

Effects of the 24/72 Hour Initial Face-to-Face Investigation Policy on the Revictimization of Children

Executive Summary

Implementation of the new policy to conduct the initial face-to-face meeting of CPS investigative social workers with alleged child victims of abuse and neglect within 24 hours for emergent and 72 hours for nonemergent referrals has resulted in a reduction in the rates of revictimization. Overall, for both emergent and nonemergent referrals, and controlling for variations in other factors, victim recurrence¹ has declined by about three percentage points (an absolute decline of about 25%), an effect found to be highly likely due to implementation of the 24-hour and 72-hour policies. For the current founded referral caseload comprising approximately 6,500 children per year, this corresponds to the protection of approximately 195 additional children from revictimization per year compared to the previous four years. Compliance with the policy results in a marked decline in revictimization rates for *nonemergent* referrals, and a similar though smaller effect on revictimization for emergent referrals. It is estimated that 100% compliance with the policy would protect a maximum of an additional 85 children per year.

Implementation of the 24-hour policy for emergent referrals began in April 2005, resulting in an increase in the percentage of emergent referrals where the children were seen within 24 hours from about 75% to about 95%. The reduction in the percentage of children revictimized in emergent referrals within six months of their initial founded referral has been from an average of 5.4% during the period of January 2001 through March 2005 to an average of 4.1% for initial founded referrals received during May 2005 - December 2005.

The 72-hour policy for nonemergent referrals was implemented in August 2005, and resulted in an increase in the percentage of nonemergent referrals where the children were seen within 72 hours from about 40% to about 90%. The reduction in children revictimized in nonemergent referrals within six months of their initial founded referral has been from a rate of 15.3% during the period of January 2001 through July 2005 to a rate of 11.1% for initial founded referrals received during September 2005 – February 2006 (estimated).

A series of multivariate analyses were conducted to verify that the observed decline in victim recurrence has been due to seeing children more quickly rather than changes in other factors². Lower rates of victim recurrence are significantly associated with a lower number of days between receipt of referral and the initial face-to-face contact with the alleged victims, and have been even before implementation of the policy. Victim recurrence rates are also strongly and significantly associated with whether the 24- or 72-hour policy was met for emergent or nonemergent referrals, respectively. These associations persist even when adjusting for changes and differences in the demographic and type of abuse composition of founded referrals over time, in the founded rate of all accepted CPS referrals, in the rates of CPS placement, and in the

¹ Measured over periods of time extending beyond the Federal six-month measurement period, using survival analysis estimation methods.

² Cox regression, using backward stepwise conditional likelihood ratio elimination of insignificant variables.

administrative region and office size³. There are also significantly lower rates of re-referral for compliance versus noncompliance in both emergent and nonemergent CPS referrals, whether the referrals are founded, inconclusive, or unfounded.

There are *not* any significant differences in victim recurrence rates for referrals granted various exceptions to the 24- and 72-hour policies, indicating that the granting of these exceptions is not, on average, compromising the safety of children. This is in contrast to the period before implementation of these policies, when children who were initially not contacted due to failed attempts were revictimized at rates about three percentage points higher than those who were contacted, a relative difference in the revictimization rate of about 25%.

Change in Revictimization Rates

Changes in the proportion of children revictimized within six months (Federal measure) are shown in the following table. Because workers have 90 days to complete their investigations and enter findings into CAMIS, rates for the latest entry cohort period that can be accurately determined by the end of September 2006 are for initial referrals received through December 2005 (allowing for a period of six months for revictimization plus 90 days for investigation and data entry).⁴

Six-Month Revictimization Rates (Federal measure)

Initial referral received	Percent revictimized (total N of children)		
	Nonemergent	Emergent	All
Jan-Jun 2001	16.6% (2175)	5.8% (1100)	13.0% (3275)
Jul-Dec 2001	16.9% (1653)	5.8% (834)	13.1% (2487)
Jan-Jun 2002	15.7% (1931)	6.0% (990)	12.4% (2921)
Jul-Dec 2002	16.5% (1695)	5.2% (866)	12.7% (2561)
Jan-Jun 2003	18.3% (1899)	3.2% (386)*	13.1% (2885)
Jul-Dec 2003	15.0% (1949)	5.4% (952)	11.8% (2901)
Jan-Jun 2004	14.3% (2130)	5.2% (1093)	11.2% (3223)
Jul-Dec 2004	14.8% (2147)	6.5% (956)	12.2% (3103)
Jan-Jun 2005	14.9% (2179)	5.2% (1137)	11.6% (3316)
Jul-Dec 2005	11.7% (2375)	4.2% (976)	9.5% (3220)

* This is an as yet unexplained anomaly, a period with a much lower number of emergent referrals and a lower recurrence rate, and a higher recurrence rate for nonemergent referrals.

