Assessment of Clark County Department of Family Services' Child Abuse Hotline

The central focus of child protective services is on assuring that children are safe from child abuse and neglect. Maintaining this focus begins with the child welfare agency's system for receiving allegations of child maltreatment. Most agencies, including the Clark County Department of Family Services, operate hotlines for this purpose. Hotlines function to receive reports and determine which meet the designated criteria to be classified as allegations of child abuse or neglect. It is important that decisions be made efficiently and accurately. Inefficient hotlines are not reliably capable of receiving reports concerning children who may be in danger. Inaccurate hotline decisions impair the child welfare agency's ability to protect children because either 1) reports are inappropriately screened out and the agency fails to take necessary protective action or 2) reports are inappropriately screened in and the agency's resources are diluted by its response to situations outside its responsibility. In most cases, all three problems coexist to some degree.

The Clark County Department of Family Services (DFS) has requested an assessment of its hotline. The review's primary focus is on the quality of decision making. More specifically, with what frequency are referrals that should be screened in screened out and, conversely, how often are referrals that should be screened out screened in? In addition, the quality of several other aspects of the Hotline's functioning is explored. Do Hotline workers gather sufficient information from callers to facilitate good decision making? Are the response priorities assigned to reports appropriate? Does the agency inappropriately delegate its responsibilities to the police? Do workers handle calls efficiently? And finally, are there categories of calls (e. g. educational neglect, medical neglect, rejection, physical neglect concerning concrete need, and environmental neglect) that would be appropriate for alternative response?

Preparation for the Review

The core activity of the assessment is the review and evaluation of actual referrals. It was necessary to undertake several activities before beginning the review.

1) Statutes, rules, policy, procedures, manuals, and other material relevant to decision making at the Hotline were reviewed. The most pertinent of these were Nevada Revised Statute 432B (Protection of Children from abuse and Neglect), Nevada Administrative Code 432B, Collaborative Intake Policy 200 (8-30-05), Clark County Intake Policies and Procedures (2-15-06), and the Clark County Hotline Training Manual.

2) Confidential telephone interviews with a small sample of community stake holders from medical and law enforcement agencies

3) On site orientation to the Hotline process, including observation of the Hotline in operation

4) Informal confidential focus group/interviews with the Hotline supervisor, Hotline caseworkers, a Child Protective Service supervisor and Child Protective Service caseworkers conducted according to protocols which are attached

5) Onsite orientation to the UNITY system and the Hotline call recording system

6) Development of a protocol to guide the review of Hotline calls

7) Development and revision of a plan to conduct the review

These preliminary activities resulted in the identification of several significant issues affecting Hotline decision making. The most notable of these concern 1) operational definitions of child abuse and neglect and 2) the decision making process. In addition, several issues concerning the structure and process of the review were identified.

Statutory and Regulatory Definitions of Child Maltreatment

NRS Chapter 432B (Protection of Children from Abuse and Neglect)

Chapter 432B of the Nevada Revised Statutes provides the legal basis for child protective services, including hotline operation and decision making, in Nevada. Among other things, the law defines situations that are to be accepted as maltreatment reports.

In order for a situation to qualify for investigation, it must be determined that the caller has information that, in light of all the surrounding facts and circumstances, would cause a reasonable person to believe that a child (any one under the age 18) has been abused or neglected. (NRS 432B.121) Second, the law identifies the individuals who, by virtue of their relationship to the child, can be alleged to have abused or neglected a child. These are, "the child's parent, guardian, a stepparent with whom the child lives, an adult person continually or regularly found in the same household as the child, or a person directly responsible or serving as a volunteer for or employed in a public or private home, institution or facility where the child actually resides or is receiving child care outside of his home for a portion of the day." (NRS 432B.130)

Finally, the law defines incidents or situations that constitute child abuse and neglect in five categories. The statutory definition of **Physical Abuse** is nonaccidental physical injury. Physical injury is further defined as including but not limited to sprains, dislocations, damage to cartilage, bone fractures, intracranial hemorrhage, injury to an internal organ, burns, cuts, lacerations, puncture wounds, bites, permanent or temporary disfigurement, and permanent or temporary loss or impairment of a part or organ of the body. (432B.020 and 432B.090)

Neglect "…occurs if a child has been abandoned, is without proper care, control and supervision or lacks the subsistence, education, shelter, medical care or other care necessary for the well-being of the child because of the faults or habits of the person responsible for his welfare or his neglect or refusal to provide them when able to do so." (432B.140) The negligent treatment must have been "…caused or allowed by a person responsible for his welfare under circumstances which indicate that the child's health or welfare is harmed or threatened with harm." 432B.020

Mental Injury is "…an injury to the intellectual or psychological capacity or the emotional condition of a child as evidenced by an observable and substantial impairment of his ability to function within his normal range of performance or behavior." (432B.070)

The definition of **Sexual Abuse** refers to criminal statutes. It includes incest, lewdness with a child, sado-masochistic abuse, sexual assault, statutory sexual seduction, open or gross lewdness, and, mutilation of the genitalia of a female child, aiding, abetting, encouraging or participating in the mutilation of the genitalia of a female child, or removal of a female child from this State for the purpose of mutilating the genitalia of the child. (432B.100)

Sexual Exploitation includes forcing, allowing or encouraging a child to solicit for or engage in prostitution, to view a pornographic film or literature, and to engage in filming, photographing or recording on videotape or posing, modeling, depiction or a live performance before an audience which involves the exhibition of a child's genitals or any sexual conduct with a child. (432B110)

While these definitions are somewhat more specific than those found in many state statues, they are far too general to serve as the basis for the day to day case level decisions made by caseworkers. As in most states, administrative rules and agency procedures serve to more specifically define abuse and neglect.

