA). This is likely because program directors approximated staff salaries when answering our survey question and because some programs probably pay a bit higher than the minimum salaries.

Table 39: Supervisory Caseload Ratios (N varies and is provided in each row)

	Minimum	Maximum	Mean	Median
Actual Supervisory Caseload Ratio- all programs (N=30)	3 to 1	7 to 1	4.8 to 1	5 to 1
What should the supervisory ratio be (all programs)? (N=31)	2 to 1	7 to 1	3.7 to 1	4 to 1
Actual Supervisory Caseload Ratio- GP (N=23)	4 to 1	7 to 1	5 to 1	5 to 1
What should the supervisory ratio be (GP)? (N=24)	2 to 1	7 to 1	3.9 to 1	4 to 1
Actual Supervisory Caseload Ratio- FRP (N=7)	3 to 1	7 to 1	4.1 to 1	3 to 1
What should the supervisory ratio be (FRP)? (N=7)	3 to 1	5 to 1	3.3 to 1	3 to 1

Table 40: Salary Comparisons

	CCC Survey Findings (Mean Salary) (N=27)	FY08 Minimum Salary without COLA	FY08 Minimum Salary (with a 3% COLA)
Bachelor's Level Caseworker	\$34,678	\$31,223	\$32,159
MSW Caseworker	\$40,603	\$38,439	\$39,592
Supervisor	\$52,414 ³⁰⁷	\$43,097	\$44,390
Program Director	N/A (CCC did not ask for this.)	\$62,983	\$64,872

³⁰⁶In State FY09, the Governor's Executive Budget included COLAs for human service workers, but failed to include preventive service workers. As part of the budget negotiations, the State Legislature added COLAs for preventive service workers. When all legislative additions were cut 50% in the State's Emergency session in August 2008, this included funding for the COLA for preventive service workers.

³⁰⁷CCC's survey findings for Supervisor salaries are partially skewed because in several programs the program director was acting as the supervisor and reported the program director salary as the supervisory salary.

FINDING: Retention of experienced frontline caseworkers is a critical issue for preventive service programs.

Caseworker retention is a critical issue in child welfare, cited often by ACS, preventive programs, parents and advocates. When a caseworker leaves a program, it means that family members on the caseload must develop new relationships with a new worker—which impacts the length of service provision and ultimately the effectiveness of the intervention. In addition, high turnover leads to higher caseloads while programs are looking to hire a replacement. Furthermore, since most programs are small and employ only a few caseworkers,³⁰⁸ one caseworker’s leaving can have a very large impact on the program.

In the CCC focus group, one of the parents described the impact of an individual caseworker in the following way: “It’s also the skills she has to work with a family. Some just graduated and came and got the position. That’s their first job and they don’t know anything about working with a family... She tried to counsel me but you can’t do that if you don’t know anything that is going on.”

In CCC’s survey interview we asked the program directors how many caseworkers their program employed at the time of the survey, how many vacancies their program had at that time, and how many caseworkers had left their program in the preceding year. While there was some variation in program size, vacancies and retention, it was clear that some programs were struggling to maintain staff.

Within CCC’s sample were programs presenting the following staffing patterns:

- 5 caseworkers employed; 1 vacancy; 3 caseworkers had left in the past year
- 6 caseworkers employed; 0 vacancies; 5 caseworkers had left in the past year
- 9 caseworkers employed; 1 vacancy; 2 caseworker had left in the past year
- 3 caseworkers employed; 1 vacancy; 1 caseworker had left in the past year

Table 42 provides caseworker staffing data for the full CCC sample.

RECOMMENDATION: Recruit and retain caseworkers to the preventive service field through manageable caseloads, adequate salaries, appropriate training, paperwork/data-entry reduction, adequate supervision, and therapeutic support to address secondary trauma.

Recruiting and retaining qualified and skilled staff to work as preventive service caseworkers who remain at the job requires making the job appealing, particularly to MSWs. To do this, CCC recommends that OCFS, ACS and the preventive programs work together to ensure the system has enough resources to maintain manageable caseloads, adequate salaries, appropriate training, paperwork/data-entry reduction, adequate supervision, and therapeutic support to address secondary trauma.

Table 41: Preventive Service Staff Salaries – In CCC’s Survey Sample N=27

	Minimum	Maximum	Mean	Median
Bachelor’s Level Caseworker	\$31,000	\$39,000	\$34,678	\$35,000
MSW Caseworker	\$35,000	\$48,000	\$40,603	\$40,000
Supervisor	\$43,000	\$70,000 ³⁰⁹	\$52,414	\$50,000

³⁰⁸ In CCC’s sample, the number of caseworkers at the program ranged from 2-21, with a mean of 6 and a median of 5.

³⁰⁹ CCC’s survey findings for Supervisor salaries are partially skewed because in several programs the program director was acting as the supervisor and reported the program director salary as the supervisory salary.

Manageable caseload size is one of the most critical factors for retaining caseworkers and meeting the needs of children and their families. CCC is grateful that ACS has adopted and baselined the funding for the City Council’s Child Safety Initiative thereby establishing 12 to 1 as the standard General Preventive caseload ratio, as opposed to 15 to 1.

In addition, CCC urges the state and the city to include preventive service workers when human service COLAs are awarded and to maintain these COLAs in upcoming budget reduction exercises. Given that child welfare is one of the lowest compensated social work career paths, yet one of the most important and challenging, it is essential to the

workforce that the caseworkers be adequately compensated. This includes the preventive service caseworkers, as they are a critical component of the child welfare system.

Finally, the other needs of front-line caseworkers must be tended to. They must receive adequate training and supervision and have enough time, free from administrative work, to spend with the families on their caseloads. Finally, child welfare is a difficult field that often creates secondary trauma. CCC recommends that OCFS, ACS and the preventive programs work together to create a program where preventive service workers (and other child welfare workers) can have their own therapeutic needs met.

Table 42: Preventive Service Caseworker Staffing Details
N=31

	Minimum	Maximum	Mean	Median
# Caseworkers (CW) employed at time of CCC survey	2	21	6.0	5.0
# CW vacancies at time of CCC survey	0	3	.45	0
Percent vacancies at time of CCC survey ³¹⁰	0%	33%	6%	0%
# CW that left the program in the prior year	0	5	1.55	1

³¹⁰ Percent vacancies was calculated by dividing the number of caseworkers employed at the time of the survey by the sum of the number of caseworkers employed and the number of vacancies.

CHAPTER 4: CONCLUSION

Over-arching Findings and Recommendations for The Future of the Preventive Service System in New York City

At the end of CCC's survey interview, we asked the program directors four open-ended questions that provided insight into New York City's preventive service system and how those most entrenched in it thought that it could be enhanced. Specifically we asked:

- *What are the top three changes you would like to make to the way ACS works with, monitors, and provides technical assistance to your program?*
- *If you could make any one change to the preventive service system in New York City, what would it be?*
- *If you could have additional resources, what change would you make to **your own preventive service program**?*
- *Is there anything else that is important for us to know about your program or about preventive services in general that you think we should know for our survey?*

Based on the very thoughtful responses of the program directors, CCC coded their ideas into 3 categories: 1) changes to the way preventive programs and ACS work together; 2) changes to their own preventive programs; and 3) changes to New York City's preventive service system.

Preventive service program directors noted tension, miscommunication, ACS caseworker non-responsiveness, and inconsistency among ACS staff as key relationship issues they hoped to change in order to improve their program's work with ACS.

When CCC asked program directors what changes they would like to make to the way ACS works with, monitors and provides technical assistance to their program, they noted many relationship-related issues that they sought to enhance. Below is a list of the most frequently cited areas of change mentioned by the program directors:

Changes Programs would like to see to the way they work with ACS:

- Improve the relationship with ACS child protective workers (51.6%)
- Standardization of ACS policies/procedures (41.9%)
- Address "attitude problems" of ACS staff (38.7%)
- More/better communication and collaboration (35.5%)
- More ACS involvement in their cases (32.3%)
- Improved ACS attitude toward families (25.8%)
- More timely responses from ACS (25.8%)

- ACS workers need to understand preventive services better (25.8%)
- Improved conditions for ACS workers (22.6%)
- Other items mentioned: better assessments by ACS; ACS should monitor substance over numbers; improved referral process; more case conferencing; less ACS micromanagement

CCC's survey interview was conducted before the Improved Outcomes for Children (IOC) model was implemented and before the transition meeting between ACS child protective workers and preventive service caseworkers was mandated for indicated cases. Many of the components of IOC are designed to address the systemic issues identified in this report, such as communication and collaboration between ACS and programs, consistent and meaningful oversight of programs, and early engagement of families in services. IOC seeks to do this through the implementation of family team conferences every six months, a new performance accountability system (Scorecard) that includes teams of ACS performance monitors assigned to each agency, ACS Technical Assistance units specializing in issues related to preventive services, and delegating case decisions to provider agencies to remove administrative barriers so as to more efficiently and effectively serve children and families. Similarly, the transition meeting between ACS child protective workers and preventive service caseworkers should address communication, coordination and relationship issues when cases are being transferred from ACS to preventive programs.

