2013 Arizona Citizen Review Panel

Annual Report and Recommendations

Prepared for the Division of Child Safety and Family Services
by **Arizona State University** School of Social Work
Center for Applied Behavioral Health Policy

Message from the Project Coordinator, **Sandra Lescoe**

I wish to thank the members of the Arizona Citizen Review Panel and staff of the Division of Child Safety and Family Services (formerly known as the Division of Children, Youth and Families) for their continued commitment and collaboration to improve the lives of Arizona children and families. The Citizen Review Panels are an important component of the Arizona child welfare system. Panel members bring their expertise, influence, and support to help achieve the safety, permanency, and well-being of children as part of the broader child welfare community. The involvement of Arizona citizens affirms that the safety and protection of children is everyone's responsibility and goes beyond the work of any single agency.

In 2013, Citizen Review Panel members demonstrated their support by volunteering to participate in case reviews, trainings, and community projects benefiting the lives of Arizona children. Their deep commitment is evident, and we thank them for their dedication to improving outcomes and services.

This is a public report summarizing the work and recommendations of the Arizona Citizen Review Panel during the 2013 calendar year. We ask that you share it with anyone who has an interest in child welfare. We hope that it will become part of the larger conversation about what each of us can do to protect and build services for children and families in need throughout Arizona.

Sandra Lescoe, MSW
Citizen Review Panel Project Coordinator

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has"

-Margaret Mead

ARIZONA CITIZEN REVIEW PANEL PROGRAM

This is your invitation to become an advocate for the protection and welfare of Arizona children and families.
Learn how to get involved.
For more information about the Arizona Citizen Review Panel Program visit
www.cabhp.asu.edu

Background and Purpose:

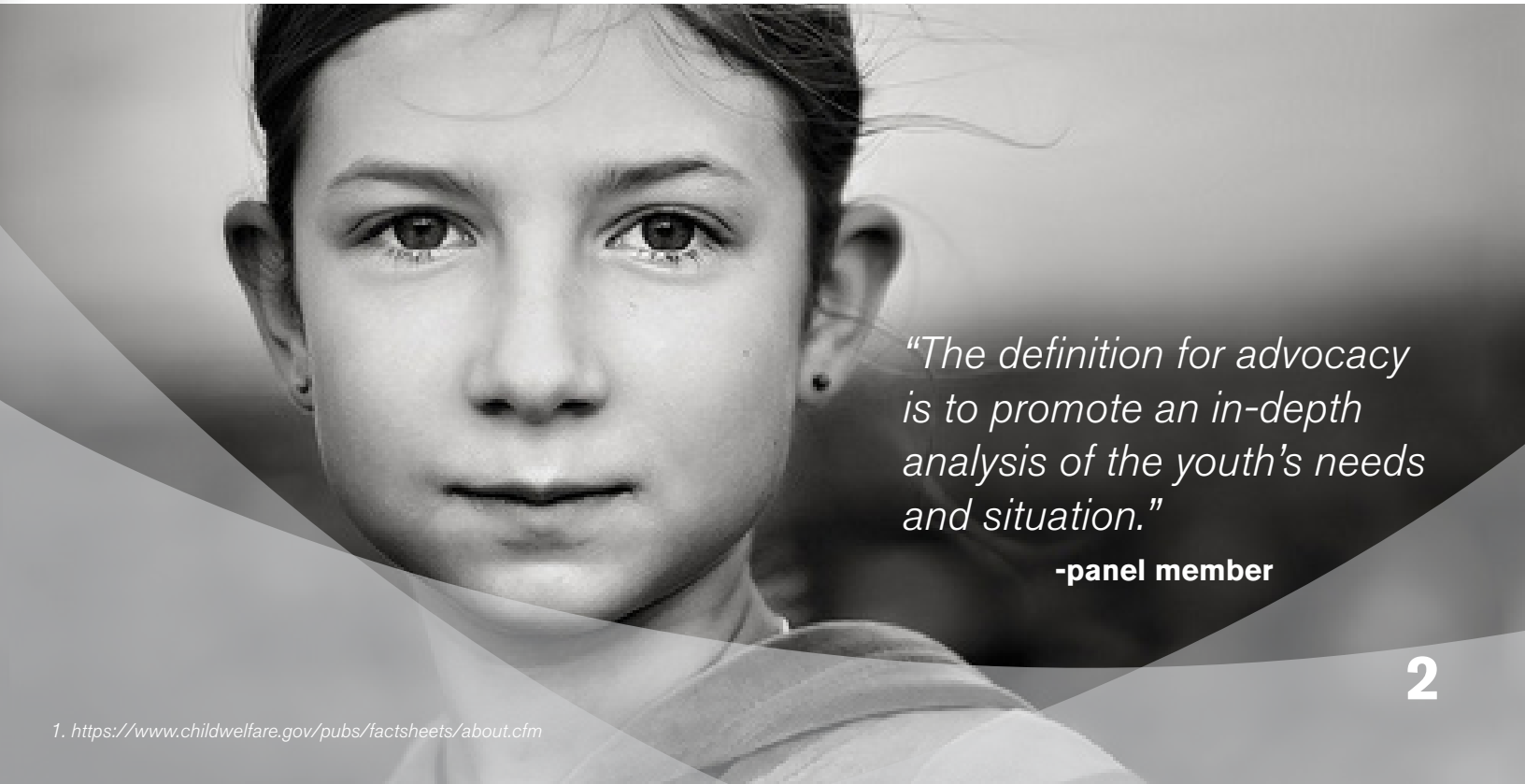
The Arizona Citizen Review Panel Program (CRP) was established in 1999 as part of the federal Child Abuse Prevention and Treatment Act (CAPTA)[1]. This Act requires states to establish citizen review panels for the purpose of determining whether state and local agencies are effectively discharging their child protection responsibilities.