State Administrative Regulation

The Nevada Administrative code provides no guidance beyond NRS 432B and merely refers to the statutory definitions of abuse and neglect. A state level Collaborative Intake Policy (200) guides the state Division of Children and Family Services, the Clark County Department of Family Services and the Washoe County Department of Social Services in (among other things) hotline operation.

The maltreatment definitions in Intake Policy 200 are even less specific than those in NRS 432B. In addition to the Intake Policy, the state's SACWIS system (UNITY) lists 56 categories of abuse and neglect. This list is important to day to day decision making because these are the categories available to Hotline caseworkers as they categorize reports. The UNITY categories are not consistent with those in NRS 432B. The UNITY Allegations are:

Physical Abuse
Beating
Biting
Bruising
Burning
Cutting
Death of a Child
Domestic Violence
Drug Affected Infant
Threat of Harm
Muchchausen (sic) Syndrome
Other
Poisoning
Ritual Abuse
Scalding
Shaken Baby
Shaking 3 years or Older

Neglect
Parent Alcohol Abuse
Abandonment
Educational Neglect
Environmental Neglect
Filthy Home
Failure to Thrive
Threat of Harm
Parent in Hospital
Parent in Jail
Legal Protection Needed
Parent Mental Incapacity
Lack of Necessity
Other
Physical Neglect
Parent Physical Incapacity
Failure to Protect Sex Abuse
Parent Substance abuse
Lack of Supervision

Emotional Abuse/Neglect
Confinement
Domestic Violence
Mental Harm
Other
Psychological Maltreatment
Rejection

Medical Neglect
Parent No Obtain Medical/Psychological Services
Parent Refuse Medical Services/Medication
Parent No Accept Medical Services
Child Need Not (?)
Other

Sexual Abuse
Behavioral Sex
Sexual Fondling
Other
View Pornography
Physical Evidence of Sex
Sexual Acting Out
Sexual Grooming
Sexual Exploitation
Sibling Victim
Verbal Sex Cont
Voyeurism/Exhibitionism

Beyond common parlance meaning, there does not seem to be any definition to any of these categories. Many of them are not allegation categories but underlying conditions (e. g. Parent Alcohol Abuse, Domestic Violence, and Parent Mental Incapacity). Others are social problems that do not rise to the level of child maltreatment (e. g. Parent in Hospital and Legal Protection Needed). Others appear to be duplicative (e. g. how does "Parent Refuse Medical Services/Medication" differ from "Parent No Accept Medical Services"?).

Local Procedure

Clark County has developed a more detailed local procedural manual, "Intake Policies and Procedures". The manual provides definitions of maltreatment in the following 14 categories:

Physical Abuse	Neglect	Substance Exposed Infant
Substance Abuse By Parent	Improper Supervision	Emotional Neglect/Abuse
Medical Neglect	Physical Neglect	Abandonment
Rejection	Environmental Neglect	Educational Neglect
Sexual Abuse	Potential Abuse	

While these seem to flow from NRS 432B in a more consistent way, they are not remotely consistent with the UNITY Allegations which are the operational categories case workers must fit referrals into. Notably, there is no definition for sexual exploitation – often a troublesome category. The definitions themselves are often incomplete and confusing. Many include a "guidelines" section that appears to be a list of examples of situations that fitting into the respective category. It is, however, unclear whether the guidelines are intended to be exhaustive lists or "including but not limited to examples".

Overall, the lack of clear categorical definitions of child maltreatment is a serious problem for the Hotline, DFS, and the community. Without a clear understanding of the definition of maltreatment, consistent decision making at the Hotline and by CPS is impossible. Furthermore, the community cannot clearly understand what should be reported and what can be expected from DFS.

That there is confusion about what constitutes maltreatment was born out in the interviews and focus groups conducted before the review. In response to the question "What guidance (i.e. procedure) does hotline staff follow in deciding whether to accept a referral for investigation?" DFS staff all mentioned NRS 432B. The Hotline supervisor acknowledged that Hotline workers had never received any training on what is or is not abuse or neglect. Both the supervisor and the workers said that the supervisor consults with newer workers when they are unsure of a decision but that more experienced workers generally make their decisions independently. Hotline caseworkers said that they had never seen the Clark County Intake Policy and Procedures Manual. At least one experienced worker said that she didn't know what the definitions were. All said the definitions were unclear to them. All workers complained about the lack of training. In addition to the law, the Hotline workers cited precedent established by their peers and their "gut" as the bases for decision making.

In interviews, stakeholders external to DFS said that they believed that they understood the definitions of abuse/neglect but that the caseworkers at the Hotline did not seem to. The stakeholders could not identify the source of their definition other than to cite the law. They found decision making to be inconsistent if not erratic. Both said that the Hotline staff seemed untrained.