Monitoring and oversight are critical to ensuring high quality preventive services for families.

Every child and family that comes into contact with New York City's preventive service system should receive high quality, effective, culturally competent services that address their needs using a strengths-based approach. Given that ACS is contracting with over 150 preventive service programs that are providing services to enable children to remain safely in their homes, ACS must carefully monitor and oversee the quality of these programs to ensure that the children and families are receiving services that will in fact strengthen and support them.

ACS's new system of preventive services monitoring and quality assurance, Scorecard, includes data reviews, case reviews, and interviews with parents participating in the program. CCC commends ACS for seeking parental input in assessing the quality of preventive service programs, and is hopeful that ACS will continue to do this and also consider seeking youth input. The in-depth analysis provided by Scorecard should both provide ACS and the programs with real-time outcome data that can be used to strengthen individual programs and the system overall.

To date, Preventive Scorecard results have not been made publicly available. While CCC appreciates ACS's decision not to release the Year One results, CCC urges ACS to make some or all of the Scorecard results public sooner rather than later. This will not only ensure programs and ACS are accountable to the public, but also provide advocates with critical information about the system's resource needs and information about which program models are most successful.

It is more important than ever that ACS carefully monitor its contractors and make the results public because as part of the Improved Outcomes for Children (IOC)³¹¹ model rolled out system-wide June 15, 2009, ACS no longer has case managers assigned to individual cases performing paper reviews and sign-offs. Instead, decision-making is now handled by the programs themselves, who will be held more accountable for case outcomes. Thus, in exchange for delegating the decision-making authority to programs, ACS must carefully monitor the programs and then take steps to hold agencies accountable for poor outcomes for children and families.

In addition, provider agency administrators, preventive service program directors and supervisors must be able to evaluate the effectiveness of their own programs, so that they are able to assess what interventions are effective for families and what programmatic changes or enhancements they need to make.

If programs had additional resources, the directors would like to enhance their programs by providing more on-site programming for families, lowering caseloads, improving conditions for their workers and by employing support staff, case aides and parent advocates.

³¹¹ Improved Outcomes for Children (IOC) is discussed in more detail on page 15.

CCC asked the program directors how they would enhance their own programs if they had additional resources. Program directors were very practical and forthcoming about what could improve the services they provided for families.

Preventive Directors spoke about providing more services for families on-site through additional programming or specialists. Specifically, many mentioned the desire to provide mental health services on-site. Others mentioned more tutoring, adolescent groups or housing specialists. Program directors also spoke about improving the quality and effectiveness of their own staff through higher salaries, lower caseloads and hiring more qualified staff. Finally, program directors thought their programs could be enhanced by adding support staff, case aides and/or parent advocates. More details are provided below:

Changes Programs would make to their own programs if they had additional resources:

- More on-site services, programming and specialists (such as mental health services, tutoring, adolescent groups and housing specialists) (42%)
- More caseworkers/lower caseloads (35.5%)
- Improved salaries and benefits (25.8%)
- More qualified staff (16.1%)
- Support staff/case aides (16.1%)
- Other: Concrete goods for families; more supervisors; more training; parent advocates; more space

The CONNECTIONS computer system (and PROMIS data entry) was overwhelmingly the change to the preventive service system that program directors most wanted addressed.

In CCC's survey interview we asked program directors what one change they would want to make to New York City's preventive service system. Many program directors could not limit themselves to one change; however, program directors overwhelmingly discussed the state's case management information system, CONNECTIONS, as well as the city's preventive service data system, PROMIS. In fact, 20 of the 31 program directors discussed the system of record, CONNECTIONS, in response to one of the four concluding questions.

CONNECTIONS is the statewide, official system of record. It is described as an extremely detailed, yet non-user-friendly system that serves as the electronic case record. It

includes case progress notes, safety and risk assessment tools, and the Family Assessment and Service Plan (FASP). According to the directors, CONNECTIONS is not a good systems' management system. Prior to the implementation of CONNECTIONS in preventive programs, ACS developed a preventive management system called PROMIS. PROMIS is described as a better systems' management tool that tracks data such as how many open cases a program has, how long the case has been open as well as family demographic information. ACS and OCFS have collaborated so that as of early 2009, there have been automated feeds between these two programs so that preventive service caseworkers do not need to do double data entry into the two systems.

Below are several examples of program director thoughts about CONNECTIONS:

- "CONNECTIONS is a headache. It takes away from time with families. The FASP [Family Assessment and Service Plan] should be revamped- it does not tell the story of our work with families. In general, more and more data entry is required, making it harder for our workers to do their primary job."
- "Throw out CONNECTIONS."
- "There are two computer systems- a state one and a city one and they have different purposes. This causes duplication of efforts and data entry. The city and state should talk to each other."
- "We must bring sanity to the paperwork."

ACS Family Support Services staff and the program directors and staff at the preventive service programs are a dedicated cadre of professionals deeply committed to strengthening and supporting families while protecting children. The unwavering commitment of these professionals is impressive and inspiring; however, the system cannot achieve its mission without having sufficient resources. In this vein, the value of preventive services needs to be more widely recognized as a critical component of the child welfare system and the community's ability to keep children safe.

The preventive service program directors had so much to say about their work on behalf of the city's children and so many ideas about how to improve the system to which they were so clearly committed. Aside from the CONNECTIONS computer system, the preventive directors repeatedly

told CCC how much preventive service programs, and the communities their programs were part of, needed resources. They also told us how much they wanted those working outside of preventive services to more highly value them and their work.

Below is the list of systemic changes most often cited by the preventive program directors:

Changes Programs would make to New York City's Preventive Service System

- Change/fix CONNECTIONS/PROMIS computer systems (64.5%)
- Preventive services would be more valued (38.7%)
- Reduced caseloads (35.5%)
- More community resources available for families (32.3%)
- More funding for preventive service programs (19.4%)
- More slots to serve more families (12.9%)
- Increased salaries (12.9%)
- Better meet language/cultural needs (9.7%)
- Other: more resources for immigrants; better collaboration with other city agencies; more work with adult, male household members

All three of the questions related to system change (work with ACS, enhancing own program and systemic change) come back to the system's need for resources for their programs and for the communities in which the families are living. The words of the program directors are, however, more telling than the numbers:

- "Preventive programs don't have enough money for good casework practice. We need more intense services, lower caseloads, multi-system wrap around services, etc. It is hard for the programs to get a good handle on what is happening in the home with just two visits per month. It is unrealistic- but there should be more home visits. I wish we had the luxury to spend more time in the homes, but we would need much lower caseloads."
- "Preventive programs have inadequate financing for an infrastructure. We also need enough money for pensions, health care coverage and salaries for employees."
- "The caseworkers are dealing with high risk, complicated family situations often involving substance abuse, psychotropic medications and other mental health issues. They need more training and support. Mental health services must be included as part of preventive services."

- “Preventive services is very demanding- leading to burnout and turnover. Clients who do not speak English require even more time. This is in addition to the huge amount of paperwork. The job is intense and demanding.”
- “This is not a 9-5 job and no one is getting rich from it. You need to have a passion for it. Turnover is a more recent concern in the last 2 ½ years. This is because of PROMIS/CONNECTIONS, cases being more complex and the salary issue. There is a disconnect between the policymakers and the social workers- they have never been in the case planner’s shoes so do not understand preventive services. Preventive services work. Engagement is valuable. Policymakers need to understand this when they create policies, modules, benchmarks, reports and outcomes. These families are real people and not numbers.”

What was perhaps most striking to CCC was not the number of program directors who spoke about the need for more resources for their programs and staff, but the number of program directors who spoke to us about the need for preventive services to be more valued both from inside and outside of the child welfare system. They wanted to make sure CCC understood that for the city to be unwavering in its commitment to strengthening families and keeping children safe, the third leg of the child welfare tripod needs to be as strong and stable as child protection and foster care. Again, it is their words that are most compelling:

- “This work takes a very special person if you look at everything the worker does—it is hard work, often with high risk families. They are clinically focused, masters level clinicians who do family therapy, but also help secure all kinds of concrete goods. I would like to see this work more highly valued with salaries reflective of what people do.”
- “I would like to see the wealth of services we offer more accessible throughout the city. If we can get families to come and see us before the problems begin, that would be great.”
- “Preventive services are unknown to the public, even though they have been available since 1975. There is ignorance by society of the services we offer.”
- “I believe in this mission. We save families and children. We need the policymakers to see that.”
- “Preventive services are so important for so many families. We can be very successful for a large percentage of families if the resources are put into place.”

OVER-ARCHING RECOMMENDATION

Preventive services must be valued as a core child welfare service by the federal, state and local governments, the child welfare providers, advocates, and the city’s communities.