Implementation of the 24-hour policy for emergent referrals began in April 2005, resulting in an increase in the percentage of emergent referrals where the children were seen within 24 hours from about 75% to about 95%. The 72-hour policy for nonemergent referrals was implemented in August 2005, and resulted in an increase in the percentage of nonemergent referrals where the children were seen within 72 hours from about 40% to about 90%.

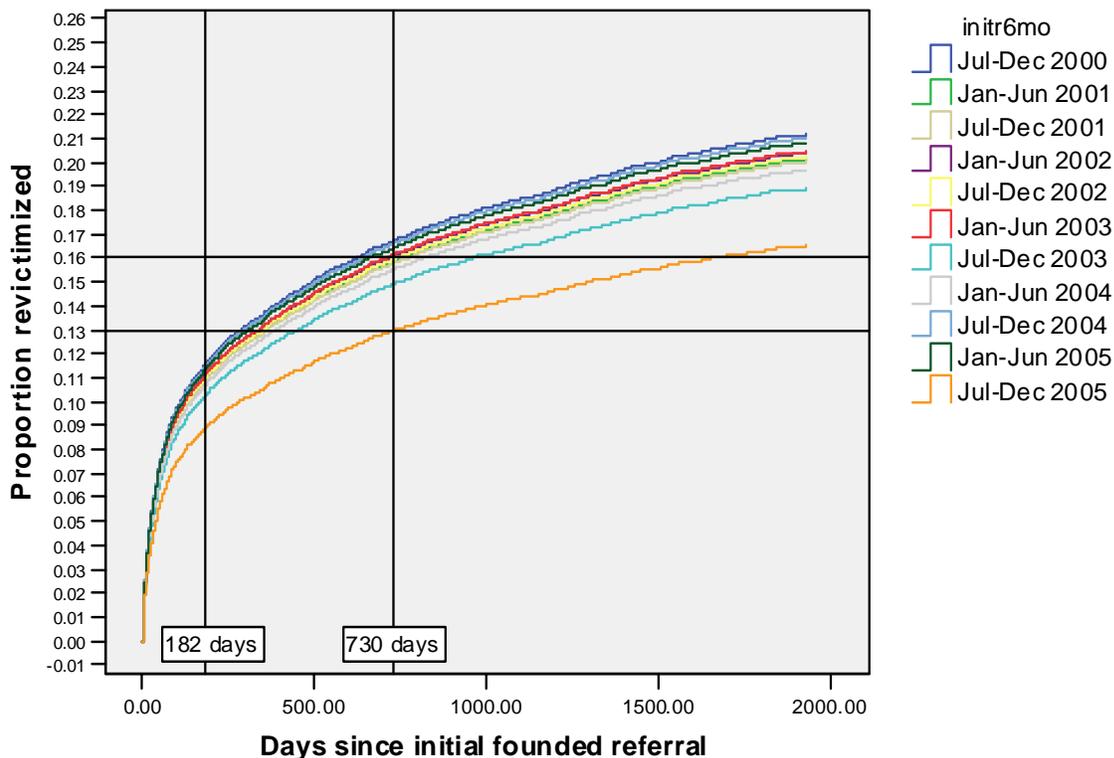
³ Variations in the recurrence rates for different demographic and administrative factors are not given here since they do not affect the principle results. They are routinely available in our usual recurrence measure reporting.

⁴ Survival analysis methods, as shown below, permit estimation of revictimization to more recent periods.

The decline in revictimization rates for the initial referral period of July-December 2005 is even more notable in that the founded rate (the percentage of all investigated CPS referrals that are founded) has increased over the past few years, from a range of 17% to 20% in CY 2001-2003, to about 22% in CY 2004 and 24% in CY 2005. In the years before 2001, revictimization rates were even higher, corresponding to the period when the founded rate was in excess of 40%. This period was before the legal requirement for notification letters of substantiation. In parallel to the experience of other States who instituted this notification policy, implementation of the legal requirement resulted in a rapid decline in the founded rate and a decline in the revictimization rate. In the past few years, in contrast, we have seen an increase in the founded rate but a recent decline in the revictimization rate.

The chart below shows a survival curve representation of the decline in revictimization rates, for different six-month initial referral periods. The curve for the period of July-December 2005 is the lowest in the chart. The vertical reference line at 182 days corresponds to the Federal six-month recurrence measure. (See Appendix for technical notes on the calculation of recurrence rates and a tutorial on the interpretation of survival curves.)