In partnership with the Department of Economic Security, Division of Children, Youth and Families (DES/DCYF) now identified as the Division of Child Safety and Family Services (DCSFS), the Center for Applied Behavioral Health Policy (CABHP), with Dr. Judy Krysik as Principal Investigator, administers and serves as the coordinator for the three fully operational panels. The panels are located in central (Phoenix), southern (Tucson), and northern (Flagstaff) regions of the state.

The three panels are comprised of volunteers who are broadly representative of their communities, and include members of various disciplines with expertise in the prevention and treatment of child abuse and neglect. Regional panel members meet a minimum of four times per year.

A defined process is utilized by the panel members for the collection and review of policies, procedures, operational analysis, and confidential information about Child Protective Services (CPS) cases. CPS cases are discussed in a group environment at each meeting. From this discussion, risk factors are identified, practices are reviewed, data are analyzed, and findings and recommendations are developed with an emphasis on strategies to improve the CPS system. Consensus is required by all panel members to formulate and approve final recommendations.

At the end of each year, the CRP Program compiles an annual report based on its activities, findings, and recommendations. This report is provided to the DCSFS and is made available to the public. It is also included in the annual CAPTA[1] report for the U.S. Department of Health and Human Services.



"The definition for advocacy is to promote an in-depth analysis of the youth's needs and situation."

-panel member

1. https://www.childwelfare.gov/pubs/factsheets/about.cfm

Panel Activities

In 2013, the three panels met quarterly in each region. Each meeting was scheduled for three hours. The case reviews centered around four themes chosen at the beginning of the year by the panel members. The four themes included: 1) investigations of criminal conduct allegations, 2) aging out of foster care, 3) unexpected disruptions and multiple placements, and 4) chronic neglect. The panel members have expressed support for this method which examines cases by theme so they can focus on more targeted recommendations to improve policies, practice, and outcomes.

