REVIEW OF THE CHILD PROTECTIVE SERVICES INTAKE PROCESS

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Contents

REVIEW OF THE OREGON DEPARTMENT OF HUMAN SERVICES CHILD PROTECTIVE SERVICES INTAKE PROCESS

EXECUTIVE SUMMARY

A. Background

- The "front-end" (intake) of the child protective services (CPS) process involves:
  - Receiving reports of abuse or neglect from reporters in the community (or from within DHS)
  - Screening the reports
  - Cross-reporting to law enforcement
  - Assessing (investigating) those reports where there is a concern for a child's safety or other key risk factors are present
- In 2002 the tragic deaths of two teenage girls raised concerns about DHS's procedures relating to the front-end of the child protective services process, including responding to telephone reports and notifying law enforcement agencies.
- DHS responded quickly to these concerns by reviewing the particular circumstances in the deaths of these two girls, reporting the findings, and rapidly implementing a number of immediate and planned changes in child abuse report screening and assessment and notification of law enforcement agencies.
- Now that many of these changes are in place or being tested, DHS has initiated a more thorough review of its child protective policies and processes throughout the state. As part of that detailed review, Public Knowledge, Inc. examined current and planned procedures in the intake "front end" of the process.

- The review included:
  - A review of relevant previous reports and studies provided by DHS
  - Site visits to four Service Delivery Areas (SDA's), including six branch offices
  - An analysis of certain 2001 data provided by DHS or obtained in the site visits
- The objectives of the review included:
  - Documenting current child protective intake practices in the branches visited
  - Assessing the impact of new and proposed changes in DHS's policies and procedures for responding to child abuse reports
  - Identifying possible improvements in DHS practices
- Because the review was narrowly focused on the child protective services intake process there are several essential elements of child welfare services that are not addressed in the report, including ongoing child protection services, substitute care, and permanency services. Nor does the report directly address the integration of child protection services with other DHS services, a key objective of the recent DHS reorganization.

B. Overview of Conclusions and Recommendations

- The provision of effective child protective services requires a careful balance between prescriptive policy direction and allowing scope for the exercise of sound professional judgment.
- We found that DHS has the policies, systems, and procedures in place needed to address the key performance requirements of an effective child protection intake system.
- We also found that the branches were making diligent efforts to comply with DHS policies.

- However, we concluded that there are opportunities for improvement related to several of the details and features of the policies, systems, and procedures.
- We have several recommendations that we believe would improve the effectiveness of DHS in protecting children from abuse and neglect, as shown in the exhibit on the following pages.

Develop a comprehensive child protection management reporting system.	
Conclusions	**Recommendations**
▪ We found no uniform system of management reports across the branches that we visited. ▪ We could identify no formal DHS performance measures pertaining to the child protection intake process and supported by routine reports of branch performance, other than the federally required indicator of repeat abuse. ▪ Without good performance measures and related management reports, the DHS capability to assure effective child protective services is constrained ▪ The DHS data and previous studies show wide variation across branches in the intermediate outcomes of the child protection intake process. ▪ FACIS caseload listings by worker are currently useful to many supervisors, but further enhancements would add value. ▪ While the branches compiled various reports pertaining to workloads, none had all of the information that we would judge to be sufficient.	▪ DHS should specify formal performance measures for the child protection intake process, set performance targets where sufficient reliable historical data are available, and distribute periodic reports to SDA's showing branch comparisons on the measures, as well as certain other comparisons. ▪ DHS should make further enhancements to FACIS caseload reports. ▪ DHS and the SDA's should routinely report certain workload and productivity statistics. ▪ DHS managers should provide appropriate training on the reporting system to SDA managers, program managers, and supervisors (e.g., through periodic regional or statewide forums) and expect them to use the reports. ▪ DHS should continue to support Mobius but should phase-out distribution of the "green bar" reports.

Refine the application of screening and assessment guidelines.	
Conclusions	**Recommendations**
▪ There are likely differences across branches in the criteria applied to screen and assess reported incidents of child abuse and neglect. ▪ DHS is addressing this concern and has undertaken a "Guided Assessment Project" (GAP) to achieve more consistent and timely decisions. ▪ Based on initial pilot test observations, the GAP template could be improved. ▪ Completion of safety assessments within 24 hours of report receipt appears achievable and desirable on a majority of cases, but not all, provided that sufficient staffing is available.	▪ DHS should commit the resources to necessary to refine the GAP template tool to facilitate the recording of a case narrative and to keep the completion time requirements manageable (we understand that related refinements are underway). ▪ If more screening time is required with the GAP template, then DHS should add staff accordingly. ▪ If an extensive template proves too time-consuming for use on every case, DHS should consider using a comprehensive template for training and quality assurance purposes. ▪ If DHS establishes a standard of completion of safety assessments within 24 hours it should also set a performance target (e.g., 90 percent) that recognizes that there will be exceptions.

Enhance the information available to screeners.	
Conclusions	**Recommendations**
▪ Screeners at the various branches do not have ready access to all of the public agency information that could be useful to them as they conduct their screenings. ▪ Law enforcement information, in particular, has proven valuable to the Multnomah Hotline, where it has been accessible. ▪ Even where there is technical access, the access can often be cumbersome for the workers making the inquiries. ▪ FACIS system unreliability – workers report that the system often is "down" – impairs screening activity.	▪ DHS should expand LEDS access to other child welfare branches beyond the Multnomah Hotline (LEDS inquiry can be centralized or regionalized). ▪ DHS should encourage other SDA's to develop agreements and systems that allow child welfare branch access to local police systems. ▪ DHS should develop a plan to expand access to other useful systems. ▪ DHS should continue to improve the user interface with these other systems, ideally establishing automated queries through FACIS. ▪ DHS should take the steps necessary to significantly reduce FACIS "downtime."

Refine and adhere to caseload and staffing guidelines.	
Conclusions	**Recommendations**
▪ Staff workloads are a critical factor affecting the quality, accuracy, and timeliness of child protection decisions. ▪ A service model that relies heavily on clinical consultation from supervisors to assure quality is weakened if supervisory workloads limit the availability of supervisors for real-time consultations. ▪ Actual staffing levels in the branches vary notably from the guidelines used to identify the number of staff needed statewide, with both supervisory ratios and caseworkers' caseloads generally higher than the guidelines. ▪ At least some SDA's that include multiple branches have developed their own methods for allocating workers among branches. ▪ The presence of a substantial number of highly aged cases in the open caseload makes use of the open caseload data to drive staffing problematic.	▪ DHS should adhere to the statewide staffing guidelines in distributing staff to SDA's, and SDA's should adhere in distributing staff to branches. ▪ To make the distribution formula credible, DHS should "clean-up" data reflecting highly aged cases (we understand that this is being done). ▪ SDA's should develop guidelines for screening staffing if they do not already have them. ▪ DHS and the SDA's should prepare periodic reports to monitor staffing and workloads in relation to the guidelines, and take corrective actions, as appropriate.

Refine law enforcement reporting protocols.	
Conclusions	**Recommendations**
▪ The recent temporary rule requiring tight time deadlines for cross-reporting child abuse cases to law enforcement agencies (LEA's) has, for the most part, not added value from either a law enforcement or a child protection perspective. ▪ The procedures that branches use to send reports to LEA's and to receive confirmation of receipt require more process steps than the ideal. ▪ Appropriate cover sheet (or e-mail) information can sometimes be more useful to law enforcement than more detailed information contained in Form 307s. ▪ Nevertheless, the temporary rule to set deadlines on LEA reporting represented a reasonable temporary approach to deal with a critical matter.	▪ DHS should continue to require branches to immediately telephone appropriate law enforcement personnel where a child's safety may be immediately or imminently at risk. ▪ DHS should require timely reporting of other child abuse reports received to the appropriate LEA, but the current temporary rule deadlines should be lengthened. ▪ Since local circumstances differ, details of the reporting and confirmation procedures should be left to the branches and the LEA's to work out (and to document in written protocols), but the local agencies should consider electronic methods that are more streamlined than reliance on fax transmissions.

Enhance quality assurance procedures.	
Conclusions	**Recommendations**
▪ Several quality assurance checks are currently built into the CPS intake process; the availability of supervisors for real-time consultation is a key element. ▪ Cases that are “logged” or “screened out” typically do not receive the same review attention as cases that are assessed. ▪ One key component of quality assurance, branch reviews, has been interrupted. ▪ As they are currently conducted, supervisory reviews of assessments are not as beneficial as they could be. ▪ Branches appear to be inconsistent in the screening and assessment criteria that they apply.	▪ In order to assure that supervisors are available for real-time case consultation, SDA’s should protect against supervisory ratios above a reasonable range and against assignment of too many duties to supervisors. ▪ DHS should strengthen the supervisory review process for assessments through use of a structured review instrument on a sample of cases, with summary reporting of the findings. ▪ DHS should continue an independent quality assurance process (branch reviews). ▪ Special procedures should be established to assure that "logged” cases and “screened out” cases receive sufficient review.

Improve telephone systems.	
Conclusions	**Recommendations**
▪ The limitations of the telephone systems in the branches constrain the efficiency of screening operations. ▪ Other than routing calls, pre-screeners do not add value to the report receipt process that cannot be readily achieved by the screeners. ▪ For many persons knowing what number to call to report child abuse could be a challenge. Telephone directory and Internet listings assume a familiarity with the organizational structure.	▪ The larger SDA's should explore the feasibility of upgraded phone systems. ▪ When appropriate phone systems are in place, the larger branches should eliminate the pre-screening step in the report receipt process. ▪ The larger branches should use the automated statistics features of upgraded telephone systems to generate reports for management use to plan screening staffing levels by time of day. ▪ DHS should make the numbers to call to report child abuse more accessible.

REVIEW OF THE OREGON DEPARTMENT OF HUMAN SERVICES CHILD PROTECTIVE SERVICES INTAKE PROCESS

A. Background

1. Introduction

- The Oregon Department of Human Services (DHS) provides child protective services to children and families in the state.
  - This service is provided by DHS field offices in 16 Service Delivery Areas (SDA's) covering the state, organized under the DHS Community Human Services group.
  - Child welfare programs, including child protective services, are also supported by the DHS Children, Adults & Families group, which promulgates child protective services policies, for example.
  - The "front-end" (intake) of the child protective services (CPS) process involves receiving reports of alleged abuse or neglect from reporters in the community (or from within DHS), screening the reports, cross-reporting to law enforcement, and assessing (investigating) those reports where there is a concern for a child's safety or other key risk factors are present.
- In 2001 there were eight reported fatalities in Oregon related to child abuse or neglect, with three of these involving families that had an open DHS child welfare case at the time of the death. This was the lowest reported number of child and abuse neglect fatalities in many years (although Oregon's statistical methodology changed in 2001 to align better with other states).[1]

[1] Source: "The Status of Children in Oregon's Child Protective System, 2001," published by the Oregon Department of Human Services (http://www.scf.hr.state.or.us/cps/index.htm).

- However, in 2002 the tragic deaths of two teenage girls raised concerns about DHS's procedures relating to the front-end of the child protective services process, including responding to telephone reports and notifying law enforcement agencies.
- DHS responded quickly to these concerns by reviewing the particular circumstances in the deaths of these two girls, reporting the findings, and rapidly implementing a number of immediate and planned changes in child abuse report screening and assessment and notification of law enforcement agencies.
- Now that many of these changes are in place or being tested, DHS has initiated a more thorough review of its child protective policies and processes throughout the state. As part of that detailed review, Public Knowledge, Inc. examined current and planned procedures in the intake "front end" of the process – the reporting of suspected child abuse and neglect, the initial screening of these reports, cross-reporting to law enforcement agencies, and further assessment of suspected cases.

2. Scope and Objectives

- The review included:
  - A review of relevant previous reports and studies provided by DHS
  - Site visits to four SDA's (six branch offices)
    - Marion
    - Multnomah (Hotline, Gresham, and St. John's) [2]
    - Hood River
    - Klamath

[2] We added St. John's because the branch is a pilot site for a new "24 hour guided assessment" process. We focused primarily on that process in our visit to the branch.

  - An analysis of certain 2001 data provided DHS or obtained in our site visits
- On the branch visits we conducted the following activities:[3]
  - Interviewed selected branch supervisors and staff
  - Interviewed Service Delivery Area managers and program managers
  - Interviewed local law enforcement personnel
  - Observed staff performing screening and other activities
  - Collected and reviewed various documents to promote our understanding of how the front-end of the child protective services process works at each branch
  - Conducted exit meetings with supervisors and managers to review our preliminary findings
  - Provided written summaries of our findings to each branch, and made revisions based on branch comments (to promote accuracy)
- The objectives of the review included:
  - Documenting current child protective intake practices in the branches we visited
  - Assessing the impact of new and proposed changes in DHS's policies and procedures for responding to child abuse reports
  - Identifying possible improvements in DHS practices

[3] We applied a structured review guide to promote consistency of the information we collected across the different branches. However, our activities varied slightly by branch, depending on the processes conducted at the branch and the level of branch activity occurring during our visits. At St. John's we focused primarily on a new "Guided Assessment" process and did not conduct a full-scope review.

- Because the review was narrowly focused on the child protective services intake process there are several essential elements of child welfare services that are not addressed in the report, including ongoing child protection services, substitute care, and permanency services. Nor does the report directly address the integration of child protection services with other DHS services, a key objective of the recent DHS reorganization.

B. Conclusions and Recommendations

1. Underlying Philosophy

- Because child protection is a critical service and because of the serious consequences of errors, DHS and other child welfare agencies seek to insure the quality, timeliness, and accuracy of the process both through detailed specifications – laws, regulations, and policy – and through supervisory oversight.
- However, prescribing the process in considerable detail may have certain disadvantages.
  - For example, overly prescribing details may make it more difficult for workers to weigh which aspects of what they do are the most important, and thus to devote sufficient attention to these aspects of their jobs.
  - Also, a prescriptive process tends to become labor intensive for workers and supervisors – an important factor when staff resources are limited – and further constrains their ability to deal effectively with workloads (for instance, to ramp up to meet unexpectedly high volumes of calls).
- The prescriptive dimension of child protective services is both desirable and inevitable, but it must be balanced with systems that give workers and supervisors sufficient flexibility to apply sound professional judgment.
  - No prescriptive approach, no matter how detailed, can be expected to adequately address all of the circumstances that child protection staff will encounter in responding to alleged abuse and neglect reports.
  - Front-line workers and supervisors require not only policy direction, but the tools necessary to help them make sound decisions consistent with the policy.

- A balanced model should:
  - Recognize that the most critical resource is experienced professionals on the front-line – screeners, “go-out” assessment workers, and supervisors – capable of making accurate and timely decisions that balance child safety and family preservation.
  - Provide more structure and support for less experienced workers than for proven professionals.
  - Recognize screening and assessment as "clinical practices" that require interviewing/listening skills, sound judgment, and clinical oversight and guidance.
  - Provide workers improved information tools to make sound decisions.
  - Assist workers to devote proper attention and effort to those children whose safety is most at risk.
  - Provide supervisors the tools needed to effectively review the quality of worker performance.
  - Provide managers the tools needed to effectively review overall program performance.
  - Recognize the importance of both clinical quality control and management oversight.