Victim Recurrence Rates and Period of Initial Victimization



The survival curves show that revictimization continues long after the Federal measurement point of six months after initial referral. A more realistic estimate of the longer-term reduction in recurrence can be obtained from the chart. The gap in recurrence rates for the period July-December 2005 compared to previous periods continues to widen over time, but

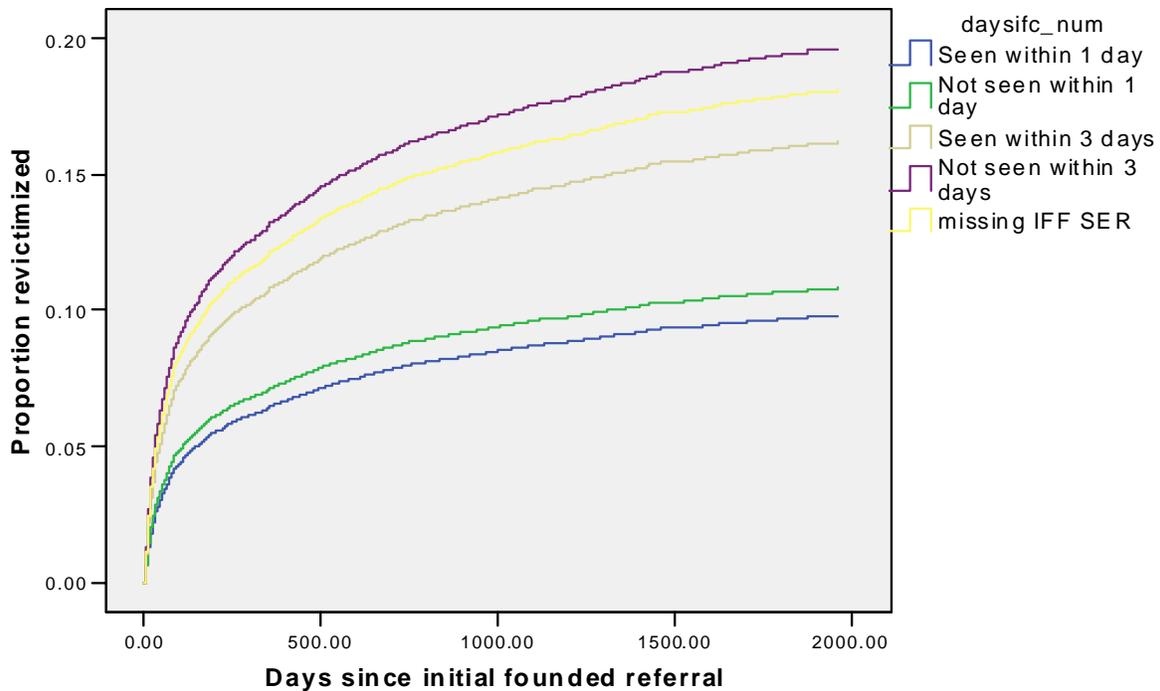
more slowly after about two years. Choosing a reference line at two years (730 days) gives a longer-term recurrence rate for the July-December 2005 period of approximately 13%, compared to an average rate for previous periods of approximately 16%. For the current annual caseload of about 6,500 children with founded referrals, this corresponds to an annual reduction of 195 in the number of children revictimized.

Revictimization and Policy Compliance

The date of contact between social workers and alleged child victims is recorded in CAMIS in a Service Episode Record (SER) for the Initial Face-to-Face (IFF) investigative meeting. A series of Cox regression analyses showed that the revictimization rate increases as the number of days between receipt of referral and IFF increases. This is true for the entire period of CY 2001 – CY 2005. This association persists even when statistically adjusting for any differences in the revictimization rate for different regions, office sizes, population type (rural/urban), types of abuse, substance abuse involvement, number of safety issues identified during the IFF, placement rates (emergency or longer-term), or child demographics. What this result shows is that, even before the 24/72 hour policy was in place, or whether or not social workers complied with this policy or the earlier response time policy of 3 days for emergent and 10 days for nonemergent referrals, the likelihood of revictimization increases as the response time increases.

It is difficult to graphically portray the effects of the variation in revictimization with changes in the response time because of variability in the data ('noise'). For ease of representation, the following chart shows the differences in revictimization rates for policy compliance/noncompliance. The curves for "Seen within 1 day" and "Not seen within 1 day" are for emergent referrals, and "Seen within 3 days" and "Not seen within 3 days" are for nonemergent referrals. The curve for "missing IFF SER" are for referrals where no initial face-to-face record could be found in CAMIS. Even though the 24/72-hour policy was not in place for the entire analysis period of CY 2001- CY 2005, using 'compliance/noncompliance' in this case is simply a convenient means of categorizing response times for display purposes. Note that a larger and significant compliance difference is seen for nonemergent referrals, which have a longer required minimum response time. The difference for emergent referrals while too small to be statistically significant is consistent throughout the time period.