All three levels of government, child welfare providers and advocates, and all New Yorkers need to understand that preventive services are a core child welfare service— an equal leg of the child protection, foster care and preventive service tripod.

Every section of this report, and all of the work CCC has done with ACS, the preventive service programs and the families participating in these programs leads us to this final, overarching recommendation. There is no question that the ACS and provider program staff working in every community district throughout New York City are deeply committed to protecting children while strengthening and supporting families—so children can remain safely in their homes without entering foster care. CCC is convinced that it is very difficult to quantify the incredible impact the preventive service system has been making for countless children and their parents. But strengthening this family support system will require additional resources.

Preventing child abuse and neglect, supporting and strengthening families and preventing foster care requires resources: to increase the system’s capacity; to implement Improved Outcomes for Children; to improve access to services; to enhance monitoring and oversight of programs; to better address language, cultural and immigration issues; to ensure manageable caseloads for a qualified workforce; to improve case practice; and to ultimately reach every child at risk.

In difficult economic and budget times, the preventive service system is even more critical. As more families lose their jobs, become homeless, struggle to pay for food and clothing for their children, and face the stressors that poverty creates, more children and more families will need to lean on the city’s preventive service system. And when this happens, this third leg of the tripod must be strong and stable.

Providing preventive services to enable children to remain safely with their families must be a core mission of government. Preventive services are cost-effective and allow for an intervention to protect children and support families early, before significant harm is done. Especially in a troubled economy, all levels and branches of government must prior-

itize these services, which protect and nurture children.

As has been discussed throughout this report, CCC believes that even when resources were at an all time high for preventive services, additional resources were still needed for the system to lower supervisory ratios, increase staff salaries, improve access to services, implement family team conferencing, and increase the system's capacity.

Ensuring sufficient resources for preventive services is a shared federal, state and city obligation. It is more critical now than ever that preventive services be properly funded. On the state level, this means protecting preventive services from budget cuts, restoring the 2% cut to its reimbursement for preventive services and restoring and increasing stable funding for home visiting programs. On the city level, this means protecting preventive services from budget cuts and investing more resources in the preventive service portion of its new RFP to increase the number of available slots.

While there is certainly more New York State and New York City can invest in the preventive service system, CCC believes that the federal government must do much more to support these services that keep children safe and out of the more costly foster care system. Federal law requires that states and localities make reasonable efforts to prevent every child's removal/ placement into foster care, but does not provide sufficient funding for the states to do this effectively. According to Casey Family Programs, for every FY 2010 dollar invested in prevention, \$8.59 was spent on children already in foster care.³¹²

To start, the three largest federal laws that address child abuse prevention, Title IV-B of the Social Security Act, the Promoting Safe and Stable Families Act, and the Child Abuse Prevention and Treatment Act (CAPTA), need to first be funded (appropriated) at the levels that have been authorized and then when these laws are reauthorized, the authorization levels must be increased.³¹³

Unfortunately, President Obama's proposed budget for federal fiscal year 2011, proposes to hold funding for child welfare programs essentially flat.³¹⁴ While there are upcoming opportunities in various reauthorizations, the President's proposal to freeze discretionary funding for three years will

make it difficult to increase spending on child welfare programs if Congress approves the freeze.

CAPTA is scheduled for reauthorization, which provides Congress with the opportunity to strengthen the federal government's role and commitment to child abuse and neglect prevention. In fiscal year 2008, approximately \$100 million was appropriated to the states through CAPTA, even though Congress had authorized the programs for \$200 million.³¹⁵ This is in comparison to the over \$7 billion dollars that was allocated for foster care in that same year. Thus, Congress and the President have the opportunity to make child abuse and neglect prevention a priority when CAPTA is reauthorized, by increasing funding.

In addition, CCC urges the federal government to allow federal IV-E funds to be used more flexibly for preventive services; to provide funding for home visiting models as preventive services;³¹⁶ and to provide funding to states for preventive services based on the number of children being served.

In conclusion, CCC urges federal, state and city elected and appointed officials, the preventive service programs and child welfare advocates to use this report to understand the facts, educate the public and then advocate to maintain and enhance funding and resources for preventive services; enhance monitoring and oversight of the system; improve case practice; and ensure the preventive service system is more strongly valued by elected and appointed officials at the city, state and federal levels, child advocates and the child welfare community.

The most vulnerable children and families in New York must not pay the price of the economic downturn and we must not wait for another senseless tragedy for attention to be paid to preventive services. The wisest investment that government can make is in New York City's preventive service system, so that families can be strengthened and supported, children can remain safely in their homes, and the trauma and costs of foster care can be avoided. If the preventive service leg of the child welfare tripod is not adequately funded, it will falter and then the entire child welfare system will collapse—the children of New York City deserve better from all of us.

³¹² Casey Family Programs. *Ending Our Nation's Overreliance on Foster Care: Investing in Strategies that Keep Children Safely at Home with their Families and Out of Foster Care. Executive Summary.* October 2009.

³¹³ The federal government can authorize programs at one level when bills are passed, but then appropriate less funding in budget bills.

³¹⁴ Voices for America's Children. *America's Children and Families in Crisis: An Analysis of the President's FY2011 Budget.* February 9, 2010.

³¹⁵ Voices for America's Children. *2009 Child Safety Legislative Priorities.*

³¹⁶ The Education Begins at Home Act (S. 244) was introduced in January 2009. Prior to her confirmation as Secretary of State, Senator Hillary Clinton was the primary sponsor of this bill. Both Senate and House Health Care Reform bills included grants to states for home visiting programs, but the enacted health care reform bill did not include home visiting.

APPENDIX 1: FINDINGS AND RECOMMENDATIONS

A) SYSTEM CAPACITY

Finding:

- New York City's preventive service system has been, and continues to be, operating on overload and is therefore in need of increased capacity to meet the need and demand for services.

Recommendations:

- New York City needs to expand, not contract, the capacity of its preventive service system so it can accommodate every family in need of preventive services.
- If ACS does significantly reduce the capacity of its preventive service system, ACS must very carefully and deliberately transition to the new contracts so as to ensure that families currently being served continue to have their needs met.

B) THE BEGINNING OF A PREVENTIVE SERVICE CASE: REFERRALS FROM ACS TO PREVENTIVE SERVICE PROGRAMS

Findings:

- There was significant disparity among surveyed programs with regard to how cases were handled when they were first referred from ACS. Some programs did not begin working with families in a timely or expeditious manner.
- According to the surveyed programs, when ACS referred cases to them they typically received an assessment of the family, but the information was not as helpful with regard to the family's service needs, the risk to the children and the family's history, as they would have liked.

Recommendations:

- To ensure more timely contact and engagement with families in crisis, ACS should intensely monitor preventive service program compliance with timeframes when cases are first referred and consider adding a deadline for the first home visit.
- To ensure transmission of critical information from ACS to preventive service programs, ACS should monitor the implementation of their new policies intended to improve information-flow between the ACS child protective units and the preventive service programs and OCFS should simplify the ability to print a family's prior case record from the CONNECTIONS system of record.

- ACS should implement a more streamlined process for providing emergency cash or goods to families and/or establish a fund for preventive programs to use to obtain these critical items.

C) INITIAL FAMILY ENGAGEMENT

Findings:

- The relationship between the family members and the caseworker is critical to successful engagement and ultimately the success of the intervention itself.
- According to the surveyed programs, parents referred from ACS typically fear that ACS will remove their children, which has an impact on engagement.
- Program directors identified the most critical factors for encouraging family participation as having hours of operation that meet the needs of working parents and school-age children; having skilled staff to counsel families; having caseworkers who speak languages besides English; and meeting a short term need and building on it.
- Program directors identified the most frequent barriers they encountered when trying to encourage family participation in their program to be resistance from parents and youth and long waiting lists for services.

Recommendation:

- To successfully engage family members in preventive services, ACS and preventive service programs must ensure there are skilled and dedicated staff at preventive service programs that can meet the language, cultural and service needs of families in their communities at hours that meet the needs of working families and school-age children.

D) ACCESSING SERVICES FOR FAMILIES

Findings:

- Every program reported providing or referring families to almost all of the services that are required or optional in the state regulations and ACS Scope of Services that accompanied the contract requirements that were in effect at the time of CCC's survey administration.

- According to program directors, caseworkers frequently face a number of barriers when trying to access services for families. The most frequent barriers reported were long waiting lists for services and the need for child care for parents to be able to participate in services.
- Program directors reported that Mental Health Services and Housing Assistance were the services families most often needed and also the services most difficult to access.
- Program directors felt that when families move in or out of the homeless shelter system it negatively impacts the continuity of services for families.
- Program directors reported that it was difficult to access services for families when family members were not citizens, partially due to payment-related issues.
- Program directors reported difficulties in accessing and providing services for teens and in working with the Department of Education (DOE).
- Programs face a range of barriers when trying to access services for families, some of which are outside of the control of the child welfare system.