Thirteen cases were selected for review in 2013. The case summaries and information presented to the panel members included quality assurance tools utilized by the Practice Improvement Specialists and outcome measures applied in the Child and Family Service Reviews (CFSR). The case summaries and panel discussions focused on these elements:

- Timeliness of initiating investigations of reports of maltreatment
- Initial child safety risk assessment
- Safety planning to protect children in-home and prevent removal
- Provision of services to reduce risk
- Determining whether maltreatment occurred
- Aftercare planning
- Reassessment of child safety risk assessment
- Permanency goals
- Concurrent permanency planning
- Independent living services
- Visitation with parents and siblings in foster care
- Relative placement
- Needs and services of children
- Case plan development
- Worker visits with child and parent
- Educational, physical, and mental/behavioral health of the child

In addition to the case reviews, three of our panel members, Marla Dedrick, Comel Belin, and Allison Thompson attended the National CRP Conference in Wyoming with Program Manager, Karin Kline. The panel members who attended found it to be informative and helpful. This opportunity has been provided the last several years and has broadened the panel's understanding of the Citizen Review Panel process.

Last winter the panels began working in their communities to support the child welfare system. The Central panel partnered with the Coalition Against Child Sexual Abuse and gave out Body Safety Boxes and the book *Those Are My Body Parts* at a local child abuse prevention event on April 6, 2013. The central panel also identified two CPS visitation rooms to redecorate which are used for family visits or for youth who have been removed and are awaiting placement. It is anticipated remodeling will be complete in the next few months. The northern panel created a community child abuse prevention calendar which included artwork from local children attending a Flagstaff art center. The calendar also includes a list of resources and child abuse prevention and parenting tips.

On December 3, 2013 a public forum was held regarding CPS. The event provided community members an opportunity to offer productive suggestions for improving CPS services. Nearly 400 people attended, including foster parents, social workers from community agencies, volunteers, and current and former CPS case managers. Participants expressed great frustration with problems in the current system and had the opportunity to offer their suggestions for improving child safety. Karin Kline, CRP Program Manager, was invited to speak and highlighted the work of the Citizen Review Panels including their findings and recommendations from the 2013 Annual Report.

2013 Panel Recommendations

Arizona Citizen Review Panels, in their position as citizen advocates, work on behalf of Arizona's most vulnerable children and families. The panels engage in discussions and formulate findings and recommendations which are meant to identify system problems, commend areas of success, and provide feedback about improving practice. The panel members identify current needs in the child welfare system based on what they learned in the case review process and their individual child welfare experience. At the end of each year, the panel members submit findings and recommendations to the Division. It is in this role that the Arizona Citizen Review Panels respectfully submit the following recommendations for 2013.

1

The Division should facilitate continuous staff development and performance support to build skill in assessing safety, risk factors, case planning, and aftercare planning. We suggest the Division provide:

- Alternative methods for staff to have access to training and staff development
- Reinforcement of practical application of policies and procedures
- Improved technology for staff to document case response, assessment, intervention and outcomes more efficiently
- Ongoing training, refreshers, and communication to the field in order to reinforce policies and procedures
- Advanced training in clinical supervision for supervisors
- Professional development opportunities that would better prepare CPS staff for the demands of the job

Panel members suggested priority be given to the following areas of practice:

- Strengthening staff skills in responding to and assessing cases involving untreated mental health disorders, domestic violence, and substance abuse with emphasis on the implications of how these affect parenting skills and influence risk to the child(ren)
- Reinforcing clinical supervision for staff and supervisors to strengthen critical thinking and best practices
- Increasing staff knowledge and understanding of policies and procedures regarding assessment of safety threats and risk factors, implementing effective intervention plans, case plans, and how to evaluate and document progress

"Until they have skills to analyze the data they collected, it is just information"

-panel member

2

The Division should develop and strengthen the supports, services, and training for foster parents, kinship providers, and the Independent Living Program. This will increase the skill set of caregivers and improve their capacity to respond to children who have high needs and who exhibit challenging behavior. By doing this, youth exiting foster care will be more likely to have a support system and community connections prior to leaving care. The Division is encouraged to:

- Examine processes that may present barriers to the receipt of services among caregivers
- Provide advanced training to all caregivers focused on child development and how to manage behavioral and medical needs of children in care
- Review existing independent living skills services through partnerships with community programs to identify and develop additional methods to help youth maintain these connections and apply learned skills once out of foster care

3

The Division should develop an automated mechanism to track historical information about the identity of relatives, efforts to locate them, placement consideration, or other family connections. The Division is encouraged to accomplish this by designating a single location in the case record to document:

- All family and relative information, supports, and placement decisions so the information is easily accessible for review and readily available for court reports, service providers, and CPS staff
- Updates and reassessment of all placement considerations, relative and kinship connections or other pertinent information under review which may be the result of a change in the child's situation, needs, and permanency plan
- Nurturing and existing relationships that are healthy and important to the child, i.e., birth siblings, and ensure that youth leaving care have social permanency should legal permanency not result

4

The Division should work with community partners in an effort to reduce the number of children who are subject to neglect or the victims of recurring maltreatment by:

- Collaborating with community partners to leverage the existing array of prevention programs, identifying gaps in the current service array, and establishing a family-focused referral process
- Collaborating with community partners to expand resources to families to address risk factors to prevent the removal of children
- Remaining in a leadership role to explore an alternative response system that will engage families in identifying their needs, strengths and solutions to meet the needs of their children and ensure safety
- Continuing to understand and reinforce trauma informed care

Link to 2012 Annual Report and Agency Response
http://cabhp.asu.edu/publications-reports/reports/2012-report/2012-arizona-citizen-review-panel-annual-report

Findings from Quarterly Meetings

Reviewing active cases allows panel members to examine events and circumstances which may be occurring in the life of a case and provides the opportunity for panel members to offer feedback in a timely manner. The review of closed cases provides panel members the opportunity to evaluate compliance with policies and procedures, case management, and supervision practices at various stages of a case. In addition to the case reviews, quarterly meetings include organized presentations from experts in the field on policy related to the quarterly themes, and input from panel members. The following key findings were identified across all quarterly meetings.

1

Workload and high staff turnover negatively impact the ability of CPS to respond effectively and consistently to children and families.

The cases reviewed appeared to be negatively impacted or compromised as a result of high workloads and staff turnover. Critical decisions were overlooked and opportunities were missed because of competing demands and the inability of staff to respond efficiently. Panel members observed CPS staff were unable to engage in thoughtful responses, complete thorough assessments, provide suitable intervention, provide adequate case management, or develop individualized case plans and aftercare planning due to high case loads.

An ongoing concern and point of discussion among panel members was that CPS Specialists were reportedly working significantly above caseload standards. The panels also recognized that the lack of adequate funding for CPS has been a significant barrier in reducing caseloads and serving families effectively. Best practice emphasizes family engagement as a critical component in building trust with families to determine family functioning and identify their individual needs. Due to workload and time constraints, CPS Specialists may not take the time required to engage with families as they would if they had lower caseloads.

CPS staff who attended the panel meetings consistently described the volume of work as daunting. The table below compares national child welfare standards established by the National Child Welfare League to current caseload standards in Arizona. In all areas the caseloads are substantially above those recommended.[2]

Employee Position	Caseload Standard	Average Workload
Investigations	10 reports	19 reports
In-home services	19 cases	36 cases
Out-of-home (foster care)	16 children	30 children

2. https://www.childwelfare.gov/management/administration/requirements/standards/

CPS guest speakers revealed the process improvement efforts, which have been implemented by the Division, to streamline cumbersome tools, reduce the time staff spend on computer entry, and create alternative methods to improve efficiency and reinforce clinical supervision. In spite of these efforts, the mounting caseloads and inadequate staff capacity show case management remains inconsistent. Case reviews by panel members revealed that the following stages of case management are impacted by high workload.

Prior CPS History

All of the thirteen cases reviewed had prior CPS involvement. Those cases with three or more prior CPS reports were missing the additional review required by policy. This policy necessitates that the CPS Specialist and the CPS Supervisor critically evaluate and document the victim(s), perpetrators, patterns of maltreatment, prior services, and outcomes to ensure the CPS Specialist is making an informed response.