Decision Making Process

The second substantive issue identified during the pre-review activity concerned the decision making process. When referrals are received at the hotline, the Hotline worker decides whether to document the referral information in UNITY. Generally, referrals made by mandated reporters are documented in UNITY, although this proved inconsistent. Referrals made by non-mandated reporter are documented in UNITY only if the worker believes the referral meets the criteria for investigation. At the point when a referral is entered into UNITY, it becomes a "report". Referrals that are screened out at the Hotline are designated "Information Only". Reports are sent electronically to CPS supervisors according to the geographic location of the family reported or the nature of the case (i. e. reports involving sex abuse and children under five are routed to specialized units). CPS supervisors review reports and determine whether they should be investigated. Sometimes this review involves telephone contacts with collateral parties relevant to the report and sometimes supervisors make decisions based on the information obtained by the Hotline. Reports screened in to investigation become "Cases". Those that are screened out by CPS become "Information Only".

Both Hotline staff and external stakeholders complained about this bifurcated decision making process. Both said that permitting multiple decision makers leads to inconsistent decisions and that screening decisions are, at times, made on the basis of the CPS units' workload rather than on child safety considerations. Both Hotline staff and external stakeholders claimed that they could identify individual supervisors who are prone to screen reports out.

Description of the Review Process

The initial plan for the review was straight forward. Every tenth call would be reviewed for three one week periods. Three non-consecutive weeks would be randomly selected and reviewed. This would result in the review of roughly 160 referrals. UNITY documentation would be pulled for each report and compared to the information received by the Hotline caseworker.

Several issues rendered this plan unworkable. First, the vast majority of call to and from the Hotline are unrelated to abuse/neglect reporting. Of 1,500 calls reviewed, only 138 (9%) were actual maltreatment referrals. Second, many referrals involved multiple phone calls. Callers are asked to call back with additional information, Hotline workers make calls out to gather information or to consult with CPS supervisors, and for technical reasons related to the call recording system, a single call may appear to be two or more calls. Other than listening to all calls in sequence, there is no way to identify subsequent calls on a referral about which there has been a previous call. Finally, except in emergency situations, the Las Vegas Metro, North Las Vegas, and Henderson Police Departments do not telephone their reports to the Hotline. Because of difficulty they have experienced in getting through, they send their abuse/neglect referrals to the Hotline by

fax or mail. Simply listening to phone calls eliminates this important category of reporter from consideration.

Sample Selection

In response to the issues identified during the pre-review activity, an alternate sampling process was used. Instead of listening to every call for three one week periods, every incoming and every outgoing call for five 24 hour periods was reviewed. The 24 hour periods extended from midnight to the following midnight. All recorded calls for Thursday June 1, Tuesday June 13, Saturday June 24, Sunday June 25, and Wednesday July 12, 2006 were reviewed. This sample generally accounts for variations that may occur over weekends and at different times of day and night. It also provides a recent view of Hotline functioning. The sample does not account for seasonal variation. To consider seasonal variation would require listening to older calls. Since Hotline staff indicated that recent improvements in the Hotline process (e. g. increased staff) had taken place, it was decided that the more current sample was more relevant.

A more important limitation is the fact that the sample almost entirely excludes law enforcement referrals. This is a significant problem because police are major reporters and often report the more serious situations. It is especially worrisome in light of assertions made by external stake holders that some mandated reporters – most notably hospitals – have given up on calling the Hotline because of long delays in getting through. Instead, it was reported that these referrals are made to the police with the understanding that the police would forward them to the Hotline.

In an effort to account for these "missing" referrals, a separate review was conducted. Originally it was thought that the written referrals for the five days for which phone calls were listened to could simply be reviewed and included in the results. This proved impossible for two reasons. First none of the police agencies send written referrals to the Hotline on the date it was received. Instead they appear bundle referrals and send them when they have several. Second, the Hotline keeps no record of the law enforcement referrals it screens in and sends to CPS. The only record of law enforcement referrals maintained at the Hotline are copies of the referrals that have been screened out.

To account for these referrals, all mailed or faxed law enforcement referrals for the month of June 2006 were reviewed. Since these were only the screened out referrals, the only analysis possible is the proportion of referrals that were screened out inappropriately. There is no information about the quality of decision making on the reports screened in or about the screening determination made by CPS. Obviously, this is an important limitation.

One final potential sampling problem related to referrals that are faxed or mailed to the Hotline by other sources. It became apparent that such referral were made when listening to calls. Staff from medical facilities made several calls to check the status of referrals they had faxed in. There does not appear to be any record of these calls at the Hotline.

Presumably, they are screened in and documented in UNITY. There was, however, no way to consider them in the review.