Victim Recurrence and Policy Compliance

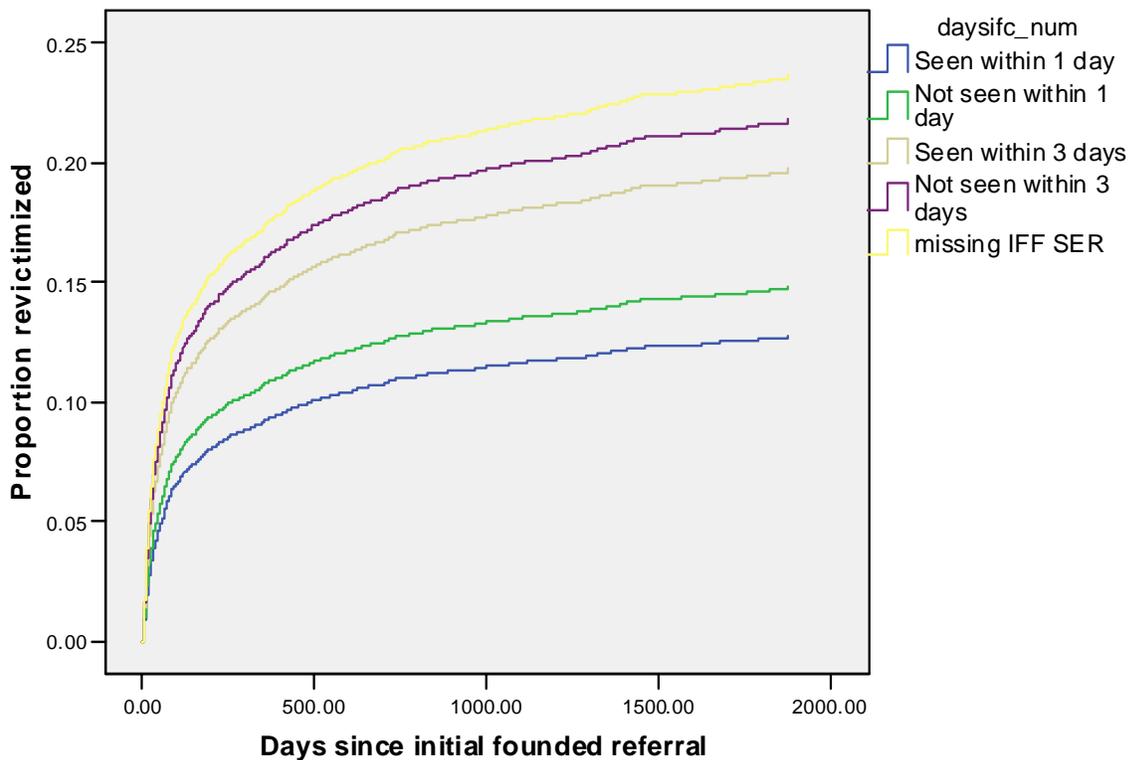


A very important feature of all the above curves is that the compliance differences in revictimization persist throughout the entire time range: that is, noncompliance results in higher revictimization regardless of the number of days between founded referrals. There has been a long debate in the Agency that some revictimizations may be an artifact of multiple referrals of the same incident that are received within a few days of each other, and that improvements in response time may result in an apparent reduction in the recurrence rate simply due to the reduction in these multiple reports. The persistent gap between the compliance versus noncompliance curves shows that this effect cannot explain the observed differences in recurrence rates. If this effect accounted for all of the observed reduction in recurrence rates, the gap between compliance and noncompliance would disappear after the first few days. In order to make doubly sure that this effect is not important, the analyses were repeated using only referrals separated by more than ten days, and by more than 30 days. The results are essentially unchanged: a significantly lower revictimization rate for compliance in nonemergent referrals, and a statistically insignificant but consistently lower rate in emergent referrals, though the effect appears to diminish after the first two years following the initial referral for emergent referrals.

