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Improving Responses to Allegations of Severe Child Abuse:
Results from the Instant Response Team Program

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August 2004

nycACS
NYC Administration for Children's Services

Executive Summary

Allegations of severe child abuse and neglect may require quick, coordinated responses by child welfare and law enforcement to reduce trauma to children, and to arrest and prosecute perpetrators. Yet few jurisdictions formally coordinate this process. In the absence of such coordination, child victims may be interviewed repeatedly by child protective workers, police, and prosecutors—increasing the trauma they experience. And when police are not present, collecting evidence, making arrests, and prosecuting the perpetrators of child abuse all become more difficult.

To reduce trauma to children and improve evidence collection, in 1998 New York City's child welfare agency, the Administration for Children's Services (ACS), in collaboration with the New York Police Department and district attorneys, launched the Instant Response Team (IRT) program. IRT aims to have child protective workers, police, and when appropriate, prosecutors respond to reports of severe child abuse or neglect within two hours and to conduct joint interviews of victims in child-friendly settings. The program has a protocol to coordinate investigations, a memorandum of understanding that encourages information sharing, and dedicated positions within child welfare to manage the program. No other jurisdiction we contacted has implemented such a comprehensive policy that aims to provide as fast or as coordinated a response to the range of cases that IRT handles.

At the request of ACS, researchers from the Vera Institute of Justice studied the operations and outcomes of the IRT program. We analyzed the program's data and matched it with information from the State Central Registry, which records all allegations of child maltreatment in New York State. We also conducted 39 interviews of program staff, talked with child protective division personnel in nine other large American cities, and shadowed child protective workers on one case.

The program has many strengths. It has identified and served its target population: 99 percent of the IRT cases we examined met the minimum criteria set out in the IRT protocol, and these cases are more likely to be indicated (52 percent compared to 35 percent of all other New York City cases). Staff from all three agencies report better information sharing, stronger working relationships, more effective and efficient case processing, and strong support for the program.

We also found a measurable impact on services to children. Incidences of multiple exams and interviews have substantially declined. Overall, 55 percent of IRT cases include a joint interview. This rate is substantially higher in more serious cases, and double the rate reported in a five-city study of joint law enforcement and child welfare investigations. The program appears to have changed trends in removals. In most IRT cases no one is removed from the home. But in IRT cases resulting in the removal of either the child or the alleged perpetrator, children were removed more often than alleged

perpetrators in 1998 (57 percent of such cases). In IRT cases in 2002, alleged perpetrators were removed more often than children (68 percent of such cases).

The main challenge the program faces is managing growth. After establishing a network of cross-agency relationships during its first two years, the program added a new category of cases in 2000. In 2002, IRT handled 4,064 cases, an increase of over 160 percent since 1999. This increase makes more efficient use of the resources child welfare invested in the program, but places additional demands on police and prosecutors.

As part of this project, ACS and Vera worked together to improve the program's data collection instrument. The updated instrument, implemented in January 2003, provides program managers with information that can be used to assess and improve caseworker response time and help IRT coordinators select cases that are more likely to need a police presence. These efforts should further improve a program that already provides a valuable and necessary service to New York City's most vulnerable children.

Acknowledgements

This report is the result of the dedication and careful attention of many individuals. At the New York City Administration for Children's Services (ACS), we would like thank William Bell for his ongoing support of this project. We owe a special thanks to Deputy Commissioner Zeinab Chahine and to ACS's Criminal Justice Coordinator Peter Alexander for the collaborative work that we engaged in conceptualizing and carrying out this project. Others at ACS who made this report possible include Acting Commissioner Lisa Parrish, former Assistant Commissioner Benjamin Charvat, Eric Nicklas, Synia Wong, Tami Suh, and Alana Gunn. We would also like to thank Deputy Commissioner Michael Farrell, Chief Joanne Jaffe, Captain John Eterno, and Tania Hedland at the New York City Police Department (NYPD), and the offices of District Attorneys Richard Brown, Charles Hynes, Robert Johnson, Robert Morgenthau, and William Murphy for their help in facilitating this research with law enforcement and prosecution staff.

Officials from the child protection divisions of child welfare agencies nationwide were among the many people who were kind enough to answer our questions and offer us information and assistance. Finally, we would like to thank the staff from ACS, NYPD, child advocacy centers, and New York City hospitals who took the time to share their experiences of working with the Instant Response Team program.

At the Vera Institute of Justice, many individuals offered their time and expertise to this project. We thank Chris Stone, Molly Armstrong, Heidi Segal, Addie Rasavong, Doreen Miranda, Craig Schwab, Janet Mandelstam, Jill Pope, Robin Campbell, Leah Edmunds, Cybele Merrick, Ajay Khashu, and Dan Currie.

Additional copies of this report can be obtained from the communications department of the Vera Institute of Justice, 233 Broadway, 12th Floor, New York, NY 10279, (212) 334-1300. An electronic version of this report is available on Vera's web site, www.vera.org.

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Introduction

Severe child abuse is a crime, yet child welfare agencies and police departments traditionally have pursued these cases independently.[1] In recent years, many jurisdictions have sought to improve coordination between police and child welfare in the worst cases of child abuse and neglect.[2] The most ambitious of these efforts may be New York City's Instant Response Team (IRT) initiative, launched in 1998. IRT seeks to coordinate responses by the police, prosecutors, and child protective workers to severe allegations of child abuse, shorten response times, reduce repeated interviews of children, and improve evidence collection. At the request of the Administration for Children's Services (ACS), New York City's child welfare agency, the Vera Institute of Justice studied the program's operations and outcomes and sought to find ways that managers could improve upon existing operations.

Child protection divisions of child welfare agencies often make few distinctions between the kinds of child abuse and neglect reported and the types of investigatory responses they require. Social service regulations usually demand that child welfare agencies initiate an investigation within a given time limit, but the involvement of other agencies, while encouraged, is rarely institutionalized. For most reports of child abuse and neglect, this is appropriate. Most allegations are unlikely to require police involvement or lead to arrests and prosecutions. But in situations involving severe abuse or neglect, failing to quickly coordinate child protective workers, police, and prosecutors can have serious consequences for a child's welfare and for law enforcement's ability to respond to crime.

In the worst case, slow responses can result in more abuse. Uncoordinated responses can also lead to multiple interviews of children by police, child protective workers, and prosecutors, forcing them to recollect painful experiences to strangers again and again. Especially when conducted in environments where children may feel uncomfortable, such as police stations or emergency rooms, multiple interviews can make an already traumatic experience that much more distressing.

Uncoordinated responses may also hamper efforts to arrest and prosecute the perpetrators of child abuse. The arrival of a child protective worker may cause a perpetrator to destroy evidence, influence responses from children, and otherwise hinder law enforcement investigations. Most child protective workers have little or no training in collecting and preserving evidence for criminal cases; their role is to protect children, not to make arrests. If police are not brought in immediately, the evidence of abuse—such as

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[1] See Susan Martin and Douglas Besharov, *Police and Child Abuse: New Policies for Expanded Responsibilities,* (Washington, DC: National Institute of Justice, 1991). National Institute of Justice will hereafter be referred to as NIJ.

[2] This information is based on calls to the child protective divisions of the ten largest cities in the United States.

marks and bruises—may disappear. Without a police presence, removing the child from danger is likely to take precedence over enforcing the law.

An example from San Diego, while dated, illustrates some of the difficulties that can occur:

> …a child was found with teeth marks on her back, [and child protective workers] asked her uncle, the suspect, to submit to photographs of his teeth…he fled the county before law enforcement had the opportunity to question and possibly arrest him. According to the police, [the child protective workers] should have waited to question the uncle until the police were alerted…But, according to [child welfare officials] the workers acted properly [because] they had to determine which family member was involved in order to protect the child's safety.[3]

In this case, the lack of a coordinated response undermined the missions of both the police and child protective workers—the police did not arrest the perpetrator, and child welfare workers could not know when or if the uncle would return to re-victimize the child.

Many child welfare administrators now recognize the need to respond more quickly to severe cases of maltreatment and to coordinate the responses of law enforcement, child protection, and other agencies. Both Houston and Dallas, for example, divide cases into high and low priority, with high priority investigations initiated within 24 hours. Chicago has a multi-agency team that specializes in the investigation of head injuries, and Los Angeles is developing an emergency response program that focuses on the problem of methamphetamine-related child abuse in families.[4]

Changes have also occurred in law enforcement. In the wake of high profile child abuse incidents and a better understanding of the damage inflicted by abusers, authorities have sought to prosecute perpetrators in criminal courts.[5] Many police departments now house specially trained squads to investigate sexual abuse and child victim crimes. Prosecutors have also become more involved in some jurisdictions. In the late 1980s, for example, San Diego established a multidisciplinary program designed specifically to prosecute cases of child physical abuse.[6] In New York City and other places, the increased involvement of law enforcement has produced concrete results: arrests for endangering the welfare of a child in New York City tripled from 303 in 1990 to 1,111 in

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[3] Barbara Smith, "Prosecuting Child Physical Abuse Cases: A Case Study in San Diego," *Research in Brief*. (Washington, DC: Office of Juvenile Justice and Delinquency Prevention, June 1995) 8. The Office of Juvenile Justice and Delinquency Prevention will hereafter be referred to as OJJDP.

[4] For more information, see Appendix A.

[5] See David Finklehor and Richard Ormrod, "Child Abuse Reported to the Police," *OJJDP Juvenile Justice Bulletin* (May 200) 1-7. This trend is also apparent in Britain: see Jo Moran-Ellis and Nigel Fielding, "A National Survey of the Investigation of Child Sexual Abuse," *British Journal of Social Work* 6, no. 2 (1996): 337-356.

[6] Barbara Smith, "Prosecuting Child Abuse Cases: Lessons Learned from the San Diego Experience," *NIJ/OJJDP Research in Brief*, June 1995.

1998, even though arrests in general increased by only 29 percent and child abuse and neglect reports remained stable.[7]

Despite these reform efforts, quick responses that coordinate the efforts of child welfare, police, and prosecutors remain the exception, not the norm. The obstacles to coordinating responses to allegations of maltreatment are significant and longstanding. Nationwide, child welfare agencies receive millions of abuse and neglect reports each year, and police departments do not have the resources to respond to every allegation. Efforts at interagency collaboration may be further impeded by bureaucratic turf wars, role confusion, and a lack of management attention.[8] Despite the benefits of collaborating, agencies often avoid initiating or joining such efforts.

This report examines New York City's effort to coordinate child protection investigations through the IRT initiative. In addition to suggestions the research might provide to New York City officials, we sought to identify issues that other large urban child welfare systems might encounter should they implement a program similar to New York's. While New York City's child welfare system is larger than those of other urban areas, the hurdles to cross-agency collaboration are likely to be similar.

Before describing the research and reporting results, a more detailed description of the program and how it was created will place the research in context.

Creating the Instant Response Team program

Prior to IRT's launch, the city's child welfare agency, the police, and the public hospital system attempted to coordinate responses to a limited number of cases in an effort known as the Joint Response program. Formed in the 1980s, this program laid out protocols for interagency collaboration with the goal of coordinating responses to serious cases of sexual abuse, serious physical injuries, and other serious forms of abuse or neglect. The program targeted children under 14 years old. Only physicians could trigger joint responses and they needed the approval of an employee of the State Central Registry, which receives and records all child abuse and neglect reports.

Despite good intentions, the Joint Response program collapsed. The program did not identify any one agency staff person as directly responsible for its operation, and there was no mechanism for holding anyone accountable for outcomes. Reports received from

[7] Alison Vreeland, "The Criminalization of Child Welfare in New York City: Sparing the Child or Spoiling the Family?" *Fordham Law Journal* 27, no. 3 (2000): 1053. Arrest statistics are from Division of Criminal Justice Services, *Criminal Justice Indicators* Last Revised: Sept. 4, 2002, http://criminaljustice.state.ny.us/crimnet/ojsa/areastat/areast.htm. The number of child abuse and neglect reports between 1990 and 1998 hit a high of 89,940 in 1992 and a low of 76,188 in 1995. See *Progress on ACS Reform Initiatives; Status Report 3*. (New York: Administration for Children's Services, March 2001) 20.

[8] For a classic discussion of the problems of interagency coordination, see Jeffrey Pressman and Aaron Wildavsky, *Implementation: How Great Expectations in Washington and Dashed in Oakland* (Berkeley: University of California Press, 1972). For an example related to law enforcement and child welfare, see Moran-Ellis and Fielding, 1996.

sources other than physicians were not eligible for a joint response, severely limiting the program's scope. As a result, no individual agency took ownership of the program.

In 1996, New York City established the Administration for Children's Services (ACS) as a freestanding agency. In 1997, ACS led the planning process for a new and more comprehensive effort to coordinate responses to severe allegations of child maltreatment. Program planners identified two primary goals: to minimize the trauma to children and to improve the quality of investigations by collecting evidence in a timely and thorough manner. Over the next year, a task force composed of child welfare officials, police, prosecutors, child advocacy center staff, and hospital staff designed the IRT program and protocol to meet these goals.

Program Description

Only police officers, detectives, and IRT coordinators can initiate an instant response. An IRT case typically begins when the State Central Registry receives a report that a child is being abused or neglected. Anyone can report child maltreatment, though certain professionals, such as doctors and teachers, are mandated to make reports when they suspect that a child is being abused or neglected. The State Central Registry routes reports to the child protective services field office closest to where the family resides. When the allegations meet the criteria for an instant response, the field office's IRT coordinator contacts the person who reported the abuse for more information and tries to establish the location of and risk to the child or children involved.

The IRT protocol lays out specific criteria for when a case is eligible for an instant response, based on the age of the child and the type of abuse alleged. For children under 11, for example, a case is eligible for an instant response if the abuse includes:

> fractures; internal bleeding injuries including subdural hematoma; "shaken baby" syndrome; widespread or serious bruises; lacerations or welts consistent with an injury being inflicted;…tissue damage caused by serious beatings; burns or scalding; [and] attempted drowning.[9]

While the criteria for physical abuse rely on observable results of maltreatment, there are often less visible signs when sexual abuse occurs. Thus, any report of a sex crime involving a child under 11 qualifies for an instant response.[10]

The protocol divides cases into three types: (Type I) fatalities; (Type II) felony sexual abuse of children under age 18 and severe maltreatment and all sexual abuse of children under age 11; (Type III) and severe maltreatment of children ages 11 to 17; and sexual abuse of children 11 to 17 not covered by Type II. Each type of case requires a different

[9] *Instant Response Team Resource Manual* (New York: City of New York, July 2002), 64. For more information, see IRT Protocol (Appendix I).
[10] For details, see the IRT protocol (Appendix I).

response. Type I cases require immediate communication and coordination between ACS and the appropriate NYPD detective squad. Type II cases require an immediate response by an ACS child protective worker and an NYPD Special Victims Squad detective. Type III cases require an immediate response by an ACS caseworker and an NYPD patrol officer.

Once the IRT coordinator determines that a case requires an instant response, he or she contacts the NYPD and dispatches a child protective worker.[11] Both the child protective worker and the police aim to initiate the IRT process within two hours after receiving the report. After a "minimal facts only" interview by whoever arrives first, the members of the team conduct a joint interview and a medical exam if necessary. Whenever possible, the interview and a medical exam should take place in child-friendly settings—ideally, a Child Advocacy Center (CAC).[12] If an arrest occurred or appears likely, a prosecutor should attend the joint interview as well. If the interview takes place at a CAC, a member of the team—which may include a CAC social worker in addition to the police, a prosecutor, and a child protective worker—conducts the interview in a room equipped with a two-way mirror while the others watch from behind the mirror.

The IRT program is distinguished from many other efforts, including the Joint Response program, by the investment child welfare officials made in planning, management, staffing, and training. Though integrated into the child protective field offices, the program has a manager who collects and analyzes program data, is the liaison with police managers, and reports directly to the deputy commissioner for child protection. To handle cases in field offices, child welfare officials hired IRT coordinators who report to the program manager. The IRT coordinators screen all allegations to determine whether a report meets the criteria for an instant response. They then arrange for the police and caseworker to respond, monitor what happens during individual cases, and record information on response times and other outcomes.

The program also aims to improve information sharing. When the program launched, child welfare, the police, and local prosecutors' offices signed a memorandum of understanding that structured the sharing of information. Copies of the IRT protocol were distributed to staff of each of the agencies involved. The program manager provides regular updates to the "IRT handbook," which contains the protocol as well as contact information for appropriate staff in child welfare, the police, prosecutors' offices, hospitals, and CACs. The program also created two training videotapes that explain its procedures.

To respond quickly to IRT cases, ACS provides child protective workers with a car service instead of relying on public transportation, the norm in non-IRT investigations.

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[11] Detectives are not assigned to every case. Patrol officers may phone in a case to the IRT coordinator or may be assigned in some cases.

[12] Child Advocacy Centers are specialized facilities staffed by doctors and social workers trained in working with victims of child abuse, and designed to offer the child a comfortable and unthreatening environment.

Depending on the case, a child protective worker may have to make several stops to find the child. Providing a car service is an attempt to enable child protective workers to arrive as quickly as their counterparts in the police department, where operations are already resourced and designed for quick response.

The following example of how a case is handled under the IRT protocol offers a stark contrast to the lack of police-child welfare coordination shown in the example from San Diego:[13]

> Jane works at a school in New York City. One Friday, she noticed that Mark, a third-grader, had a chunk of skin missing from his hand and wounds on his head. The child told Jane that his mother beat him with a curtain rod and stabbed him in the head with a fork. Jane called the New York State Child Abuse Hotline operated by the State Central Registry, which contacted the Administration for Children's Services (ACS). Given the severity of the allegations and the possibility that the child might be attacked again, ACS staff initiated an instant response. In less than an hour, officers from the New York City Police Department's Special Victims Unit and a child protective worker from ACS arrived at the child's school.
>
> To minimize the trauma experienced by Mark and his siblings, the police and ACS conducted joint interviews with each child so that the children would have to explain what happened to them only once. The interviews indicated that the children were at imminent risk of further abuse, and the child protective worker arranged for them to be transported to ACS's newly constructed Children's Center. There, a nurse experienced in child abuse cases conducted a physical exam and determined that Mark did not need to go to the hospital for further medical care. ACS placement staff then arranged placements for the children in a foster care home. Based on the physical evidence and the children's statements, the police arrested the children's mother for child abuse.