Detailed Description of the Telephone Review Process

As is explained above, the telephone review involved listening to every call to the Hotline for five days in June and July 2006. As the calls were reviewed, information was recorded on the "Clark County Hotline Decision Making Assessment Protocol". (attached) Prior to the review, DFS provided information concerning the number of calls received per day. These numbers bear no resemblance to the number of calls recorded by the Hotline call recoding system. For example, On June 13 the telephone records provided by DFS indicate that a total of 270 calls were received or made at the Hotline. There are recordings of 433 calls. There is similar variation in the call totals for the other days reviewed. A substantial number of recorded calls are very brief. Approximately 7% are less than ten seconds and about 20% are less than one minute in duration. This may account for some of the difference in the call totals. Obviously these very short "calls" did not involve any meaningful activity. Finally, there were several instances where something seemed to wrong with the recording system. Between 4:14 AM and 6:00 AM on June 24 and again between 12:38 AM and 5: 57 AM on July 12, no calls were recorded.

Once identifying information was gathered from a call, DFS staff from programs other than the Hotline searched UNITY for documentation of the referral. Excepting the referrals that were obviously screened out at the Hotline and not entered into the system, UNITY documentation was found for all but one referral. That referral included very little identifying information. The UNITY documentation was compared to the information gathered by the Hotline worker during the phone call. It was used to identify the intake determination for the referral (screened in or out at the Hotline / screened in or out by CPS) and the response priority assigned for cases that were screened in.

Table 1 below summarizes the surprising fact that slightly fewer than 10% of the calls to and from the Hotline were actually related to abuse/neglect referrals from the community.

Table 1

DATE	TOTAL CALLS	REFERRALS	% Referrals
Thursday June 1	440	48	11%
Tuesday June 13	433	39	9%
Saturday June 24	143	8	6%
Sunday June24	86	7	8%
Wednesday July 12	398	36	9%
TOTAL	**1500**	**138**	**9%**

Calls and Referrals Per Review Day

The list of other types of calls is a long one. It includes some calls that would seem to be appropriate and many that would seem inappropriate:

- Data Checks for Law Enforcement: Calls from the police seeking information about abuse/neglect histories involving families they were currently responding to. Although it was often obvious that the police were intervening in relationship to an allegation of child maltreatment, the Hotline worker almost never made any inquiry about the current issue.

- Case Finding: Calls from the community seeking the identity of an assigned case worker.

- Child Haven Management: Calls related to admission and visitation concerning Child Haven.

- Directory Assistance: Calls from DFS staff seeking the phone numbers of other DFS staff.

- Technical Assistance with Court Documents: Calls from DFS staff requesting that the Hotline assist with or actually prepare court documents for them. According to Hotline staff, a directive has been issued to stop this but they say it continues. It certainly occurred as late as July 12.

- Technical Assistance with UNITY: DFS field staff called the Hotline requesting help with the UNITY system.

- MapQuest: Calls from DFS caseworkers in the field asking the Hotline for driving directions.

- Personal Calls: Many personal calls. Personal calls were tallied for one day because it was noted that there was such a surprising number. The proportion of personal calls was about the same as the proportion of calls related to maltreatment referrals.

Decision Making Results

The core purpose of the review is to assess the quality of decision making at the hotline. Because of the diffuse nature of the decision making process, this proved to be more complicated than originally anticipated. Although the Hotline screens referrals out, its decisions related to reports screened in are preliminary and are often changed by CPS supervisors. The same is true for response priorities for cases that are screened in by both the Hotline and CPS. For this reason, two analyses are needed for decisions about referrals screened in by the Hotline; one analysis of the Hotline decision and a second for the CPS decision.

Hotline Screening Decisions

As has been mentioned, 138 referrals were considered by the Hotline over the five days reviewed. One of these that may have been screened in could not be located in UNITY and was excluded from the review. Of the 137 referrals that remain, the Hotline screened 92 (67% of 137) in and 45 (33% of 137) out. This is comparable to the national average. According to NCAND data, in 2002 about 62% of abuse neglect reports were screened in for CPS response nationally. The key, of course, is not to screen the right proportion in but to screen the right referrals in.

In the original plan two judgments about screen in /screen out decisions were to be made: 1) was the decision consistent with applicable regulation? and 2) was the decision in keeping with good practice as it relates to child safety? Because the relevant law, regulation, and procedure define child abuse and neglect in an inconsistent and confusing manner, the first of these judgments is impossible to make. There simply is no consistent legal/procedural standard against which to measure individual decisions. Given this, the quality of Hotline decisions judged from the perspective of good practice as it relates to child safety is depicted in Table 2.

Table 2

N = 137	Referrals Screen In	Referrals Screen Out	Total
Insufficient Info	5	6	11
% Insufficient Info (of 137)	4%	4%	8%
Reasonable	69	36	105
% Reasonable (of 137)	50%	26%	77%
Questionable	18	3	21
% Questionable (of 137)	13%	2%	15%
Total	**92**	**45**	**137**
% of Total (137)	**67%**	**33%**	**100%**

Hotline Screening Decisions

Overall, good decisions were made in 77% of the referrals considered. The Hotline was far more likely to screen referrals in that should have been screened out (13% of the 137 decisions) than it was to screen referrals out that should have been screened in (only 2% of 137).

Among referrals inappropriately screened in were:

- A psychologist reported sexual abuse after a mother sought treatment for her 6 year old daughter who had been the victim of sexual abuse by her father's girl friend two years before. The previous allegation had been reported to DFS and investigated. The mother has sole custody. The mother was concerned because she caught the 6 year old touching her 3 year old in a sexual manner. The psychologist stated that the mother had taken appropriate steps to protect both children.