2. A Model Child Protection Intake Process

- The exhibit on the following pages outlines the components of a child protection intake process, the requirements to perform each component effectively, and some system features that support the achievement of the performance requirements.
- The recommendations that follow the exhibit are based on this model.

	KEY PERFORMANCE REQUIREMENTS	***SYSTEM FEATURES THAT HELP TO ACHIEVE THESE REQUIREMENTS***
Report Receipt	▪ Community awareness of when and how to report ▪ Minimal wait to reach the appropriate person ▪ 24 hour/seven day response	▪ Effective use of the Internet, phone directories, and other community information resources ▪ Enhanced phone systems that provide real time information, manage call distribution to available workers, and support estimations of staffing requirements
Screening	▪ Immediate response to high risk situations ▪ Reasonable timeliness of decisions on other situations ▪ Sound screening decisions – no allegations with children at risk screened out and no reports inappropriate for child protection response screened in	▪ Screening guidelines that provide consistent direction but do not constrain experienced workers' ability to do the job ▪ Immediate access to relevant information systems, such as LEDS ▪ Real-time consultation from experienced supervisors ▪ Periodic reviews of screened-out cases as well as screened-in cases
Law Enforcement Interface	▪ Effective coordination with law enforcement on immediate responses ▪ Timely reporting to law enforcement agencies (LEA's) on cases of potential interest to the LEA's ▪ Timely reporting from LEA's to child protection on appropriate cases	▪ Protocols that promote coordination of law enforcement, child protection, medical, and school professionals in interviewing alleged victims of child abuse ▪ Simplified cross-reporting to LEA's through effective triaging and electronic means ▪ Time deadlines that fit the nature of the cases that are being cross-reported

	KEY PERFORMANCE REQUIREMENTS	***SYSTEM FEATURES THAT HELP TO ACHIEVE THESE REQUIREMENTS***
Assessment	▪ Sufficient thoroughness; reasonable and prudent efforts made to obtain relevant information ▪ Timeliness of decisions ▪ Decisions consistent with the information and with policy	▪ Assessment guidelines that provide consistent direction but do not constrain experienced workers' ability to do the job ▪ Assessment timeliness requirements that balance thorough information gathering with responsiveness ▪ Reasonable assessment caseloads ▪ Accessible consultation from experienced supervisors
Management Reporting	▪ Information that enables management to make sound judgments regarding overall performance and other matters, such as staffing requirements ▪ Information that enables supervisors to manage caseloads and monitor quality and timeliness ▪ Use of the information to identify targeted improvements where needed	▪ Real-time information on call volumes, call wait times, etc. (for larger offices) ▪ Reports at both the detailed (by worker) and summary (by unit) level on caseloads and case status (pending deadlines, overdue, etc.) ▪ Reports of quality assurance findings ▪ Designation of specific performance measures that will be tracked and monitored, with comparisons across local offices ▪ Management reports on overall program performance including workload, timeliness, quality assurance results, assessment outcomes, etc., available to program managers and SDA managers

3. Overview of Conclusions and Recommendations

Overview

- We found that DHS has the policies, systems, and procedures in place needed to address the key performance requirements of an effective child protection intake system.
- We also found that the branches were making diligent efforts to comply with DHS policies.
- However, we concluded that there are opportunities for improvement related to several of the details and features of the policies, systems, and procedures.
- We have several recommendations that we believe would improve the effectiveness of DHS in protecting children from abuse and neglect::
  - Develop a comprehensive child protection management reporting system.
  - Refine the application of screening and assessment guidelines.
  - Enhance the information available to screeners.
  - Refine and adhere to caseload and staffing guidelines.
  - Refine law enforcement reporting protocols.
  - Enhance quality assurance procedures.
  - Improve telephone systems.

4. Develop a Comprehensive Child Protection Management Reporting System

Related conclusions

- We found no uniform system of management reports across the branches that we visited. Instead, the reports used by managers and supervisors depended largely on their own personal familiarity with available data, their ability to generate related reports, and their interest in having and using the information.
- We could identify no formal DHS performance measures pertaining to the child protection intake process and supported by routine reports of branch performance, other than the federally-required indicator of repeat maltreatment.
  - While there are clearly timeliness expectations embedded in DHS policy, we found no branches using summary level reports indicating how well they were meeting timeliness deadlines.
  - While data on various intermediate outcomes in the intake process are available – including the percent of referrals assessed and the percent of assessments founded, for example – we found only one branch that had a report showing how it compared to others on these measures.
  - Branch personnel reported that regional meetings were formerly one means of reviewing certain comparative performance data across branches, but that these meetings no longer occur.
- Without good performance measures and related management reports, the DHS capability to assure effective child protective services is constrained:
  - Managers and supervisors do not have all of the information they need to guide program operations (other than individual case reviews and caseload reports).
  - It is difficult for DHS to objectively determine whether changes in procedures have achieved any improvement over the previous procedures.

- The DHS data and previous studies show wide variation across branches in the intermediate outcomes of the child protection intake process.
- FACIS caseload listings by worker are currently useful to many supervisors, but further enhancements would add value.
- While the branches we visited compiled various reports pertaining to workloads, none had all of the information that we would judge to be sufficient.
- The report generation capabilities of branch offices was impaired in at least some cases when the office manager position was eliminated.

Recommendation detail

- DHS should specify formal performance measures for the child protection intake process.
  - The federally-required repeat maltreatment measure should be included, with breakdowns by:
    - Cases that were previously assessed
    - Cases that were previously "screened out"
    - Cases that were previously "logged"
  - Timeliness measures should be included.
    - Percent of assessment face-to-face visits within 24 hours (for those required to be within 24 hours) and within five business days (for those required to be within five business days)
    - Percent of assessments closed within 30 days
    - Percent of any other actions meeting deadlines established in DHS policy [4]

[4] If deadlines remain for reporting to law enforcement, for example.

  - Screening and assessment volume and outcome measures should be included.
    - Number and percentage of reports "logged"
    - Number and percentage of reports "referred"
    - Number and percentage of referred reports assessed
    - Percentage of assessments determined to be founded, unfounded, or unable to determine
- DHS should set performance targets for the measures where sufficient reliable historical data are available.
  - A federal target applies as a maximum for repeat maltreatment.
  - To allow for legitimate exceptions, the targets for percentages complying with timeliness deadlines should probably not be 100 percent, but should be close enough to it to achieve the policy intent of the deadlines (for instance, the federal target for similar measures is 90 percent).
  - For the screening and assessment volume and outcome measures there is no single target level that is necessarily the "desirable" one since the nature of the reports received will vary by community. However, DHS should look first to the extremes, those branches that are either very high or very low in relation to the norms, and seek to understand the reasons for the variance.
- DHS should produce and distribute to all SDA's monthly reports that track the performance measures, and quarterly reports showing how each SDA compares to the others statewide.[5]
- DHS should also regularly produce and distribute other comparative reports that would be useful to SDA managers, program managers, and supervisors.[6]

[5] By "distribute" we do not necessarily mean distribution of hard copies. Electronic access would be preferable, provided that all report users know how to execute the electronic access.

- An annual comparative report showing child abuse report sources (schools, law enforcement, medical, etc.) could be helpful in identifying community awareness issues.
- An annual comparative report showing the reported types of abuse (physical abuse, sexual abuse, threat of harm, etc.) could be helpful in identifying possible inconsistency issues in how the categories are applied in the various SDA's (particularly "threat of harm").
- Other comparative reports that present descriptive statistics that characterize the abuse and neglect reports received, such as the age and gender of the alleged child victims, could be helpful in planning actions to address community issues.
- Reports showing SDA trends in the statistics noted above would also possibly be helpful in identifying emerging community issues.

- DHS should make further enhancements to FACIS caseload reports.
  - The recent addition of contact date information enables supervisors to better track the timeliness of face-to-face contacts, provided that workers enter the information in a timely manner. To make the information timely and accurate, worker education is needed.
  - A summary report by worker and by unit, showing the number of cases currently in each status category and sorted into aging groups (specified categories for the number of days since receipt of the report, including "overdue") would paint an overall picture that is easier for managers to assimilate than are the detailed caseload listings.
  - Refresher training on how to use the FACIS reporting capabilities, especially any features recently added, would be useful for many supervisors.

[6] The statistics noted here appear in the annual report "The Status of Children in Oregon's Child Protection System," which presents only statewide data and does not show comparisons across SDA's.

- DHS and the SDA's should routinely report certain workload and productivity statistics.
  - Some of the data are available in FACIS (and overlap with the recommended performance measures); for example:
    - Number of reports received
    - Number of reports screened
    - Number of assessments
  - Other data can be compiled locally, provided that the necessary procedures are established.
  - Certain branches already manually compile data such as:
    - Call volumes
    - Number of collateral contacts made in screening
    - Number of law enforcement data inquiries made
    - Number of police reports received
  - More sophisticated telephone systems could provide call volumes and other call characteristics by time of day (see the recommendation pertaining to telephone systems).
- DHS should provide training to SDA managers, program managers, and supervisors on the performance reporting and workload/productivity reporting systems; for instance.
  - Discuss the reporting system and comparative performance results at periodic regional or statewide forums.
  - Incorporate the performance reporting system into future branch reviews.
- DHS should continue to support Mobius reports.

  - The "self-service" capacity of the system is a good feature for those who know how to use it, but this knowledge appears to be currently limited among those in the branches.
  - More training would be desirable if the system is to be sustained.
- DHS should phase-out the distribution of "green bar" listings to the field.
  - Only a minority of supervisors and managers in the field appear to be using these reports.
  - The same or similar information is available directly from FACIS.
  - Supervisors believe that the FACIS data are more current, and therefore more accurate.
- To produce the reports identified above data system revisions may be necessary in some cases, but most of the data needed are already available.
- The reliability of the reports will be sensitive to worker training and promptness in entering the relevant data (for instance, timeliness information drawn from FACIS will be accurate only if workers promptly enter completion dates).
- SDA managers, program managers, and supervisors should use the reports specified above to manage operations, to identify needs for management actions or for further research, and to evaluate the applicable actions.

5. Refine the Application of Screening and Assessment Guidelines

Related conclusions

- There are likely differences across branches in the criteria applied to screen and assess reported incidents of alleged child abuse and neglect.
  - The 2001 percentages of reports "logged," referred, and assessed varied notably by county.

- There was less variation in the percentage of cases assessed that were determined to be founded, but the percentage coded as "unable to determine" varied widely across counties.
- A 2001 federal "Child and Families Services Review" reported that stakeholders and reviewers "noted concerns about consistency related to screening decisions, response time designations, application of threat of harm, and investigative/assessment disposition."
- A 2001 NRCCM study reviewed cases at selected branches and concluded that there were likely inconsistencies.
- Certain branch reviews in 1998-99 expressed concerns about the inconsistent over-use of "threat of harm" as a type of abuse, and the 2001 NRCCM study raised a similar concern.
- Possible screening inconsistency appears to be an issue nationally (2000 Urban Institute study).
- While both screeners and assessment workers appeared familiar with the various screening and assessment guidelines promulgated by DHS and may have used the relevant checklists directly earlier in their careers, the workers we talked with screened and assessed based on their professional judgment and experience and did not directly complete criteria checklists as they conducted their case interviews (with the exception of the GAP pilot at the Multnomah Hotline and St. John's).

- In response to findings such as those noted above, DHS has undertaken a "Guided Assessment Project" (GAP), now in a pilot test phase, to help achieve more consistent and timely case decisions. Early observations suggest that this process will need to be refined if it is to achieve its goals without negatively affecting other elements of child welfare services.
  - Completion of the computer template used in the guided assessment may require more time in screening than the current norm, meaning that the added staff time for screening will need to be drawn from some other aspect of child welfare services.

  - Workers expressed concern that the template does not provide a way to readily record a single unified narrative of the case. They believe that such a narrative "story" is useful to promote understanding of the case when it is passed to another worker and that it refreshes them when they pick up the case again after time has passed.
  - DHS plans an evaluation of the pilot before the guided assessment process is implemented statewide.
- Completion of safety assessments within 24 hours of report receipt appears achievable and desirable on a majority of cases, but not all, provided that sufficient staffing is available.
  - An NRCCM review showed that little, if any, useful information is added on most cases when screenings or assessments are extended.
  - The St. John's branch reports that it has been able to achieve the 24 hour completion target on a majority of its assessments (although back-up has been needed from another branch recently).
  - There will be a minority of cases where completion within 24 hours is either not possible (e.g., unable to locate the child or the family) or not desirable (e.g., safety not immediately at risk and a need to wait for information from a key collateral).

<u>Recommendation detail</u>

- DHS should commit the resources to necessary to refine the GAP template tool (we understand that certain revisions are underway); for example:
  - Modification of the template to include a place for a unified case narrative
  - Modification of the screening template to reduce the average completion time

- The evaluation of the Guided Assessment Project should determine how long screenings require using the GAP template versus former methods. If the added time required is material, DHS should project the potential staffing impact and should make staffing adjustments accordingly.
- The evaluation, if the GAP is to be credible to workers, should also assess workers' opinion on issues such as whether the GAP:
  - Improves their decision-making skills
  - Helps them be more consistent in their work
  - Helps them feel more comfortable with their assessment
- DHS should consider two approaches to achieve the benefits of the uniform guided assessment template while managing the potential workload impact (these are not mutually exclusive):
  - Use the guided assessment template as a training tool for new workers, requiring them to use it through an established probationary period, but allow experienced workers to use a template that is less time consuming.
  - Use the guided assessment template as a quality assurance tool, as the checklist to guide reviews of a sample of cases by supervisors or others. Otherwise allow experienced workers to use a template that is less time consuming.
- If DHS establishes a standard for completion of safety assessments within 24 hours it should also set a performance target (e.g., 90 percent) that recognizes that there will be exceptions.
  - The percentage completed within 24 hours should be one of the performance measures that DHS routinely tracks (see the management reporting recommendations above).
  - A supervisor should approve any where more than 24 hours will be allowed and document the reason for the exception.

- DHS should retain a deadline for the exceptions (e.g., within five business days).

6. Enhance the Information Available to Screeners

Related conclusions

- Screeners in the various branches do not have ready access to all of the public agency information that could be useful to them at the time they conduct their screenings.
  - Only the Multnomah Hotline has online access to the State's Law Enforcement Data System (LEDS) and to local police systems to check criminal histories on persons identified in reported cases of child abuse and neglect.
  - Some, but apparently not all, branches are able to access other State systems such as OJIN, Motor Vehicles, Support Enforcement, and Probation systems. [7]
  - Just one branch we visited indicated that it could access the county jail information system.
  - One uniform capability is that all of the branches are able to identify whether a report relates to an existing Self-Sufficiency case.
- Law enforcement information, in particular, has proven valuable to screening and assessment workers in Multnomah County.
- Even where there is technical access to certain other public agency systems, the access can often be cumbersome for the workers making the inquiries.
  - Except for certain elements of Self-Sufficiency, the access capabilities require entry into systems other than FACIS.