Research Methods

We used both quantitative and qualitative methods to assess the program. We analyzed data collected by the IRT program's coordinators—the people who select cases for an instant response and who coordinate the response—from 1998 to 2002. These data contain individual-level case information such as where interviews took place, whether joint interviews occurred, and whether a child was removed. We matched this information with data on child abuse reports and investigations from the State Central Registry (SCR) for 2000—the most recent year available for research purposes. The SCR records all allegations of child abuse and neglect in the state and contains details of the subsequent investigation, such as whether allegations were substantiated. To further

[13] This is an actual case, but the names and other identifying information have been changed to maintain confidentiality.

analyze how IRT cases are reported, we studied phone traffic through the IRT hotline, a number designed to give the police a direct link to their local IRT coordinator.[14]

To better understand how the program works, we conducted 39 interviews with staff from all of the agencies involved. From child welfare we interviewed IRT coordinators and child protective workers from each of the five boroughs, the Office of Confidential Investigations and Emergency Children's Services; and supervisors and managers who encounter IRT cases daily. We were in constant contact with the program's director; reviewed the program's protocols, training materials, and handbook; and obtained materials on the city's previous efforts to coordinate responses to severe cases of maltreatment. Outside of child welfare, we interviewed social workers and the directors of Child Advocacy Centers (CACs)—facilities operated by nonprofit agencies that are designed to be comfortable places for children to be interviewed and that are staffed by doctors and social workers trained to work with victimized children—and the directors of specialized hospital-based centers. We spoke with child protection coordinators from New York City hospitals and assistant district attorneys with experience in the program from each borough. From the NYPD, we interviewed five members of the Special Victims Squad. We asked staff for their opinions about the program, examples of recent cases, and a description of a typical IRT case.[15] Finally, we accompanied child protective workers on an IRT case.

Even when staff are promised confidentiality, interviews by external researchers that ask sensitive questions may not elicit critical answers. To compensate, we visited a variety of locations and interviewed staff at different levels of responsibility. We also paid special attention when our respondents reported problems.

We reviewed the limited amount of previous research on this topic to find examples of other programs that use interagency cooperation when responding to reports of severe child maltreatment. We also spoke with officials from child welfare agencies in nine other large cities to learn how they handle severe cases of child abuse and what efforts they make to coordinate responses.[16]

[14] For a description of the SCR data sets and how they were matched and analyzed, see Appendix B.
[15] For an example of the interview instruments used, see Appendix C.
[16] See Appendix A for a list of cities and programs.

Results

We report only our key findings in this section. Additional analyses and supporting information are provided in the appendices. We begin by discussing how IRT members are trained, the ways IRT cases are reported, and how cases are selected for an instant response. We then focus on how police, child welfare, and prosecutors coordinate their activities in the field. Finally, we examine the outcomes of IRT cases. We look at indication rates—how often child protective workers find sufficient evidence to support at least one allegation of severe abuse or neglect—in addition to how quickly caseworkers and police officers respond to IRT cases, the frequency of joint interviews, and how often these interviews take place in child-friendly settings.

Training

In 1998 ACS and the NYPD conducted joint training sessions for staff assigned to work on the IRT program. The training included videotaped example of how the IRT program is designed to function, explanations of the IRT protocol, and marketing of the IRT hotline. In-service trainings were held for patrol staff and caseworkers. Since then, the two agencies have trained their staff independently. Training materials for police and prosecutors working on sex crimes include copies of the IRT protocol.

ACS has an ongoing training program at its caseworker training facility, the Satterwhite Academy. During interviews, one assistant district attorney felt that more frequent training could improve the program's performance. The NYPD does not offer continual training, and in late 2002, Special Victims Squad detectives we talked to had not received training since the program's launch. However, the NYPD conducted a refresher training class on the IRT protocol in 2003. In addition, police managers keep their officers informed through posters and other information posted in precincts and detective meeting rooms at police headquarters.

Though less central to the program's functioning, Child Advocacy Center (CAC) and hospital staff might benefit from increased outreach activities. Our interviews found some role confusion and occasional tension between child protective staff and their counterparts at CACs and hospitals. Training on the roles of staff assigned to IRT cases and the program's goals and procedures might smooth working relationships between caseworkers and social workers.[17]

Reporting cases: The use of the IRT hotline

One of the innovations designed to coordinate the members of the Instant Response Team is the IRT hotline. The hotline is exclusively available to the police and provides them with a direct link to the IRT program. Police can use the hotline to initiate an instant

[17] For more information on staff training, see Appendix D.

response or to talk with a coordinator if they are unsure about whether a case qualifies for the program. The police still must make a report to the State Central Registry, but first contacting the IRT coordinator allows child welfare to dispatch a caseworker immediately.

Our examination of phone records from January 2000 to January 2001 revealed that 37 percent of hotline calls were placed on weekends. Of calls made on weekdays, 96 percent took place outside of normal ACS working hours, 8 am to 4 pm.[18] Overall, the police initiated 635 instant responses. Of these, 322 calls went through the Instant Response Team (IRT) hotline, regarding approximately 260 cases, or 41 percent of the cases initiated.[19]

This suggests that the police use the hotline primarily when the regular IRT coordinators are not working: on weekends and after regular working hours. During regular working hours, Special Victims Squad detectives call the IRT coordinators directly, eschewing the toll-free hotline number. Most supervisors, IRT coordinators, and police staff indicated that the hotline is useful for patrol officers and for detectives unfamiliar with the program. Once police build a relationship with their local IRT coordinator, they use the hotline as a convenient back up during off hours.

Selecting Cases

The program aims to take all reports of severe maltreatment. Still, child welfare and the police face a balancing act in selecting cases for the IRT program. Neither the police nor child welfare has the resources to initiate an instant response in every case of child maltreatment, and fortunately the vast majority of cases do not require one. On the other hand, both agencies have invested resources in building an instant response capacity that would not be used efficiently if only a small number of cases qualified.

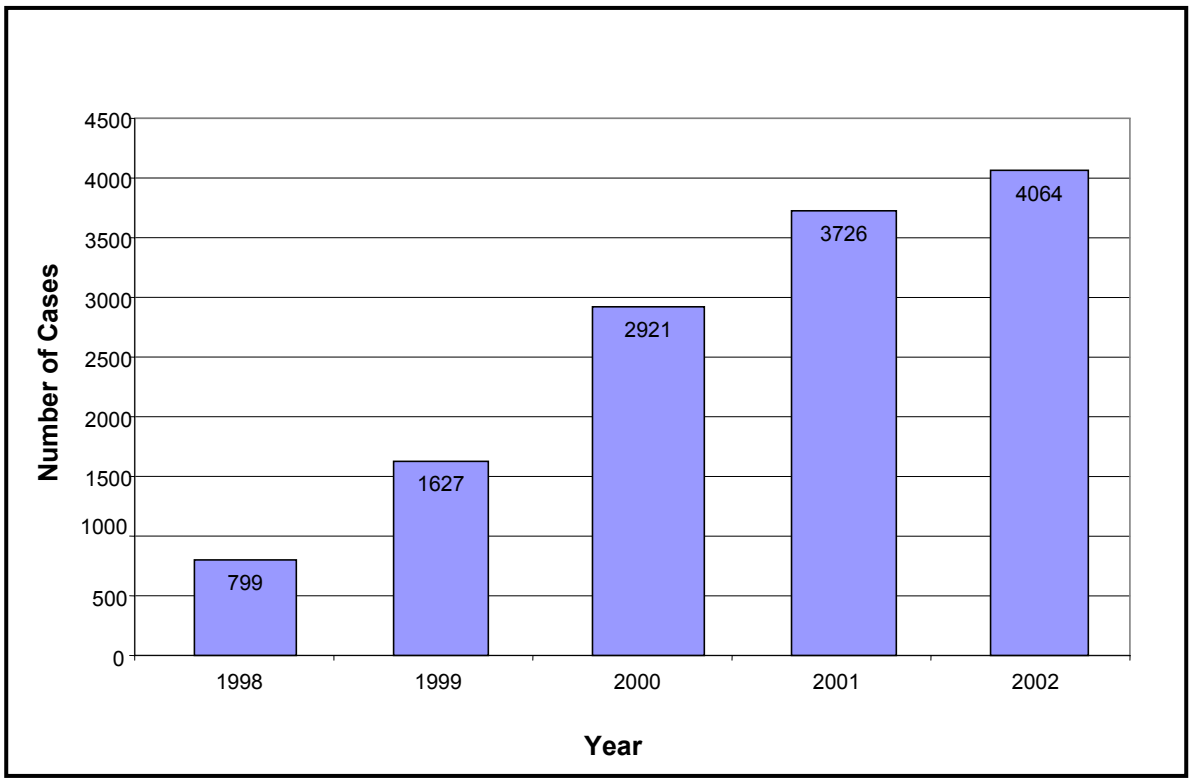
We examined how the number of IRT cases has changed over time and whether the types of cases selected for an instant response match the criteria stated in the program's manual. We also identified how often IRT cases were indicated.

The number of IRT cases has grown in each of the program's five years (see Figure 1). In 2002, 4,064 cases received an instant response, an increase of 160 percent since 1999. As planned, the program added Type III cases in 2000. Though Type III cases are now the majority of all IRT cases, Type I and II cases have also increased over time.[20] During the same five-year period, the total number of maltreatment reports stayed

[18] Calls made to the IRT hotline on the weekend and between 4 pm and 8 am on weekdays are routed to the IRT coordinators at Emergency Children's Services, the office of ACS that handles after-hours cases.
[19] Without knowing the content of these calls, we cannot determine how many were part of a series of calls on the same case, or how many resulted in an Instant Response. To adjust for this possibility, we assumed that calls made from the same number within three hours referred to the same case. Eliminating these calls reduces the total number of calls to 260.
[20] In 2000, the IRT eligibility criteria were widened to include severe neglect of 11-17 and lesser degrees of sexual abuse of children 11-17.

constant at around 55,000, with the police and ACS initiating cases in the same proportion as in prior years.[21]

Figure 1: Number of IRT Cases, 1998-2002



Growth in Queens and Manhattan outpaced increases in other boroughs. Queens's share of IRT cases grew from 15 percent of all cases in 1998 to 24 percent in 2002, while Manhattan's share grew from 13 percent to 21 percent in the same period. Brooklyn has more IRT cases than any other borough, but its share of all IRT cases dropped from 45 percent in 1998 to 34 percent in 2002. In Queens, the share of cases initiated by the police (as opposed to ACS) jumped from 16 percent in 1998 to 36 percent in 2002, and a similar though less pronounced change occurred in Manhattan. In contrast, the share of cases initiated by the police in the Bronx declined from 22 percent in 1998 to just 5 percent in 2002. Citywide, the ratio of cases initiated by the police remained steady at about 16 percent.

IRT coordinators are selecting cases defined by the IRT protocol. Our examination of State Central Registry data for IRT cases in 2000 showed that of cases selected for an

[21] The sources for these statistics are "ACS Update Annual Report 2001" and Vera's analysis of program data.

instant response, 99 percent met the minimum criteria of having at least one allegation of physical abuse, sexual abuse, or neglect, as outlined in the IRT protocol. In addition, IRT cases involved more severe allegations than non-IRT cases, and more of these allegations were substantiated. While both IRT cases and non-IRT cases averaged three allegations per case, an average of 1.4 allegations were substantiated in IRT cases, compared to 0.9 in non-IRT cases. Overall, 52 percent of IRT cases were indicated compared to 35 percent of all other cases—well above the national indication rate in maltreatment cases, 29 percent.[22] Queens and the Bronx have higher indication rates for IRT cases than other boroughs. A variety of factors may produce higher indication rates in one borough when compared to another, but the IRT cases in these two boroughs are also indicated at a higher rate than the non-IRT cases within their boundaries.[23]

Although IRT coordinators select cases that meet the program's criteria, our interviews found that the selection process is as much art as science. Allegations of child maltreatment come from a variety of sources and differ in quality and amount of information provided.[24] Cases called in by people who are mandated by law to report signs of abuse and neglect generally have higher indication rates than cases reported from other sources. Even so, less than half of all cases reported by mandated reporters are indicated.[25]

In practice, IRT coordinators have substantial discretion in selecting cases and exercise that discretion in different ways. Some coordinators said that they took a "better safe than sorry" approach, and initiated instant responses whenever they felt it might be warranted. Others said that they called for an instant response only when they felt it was absolutely necessary. Because many reports meet the minimum criteria for an instant response, how IRT coordinators exercise their discretion plays a large role in determining the number of cases the program handles.

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[22] Based on 1999 reports from the states to the National Child Abuse and Neglect Data System. For further information see http://www.acf.dhhs.gov/programs/cb/publications/cm99/index.htm. Each case may have multiple allegations. For a case to be indicated means that at least one allegation has been substantiated.

[23] Appendix E explains the methods used to arrive at these calculations, and includes tables and additional analysis of the data.

[24] For a discussion of issues related to reporting child maltreatment, see G. Zelman, and K.C. Faller, "Reporting of Child Maltreatment," J. Briere et al. eds., *The APSAC Handbook on Child Maltreatment* (Thousand Oaks, CA: Sage Publications, 1996).

[25] This statistic is based on analysis of State Central Registry data by the Administration for Children's Services. See also M.C. Kenny, "Compliance with Mandated Child Abuse Reporting: Comparing Physicians and Teachers," *Journal of Offender Rehabilitation* 34, no. 1 (2001): 11. Though the laws and regulations surrounding mandated reporting vary by state, occupations covered typically include medical personnel, social workers, and in some cases educators.

Internal coordination

Insufficient organization and instability *within* (as opposed to between) individual organizations may hinder attempts at interagency coordination.[26] Before examining the degree of coordination among agencies, we sought to determine the degree to which child protective staff involved in the Instant Response Team program coordinated their agency's activities.

Overall, we found that IRT coordinators, supervisors, and child protective workers worked well together. Despite some initial difficulties, particularly in adjusting to a new chain of command, the program has kept internal conflict to a minimum. Caseworkers and IRT coordinators almost universally reported a good relationship with each other. Only one caseworker and one IRT coordinator out of the group of 14 discussed any complications with working together, and the issues they described arose in the early days of the program and have since subsided.

Although resources did not allow us to interview a statistically representative sample, our interviews suggested that there is occasional friction between IRT coordinators and child protective supervisors. By designating cases for instant response, IRT coordinators are forcing supervisors to immediately assign a child protective worker. Supervisors have no say in determining whether a case should be deemed an instant response. Yet child protective workers on IRT cases report to these supervisors, not the IRT coordinator. These "cross-jurisdictional" demands have the potential to create conflict. Yet most supervisors and managers we interviewed were able to balance these sometimes conflicting demands. Only one person in this group felt strongly that the challenges of coordination outweighed its benefits.

Responding to cases

Nearly every person we interviewed reported that the IRT program has vastly improved coordination among the agencies. Special Victims Squad detectives reported that the program has led to more information sharing, better processing of cases, and improved relations overall. IRT coordinators and their contacts in the police department have developed solid working relationships and a high level of phone contact. "I think the IRT program is one of the best things we've ever done," reported one detective, expressing a common level of enthusiasm.

All five assistant district attorneys believe that agency coordination improves prosecutions, and most said that the IRT program strengthened the partnership between law enforcement and child protection. "Pre-IRT, no one was coordinated with each other," said one. "Everyone was just doing their own job and not even thinking about

[26] Nancy Wolf, "Interactions between Mental Health and Law Enforcement Systems: Problems and Prospects for Cooperation," *Journal of Health Politics, Policy and Law* 23, no. 1 (1998): 139.

how it might be affecting children. Post-IRT, everyone understands why they should be working together."

This widespread support exists despite the obstacles that staff must overcome to implement the IRT protocol. For the program to be effective, front line staff must address the complications inherent in coordinating fieldwork and balancing workload pressures. The sections below examine how child welfare workers and the police respond to IRT cases, the various pathways that IRT cases may take after contact is made with a child, the challenges in arranging joint interviews, and the outcomes of IRT cases.

Timing. We examined response times by looking at data collected by the program and by discussing the subject in interviews.

All IRT coordinators keep a weekly log of response times, which they uniformly defined as the time that elapses from when the field office receives a report to when the caseworker leaves the field office, not when the caseworker makes contact with the child. The response data are divided into ranges: less than an hour, one to two hours, more than two hours.[27] The log data show that in the past year half of all caseworkers responding to IRT cases left the office in less than an hour of a case's initiation, and almost 90 percent left within two hours—although times varied widely by borough (see Table 1).[28] Since the first year of the program, caseworkers citywide have decreased the amount of time it takes them to leave the office. In 1998 it took more than two hours to depart in 26 percent of cases. By 2002, it took that long in only eight percent of cases (see Figure 2).

Table 1: ACS Response Times by Borough, 8/1/01-7/31/02

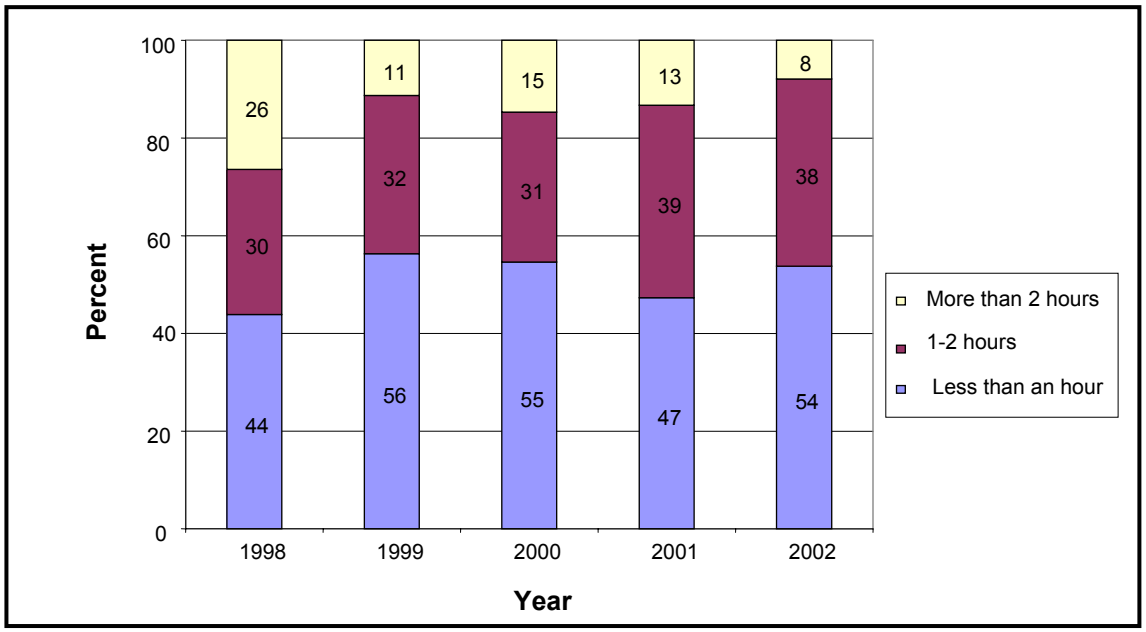
	ACS Response Time		
Borough	**Less than an hour**	**1-2 hours**	**More than two hours**
Bronx	38.2%	54.8%	7.0%
Brooklyn	20.9%	66.7%	12.4%
Manhattan	80.2%	18.8%	0.9%
Queens	71.3%	8.4%	20.3%
Staten Island	85.9%	10.7%	3.4%

Note: Response time refers to the time elapsed between the receipt of the report that triggered the instant response and the time the caseworker left the field office.