The relationship between revictimization and length of stay in placement is very complex. Children who enter placement following their initial founded referral represent more serious cases, and as such are more likely to be revictimized upon their return home. On the other hand, as long as they remain in placement they are much less likely to be victimized again. Adding to this problem is the inability to conclusively link referrals to placements with CAMIS data: the actual referral or referrals that led to the placement decision are not known (there is no indication in CAMIS that a particular referral was the reason for a particular placement) and

must instead be inferred by proximity in time. Although adjusting for placement status and placement rates does not significantly change the observed compliance/noncompliance recurrence rates noted above, due to the complexity of the placement situation, the possibility remains that the differences in revictimization may be due to changes in the placement rate or length of stay of children. The placement rate has increased slightly over the past 18 months, and since the placement rate is higher for children in emergent versus nonemergent referrals, slight changes may be important. In order to ensure that changes in placement strategies in the field are not accounting for the observed differences in recurrence rates, the analysis was repeated solely for those children who never entered placement or entered only after the second referral. The chart below shows that, while the overall rates of revictimization are different as expected, the variations in the rates for policy compliance versus noncompliance are similar.

Victim Recurrence and Policy Compliance; No Placement between Referrals

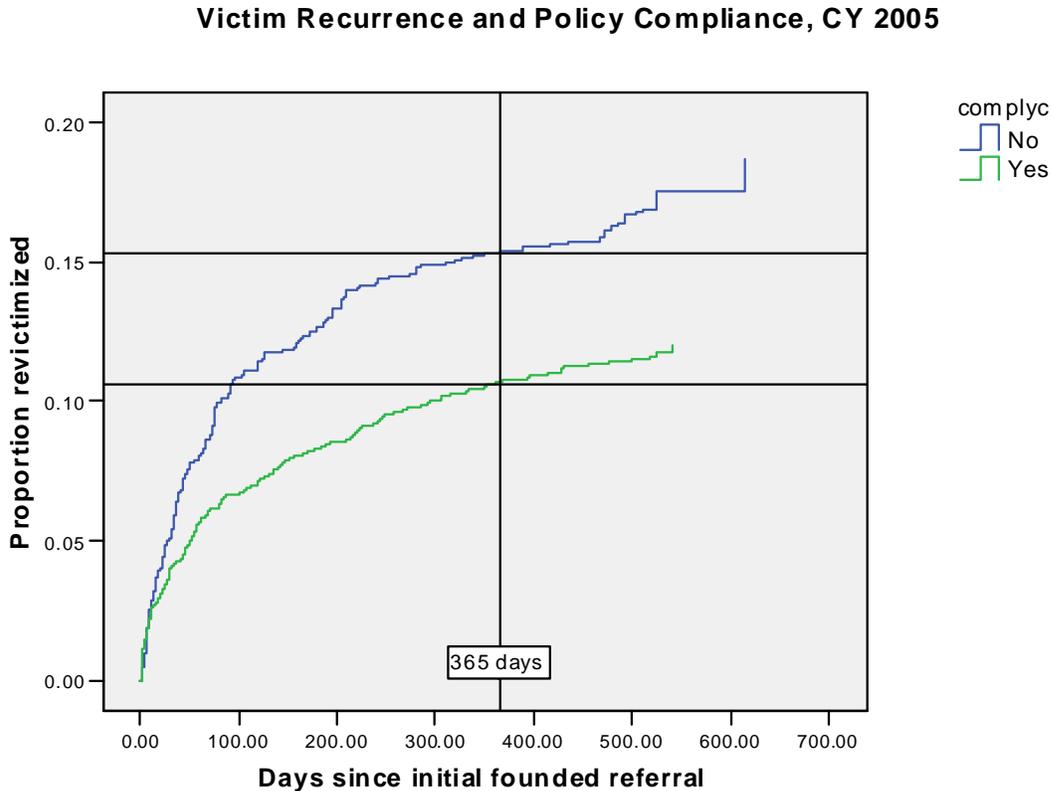


Exceptions to Policy

There are *not* any significant differences in victim recurrence rates for referrals granted various exceptions to the 24- and 72-hour policies, indicating that the granting of these exceptions is not, on average, compromising the safety of children. This is in contrast to the period before implementation of these policies, when children who were initially not contacted due to failed attempts were revictimized at rates about three percentage points higher than those who were contacted, a relative increase in revictimization of about 25%.

Number of Children Affected by Noncompliance

In order to estimate the number of children affected by noncompliance with the response time policy, we combine the results for emergent and nonemergent referrals. When doing so, records with missing IFF records are found to be statistically indistinguishable from noncompliant records, and were therefore also combined. The following chart shows the difference in revictimization for these combined groups, for initial referrals received in CY 2005.