[7] In some case the access limitation may not be that the system is not technically accessible, but rather that branch staff are not familiar with how to do it.

  - The LEDS access at the Multnomah Hotline requires the assigned staff to use separate terminals (distinct from their desktop computers), and to prepare hand-written notes from the terminal screen.
- FACIS system unreliability – workers report that the system often is "down" – impairs screening activity. To avoid losing information should FACIS go "down" , workers typically record information in hand-written notes during a telephone call and then enter that information into FACIS after they complete the call.

Recommendation detail

- DHS should expand LEDS access to other child welfare branches beyond the Multnomah Hotline.
  - LEDS inquiry staff need not be present in all of the branches served, but can be centralized at the Multnomah Hotline or at other locations, provided that staffing and equipment are augmented to handle additional volumes of inquiries.
  - The communication between the branch and the LEDS inquiry site should preferably be electronic rather than phone and fax, although if necessary, phone and fax could work in the interim until more efficient methods are established.
  - This recommendation pertains directly to the concerns that prompted this review, identifying the criminal history of alleged child abuse perpetrators to help branch staff assign an appropriate priority to the reports received.
- DHS should encourage other SDA's (in addition to Multnomah) to develop agreements and systems that allow child welfare branch access to local police systems to identify the reported incident history of alleged perpetrators of child abuse.
- DHS should determine what other public agency systems have proven the most useful to those who have used them, and should develop a plan to assure that all branches have access to these systems and that staff know how to use them.

- DHS should continue to improve user interfaces to make workers' access to these other systems more seamless. The ideal would be a capability within FACIS to automatically query other selected systems once perpetrator, victim, and family information is entered.
- DHS should take the steps necessary to significantly reduce FACIS "downtime." However, some tolerance of minimal downtime may be needed to keep the costs of system improvements manageable.

7. Refine and Adhere to Caseload and Staffing Guidelines

Related conclusions

- Staff workloads – for screeners, "go out" assessment workers, and supervisors – are a critical factor affecting the quality, accuracy, and timeliness of child protection decisions.
- A service model that relies heavily on clinical consultation from supervisors to assure quality is weakened if supervisory workloads limit the availability of the supervisors for real-time consultations.
- While there are statewide guidelines to estimate the number of staff needed for various child welfare functions, the actual staffing at the branches we visited differed notably from the guidelines.
  - Most supervisors had more than 9.5 caseworkers and SSA's in their units.
  - Many assessment workers had notably more than 14 open cases, but some also had less.
  - We identified no formal guidelines for the number of screeners. [8]
- At least some SDA's that include multiple branches have developed their own methods for allocating workers among branches, but these methods are not necessarily consistent with the State formulas nor consistent across SDA's.

[8] Although certain branches may have an informal guideline, such as 20 calls per screener per day.

- Use of open caseload data to drive staffing is problematic if a significant number of open cases are highly aged and not receiving worker attention. There is some evidence that this is an issue with respect to at least some SDA's.

Recommendation detail

- In the absence of a more credible model, DHS should distribute staffing funds to each SDA based on the ratios applied to determine statewide staffing (we understand this to be the current plan). Some "clean-up" of highly aged assessment cases will be required to make this distribution credible (we understand that this is being done).
- SDA's should develop guidelines for screening staffing if they do not already have them.
  - If only assessment positions, and not screeners, are allocated to SDA's via the DHS formula, any screening positions established in the SDA will most likely need to be drawn from assessment.
    - To achieve balance with the DHS formula, this will increase the required number of cases per assessment worker
    - One rationale for screening is that it can help to limit the number of cases assigned to assessment workers.
  - Automated "call center" telephone equipment could better support sound determinations of the number of screeners required (including by time of day), especially in the larger SDA's (see the telephone system recommendation below).
- Most importantly, DHS and the SDA's should *adhere* as closely as possible to the established guidelines, which were presumably built on the best professional judgment in the circumstances (in the absence of more credible data and given a recognition that funding will likely be limited).

- To monitor staffing DHS should prepare periodic reports (e.g., semi-annually) that compare actual staffing by SDA to the guidelines.
  - The most recent caseload data should be applied in these comparisons.
  - DHS should take corrective actions where staffing appears to be significantly out of line with the guidelines.
- The SDA's should also prepare monthly workload reports.
  - These reports should include:
    - The number of screenings conducted per screener for the month
    - The number of assessments completed per assessment worker for the month
    - The number of caseworkers, SSA's, and clerical staff assigned to each supervisor
  - Using these reports, SDA's should monitor screener and assessment worker workloads by worker, as well as supervisory ratios, and should take corrective actions where appropriate.

8. Refine Law Enforcement Reporting Protocols

Related conclusions

- The recent temporary rule requiring tight time deadlines for cross-reporting child abuse cases to law enforcement agencies (LEA's) has, for the most part, not added value from either a law enforcement or a child protection perspective.
  - Just as previously, the child protection branches continue to notify LEA's immediately on immediate response (IR) cases, and these are the only cases (or very nearly the only cases) to which law enforcement will respond to immediately.

- Other reports are not likely to generate a law enforcement response the same day, even though the child protection branch is sending them within the one-hour and three-hour deadlines.
- LEA's still expect the child protection branches to call their attention to those cases that should likely receive LEA attention, just as they did in the past. This is only a minority of the cases sent by the branches to LEA's each day.
- Some LEA's may wish to enter the cases received into their own data systems, but same day timeliness is not critical for this purpose (other than for immediate response cases).

- The procedures that branches use to send reports to LEA's and to receive confirmation of receipt require more process steps than the ideal .
  - All of the branches we visited, with the exception of the Multnomah Hotline (which is co-located with LEA representatives) were using fax transmissions to report to LEA's, and receiving confirmation of receipt back either by fax or phone.
  - Depending on the branch and the LEA, this process could involve many of the following steps, for example: [9]
    - Determining which LEA has jurisdiction
    - Preparing a cover sheet to go with the fax
    - Attaching a Form 307 to the cover sheet
    - Sending the fax transmission
    - Entering information on a fax transmission log (some branches have more than one log)
    - Printing from the sending fax machine a confirmation that the transmission went through

[9] No branch that we visited performs all of these steps, but each performs a majority of them.

- Twice-a-day initialing by the supervisor on the transmission log
- Calling the LEA to inform them that the fax was sent and checking to see if it was received
- LEA photocopying of the fax for internal LEA distribution
- Sending the daily log by fax to the LEA to for a check to confirm that all of the reports were received
- LEA initialing the cover sheet of each fax and returning it by fax to the branch to confirm receipt
- LEA calling back to the branch to confirm that a fax was received or that the transmissions indicated on the daily log either were or were not all received

- Appropriate cover sheet (or e-mail) information can sometimes be more useful to law enforcement than more detailed information contained in Form 307s.
  - A key item for LEA's is the identity of the alleged perpetrator, if known. It is helpful if this information is placed where the LEA can easily locate it.
  - Check-boxes to classify the nature of the report can aid the LEA to readily identify whether the report is one that it should be interested in (the branches we visited are using checkboxes, but they could be refined).
- Nevertheless, the temporary rule to set deadlines on LEA reporting and to require confirmation procedures represented a reasonable temporary approach to deal with a critical matter. Based on this review and other information developed since the issuance of the temporary rule, DHS can now refine its cross-reporting policy to better assure that both LEA and child protection objectives are efficiently and effectively achieved.

Recommendation detail

- DHS should continue to require branches to immediately telephone appropriate law enforcement personnel where a child's safety may be immediately or imminently at risk.
  - In Multnomah County, if the case is an emergency, the hotline should call the appropriate LEA before referring the case to the appropriate branch.
  - If the case is not an emergency, the hotline should first notify the appropriate branch and then branch staff should notify law enforcement. This approach, which was used formerly but recently changed, will allow the child protection assessment worker and the law enforcement official to better coordinate their arrival at the location of the alleged victim.
- DHS should require timely cross-reporting to the appropriate LEA of other child abuse reports received by child protection branches.
  - Some deadline longer than the current temporary one-hour and three-hour policies seems warranted (perhaps "same day," for example) in order to give branches latitude to allocate staff time to those matters which are deemed to be higher short-term priorities (such as responding to new report calls) during periods of peak loads.
  - The branches should establish procedures (with concurrence of the relevant LEA's) to draw special attention to those cases most likely to be of interest to law enforcement.
    - Cases with alleged third-party perpetrators
    - Other cases determined by the child protection branch or by local protocol agreement to be of potential interest to law enforcement

- Since local circumstances differ, details of the reporting and confirmation procedures should be left to the branches and the LEA's to work out (and to document in written protocols), but the local agencies should consider electronic methods that are more streamlined than reliance on fax transmissions.
  - Electronic transmission directly from FACIS or e-mail would be more efficient, provided that the appropriate information from the Form 307 (or some synopsis of it) could be readily included.
    - A form could be set-up to include summary information now included on fax cover pages
    - There would be an electronic record of the date and time sent.
    - Receipt could be confirmed electronically.
    - The receiving LEA would not have to make photocopies for internal routing (but instead could forward the report electronically to the appropriate personnel).
    - The receiving LEA could reply by e-mail to indicate what it planned to do with the case.
    - Typed information will be more legible to all concerned, versus the handwriting now required on fax cover sheets.
    - Files of reports sent and received could be readily stored and retrieved in electronic folders.
  - Local branches and LEA's should consider whether the Form 307s are needed by LEA's on all or most of the cases For certain types of cases an appropriate summary may meet law enforcement's needs just as well or better.
  - Where it is determined that at least some, if not all, Form 307 information should be included there are alternatives to make it work electronically.
    - Preferably, FACIS could be modified to allow the Form 307 to be transmitted directly or, if not, then attached to an e-mail.

  - Or, workers could cut and paste the relevant parts of the Form 307 into the e-mail document or an attached word processing document.

- The ability of child protection branches to have electronic access to certain law enforcement data systems would strengthen the screening process, as addressed in a recommendation above.

9. Enhance Quality Assurance Procedures

Related conclusions

- Several quality assurance checks are built into the intake process, including:
  - Real-time consultation from supervisors
  - Staffing review meetings, including supervisors and caseworkers, where reported abuse cases are discussed
  - Reviews of selected cases at multidisciplinary team meetings (or in similar forums involving personnel from other agencies)
  - Supervisory review of assessments when the assessments are completed
- However, cases that are "logged" and those that are "screened out" do not get the same level of review as those that are assessed.
  - In general, once a case is "logged" or "screened out" it does not receive further review.
  - The "logged" decision may occur before a case reaches a staffing meeting (although procedures vary by branch).
  - The "screened out" decision is typically made in staffing meetings, but is limited to information obtained by the screener.

- One key component of quality assurance has been interrupted.
  - DHS once performed "branch reviews" of each branch every few years. These branch visits involved quality assurance reviews of cases by professionals independent of the branch.
  - Among the branches we visited, the most recent review was reported in June 1999.
- As they are currently conducted, supervisory reviews of assessments are not as beneficial as they could be.
  - Supervisors are expected to review 100 percent of assessments, but due to time constraints many cases are likely to receive only limited attention.
  - There is no standard review instrument applied in this process, so no summary information is captured that could possibly identify practice patterns requiring management attention.
- Branches appear to be inconsistent in the screening and assessment criteria that they apply (as reported above related to the recommendation on screening and assessment guidelines).

<u>Recommendation detail</u>

- In order to help assure that supervisors are available for real-time consultation and for other clinical case review activities, the SDA's should assure that:
  - Supervisory ratios in child protective intake are maintained within a reasonable range (see the related recommendations on staffing above)
  - Supervisors are not assigned too many duties in addition to clinical supervision (such as supervision of office business staff)
- DHS should strengthen the supervisory review process for assessments:

  - There should be a standard supervisory review instrument, reflecting key elements of the guided assessment process.
  - Using the completed instruments as the database, periodic reports of summary findings should be compiled showing the types and frequency of deficiencies identified in the reviews.
  - SDA's should apply the findings to plan corrective actions, as appropriate.
  - To provide adequate time to conduct the reviews, the process can be based on selected samples of cases rather than on 100 percent of the completed assessments.
  - Supervisors should continue to use their professional discretion to review certain cases not included in the samples in more depth (for instance, giving more attention to the cases assigned to newer workers).
  - DHS should pilot test alternative approaches before establishing statewide requirements.
- DHS should continue an independent quality assurance process conducted by professionals who are independent of the branch subject to review (we understand that such a process will continue as part of the Performance Improvement Plan in response to the federal CSFR).
  - The reviews should occur with sufficient frequency to allow meaningful follow-up on previous findings (for example, no less than every two years, which we understand to be the current plan).
  - The reviews should include quality assurance checks on sufficient samples of both "screened in" and "screened out" cases to assess the reviewers' concurrence with key case decisions.
  - A key objective should be attaining consistency across branches in the screening and assessment criteria applied, compliant with State policy and professional "best practices."
- Compilations of analyses of repeat maltreatment (see the recommendation above on management reporting) should include breakdowns according to whether the case was previously assessed, "screened

out," or merely "logged." The findings will help to identify whether there are any patterns of concern with respect to logging and screening procedures.

- In those branches where "logged" cases do not go to staffing meetings, SDA's should establish a process to review a representative sample of those cases to assure that "logging" criteria are being appropriately applied.

10. Improve Telephone Systems

Related conclusions

- The limitations of the telephone systems in the branches constrain the efficiency of screening operations.
  - Some branches use "pre-screeners" to perform call routing functions that could be accomplished by a suitable telephone system.
  - The current systems are not generating automated statistics that would be useful to management in planning and staffing screening operations.
- Other than routing calls, pre-screeners do not add value to the report receipt process that cannot be readily achieved by the screeners.
  - Currently, pre-screeners who engage in only short conversations with callers are needed in the larger branches to help assure that the hotline phone will not be busy (or ring too long) and that the call can be passed on to an available screener for the necessary longer conversation.
  - Screeners often have to inquire again about information already obtained by the pre-screener (if only to confirm it).
  - Information obtained by the pre-screener can just as easily be obtained by a screener, and without redundancy.

- For many persons knowing what number to call to report child abuse could be a challenge. Telephone directory and Internet listings assume a familiarity with the organizational structure.