[27] As part of this project, program staff and Vera researchers worked together to redesign the IRT data collection log. The new log, launched in January 2003, records more precise information on response time and other variables.

[28] This data refers to 8/1/01 to 7/31/02.

Figure 2: ACS Response Time by Year, 1998-2002



Note: Response time refers to the time elapsed between the receipt of the report that triggered the instant response and the time the caseworker left the field office.

A number of factors hinder even faster departures. ACS has markedly lowered the caseloads of child protective workers over the last six years, but during busy periods there may not be a caseworker immediately available. At other times, an IRT unit may be "capped," meaning that the unit has exceeded the number of cases that it is authorized to respond to per month. If a unit is capped when a new case arrives, the IRT coordinator must find another unit to handle the case. Our examination of IRT log data from one unit showed a range of response times. The vast majority of caseworkers responded quickly, with a small number accounting for a disproportionate percentage of slow responses.[29]

Once caseworkers leave the office, they must navigate a range of obstacles over which they have little control. The car service may come late, and traffic may cause delays. In contrast, the police have their own cars and can clear traffic with sirens. Once in the field, caseworkers need to find the child or children who are the subject of the allegations. By contract, the car service waits one hour for the caseworker at any one location. If the caseworker stays at a location for more than an hour, the process of obtaining a car must start from the beginning. In some cases, this can cause serious delays: caseworkers report that finding a child may involve as many as six different stops, including school, the child's home, the homes of the child's extended family, friends, neighbors, and other locations.

[29] The analysis of this data can be found in Appendix F. As part of this project, Vera staff provided ACS with software code that would allow analysts to monitor the response time performance of boroughs, units, and if ACS chose to do so, individual caseworkers.

The police, too, face challenges in responding to Instant Response Team (IRT) cases. In two boroughs, caseworkers in Type II cases frequently go to the scene alone and bring the child to a Child Advocacy Center (CAC) or other facility for a joint interview with a Special Victims Squad detective. Both ACS staff and the police report that workload pressures can make detectives and patrol officers reluctant to accompany child protective workers on IRT cases. To balance these competing interests, police officers may ask child protective staff to start investigations alone and let them know if they are needed. One police officer reported that for him, the typical IRT case involves going to the interview site—usually a hospital—after ACS had already transported the child. Both officers and child protective workers report making good-faith efforts to work together, but noted that when their counterparts did not arrive when they did, time constraints made it necessary to proceed without them.

At the scene. Police and caseworkers alike report few problems coordinating their work when they were at the scene together. Both parties perceived the other as additional help and appreciated their presence. When asked who decides who will conduct a joint interview, both child protective workers and the police responded that whoever has the best rapport with the child conducts the interview. Mentions of conflict over this issue, which other research in this area highlights, were notably absent.[30] The interviews provided no evidence of role confusion, arguments over turf, or other common frontline problems associated with collaboration.

Prosecutors, police, and ACS staff all agreed that the speed of the response by child protective workers and the availability of the police play key roles in determining what happens in the field, including whether joint interviews occur, the number of interviews that take place, and the follow-up required by all parties. Reliant on a car service instead of a fleet of radio- and siren-equipped patrol cars, child protective workers face a bigger challenge than the police. Detectives and district attorneys report that when they arrive on the scene first they wait for ACS, but the pressure of other work means that they cannot afford to wait too long. In some situations, the facts of a case may force police to conduct investigations immediately. If the police believe that an interview needs to be conducted immediately to collect evidence, then they will not wait for child protective workers to arrive. If caseworkers find children that need immediate medical attention, they will not wait for the police to arrive.

Police officers who reported experiencing delays expressed support for the IRT program. When asked what he does if ACS has not arrived at the scene, one detective remarked, "We try to wait. If [the case] is with the IRT unit there are not too many problems. If they're capped and it goes to the normal unit, you can forget about it. You

[30] See Jo Moran-Ellis and Nigel Fielding, "A National Survey of the Investigation of Child Sexual Abuse," *British Journal of Social Work* 6, no. 2 (1996): 337-356.

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might as well do the case yourself." For many reasons, the typical pace of front-line police work is usually faster than that of child protection. The additional resources devoted to IRT cases increase the capacity of child protective workers to respond quickly in critical situations.

Minimizing trauma: interviews and exams. The IRT program seeks to minimize trauma for children involved in investigations of abuse or neglect in two ways: by reducing the number of interviews and medical examinations and, whenever possible, by conducting joint interviews and medical exams in child-friendly settings, such as CACs and specialized hospital-based centers.

Prior to IRT, no agency collected data on the number of exams or interviews conducted. Since the program's inception, however, cases involving multiple exams and interviews have declined. Of those children needing a medical exam in 1998, 19 percent received more than one exam and 10 percent were examined three or more times. Five years later, in 2002, almost every child experienced only one exam (96 percent) and no child underwent more than two exams.

Similar progress has occurred in the number of interviews children undergo in the initial investigation. In 1998, 14 percent of children were interviewed three times or more. By 2002, almost no cases involved more than two interviews. This change is not due to the addition of marginal cases; the absolute number of cases with two or more interviews has declined.

It is not possible to know how many interviews and exams took place before the IRT program began, but the sizable number of cases with multiple interviews and exams that occurred during the first year—a time when key managers focused attention on the issue—suggests that there were more of these cases before the program existed. Child welfare staff, police, and prosecutors who worked on child abuse cases before IRT believe that the program streamlined case processing. One detective commented that ACS used to refer cases to the district attorney's office, which then referred the case to the police for investigation a week or two after an allegation was initially reported. This meant that at least two interviews were conducted (one by child protection, another by the detective), and that marks, bruises, and other evidence of child abuse had disappeared. This detective now rarely receives a case from the district attorney; most start either as IRT cases or become IRT cases after an initial investigation.

Joint interviews. The IRT program seeks to conduct joint interviews whenever further investigation of a case is warranted. Child advocates have long argued for more joint interviews and investigations, and a five-city study of cases of sexual abuse and serious

physical abuse concluded that "joint investigations result in good outcomes for both children and practitioners."[31]

The overall rate of joint interviews in IRT cases has stayed near 55 percent over the five years of the program, twice the 27 percent found in the five-city study cited above.[32] This rate includes all cases, even those that did not need a medical exam, or have even one interview. Those cases that receive the higher levels of attention, Type I and II cases, had higher rates of joint interviewing in 2002 (81 percent and 61 percent respectively) than Type III cases (44 percent).[33]

In cases with more legal activity, joint interviews took place more often. The rate of joint interviews significantly increased ($p<.001$) within each type in cases where a) ACS or the police removed a child b) the family court was involved or c) where the family court granted remand. For example, police and child protective workers conducted joint interviews in 71 percent of Type II cases that involved a removal compared to 57 percent of Type II cases that did not involve a removal.

To further understand the factors associated with joint interviews, we used the program's data to conduct a multivariate analysis (See Appendix H for results and methodological details). Multivariate techniques can show the impact of one factor alone, after controlling for other variables that might influence a result. We limited the model to variables that referred to case characteristics known before a joint interview occurred. Using post-interview variables, such as family court involvement or child removals, had the possibility of mixing cause and effect: the joint interview process itself might lead to different case outcomes.

This analysis identified five variables that contribute to the likelihood of a joint interview occurring: the type of case, where the interview occurred, arrival sequence, and the borough in which the case took place ($p<.001$). Factors such as the year or weekday of the case, whether Emergency Children's Services initiated the case, and whether an arrest occurred were not significant predictors of whether a joint interview occurred.

Geography and case type both had significant independent effects. Type II cases were more likely than either Type I or III cases to involve joint interviews, as were cases that took place in Staten Island and Queens. Joint interviews occurred more often in CACs, police stations and hospitals (respectively), and least often at the child's home. The multivariate analysis also had an interesting finding on response times: joint interviews took place more often when ACS and the police arrived at about the same time (within the same response time category). If either the police or ACS arrived before the other (in different response time categories), the likelihood of a joint interview declined in about equal amounts.

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[31] Tjaden and Anhalt, *The Impact of Joint Law Enforcement Child Protective Services Investigations in Child Maltreatment Cases*, a final report for grant number 90-CA-1446, from the National Center on Child Abuse and Neglect (Denver, CO: Center for Policy Research, 1994) iv.
[32] Ibid, p. 44.
[33] For more information, see Appendix G.

Where an interview occurs is associated with the likelihood of a joint interview. After controlling for other factors, joint interviews take place more frequently in CACs and police stations, and to a lesser degree in hospitals. Joint interviews occur less frequently when conducted in a child's home, school, or at an ACS office. This finding may pose a dilemma for the program: though not the child friendly setting the program seeks to use for interviews, increasing the use of police precincts might raise the rate of joint interviews.

Joint interviews do not occur in every case for many reasons. As discussed above, differing response times or lack of staff can make coordination difficult. Having the police and child protective workers on the scene at the same time is a necessary but not sufficient condition for a joint interview. When emergency rooms are experiencing high volume, child protective or police staff may not be able to wait for doctors to finish their exam so that they can conduct a joint interview. Occasionally, parents refuse to consent to a child's removal or cannot be located to give their consent. Four of the five assistant district attorneys (ADAs) assigned to child abuse or special victims prosecution that we interviewed regularly attend joint interviews, but the fifth cited understaffing in the prosecutor's office for not having attended a joint interview.

Interview and exam locations. The IRT program aims to have joint interviews and medical exams to be conducted in child-friendly settings, ideally a Child Advocacy Center (CAC) or a specialized hospital center. The type of case can effect where interviews take place. About one in five Type II cases hold interviews in CACs, compared to four percent of Type III cases (see analysis in Appendix H). The majority of Type III cases take place in a child's home compared to a third of Type II cases. Fewer than one in ten cases have interviews in ACS offices or schools. Because Type I cases are less than three percent of all IRT cases, comparisons on this variable are inappropriate.

Three of every four medical exams take place in hospital emergency rooms, with the remainder occurring in CACs, pediatric centers, and at private doctors offices. Given the critical nature of IRT cases, this is not surprising.

Many barriers prevent more widespread use of Child Advocacy Centers. There are no CACs in Queens, despite reports of longstanding promises to open one. Most CACs do not have doctors on 24-hour call, and ACS staff report that others have turned away cases due to inadequate staffing. Also, some CACs only accept certain types of cases. The primary obstacle, however, seems to be that most Child Advocacy Centers operate only during normal business hours. While many IRT cases are initiated during the day, by the time caseworkers and police locate the child and decide that an exam or interview should take place at a CAC, the facilities are often closed. Cases initiated after hours or on weekends cannot make use of most CACs.

Explanations for why the number of interviews at CACs has declined are harder to develop. The confusion and conflict that occasionally occur between CAC and hospital

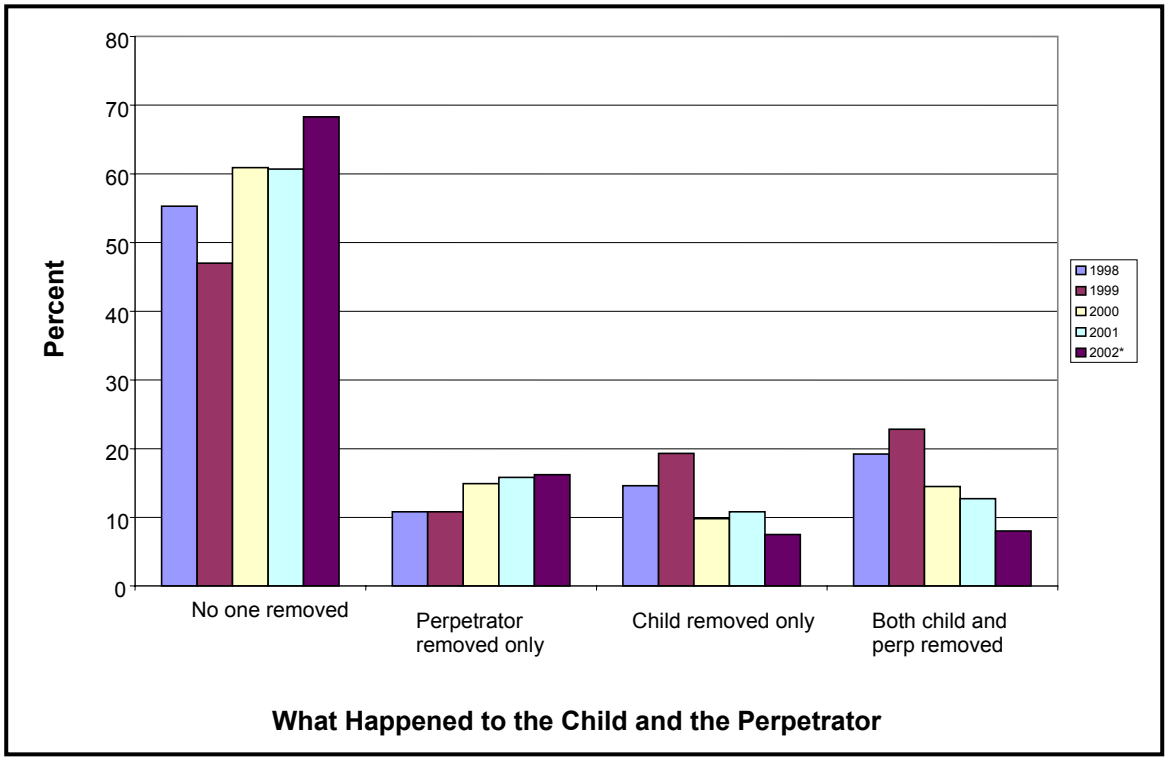
social workers and child welfare caseworkers may be a factor. In some situations, responsibilities are not clearly delineated between child welfare workers and the hospital or CAC staff. Hospital, CAC, and child welfare caseworkers all voiced concerns about these issues. Two of the seven CAC and hospital representatives we interviewed reported that they felt better qualified to interview children than child welfare caseworkers. Several caseworkers and IRT coordinators voiced concerns that ACS representatives are almost never included in joint interviews at CACs and are usually relegated to an observation role. Said one IRT coordinator, "It stifles the caseworker; it doesn't allow them to develop their skills as interviewers."

Case outcomes

In combining child welfare and police investigations, the IRT program seeks to remove perpetrators from the home, rather than children, while maintaining child welfare's goals of ensuring child safety and preserving families. Those who advocate for a greater role for law enforcement point out that before the program was established, reports of abuse and neglect often resulted in the removal of children, while the alleged perpetrators remained at home. From this point of view, the lack of a police presence risked further trauma to already abused and neglected children.

The trends in IRT cases show a decline in the removal of children and an increase in arrests (Figure 7). The proportion of cases in which only the perpetrator was removed (defined as arrest made, but the child not removed) rose from 11 percent in 1998 to 16 percent in 2002. The percentage of IRT cases in which only a child was removed fell from 15 percent to 8 percent during the same period. Cases that resulted in the removal of both the child and the perpetrator also fell. Overall, cases involving child removals fell sharply from 35 percent in 1998 to 17 percent in 2002, while arrests declined from 30 percent in 1998 to 24 percent in 2002.

Figure 7: Removal Trends in IRT Cases, 1998-2002



Note: Perpetrator removals are defined as an arrest made (N=11,750).

These trends in removals are consistent with the program's goals. In most IRT cases no one is removed from the home. But in IRT cases resulting in the removal of either the child or the alleged perpetrator, children were removed more often than alleged perpetrators in 1998 (57 percent of such cases). By 2002, alleged perpetrators were removed more often than children (68 percent of such cases). Among those cases where no removal took place in 2000, State Central Registry data show that two-thirds were unfounded. The remainder involved cases with substantiated allegations that did not result in removals.

Data on prosecutions and sentencing are hard to collect. The decision to prosecute may not occur until days or weeks after the initial investigation, and collecting this information is labor intensive. Sentencing occurs even later. Future research might select a sample of IRT cases to see how the program effects prosecution and sentencing.

Discussion

Our research shows that the IRT program has been successfully implemented and that on key indicators, the program has changed the way that children involved in cases of severe maltreatment are treated. As we note in our conclusion, the success of this model has implications for other child welfare systems. In this discussion, we examine ways that the program might build on its success.

Child welfare officials planned to have the IRT program respond to every allegation of severe maltreatment. Indeed, the program expanded to over 4,000 cases from 1998 to 2002, a period when the caseloads of child protective workers declined. IRT may contribute to the capacity of child protective workers to handle cases. Child protective workers on IRT cases save travel time that can be used to handle other cases. In addition, increasing the size of the program brings economies of scale. The human resources that child welfare devoted to the program—a program manager and the IRT coordinators—have remained constant despite the increase in caseloads.

The continued growth in the number of IRT cases increases demands on the police and prosecutors. While we found strong support for the program among front line staff at these agencies, workers at each agency cited workload pressure as a primary concern. Police often see their job as making arrests and developing cases. With only a quarter of all IRT cases resulting in arrests, some officers may fear that spending too much time responding to IRT cases will make them look unproductive. In some boroughs, heavy workloads appear to be the primary reason that front line police and prosecutor staff have developed work patterns that deviate from the IRT protocol.

Many of the people we interviewed recommended that the program receive more resources. Adding more staff at each of the three agencies, providing additional funding for CACs, and arranging more comprehensive access to car services would likely improve the program. Budgetary constraints, however, make this an unlikely development.

While IRT is a joint program, child welfare has the most at stake. It is the agency that has committed the most resources and has the management and data resources best suited to address issues associated with growth. The ideas below might improve the program's efficiency, allowing IRT to better target those cases that are most likely to require police involvement. In addition, introducing some data driven accountability mechanisms for individual caseworkers and IRT coordinators might further improve the performance of frontline staff.

Identifying cases. There is no established limit on the number of cases that the program can handle, and for good reason: all cases of severe maltreatment can benefit from an instant response. To manage how its coordinators use their discretion in selecting cases, child welfare implemented a cap system to restrict the number of cases each unit handles.

This system has not produced the desired results. Well-intentioned staff have found ways to work around the cap system when they feel a case demands an instant response. These improvisations reduce the program's efficiency as coordinators scramble to find uncapped units and the time they consume delays caseworkers.

As part of this project, ACS revised its data collection instrument with the help of Vera researchers. The revised instrument, implemented in January 2003, allows managers to disseminate aggregate, coordinator-level reports on the results of IRT cases, lets coordinators see patterns in the cases they select, and allows managers to identify and work with coordinators who may be selecting inappropriate cases. Regular borough-level meetings with managers to review the data for the borough would create opportunities for increased learning. Child protective managers might set up these meetings using the NYPD's widely heralded Compstat model, and could include a police and prosecutor representatives.[34]

The coordinator-level information also could be used in regular meetings of the IRT coordinators themselves to review case studies of decisions that each IRT coordinator made. These meetings might involve examining the data IRT coordinators received from the State Central Registry and other information that coordinators used to make decisions about initiating an instant response. By working as a group, the coordinators could share successful techniques for weeding out unfounded cases and developing a set of best practices to inform their work. Future research might focus on identifying individual level factors—such as the type of abuse alleged and who reported the abuse—that increase the probability that the police will be needed in an investigation.