- A hospital case manager reported that a 15 year old boy had been brought to the hospital following an automobile accident. The boy had been using alcohol and marijuana. His mother was not immediately available by phone and the hospital wanted the child removed from the ER. He had been there for just over an hour.

While one might think it best to "err on the side of caution", inappropriately sending investigations to the field has the effect of reducing child safety because it dilutes CPS resources.

The referrals inappropriately screened out were:

- A neighbor reported seeing a very young child with marks "all over". The neighbor said that she had seen the mother hit the child while at the park. The reporter hung up after providing all necessary information.

- A live in paramour was arrested for domestic violence and for hitting an 11 year old child leaving significant marks. The report was screened out because the paramour was in jail at the time of the call.

- A mother reported that the father of her 15 year old son beat and choked the child, giving him a black eye and leaving marks on his neck. The father allegedly put the child out the home in the middle of the night. This report was made information only because it involved an active case.

The Hotline worker did not gather enough information to determine whether referrals should be screened in or not in 11 (8%) of the 137 referrals considered. Referrals were included in this category only if there was important information that was not sought by the worker from the reporting source and the information was necessary to a screening decision. There were some calls in which the worker could have gathered additional useful information that was not critical to the screening decision. These referrals were not included in this "insufficient information" category. Referrals for which insufficient

information was gathered are about equally split between those screened in and those screened out.

Hotline decision making was considered according to the day on which questionable decisions were made. Significant variation by day would suggest the possibility that differences in assigned staff might affect the quality of decision making. Furthermore, a steady change in the quality of decision making might be the result of improving or deteriorating practice.

For the purpose of Table 3, "problematic decisions" include those found to be questionable and those made after the Hotline gathered insufficient information to make sound decisions.

Table 3

Review Day	Decisions	Number Problematic	% Problematic
June 1	47	12	26%
June 13	39	10	26%
June 24	8	2	25%
June 25	7	0	0%
July 12	36	8	22%
Total	**137**	**32**	**23%**

Problematic Decisions By Day

With exception of Sunday June 25 -- when the Hotline made only seven screening decisions -- there is no significant variance by day.

CPS Screening Decisions

When referrals are screened in by the Hotline, they are sent to CPS supervisors who may decide to screen them out. Sometimes CPS supervisors make this decision solely on the basis of the information gathered by the Hotline. At other times CPS supervisors gather additional information by making phone calls. The next table illustrates the decisions made by CPS about the referrals the Hotline screened in. Although the hotline routed 92 reports to CPS, five were referrals for which the Hotline gathered insufficient information to make a sound screening decision. Of these five, CPS screened three in and two out. These five referrals are not included in Table 4 or in the analysis of CPS decision making.

Table 4

N = 87	Referrals Screen In	Referrals Screen Out	Total
Reasonable	61	10	71
% Reasonable (of 87)	70%	11%	82%
Questionable	8	8	16
% Questionable (of 87)	9%	9%	18%
Total	**69**	**18**	**87**
% of Total (87)	**79%**	**21%**	**100%**

CPS Screening Decisions

Overall, 82% of the Screening decisions made by CPS supervisors were found to be reasonable. The 16 decisions found to be questionable were evenly split between reports screened in and those screened out .

Table 5

	Hotline Decision Reasonable	Hotline Decision Questionable
CPS Screened In	61	8
CPS Screened Out	8	10

CPS Decisions By Hotline Decision

Of the 18 reports for which the Hotline's decision to screen in was questionable, 10 were screened out by CPS. Thus, 10 Hotline "errors" were corrected. On the other hand, almost as many sound decisions made by the Hotline were reversed, with eight reports that should have been investigated screened out by CPS. These include:

- A middle school counselor reported that an emotionally disturbed 12 year old boy came to school with scratches on his face saying that his mother scratched and hit him. CPS screened the report out on the basis that it "did not rise to the level of CPS."

- An employee of a bail bonds company reported that a mother, accompanied by her 5 year old son, came in to obtain bail for her boyfriend. The boy was crying, had scratches all over his face, and appeared to have been beaten up. The child said that his mother had hit him and looked frightened. The mother continually yanked the child by the arm in way that appeared to be painful. The Hotline contacted the police for immediate response because the report came in at 10:30 PM. CPS screened the report out after contacting the police who said that the home was appropriate, there was plenty of food, the child did have scratches on his face, but he appeared to be happy.

- A 4 year old was left alone at McDonalds for at least an hour. The police responded and contacted the Hotline. The mother claimed that the child was left as the result of a mix up between the mother and her boyfriend. The police reported that the mother has a history of using methamphetamines and they believed she was still using.

It is worth noting that the Hotline tends to screen reports in inappropriately while CPS is as likely to inappropriately screen out as to screen in. This may reflect different decision making environments. At the Hotline there is not the same consequence associated with the decision to screen in as there is for CPS for which the decision to screen in increases workload. In an effort to test this idea, the total of number of reports received by CPS was correlated with the proportion of reports screened out by CPS for a seven month period ending in July 2006. If CPS workload is a factor in decisions CPS supervisors make to screen reports out, there should be a correlation between the total number of reports received by CPS and the proportion of those reports that are screened out. Table 6 uses administrative data from UNITY.