Recommendation detail

- The larger SDA's should explore the feasibility of upgraded phone systems.
  - Certain features available in systems now used by many "call centers" would be helpful.
    - Automated routing features could eliminate the need for pre-screeners
    - Automated call statistics (e.g., call volumes by time of day, wait times, dropped calls, call durations, etc.) could help supervisors and managers plan staffing and monitor service levels
  - The feasibility analysis should weigh the projected system costs against the anticipated benefits.
- When appropriate phone systems are in place, the larger branches should eliminate the pre-screening step in the report receipt process.
- The larger branches should use the automated statistics features of upgraded telephone systems to generate reports for management use to plan screening staffing levels by time of day.
- Private and public sector call centers apply an industry-accepted formula to determine overall staffing levels required to provide a desired level of service (percentage of calls answered within a given time period). Applying this formula could more precisely determine staffing levels required at larger branches.
- In addition to placement under the appropriate organizational entity in the listings, SDA's should list the number under "Child Abuse Reporting" in local phone directories.
  - On the "emergency numbers" page of local directories
  - Under the State of Oregon in the "blue pages" of local directories

  - In “community services” pages of local directories, where applicable
- DHS should include linkages to local numbers at logical points on its Internet pages (e.g., on the DHS home page).

Appendix 1 – Summary of Relevant Previous Studies and Reports

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Child and Families Services Review Final Report

- This report was issued in August 2001 by the Seattle Regional Office of the U.S, Department of Health and Human Services Administration for Children and Families.
- One theme in the findings of this report is that, "Stakeholders and reviewers noted concerns about consistency related to screening decisions, response time designations, application of threat of harm, and investigative/assessment disposition."
- The review team reviewed 50 cases focusing on the goal that children are, first and foremost, protected from abuse and neglect, the reviewers found that:
  - The goal was "substantially achieved" in 86 percent of the cases (versus a target of 90 percent).
  - It was "partially achieved in six percent of the cases.
  - And it was not achieved or addressed in eight percent of the cases.
- The authors found that repeat maltreatment (within six months) occurred in 6.81 percent of Oregon's cases, versus a national standard of 6.1 percent or lower.
- The reviewers had concerns about the timeliness of face-to-face assessments, finding that in seven out of 21 cases (33 percent) the contact was not within the expected timelines.
- DHS responded to this report with Oregon's Children and Family Services Review (CFSR) Program Improvement Plan (effective July 9, 2002).
  - A key initiative in plan is the "Guided Assessment Project (GAP), which is aimed at more consistent and timely investigations.

- Among the action steps in the DHS plan are the following:
  - Provide summary and detailed data to field offices on the timeliness of child protective services (CPS) investigations. This includes a revision to FACIS to include the date of first contact and attempted contact information.
  - Create uniform standards, tools, and procedures for assessing child safety/risk factors present and care giver capacity.
  - Clarify the categories for indicating the type of abuse.
  - Provide quarterly summary and detailed data to field offices on repeat maltreatment.

<u>The National Resource Center on Child Maltreatment (NRCCM) technical assistance</u>

- The NRCCM reviewed a sample of case files at three branches (Lane, Yamhill, and Midtown) in March, 2001, covering cases from the January through June 2000 period. The NRCCM found a high percentage of cases had experienced "extended screening" of seven days or more, and concluded that this "extended screening" did not necessarily generate additional information useful to decision making.
  - In about one third of the referrals in the sample the reviewers did not agree with the response time.
  - A particular concern was that "Nineteen percent of the referrals that experienced 'extended screening' contained present danger influences.
- NRCCM found high compliance (about 91 percent) with statutory standards on screening decisions where the referral was accepted, and in 92 percent reviewers agreed with the decision to accept the referral.
- But NRCCM found lower compliance (about 73 percent) with State standards on decisions to close cases at screening, and in about 36 percent of the sample cases closed at screening the reviewer did not agree with the closure decision.

- The NRCCM also observed notable differences across the branches in the percent of referrals screened out and the percent of referrals substantiated.
- The findings caused NRCCM to conclude that the screening guidelines "…could be improved with additional specification and provisions for specifically when and how they apply."

Urban Institute paper: "The Decision to Investigate: Understanding Child Welfare Screening Policies and Practices"

- The authors of this May 2000 paper, Karen C. Tumlin and Rob Geen, collected information from 31 states pertaining to the child abuse report screening and assessment process. Using 1996 data appearing in this report, Oregon compared to the national median as shown in the table below:

	Oregon	National Median
Percentage of reports screened out before investigation	38.4%	35.8%
Percentage of investigate reports substantiated	59.7%	38.0%
Percentage of all reports substantiated	36.7%	26.7%

- Tumlin and Geen concluded that, "…since few states have explicit guidelines, workers use their discretion and biases when making screening decisions…. Moreover, since screening decisions may be influenced by agency demand and capacity, informal criteria for investigating a child maltreatment referral may fluctuate over time. This fluidity and cross variation may send mixed messages to potential reporters about what constitutes abusive or neglectful behavior."

Branch reviews

- We reviewed “branch review” reports prepared by the then DHS Services to Children and Families Division in the past few years for certain of the branches we visited.
- The most recent review we obtained for these branches was reported in June 1999.
- There were some common themes across the reviews of the different branches. For example, most reviews identified over-use of "threat of harm" as the type of abuse recorded for completed assessments.
- A summary of the reviews appears in the following appendix.

Appendix 2 – Summary of Previous DHS Branch Reviews

Summary of Previous DHS Branch Reviews

Local Office	Date of Last Review	Approach	Themes Relating to CPS Screening and Assessment
Klamath Falls	March, 1998	▪ Branch status report and performance measures ▪ Previous branch review –1996 ▪ Complaint data from governor's advocacy Office and SCF ▪ Case review including Protective Services assessments ▪ Interviews of management, staff, partners, foster parents	▪ Excellent relations with court, workers held in high respect ▪ Branch and community cooperation and empowerment ▪ Appropriate and timely screening and assessment decisions ▪ Case review: adequate documentation (84%); agreement with referral type (97%); information adequate to determine if assessment required (96%); supervisor review (87%); agreement with IR decision (90%); 7 day face-to-face and 30 day assessment completion met 95% of the time
Marion County	April, 1999	▪ Branch profile and performance measures ▪ Complaint data ▪ Training records and forms ▪ Case readings ▪ Interviews with branch management and staff, partners, foster parents	▪ Case review: adequate documentation (86%); screening decision (89%); referral type (83%) agreement ▪ 69% of cases reviewed by supervisor within 30 days ▪ Documentation of LEA report within 24 hours was 32% ▪ Better documentation needed; good IR determination (96% agreement)

Local Office	Date of Last Review	Approach	Themes Relating to CPS Screening and Assessment
			determination (96% agreement) ▪ Face-to-face contact in 7 days in 71% of cases; 65% assessment completion within 30 days ▪ Several screening areas did not meet 90% standard
Hood River	February, 1999	▪ Branch status report and performance measures ▪ Branch Performance profile, caseload and other statistics ▪ Case reviews ▪ Interviews with branch management, staff, partners and foster parents	▪ Team effort in decision making ▪ Case review: adequate documentation (94%); agreement with screening decision (88%); agreement with referral type (88%); IR determination (86%); 86% of assessments completed within 30 days; 93% timely or had documented extension, ▪ Overall high CPS performance in relation to the 90% standard
Gresham	East Branch Review April 1998	▪ Branch profile report, previous reviews ▪ Case reviews ▪ Interviews of community partners, branch management and staff	▪ Timely screenings ▪ Peer consultation available ▪ Good LEA and court relationships ▪ Case file review: high percentage of adequate documentation; high agreement with referral type; high percentage of supervisory review (48 days average); 83% agreement on determination of IR; 63% of cases received face-to-face in 7

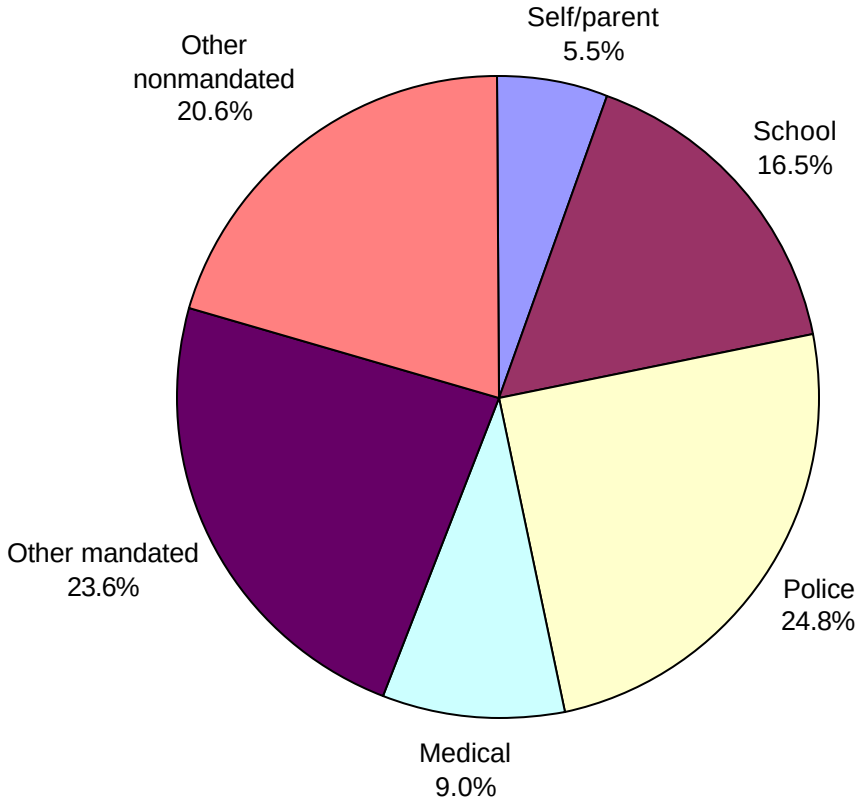
Local Office	Date of Last Review	Approach	Themes Relating to CPS Screening and Assessment
			days; 30 day assessment timeliness 73%
Multnomah (Metro Region) Child Abuse Hotline	June, 1999	▪ Branch profile report, flow chart of assessment process ▪ Review of cases assessed or sent to branches ▪ Review of cases sent to branches to compare screeners' description of issues with field workers' assessment ▪ Comparison of percentage of "founded" reports from mandatory reporters with public at large ▪ Manager, staff and community partner interviews ▪ Customer satisfaction survey	▪ Consistent high quality service and supervision ▪ Experienced, professional staff ▪ Peer support and good teamwork with partners ▪ High stress, high volume environment ▪ Case file review: adequate documentation (87%): agreement with screener's decision to assign or close (79%): agreement with type of referral (95%): 100% supervisory review conducted (90%) within 60 days. ▪ Perceived inconsistency in skill levels between daytime staff and night/weekend screeners (PROTOCOL) ▪ More communication needed with partners ▪ Perceived lack of expertise in domestic violence ▪ 24 hour coverage with experienced staff desired by partners

Appendix 3 – Data Analysis

Appendix 3 - Data Analysis

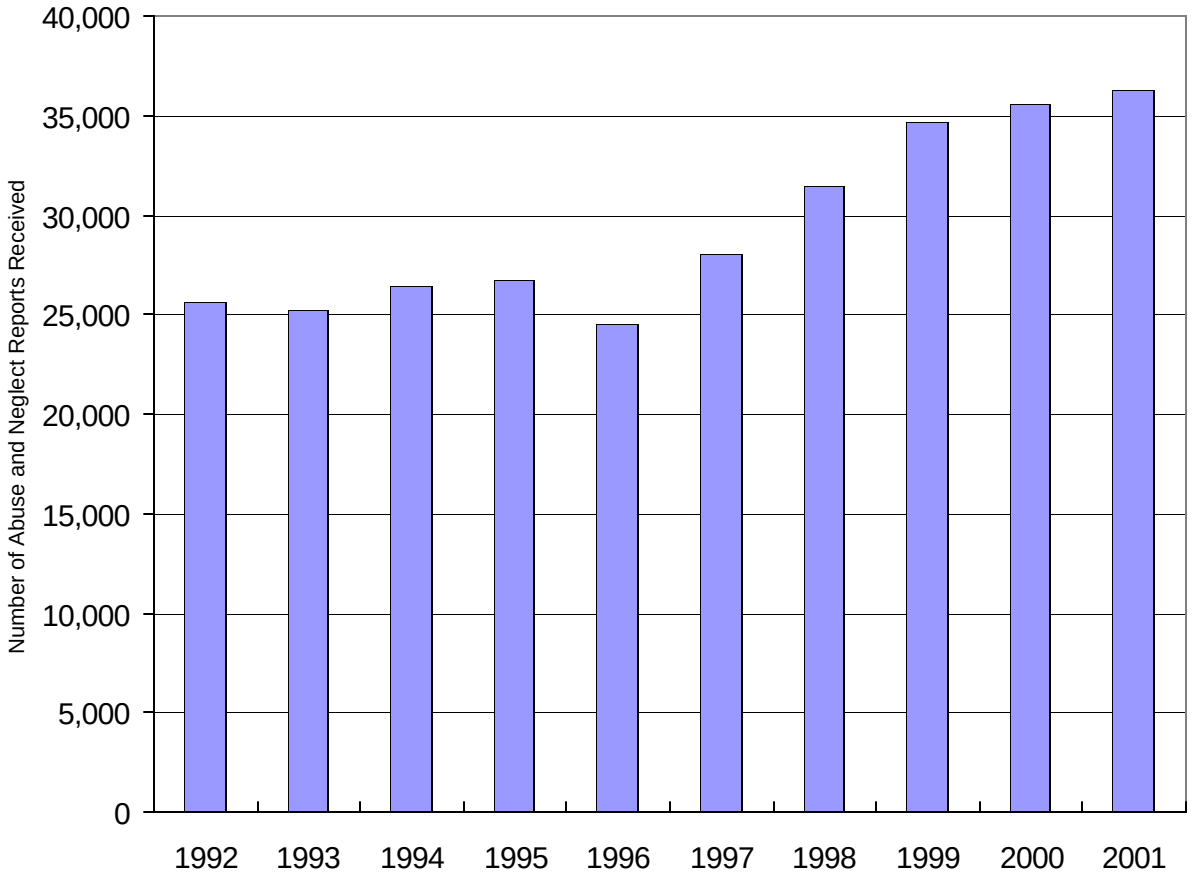
A. 2001 Statewide Data

About 78 percent of the 36,3003 child abuse and neglect reports came from mandatory reporters.