Finally, managers could use data available in the redesigned IRT database to assess and improve caseworker response time. Examining patterns in caseworker response times would allow managers to reward those caseworkers with consistently strong performance and work with the few weak performers to identify and solve problems. Making response times a component of caseworker evaluation would further emphasize the need to handle IRT cases with the utmost urgency. Improving the coordinators' abilities to spot the most serious cases would reinforce the fact that IRT cases are special events that demand immediate attention.

IRT cases are already divided into three types, with the primary operational difference being the rank of the police respondent. A more radical reform might keep the current types, but split IRT cases into two categories. One category could involve the most serious allegations that warrant an immediate police response. This category might be reserved for cases involving allegations of severe maltreatment, where the child's location is known and there is imminent danger to the child. Police would be expected to

[34] For a discussion of Compstat, see Vincent E. Henry and William J. Bratton, *The Compstat Paradigm: Management Accountability in Policing, Business and the Public Sector* (New York: Looseleaf Law Publications, Inc., 2002).

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arrive within two hours, as would ACS caseworkers. A second category might include cases involving allegations of severe maltreatment, but where the location of the child is unknown, or where the child does not appear to be in imminent danger. In these cases, caseworkers would be dispatched immediately by car service, but police would be called in only after an initial investigation by the caseworker. Police could meet caseworkers at CACs or other locations once doctors had completed necessary medical exams. If caseworkers needed a police officer or Special Victims Squad detective at the scene, they could request one through the IRT coordinator or the 911 system. This approach would allow a quicker response than the existing "rapid response" standard (a visit within 24 hours) and might make more efficient use of the police.

Improvements in response time and case selection would give child welfare managers leverage in efforts to increase training of police and prosecutors. More regular training, perhaps coordinated with the training received by caseworkers at the Satterwhite Academy might lead to a better understanding of the program. Though police and prosecutors have some training on IRT built into their orientation programs, much of what new police officers and detectives know they learn on the job. This increases the potential for new officers to think that any "short cuts" they observe are standard procedure. Child welfare staff report significant turnover among Special Victims Squad detectives, which offers the opportunity to reinforce the program's goals and procedures. CAC and hospital social workers might also benefit from these sessions. Outreach to these groups could smooth the process of conducting joint interviews, and training could clarify roles and emphasize the need for child welfare caseworkers and medical social workers to share knowledge.

Conclusion

Child welfare agencies, the police, and prosecutors have much to gain by coordinating child protective investigations. The IRT program demonstrates that fast, coordinated responses can improve information sharing and case processing and also increase the effectiveness of law enforcement and prosecution. The vulnerable children involved in these cases are the biggest and most important winners: reduced trauma and a process that allows more children to stay home are major improvements.

The IRT program has the potential to be a national model for how local jurisdictions can best handle reports of severe child maltreatment. But jurisdictions interested in creating a version of the program cannot simply replicate the program's protocol. This study and past research show the value of planning and management resources. IRT succeeded in large part because of the investment in solving issues of accountability, role definition, information sharing, management, and case processing procedures—issues that were not sufficiently addressed in past efforts in New York City and elsewhere.

Other studies show that collaborative efforts often require ongoing attention. Collaborative routines can deteriorate over time as excitement about new programs fades and the environments in which they operate change. These tendencies are countered, however, by the benefits of a well-functioning collaboration. IRT has created a new way of handling reports of severe child maltreatment—a method that advances the mission of each of the agencies involved. The web of interagency relationships and strong support of frontline staff has created a reserve of good will that each agency can draw upon to sustain their enhanced ability to serve children in need.

Bibliography

Administration for Children's Services, Office of Management, Development, and Research. *Abuse & Neglect Reports in CY 2000.* New York: Administration for Children's Services, 2000.

Besharov, D.J. *Combating Child Abuse: Guidelines for Cooperation Between Law Enforcement and Child Protective Services.* Washington, DC: American Institute for Public Policy Research, 1990.

Cage, Richard L., and Donna M. Pence. *Investigation of Child Sexual Abuse.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (OJJDP), May 1997.

Dinsmore, J. *Joint Investigations of Child Abuse: Report of a Symposium*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, July 1993.

Ellis, Mark. *Forming a Multidisciplinary Team to Investigate Child Abuse.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, OJJDP, 2000.

Finkehol, David, and Richard Ormrod. *Child Abuse Reported to the Police.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, OJJDP, 2001.

Froum, A.G., and K.A. Kendall-Tickett. "Law Enforcement Officer's Approaches to Evaluations of Child Sexual Abuse." *Child Abuse and Neglect* 22, no. 9 (1998): 939-942.

Henry, Vincent E., and William J. Bratton. *The Compstat Paradigm: Management Accountability in Policing, Business and the Public Sector*. New York: Looseleaf Law Publications, Inc., 2002.

Kollis, G.H. "The Role of Law Enforcement in the Investigation of Child Maltreatment," in *Recognition of Child Abuse for the Mandated Reporter,* edited by J.A. Monteleone. St. Louis, MO: G.W. Medical Publishing, Inc., 1996.

Hammond, Carl. *Law Enforcement Response to Child Abuse.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, OJJDP, May 2001.

Maricopa County Interagency Council. *Multidisciplinary Protocol for the Investigation of Child Abuse*, 1999.

Martin, S.E., and D.J. Besharov. *Police and Child Abuse: New Policies for Expanded Responsibilities.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1991.

Moran-Ellis, Jo, and Nigel Fielding. "A National Survey of the Investigation of Child Sexual Abuse." *British Journal of Social Work* 6, no. 2 (1996): 337-356.

Pence, Donna, and Charles Wilson. *The Role of Law Enforcement in the Response to Child Abuse and Neglect.* McLean, VA: The Circle, Inc., 1992.

Pressman, Jeffrey, and Aaron Wildavsky, *Implementation: How Great Expectations in Washington are Dashed in Oakland*. Berkeley, CA: University of California Press, 1972.

Rogers, C. "The Child Victim Rapid Response Program." *Family Futures* 2, no. 4 (1998): 26-29.

Saywitz, Karen J., and Kathleen Coulborn Faller. *Interviewing Child Witnesses and Victims of Sexual Abuse.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, OJJDP, August 1996.

Smith, Barbara E. *Prosecuting Child Physical Abuse Cases: A Case Study in San Diego.* Washington, DC: U.S. Department of Justice, Office of Justice Program, National Institute of Justice, June 1995.

State of Michigan. *Children's Protective Services Manual: CFP 712-3*, 2001.

State of Michigan. *Children's Protective Services Manual: CFP 712-4*, 2001.

State of Michigan. *Governor's Task Force on Children's Justice–A Model Child Abuse Protocol,* 1998.

Tjaden, P.G., and J. Anhalt. *The Impact of Joint Law Enforcement-Child Protective Services Investigations in Child Abuse* Cases (Denver, CO: Center for Policy Research), 1995.

U.S. Department of Health and Human Services. *Child Maltreatment 1999.* September 20, 2002. http://www.acf.dhhs.gov/programs/cb/publications/cm99/index.htm.

Vreeland, A.B. "The Criminalization of Child Welfare in New York City: Sparing the Child or Spoiling the Family?" *Fordham Urban Law Journal* 27, no. 3 (2000): 1053-1103.

APPENDICES

Appendix A: Similar Programs in Other Large Cities

Across the country, child welfare administrators have recognized the need to respond more quickly to allegations of severe child abuse and neglect, and also to involve law enforcement in these cases to prosecute accused child abusers in criminal courts. New York's Instant Response Team program has the particularly challenging task of coordinating the efforts of multiple agencies in a city of nine million. A look at multidisciplinary programs in other large U.S. cities illustrates the diverse ways they respond to this challenge. Here is a snapshot of how other city governments are coordinating their agencies' efforts to better protect children and serve families.

Houston, **Dallas,** and **San Antonio** divide child abuse and neglect cases into high and low priority, with high priority investigations initiated within 24 hours. These cities also use Child Advocacy Centers (CACs)—facilities designed to provide services to families in a child-friendly environment. **Houston** boasts a large and inclusive CAC, where 15 partner agencies are housed, among them police, DAs and county attorneys, the FBI, Crimestoppers, child advocates, religious groups, schools, hospitals, and mental health agencies. Houston's CAC is equipped with interview rooms, child-friendly examining rooms, and staff doctors. At **Dallas**' CAC, law enforcement, mental health, and medical professionals work with child protective staff to handle cases of physical and sexual abuse. The **San Antonio** CAC was launched in 1992 and puts child welfare, an assistant DA, police detectives, medical staff, a clinical director and four therapists under one roof.

In **Chicago** a new program is in development that will focus on child abuse cases involving serious head injuries. In addition, Chicago has a new and expanding CAC, currently used largely to investigate cases of alleged sexual abuse. **Los Angeles** is preparing to implement a Triage Assessment Team to provide support in cases of severe child maltreatment. Complex or high-risk cases are assigned a team that consists of a social worker, a public health nurse, and a clerical worker. The team helps child welfare and police investigate these cases, and makes recommendations for how best to serve each family's needs. Los Angeles is also launching a separate multi-disciplinary emergency response program that targets methamphetamine abuse in families.

In **San Diego**, a program launched in the late 1980s combines the efforts of child welfare, law enforcement, and the medical community to aid the prosecution of child physical abuse, sexual abuse, and neglect cases. In **Philadelphia**, the mandate for interagency coordination covers a wide range of cases, including abuse not perpetrated by the child's caretaker. The city also has a program that calls for a team to be established after two reports of child abuse. **Phoenix** follows a protocol for multi-agency coordination that stresses that child welfare and police conduct joint investigations in high-priority or high-risk cases. Other participating agencies include youth and church groups, school districts, and hospitals. Finally, **Detroit** uses the detailed protocol for

coordinated investigative teams laid out by Michigan's child welfare office. These teams respond quickly to high priority cases and include a prosecuting attorney, police investigators, and medical and mental health professionals.

An evaluation of San Diego's multi-disciplinary approach by the Office of Juvenile Justice and Delinquency Prevention focused on its effectiveness in facilitating the prosecution of physical abuse cases. It found that a multi-agency approach to these cases was critical in collecting and interpreting evidence that could be used for prosecution. Most efforts at multi-agency coordination in the country's largest cities are new or experimental, and little research exists on their effectiveness. We hope this study will be a useful addition to the literature, and inform similar programs in other cities.

Appendix B: State Central Registry Datasets and Methodology

The State Central Registry records data on every report of alleged child abuse or neglect in New York State. Their data system, called "CONNECTIONS," is a relational database consisting of tables linked by common identifying numbers. Each table contains information on a single aspect of child maltreatment cases. For example, the "Allegation" table details the type of maltreatment alleged, as well as the eventual fact-finding determination for each allegation. The "Perpetrator" table contains demographic information on each alleged perpetrator, describes his or her relationship to the victims, and indicates whether the alleged maltreatment was confirmed.

Each table in CONNECTIONS is based on a different unit of measure. The Allegation table, for instance, has one record for each allegation. Each allegation of maltreatment by each perpetrator, against each victim, is considered distinct. Thus, the table has multiple allegations per perpetrator and multiple allegations per child, creating a large and detailed dataset. Similarly, the Perpetrator table contains one record per allegation type, per perpetrator.

For this report, we requested CONNECTIONS data on all reports from New York City in 2000 that became Instant Response Team (IRT) cases. We chose 2000 because it was the most recent year that New York City's Administration for Children's Services (ACS) had analyzed the data on maltreatment reports. We compare our results with those presented in *Abuse and Neglect Reports in CY 2000*, an internal document prepared by the ACS Office of Management, Development, and Research.

To identify the reports that became IRT cases, we acquired state identification numbers from the IRT administrative database. These numbers were matched with identifiers in the CONNECTIONS data, and we were given the resulting datasets containing information on reporters, children, allegations, perpetrators, and safety assessment outcomes for all IRT cases. We then compared IRT cases with other child maltreatment cases in New York City in 2000, by replicating the analyses that ACS staff had performed in their report. The findings provide the first ever in-depth comparison of IRT cases with all other child maltreatment cases in New York City.

Appendix C: Examples of Staff Interview Instruments

Several instruments were created for this research, though most contained a similar set of core questions. The instrument below is a sample—for a complete set of instruments, contact the Vera Institute.

ACS Caseworker

To the interviewee: Hello. My name is _____. I work for the Vera Institute of Justice. Thank you for taking the time to meet with me today. I am trying to find out more about the Instant Response Team. Anything that you say in this interview will be strictly confidential, and will not be reported to anyone in your agency or outside of the Vera Institute of Justice. If we use material from this interview in a report, your name will never appear with it.

SECTION I

To the interviewee: I'd like to start by asking a few quick questions that describe your position.

1. What is your title?
2. How long have you been at this job?
3. What did you do before working in this position?
4. Did you receive any special training for working in the IRT program?
   (If yes)
   a. what did it consist of?
   b. how long did it last?
   c. did you receive training before or after starting work in the IRT program?
5. What are your primary responsibilities?

SECTION II

To the interviewee: Now I'd like to ask you some questions about the specific things that go on once you arrive on the scene of an instant response incident.

6. Walk me through a typical IRT event.
7. What role do you have in deciding whether the child is removed from the home?
8. When do you decide to leave the scene?
9. When do the police officers leave?
10. How much contact do you have with IRT coordinators?
11. Can you give me some examples of experiences you've had with IRT coordinators?

SECTION IV

To the interviewee: The next questions have to do with the joint interview process. We would like to hear from your experience about joint interviews.

12. After the minimal facts-only interview, how do you decide whether to conduct a joint interview?
13. How do you decide *who* conducts a joint interview?

14. What determines how much you participate (speak) during a joint interview?
15. Under what circumstances might the Instant Response Team decide *not* to conduct a joint interview?
16. As you know, one of the IRT program's goals is to conduct interviews in child friendly settings, including Child Advocacy Centers (CAC). What are the barriers to using CACs more often?
17. When a joint interview takes place, how do you decide whether an interview is conducted at a CAC as opposed to another setting?
18. Would you give me some examples of typical cases that involve joint interviews?

SECTION V

To the interviewee: The IRT protocol covers a wide range of cases involving kids with a range of characteristics. We are interested in learning how the program works with different types of kids.

19. What is different about how you handle a case where the victim is young, say five and under?
    a. How is this different from cases that involve teenagers?
20. How might the age of the victim affect the events in an Instant Response?
21. Girls and boys often suffer from different types of abuse. Are there occasions where it would be necessary to handle the case of a boy differently from a girl?
22. What examples of cases like these can you share?

SECTION VI

To the interviewee: We are interested in finding out how the collaboration between ACS and the NYPD could be improved. These questions ask for your opinions. Again, all responses you give to us will be held in confidence.

23. In your own words, how would you describe the goals of the Instant Response Team program?
24. How well do you think these goals were accomplished before the IRT program began?
25. Has the Instant Response Team program changed the way you work with the NYPD?
    a. If yes, how?
26. What difficulties or frustrations do you encounter in your work with the IRT program?
27. If you could add anything to the program to make it run more smoothly, what would it be?
28. Who else would you recommend that I talk to about the IRT program?

Thank you for your time and input.

NYPD Detective

SECTION I

To the interviewee: Hello. My name is _____. I work for the Vera Institute of Justice. Thank you for taking the time to meet with me today. I am trying to find out more about the Instant Response Team. Anything that you say in this interview will be strictly

confidential, and will not be reported to anyone in your agency or outside of the Vera Institute of Justice. If we use material from this interview in a report, your name will never appear with it. I'd like to start by asking a few quick questions that describe your position.

1. What is the title of your position?
2. How long have you been at this job? From ____ (month/year) to ____ (month/year)
   At the NYPD? From ____ (month/year) to ____ (month/year)

What did you do before working in this position?

3. Did you receive any special training for working in the IRT program?
   Y____ N____
   a. (If yes :) What did it entail?
   b. how long before your work in the IRT program did it begin?
4. What are your primary responsibilities?
5. What percentage of your time do you spend on IRT related work?

SECTION II

To the interviewee: Now I'd like to ask you some questions about the specific things that go on once you arrive on the scene of an instant response incident.

6. Walk me through a typical IRT event.
   If you arrive before ACS, what is the first thing that you do after a minimal facts-only interview?
   Once this is done, if ACS still hasn't arrived, what is the first thing you do?
   If ACS has already arrived when you get there, what is the first thing you do?
7. As you know, one of the IRT program's goals is to conduct interviews in child friendly settings, including Child Advocacy Centers (CAC). What are the barriers to using CACs more often? What factors determine whether an interview is conducted at a CAC as opposed to another setting?
8. What do you do if ACS is not there when you arrive?

SECTION III

To the interviewee: The next questions have to do with the joint interview process. We would like to hear from your experience about joint interviews.

9. After the minimal facts-only interview, how do you decide whether to conduct a joint interview?
10. When a joint interview takes place, how do you decide where the child should be interviewed?
11. How do you decide *who* conducts a joint interview?
12. Who might be present at a joint interview? (besides detectives and caseworkers)
13. How often is the DA present at the joint interview? (if ever)
14. Would you give me some examples of typical cases that involve joint interviews?
15. Under what circumstances might the Instant Response Team decide *not* to conduct a joint interview?

SECTION IV

To the interviewee: The exact circumstances of these events are not always cut and dried, and police officers have to use their judgment to determine if an arrest is necessary. I would like to get an idea of the mitigating factors that affect whether an arrest is made.

16. When you arrive at the scene of an Instant Response event, is it usually obvious whether an arrest will be necessary?
17. Where and when does an arrest happen?
18. What might contribute to deciding not to make an arrest?
19. Would you give me some examples?

SECTION V

To the interviewee: The IRT protocol covers a wide range of cases involving kids with a range of characteristics. We are interested in learning how the program works with different types of kids.

20. Girls and boys often suffer from different types of abuse. Are there occasions where it would be necessary to handle the case of a boy differently from a girl?
21. What examples of cases like these can you share?

SECTION VI

To the interviewee: The following questions address how the IRT hotline works.

22. In what cases do you use the IRT hotline?
23. Why might you not use the IRT hotline?
24. How easy or difficult is it to request an Instant Response using the hotline?
25. How much contact do you have with IRT coordinators?
26. Can you give me some examples of experiences you've had with IRT coordinators?

SECTION VII

To the interviewee: We are interested in finding out how the collaboration between ACS and the NYPD could be improved. These questions ask for your opinions.

27. In your own words, how would you describe the goals of the Instant Response Team program?
28. How well do you think the NYPD accomplished these goals before the IRT program began?
29. What difficulties or frustrations do you encounter in your work with the IRT program?
30. Has the program changed the way you work with ACS?
31. If you could change anything about the program to make it run more smoothly, what would it be?
32. Who else would you recommend that I talk to about the IRT program?