Recommendations:

- **Accessing Services**
 - New York City should ensure that the rate paid to preventive service programs is sufficient to enable programs to pay for the services families need, be they provided on-site or through referrals.
 - ACS should explore options for creating a fund that would be available to pay for services when traditional payment options are not available.
 - ACS should expand the tasks of their Community Partnership Initiative (CPI) to better implement the stated goals of expanding child welfare linkages and ACS should continue to monitor the effectiveness of CPI. If CPI is found to be effective at improving access to services in the 11 CPIs, then ACS should expand CPI to all of NYC's high-risk communities. If CPI is not found to be an effective mechanism for creating community coalitions that expand child welfare linkages, then ACS should reinvest the CPI funding into another initiative that improves access to services.
- Preventive programs should continue to provide services on-site, expand on-site service provision when possible and develop additional linkages to other service providers that can give priority to families receiving preventive services. ACS should closely monitor this and provide assistance to programs lacking effective service linkages.
- ACS, OCFS and the preventive service programs should work to develop a child care model, in which child care would be available to parents while they are participating in services.
- **Housing Assistance**
 - New York State and New York City should increase the \$300 preventive services housing subsidy to an amount that is sufficient to stabilize a family's housing situation.
 - ACS should provide preventive service programs with resources to have access to Housing Specialists.
 - The state and the city should expand child welfare housing initiatives to include families receiving preventive services.
 - New York State and New York City should create and implement short-term and long-term strategies to address the city's affordable housing crisis.
 - ACS and the city's Department of Homeless Services (DHS) should work together to enhance their coordination and collaboration on behalf of families in both the preventive service system and the homeless shelter system.
- **Mental Health Services**
 - Maintain and enhance the ability of preventive programs to access on-site mental health services such as MSW caseworkers, mental health consultants and on-site therapists.
 - Expand the functions of the ACS Mental Health Technical Assistance Unit to include providing support to preventive service providers.
 - Expand partnerships between preventive service programs and mental health clinics to improve timely access to quality mental health services and ensure preventive programs and mental health clinics are adequately reimbursed for their services.
- **Youth**
 - Revive the Enhanced Preventive Services For Teens model.

- **Education**

- Improve coordination and collaboration among ACS, preventive service programs and the Department of Education (DOE) by improving DOE's access to social service supports, truancy prevention programs and school based mental health services and by fully integrating DOE into the Community Partnership Initiative (CPI).

E) ENGAGING MEN IN PREVENTIVE SERVICES

Findings:

- Preventive service programs do not always require caseworkers to work with men/fathers even when they are living in the home.
- While research shows that fathers play a critical role in parenting children and that unrelated adults living in the home may have an increased likelihood of abusing the children, parent education programs and preventive programs do not always engage men and other unrelated adults in the home in preventive services.

Recommendation:

- Fathers and unrelated household members need to be more engaged in preventive services. ACS should directly mandate the inclusion of fathers in assessments and service provision (where appropriate) and strictly monitor programs' effectiveness in engaging fathers.

F) LANGUAGE ACCESS AND CULTURAL COMPETENCE

Finding:

- Language access and cultural competence are critical for NYC's preventive service programs to be able to meet the needs of New York City's diverse population. ACS and preventive programs have taken steps to improve the system's ability to meet the language needs of families and the city's cultural diversity, but there is still a need for more bilingual and culturally competent staff.

Recommendations:

- Increase the number of preventive service slots available to families at preventive service programs specifically designed to meet language and cultural needs of immigrant families and families not proficient in English, and ensure that preventive service programs are funded to hire trained, qualified, bilingual, culturally competent staff.
- Educate the child welfare community on various cultures and their customs related to child-rearing in an effort to provide for more culturally competent interventions.

G) COURT ORDERED SUPERVISION (COS)

Findings:

- There has been a very large increase in the number of Court Ordered Supervision cases and a decrease in ACS's ability to make the required two home visits per month in these cases.
- Although there has been a dramatic increase in the number of court ordered supervision cases since 2005, preventive service program directors did not report that a high percentage of their preventive cases had court ordered supervision. In addition, less than one third of the program directors had noticed a substantial increase in the number of COS cases in their programs.

Recommendations:

- ACS should assess whether there should be an increase in the number of court ordered supervision cases that are referred to preventive service programs.
- OCFS and ACS should improve their data collection systems so that data on the number of cases open in both ACS Family Service Units (Court Ordered Supervision units) and preventive service programs can be readily accessible.
- ACS and the preventive service programs should improve their coordination and collaboration in shared court ordered supervision cases.

H) IDENTIFYING AND ADDRESSING SAFETY AND RISK FACTORS IN FAMILIES

Findings:

- Preventive service programs do not all have the same understanding of their role with regard to assessing safety and risk.

- ACS's new RFP more clearly articulates the role of preventive service providers in assessing safety and risk.
- Preventive service programs regularly make reports to the State Central Register (SCR).
- Programs reported that they work differently with high-risk families, including making more home visits, providing additional services, holding more case conferences, and intensifying services.
- When program directors were asked how their programs measure or assess a family's progress with services, most of the directors focused on tools and casework tasks rather than changes in behaviors.

Recommendations:

- ACS should ensure that all preventive programs are always aware of their expectations regarding assessing safety and risk.
- ACS should share system-wide and individual program results from their monitoring efforts, with regard to how well programs assess safety and risk and measure family progress with services, so that their findings can be used to develop targeted training curricula and policies where necessary.
- When preventive service programs hire new caseworkers or supervisors, they should be required to receive training or refresher training on identifying, assessing and addressing safety and risk before they begin working with families.
- ACS and OCFS should provide safety and risk training for preventive service staff at least annually.

I) TRAINING

Findings:

- Preventive service caseworkers seem to receive little, if any, training before they start working with families.
- The 1998 *Standards and Indicators* and the *Standards and Indicators* in the new RFP both require training for preventive service caseworkers.

Recommendations:

- OCFS and ACS should mandate that all preventive service caseworkers receive a basic child welfare training before they start working with families.

- OCFS and ACS should develop curricula and assist programs in providing the training to the preventive service caseworkers. The federal government should provide funding for training preventive service caseworkers.

J) CLOSING CASES

Findings:

- A review of ACS data, policies and the new RFP shows that even though ACS has been encouraging programs to shorten their length of service provision, many preventive service cases are open for over 18 months.
- Preventive service program directors generally believed that there are cases that should be open for longer than two years.
- After the surveyed programs closed cases, families did not return to their preventive service programs for additional support or services very often.
- Many of the surveyed program directors believed that aftercare for preventive services would enable them to close cases more quickly.

Recommendations:

- ACS must very closely monitor the programs and cases to ensure that children will be safe when the cases are closed because ACS is providing incentives to reduce the length of service provision, instituting a 12 month average length of service provision, and delegating the decision to close cases to programs.
- ACS should conduct an analysis of the cases that have been open for longer than three years to gain a better understanding of the issues facing these families and to determine whether there is another system that could better serve these families, whether there is another type of preventive service needed for these families, and/or whether there are certain types of cases that need long-term preventive services.
- ACS should implement a funded "aftercare" period for preventive services.
- Given concerns about child safety and having enough slots to meet the needs of NYC's families, ACS must reassess whether the elimination of almost 4,000 slots, the implementation of a 12-month average length of service provision linked to funding, and the delegation of case closing decisions are feasible and safe.

K) PREVENTIVE SERVICES WORKFORCE

Findings:

- The child welfare workforce faces high caseloads, high turnover and low salaries.
- FRP caseworker caseload ratios tended to be 10 to 1, which is consistent with how the programs are funded.
- GP caseworker caseload ratios tended to be higher than 12 to 1, which is the ratio for which they were funded.
- Preventive service program directors generally believed that caseloads should be lower.
- The percentage of caseworkers with a Master's in Social Work (MSWs) or an equivalent Master's Level Degree varied widely.
- Preventive Service Program Directors generally believed supervisory caseload ratios should be lower than they were.
- The preventive programs surveyed were generally offering salaries slightly higher than the minimum requirements, yet these salaries were still fairly low.
- Retention of experienced frontline caseworkers is a critical issue for preventive service programs.

Recommendation:

- Recruit and retain caseworkers to the preventive service field through manageable caseloads, adequate salaries, appropriate training, paperwork/data-entry reduction, adequate supervision, and therapeutic support to address secondary trauma.