Table 6

	Total Referrals	CPS Scrnd Out	% Scrnd Out
January 2006	1128	247	21.9%
February 2006	1009	201	19.9%
March 2006	1272	293	23.0%
April 2006	1066	235	22.0%
May 2006	1269	227	17.9%
June 2006	966	178	18.4%
July 2006	969	152	15.7%

Reports Screened Out by CPS By Month

In Table 7 the rank of each month according to the number of reports received by CPS from the Hotline is compared with each month's rank in the percentage of reports screened out by CPS supervisors.

Table 7

Month	Rank of Reports Received	Rank of % Screened Out
March	1	1
May	2	6
January	3	3
April	4	2
February	5	4
July	6	5
June	7	7

Rank Comparison: CPS Intake v. Reports Screened Out

While the correlation is not perfect, with the exception of May, the likelihood of a report being screened out by CPS to tracks CPS intake. This is by no means conclusive. It does suggest, however, that intake may very well influence CPS supervisors' decisions to screen reports out.

Overall DFS Screening

By combining the analyses of Hotline and CPS screening decisions, one gets a picture of overall agency performance. Table 8 excludes the reports that the Hotline screened in after gathering insufficient information to make a good decision from the CPS total. The total number of decisions is, therefore, 224.

Table 8

N = 224	Screen In Decisions	Referrals Screen Out	Total
Insufficient Info	5	6	11
% Insufficient Info (of 137)	2%	3%	5%
Reasonable	130	46	176
% Reasonable (of 137)	58%	21%	79%
Questionable	26	11	37
% Questionable (of 137)	12%	5%	17%
Total	**161**	**63**	**224**
% of Total (224)	**72%**	**28%**	**100%**

DFS Screening Decisions

Although overall screening decisions appear better than those for either program separately, the fact that more than 20% are questionable or are made without important information is troubling.

Law Enforcement Issues

Hotline Screening Decisions of Police Referrals

As has been discussed, law enforcement referrals are usually sent to the hotline by telefax or mail. Consequently, these referrals were not included in the review of Hotline calls. Instead, copies of all written police referrals received at the Hotline during June 2006 were reviewed. Since the Hotline retains only the referrals that it screens out, and since there is no log of the police referrals forwarded to CPS, the review is limited to considering whether police referrals that should have been screened in were screened out. Thirty-nine referrals were reviewed. The North Las Vegas and Las Vegas Metro Police Departments fax their referrals to the Hotline. The North Las Vegas Police Department mails them. Table 9 identifies the police referrals by sources.

Table 9

Police Department	Number of Referrals
Las Vegas Metro	31
North Las Vegas	2
Henderson	6
Total	39

Police Referral by Source

According to administrative data from UNITY, a total of 66 law enforcement referrals were received by the Hotline during June. Presumably, these are reports that the Hotline screened in and sent to CPS (since they were entered in UNITY). Based on this assumption, the total number of referrals mailed or faxed by the police was 105. The Hotline screened out 37% of police referrals. This is consistent with the 33% of referrals that the Hotline screened out overall. Table 10 reflects Hotline decision making as it relates to screened out police referrals.

Table 10

N = 39	**Referrals Screen Out**
Insufficient Info	3
% Insufficient Info (of 105)	8%
Reasonable	32
% Reasonable (of 105)	82%
Questionable	4
% Questionable (of 105)	10%

Hotline Screen Out Decisions for Faxed/Mailed Law Enforcement Referrals

The documentation provided in three police referrals was not sufficient to inform a sound decision. One of these was simply illegible. For the other two, it is possible that

additional information was sought from the police before the Hotline decided to screen out. Presumably, if this were the case the additional information would have been documented and included with the referral. None was. The Hotline decision to screen out police referrals was found to be reasonable 82% of the time. This is almost identical to the 80% for referrals overall. Among the four referrals screened out inappropriately were:

- The police verified that a 6 year old had been left alone by his father from 8:00 PM until 10:40 PM. The police admonished the father.

- A 14 year old girl living with her mother and stepfather alleged that an adult man, also living in the home, had molested her continuously for a period of months.

- The police verified that an 8 year old had bruises on his leg. The police determined that the bruises were inflicted when the child's stepfather pinched him as punishment. The police obtained a warrant for the stepfather's arrest.

Other Police Issues

Two other issues concerning law enforcement were considered. First, one stakeholder external to DFS said, during an interview, that DFS often told Hotline callers to call the police as a means of making a child abuse/neglect report. Because police are mandated reporters, any report to them would, as a matter of course, be forwarded to the Hotline. This would reduce the workload at the Hotline. Although there were some calls that were appropriately screened out during which the Hotline worker suggested to the caller that the reported issue was a police matter, there were no calls where the hotline suggested that the police be used as a conduit of information to the Hotline.