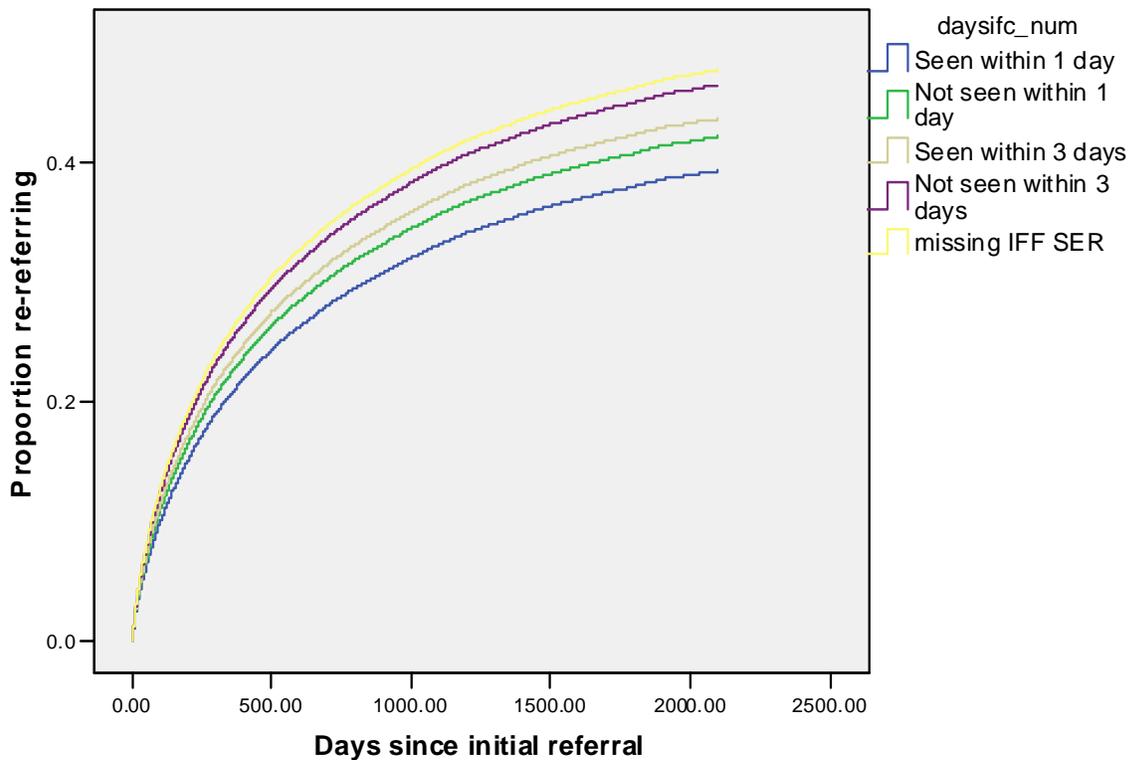


Using the rates at one year as a reference, the overall recurrence rate for children in policy-compliant referrals was 10.65%, and for noncompliant referrals was 15.3%. If the 1,834 children in founded referrals with noncompliant or missing IFFs in CY 2005 had been seen within the required response times, an additional 85 children would have been protected from revictimization. This calculation does not take into account those “noncompliant” referrals that were given allowable exceptions, and therefore represents a maximum value.

Comparison with Rates of Re-Referral

Substantiated (founded) referrals currently comprise about 25% of all investigated CPS referrals. Many research studies both nationally and in Washington State have consistently shown that abuse and neglect occurs in ‘unsubstantiated’ referrals, and that the long-term implications for children and families who frequently refer to CPS are more or less independent of the substantiation status of any particular referral. The likelihood of a second referral being substantiated is only very weakly dependent on the substantiation status of the initial referral: in other words, substantial proportions of unfounded and inconclusive referrals are followed by a later founded referral. The chart below examines the effect of policy compliance on the re-referral of children, regardless of the substantiation status of the referrals. The same basic patterns are observed: a lower rate of recidivism for compliance versus noncompliance. In this case, because of the larger sample size, all differences are statistically significant.