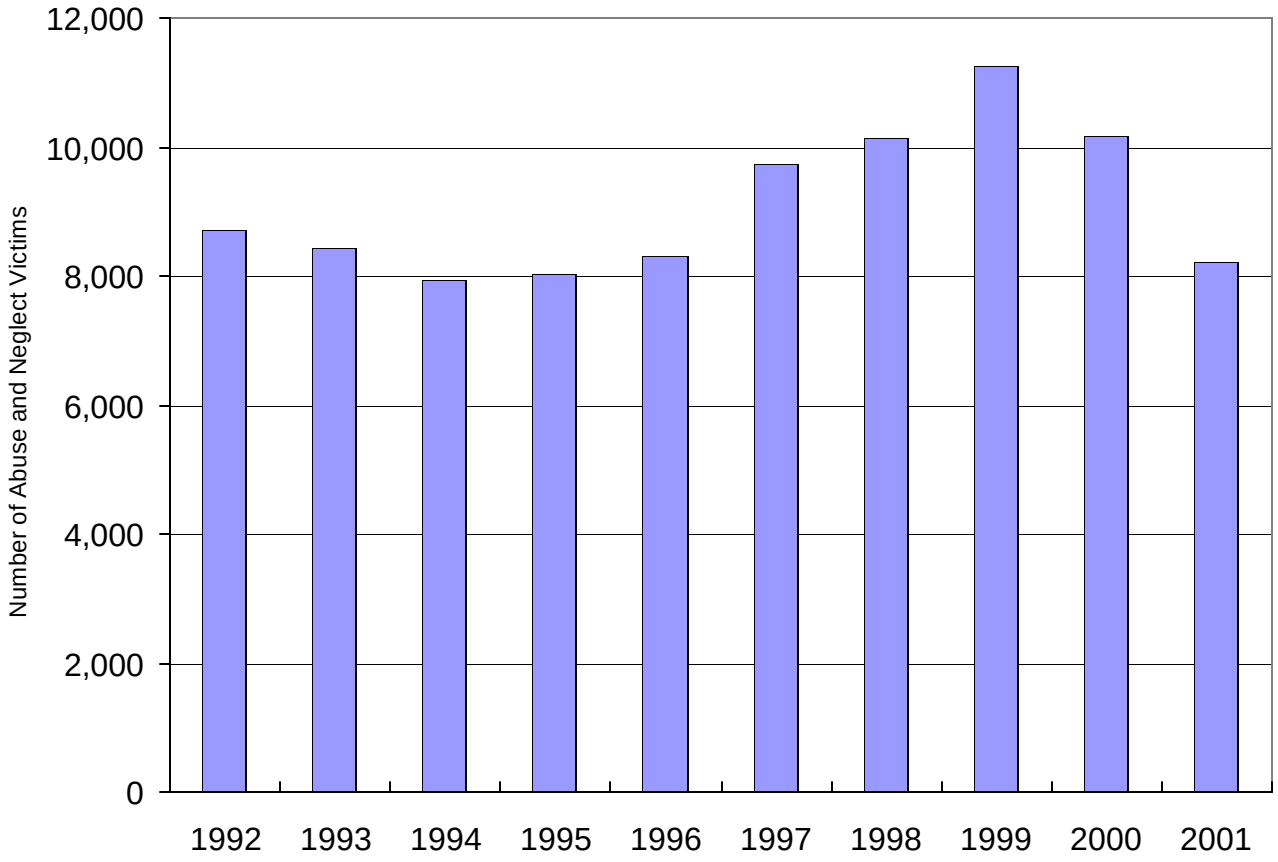
Source: DHS, "The Status of Children in Oregon's Child Protection System, 2001"

The number of reports received has risen over the past ten years.



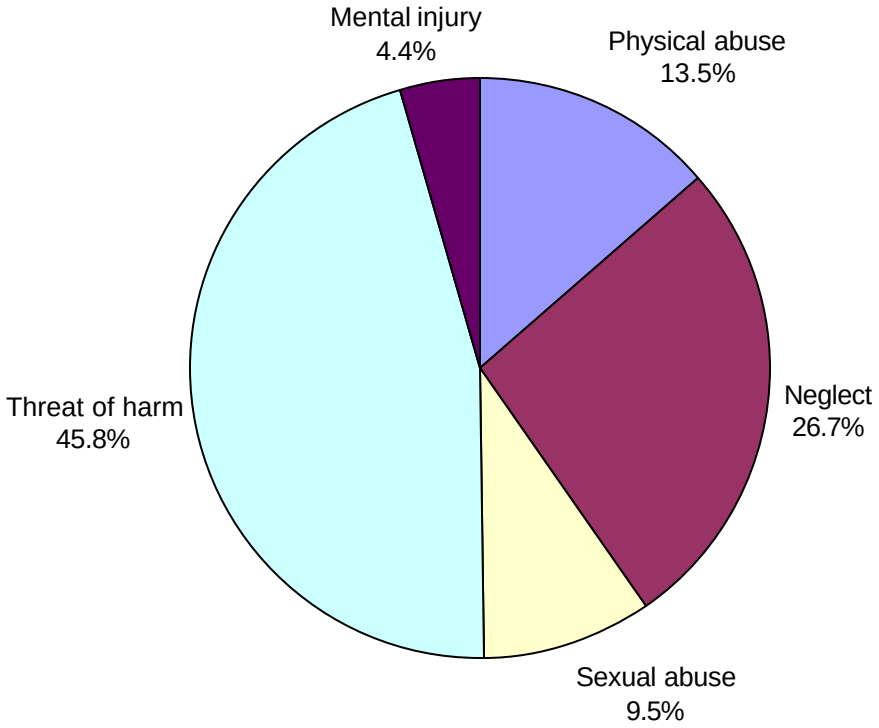
Source: DHS, "The Status of Children in Oregon's Child Protection System, 2001"

But the number of child abuse and neglect victims (unduplicated count) decreased in 2001.



Source: DHS, "The Status of Children in Oregon's Child Protection System, 2001"

Almost half of the reported incidents in 2001 were classified as "threat of harm."



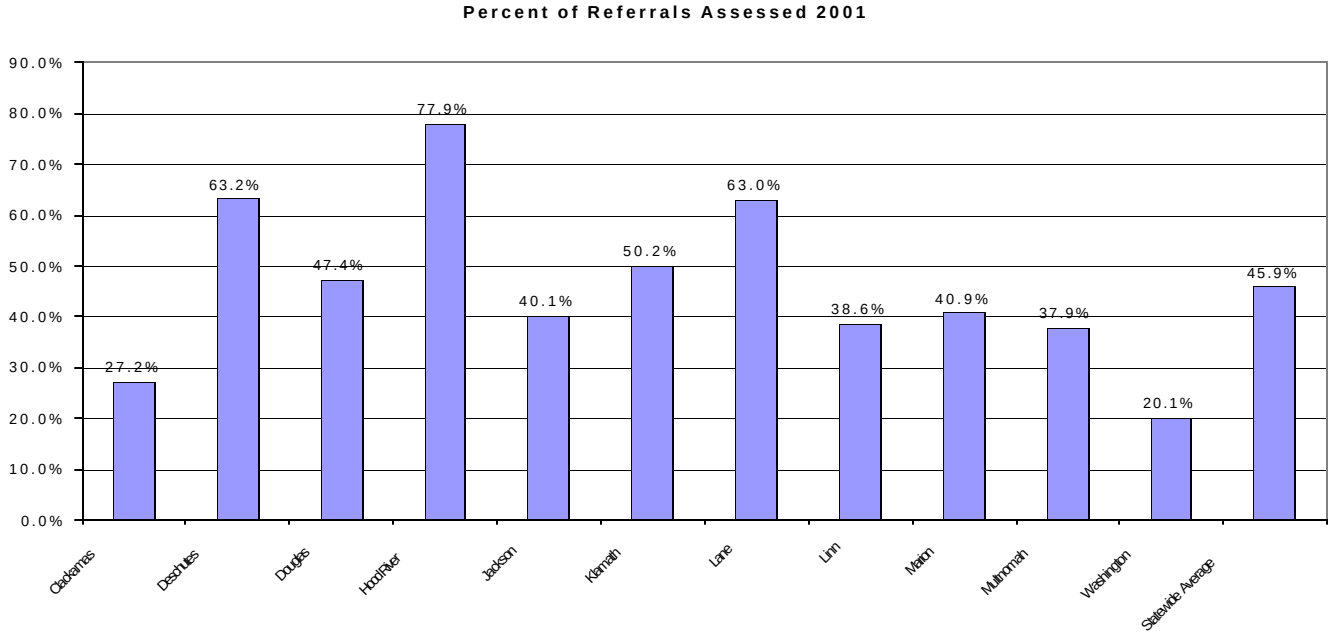
Source: DHS, "The Status of Children in Oregon's Child Protection System, 2001"

Almost 95 percent of the alleged perpetrators were familial (mother, father, stepfather, brother, etc.). Only about five percent were non-familial (neighbor, friend, unknown, etc.).

B. County Comparisons

There was wide variation across counties in 2001 in the percentage of referrals that were assessed (that is, "screened in" versus "screened out").[10]

- The standard deviation when all counties are included was about 21 percentage points.
- The standard deviation for the eleven counties shown below was about 16 percentage points.[11]

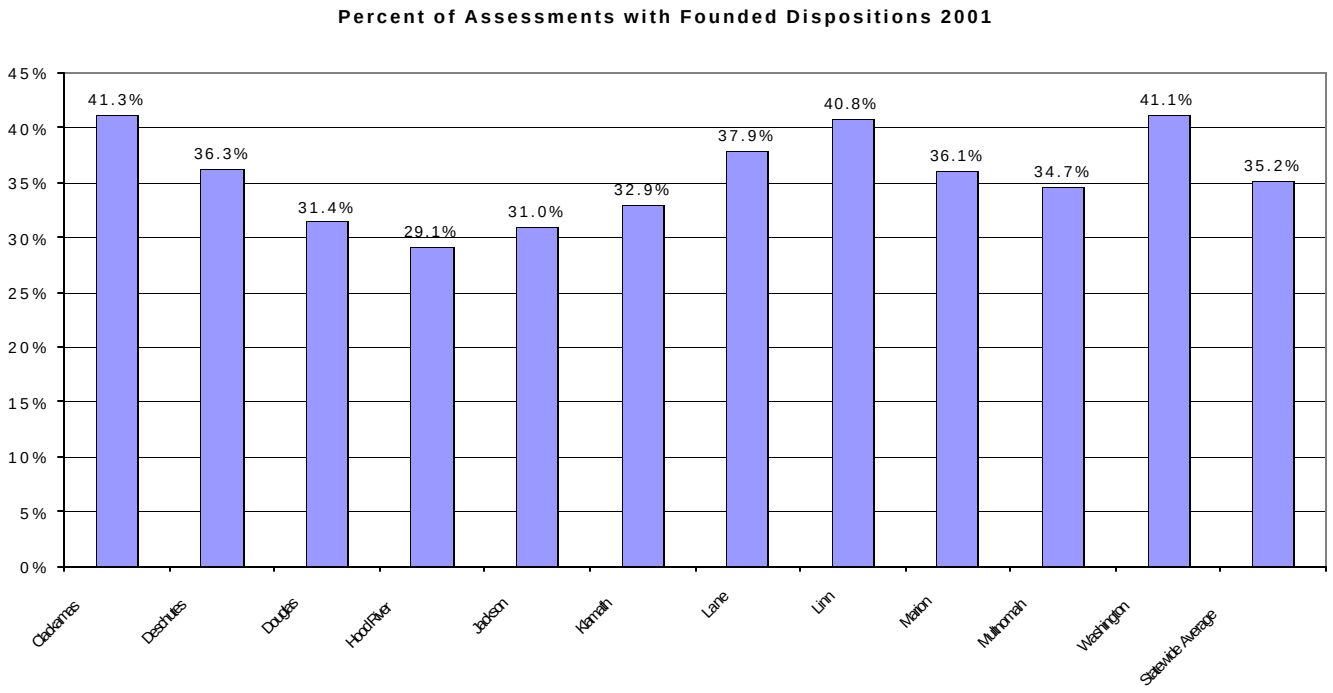


Source: DHS FACIS datamart; file provided by Children, Adults and Families research staff

[10] The number of "referrals" applied to calculate these percentages does not include cases that were "logged" (and thus not "referred") in FACIS.

However, of those referrals that were assessed, there was notably less variation in the percentages determined to be "founded."

- The standard deviation when all counties are included was about 9 percentage points.
- The standard deviation for the eleven counties shown below was only about 4 percentage points.

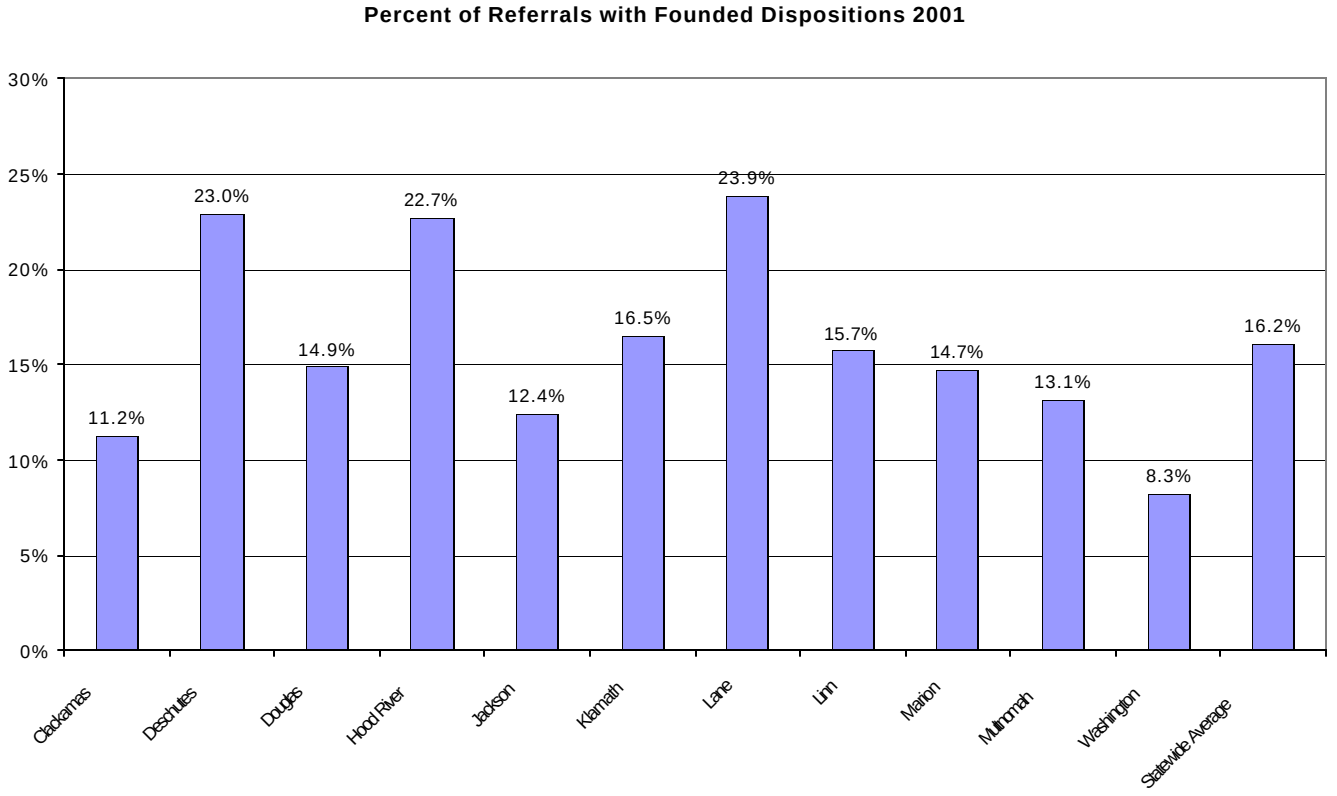


Source: DHS FACIS datamart; file provided by Children, Adults and Families research staff

[11] The graphs include the larger counties, plus Hood River (in order to cover each of the counties we visited). This group represents about 80 percent of the abuse and neglect reports received in the state in 2001.