Over-arching Findings for The Future of the Preventive Service System in New York City

- Preventive service program directors noted tension, miscommunication, ACS caseworker non-responsiveness, and inconsistency among ACS staff as key relationship issues they hoped to change in order to improve their program's work with ACS.
- Monitoring and oversight are critical to ensuring high quality preventive services for families.
- If programs had additional resources, the directors would like to enhance their programs by providing more on-site programming for families, lowering caseloads, improving conditions for their workers and by employing support staff, case aides and parent advocates.
- The CONNECTIONS computer system (and PROMIS data entry) was overwhelmingly the change to the preventive service system that program directors most wanted addressed.
- ACS Family Support Services staff and the program directors and staff at the preventive service programs are a dedicated cadre of professionals deeply committed to strengthening and supporting families while protecting children. The unwavering commitment of these professionals is impressive and inspiring; however, the system cannot achieve its mission without having sufficient resources. In this vein, the value of preventive services needs to be more widely recognized as a critical component of the child welfare system and the community's ability to keep children safe.

Over-arching Recommendation:

- Preventive services must be valued as a core child welfare service by the federal, state and local governments, the child welfare providers, advocates, and the city's communities.

APPENDIX 2: THE HISTORY OF PREVENTIVE SERVICES IN NYC (1995-2010)

Prior to 1995:

The city's child welfare agency was called the Bureau of Child Welfare (BCW) and was part of a larger city agency called the Human Resources Administration (HRA). The state reimbursed counties for preventive services at an uncapped matching rate of 75% state/ 25% city. The city's budget for preventive services in Fiscal Year 1994 was \$152 million.

1995 – The State Block Grant:

The state implements the New York State Family and Children's Services Block Grant for all child welfare services. This reduces state funding for child welfare services by 25% statewide, or \$151 million, of which \$131 million was cut from New York City.

1995 – The Death of Elisa Izquierdo:

The tragic death of six-year old Elisa Izquierdo, who was killed by her abusive mother after being returned home from foster care, sparks outcry in New York City.

1996 – The Creation of ACS:

In his 1996 State of the City Address, Mayor Giuliani pledges to improve the lives of New York City's children by creating a separate city agency responsible for child welfare services.¹ An Executive Order is issued making the Administration for Children's Services (ACS) a free-standing agency reporting directly to the Mayor (and no longer the Child Welfare Administration within the Human Resources Administration.) Commissioner Nicholas Scoppetta is named the first Commissioner of the new agency. He and his team release *Protecting the Children of New York*, a reform plan for the initial structural and managerial changes intended to improve practice and enhance training at the city's child welfare agency.

1996 and 1997 – Preventive Funding Decreases:

Due to the state's Children's Services Block Grant, funding for preventive services in New York City consistently decreased. The City Fiscal Year 1996 total federal, state and city funding for preventive services is \$113.7 million, a \$38.3 million decrease from the prior fiscal year. Then in City Fiscal

Year 1997, the preventive services budget decreases another \$35.6 million to just over \$78 million.²

1998-2000 – Preventive Funding Increases/Neighborhood Based Services:

"Child welfare agencies could scarcely believe the news. . . The city will sharply increase funding for [preventive services]."³ ACS increases funding for preventive services by 27% as part of its new neighborhood-based services contracts for preventive services by community district. By 2000, ACS completes citywide contracting for neighborhood based preventive services. As part of this new contract with preventive programs, ACS institutes the Model Budget, which sets minimal salary, caseload, and per family spending at the preventive programs. This brings some uniformity to preventive programs.

2001 – More Prevention Than Foster Care:

For the first time, in 2001, New York City serves more children with preventive services than foster care services. This has remained true since 2001.

January 2002:

William C. Bell becomes the second Commissioner of the Administration for Children's Services.

2002 – Child Welfare Financing:

The state replaces the Family and Children's Services Block Grant with a block grant that is only for foster care. All other local child welfare spending, including preventive services, is reimbursed at an uncapped matching rate of 65% state/ 35% local (after meeting a maintenance of effort requirement.)

July 2004:

John B. Mattingly becomes the third Commissioner of the Administration for Children's Services, commonly referred to as Children's Services.

2005 – Rightsizing, Reinvestment and Realignment:

ACS releases *Protecting Children and Strengthening Families*, a plan to rightsize the system's foster care and congregate care

¹ Archives of Rudolph Giuliani State of the City Address. (January 11, 1996). <http://www.nyc.gov/html/records/rwg/html/96/city.html>

² Citizens' Committee for Children. *Carrots and Sticks: The Impact of the New York State Family and Children's Services Block Grant on Child Welfare Services in New York City*. (1998).

³ City Limits. *Bounce of Prevention*. (August 24, 1998).

capacity; to reinvest foster care savings into more intensive front-end preventive services and post-foster care aftercare services, and to realign service delivery so that neighborhood-centered family support programs are bolstered. Starting in Fiscal Year 2006, \$27 million is reinvested from foster care savings into preventive services. Specifically, \$9 million is for “front-end” intensive preventive services for babies and teens and \$18 million is for aftercare services for children reuniting from foster care.

2006 – Increased demands on the preventive service system:

After several highly publicized child fatalities, including that of Nixzmary Brown, ACS reaffirms its commitment to strengthening its ability to keep children safe. This includes changing its practice so that fewer of the cases that are substantiated for abuse or neglect are subsequently closed without services for the family—instead these cases are to be referred to preventive service programs. In addition, in the wake of tremendous media attention and new protocols at the Department of Education,⁴ reports of abuse or neglect increase 22% from FY05 to FY06, with a 36% increase from January (the month of Nixzmary’s death) to the end of the fiscal year in June.⁵ By the end of the 2006 fiscal year, the indication rate has increased from about 33% to over 41%.⁶ Given the increased number of reports and the higher indication rate, many more families are in need of preventive services.

2006-2007 – Increased resources for prevention:

Due to the increased number of cases coming to ACS and the preventive programs, additional resources are added. Specifically, in FY07 the City Council added \$4.2 million city tax levy (\$12 million with the state matching funds) to reduce preventive service caseloads to 12 to 1 (from 15 to 1) at General Preventive programs and to reduce caseloads at Medically Fragile programs. This initiative is commonly known as the Child Safety Initiative. In addition, starting in

2006, ACS finds funds to provide \$3.2 million city tax levy (\$9 million with the state matching funds) to provide preventive service enhancement funding to the programs, which is money that programs can use flexibly to meet the needs of their programs and the families they serve. With preventive service programs operating at or over 100% utilization, the city phases in 1,000 additional preventive service slots in FY08 to better meet the increased demand for preventive services (at a cost of \$2.4 million city funds for a total of \$6.8 million with state matching funds).

2007 – Improved Outcomes for Children (IOC):

ACS releases its Improved Outcomes for Children (IOC) plan, which seeks to reform the way ACS works with its contracted foster care and preventive partners by enhancing ACS’s monitoring of programs, adding family team conferencing, changing the way foster care is financed and giving private agencies more authority to make decisions in individual cases by delegating case management from ACS to the preventive service programs and foster care agencies. Eleven preventive service programs in Brooklyn participate in Phase 1 and an additional 21 programs participate in Phase 1A. While CCC and other advocates feel that IOC moves the child welfare system in the right direction, it requires case conferences and more decision-making by preventive service programs but does not provide programs, with additional resources.

2008 – Budget Cuts at the Start of the Economic Downturn:

In the state’s Fiscal Year 2008-2009 Budget, the state’s reimbursement for preventive services was cut by 2%, which lowered the state uncapped match for preventive services from 65% to 63.7%. In addition, the city’s Fiscal Year 2009 budget cut preventive services by failing to fund the 1,000 new preventive service slots (although many remained in the system), allocating only \$4.5 million in enhancement money (down from \$9 million) to preventive programs and only partially restoring (85%) funds to reduce caseload ratios to 12 to 1 (from 15 to 1) in General Preventive and Medically Fragile programs.

⁴ This includes weekly school absence alerts automatically generated when a child misses 10 days of school. See City of New York. Office of the Deputy Mayor for Health and Human Services. *Report of the Interagency Task Force on Child Welfare and Safety: Findings and Initiatives*, at 8. (March 29, 2006).

⁵ City of New York. *The Mayor’s Management Report, FY 2006*, at 33.

⁶ New York City Administration for Children’s Services. *ACS July 2007 Update*, FY06, at 1.

2009 – Implementing IOC, Issuing a new RFP, and More Budget Cuts:

The state's FY09-10 adopted budget extends the child welfare financing legislation until June 2012, providing continued uncapped state reimbursement for preventive services. The state continues the 2% reimbursement reduction so counties receive 98% of the state's 65% share (which is 63.7%). Many of the state's proposed budget cuts are temporarily restored with TANF surplus funds and federal stimulus funds (American Assistance and Recovery Act).

In May 2009, ACS issues a new RFP for preventive services, due to be effective in 2010. The new RFP contractually implements IOC, which was implemented system-wide on July 15, 2009. The new RFP reduces the capacity of the preventive services system by approximately 2,500-3,000 slots, while also intensifying the service model, instituting a performance-based 12 month average length of service requirement and creating several new specialized models.