Rates of Re-Referral and Policy Compliance



Appendix

Technical Note on Recurrence Rates

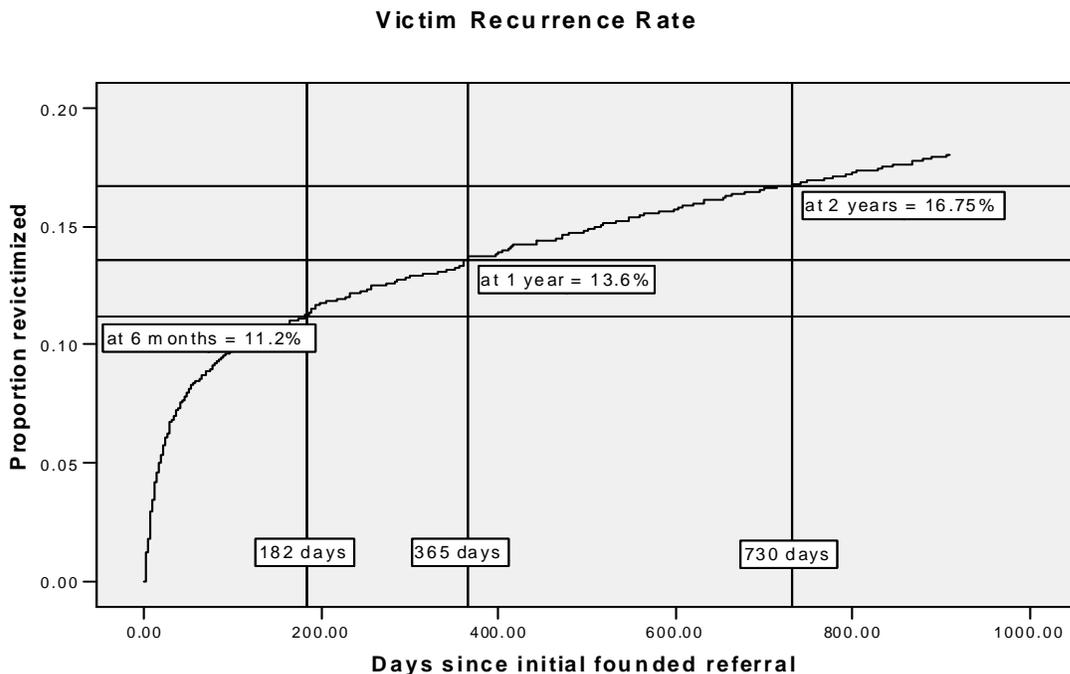
Changes and corrections to data in CAMIS by the field occur for sometimes considerably long periods after their initial entry, and there are sometimes long delays in, for example, the conclusion of investigations. The victim recurrence rates reported here were calculated from a CAMIS data download of October 5, 2006 and will differ very slightly from rates for the same historical periods calculated and reported earlier. (Because of the ongoing corrections, the figures reported here will actually be more accurate.)

More significantly, the rate of victim recurrence has historically been and continues to be substantially lower for children whose initial referral captured in any cohort happens to be their very first referral to CPS, compared to children and families who have been referred multiple times (that is, the rate of recurrence increases dramatically for the 2nd, 3rd, 4th, or 5th referral compared to the first). The Federal measure of victim recurrence that we typically report does not take this effect into account, but rather lumps together first and subsequent 'initial' referrals together in the same reporting cohorts. This does not create a problem or error for our usual calculations of separate six-month entry cohorts, but does cause a problem when attempting to study changes in the recurrence rates over longer periods of time using a single analysis dataset, as was required for some aspects of this report. There is a higher probability that an 'initial' referral is actually the first referral as the period of initial referral moves closer to the present and one can check further back in time for prior referrals. Conversely, the earlier the period, the less likely the 'initial' referral is the very first referral, as there is less of a predated historical period in CAMIS available to check. The net effect is that plotting changes in the victim recurrence rate over time using a single multi-year dataset results, all other factors being equal, in an *apparent* though slight improvement in the recurrence rate over time, as the proportion of 'initial' referrals that are actually first referrals increases as one approaches the present. This effect is small enough that it does not at all corrupt the measures of statistical association of the recurrence rate with other factors, but it does mean that the precise values of the recurrence rate at a given point in time (e.g., the typical six month rate) will be slightly lower than the rate reported for a more narrowly defined cohort using the Federal measure. For this reason, any values of the six-month recurrence rates reported here are calculated using the Federal method, but may be slightly different from values read from the survival analysis curves at the six-month point for the same initial referral period.

Interpretation of Survival Curves

The principle methodology used in this report, Cox regression, is a member of a class of regression and estimation techniques for time series data known as survival analysis. These techniques solve the problem of statistically estimating the proportion of a population that will eventually experience a given event without needing to wait until all members of the population experience the event. These methods were initially developed for the life insurance industry, hence the term ‘survival analysis,’ since the need of the industry is to estimate the probable life expectancy of its clients well before waiting for them all to die. The survival curve is the proportion of a group of people born during a given period (an ‘entry cohort’) who survive to a certain number of days after birth. The estimated part of the curve extends past the date of analysis, i.e., predicts the likely proportion of the entry cohort that will remain alive at a given number of days after birth in the future.