Thank you for your time and input.

Appendix D: Training of IRT Staff

Our interviews explored what training IRT staff had received for the program. In addition, we compared staff descriptions of the program's goals with those laid out in the IRT protocol, as a measure of how effectively they were trained. According to ACS, police and child protective staff receive formal training by their respective agencies. The NYPD is trained in the IRT protocol as part of a more general "sex crimes" training, which is given to all Special Victims Squad detectives. No formal training is given to CAC or hospital representatives, since their role in IRT cases remains largely the same as in other child maltreatment cases.

Of the 29 respondents from ACS and law enforcement, 22 said that they had received training of some kind for the program; four said they had not, and three were not sure. Of those that received training, 16 cited a formal training (often at the Satterwhite Academy), and six had informal, or on-the-job training. Nine of the 12 respondents who had been at their position since the program launched said they had received some kind of training, one had not, and two were not sure. Fourteen of the 16 respondents who received formal training said that it lasted three days or less.

To gauge the educational effect of the training, we asked the staff to state the program's goals. Responses were correlated with agency affiliation. For example, ACS interviewees had a better understanding of the program's attempts to minimize trauma to children, while most assistant district attorneys saw IRT as a way to increase prosecutions by improving evidence collection. As expected, IRT coordinators were best able to articulate both of the programs goals. One group stood out from this general pattern: the majority of caseworkers had only a vague understanding of the goals of the program, and only one caseworker out of six described the program's goals with full accuracy.

CAC representatives had a more general understanding of the program objectives, and were less likely to name the specific goals set out in the IRT protocol. Three out of six representatives of hospitals or specialized hospital-based centers were able to name both specific goals of the program. This makes sense, as neither CAC nor hospital staff are routinely trained by ACS.

Figure D-1: Training of ACS and Law-enforcement Staff

	Did you receive training for the IRT program?	
	Number	Percent
No	4	13.8
Yes	22	75.9
Not Sure	3	10.3
Total	29	100

Appendix E: Case Selection Process

In 2000, ACS received 53,098 reports alleging child maltreatment, but only 4.4 percent resulted in an instant response.[35] The proportion of cases selected for an instant response varied by borough, with the Bronx selecting less than half the proportion of cases selected by Manhattan and Brooklyn.

The IRT program seeks to aid in the investigation of the most severe cases of child abuse. One indicator of whether IRT coordinators are effectively choosing the most severe cases is how often IRT cases are indicated. This is an imperfect measurement—in individual cases, the severity of a report may not correlate with the severity of the actual case. Other factors such as "current workload; public opinion; supervisory emphases; local custom; and personal beliefs, prejudices, and other idiosyncrasies" also influence case determination.[36] Nonetheless, relative to non-IRT cases, we believe that indication rates are an important variable. There is little reason for police involvement in unfounded cases, and if the indication rate for IRT cases is the same for non-IRT cases, it is hard to imagine that support for IRT will remain.

In each of the five boroughs, there were positive differences in indication rates between IRT and non-IRT cases (see Table E-1). The degrees of difference, however, appear to correlate with the relative percent of cases that receive an instant response. In other words, the boroughs that accept the greatest portion of their cases for instant response also have the least difference in indication rates between IRT and non-IRT cases. To further understand how cases are selected for the IRT program, we will discuss the process whereby IRT coordinators select cases for instant response.

[35] Data on all 2000 abuse/neglect cases in this section is taken from "Abuse & Neglect Reports in CY 2000," an unpublished report from the Office of Management, Development and Research at ACS. The figure 53,098 excludes reports regarding children in family-based foster care or publicly funded child care (three percent of the total).

[36] Jeffrey Leiter, Kristen A. Myers, and Matthew T. Zingraff, "Substantiated and unsubstantiated cases of child maltreatment: Do their consequences differ?" *Social Work Research* 18, no. 2 (1994): 68.

Table E-1: Abuse/Neglect Reports by Borough with Indication Rates, 2000

Borough	Total Reports	IRT Cases (%)	Indication Rate of IRT Reports	Indication Rate of Non-IRT Reports	Difference in Indication Rates
Manhattan	7,685	462 (6.0%)	54.5%	44.9%	+ 9.6%
Brooklyn	16,330	923 (5.7%)	45.1%	32.6%	+ 12.5%
Staten Island	2,338	105 (5.5%)	41.5%	33.8%	+ 7.7%
Queens	10,566	476 (4.5%)	60.4%	35.7%	+ 24.7%
Bronx	13,125	344 (2.6%)	57.9%	35.9%	+ 22.0%
Total[37]	53,098	2,310 (4.4%)	51.9%	36.2%	+15.7%

When an IRT coordinator receives a potential IRT report, he or she first determines whether an IRT-eligible type of maltreatment was alleged. The IRT protocol specifies that three of the seven types of alleged maltreatment are suitable for an instant response: sexual abuse, physical abuse, and neglect.[38] If the report contains an appropriate allegation, the coordinator must then attempt to verify the report by contacting the reporter.[39] The coordinator may also consult with his or her supervisor, and/or check for prior child welfare records on the people involved in the allegations. The IRT coordinator obtains allegation information and supplementary case characteristics from a document called the Oral Report Transmission provided by the State Central Registry. The written narrative from this report also contributes to the decision of whether the report warrants an instant response.

We investigated what types of reports IRT coordinators select for instant responses by comparing IRT cases to all other abuse/neglect cases handled by ACS in 2000.[40] The report characteristics we looked at included the types of maltreatment alleged, how many distinct allegations were alleged, and who called in the report. Other factors potentially contribute to this decision such as the age of the child and the family's child welfare record; however, we could not analyze these due to time and data restrictions.

The State Central Registry (SCR) records the types and number of allegations reported, as well as the identity of the reporter. SCR data for 2000 suggests that IRT coordinators are more likely to select reports that allege physical or sexual abuse than those that do not (see Table E-2). The portion of allegations that sexual abuse made up in

[37] The total number of reports citywide in 2000 includes reports where the child resided outside of New York City, and reports where the borough of residence was unknown (n=3,054).
[38] The criteria exclude allegations of psychological abuse, lack of medical care, educational neglect, and "other."
[39] According to SCR data, 99 percent of the IRT cases in 2000 fit the allegation criteria, meaning they had at least one allegation of physical abuse, sexual abuse, or neglect.
[40] The data on all abuse/neglect cases in 2000 was taken from "Abuse & Neglect Reports in CY 2000," prepared by the Administration for Children's Services.

IRT reports was more than six times greater than in non-IRT reports. Similarly, physical abuse allegations were more than twice as common in IRT reports. Other forms of maltreatment that might not warrant an instant response, such as educational neglect and "other," were considerably less common in IRT reports.

Table E-2: Allegation Type Distribution (percent of all allegations)

	IRT Cases	All Other Cases
Allegation Type		
Sexual Abuse	13.5%	2.0%
Physical Abuse	34.5%	14.3%
Neglect	44.0%	57.1%
Educational Neglect	0.9%	8.7%
Other[41]	4.3%	14.0%
Lack of Medical Care	2.4%	3.1%
Psychological Abuse	0.4%	0.9%

All cases (IRT cases included) averaged about three allegations per report. However, the average numbers of *substantiated* allegations for non-IRT and IRT cases are 0.9 and 1.4, respectively. In other words, 47 percent of the allegations in IRT cases were substantiated compared to only 30 percent for non-IRT cases. By definition, this influences case indication rates.[42] Again, it should be noted that investigation determinations can be influenced by factors beyond measurable report characteristics. However, those additional factors would likely have less effect within a single borough than across multiple boroughs.

The distribution of reporter types also differed substantially between IRT and all other cases (see Table E-3). One point of variation was the percentage of reports that were made by legally mandated reporters; non-mandated reporters in IRT cases made up half the portion they did in other cases. Of mandated reporters, school and social services personnel were the most common reporters of alleged maltreatment in all cases. The clearest difference found in specific reporter types is the greater frequency with which health care workers report IRT cases than they do other abuse/neglect cases. Prior research has shown that while physicians typically report low numbers of child abuse cases, the cases they do report are likely to be confirmed.[43] This suggests that IRT cases provide more concrete evidence of abuse or neglect, which in turn emboldens health care workers to report them more frequently.

[41] In IRT reports in 2000, more than half of allegations in the "other" category were for parent's drug and/or alcohol misuse, and another 30 percent were for the "other" sub-category. This information was not available for non-IRT reports.
[42] When at least one allegation is substantiated, a case is deemed indicated by ACS.
[43] F.T. Saulsbury and G.F. Hayden, "Child Abuse Reporting by Physicians," *Southern Medical Journal* 139, no. 5 (1986): 585-587.

Table E-3: Report Distribution and Case Indication Rates by Reporter Type, 2000

	% of Non-IRT Reports	% of IRT Reports
Reporter Type		
Mandated Reporters		
School	28.0	26.2
Social Services	22.8	25.0
Health Care	7.4	17.9
Law Enforcement	12.4	17.8
All mandated reporters	69.9	86.9
Non-mandated Reporters		
Family Members or Friends	12.6	6.2
Other	16.8	7.1
All non-mandated reporters	30.1	13.1

In sum, the most common cases selected by IRT coordinators in 2000 included allegations of neglect and/or physical abuse, contained three distinct allegations, and were reported by school or social service personnel. The report characteristics that most clearly distinguished IRT cases from all others were the greater prevalence of sexual abuse allegations and the higher percentage of reports made by health care staff. Case indication rates were also higher in all boroughs for IRT cases compared to non-IRT cases. Citywide, 52 percent of IRT cases were indicated compared to only 35 percent of all other cases. As a point of reference, only 29 percent of abuse/neglect cases nationwide were indicated in 1999.[44]

[44] Based on 1999 reports from the States to the National Child Abuse and Neglect Data System. For further information see http://www.acf.dhhs.gov/programs/cb/publications/cm99/index.htm.

Appendix F: Unit-level analysis

The Outcomes of a Co-located Unit: A Mini-study of Unit 180

At ACS's request we examined Unit 180 in Brooklyn, the only ACS unit using a "co-located model" that houses a Child Advocacy Center, child protective workers, and the NYPD in one location. Sexual abuse cases receiving a Type II instant response account for virtually all of Unit 180's cases. We compared Unit 180's rate of joint interviews, arrests, prosecutions, child removals, and response times to similar cases originating in the rest of Brooklyn. The comparisons we report are by type of response, but the analyses are the same if separated by type of maltreatment.

In sum, Unit 180 had a comparatively high rate of joint interviews—a result one might expect from a co-located model—and removed children at lower rate. Arrest and prosecution patterns were similar to the rest of Brooklyn. Response times for the unit were substantially slower, though as we report elsewhere, the quality of the response time data prevents us from making firm conclusions.

Joint Interviews

Like IRT cases generally, Unit 180 cases are largely Type II cases, and a breakdown by type allows us to compare Unit 180's outcomes to cases with similar circumstances in the rest of Brooklyn. Joint interviews occurred in a majority of Unit 180's cases over four years. On average over the four year period, Unit 180 had a joint interview rate 21 percentage point higher than Brooklyn as a whole (74 percent compared to 53 percent—see Fig. F-1).

Arrests and Prosecutions

Arrests occurred less often in cases handled by Unit 180 between 1998 and 2001 than Brooklyn as a whole (See Fig. F-2). This may be explained by the difficulty of collecting reliable eyewitness accounts from the young children typical to Type II cases, which Unit 180 handled in large volume during these four years. In Unit 180 cases where an arrest occurred, most (79 percent of all Type II cases) led to prosecutions (See Fig. F-3). The relatively small percentage of arrests in Type II cases as well as the high rate of prosecutions corresponds with trends in the rest of Brooklyn.

Issues of swearability where young children are involved complicates the ability to make an arrest in child abuse cases, as does the percentage of cases where severe abuse is alleged that do not prove to be substantiated. Both of these factors may contribute to the low arrest rate for the borough of Brooklyn, including Unit 180.

Child Removals

Unit 180 consistently removes relatively few children from their homes, one of the aims of the Instant Response Team program. The percentage of child removals for Unit 180 has been below 32 percent each year since the program's inception, falling to six percent in Type II and sexual abuse cases in 2001. While child removals for Type II cases are in the minority for Brooklyn as a whole, the percentage of children removed was consistently lower for Unit 180 than for the rest of Brooklyn over four years (See Fig. F-4).

Figure F-1: Joint Interviews by Type of IRT case
for Brooklyn and Unit 180, 1998-2001

		Joint interview									
		Brooklyn Yes		Unit 180 Yes		Brooklyn Data Missing		Unit 180 Data Missing		Brooklyn Total	Unit 180 Total
		No.	%	No.	%	No.	%	No.	%	No.	No.
Type I	1998	8	36.4	0	0	1	4.5	0	0	22	0
	1999	4	44.4	0	0	0	0.0	0	0	9	0
	2000	8	27.6	2	100	0	0.0	0	0	29	2
	2001	11	52.4	1	100	4	19.0	0	0	21	1
	Total	31	38.3	3	100	5	6.2	0	0	81	3
Type II	1998	120	41.8	31	62	0	0.0	0	0	287	50
	1999	351	59.0	73	72.3	5	0.8	0	0	595	101
	2000	396	55.1	61	80.3	16	2.2	4	5.3	719	76
	2001	350	51.7	64	79.0	34	5.0	4	4.9	677	81
	Total	1217	53.4	229	74.4	55	2.4	8	2.6	2278	308
Type III	1998	1	50.0	0	0.0	0	0.0	0	0	2	0
	1999	5	33.3	0	0	0	0.0	0	0	15	0
	2000	133	44.6	2	100	8	2.7	0	0	298	2
	2001	99	45.4	1	100	10	4.6	0	0	218	1
	Total	238	44.7	3	100	18	3.4	0	0	533	3

Note: There are three possible categories for the "Joint Interview" variable: "Yes," "No," and "Data Missing." In this chart, the "No" percentage can be inferred from the "Yes" and "Data missing" columns. For example, in Type II cases in 2000, joint interviews occurred in 55 percent of Brooklyn's cases, and the data is missing for two percent of cases. Therefore, joint interviews did *not* occur in 43 percent of cases.

Figure F-2: Arrests by Type of IRT case for Brooklyn and Unit 180, 1998-2001

		Arrest made									
		Brooklyn Yes		Unit 180 Yes		Brooklyn Data Missing		Unit 180 Data Missing		Brooklyn Total	Unit 180 Total
		No.	%	No.	%	No.	%	No.	%	No.	No.
Type I	1998	6	27.3	0	0	3	13.6	0	0	22	0
	1999	3	33.3	0	0	0	0.0	0	0	9	0
	2000	6	20.7	1	50	2	6.9	0	0	29	2
	2001	5	23.8	0	0	4	19.0	1	100	21	1
	Total	20	24.7	1	33.3	9	11.1	1	33.3	81	3
Type II	1998	69	24.0	11	22.0	32	11.1	12	24.0	287	50
	1999	187	31.4	24	23.8	37	6.2	5	5.0	595	101
	2000	130	18.1	16	21.1	93	13.0	19	25.0	718	76
	2001	110	16.2	14	17.3	65	9.6	11	13.6	677	81
	Total	496	21.8	65	21.1	227	10.0	47	15.3	2277	308
Type III	1998	0	0.0	0	0	0	0	0	0	2	0
	1999	2	13.3	0	0	0	0	0	0	15	0
	2000	64	21.5	0	0	44	14.8	1	50.0	298	2
	2001	63	28.9	0	0	18	8.3	0	0.0	218	1
	Total	129	24.2	0	0	62	11.6	1	33.3	533	3

Note: There are three possible categories for the "Arrest Made" variable: "Yes," "No," and "Data Missing." In this chart, the "No" percentage can be inferred from the "Yes" and "Data Missing" columns. For example, in Type II cases in 2001, Unit 180 made arrests in 17 percent of cases, and the data is missing for 14 percent of cases. Therefore, Unit 180 did *not* make arrests in 69 percent of cases.

Figure F-3: Arrests That Lead to Prosecutions by Type of IRT Case for Brooklyn and Unit 180, 1998-2001

		Case prosecuted									
		Brooklyn Yes		Unit 180 Yes		Brooklyn Missing		Unit 180 Missing		Brooklyn Total	Unit 180 Total
		No.	%	No.	%	No.	%	No.	%	No.	No.
Type I	1998	6	100	0	0	0	0	0	0	6	0
	1999	3	100	0	0	0	0	0	0	3	0
	2000	5	83.3	1	100	0	0	0	0	6	1
	2001	5	100.0	0	0	0	0	0	0	5	0
	Total	19	95.0	1	100	0	0	0	36.4	20	1
Type II	1998	42	60.9	7	63.6	19	27.5	4	8.3	69	11
	1999	151	80.7	18	75.0	16	8.6	2	18.8	187	24
	2000	103	79.2	13	81.3	20	15.4	3	7.1	130	16
	2001	101	91.8	13	92.9	6	5.5	1	15.4	110	14
	Total	397	80.0	51	78.5	61	12.3	10	0	496	65
Type III	1999	1	50.0	0	0	1	50.0	0	0	2	0
	2000	46	71.9	0	0	14	21.9	0	0	64	0
	2001	51	81.0	0	0	8	12.7	0	0	63	0
	Total	98	76.0	0	0	23	17.8	0	0	129	0

Note: There are three possible categories for the "Case Prosecuted" variable: "Yes," "No," and "Data Missing." In this chart, the "No" percentage can be inferred from the "Yes" and "Data Missing" columns. For example, in Type II cases in 1998, 75 percent of Unit 180's cases were prosecuted, and the data is missing for eight percent of cases. Therefore, the district attorney did *not* prosecute 17 percent of Unit 180's cases.

Figure F-4: Child Removals by Type of IRT Case for Brooklyn and Unit 180, 1998-2001

		Child removed									
		Brooklyn Yes		Unit 180 Yes		Brooklyn Missing		Unit 180 Missing		Brooklyn Total	Unit 180 Total
		No.	%	No.	%	No.	%	No.	%	No.	No.
Type I	1998	18	81.8	0	0	1	4.5	0	0	22	0
	1999	4	44.4	0	0	1	11.1	0	0	9	0
	2000	11	37.9	1	50	7	24.1	0	0	29	2
	2001	6	28.6	0	0	8	38.1	1	100	21	1
	Total	39	48.1	1	33.3	17	21.0	1	33.3	81	3
Type II	1998	79	27.5	7	14.0	19	6.6	5	10.0	287	50
	1999	229	38.5	26	25.7	11	1.8	1	1.0	595	101
	2000	122	17.0	11	14.5	35	4.9	5	6.6	719	76
	2001	129	19.1	5	6.2	19	2.8	4	4.9	677	81
	Total	559	24.5	49	15.9	84	3.7	15	4.9	2278	308
Type III	1998	2	100.0	0	0	0	0	0	0	0	0
	1999	8	53.3	0	0	0	0	0	0	2	0
	2000	56	18.8	0	0	17	5.7	0	0	15	2
	2001	49	22.5	0	0	5	2.3	0	0	298	1
	Total	115	21.6	0	0	22	4.1	0	0	218	3

Note: There are three possible categories for the "Child Removed" variable: "Yes," "No," and "Data Missing." In this chart, the "No" percentage can be inferred from the "Yes" and "Data Missing" columns. For example, in Type II cases in 1998, Unit 180 removed children in 14 percent of cases, and the data is missing for 10 percent of cases. Therefore, Unit 180 did *not* remove children in 76 percent of cases.