Investigation Stage

During the case reviews, panel members evaluated numerous aspects of each investigation and identified areas of strengths and weakness within the system. These include:

- Initiating a response to a report of child maltreatment was found to be timely in nine of the thirteen cases, the majority of which remained open and/or had previous CPS reports of maltreatment. The other four cases had delays in assignment because there was no staff available for assignment as noted in the case record
- Police responded to several cases involving domestic violence but did not make contact with CPS. CPS had open cases on these families, but there was no collaboration documented
- There were several reports containing criminal conduct allegations which require a joint investigation with law enforcement. In two of these, the CPS Specialist did not initiate a joint investigation for unknown reasons

"Without coordination of the involved various disciplines, each system representative focuses only on what they can or can't do. We see this over and over and over."

-panel member

Findings from Quarterly Meetings (cont'd)

Present Danger Assessment and Child Safety Risk Assessment

The initial assessment often had a determination about whether or not a child was in present danger, however, the documentation to support these decisions was sometimes missing or not entered in the case record. The Child Safety Risk Assessments (CSRAs) that were completed by CPS were either inconsistent or lacked adequate documentation as required by Division policy. This was most prevalent in the case reviews involving children with multiple placements and children who experience chronic neglect. Some examples of missing information include:

- Gathering background information on prior CPS history from other states such as police, medical, behavioral, and education records, which is vital for making safety decisions and risk assessments
- In four of the cases, significant concerns were raised about safety planning decisions put in place to protect children in their home and prevent removal. In these situations, the alleged perpetrator still had access to the children even though there was a history of violence, and it was evident the safety monitor was not following the CPS plan he/she had agreed to
- Interviews with all relevant persons and children involved in a case, were sometimes unclear or vaguely documented. CPS staff reported this was partially attributed to the number of staff who resign and leave their case files unfinished
- No identification of risk factors, what services were considered, or follow-up when there were ongoing concerns. However, in one case that involved multiple CPS priors, panel members felt the CPS Specialist who completed the CSRA did an outstanding assessment, making it clear how her decisions were made, thereby ensuring safety of the children

Court Involved Cases and Case Planning

The panels determined a lack of consistency in the Continuous Child Safety Risk Assessment (C-CSRA) for in-home and out-of-home cases. Case plan permanency goals were noted as appropriate in all but four of the cases which involved parents who had a long prior history of maltreating their children, had their rights severed as to other children, and never remedied the behaviors which brought their children into CPS care. Their safety and risk assessments had missing information, limited documentation, and the reasons for the intervention provided was not consistent. In these cases, panel members found there was inadequate follow through in making contact with relatives who wanted to be considered as a placement or who wanted to maintain connections to the child(ren).

Arranged visitation between parents and siblings in foster care was well executed in most case reviews. CPS Specialist visits with parents and children were very consistent given the high workload. There was only one case reviewed in which the siblings lived close to one another and visits were not coordinated in a timely manner. The panels also recognized some of the case plans developed for families appeared overwhelming and it was unclear whether parents were involved in identifying their needs and how system partners had contributed in the case planning process. Some of the case plans were described by panel members as "one-size-fits-all," meaning the safety threats or risk factors were unclear in relationship to the permanency plan, case plan goal, and designated tasks. CPS Program Improvement Specialists reported the growing workload continues to be a challenge, and this is an area that has suffered greatly.

Case Closure

The panels concluded more than half of the cases closed by the CPS Specialist did not adequately resolve safety issues or high risk factors. Case closure time frames were often untimely due to delays in data entry, or the CPS Specialist was awaiting clinical supervision with his/her supervisor.

2

It is unclear whether Supervisors and CPS Specialists are provided opportunities to enhance their knowledge and strengthen skill deficits which are essential in practice and for making decisions throughout the life of a case.

In addition to workload, the panels recognized critical documents and/or information was absent in the child safety and risk assessments. Based on panel members' review of policy and procedures, CPS Specialists failed to gather and analyze all relevant information to make methodical child safety and risk determinations for intervention, case planning, and aftercare planning. This has been a repeated finding in CRP annual reports for several years. Panel members believe the CPS Specialist will focus on the incident itself and overlook the underlying issues, which can result in repeated CPS reports. Panel members suggested CPS Specialists may be limited in their interviewing and documentation skills and/or may not be receiving timely and adequate supervision. Panel members also raised concerns about whether inexperienced case workers are given enough time to learn adequate assessment skills before they begin making decisions about child safety.