2010 and Beyond – Budget Cuts But Continuing Demands:

State and city budget shortfalls continue to loom. At the state level, funds for preventive service contracts (including post-adoption services) and home visiting programs remain at risk. At the city level, the preventive service system's capacity and rates are in jeopardy. The Mayor's Preliminary Budget for Fiscal Year 2011 proposed a \$3.6 million cut to preventive services and the Mayor suggested that an additional 2,500 slots could be cut if the state's proposed budget is adopted. Meanwhile, awards for ACS's new preventive contracts will be announced in the Spring of 2010 and new contracts will begin between July 1 and December 1, 2010.

As state and city budget deficits remain large, a great deal of advocacy is required to ensure that ACS and the preventive service programs receive enough funding to ensure that every family needing services to ensure their children can remain safely in their homes, has access to high quality preventive services in their neighborhoods.

APPENDIX 3

Citizens' Committee for Children of New York, Inc. Task Force on Preventive Services



SITE VISIT QUESTIONNAIRE

Thank you for taking the time to meet with us to discuss how your program provides preventive services to the children and families in your community. Citizens' Committee for Children of New York, Inc. (CCC) is a 63-year-old child advocacy organization working to ensure New York's children are healthy, housed, educated and safe. We are making site visits to preventive service programs as part of a study that will document the services, processes, outcomes, potential barriers, and ideas for the future regarding New York City's preventive services system.

Please know that CCC keeps all survey results confidential. No administrator, staff person, parent, child or program name will be identified by name in any CCC publication or advocacy effort.

General Information (completed before site visit and confirmed with interviewee):

1. Name of Program: _____
2. Name of Agency: _____
3. Borough served by Program: _____
4. CD(s) served by Program: _____
5. # of preventive slots allocated to the program: _____
6. Type of Preventive Program (check one):
 General Preventive Family Rehabilitation Program (FRP)
 Other: _____
7. Title(s) of Person(s) being interviewed: _____
Name of Person(s) Being Interviewed:

Name of CCC Volunteer(s) completing survey:

Date of Interview: _____

General Questions: We are going to start by asking you some general questions about your program:

8. How many open cases does your program **currently** have, **NOT** including the cases in your **intake** unit?

9. How many cases are **currently** pending in your **intake** unit?

10. What is your current utilization rate?

10a. If your utilization rate is over 100%, for approximately how many months has your program been over 100%?

11. Right now, approximately what percent of **all** your preventive services cases are families who were referred from ACS?

12. In cases that are **NOT** referred from ACS, which of the below are the 2 most frequent ways families are referred to your program?

Note to Interviewer: Please check the 2 boxes next to the items selected by the interviewee.

a <input type="checkbox"/> Child's school
b <input type="checkbox"/> Word of mouth in community
c <input type="checkbox"/> Referral from other community based organization
d <input type="checkbox"/> Referral from foster care agency
e <input type="checkbox"/> Self-referral
f <input type="checkbox"/> Other:

13. Over the past 6 months, have you had to turn away any families because your program was filled to capacity?

No

Yes. If Yes: Were these families ACS referred families, walk-ins or both?

ACS Referred Families

Approximate Percentage: _____

Not ACS-referred/Walk-ins

Approximate percentage: _____

14. Do you think more preventive service slots are needed for the community/communities your program serves?

No

Yes

15. We are going to ask you a series of questions related to how many **days/weeks** elapse on average between the time your program receives a referral from ACS and several other events related to engaging and serving families.

How many days typically elapse between the time your program receives a referral from ACS and:

a. Your program has contact with the family: _____

How many days typically elapse between the time your program receives a referral from ACS and...

b. Someone from your program makes a home visit: _____

c. Your program does an initial assessment of the family's needs:

d. Your program provides a service to address the family's presenting need(s):

e. Your program does a safety assessment: _____

f. The family receives emergency cash or other emergency assistance (such as food, clothing, cribs, etc.) if it is needed:

g. Your program tells ACS whether or not the case is accepted or rejected:

h. Your program assigns the family to a preventive services caseworker's caseload:

Involvement of ACS: We are going to ask you a few questions about the role of ACS when cases are referred to your program.

16. When families are referred to your program from ACS, how often does ACS give you an assessment of the family?

- Almost always
- Sometimes
- Rarely
- Never

17. We are going to ask you a series of questions about the helpfulness of the information your program receives when cases are referred from ACS.

a. How helpful would you say ACS's assessment is in telling your program the **family's service needs**?

- Very Helpful
- Somewhat Helpful
- Not Too Helpful

b. How helpful would you say ACS's assessment is in telling your program the **risk to the children**?

- Very Helpful
- Somewhat Helpful
- Not Too Helpful

c. How helpful would you say ACS's assessment is in telling your program the **family's history**?

- Very Helpful
- Somewhat Helpful
- Not Too Helpful

18. How common is it that families referred from ACS fear that ACS will remove their children?

- Very common
- Moderately common
- Not too common

19. When you are working with families who are fearful that ACS will remove their children, what impact does this have on a family's participation in services?

- The families are usually *more receptive* to participating in services
- The families are usually *less receptive* to participating in services
- There is roughly an *even split* of families who are more receptive and families who are less receptive
- N/A- This has no impact on a family's participation with your program*

Cases That Are Rejected For Services by Your Program: We would like to understand more about the cases that are **referred to you and are then not accepted** by your program. We are going to refer to these cases as “rejected”.

20. In an **ACS referred case**, what is the **title** of the staff person from your program who decides whether to accept or reject the case?

21. Below is a list of reasons a preventive program may reject a case. After reviewing the list, please tell us the 3 most frequent reasons cases are rejected by your program.

Note to interviewer: Please put #1 next to the most frequent; #2 next to the second most frequent and #3 next to the third most frequent.

- ___ a. The family *did not want to participate* in services
- ___ b. The family is living in a *CD not served* by your program
- ___ c. The family's *primary language* is one that your program cannot serve
- ___ d. The family is living in the *shelter system*
- ___ e. There is *not enough staff available* at your program to take an additional case
- ___ f. Your program feels that the *risk to the children is too high* for you to be able to meet the needs of the family
- ___ g. Your program has *previously worked with the family* and feels that there is nothing more you can do to help the family
- ___ h. The family is *not answering the door/phone*

22. Encouraging Family Participation: We are interested in understanding how preventive programs encourage families to work with them *when their cases are first referred*. Below is a list of items. With respect to each, please tell us **how critical each one is for encouraging families to participate** in your program.

1=Very critical

2=Moderately critical

3=Not too critical

4=Not at all critical

Note to interviewer: You may need to say after some items, "Is it very critical, moderately critical, not too critical, or not at all critical for encouraging family participation?"

<i>How critical is it that...</i>	(1) Very critical	(2) Moderately critical	(3) Not too critical	(4) Not at all critical
a. Your program site appears and feels welcoming to families				
b. The days/hours of your program meet the needs of the working parents and school age children				
c. When necessary, your program's caseworkers speak languages besides English				
d. Your program has skilled staff who can counsel families into wanting to participate				
e. Your program can meet an immediate short-term need of the family and then build on this success				
f. The family feels your program is part of their community				
g. The family knows other families who had positive experiences with your program				
h. Your program provides reimbursement for the family's transportation costs to and from services				

23. Barriers to Family Participation: We are interested in understanding which barriers your program most frequently encounters when **trying to encourage families to participate in your program**. Below is a list of potential barriers. Think about the families your program has served this past year and then tell us how often your program encountered each of these barriers.

- 1= A barrier in *almost every case*
- 2= A barrier in *many cases*
- 3= A barrier in *some cases*
- 4= A barrier in *a few or no cases*

If an item is *not applicable* (N/A) because you *do not consider it a barrier*, please tell us.

Note to interviewer: You may need to say after some items, "Is this a barrier in almost every case, many cases, some cases, a few cases, or is the item itself not something you consider a barrier?"

	(1) Almost every case	(2) Many Cases	(3) Some cases	(4) A few cases or no cases	
a. Long waiting lists inhibit your program's ability to meet the family's immediate needs N/A					<input type="checkbox"/> N/A
b. Parent(s)/caregiver(s)' working hours conflict with times when the services are offered					<input type="checkbox"/> N/A
c. Cultural differences between your program's staff and the family					<input type="checkbox"/> N/A
d. Language differences between your program's staff and the family					<input type="checkbox"/> N/A
e. The family's fears due to their immigration status					<input type="checkbox"/> N/A
f. Your program and/or the services you refer the families to are not conveniently located for the family					<input type="checkbox"/> N/A
g. A parent/caregiver is not fully committed to working on their issues					<input type="checkbox"/> N/A
h. The child/youth is resistant to working with your program					<input type="checkbox"/> N/A

Court Ordered Supervision: We are now going to ask you some questions about court ordered supervision cases. When answering these questions, please keep in mind we are asking about the cases where the court has ordered ACS to supervise AND the family is receiving services through your preventive program.