Response Times

Our interviews indicate that response times for ACS are often measured by the amount of time that elapsed from when ACS received an allegation to when the child protective worker left the office. A better measure of response time would be the time elapsed from when ACS received the allegation to when the child protective worker came into contact with the child. Preliminary research indicates that to record NYPD response time, IRT coordinators rely heavily on educated guesses and that these response times may not be recorded consistently in different zones. Thus, comparisons between ACS and NYPD response times should be read with caution.

The data suggest that Unit 180 child protective workers take longer to respond to IRT events than child protective workers in the rest of Brooklyn. The same applies to the NYPD, but the gap between NYPD officers in Unit 180 and the rest of Brooklyn is not as large. NYPD and ACS response times for Unit 180 improved markedly from 1998 to 1999. Whereas child protective workers took over two hours to arrive in almost half of all cases in 1998, in 1999 this occurred in less than a fifth of all cases. The police reduced their incidence of late arrivals even more during that period, with late arrivals occurring in only one of every ten IRT events (See Figs. F-5 and F-6). The performance in 1999 suggests that response times can improve dramatically.

Unfortunately, neither ACS nor the NYPD in Unit 180 sustained these improvements. Late arrivals for Unit 180 child protective workers jumped from 16 percent in 1999 to 39 percent of all IRT cases in 2000, and declined only slightly in 2001. In 2000 and 2001, both child protective workers and police officers from Unit 180 arrived late more often than their counterparts in other Brooklyn units.

Figure F-5: NYPD Response Time for Brooklyn and Unit 180 by Year

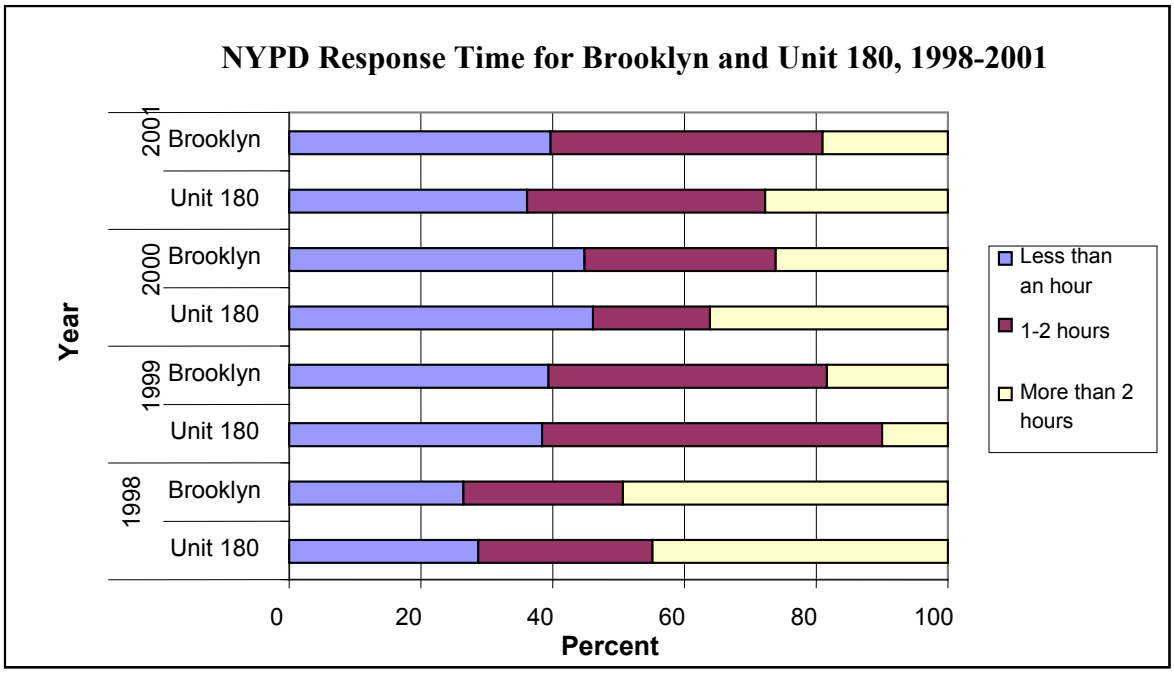
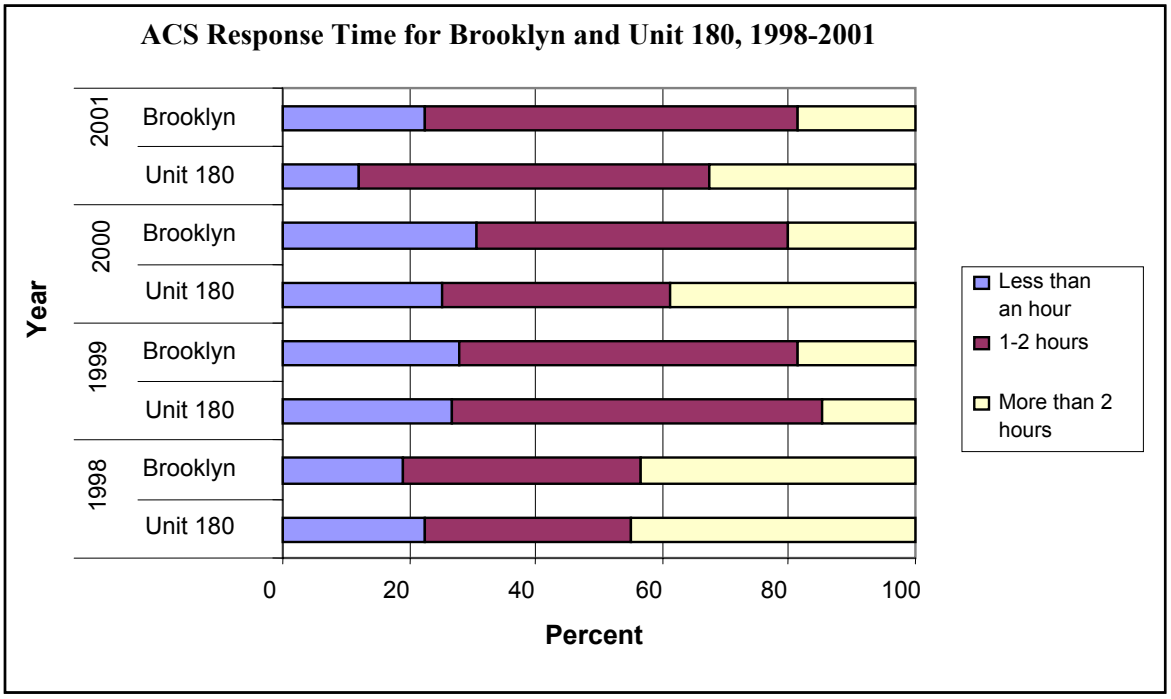


Figure F-6: ACS Response Time for Brooklyn and Unit 180 by Year



Brooklyn Instant Response Team Units

A comparison of Unit 180 with the other IRT units in Brooklyn in the year 2001 puts the numbers in context. The number of cases handled is one of many factors that could affect Unit's 180's response times and other outcomes. The data show that in 2001, Unit 180 fell in the middle range of case volume, ranking fourth out of eight units in quantity of cases (See Fig. F-7).

Figure F-7: Brooklyn IRT Units by Number of cases in 2001, sorted descending by case volume

Unit	Cases in 2001	
	No.	%
267	148	23.5
217	106	16.8
237	96	15.2
180	83	13.2
175	55	8.7
205	50	7.9
238	47	7.4
231	44	7.0
Total	631	100

Note: We excluded Unit 240 from the rankings because it handled only two IRT cases in 2001.

When IRT units are ordered according to the lowest percentage of late response times in 2001, Unit 180 falls second to last on the list for NYPD response time (See Fig. F-8), and ranks last out of all units in ACS response time (See Fig. F-9). When listed in descending order from the largest percentage of *quick* response times in 2001, Unit 180's NYPD response time ranks fourth out of eight units (See Fig. F-10), and its ACS response time ranks sixth out of eight (See Fig. F-11).

Even taking into account its volume of cases in relation to other IRT units in Brooklyn, Unit 180 arrived late in more instances than would be expected based on case volume in 2001.

Figure F-8: Brooklyn IRT Units in 2001 sorted by lowest percentage of NYPD response times of more than two hours.

ACS Unit	NYPD response time						Total
	More than 2 hours		Less than an hour		1-2 hours		
	No.	%	No.	%	No.	%	No.
175	0	0.0	39	70.9	16	29.1	55
231	0	0.0	20	45.5	24	54.5	44
238	5	10.6	17	36.2	25	53.2	47
237	24	25.0	23	24.0	49	51.0	96
267	38	25.7	48	32.4	62	41.9	148
205	13	26.0	14	28.0	23	46.0	50
180	23	27.7	30	36.1	30	36.1	83
217	39	36.8	22	20.8	45	42.5	106
Total	143	22.7	213	33.8	275	43.6	631

Note: We excluded Unit 240 from the rankings because it handled only two IRT cases in 2001.

Figure F-9: Brooklyn IRT units in 2001 sorted by highest percentage of NYPD response times of less than an hour.

ACS Unit	NYPD response time						Total
	More than 2 hours		1-2 hours		Less than an hour		
	No.	%	No.	%	No.	%	No.
175	0	0	16	29.1	39	70.9	55
231	0	0	24	54.5	20	45.5	44
238	5	10.6	25	53.2	17	36.2	47
180	23	27.7	30	36.1	30	36.1	83
267	38	25.7	62	41.9	48	32.4	148
205	13	26.0	23	46.0	14	28.0	50
237	24	25.0	49	51.0	23	24.0	96
217	39	36.8	45	42.5	22	20.8	106
Total	143	22.7	275	43.6	213	33.8	631

Note: We excluded Unit 240 from the rankings because it handled only two IRT cases in 2001.

Figure F-10: Brooklyn IRT units in 2001 sorted by lowest percentage of ACS response times of more than two hours.

ACS Unit	ACS response time						Total
	More than 2 hours		Less than an hour		1-2 hours		
	No.	%	No.	%	No.	%	No.
231	0	0.0	3	6.8	41	93.2	44
238	5	10.6	5	10.6	37	78.7	47
175	7	12.7	17	30.9	31	56.4	55
205	9	18.0	8	16.0	33	66.0	50
237	20	20.8	17	17.7	59	61.5	96
267	31	20.9	42	28.4	75	50.7	148
217	27	25.5	22	20.8	57	53.8	106
180	27	32.5	10	12.0	46	55.4	83
Total	126	20.0	124	19.7	379	60.3	629

Note: We excluded Unit 240 from the rankings because it handled only two IRT cases in 2001.

Figure F-11: Brooklyn IRT units in 2001 sorted by highest percentage of ACS response times of less than an hour.

ACS Unit	ACS response time						Total
	More than 2 hours		1-2 hours		Less than an hour		
	No.	%	No.	%	No.	%	No.
175	7	12.7	31	56.4	17	30.9	55
267	31	20.9	75	50.7	42	28.4	148
217	27	25.5	57	53.8	22	20.8	106
237	20	20.8	59	61.5	17	17.7	96
205	9	18.0	33	66.0	8	16.0	50
180	27	32.5	46	55.4	10	12.0	83
238	5	10.6	37	78.7	5	10.6	47
231	0	0	41	93.2	3	6.8	44
Total	127	20.1	380	60.2	124	19.7	631

Note: We excluded Unit 240 from the rankings because it handled only two IRT cases in 2001.

Conclusion

A co-located model has many potential benefits for joint investigations of child abuse, and research into Unit 180's work shows that in the areas of joint interviews and child removals, the unit is moving in the right direction toward achieving the goals of the IRT program. Arrest and prosecution rates for Unit 180 are similar to those for the borough of Brooklyn, and as noted above, arrests can be difficult in Type II cases, thereby helping to explain Unit 180's low arrest rate. Where response time is concerned, a number of factors, such as large caseloads and data collection methods, may lead to the reports of late response times for Unit 180. While data quality issues surrounding the response time data are important, re-emphasizing the importance of a quick response to Unit 180 staff is worth considering.

Appendix G: Additional analyses of IRT program data

This appendix contains additional analyses of the IRT program specifically requested by ACS.

Table G-1: Number of interviews per case by year, N=10,718*

Year	Number of Interviews (% within year)				
	1	2	3	4	5
1998	49.6	42.2	7.0	0.7	0.6
1999	55.9	39.1	4.4	0.5	--
2000	51.0	47.5	1.5	--	--
2001	55.6	44.4	0.0	--	--
2002**	55.6	44.3	0.1	--	--
Total	54.1	44.3	1.5	0.1	0.0

*1,032 cases (8.8 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-2: Number of exams per case by year, N=7,787*

Year	Number of Exams (% within year)		
	1	2	3
1998	89.6	10.1	0.3
1999	90.7	9.0	0.3
2000	91.3	8.5	0.2
2001	94.4	5.6	--
2002**	95.9	4.1	--
Total	92.8	7.0	0.1

*3,963 cases (33.7 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-3: Total contacts (interviews and exams) per case by year, N=7,152*

Year	Number of Exams (% within year)					
	2	3	4	5	6	7
1998	43.8	43.8	9.7	1.8	0.4	0.6
1999	52.2	39.3	7.1	1.3	0.2	--
2000	45.7	48.6	5.4	0.3	--	--
2001	54.2	43.8	2.0	--	--	--
2002**	53.9	44.5	1.6	--	--	--
Total	50.8	44.3	4.3	0.4	0.1	0.0

*4,598 cases (39.1%) were excluded due to incomplete data.
** Data for 2002 cover the year through 8/23/02; the most recent data available when these statistics were calculated.

Table G-4: Type of instant response by year

Year	Type of instant response (% within year)		
	Type I	Type II	Type III
1998	47 (5.9)	741 (92.7)	11 (1.4)
1999	51 (3.1)	1,484 (91.2)	92 (5.7)
2000	74 (2.5)	1,952 (66.8)	895 (30.6)
2001	88 (2.4)	2,367 (63.5)	1,271 (34.1)
2002*	85 (2.1)	2,378 (58.5)	1,601 (39.4)
Total	347 (2.7)	8,975 (69.0)	3,909 (28.3)

*We have actual data through 8/23/02 and the total number of IRT cases in 2002 (4,064). The cells are calculated by multiplying the percentage of cases in each type through August 23, 2002 by the total number of cases for the year.

Table G-5: Joint interview rate by type of instant response, by year, N=10,941*

Type of instant response	Year	Joint interview? (% within year)	
		No	Yes
Type I	1998	59.5	40.5
	1999	55.6	44.4
	2000	63.8	36.2
	2001	33.3	66.7
	2002**	19.4	80.6
	Total	48.6	51.4
Type II	1998	43.5	56.5
	1999	32.3	67.7
	2000	40.9	59.1
	2001	39.2	60.8
	2002**	39.0	61.0
	Total	38.6	61.4
Type III	1998	27.3	72.7
	1999	34.8	65.2
	2000	53.8	46.2
	2001	54.1	45.9
	2002**	56.3	43.7
	Total	54.0	46.0

*809 cases (6.9 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-6: Location of interview by year N=10,938*

Year	Location of interview (% within year)						
	Child Advocacy Center	Hospital	Police station	ACS offices	Child's home	School	Other
1998	18.2	33.8	8.1	2.3	26.9	4.2	6.6
1999	26.2	26.7	10.9	2.5	26.9	4.4	2.4
2000	16.0	23.0	14.2	2.9	35.6	6.3	2.0
2001	12.6	18.7	13.1	2.7	43.9	6.7	2.4
2002**	12.5	17.4	12.7	3.1	44.8	7.7	1.8
Total	15.8	21.7	12.6	2.8	38.3	6.3	2.5

*812 cases (6.9 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-7: Location of medical exam by year
N=7,854*

Year	Location of exam (% within year)				
	Emergency room	Pediatric center	Child Advocacy Center	Private doctor	Other
1998	66.2	6.6	7.4	4.1	15.7
1999	78.3	4.4	9.0	4.1	4.3
2000	76.6	4.4	6.9	4.6	7.5
2001	70.3	5.4	8.2	4.9	11.2
2002**	76.9	2.8	10.9	4.5	4.9
Total	74.0	4.6	8.4	4.5	8.4

*3,896 cases (33.2 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-8: NYPD response time by year
N=11,630*

Year	NYPD response time (% within year)		
	Less than an hour	1-2 hours	More than 2 hours
1998	49.8	20.8	29.4
1999	64.9	23.3	11.9
2000	65.5	18.3	16.2
2001	62.5	24.9	12.6
2002**	66.2	25.6	8.3
Total	63.6	22.9	13.5

*120 cases (1.0 percent) were excluded due to incomplete data.
**Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-9: NYPD response time by borough, 5/5/98-8/23/02
N=11,630*

Borough	NYPD response time (% within borough)		
	Less than an hour	1-2 hours	More than 2 hours
Bronx	73.1	19.9	7.0
Brooklyn	40.1	39.0	21.0
Manhattan	73.5	16.5	10.1
Queens	83.2	6.4	10.4
Staten Island	84.8	9.2	6.0
Total	63.6	22.9	13.5

*120 cases (1.0%) were excluded due to incomplete data.

Table G-10: ACS response time by borough, 5/5/98-8/23/02
N=11,729*

Borough	ACS response time (% within borough)		
	Less than an hour	1-2 hours	More than 2 hours
Bronx	53.7	38.0	8.3
Brooklyn	24.9	56.2	18.8
Manhattan	61.0	29.9	9.2
Queens	80.1	8.2	11.8
Staten Island	87.7	8.0	4.3
Total	51.6	35.4	13.0

*21 cases (0.2%) were excluded due to incomplete data.