Another common finding in the case reviews was the lack of documentation about efforts to place children who had been removed from their home with family members. Historical information regarding the identity of relatives and efforts to locate or involve them was seemingly lost in the case record. This practice was also attributed to workload, although there are policies which require retrieval of this information at various stages of a case.

3

A continuum of services and improved collaboration with child welfare service partners is needed in order to effectively support children, families, kinship providers, and foster parents.

Panel members' concern for youth who grow up and age out of the CPS system was examined in the second quarter. Results from these case reviews found youth leaving foster care with limited living skills and few meaningful connections. The panel members concluded that some relative and family connections were ignored, and that connections ruled out early in the life of the case were not reconsidered or reassessed at a later time.

According to a CPS representative, who presented an overview of the current policy, practices, and services available to youth in care, those between the ages of 13 and 21 are eligible for the Independent Living Program (ILP), also referred to as Arizona Young Adult Program (YAP). The ILP/YAP is available to young adults who are either currently involved in state/tribal foster care services or who are adopted after their 16th birthdays. Although the ILP/YAP offers specialized services and training in basic life skills, youth without mentorship are often unable to benefit fully from them. A presentation delivered by an individual who aged out of the CPS system stated that it is common for youth to express a desire to reconnect with relatives. Panel members concurred it is imperative that youth who are leaving care have established relationships with adults and mentors who can help them build capacity for resiliency, stability, and self-sufficiency.

There are many factors which can impact the ability to maintain children in their original placements and minimize disruptions while in CPS custody. Panel members observed that the trauma of repeated moves often occurred when children's needs exceeded the skillsets of their caregivers and when needed services and supports, especially behavioral health services, were inadequate, delayed, or not available. The cases involving children in out of home care revealed that foster parents are often left trying to deal with unmanageable situations utilizing limited resources, and that complex mental health issues, behavior problems, or health issues often foretell a struggle to maintain placements. Foster parent and mental health panel representatives collectively shared it was not uncommon for a child or youth's past trauma to surface at a later time. Visitation between the child(ren) and the parent(s) also can result in emotional outbursts and acting out behavior. Although the caregivers understood the CPS Specialist was obligated to arrange visitation between parents, children, and siblings, caregivers reported children's behavior sometimes deteriorates or escalates to a point the caregiver cannot handle them. Foster parent representatives from all three panels stated they often lack the capacity to provide children the attention they deserve because they are also caring for other children in their home, and there is no additional support, training, or respite services from foster care licensing agencies, especially age-appropriate training tied to children's developmental stages.

Another finding compounding the pressure for the child and caregiver is a licensing, payment, and placement structure that causes disruption when a specialized placement is required to meet a child's needs. Once the child or youth no longer meets the criteria of specialized care, they are moved to another placement which is less restrictive due to a systemic funding structure. In two of the cases reviewed, children under the age of 10 experienced as many as 13 different placement disruptions.

The panel found that there is a shortage of foster homes for youth who are age 12 years or older due to foster parent preferences and common beliefs about potential problems and behaviors of this age group. Panel members found the poor performance of advocates for youth and other youth in the child welfare system in the absence of parents, to be a cause of excessive disruptions. One panel member stated, "The definition for advocacy is to promote an in-depth analysis of the youth's needs and situation. Advocacy is promoting what is best for the child to help them succeed in life and not accepting this is the best we have for now."

4

System building and high level relationships between agencies and stakeholders is required to address the complex needs of families.

Collaboration between system partners is necessary to provide the correct services and supports to children and their families. Panel members have identified chronic child neglect, an enduring pattern of a child's basic physical, developmental, and socio-emotional needs regularly unmet, as one of the most persistent and difficult challenges facing the child welfare system. The case reviews revealed, as they have in past reviews, that these families may be able to fix the problem that initially brought them to the attention of CPS, but over time, the issues resurface and lead to another crisis situation. Panel members were concerned that the children in these families suffer long term negative outcomes that impact their successful transition to adulthood and their own parenting. Panel members found that the continuum of services for these families is limited and lacks focus on the presenting problem. The panel members also found comprehensive services were lacking and existing services are unable to maintain long term change in these families. Panel members recognized that a common challenge in referring families to community services is limited availability of free services, transportation issues, and inability to follow through in programs because the parent can't maneuver through the system.