Second, concern has been expressed that, at times, the agency inappropriately delegates its responsibilities to the police. Although there are some instances where this seems to occur, with one exception, this problem appears to be more relevant to CPS than to the Hotline. At times CPS made the decision to screen a referral out after the police have been out because the police have intervened. This despite the fact that the police intervention was focused on criminal investigation and was not specifically relevant to child protective services. In some such examples, children were left in potentially dangerous situations. In other instances, the Hotline identified referrals as needing immediate intervention and contacted the CPS supervisor to whom the report was being assigned. In several instances the CPS supervisor told the Hotline worker to contact the police because no CPS staff was available to respond. These issues are noted anecdotally and were not quantified during the review.

Inappropriate use of the police is relevant to the Hotline in relation to emergencies after hours. CPS staff is assigned emergency referrals on week days between the hours of 8:00 AM and 3:00 PM. Between 3:00 PM and 10:30 PM on week days and between 7:00 AM and 10:30 PM on weekends, the Swing Shift is assigned emergency referrals. Between 10:30 PM and 7:00 AM seven days per week, no CPS staff is available to respond to emergencies. Any emergency reported during this time is sent to the police. The Clark

County Policy and Procedures Manual instructs Hotline staff to "dispatch law enforcement" when no CPS staff is available. This is a serious problem at for at least two reasons. First, the police conduct investigations for reasons that are very different from those conducted by CPS. They are not trained or oriented to respond in a way that is focused on child protection except as it relates to criminal prosecution. Second, the police often lack the time and orientation to apply child protective measures other than substitute care. Consequently, the Hotline and the police often agree that children should be taken into custody. In some of these instances further CPS investigation could either result in the determination that placement is unnecessary or that other interventions could assure child safety. There were four such instances identified during the review. While the number of referrals in which law enforcement assumed this CPS responsibility is small, it is an important problem.

Response Codes

Collaborative Intake Policy (200) establishes investigative response priorities. According to the policy the priorities are:

- Priority 1 (Immediate Danger): Respond as soon as possible but within 2 hours of receipt of the report.

- Priority 2 (Foreseeable Danger): Respond as soon as possible but within 2 to 12 hours of receipt of the report.

- Priority 3 (Maltreatment Indicated but no safety factors identified): Respond within 12 to 72 hours of receipt of the report.

Because response codes are determined by CPS, the only response code that is specifically related to the Hotline is Priority 1 (Immediate Danger). Obviously, unless emergency situations are identified at the Hotline, CPS cannot be mobilized to respond within the required time frame. Of 19 emergency referrals identified during the review, the Hotline failed to handle six (or 32%) as emergencies. These included:

- A home visiting agency reported that a 9 month old was born at home and had never had any medical care, The child was screaming because it was hungry. There was no food in the house and the mother told the reporter she was too depressed to care for the baby.

- A home health worker reported that a woman who was a Katrina victim whose husband was working out of town on a long term basis was the mother of a severely hydrocephalic child (nonverbal and nonambulatory). The mother was isolated and overwhelmed by caring for her child. The mother was agitated and saying that she wanted the child out.

When Hotline workers identified emergencies, CPS supervisors or the police were quickly contacted.

Problems concerning response codes appear more relevant to CPS. In emergency situations to which the police responded, the response code was documented by CPS as "not applicable". Assuming that this is an indication that quick CPS response to these reports was not a high priority, this is a significant problem for the reasons having to do with police orientation that are discussed above. It is notable that, at times, these reports are screened out by CPS. Similarly, when children have been brought to Child Haven, the assigned response code is priority 3, apparently because these children are presumed to be safe. It is important that cases involving child placement receive immediate attention. Given the nature of placement cases that were reviewed, it is likely that a substantial number of the children placed could be safely maintained at home. If this is true, returning them quickly would be beneficial both to the children and to the substitute care system.

Finally, the guidance in the Collaborative Intake Policy related to the nature of the response is permissive. First, the response times are held in abeyance at night and on weekends and holidays. Reports received during off hours are to be responded to the next business day. This is entirely inconsistent with good child protection practice. Second, although the policy identifies face to face contact by the CPS agency as the "preferred" response type, it permits such responses as phone calls to collateral sources and case conferences at the supervisor's discretion. Again, this is not consistent with good child protection practice.

Quality of Call Takers' Response

Hotline Caseworker Efficiency

During the review of telephone referrals, a wide variation in the quality of caseworker response was noted. In most cases the necessary information was gathered as quickly as could reasonably be expected. There were, however, some calls during which the worker repeatedly asked the same questions. There were several calls in which the worker and caller engaged in lengthy, irrelevant conversations. There was one call that the worker put on hold for about five minutes in order to take a personal call. For the purpose of the review, call taker response was viewed as being inefficient when calls lasted substantially longer than they needed to. Overall, 20 or 14% of the 138 abuse/neglect referrals reviewed were handled inefficiently. Of course this is an important problem given the difficulty callers experience getting through to the Hotline.

Hotline Caseworker Professionalism

Generally, Hotline caseworkers handled difficult, distraught, and, sometimes, angry callers sensitively and professionally. In only one instance did a caseworker allow him/herself to be drawn into an inappropriate argument with a caller. In two instances a

caseworker inappropriately expressed obviously heartfelt criticism of the UNITY system to a caller. Otherwise, Hotline caseworkers were courteous and professional as they took calls.