24. When a case that already has court ordered supervision (COS) is referred to you, how often does your program learn about the court's involvement at the time of the referral?
- Almost always
 - Frequently
 - Sometimes
 - Rarely
 - Never
25. For cases that become court ordered supervision (COS) after they have already been open for services in your program, how often do you learn in a **timely fashion** (within a month) that the case has become a COS case?
- Almost always
 - Frequently
 - Sometimes
 - Rarely
 - Never
26. Do you know approximately what percent of your program's currently open cases have court ordered supervision?
- No- don't know
 - Yes. If Yes: What is this approximate percentage?
Percent: _____
27. In the past year, has your program seen a substantial increase in the number of court ordered supervision cases?
- Unsure
 - No
 - Yes
28. On average, what impact does court involvement usually have on a family's participation in your program?
Families are *more* willing to participate in services
- Families are *less* willing to participate in services
 - Approximately *equal* number of families who are more and less willing to participate
 - Court orders seem to have *no impact* on a family's willingness to participate in services

Service Provision: We are now going to ask you some questions about the services your program provides to families and those that you refer them to.

29. Please look at the chart below and for each item tell us whether it is a service your program provides on-site OR one you refer families to OR a service you do not provide for families.
(Note: If it is a service provided both on-site and that families are referred to, please select the one that happens in the majority of the cases.)

SERVICE	Service Provided On-site	Refer families off-site for this service	Service not provided
Homemaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent training/parent education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational counseling and training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vocational training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preventive medical care and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immigration services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational advocacy for the children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency cash or goods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Independent living for youth 14 and older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol and substance abuse treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family counseling/therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Individual counseling/therapy—for parents/caregivers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities for parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services for adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational activities for children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groups for parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groups for children/youth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic violence counseling (for victim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tutoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Batterer's treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anger Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. What are the 3 services that the families served by your program most often need?

1.

2.

3.

31. What are the 3 most difficult services for your preventive program to access for families?

1.

2.

3.

32. Barriers to Accessing Services:

We understand that your caseworkers sometimes face **barriers when trying to access services for families**. Below is a list of potential barriers. Think about the families your program has served this past year and then tell us how often your caseworkers faced this barrier.

- 1= A barrier in *almost every case*
- 2= A barrier in *many cases*
- 3= A barrier in *some cases*
- 4= A barrier in *a few cases/no cases*

If an item is *not applicable* (N/A) because you do *not consider it a barrier*, please tell us.

Note to interviewer: You may need to say, "Was this a barrier to accessing services in almost every case, many cases, some cases, a few cases/no cases or is this item not a barrier to accessing services?"

	(1) Almost every case	(2) Many cases	(3) Some case	4) A few cases (/no cases)	(5) Not a barrier to accessing services	
a. Services in the family's primary language were difficult to locate or could not be located.						<input type="checkbox"/> N/A
b. There were long waiting lists for the services needed						<input type="checkbox"/> N/A
c. The family lacked transportation						<input type="checkbox"/> N/A
d. The parents' immigration status impacted the ability to access and/or pay for services						<input type="checkbox"/> N/A
e. The cost of the service was not covered by Medicaid (ex. Batterer's treatment).						<input type="checkbox"/> N/A
f. The service needed was not available in the family's community						<input type="checkbox"/> N/A
g. The service was only available at times when the parent(s) was working						<input type="checkbox"/> N/A
h. The services were not culturally competent						<input type="checkbox"/> N/A
i. The parent/caregiver needed child care to participate in services						<input type="checkbox"/> N/A
j. There was no ability to pay for services for the non-related adults living in the home						<input type="checkbox"/> N/A

Working with Families: We are now going to ask you some questions about how your program works with families.

33. When your caseworkers are working with a mother, are they also **required** to try to work with a child's father if that father is living **in the home**?
- No
 Yes
34. When your caseworkers are working with a mother, are they also **required** to try to work with the child's father if that father is living **outside the home**?
- No
 Yes
35. When your program is working with a mother, is the caseworker also required to try to work with her boyfriend when he is an unrelated male living **in the home**?
- No
 Yes
36. Does your program serve families outside the CD (community district) your program is physically located in?
- No
 Yes

If Yes: How often do you find that this additional distance negatively impacts the family's participation in services?

- Almost always
 Often
 Sometimes
 Rarely
 Almost never
37. Think about the families your program has served this past year who had entered or left the shelter system and were then living in a different CD. How often did this change in home address make it more difficult for your program to continue to provide services to the family?
- Almost always
 Often
 Sometimes
 Rarely
 Almost never
38. In what languages is your program currently able to provide services to families?
- | | |
|-----------------------------------|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Haitian/Creole |
| <input type="checkbox"/> Mexteco | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Other: _____ |

39. In your experience, based on both the needs of the families referred to your program and the families served by your program, what languages are you finding that families are speaking yet are hard for your program to serve?

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> English | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Haitian/Creole |
| <input type="checkbox"/> Mexteco | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Mandarin | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Urdu | <input type="checkbox"/> Other: _____ |

40. Over the past 6 months, approximately how many times has your program called in a report to the State Central Register (SCR)?

41. Does your program work with high-risk families differently than families where there is a lower level of risk?

- No
 Yes.

If Yes: Please tell us how typical it is that each of the following are done differently for families identified as being higher risk:

a. More home visits

- | | | |
|--|----------------------------------|------------------------------------|
| <input type="checkbox"/> Almost always | <input type="checkbox"/> Usually | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Never | |

b. Additional services provided

- | | | |
|--|----------------------------------|------------------------------------|
| <input type="checkbox"/> Almost always | <input type="checkbox"/> Usually | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Never | |

c. Hold more case conferences

- | | | |
|--|----------------------------------|------------------------------------|
| <input type="checkbox"/> Almost always | <input type="checkbox"/> Usually | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Never | |

d. Services are intensified

- | | | |
|--|----------------------------------|------------------------------------|
| <input type="checkbox"/> Almost always | <input type="checkbox"/> Usually | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Never | |

42. Do you measure or assess a family's progress with services?

- No
 Yes.

If Yes: Please explain how you do this:

43. Is your preventive program part of an agency that provides other types of services besides preventive services?

No

Yes

If Yes:

43a. What are these other types of services? (Examples: foster care, child care, after school programs, food pantry, etc.)

43b. Aside from foster care services, are the families in your preventive program able to access these other services your agency provides?

No

Yes

44. Do you think that it is or is not a good idea for preventive service programs to have different levels, or tiers, of service provision, so that service intensity, duration and frequency, home visits, etc. would be based on the family's level of need?

No, I do not think that is a good idea

Yes, I think that is a good idea

44a. Does your program have this tiered-type approach to preventive service provision?

No

Yes

Case Closing: We are now going to ask you a few questions about closing cases.

45. Do you believe that a preventive services case should ever be open for longer than 2 years?

No

Yes

If Yes: What are the 2 main reasons that a case might stay open for more than 2 years?

1.

2.

-
46. How often do you find that after you close a preventive case the family comes back to your program seeking additional support or services?
- Almost always
 - Often
 - Sometimes
 - Rarely
47. If there was a way for your program to receive resources to provide ongoing support or assistance to families when it was needed, without having to re-open a preventive case, how often would this lead your program to close cases more quickly?
- Almost always
 - Often
 - Sometimes
 - Rarely

Your Program:

48. What are your days/hours of operation?

Monday- Friday:

Saturday:

Sunday:

49. Your caseworkers:

a. How many full-time equivalent caseworkers/ case planners does your program currently employ?

b. How many of these caseworkers have MSWs?

c. How many caseworker vacancies do you currently have?

d. What is the average salary for a caseworker?

Without an MSW: _____

With an MSW: _____

e. What is your caseworker to family ratio right now?

f. What do you think the caseworker to family ratio should be?

g. How many caseworkers have left your program this past year?

50. Your supervisors:

- a. How many full-time equivalent supervisors do you currently employ in your program?
- b. How many supervisory vacancies do you currently have?
- c. What is the average salary for a supervisor?
- d. What is your current supervisor to caseworker ratio right now?
- e. What do you think the supervisor to caseworker ratio should be?

51. Your other staff:

- a. How many parent aides do you currently have?
- b. How many clerical staff do you currently have?

52. What training is required for caseworkers before they start working with families?

Working with ACS:

53. What are the top 3 changes you would like to make to the way ACS works with, monitors, and provides technical assistance to your program?

1.

2.

3.

The Future:

54. If you could make any 1 change to the preventive services **system** in New York City, what would it be?

55. If you could have additional resources, what change would you make to **your own preventive services program**?

56. Before we end, we just wanted to ask you whether you think there is anything else that is important for us to know about your program or about preventive services in general that you think we should know for our survey?

Thank the Interviewee(s): We would like to thank you for taking the time to help us with our survey. We understand how busy you are and appreciate that you took the time to meet with us. We also want to thank you for all of the work you do for New York City's children and families.