According to information noted in the Child Welfare Reporting Requirements semi-annual report, over 67% of reports were allegations of neglect; not abuse. Panel members observed that it would be helpful to have a hierarchy of responses for cases that would allow some of these reports to be handled locally through contracted community services.

In case reviews involving multiple reports over many years, children were observed to have increasing developmental, educational, emotional, and behavioral problems as time went on and CPS reports continued. Intervention during investigations was limited to the presenting problem while the underlying problems in the family and presenting problems in the children went untreated. Panel members found services and supports both pre- and post- CPS involvement were not available or provided. Panel members thought if there were more services and supports available to these families in earlier stages, perhaps some of the issues could have been averted or mitigated before they escalated and caused additional CPS reports. Panel members found once the CPS case was closed, very little was done to ensure ongoing support for the family in the community, which may have also helped.

Findings from Quarterly Meetings (cont'd)

Cases involving chronic neglect or identified as having low to moderate risk factors were rarely offered the types of services that would alleviate some of their stress and deteriorating circumstances. Several cases involved ongoing neglect (medical and dental), but the maltreatment did not rise to the level of removal. Community services were recommended but there was limited follow through, and the cases were closed. The panel members felt these were missed opportunities to involve and connect families to community services versus waiting until families were in crisis. The lack of collaboration between agencies, creates gaps in resources for families who do not reach the threshold of having their child(ren) removed. In all of the 13 case reviews, other system partners were also involved with the families; these included the mental health system, adult and juvenile court, school system, medical providers, and Division of Developmental Disabilities. Panel members observed very little documentation of communication between CPS and these partners, making it difficult to determine whether service coordination was taking place.

Risk Factors Observed in the Case Reviews

Each year, as part of the case reviews, risk factors are identified and gathered. The following is a tabulation of the more common risk factors found across all 13 cases. Panel members observed that the number of risk factors identified in individual case reviews reflected the complexity of problems found in the families reported to CPS. It also underscores the need for services and supports that need to be coordinated.

Parent, guardian, or custodian risk factors that would tend to decrease the ability to provide adequate care for children.

domestic violence	9
history of abuse/neglect as a child	9
lack of parenting skills	7
mental health	7
lack of paternal involvement	6
lack of motivation to provide adequate care	5
intellectual or physical impairments	5
history of violence non-family	4
incarcerated parent	2
failure to protect	2
co-sleeping with infant	2
motivation to change and cooperate	1
substance abuse	1
teen parent	0

Family risk factors that would decrease the ability of the family to care for children.

lack of resources for adequate care food/shelter/medical/child care	6
unresolved grief/loss	1
lack of family/social support system	0
family stressors/chaotic household	0

Prior CPS involvement

prior to the most recent report	10
prior substantiated reports	9
prior removals or severances by CPS	4

Child-level risk factors identified that would tend to increase the risk of the child becoming a victim of maltreatment.

developmental	8
emotional/behavioral	8
special medical needs	7
child alcohol or drug abuse	3

Citizen Review Panel Members by Region

Central Region

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Andrew Marioni
Division of Child Safety and Family Services

Beth Rosenberg
Children's Action Alliance

Emilio Gonzales
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Merri Tiseth
AZ Coalition Against Domestic Violence

Pamela Fitzgerald
Citizen/Former Teacher

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ASU Student Participants
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We are looking to add to our CRP volunteers and are specifically in need of representation from parents, adults with personal experience with the child welfare system, juvenile justice personnel, military personnel, foster and adoptive parents and tribal members. For more information on the Arizona Citizen Review Panel Program, visit https://cabhp.asu.edu or contact:

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- Apache
- Coconino
- La Paz
- Mohave
- Navajo
- Yavapai
- Yuma

Central Panel
- Maricopa

Southern Panel
- Cochise
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- Gila
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