Hotline Caseworker Documentation

After making the decision to document referrals in UNITY, Hotline caseworkers provided thorough and accurate recording of the information gathered. Inaccuracies or omissions were found in only two reports, neither of which was critical.

Alternative Response Categories

DFS requested that the review consider whether there are categories of calls (e. g. educational neglect, medical neglect, rejection, physical neglect concerning concrete need, and environmental neglect) that might be appropriate for alternative response. This alternative response would involve sending referrals to another agency. Although three screened in referrals did appear appropriate for such an alternative response, there were no categories that appear to be generally appropriate. The three calls identified involved rejection, educational neglect, and an out of control 11 year old. This does not preclude consideration of alternative response. One way to identify categories of referrals appropriate for diversion would be to examine case out comes for categories of referrals possibly taking the victims' age into account. Rejection and Educational Neglect would certainly be good candidates for consideration.

Conclusion

In conclusion, the Clark County Department of Family Services Hotline is not a Hotline at all. Rather, it is a reception center that, almost as an aside, screens referrals of child abuse and neglect. Fewer that 10% of the calls received are actually related to current maltreatment reports. In addition to screening abuse/neglect referrals, the Hotline caseworkers are responsible for a wide variety of unrelated tasks ranging from admitting children to Child Haven to preparing court documents for caseworkers to giving caseworkers driving directions in the field. Consequently, critical Hotline decisions do not receive the priority or attention that they deserve. Hotline caseworkers are almost completely untrained and receive minimal supervision. Even if these things were not the case, the procedural guidance they receive in making decisions – most notably the lack of clear specific operating definitions of child abuse and neglect – would render consistently sound decision making highly unlikely. Given all of this, it is not surprising that the Hotline fails to makes a sound decision about one in four referrals.

Recommendations

The following recommendations are offered in response to issues identified by the review.

1. Clear operational definitions of child abuse and neglect should be developed for each specific form of maltreatment. Obviously the definitions must be consistent with NRS 432B. They should also be consistent with choices the UNITY system makes available to Hotline caseworkers. Ideally, the current list of UNITY allegations should be revised. Given, however, that UNITY is a statewide system, it may be possible to create workable definitions using the Unity categories.

2. After definitions are developed, all Hotline and CPS staff should receive intensive training on them. It is important that the Hotline and CPS staff receive the same training and have the same understanding about what is and what is not abuse and neglect. Such training can be accomplished in four or five half day sessions.

3. Supervisory oversight of the Hotline should be dramatically increased. One supervisor responsible for 21 staff and an around the clock operation results in almost no supervision at the individual level. At least three supervisors are necessary to supervise the number of staff assigned to the Hotline. Because it is a 24 hour/seven day operation, three may be too few. There should be the capacity to provide supervisory oversight to caseworkers and the decisions they make around the clock. In addition to increasing the number of Hotline supervisors, it may be worth considering the creation of senior caseworker positions (preferably filled by staff with investigative and Hotline experience) to provide back up to supervisors. By staggering schedules, this staff could provide supervision during times when call volume is low.

4. Specific supervisory expectations should be developed. These should include 1) random and structured monitoring of a predetermined number of calls for each Hotline caseworker, 2) use of "by worker" administrative data related to decision making (i. e. what proportion of calls are screened in/out?) and productivity (i. e. how many calls were taken and how long did they last?) to identify outliers who should receive extra supervisory attention, 3) identification of decisions requiring supervisory approval (e.g. screening out reports made by physicians, police, or other mandated reporters), 4) identification of formal and on the job training for newly assigned Hotline caseworkers, and 5) mandated periodic individual supervision.

5. Following the development of new maltreatment definitions and thoroughly training Hotline staff on their use, responsibility for decision making about screening and about response priorities should be centralized at the Hotline. CPS should be required to conduct investigations of all reports received at from the Hotline. A regular mechanism for communication between CPS supervisors and the Hotline should be established in order to facilitate a common understanding about what decisions should be made at the Hotline. This will raise the level of consistency in decision

making and discourage any potential to make screening decisions on criteria unrelated to child safety.

6. The Hotline should be relieved of all duties other than receiving, evaluating and screening child abuse neglect referrals. A new mechanism to handle the other activities currently the Hotline's responsibility should be developed. This will free Hotline workers to focus on information gathering and decision making.

7. Hotline caseworkers should be forbidden from making or accepting personal phone calls on the Hotline. When such calls are necessary they should be made during breaks, using phones other than the Hotline, and away from the call floor.

8. DFS should develop a 24 hour capacity to respond to CPS emergencies. This will improve decision making and reduce the number of children unnecessarily entering substitute care.

9. Police and others should be discouraged from sending referrals by mail and telefax. Written referrals deprive DFS of the ability to ask questions and delay the receipt of referrals. This will be more easily accomplished if the Hotline operates more efficiently and there is less time consumed in getting through. It may be worth considering a special "police only" phone line in order to gain police cooperation.

10. Hotline staff should receive training related to taking calls similar to that received by customer service representatives in the private sector. This could increase call taking efficiency and result in a less frustrated reporting community.

11. Hotline staff should receive training about child protective services – in particular about the investigative process. Few Hotline caseworkers have CPS experience.

12. A concerted mandated reporter training effort should be launched after new maltreatment definitions are developed.