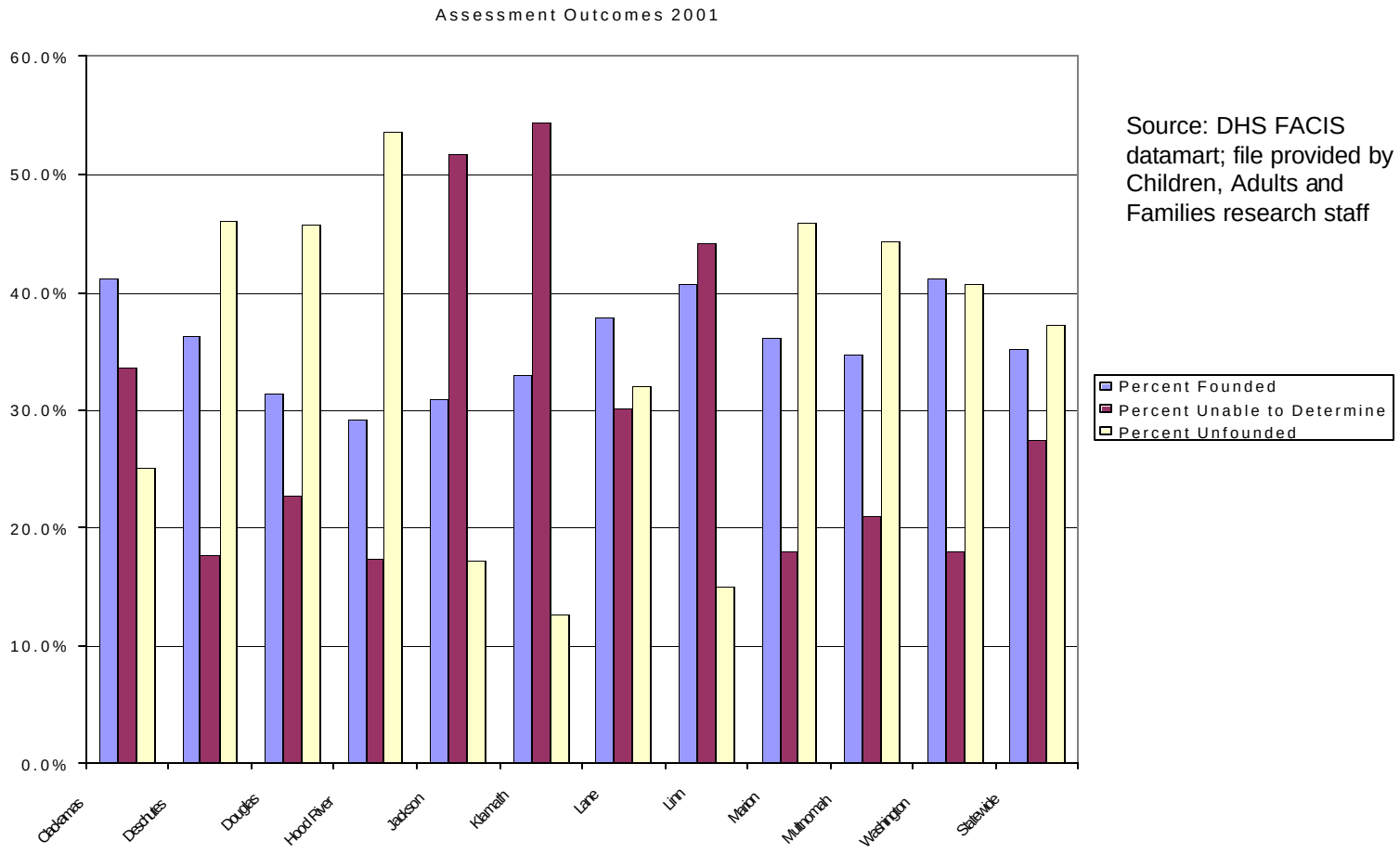
The variation was slightly greater when founded assessments are measured as a percentage of the referrals received.

- The standard deviation when all counties are included was about 12 percentage points.
- The standard deviation for the eleven counties shown below was about 5 percentage points.



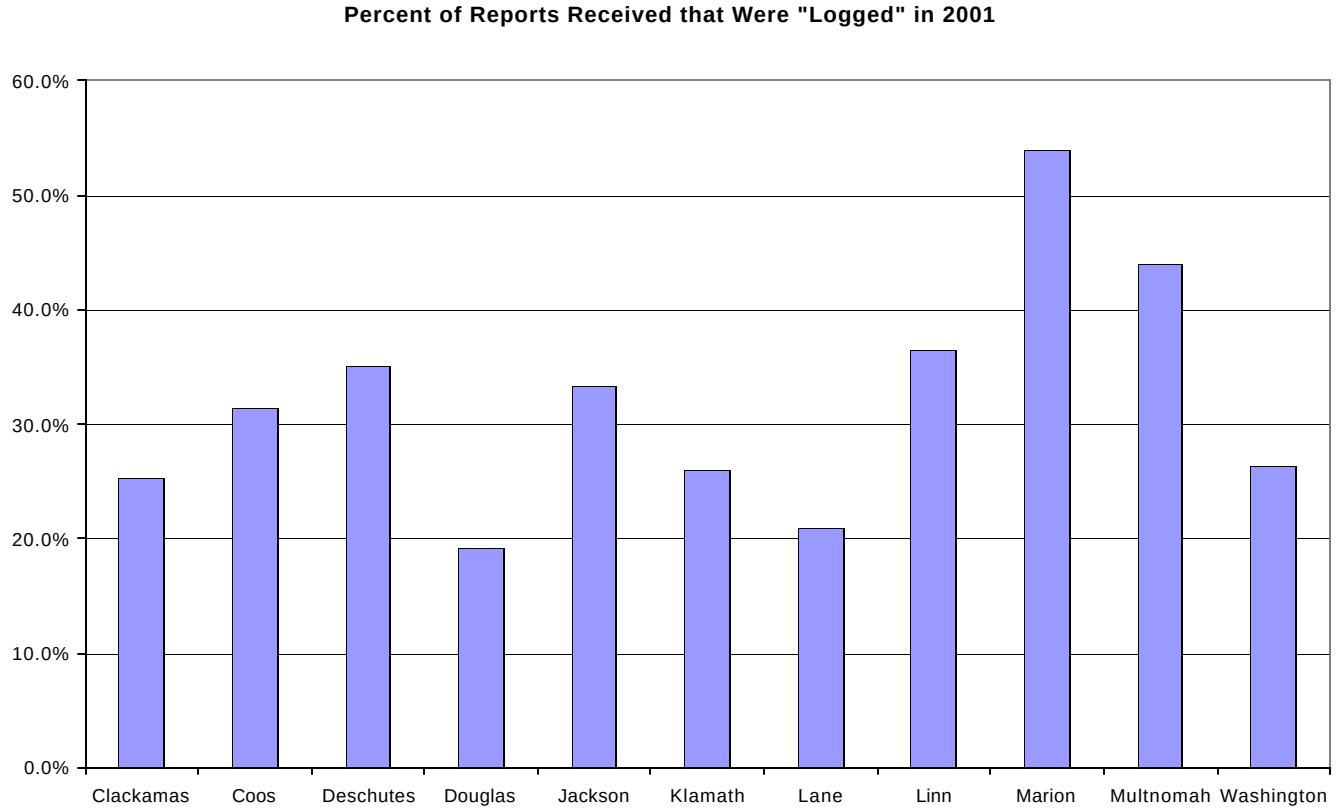
Source: DHS FACIS datamart; file provided by Children, Adults and Families research staff

The percentage of assessments where the outcome was "unable to determine" also varied notably across counties, and averaged over 27 percent statewide.



Source: DHS FACIS datamart; file provided by Children, Adults and Families research staff

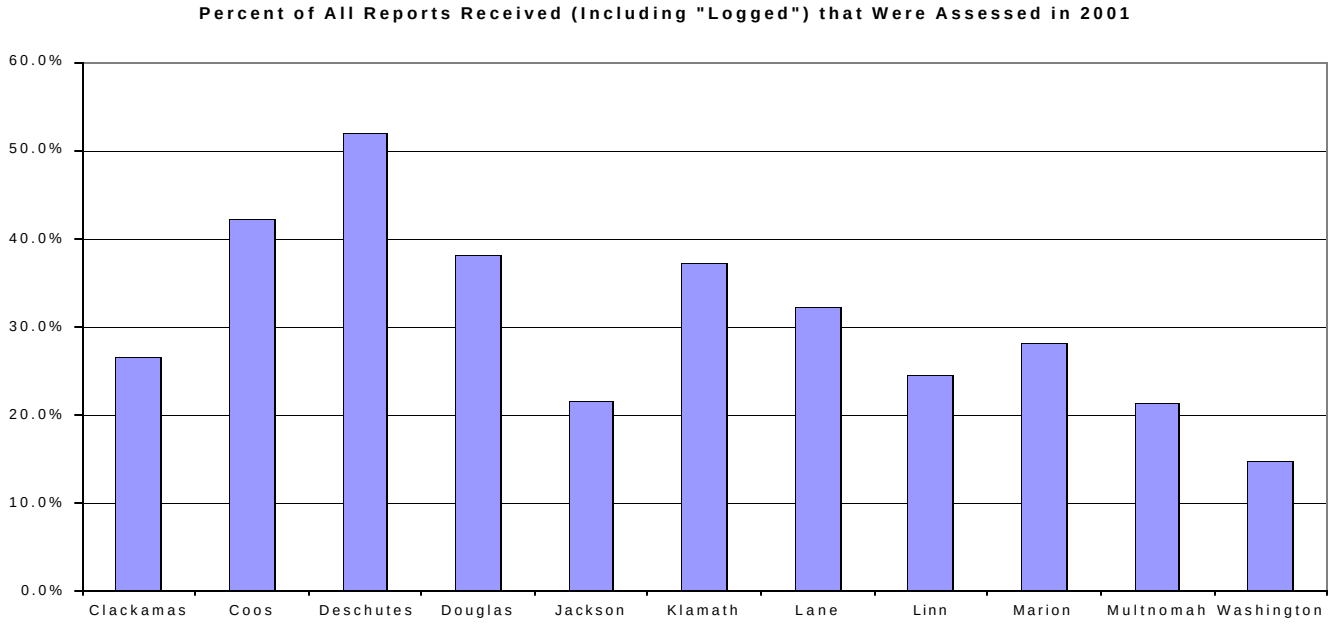
The percentage of reports received that were "logged" (and not referred for assessment) varied notably among counties in 2001.



Source: FACIS data provided by the Multnomah County Hotline (note that Coos is included, but not Hood River because the Hotline selected only the largest counties)

When the "logged" reports are added to the "referred" reports to compile the total reports received, the number of cases assessed as a percentage of the total reports received still varied notably across counties in 2001.

- The standard deviation for the group shown below was about 11 percentage points
- There was a notable negative correlation between county size and the percentage of reports receiving an assessment ("r squared equal to about 0.43); the relatively smaller counties in the group below were more likely to conduct an assessment.



Source: FACIS data provided by the Multnomah County Hotline (note that Coos is included, but not Hood River because the Hotline selected only the largest counties)

Appendix 4 – Summary of Branch Visit Findings

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1. Receipt of Child Abuse Reports

Telephone reception procedure

- Each branch has a telephone reception procedure designed to give immediate attention to child abuse report calls, but the procedures differ.
  - Multnomah operates a hotline with a separate number listed for child abuse reporting. If a child abuse reporter calls a branch he or she is instructed to call the hotline. Marion also lists a separate number for child abuse reporting (and also includes a menu option in the answering message at the regular number, identifying the extension to dial). In both counties calls to the designated numbers go directly to a child abuse reporting pre-screener.
  - In Hood River and Klamath the number to call to report child abuse is the general number for the branch. The phone messages direct the caller to "press 0 for a receptionist."
- The numbers to call to report child abuse are listed in the local phone directories and on the Internet, but potential callers need to be familiar with the organizational placement of the child protection agency; for instance:
  - In the Portland Qwest directory if one goes to the "Government Pages" ("Blue Pages") one must know to first go to the State section, then to "Services to Children and Families" (prior title remains until a new phone directory is issued), then to "Child Abuse Reporting in Multnomah County – Day & Night."
  - In Hood River one needs to know to go to the "Pink Pages" for community services.

  - The numbers of the local offices are listed on the state government web site under "local office," under "Reporting Abuse," which is under "Child Protective Services," which is under "Services to Children and Families" (prior title remains on the web site).

- At lest some local branches have prepared brochures (or share brochures with other agencies) that are distributed to targeted audiences and these brochures list the number to call.
- The majority of callers are mandatory reporters, and child protection workers believe that, in general, these callers do not have difficulty in understanding how to contact the agency.
- The answering messages at all four branches we visited are bilingual, English/Spanish.
- None of the branches has a phone system that records key statistical information about calls (call volume by time of day, number of calls dropped, wait times, number receiving busy signal, etc.). The pre-screeners at the Multnomah Hotline and at Klamath hand-tabulate call volume.
- The branches have different methods to deal with the receipt of multiple child abuse report calls at the same time.
  - The larger branches (the Multnomah Hotline and Marion) have multiple phone lines for the pre-screener.
    - If two or more lines are busy at once the pre-screener will either place one or more of the calls on hold (what we observed in Multnomah) or a back-up pre-screener will pick up the new call.
    - The pre-screener at the Multnomah Hotline reported that phone had been re-set from six rings to eight rings (before defaulting to a message) to better enable answering of simultaneous calls.
  - The smaller branches (Hood River and Klamath) have back-up procedures for when the screener's extension is busy.
    - Hood River reception will ring the extension of the designated back-up screener for the day.

- Klamath has a cell phone which is placed in the office area of the CPS workers. Reception will instruct the caller to dial the cell phone number.

24 hour response

- The Multnomah Hotline is staffed between 8:00 am and 10:00 pm on weekdays (to be expanded to 24 hours) and from noon to 10:00 pm on weekends. Each of the other branches we visited is staffed during normal business hours on weekdays.
- When it is not staffed the Multnomah Hotline uses a private emergency answering service. Callers are automatically routed to that service.
- Off-hours answering messages at the other branches instruct the caller to dial 911 if he or she is calling to report child abuse.
- Law enforcement responds to off-hours emergency and imminent situations in each of the counties we visited. Each county also has at least one on-call CPS worker who law enforcement can contact to go out on the call. Multnomah has a group of CPS workers designated to cover the 5:00 pm to 10:00 pm weekday hours.