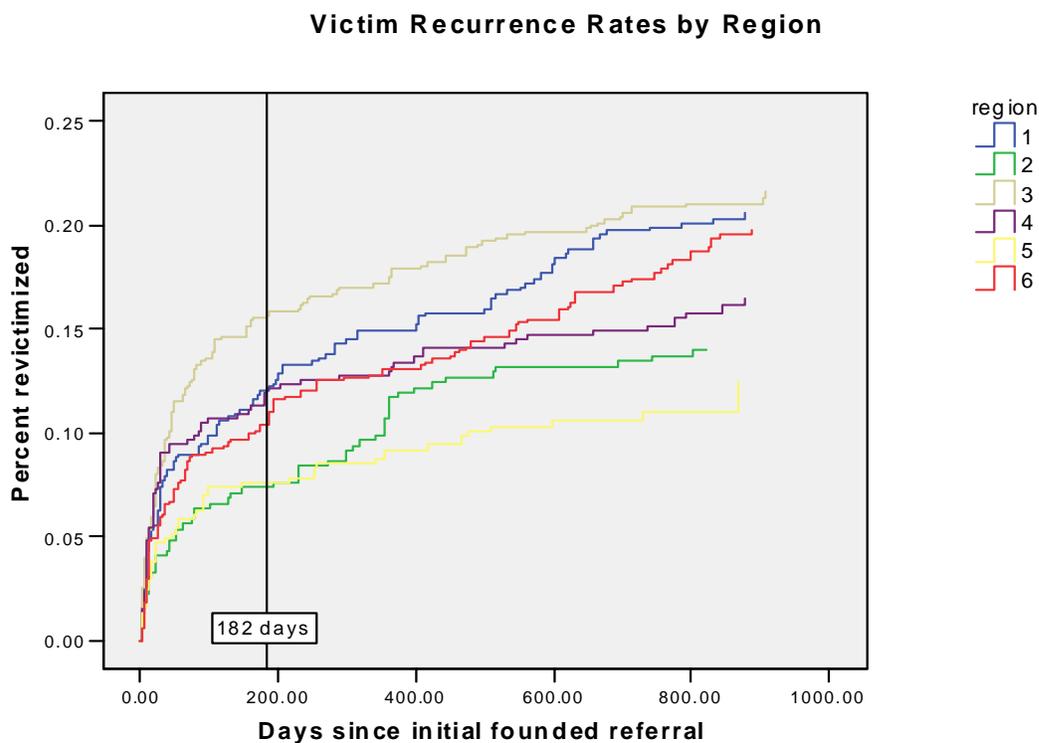
In this application, ‘birth’ is the receipt of an initial founded referral for abuse or neglect, and the ‘terminal’ event is the revictimization of children, i.e., the receipt of a subsequent founded referral for abuse or neglect. ‘Survival’ in this case means that a second founded referral does not occur. The Federal definition of victim recurrence or revictimization is the proportion of children who receive a subsequent founded referral within six months of receipt of an initial founded referral. Compared to a survival analysis, this definition severely restricts the information that is possible to attain from studying the phenomenon revictimization, potentially obscuring details that may be important from a practice standpoint. This is illustrated by the following chart, which is a survival analysis curve⁵ for the revictimization of a cohort of children with an initial founded referral received during the first half of 2004. The Federal measure of revictimization for this cohort is 11.2%.



⁵ Technically, a plot of the proportion revictimized is a **non**-survival curve, one minus the survival curve.

The chart plots the proportion of the children with an initial founded referral received during January-June 2004 who are reported and founded again, as a function of the number of days since receipt of their initial referral. The Federal measure of this proportion at six months can be read from the chart by drawing a vertical line up from 182 days to its intersection with the survival curve, then reading over horizontally to the y-axis value of 0.112 (11.2%). As shown, however, children continue to be revictimized well past six months, with 16.75% revictimized by two years later, and no leveling off of the curve is apparent even after 900+ days.

The deficiencies of the Federal (or any single-point) measure are more glaring when considering differences in performance over time. The next chart shows the regional differences in victim recurrence for this same January-June 2004 entry cohort:



One would conclude from a comparison of the Federal measures for the regions that region 2 has a low and nearly identical rate to that of region 5, even though after a year its rate is 2-3 percentage points higher, a relative difference of 30%. The rate of revictimization appears to level off for region 6 after the first 9 months, but later actually increases again from 400 to 800 days after the initial referral. In general, the dynamics of revictimization are different in the regions, which may relate to different practice implications and call for different strategies for improvement.

Finally, Cox regression, like other multivariate regression methods, allows for the adjustment of the survival curves for the simultaneous effect of other variables. This allows testing to see if any observed differences in rates are due to the influence of other factors.