APPENDIX 4: PREVENTIVE SERVICE SLOT REDUCTION BY COMMUNITY DISTRICT (CD)

	Current GP Slots	Projected GP Slots	GP # change	GP % change	Current FRP Slots	Projected FT/R Slots	FRP (FT/R) # change	FRP (FT/R) % change	Current Total GP and FRP Slots	Projected Total GP and FT/R Slots	Total # Change	Total % Change
Bronx CD 1	315	204	-111	-35.2%	56	50	-6	-10.7%	371	254	-117	-31.5%
Bronx CD 2	135	108	-27	-20.0%	28	30	2	7.1%	163	138	-25	-15.3%
Bronx CD 3	255	192	-63	-24.7%	38	50	12	31.6%	293	242	-51	-17.4%
Bronx CD 4	375	240	-135	-36.0%	66	60	-6	-9.1%	441	300	-141	-32.0%
Bronx CD 5	315	240	-75	-23.8%	44	60	16	36.4%	359	300	-59	-16.4%
Bronx CD 6	240	216	-24	-10.0%	40	50	10	25.0%	280	266	-14	-5.0%
Bronx CD 7	275	192	-83	-30.2%	30	50	20	66.7%	305	242	-63	-20.7%
Bronx CD 8	50	48	-2	-4.0%	10	10	0	0.0%	60	58	-2	-3.3%
Bronx CD 9	345	264	-81	-23.5%	52	70	18	34.6%	397	334	-63	-15.9%
Bronx CD 10	75	72	-3	-4.0%	13	20	7	53.8%	88	92	4	4.5%
Bronx CD 11	95	108	13	13.7%	10	30	20	200.0%	105	138	33	31.4%
Bronx CD 12	240	204	-36	-15.0%	23	50	27	117.4%	263	254	-9	-3.4%
Bronx Total	2,715	2,088	-627	-23.1%	410	530	120	29.3%	3,125	2,618	-507	-16.2%
Brooklyn CD 1	240	96	-144	-60.0%	30	20	-10	-33.3%	270	116	-154	-57.0%
Brooklyn CD 2	170	60	-110	-64.7%	20	20	0	0.0%	190	80	-110	-57.9%
Brooklyn CD 3	490	336	-154	-31.4%	50	80	30	60.0%	540	416	-124	-23.0%
Brooklyn CD 4	305	156	-149	-48.9%	50	40	-10	-20.0%	355	196	-159	-44.8%
Brooklyn CD 5	415	336	-79	-19.0%	70	70	0	0.0%	485	406	-79	-16.3%
Brooklyn CD 6	260	120	-140	-53.8%	25	10	-15	-60.0%	285	130	-155	-54.4%
Brooklyn CD 7	216	204	-12	-5.6%	15	20	5	33.3%	231	224	-7	-3.0%
Brooklyn CD 8	243	144	-99	-40.7%	30	30	0	0.0%	273	174	-99	-36.3%
Brooklyn CD 9	207	84	-123	-59.4%	22	20	-2	-9.1%	229	104	-125	-54.6%
Brooklyn CD 10	66	48	-18	-27.3%		0	10	10	66	58	-8	-12.1%
Brooklyn CD 11	81	60	-21	-25.9%	4	20	16	400.0%	85	80	-5	-5.9%
Brooklyn CD 12	71	72	1	1.4%	7	10	3	42.9%	78	82	4	5.1%
Brooklyn CD 13	135	108	-27	-20.0%	18	20	2	11.1%	153	128	-25	-16.3%
Brooklyn CD 14	235	156	-79	-33.6%	20	30	10	50.0%	255	186	-69	-27.1%
Brooklyn CD 15	71	60	-11	-15.5%	8	20	12	150.0%	79	80	1	1.3%
Brooklyn CD 16	265	228	-37	-14.0%	30	50	20	66.7%	295	278	-17	-5.8%
Brooklyn CD 17	100	180	80	80.0%	31	30	-1	-3.2%	131	210	79	60.3%
Brooklyn CD 18	120	144	24	20.0%	20	30	10	50.0%	140	174	34	24.3%
Brooklyn Total	3,690	2,592	-1,098	-29.8%	450	530	80	17.8%	4,140	3,122	-1,018	-24.6%

	Current GP Slots	Projected GP Slots	GP # change	GP % change	Current FRP Slots	Projected FT/R Slots	FRP (FT/R) # change	FRP (FT/R) % change	Current Total GP and FRP Slots	Projected Total GP and FT/R Slots	Total # Change	Total % Change
Manhattan CD 1	5	12	7	140.0%	0	0	0	0.0%	5	12	7	140.0%
Manhattan CD 2	0	12	12		0	0	0	0.0%	0	12	12	100.0%
Manhattan CD 3	300	156	-144	-48.0%	40	40	0	0.0%	340	196	-144	-42.4%
Manhattan CD 4	45	36	-9	-20.0%	5	10	5	100.0%	50	46	-4	-8.0%
Manhattan CD 5	5	24	19	380.0%	0	0	0	0.0%	5	24	19	380.0%
Manhattan CD 6	10	12	2	20.0%	2	0	-2	100.0%	12	12	0	0.0%
Manhattan CD 7	130	108	-22	-16.9%	30	20	-10	-33.3%	160	128	-32	-20.0%
Manhattan CD 8	32	36	4	12.5%	3	10	7	233.3%	35	46	11	31.4%
Manhattan CD 9	265	120	-145	-54.7%	50	30	-20	-40.0%	315	150	-165	-52.4%
Manhattan CD 10	356	228	-128	-36.0%	55	50	-5	-9.1%	411	278	-133	-32.4%
Manhattan CD 11	582	264	-318	-54.6%	45	60	15	33.3%	627	324	-303	-48.3%
Manhattan CD 12	330	180	-150	-45.5%	60	40	-20	-33.3%	390	220	-170	-43.6%
Manhattan Total	2,060	1,188	-872	-42.3%	290	260	-30	-10.3%	2,350	1,448	-902	-38.4%
Queens CD 1	196	96	-100	-51.0%	30	20	-10	-33.3%	226	116	-110	-48.7%
Queens CD 2	77	48	-29	-37.7%	15	10	-5	-33.3%	92	58	-34	-37.0%
Queens CD 3	114	120	6	5.3%	15	30	15	100.0%	129	150	21	16.3%
Queens CD 4	122	120	-2	-1.6%	20	20	0	0.0%	142	140	-2	-1.4%
Queens CD 5	110	72	-38	-34.5%	20	20	0	0.0%	130	92	-38	-29.2%
Queens CD 6	38	12	-26	-68.4%	3	10	7	233.3%	41	22	-19	-46.3%
Queens CD 7	105	72	-33	-31.4%	7	10	3	42.9%	112	82	-30	-26.8%
Queens CD 8	67	48	-19	-28.4%	7	10	3	42.9%	74	58	-16	-21.6%
Queens CD 9	118	120	2	1.7%	10	30	20	200.0%	128	150	22	17.2%
Queens CD 10	120	72	-48	-40.0%	22	20	-2	-9.1%	142	92	-50	-35.2%
Queens CD 11	25	12	-13	-52.0%	4	10	6	150.0%	29	22	-7	-24.1%
Queens CD 12	468	276	-192	-41.0%	53	70	17	32.1%	521	346	-175	-33.6%
Queens CD 13	115	144	29	25.2%	15	30	15	100.0%	130	174	44	33.8%
Queens CD 14	195	168	-27	-13.8%	19	40	21	110.5%	214	208	-6	-2.8%
Queens Total	1,870	1,380	-490	-26.2%	240	330	90	37.5%	2,110	1,710	-400	-19.0%
Staten Island CD 1	230	240	10	4.3%	20	70	50	250.0%	250	310	60	24.0%
Staten Island CD 2	35	60	25	71.4%	5	20	15	300.0%	40	80	40	100.0%
Staten Island CD 3	25	48	23	92.0%	5	10	5	100.0%	30	58	28	93.3%
Staten Island Total	290	348	58	20.0%	30	100	70	233.3%	320	448	128	40.0%
NYC	10,625	7,596	-3,029	-28.5%	1,420	1,750	330	23.2%	12,045	9,346	-2,699	-22.4%

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Since 1944, Citizens' Committee for Children of New York, Inc. (CCC) has convened, informed and mobilized New Yorkers to make the city a better place for children. CCC's approach to child advocacy is fact-based and combines the best features of public policy advocacy with a tradition of citizen activism. Our focus is on identifying the causes and effects of vulnerability and disadvantage, recommending solutions to problems children face and working to make public policies, budgets, services and benefits more responsive to children. Our mission is to ensure that every New York City child is healthy, housed, educated and safe.

CCC is a non-profit organization supported entirely by individuals, foundations and corporations.



CITIZENS' COMMITTEE for CHILDREN
OF NEW YORK INC

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