Other report receipt methods

- All of the branches receive written reports from law enforcement (in addition to phone reports in imminent situations where law enforcement seeks the participation of a CPS worker). However, there are some relevant differences among branches, as discussed below under "law enforcement reporting."
- Branches may have relationships with other community agencies to receive written reports, though we observed no consistent pattern across the branches. Marion, for example, receives and reviews hospital reports of births to teen mothers (primarily for the purpose of sending community services referral information to the mother).

- All of the branches receive walk-in reports during normal business hours, with a worker designated to conduct interviews.

2. Screening

Pre-screening

- The Multnomah Hotline and Marion have pre-screeners who receive child abuse report calls.
  - The Multnomah pre-screener determines the nature of the call and if it is a report of abuse and pertains to Multnomah County she switches the call to a screener.
    - The conversation is typically very brief (a minute or two).
    - Some calls may be screened out at this point; many may be given community referral information.
  - The Marion pre-screener seeks caller and family identity information and takes notes on the caller's concern.
    - This duty rotates among the social service specialists who also perform screening.
    - The process remains brief (typically less than five minutes), but generally longer than in Multnomah.
    - Calls with no child protective issues can be screened out at this point and, often, given community referral information.
    - Marion typically "logs" calls only after they have passed through pre-screening to a screener.
- At the Multnomah Hotline and in Marion the pre-screeners are located close to the screeners' desks in the respective offices, and often rely on direct voice communication (that is, not on the phone) with the screeners in order to pass calls from pre-screening to screening.

- In Multnomah the pre-screener keeps tick marks on a chart at her desk in order to help rotate calls among screeners.
- In Marion the pre-screener passes her call notes on to the next available screener in the rotation.

Staffing

- Multnomah and Marion have groups of workers assigned to screening.
  - In Marion there are six workers assigned to the screening group (with one rotating into the pre-screening responsibility each day).
  - Fourteen Multnomah screeners (six half-time) are assigned to shifts, and the number on duty at any given time depends on the time of day (not less than two, and about six in the early afternoon on the day of our visit).
- Hood River and Klamath have a single primary screener (with back-up) assigned each day.
  - The responsibility rotates among certain child protection workers in Hood River.
  - In Klamath one child protection worker specializes in screening.
- None of the branches we visited has formal criteria or procedures to determine how many persons should be assigned to screening at any given time, though two (Multnomah and Klamath) had data on screening volumes that supervisors reviewed.

Screening criteria and information obtained

- At each of the branches the screeners indicated that they seek to establish the nature of the allegation, how the caller knows about it, and the safety status of the child victim(s), among other factors, following the State screening guidelines.

- The screeners we interviewed rely primarily on their professional judgment and experience to conduct the screening.
  - They are not using formal checklists directly in each screening (with the exception of the guided assessment pilot addressed below).
  - But they seemed to have ready access to the State checklists and criteria, and some reported that they relied more on the checklists earlier in their careers.
- Multnomah is participating in a pilot test of guided assessment procedure that applies a computer template in both the screening and assessment steps.
  - DHS Children, Adults, and Families is evaluating this pilot.
  - The screener we interviewed noted a few concerns based on her initial limited experience with the tool:
    - The guided assessment takes more time than the normal screening method.
    - There is no single place in the template to record a unified narrative of the case.
- In each county the screener (or the pre-screener) will check FACIS for a prior history on the case.
- Workers at each of the branches reported that FACIS is often "down," preventing them from obtaining or entering screening information on-line.
- The computer access to other agencies' information systems at the time of screening varies among the branches we visited (and varies further based on differences in workers' knowledge of the various systems that may be available).
  - Marion reported access to the Self-Sufficiency, OJIN, County Jail, Motor Vehicles, and Probation systems.
  - In addition to the systems available to Marion, the Multnomah Hotline has access to LEDS and police systems (see below) and to a Portland Schools system.

  - Hood River reported access to Self-Sufficiency and Support Enforcement systems.
  - Klamath reported access to Self-Sufficiency and OJIN.
  - Screeners in any of the branches may also sometimes place calls to other agencies (e.g., the district attorney or police) to obtain information on a case.
- Several support staff at the Multnomah Hotline are trained and certified in using the LEDS criminal history data system, and can also access the Portland Police and Multnomah County Sheriff's systems (and potentially Gresham, as well, pending resolution of technical issues).
  - Screeners frequently request a criminal history check from these staff, who then perform the inquiry and report the results (hand-written on a form) to the screener, prior to the screening decision if possible.
  - All of the screeners and assessment workers and supervisors that we questioned about this capability in Multnomah reported that they often find the criminal history information valuable.
- Depending on time exigencies and other factors, the screeners may follow-up with calls to collaterals to supplement information obtained from the caller.
  - Our impression was that this is more frequent in the smaller branches, and perhaps more frequent in Marion than in Multnomah.
  - Only Klamath had statistics on the number of collateral contacts made.
    - About 0.4 collateral contacts per child abuse allegation call received in October 2002
    - About 1.2 collateral contacts per referral assigned for assessment in October 2002
- For those cases that do not require an emergency response but are to be referred for assessment, the time between screening and assessment varies based on local procedures.

- Multnomah (Gresham), Marion, and Klamath assign "screened in" cases from the previous day at daily morning staffing meetings.
- Hood River conducts its case assignment staffing meetings on Tuesdays and Thursdays.
- In Hood River and Klamath screeners may sometimes hold certain cases (a minority) for a few days to collect more information.

Immediate response

- All of the branches we visited have established procedures to deal with immediate response cases, including certain common elements:
  - State guidelines are applied to ascertain potential immediate response situations.
  - The screener is expected to immediately consult with a supervisor (or a surrogate when the supervisor is not immediately available) if there is a possibility that an immediate response is needed.
  - If it is determined that an immediate response is required, the appropriate law enforcement agency is notified immediately.
  - Law enforcement is expected to respond to the call, and in most situations a child protection worker as well (exceptions would be, for example, if the call was so emergent that a worker could not possibly get there in time or if, because of the situation, law enforcement prefers to respond without the child protection worker).
  - At least one child protection worker is assigned to the immediate response (IR) responsibility each day.
  - The screener or the supervisor, or both, communicate what is known from the screening to either the IR worker or supervisor, or both (in smaller branches the supervisor for screening is also the supervisor for IR).

  - The IR worker is provided as much of the documented information as is available at the time, typically (but not always) including the Form 307 completed from the screening.
- Due to location issues, the communications methods differ.
  - The screeners and the assigned immediate response workers are physically proximate in the same office in Marion, Hood River, and Klamath, so the pass-off from screening to assessment is face-to-face.
  - In Multnomah, a hotline supervisor will call the appropriate supervisor at the relevant branch to inform him or her of the immediate response case.
    - The Form 307 and other pertinent information is faxed.
    - The completed Form 307 should also show up in FACIS at the branch office.
- The branches attempt to coordinate the child protection worker's arrival with that of law enforcement, where possible.
  - However, now Multnomah Hotline calls law enforcement first and then calls the relevant branch (previously if the call was not an emergency the procedure was for the branch to contact law enforcement). Two branches report that this makes coordination more difficult.
    - Gresham reported that its IR workers may sometimes have to wait at the visit site for some time before law enforcement arrives.
    - St. John's reported that because their territory is so large, law enforcement frequently arrives much earlier at the visit site.
  - The coordination appears to easier to achieve in smaller counties, especially where just a few designated law enforcement officers make most of the child protection calls.

Screening review

- The primary check point (on cases that are not IR) is the case staffing held in each branch (daily in Marion, Gresham, and Klamath; twice per week in Hood River) – screening decisions are typically made in these staffings.
  - The supervisor (more than one in Marion) and the relevant child protection workers participate collectively in these meeting to discuss each screened case; in some cases other professionals (for instance, a law enforcement or Self-Sufficiency representative) may participate as well.
  - Supervisors may review cases between staffing meetings. For instance, the Hood River supervisor expects referrals to be put in her box each day and she reviews them that day. Some may be immediately assigned, and others may be assigned at the next staffing meeting.
  - "Logged" cases are not addressed the same way in these staffings across the different branches.[12]
    - In Multnomah and Marion the "logged" decision is typically made at screening (though at the Gresham branch the "logged" cases are received from the hotline and distributed to supervisors, so they are seen by someone other than the hotline supervisor and screener).
    - "Logged" cases are reviewed in the case staffing in Hood River.
    - Klamath uses the case staffing to determine whether to classify a case as "logged."

[12] Classifying a case as "logged" basically means that the report did not rise to the level of a report of child abuse or neglect. Reasons could be that not enough information could be obtained to identify the child/family; or, the report does not constitute abuse, neglect, or threat of harm, but the branch believes that retention of the information could aid future decision making. Reports from mandatory reporters that do not constitute abuse, neglect, or threat of harm but where the reporter believed that he or she had an obligation to make a report will generally be "logged."

- The supervisors at the branches we visited report that they sign off on all Form 307s following screening decisions from the staffings, and in Multnomah a hotline supervisor has signed off on Form 307s (other than IR cases) before they are sent to the field.
- Selected cases, including some that have been screened out or simply "logged," may be brought up for discussion in other forums, but these typically represent only a small portion of the number of reports received.
  - In the smaller counties (Hood River and Klamath) selected cases are discussed at MDT meetings (held every two weeks).
  - The Multnomah Hotline has established weekly "triage" meetings to discuss selected cases with law enforcement and District Attorney representatives.
- Other than the procedures noted above, the branches did not report any systematic procedures to review cases that are "logged" or screened out without an assessment referral (those cases proceeding to assessment receive further review).

3. Law Enforcement Interface

Liaison arrangements

- All of the branches participate in Multidisciplinary Teams (MDT's) with designated law enforcement representatives and representatives of other community agencies.
- The smaller branches typically deal with just a few law enforcement officers.
  - Supported by CAMI funding, Hood River has a State Police officer assigned full-time to cover child abuse and sex crimes in Hood River and Wasco Counties. She, a Sheriff's detective, and just a few local police are the primary law enforcement contacts for the branch.

  - Klamath works with a Klamath Falls detective and with just a few Sheriff's and State Police detectives.
  - In Hood River and Klamath the officers sent on immediate response calls are typically (but not always) the officers assigned as liaisons to child protection.
  - In Klamath the designated Klamath Falls detective tries to attend as many of the child protection case staffings as possible.
- Workers in the larger branches deal with a much larger group of law enforcement officers.
  - In Multnomah and Marion the officers sent on immediate response calls are determined by police dispatch procedures, drawing from pools of officers on duty in the appropriate precinct or area at the time.
  - The Multnomah Hotline is co-located with a group of police detectives (mostly Portland, but also Sheriff's and Gresham representatives) that work child abuse cases and with law enforcement domestic violence teams.

Sending reports

- Each of the branches we visited was attempting to comply with the temporary rule requiring written reports to law enforcement within one hour on cases requiring immediate response (in conjunction with an immediate phone call) and cases alleging a third-party perpetrator.
- Each of the branches we visited was also attempting to comply with the temporary rule requiring written reports to law enforcement within three hours (or the close of business, whichever comes first) on all other child abuse reports received.
- The branches methods differ for getting the reports to law enforcement and receiving confirmation of receipt.

- At the Multnomah Hotline a group of detectives is co-located one floor below. Hotline staff place copies of completed 307s in one of two boxes at the hotline: (1) possible physical or sex crimes; and (2) abuse or neglect allegations, but not crimes. Someone from the detectives' office periodically stops by during the day to pick up batches of the reports.
- The Marion office faxes the Form 307 and a cover sheet to on all screened cases to the appropriate law enforcement agency.
  - A master log of cases faxed to law enforcement, organized by agency, is maintained during the day and then sent at the end of the day to the various law enforcement agencies for confirmation of receipt.
  - Screeners sometimes work past normal business hours to assure the that reports are faxed the same day, although the shift of detectives at the receiving police agency may have already completed their business day.
  - The procedure calls for law enforcement to call back the next day to acknowledge the confirmation log.
  - Supervisors reported that they review the log twice per day, per policy.
  - Staff indicated that it is sometimes takes time to find the correct law enforcement jurisdiction for the address, since the branch covers multiple law enforcement jurisdictions.
- Hood River faxes a cover sheet and the Form 307 (though this form is not always attached) to law enforcement on all screened cases other than "logged" cases.
  - The reports are faxed both to the State Police officer assigned to child abuse and to the police agency with jurisdiction (either the County Sheriff or the Hood River Police).

- Workers also typically call law enforcement to give them notice and to confirm receipt of the fax (always on immediate response cases or cases that law enforcement is likely to interested in, and often on other cases as well).
- A master log of cases faxed to law enforcement is maintained during the day and initialed by the supervisor twice a day.

– Klamath faxes a cover sheet and the Form 307 to law enforcement on all screened cases (including those that turn out to be "logged" cases).

- The branch, which relies on a single screener, has found meeting the reporting deadlines to be not always possible, and the supervisor has established taking calls and staffing reports that need an immediate response as higher priorities than faxing reports within the deadlines.
- The faxes are sent to either the Klamath Falls Police or the State Police (the State Police determine which ones will be referred to the Sheriff).
- A master log of cases faxed to law enforcement is maintained during the day and initialed by the supervisor twice a day (one sheet lists one hour cases and one sheet lists three hour cases).
- The receipt of the fax is confirmed by (1) printing the automated fax log to show that the fax went through; (2) receiving the cover sheet back from law enforcement with a signature acknowledging receipt; and (3) a phone call to the law enforcement agency (in some cases).
- A cover sheet summarizing each case discussed in staffing meetings is forwarded to the District Attorney.

▪ For those branches that have fax logs it would be possible to use detailed entries from the logs and Form 307 information to determine whether reports were faxed to law enforcement within the deadlines established by the temporary rule, but none of the branches compiles summary reports showing the percentage meeting (or not meeting) the deadlines.

- The two smaller branches (Hood River and Klamath) discuss a selection of cases in their biweekly Multidisciplinary Team (MDT) meetings, and the Multnomah Hotline has set-up weekly "triage" meetings with District Attorney and police agency representatives to discuss a selection of cases.

Law enforcement action on cases reported from the child protection branches

- The reports sent from the smaller branches are reviewed directly by the law enforcement personnel that serve as liaisons for child abuse.
  - In Hood River all reports go to the State Police liaison and in consultation with an officer from the agency with jurisdiction she determines which cases will be investigated and who will do it.
  - In Klamath the reports that go to the Klamath Falls Police are all reviewed by the detective assigned to child abuse. Those that go to the State Police are reviewed by a detective, who determines which cases will be kept with the State Police and which will be assigned to the Sheriff.
- Eleven different law enforcement agencies receive reports forwarded by the Marion branch, and each agency has its own procedures to determine what actions to take, if any.
- The Child Abuse Team (CAT) of detectives co-located with the Multnomah Hotline receive the reports from the hotline.
  - "Pink copies" of Form 307's are retrieved from the hotline, assigned a case number, and batched for entry into the police data system, though the data entry was about 75 days behind when we visited.
  - The group also receives a lesser number of "white copies" of Form 307's that (according to the police) have been reviewed by the co-located District Attorney (DA) staff. They review these, and some may be discussed at weekly triage meetings involving the CAT team, DA staff, and hotline staff.