Table G-11: ACS response time by borough, 2001 only
N=3,726

Borough	ACS response time (% within borough)		
	Less than an hour	1-2 hours	More than 2 hours
Bronx	54.7	36.8	8.5
Brooklyn	21.2	59.7	19.1
Manhattan	38.7	54.2	7.1
Queens	76.9	7.3	15.8
Staten Island	92.3	7.1	0.6
Total	47.3	39.4	13.3

Table G-12: Order of arrival by year
N=11,625*

Year	Who arrived first? (% within year)		
	Arrived about the same time	NYPD arrived first	ACS arrived first
1998	68.8	17.0	14.1
1999	79.1	13.1	7.8
2000	65.6	21.0	13.5
2001	70.1	21.4	8.5
2002**	74.0	18.4	7.7
Total	71.0	19.2	9.8

*125 cases (1.1 percent) were excluded due to incomplete data.
**Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-13: Arrest rate by type of instant response by year
N=10,206*

Type of instant response	Year	Arrest made? (% within year)	
		No	Yes
Type I	1998	68.4	31.6
	1999	59.6	40.4
	2000	70.8	29.2
	2001	66.2	33.8
	2002**	80.9	19.1
	Total	69.0	31.0
Type II	1998	70.4	29.6
	1999	66.9	33.1
	2000	71.7	28.3
	2001	74.6	25.4
	2002**	80.2	19.8
	Total	72.9	27.1
Type III	1998	60.0	40.0
	1999	59.6	40.4
	2000	67.8	32.2
	2001	65.7	34.3
	2002**	68.2	31.8
	Total	66.8	33.2

*1,544 cases (13.1 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-14: Prosecution rate by type of instant response, by year
N=6,620*

Type of instant response	Year	Case prosecuted? (% within year)	
		No	Yes
Type I	1998	65.4	34.6
	1999	58.8	41.2
	2000	68.2	31.8
	2001	50.0	50.0
	2002**	82.6	17.4
	Total	63.8	36.2
Type II	1998	72.8	27.2
	1999	72.1	27.9
	2000	75.1	24.9
	2001	77.5	22.5
	2002**	86.8	13.2
	Total	76.6	23.4
Type III	1998	66.7	33.3
	1999	76.8	23.2
	2000	73.7	26.3
	2001	72.2	27.8
	2002**	84.0	16.0
	Total	75.6	24.4

*5,130 cases (43.7 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-15: Removal trends by year
N=10,019*

Year	What happened to perpetrators and children? (% within year)			
	No one removed	Perpetrator removed only	Child removed only	Both child and perpetrator removed
1998	55.3	10.8	14.6	19.2
1999	47.0	10.8	19.3	22.8
2000	60.9	14.9	9.8	14.5
2001	60.7	15.8	10.8	12.7
2002**	68.3	16.2	7.5	8.0
Total	59.8	14.5	11.5	14.2

*1,731 cases (14.7%) were excluded due to incomplete data.
**Data for 2002 cover the year through 8/23/02; the most recent data available when these statistics were calculated.

Table G-16: Removal trends by type of case, by year
N=8,609*

Type of instant response	Year	What happened to perpetrators and children? (% within year)			
		No one removed	Perpetrator removed only	Child removed only	Both child and perpetrator removed
Physical Abuse	1998	50.0	--	25.0	25.0
	1999	42.9	7.8	24.1	25.2
	2000	60.3	12.7	10.0	17.0
	2001	61.3	13.0	10.0	15.6
	2002**	71.4	13.5	6.3	8.8
	Total	61.9	12.6	10.3	15.2
Sexual Abuse	1998	58.6	3.4	24.1	13.8
	1999	44.9	14.2	23.5	17.4
	2000	64.6	18.7	7.1	9.6
	2001	63.9	19.2	9.6	7.2
	2002**	68.8	19.8	6.0	5.5
	Total	62.7	18.4	10.1	8.8
Neglect	1998	--	--	--	--
	1999	43.6	7.7	28.2	20.5
	2000	49.5	16.3	19.6	14.7
	2001	45.9	19.0	19.3	15.9
	2002**	52.3	19.7	17.2	10.9
	Total	48.5	18.0	19.1	14.3

*3,141 cases (26.7 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-17: Family court involvement by type of instant response, by year
N=9,763*

Type of instant response	Year	Was the family court involved? (% within year)	
		No	**Yes**
Type I	1998	22.5	77.5
	1999	46.0	54.0
	2000	43.1	56.9
	2001	37.9	62.1
	2002**	61.5	38.5
	Total	41.9	58.1
Type II	1998	58.2	41.8
	1999	59.5	40.5
	2000	60.9	39.1
	2001	65.4	34.6
	2002**	69.6	30.4
	Total	63.0	37.0
Type III	1998	18.2	81.8
	1999	45.7	54.3
	2000	57.1	42.9
	2001	56.9	43.1
	2002**	60.0	40.0
	Total	57.3	42.7

*1,987 cases (16.9 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Table G-18: Remand rate for cases with family court involvement, by type of instant response, by year
N=3,513*

Type of instant response	Year	Was remand granted? (% within year)	
		No	Yes
Type I	1998	38.5	61.5
	1999	16.7	83.3
	2000	37.9	62.1
	2001	31.4	65.7
	2002**	33.3	66.7
	Total	31.8	67.4
Type II	1998	32.2	67.8
	1999	25.6	74.4
	2000	31.6	68.4
	2001	32.0	68.0
	2002**	43.3	56.7
	Total	31.9	68.1
Type III	1998	57.1	42.9
	1999	32.0	68.0
	2000	39.4	60.6
	2001	46.3	53.7
	2002**	55.9	44.1
	Total	46.7	53.3

*308 cases (8.1 percent) were excluded due to incomplete data.
** Data for 2002 cover the year through August 23, 2002; the most recent data available when these statistics were calculated.

Appendix H: Multinomial Logistic Regression Output for Joint Interviews

Logistic regression is an appropriate technique when the dependent variable is dichotomous. Multinomial logistic regression allows the use of variables that have multiple categories, such as borough or type of case. This technique takes a single variable with multiple categories and transforms them into a series of dichotomized variables. For example, the single variable "borough" is transformed into five dichotomous variables (one for each borough). Results are then reported that have a reference category. In the analysis below, for example, Bronx County is the reference variable for the borough category.

The reference category for the dependent variable in the analysis below is "yes, a joint interview occurred." Thus negative betas indicate a lower likelihood of "no joint interview"—in other words, a higher likelihood of a joint interview.

We created the model by first putting in all relevant variables that existed in the program's database. This included day of week, year, did Emergency Children's Services initiate the interview, borough, place of interview, place of exam, and who arrived first. Variables that were not statistically significant at the .1 level were eliminated, and different variable combinations modeled.

We do not claim that significant variables cause joint interviews to occur, only that they are associated with joint interviews. The program's database does not include all potentially relevant variables. For example, distance from nearest interview facility, the length of Instant Response Team (IRT) training, the child's medical condition and other case level factors, and individual staff experiences with collaborative programs are not variables kept in the program's database that might affect the likelihood of a joint interview occurring on any particular case.

Our interviews revealed no problems with data collection procedures with one exception. The variable for "who arrived first" is derived from two variables: ACS response time and NYPD response time. Our interviews suggested that the variable NYPD response time was inconsistently collected because IRT coordinators do not have an easy method for finding out when the NYPD first received noticed of the IRT event. Still, because the data is collected in wide ranges (0-1 hour, 1-2 hours, and 2 hours or more), the chances of error are reduced. Removing this variable from the equation moderately reduced the explanatory power of the model (Cox and Snell pseudo R-squared reduced from .21 to .19).

Multinomial regression output

Case Processing Summary

		N	Marginal Percentage
Joint interview?	No	3247	41.5%
	Yes	4578	58.5%
Place of interview	Child Advocacy Center	1349	17.2%
	Hospital	1832	23.4%
	Police station	989	12.6%
	ACS offices	216	2.8%
	Child's home	2791	35.7%
	School	446	5.7%
	Other	202	2.6%
Type of Instant Response	Type I	199	2.5%
	Type II	5720	73.1%
	Type III	1906	24.4%
Borough	Queens	1666	21.3%
	Manhattan	1382	17.7%
	Kings	3074	39.3%
	Staten Island	420	5.4%
	Bronx	1283	16.4%
Who Arrived First?	Arrived about same time	5511	70.4%
	NYPD arrived first	1496	19.1%
	ACS arrived first	818	10.5%
Valid		7825	100.0%
Missing		563	
Total		8388	
Subpopulation		235 [a]	

a. The dependent variable has only one value observed in 58 (24.7%) subpopulations.

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	3004.485			
Final	1202.671	1801.814	14	.000

Pseudo R-Square

Cox and Snell	.206
Nagelkerke	.277
McFadden	.170

Likelihood Ratio Tests

Effect	-2 Log Likelihood of Reduced Model	Chi-Square	df	Sig.
Intercept	1202.671[a]	.000	0	.
PLACEINT	2387.903	1185.231	6	.000
TYPERESP	1251.150	48.479	2	.000
BORO	1525.335	322.663	4	.000
WHOFIRST	1410.320	207.649	2	.000

The chi-square statistic is the difference in -2 log-likelihoods between the final model and a reduced model. The reduced model is formed by omitting an effect from the final model. The null hypothesis is that all parameters of that effect are 0.

a. This reduced model is equivalent to the final model because omitting the effect does not increase the degrees of freedom.

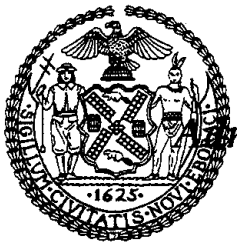
Parameter Estimates

Joint interview?[a]		B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B)	
								Lower Bound	Upper Bound
No	Intercept	1.089	.182	35.753	1	.000			
	[PLACEINT=1]	-2.695	.177	233.016	1	.000	.068	.048	.095
	[PLACEINT=2]	-.837	.159	27.682	1	.000	.433	.317	.592
	[PLACEINT=3]	-1.658	.169	95.996	1	.000	.190	.137	.265
	[PLACEINT=4]	-.436	.208	4.380	1	.036	.647	.430	.973
	[PLACEINT=5]	.026	.156	.028	1	.868	1.026	.755	1.394
	[PLACEINT=6]	-.523	.183	8.205	1	.004	.593	.414	.848
	[PLACEINT=7]	0[b]	.	.	0	.	.	.	.
	[TYPERESP=1]	.227	.165	1.884	1	.170	1.255	.907	1.735
	[TYPERESP=2]	-.378	.061	38.213	1	.000	.685	.608	.773
	[TYPERESP=3]	0[b]	.	.	0	.	.	.	.
	[BORO=1]	-.508	.085	35.739	1	.000	.602	.509	.711
	[BORO=2]	.436	.087	25.302	1	.000	1.546	1.305	1.832
	[BORO=3]	.535	.078	47.198	1	.000	1.708	1.466	1.989
	[BORO=4]	-.976	.146	44.430	1	.000	.377	.283	.502
	[BORO=5]	0[b]	.	.	0	.	.	.	.
	[WHOFIRST=1.00]	-.747	.084	78.472	1	.000	.474	.401	.559
	[WHOFIRST=2.00]	.096	.098	.964	1	.326	1.101	.908	1.335
	[WHOFIRST=3.00]	0[b]	.	.	0	.	.	.	.

a. The reference category is: Yes.

b. This parameter is set to zero because it is redundant.

Appendix I: Instant Response Team Protocol



The City of New York

Administration for Children's Services

Division of Child Protection

Michael R. Bloomberg
Mayor

William C. Bell
Commissioner

Zeinab Chahine
Deputy Commissioner

ADMINISTRATION FOR CHILDREN'S SERVICES

AND

LAW ENFORCEMENT

INSTANT RESPONSE TEAMS

PROTOCOL

FEBRUARY 1998

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INSTANT RESPONSE TEAMS WORK GROUP

An Instant Response Work Group comprised of representatives from the Administration for Children's Services, and the New York City Police Department, as well as participants from the District Attorney's Office, the Mayor's Office of the Criminal Justice Coordinator, Health and Hospital, and the Child Advocacy Centers was convened in February 1997 by the Administration for Children's Services (see below). The mission of the Work Group was to develop a draft protocol for the implementation of Instant Response Teams (IRT) as recommended in "Protecting the Children Of New York: A PLAN FOR ACTION FOR THE ADMINISTRATION FOR CHILDREN'S SERVICES," issued by the Mayor of the City of New York, the Honorable Rudolph W. Giuliani and Commissioner Nicholas Scoppetta on December 19, 1996.

INSTANT RESPONSE TEAMS WORK GROUP MEMBERS

Administration for Children's Services

Zeinab Chahine, Manhattan Borough Director, DCP, Chair
Julie Lilien, Executive Assistant, William C. Bell, DCP
Kate Frucher, Special Assistant, Linda Gibbs, DMA
Melvina Thompson, Queens Borough Director, DCP
Mary Rosenberg, Staten Island Borough Dir., DCP
Lisa Gersten, Criminal Justice Coordinator
Marc Stolzenberg, DLS Administration
Richard Bernstein, Director ECS, DCP
Audrey Eadie, First Deputy, Bronx, DCP
Rosemary Sherman, Dir. Curriculum Dev. Satterwhite Academy
Cyprian Belle, Brooklyn Borough Director, DCP

New York City Police Department

Capt. Carl Sandel, OMAP
Lt. Kevin Walsh, OMAP
Lt. Susan Morley, Special Victim Liaison Unit
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Det. Clare Romano, Special Victim Liaison Unit
Det. Lisa Newell, Special Victim Liaison Unit

Participants From Other Agencies

Pat Henry, Office of the Criminal Justice Coordinator
Jane Barker, Brooklyn CAC/ CARCC, Victim Services
Jocelyn Brown, Columbia Presbyterian Hospital
Tracey Smith, NYS CARCC, Victim Services
Lori Levinson, Greater New York Hospital Association
Cecile Noel, Health and Hospital Corporation

District Attorney Offices

Carol Stokinger, NY
Mary Clarke, Bronx
Lucinda Suarez, Queens
Lourdes Martinez, Brooklyn
Yolanda Rudich, Staten Island

The following individuals worked with the Instant Response Teams Work Group on IRT Training

Administration For Children's Services

Tatyana Gimein, Satterwhite Academy
Mark S. Hugel, Satterwhite Academy
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Sgt. Lisa Gong, Chief of Patrol Office
Sgt. Joanne Smith, Queens SVS
Sgt. James Talamsa, Police Academy
Sgt. Vito Colamussi, Det. Bureau Training Unit

INSTANT RESPONSE TEAMS MISSION/ OBJECTIVES

Mission:

The Mission of the Instant Response Teams is to improve coordination between the Administration for Children's Services (ACS) and Law Enforcement in order to enhance the protection of children in New York City. In cases involving **severe abuse and severe maltreatment** committed by a parent or person legally responsible, personnel from ACS, the New York City Police Department (NYPD), and the District Attorney's Offices (DA) will work together on "Instant Response Teams" in order to accomplish the

following objectives:

1) Protect children from abuse and maltreatment by ensuring that evidence is gathered in a timely, effective, and coordinated manner, thereby laying the foundation for necessary intervention, and, where appropriate, removing the alleged abuser instead of the children;

2) Minimize trauma to the child(ren) during the investigation process by: reducing the need for repetitive interviewing by law enforcement, medical and social service staff, and by holding interviews and medical examinations in child-friendly surroundings, such as Child Advocacy Centers and special child abuse clinics when possible.

RESPECTIVE ROLES AND LEGAL MANDATES OF PARTICIPATING AGENCIES

ACS and Law Enforcement Instant Response Teams will operate in accordance with their respective agencies' procedures and legal mandates. They will share information pursuant to relevant Statutory Law and as per the existing **Memorandum of Understanding** between The Administration for Children's Services, the New York City District Attorney's Offices, and the New York City Police Department.

The mission of the Administration for Children's Services is to ensure the safety and well being of all the children of New York City. To this end, ACS is responsible for receiving and investigating suspected cases of child abuse and maltreatment that are reported to the New York State Central Register; assessing the safety and needs of all the children in the family; providing services to keep families together; removing children in imminent danger; initiating the process of legal intervention by the Family Court and providing foster care placements when needed.

The general mandate of New York City Police Department is to protect life and property. The primary role of NYPD in child abuse and maltreatment cases is to investigate allegations of criminal activity and to enforce the law.

The role of the District Attorney's Office in child abuse and maltreatment cases is to prosecute the offenders when sufficient evidence exists.

Team members should not interfere with each other's ability to effectuate their agency mandates as outlined above, most importantly, the ability to remove children in imminent danger. In cases where jurisdictional issues or differences arise, they will be resolved through the management/ supervisory structure of the respective agencies.

HOSPITALS AND CHILD ADVOCACY CENTERS' ROLE IN INSTANT RESPONSE

Hospitals:

Hospitals should continue to call the NYPD Special Victims Squad as is currently required under the Prompt Response Protocol. Special Victims Squad will initiate Instant Response with ACS on cases referred to them by hospitals. ACS will be responsible for initiating an Instant Response on Non-Prompt Response cases after the hospitals contact the SCR.

Child Advocacy or Specialized Centers:

The Child Advocacy or Specialized Centers using multidisciplinary teams will continue to operate under existing protocols. A Work Group was convened by ACS to examine existing Child Advocacy/ Specialized Centers in each borough and to make recommendation regarding the utilization of these centers by ACS in general and the Instant Response Teams in particular. The Work Group has compiled a directory listing the availability of these resources in each borough. The Group recommended that the Instant Response Teams should utilize Child Advocacy or Specialized Centers to conduct joint interviews whenever possible.

TYPES OF RESPONSE TEAMS AND COORDINATION BETWEEN ACS AND LAW ENFORCEMENT

This protocol will outline the types of Response Teams that ACS and Law Enforcement will create to respond to severe child physical /sexual abuse and maltreatment situations or child fatalities. It will also describe coordination procedures on cases that do not require Instant Response.

- **Response Team Type I:** Instant Response on recent fatality cases by ACS {Division of Child Protection Field Offices, Emergency Children's Services (ECS), and Office of Confidential Investigations (OCI)} and NYPD (Patrol, Detective Squad, and Night Watch).

- **Response Team Type II:** Instant Response on severe abuse cases of children under 11, felony sex abuse of children under 18, and all sex abuse of children under 11, by ACS (Division of Child Protection Field Offices, Emergency Children's Services, and Office of Confidential Investigations) and NYPD (Patrol, Special Victim Squad, and Night Watch).

- **Response Team Type III:** Instant Response on severe abuse and maltreatment cases of children 11-17 and sexual abuse of children 11-17 not covered by Type II, by ACS (Division of Child Protection Field Offices, Emergency Children's Services, and Office of Confidential Investigations) and NYPD (Patrol, Detective Squad, and Night Watch).

- **Coordination /Assistance/ Information Sharing on Other Types of Cases:** ACS and Law enforcement will coordinate on severe abuse and maltreatment cases that do not require an emergency Instant Response but a multidisciplinary team response. ACS and NYPD will coordinate on other types of cases, i.e., Domestic Violence, provide assistance and share information as needed.

RESPONSE TEAMS PROCESS- GENERAL STEPS

The Instant Response Team members (ACS and Law Enforcement) will respond to reports that meet the IRT criteria described below with the objective to assemble the group at the scene and work as a team whenever possible. ACS staff (Field Office, ECS, OCI) along with the appropriate NYPD personnel will respond to the scene when alerted to the need for an Instant Response. The process outlined below applies if the report is received by ACS' Office of Field Services, Office of Confidential Investigations or Emergency Children's Services.