  - A primary interest for the police is who the perpetrator is in each case, but this information is not always available in the report received from the hotline (because the caller may not have had enough information to provide the identity).
  - Only about five percent or less (estimate) of the "white copy" cases received get follow-up from law enforcement.
- In all of the jurisdictions the law enforcement agencies are likely to choose to investigate only those cases that potentially involve a crime.
- Several of the law enforcement representatives we interviewed indicated that receiving reports on all reported child abuse incidents did not add value for them.
  - They would prefer a practice where the reports forwarded to them would be limited to those to be of potential interest to law enforcement (although receiving all reports appeared to be less of a concern in the smaller jurisdictions where the overall report volume is much more limited).
  - Categories indicated on the cover sheets used by the child protection branches on the forwarded reports are one means of helping law enforcement sort the reports received. Phone calls about cases to be of likely interest are another.
- Some of the law enforcement officers we interviewed suggested that one value in receiving all of the reports is that the information received can sometimes support an investigation of suspects of crimes other than child-related crimes.

Law enforcement reporting to child protection

- The child protection offices receive reports from law enforcement that include:
  - Telephone calls on imminent situations where law enforcement may desire the assistance of a child protection worker.

  - Written police reports of child protection calls received by law enforcement during the off-hours of the child protection agency.
  - Written police reports on other incidents of potential child abuse that have come to the attention of law enforcement.
- Each of the branches (with Multnomah represented by the hotline) enters all reports of potential child abuse received from law enforcement into FACIS.
  - These cases (if not an immediate response) proceed through the normal screening and assessment process.
  - Some, but not all, police reports received by the hotline in Multnomah are distributed to the field branches.
- In the smaller jurisdictions the law enforcement liaisons have the opportunity to review all (or most) arrest reports to ascertain whether there was potential child abuse, and can then select the cases to refer to child protection. But in the larger jurisdictions the volume of reports is too great, and thus there is more reliance on individual officers to determine which cases should be reported.
- A few of the persons we interviewed (including both child protection and law enforcement personnel) believed that law enforcement agencies are not consistent in the nature and timeliness of what they report to DHS.
  - One example: a DUI arrest with children in the car may or may not be reported to the child protection agency, depending on the arresting officer.
  - Some reports from law enforcement may reach the child protection agency only several days or weeks after the reported incident.

4. Assessment

Organization

- The organizational placement of the workers who conduct the "go out" assessments differs among the branches we visited:
  - In Marion the screeners are specialized, so that a different group of workers perform the assessments.
    - The assessment workers are in the same office as the screeners, with some (but not all) in the same supervisory unit.
    - Three units are involved in performing assessments.
  - In Multnomah the "go out" assessment workers are in units at the field branches, not at the hotline (except for a unit at the hotline that handles in-home cases). The organization at the various branches differs.
    - In Gresham "go out" workers can be from any one of three supervisory units.
    - At St. John's the "go out" workers are in a single child protection unit.
  - In Hood River there is only one child welfare unit, covering all of the services of the branch.
    - One worker performs the majority of the "go out" assessments, but other child protection workers perform assessments as well.
    - Since the screening responsibility rotates among workers, the assessment workers also perform screenings on assigned days.
  - In Klamath there are three supervisory units, one primarily responsible for child protection screening and assessment.

- One worker specializes in screening, and others from the CPS unit are assigned to perform the "go out" assessments.
- There are a few workers in the other units experienced in child protection, and they can perform back-up if necessary.

- Worker locations have an impact on procedures.
  - Locations affect how cases are transferred from screening to assessment.
    - In Marion, Hood River, and Klamath the assessment workers are in the same office as the screeners, so the physical transfer is straight-forward.
    - In Multnomah the screened cases are transmitted to the appropriate branch by fax and later by a shuttle service (and also through an automated transfer on FACIS).
  - The number of qualified child protection assessment workers at the location may affect the timeliness of the assessments.
    - For example, Klamath, with only one primary screener and four "go out" workers in the child protection unit, sometimes must rely on workers in other units to help cover screening and assessment responsibilities.
    - St. John's, which is piloting the "24 hour guided assessment" and attempting to get out within 24 hours on all assessments, relies on the Northeast Portland branch as back-up in some cases.
  - Having more than one supervisor qualified in child protective services assigned to a location is helpful to provide supervisory back-up when the primary supervisor is not available (for instance, on vacation or at an out-of-office meeting and not readily accessible by cell phone or pager).

Case assignment

- Each of the branches (with Gresham and St. John's representing Multnomah) assign cases (those that did not require an immediate response) in staffing meetings involving both supervisors and child protection workers.
  - Marion, Gresham, St. John's, and Klamath hold these meetings each weekday morning.
  - Hood River conducts the meeting on Tuesday and Thursday mornings, but the supervisor often assigns cases between the meetings.
- Supervisors indicated that cases are assigned to individual workers typically based on current workloads, with factors such as the nature and history of the case sometimes affecting the assignment as well. Some branches seem to follow a more formal "rotation" policy than others.
- None of the branches we visited has formal standards for the number of assessments assigned to a worker.
  - Although, the supervisors we interviewed on this point generally had in mind some number of open assessment cases that they believed was an appropriate workload for each worker.
  - In a brief review of some selected FACIS caseload reports we observed a wide variation in the number of open assessments assigned per worker, with many less than 10 and some more than 30.

Timeliness

- All of the branches were presently attempting to comply with current assessment timeliness policies. For all of the branches except St. John's this means:
  - Making face-to-face contact and completing assessments within 24 hours of the call receipt in cases where the child's safety is potentially at risk (and sooner on immediate response cases).

  - Where a child is not at risk, completing a face-to-face within five business days and completion of the written assessment within 30 days.

- St. John's is piloting the "24 hour guided assessment" and was attempting to complete all assessments (at least as they pertain to child safety) within 24 hours.
  - The branch has been attempting to make the first "go out" visit within 24 hours for the past few years, and indicates that on most cases they have been able to do it. Staff reported that this is not always possible, however.
    - In some cases the worker may not be able to locate the alleged victim or the family within 24 hours.
    - The number of staff available also imposes a possible limitation.
  - Various persons we interviewed, not only at St. John's, do not believe that 24 hour closure of the assessment is desirable on many cases where children are not at immediate risk; for instance:
    - More time may be necessary to collect the collateral information needed to make a sound decision on the case.
    - Sometimes coordination of several parties in necessary to develop a workable safety plan, and it can take time to get them together.
  - A large chart is placed outside the supervisor's office, indicating the time each case was received and who it was assigned to. Workers are expected to enter the date and time of their completion of the face-to-face visit on this chart.
- All of the branches expect assessments to be completed within 30 days (if not sooner, as indicated above) unless the supervisor approves an extension. But several supervisors we interviewed indicated that many assessments extend beyond 30 days.

  - Some supervisors stated that they are more concerned that the assessment is done and a plan for the child (or children) has been implemented within 30 days, if called for, than that all of the paperwork be "written up."
  - In a brief review of selected FACIS caseload reports we found many cases to be labeled "overdue" for the 30 day closure.
- The primary mechanism most (but not all) supervisors use to monitor the 30 day timeliness is FACIS caseload reports, sorted by worker.
  - Supervisors can view (and print) these reports at their own initiative.
  - Some supervisors annotate case status information on these reports based on discussions with workers.
- Some supervisors have other techniques to monitor caseloads and 30 day timeliness, such as manual log books.

<u>Assessment criteria</u>

- At each of the branches the "go out" workers seek to establish the safety status of the alleged child victims, to determine whether the allegations are founded, and to establish safety plans, if required, following the State assessment guidelines.
- The "go out" caseworkers rely primarily on their professional judgment to conduct the assessment.
  - They are not using formal checklists directly in each assessment (with the exception of the guided assessment pilot at St. John's).
  - But they seemed to have ready access to the State checklists and criteria.

- We interviewed one worker at St. John's who had very limited experience using the guided assessment tool (the branch had just started using it), and she reported finding it somewhat cumbersome to record a coherent narrative summary of the case in one place since the template is broken down into several distinct elements.

Assessment reviews

- In each branch that we visited both supervisors and workers indicated that workers typically consult with their supervisor (or another experienced supervisor or worker if their supervisor is not available) on key case decisions before the decisions are finalized.
- The supervisors we interviewed reported that they reviewed and signed all completed assessments.
  - The reviews are based on the supervisors' professional judgment and do not apply a structured supervisory review instrument.
  - Some supervisors noted that they give more attention to reviews of the cases of less experienced workers, and may review the cases of experienced workers more quickly.
  - Several supervisors indicated that it was difficult for them to keep up with the timing requirement of singing off within three days of the receipt of assessment cases from workers.

Supervisory spans

- The supervisory spans of control we observed were generally higher than the workload standard applied to determine the statewide staffing.
  - The "01-03 Earned Workload Ratios" establish a standard of one supervisor for every 9.5 caseworkers and SSA's.

  - In the units to which the child protective assessment workers were assigned, we observed ratios between 9 and 13 caseworkers and SSA's per supervisor (and at one branch a temporary supervisory vacancy caused the ratios to be even higher).
- Some supervisors stated that their responsibilities have increased since office manager positions were eliminated in the branches.
  - In some branches the child protective supervisors also supervise some clerical staff, increasing the ratios reported above where just caseworkers and SSA's were counted.
  - Some duties previously performed by office managers are now the responsibilities of child protection supervisors some branches, depending on how the branch is organized.

5. Management Reporting

<u>Reports seen by branch supervisors and SDA management</u>

- The reports seen and used by managers at the branches differ somewhat by branch, but focus primarily on measurements of workload.
  - Most supervisors reported using FACIS caseload reports, sorted by worker.
  - The lead line manger at the Multnomah Hotline reviews a monthly report with statistics on:
    - The number of calls taken, by shift
    - The number of cases logged into FACIS but not referred
    - The number of cases referred to branches for assessment
    - The number of assessments completed by Hotline staff (out-of-home care workers) and the number determined founded, unfounded, and unable to determine

  - A breakdown of the types of abuse on the cases referred
  - The number of police reports received
  - The number of criminal history checks conducted
- At the Gresham branch the SDA community manager (program manager) sees the statistical report produced by the hotline showing referrals to the branch and certain "green bar" reports showing cases opened, closed, etc.
- The SDA program manager in Hood River generates both Mobius and FACIS reports, primarily dealing with caseloads, but also including, for example, the number of cases involving face-to-face visits.
- In Klamath:
  - The screener maintains a tick-mark report of the number of calls received, the number of collateral contacts made, the number of referrals screened out, and the number of referrals assigned. The CPS supervisor and the program manager see this report.
  - The supervisor keeps an "Intake Assignments" log book with a page for each worker. This log shows the cases assigned and the status of each, including the date of contact.
  - The CPS supervisor, the program manager, and the SDA manager indicated that they do not receive or review regular Mobius or FACIS reports with statistics on the screening and assessment processes.

- Other than the timeliness notations that appear by case on the FACIS caseload reports and in the logs used by some supervisors, no one reported compiling or routinely reviewing any summary statistics on the percentage of cases meeting timeliness deadlines such as:
  - Report submissions to the police within required deadlines (one hour and three hours)

  - Cases receiving a face-to-face visit within 24 hours, five days, etc.
  - The 30 day assessment closure target
- The lead line manager at the Multnomah Hotline had prepared a one-time analysis of certain comparative data across counties (for 2001):
  - Ratio of cases referred for assessment to cases logged but not referred
  - Ratio of cases with no disposition (screened out) to those with a disposition (assessed)
- We found no other examples of branches routinely generating, receiving, or using reports comparing the branch's child abuse and assessment activity and results to those of other branches (or SDA's).
- Some of the persons we interviewed indicated that at many branches, at least, the office manager was trained in producing certain reports (from Mobius, for example) and that the branches' ability to produce various reports declined when the office manager position was eliminated.

Performance measures

- One federally-required performance measure, "repeat maltreatment," is an indicator of how well the goal of protecting children from abuse and neglect is met. It measures the percentage of children experiencing a substantiated recurrence of maltreatment within six months.
  - DHS has produced a "Performance Indicator Comparison as of June 2002" which shows branch comparisons for this measure ("re-abuse, both including and excluding "threat of harm").
  - When we queried managers and supervisors about the management reports that they see, they did not bring this report to our attention.
- Other than timeliness requirements embedded in policy, we found no evidence of branch awareness of any other formal performance measures established by the State and pertaining to the "front end" of the child protection process.

- Most of the federally-required measures pertain to placement, permanency goals, and child and family well-being goals, not to the report receipt, screening, and assessment "front-end" of the child protection process. The DHS "Performance Indicator Comparison" includes some of these as well.
- Certain supervisors and managers we interviewed indicated that they would like to see how their branch compares to others on certain measures or statistics, but that they see less of this now than they once did under the previous organizational structure.

Appendix 5 – Recent Child Protective Services Policy Developments

RECENT CHILD PROTECTIVE SERVICES POLICY DEVELOPMENTS

Policy Detail	Timeliness	Reference
DHS Child Welfare Office Cross Reporting Responsibility		
A report of child abuse/neglect which requires an immediate response and all reports of abuse by a third party	Within 1 hour of receiving a report a written report will be submitted to law enforcement in conjunction with a phone call (immediate) Also for third party abuse: subsequent reports on the same incident that contain new information shall be reported to law enforcement within 1 hour of receipt of said reports	Temporary rule effective September 27, 2002; expires March 25, 2003 Policy I-B.2.1
All other reports	A written report will be submitted to law enforcement in writing within 3 hours or before the end of the business day, whichever occurs first	
Supervisor Review and Approval of Child Abuse/Neglect Report Actions		
Designated supervisor initials time and date written on hard copy of screened-in report (307) that verifies initial screening is completed and level of response is indicated		Temporary rule effective September 27, 2002; expires March 25, 2003 Policy I-B.2.1 and 2.2

Policy Detail	Timeliness	Reference
Supervisor will review and initial log of reports sent to law enforcement	Twice per day (mid-day and end of day)	
Supervisory review and FACIS approval of all reports of child abuse/neglect that identify a report closed at screening	Within 3 working days of completion of screening or by noon of the following business day if the third working day falls on a non-business day	
Supervisor must review and approve a completed CPS assessment	Within 3 working days of the electronic submission of the assessment by the child welfare caseworker or by noon of the following business day if the third working day falls on a non-business day	
Initial Child Safety Assessment		
Immediate Safety Threat	Child safety assessment to be completed within the same working day the report was received	Draft policy I-B.2.2
Impending Safety	Child safety assessment to be completed within 24 clock hours of the time the report was received	
Response Required (not immediate or impending)	Child safety assessment to be completed within 5 days from the date the report was received	
Initial Child Safety Plan	Developed immediately when a safety threat has been identified as a result of a child safety assessment	
Comprehensive CPS Assessment	Within 30 working days	