Note: ACS staff can participate in the Instant Response Teams prior to the receipt of an SCR report as long as a report is in the process of being called into the SCR. The expectation is that a report will be called in as soon as possible.

1. Initiating an Instant Response

An Instant Response Team is triggered when:

a) ACS receives a State Central Register (SCR) report in a field office and determines that it falls under the Instant Response protocol.

Note: ACS caseworkers and supervisors should make every effort to determine the seriousness of the allegations before triggering an Instant Response. The source of the report should be contacted by the caseworker. In some cases, including when the source of a report is anonymous or unreachable, this may mean that an ACS caseworker makes a field visit before initiating an Instant Response.

b) An ACS Response Team Coordinator (IRT Coordinator) receives a contact from a Law Enforcement Officer or an ACS worker in the field requesting an Instant Response on a case (refer to IR Types). ACS staff can initiate an IRT on open cases by directly calling the IRT Coordinator in their borough or at ECS (depending on the time of day). ACS staff should continue to contact 911 in emergency situations.

IRT Coordinators will be ACS staff members from the Division of Child Protection. IRT Coordinators stationed at the borough Field Offices and Office of Confidential Investigations will receive referrals from 8:00 AM to 4:00 PM Monday through Friday. Coordinators will also be stationed at ECS during evening/night time/ weekends and holidays and will receive IRT referrals during those times. (The Borough Office IRT Coordinators phones will be forwarded to ECS during off hours). The IRT coordinators also coordinate activities and serve as consultants to the IR Teams. The ACS unit supervisors will provide supervision and direction to the caseworkers involved on the IR Teams.

For eligible cases, the ACS **IRT Coordinator** in the borough in which the incident has occurred should be contacted. If the case belongs to a borough other than where the incident has occurred, the **IRT Coordinator** who receives the first contact will notify the **IRT Coordinator** in the appropriate borough.

Whenever agency personnel become aware of an allegation potentially warranting an Instant Response, **they should not** assume that the IRT Coordinator or the SCR have been notified and they should make these notifications as soon as possible.

RESPONSE TEAMS PROCESS- GENERAL STEPS

When ACS workers call the police directly (through 911) in emergency situations or when police officers and caseworkers coincidentally meet at a scene, the ACS worker must inform their supervisor and the IRT Coordinator that an Instant Response took place as soon as possible. The IRT Coordinator will complete the IRT Intake Form and follow-up information as required.

2. Process for Assembling the Team

a) ACS Initiated Instant Response:

- First, all reports received from the SCR that fit the IRT criteria will be assigned immediately by ACS' Application supervisor (Routing Coordinator) to the appropriate ACS unit supervisor.

- Second, the Application supervisor (Routing Coordinator) would assign the case and immediately alert the **IRT Coordinator.** They should also provide a copy of the report to the **IRT Coordinator** with an annotation of the assigned unit (or e-mail the case name and report number to the IRT coordinator who in turn will access the report using Connections). The **IRT Coordinator** should be consulted if the Routing coordinator is unsure whether the report meets the IRT criteria.

- Third, the **IRT Coordinator** contacts the ACS supervisor to discuss the need for an Instant Response and provides the unit supervisor with the appropriate NYPD contact.

- Fourth, the unit supervisor or caseworker after preliminary screening alerts the appropriate NYPD personnel that an Instant Response is needed and begins coordination of the investigation. The IRT Coordinator will troubleshoot if coordination problems arise.

b) Law Enforcement initiated Instant Response:

- First, the **IRT Coordinator** receives the call from a Law Enforcement Officer, inquires whether the SCR Hotline accepted the report, obtains the report number, if available, and records additional information.

- Second, If the SCR has not been contacted, the **IRT Coordinator** would advise the caller to immediately contact the SCR, identify the report as Instant Response, and obtain an identification number. Under exceptional circumstances, if the Law Enforcement Officer is unable to make the call, the **IRT Coordinator** will contact the SCR.

- Third, the **IRT Coordinator**, when notified that an Instant Response is needed prior to the receipt of the SCR report, will contact the Application Supervisor (Routing Coordinator) to obtain the next available unit (the case is recorded as a pending) . The **IRT Coordinator** will immediately alert and provide the unit supervisor with all the available information.

- Fourth, the unit supervisor will immediately assign a caseworker to participate in the Instant Response Team and contact the appropriate NYPD personnel. The supervisor should also provide the **IRT Coordinator** with the assigned caseworker's name.

The **IRT Coordinator** will follow-up with the unit supervisor to ensure that the Instant Response Team members have successfully established contact. (See IRT Coordinator Follow-up Responsibilities for more on-going roles).

3. Instant Response Team Process at the Scene

- In order to determine immediate danger to the children, the investigation may begin as soon as any of the IRT members arrives at the scene.

- Unless there is immediate danger to the children or victims at the scene of the crime, physical evidence should not be disturbed. This is especially important in serious crimes or fatalities, where the initial investigation by the police or crime scene detective is imperative.

- To avoid multiple interviews of the child victim and minimize trauma, every effort should be made to assemble the IR team to conduct a *joint interview*, preferably at a child friendly setting. A **MINIMAL FACTS ONLY INTERVIEW** will be initiated by team member(s) on the scene in order to determine the necessary steps to assure the safety of the child and other potential victims as well as to evaluate the need for medical attention. When the team member(s) on the scene determine that an expansion of the minimal fact interview is necessary, policy should give way to investigative judgment. Following a Minimal Facts Only Interview, a follow-up **IN-DEPTH INTERVIEW** will be conducted as needed by the IR Team as soon as possible preferably at a child friendly setting.

A Minimal Fact Interview should be limited to:

- What happened?
- Where did it happen?
- When did it happen?
- Who is/are the alleged perpetrators?
- Are there witnesses and/or fellow victims?

The IR Team members will hold a **Pre- Interview Consultation** in order to determine the team member who will commence the joint interview. In cases where a criminal investigation is likely, NYPD, after conferring with ACS, will commence the joint interview. In all other cases, the following factors will be considered to determine the interviewer(s): language spoken by the child, special needs of the child, comfort of child with any specific member, specific expertise of team member.

IRT Coordinators Follow-up Responsibilities

- In order to ensure continuity and follow-up, the **IRT Coordinators** from ECS will fax or e-mail the day time IRT Coordinator copies of the Instant Response Intake Reports (format to be developed).

- The ACS daytime **IRT Coordinators** will be responsible for tracking all Instant Response cases within 72 hours to obtain the results of the IRT investigations.

- On a long-term basis, the daytime **IRT Coordinators** will track IRT cases from referral through disposition. The **IRT Coordinator** will obtain information from the DA's office on arrests, prosecution and conviction rates on IRT cases.

- The **IRT Coordinators** will also follow up to obtain placement and Family Court information on IRT cases from ACS staff.

- The **IRT Coordinators** will then forward this information to ACS' Management Information Systems for the monthly IRT reports.

Criteria for Instant Response Team Cases

The following describes the criteria for Instant Response Teams. This protocol is limited to child abuse and maltreatment situations involving a parent or a person legally responsible. **At all times, professional judgment will determine a case's suitability to this protocol and the type of response required**. If the reporter is not sure whether a case fits, a call to discuss its applicability would be welcomed by the IRT Coordinator.

INSTANT RESPONSE TYPE I

Criteria: **Fatalities involving children under 18**

Specific Response Procedure:

Instant Response Type I Requires **immediate communication and coordination between ACS and NYPD- Detective Squad.**

- When NYPD receives an investigation involving a suspicious fatality, they will immediately notify the ACS IRT Coordinator to begin the coordination of the investigation and response.

- When ACS receives an investigation involving a suspicious fatality, the IRT Coordinator should telephone the District Attorney's office in the borough where the incident occurred and Fax the SCR Report. The DA will assist ACS in the identification of the appropriate NYPD squad to be contacted. The IRT Coordinator will contact the appropriate precinct detective squad.

Participants:

- ACS
- NYPD – Patrol *, Precinct Detective Squad or Night Watch.
- DA
- Medical Examiner
- Other disciplines as needed: hospitals, EMS, ACS Division of Legal Services, other service providers.

* Note: Patrol is usually first on the scene and will alert the appropriate Detective Squad as required under NYPD procedures.

INSTANT RESPONSE TYPE II

General Criteria: (see specific criteria below for more details)

- **Severe physical abuse of children under 11**
- **Sexual offenses involving children under 11**
- **Rape, sodomy, or forcible sexual abuse involving children under 18**

Response Procedure:

Requires an immediate, team response between ACS and NYPD- Special Victim Squad. Instant Response Type II pertains to children whose injury was inflicted by a parent or legally responsible person, is not consistent with the statement/story/history, or is unexplained.

- When SVS determines the need for a Type II response, the assigned detective will immediately notify the IRT Coordinator to initiate a team response (refer to Response Team Process- General Steps p. 6 of the Instant Response Protocol). In arrest cases, Patrol* will alert SVS who in turn will notify the IRT Coordinator.

- When ACS determines the need for an Instant Response Type II after conducting a preliminary screening, the ACS caseworker or supervisor will contact SVS to initiate a team response (refer to Response Team Process- General Steps, p. 6 of the Instant Response Protocol).

- If the team determines that an Instant Response is not needed, they should coordinate a multidisciplinary response (refer to the IR protocol section on coordination between ACS and NYPD).

Participants:

- ACS
- NYPD- Patrol, SVS, or Night Watch
- Other disciplines as needed: DA, hospitals, ACS Division of Legal Services, Child Advocacy Centers, EMS, other service providers.

* Note: Patrol is usually first on the scene and will alert the Special Victim Squad as required under NYPD procedures.

INSTANT RESPONSE TYPE II CONTINUED

Specific Criteria for Type II:

Severe physical abuse of children under 11 include:

1. Fractures

2. Internal bleeding injuries including subdural hematoma, "shaken baby" syndrome.

3. Widespread or serious bruises, lacerations or welts, consistent with injury being inflicted.

4. Severe or widespread soft tissue damage caused by serious beatings.

5. Burns and scalding.

6. Attempted drowning or asphyxiation.

Clearly "3" and "4" involve judgment calls about the seriousness of the injuries for the purpose of requiring immediate law enforcement involvement. It is the very serious cases to which this protocol applies.

In cases involving **sexual offenses** for children under 11, an IRT is needed when:

1. Child indicates that he or she is a victim of a sex crime ; or

2. there is evidence of the same: or

3. available person, such as family member or other adults known to family allege to have witnessed or have knowledge of sexual abuse of child victim and the child is present at the scene.

In cases involving **rape, sodomy, or forcible sexual abuse** of children under 18, an IRT is needed when:

1. Child indicates that a rape, sodomy or forcible sex abuse has occurred; or

2. Available person, such as family member or other adults known to family alleges to have witnessed or have knowledge of sexual abuse of child victim and the child is present at the scene; and

3. Abuse occurred within 72 hours or physical evidence of the same.

Because Hospital Emergency Rooms are often ill equipped to handle sexual abuse exams, team members, whenever possible, should make maximum use of hospital's sex abuse, pediatric clinic or Child Advocacy or specialized center.

INSTANT RESPONSE TYPE III

General Criteria: (Refer for specific criteria below for more details)

- **Severe physical abuse of children 11 - 17**
- **Severe maltreatment of children under 18**
- **Sexual abuse of children 11- 17 not covered by Instant Response Type II**

Response Procedure:

Requires an immediate team response between ACS and NYPD Patrol. Instant Response Type III pertains to children whose injury was inflicted or was not consistent with statement/story/history by caretakers or is unexplained.

- When NYPD initiates:

NYPD Patrol will notify the ACS IRT Coordinator via telephone that an Instant Response is needed when either an arrest is being made or children are being removed. After ACS is contacted, the worker will meet the police at the appropriate destination, i.e., Hospital or precinct. NYPD must also notify the SCR.

When there is no arrest or removal by NYPD Patrol, the case will be referred to a precinct detective. The assigned detective will coordinate the investigation with the ACS staff. The detective will contact the IRT Coordinator to initiate the coordination and multidisciplinary response as needed.

- When ACS initiates:

In cases where ACS has responded to a severe abuse situation involving criminal activity, the ACS worker should first contact 911 for emergency assistance and then contact the IRT Coordinator.

On ACS reports where safety issues may be a factor (e.g., weapons, drug selling or incidents of violence), the ACS caseworker should report in person to the precinct to request police assistance in making the home visit. NYPD will respond not only for the purpose of ensuring the safety and well being of all concerned but also for investigating possible criminal activity.

Participants:

- ACS
- NYPD—Patrol, Precinct Detective Squad or Night Watch
- Other disciplines as needed: Hospitals, DA, EMS, Child Advocacy Centers, ACS Division of Legal Services, service providers.

INSTANT RESPONSE TYPE III CONTINUED

Specific Criteria for Type III

Severe physical abuse of children 11 -17 include:

1. Fractures.

2. Internal bleeding injuries including subdural hematoma.

3. Widespread or serious bruises, lacerations or welts, consistent with injury being inflicted.

4. Severe or widespread soft tissue damage caused by serious beatings.

5. Burns and scalding.

6. Attempted drowning or asphyxiation.

Clearly "3" and "4" involve judgment calls about the seriousness of the injuries for the purpose of expecting and requiring immediate law enforcement involvement. It is the very serious cases to which this protocol applies.

Severe maltreatment of children under 18 include:

1. MALNUTRITION: Life-threatening malnutrition, or intentional starvation, e.g., no food provided or available to child or report of child being deprived of food for long periods of time that is evident when seeing child.

In Cases involving **sexual abuse** of children 11 - 17 not covered by Instant Response Type II, an IRT is needed when:

1. Sex abuse of child where no force was involved and victim under age 17 indicates that a sex abuse incident has occurred; or

2. Available person, such as family member or other adults known to family allege to have witnessed or have knowledge of sexual abuse of child victim and the child is present at the scene; and

3. Perpetrator present, arrested or there is concern about the safety of the child; and

4. Abuse occurred within 72 hours or physical evidence of the same.

COORDINATION BETWEEN ACS AND LAW ENFORCEMENT ON OTHER CASES

ACS and NYPD will coordinate on cases not requiring an Instant Response as needed. This coordination may include the following:

- **Multidisciplinary Teams**
- **Requests for Assistance by ACS**
- **Domestic Violence Cases**

1. **Multidisciplinary Teams:** ACS and Law enforcement will coordinate activities and conduct multidisciplinary interviews as a team when appropriate at a child friendly setting, i.e., Child Advocacy Center or Specialized Child Abuse Clinic. This type of response includes cases where the IR team members conducted a **Minimal Fact Only Interview** at the scene and an **IN-DEPTH** interview is needed when the other participants are present.

2. **Requests for Assistance by ACS:** In cases that warrant assistance from NYPD by an ACS worker, e.g., cases involving weapons, drug selling, or incidence of violence in the home where children reside, or Family Court warrants to be served, the ACS caseworker should report to the precinct and request assistance from the Desk Officer. NYPD will respond not only for the purpose of ensuring the safety of all concerned but also for the investigating possible criminal activity. **ACS staff should contact "911" in emergency situations.**

3. **Domestic Violence Cases:** recognizing the connection between child abuse and domestic violence, ACS and NYPD have committed to work together to develop effective strategies to address domestic violence cases. This has been evident through the implementation of the Zone C. Domestic Violence Project in ACS' Manhattan Field Office and the planned pilot of a Family Violence Prevention Project to be implemented in the near future in the same Office.

Under the Instant Response Protocol, the two agencies will share information and cooperate on domestic violence cases as outlined below:

- ACS cases involving a Domestic Violence high risk allegation should be referred to the Domestic Violence Prevention Officer (DVPO) for purposes of follow-up. ACS will fax a copy of the SCR report to the DVPO. The name and phone number of the ACS worker investigating these reports should also be forwarded to the DVPO.

- ACS will contact the DVPO in precincts on reports involving Domestic Violence (DV) in order to find out if there are records of Domestic Violence Incident Reports (DIRs) on the perpetrator.

*NOTE: ACS and NYPD will continue to work together through the Zone C pilot project to develop a more comprehensive strategy with regard to domestic violence cases.

INFORMATION SHARING BETWEEN ACS AND LAW ENFORCEMENT

1. Information that can be disclosed to law enforcement by ACS:

Social Service Law Section 422 (4) (A) (I) authorizes the disclosure of child protective records to the District Attorney Offices and NYPD. It states that records may be disclosed when necessary to conduct a criminal investigation or prosecution of a person, that there is reasonable cause to believe that such person is the subject of an Report and that due to the nature of the crime, such records may be related to the investigation or prosecution. The following describes the type of reports that can be disclosed by ACS:

- **Oral Report Transmittals (ORT) or (SCR Child Abuse/Neglect Intake Reports)** : ACS will continue to forward the ORT's (or Intake Reports) to the DA's Office as defined in the MOU and upon written agreement in the appropriate circumstances to NYPD.

- **Protective Records Disclosure**;

a) Current investigations

b) Indicated Reports: Information from ongoing or prior indicated reports.

c) Unfounded Reports prior to 2/12/96: No information can be disclosed concerning these reports.

d) Unfounded Reports Post 2/12/96: No information can be disclosed except to the extent the information is incorporated into the records of a current investigation.

- **Foster Care Records:** As per SSL Sec. 372, Foster Care records can only be disclosed through written permission of the State Department of Social Services or by a Court Order, when required for a trial, and notice is given to all parties.

- **Preventive Case Records:** Departmental Regulations, Section 423.7 indicates that preventive records can only be disclosed by court order to entities such as NYPD.

ACS STAFF MAY VERBALLY DISCLOSE THE INFORMATION ALOWED UNDER THE LAW WHILE RESPONDING JOINTLY WITH LAW ENFORCEMENT. A WRITTEN REQUEST FOR THE INFORMATION INDICATING THAT THE REQUEST IS IN COMPLIANCE WITH SSL SECTION 422 (4) (A) (I) MUST BE FORWARDED TO ACS AS SOON AS POSSIBLE. ACS STAFF MAY ALSO SHARE THE SCR REPORT ON AN IRT CASE WHILE RESPONDING WITH NYPD.

INFORMATION SHARING BETWEEN ACS AND LAW ENFORCEMENT CONTINUED

2. Information that can be disclosed by NYPD to ACS:

The NYPD will provide all relevant and available information requested by ACS in accordance with applicable laws. NYPD can disclose the following information only if ACS is investigating the same victim:

- Name and identity of the victim
- Statements made by a victim
- Witness information
- Names and addresses of family members
- Existence of an order of protection

Other information that can be disclosed:

- Detention location of defendants in arrest situations.
- Arrest and complaint reports that have not been sealed.
- Domestic Incident Reports

Information regarding sex crimes can be shared only if ACS is investigating the same victim.

3. Information that can be disclosed by District Attorney's Office to ACS:

The District Attorney's Office shall provide ACS with all information requested which is in their possession and contained in public documents.