Arizona Department of Child Safety

Title IV-E Waiver Demonstration Project

Fourth Quarterly Report

January 11, 2016

State of Arizona
Arizona Department of Child Safety
3003 N. Central Avenue
Site Code CH010-23B
Phoenix, AZ 85012
(602) 255-2500
www.dcs.az.gov

I. Overview

The overview should include a short introduction to the waiver demonstration that summarizes the problem(s) the title IV-E agency is attempting to address, the target population(s), and the project's intervention(s). Depending on the scope of the waiver demonstration, title IV-E agency projects may have one intervention or several.

In addition, the overview should articulate the waiver demonstration's overall theory of change, including the expected short-term and long-term outcomes of the project and how and why the waiver demonstration interventions are expected to address the identified needs of the target population(s). The theory of change provides an opportunity to tell a concise story of how the title IV-E agency is defining the problem(s) it hopes to address, outline the demonstration's intended outcomes, and explain how the demonstration's intervention(s) will address these problems and achieve the intended outcomes.

More importantly, the theory of change should demonstrate the series of connections that link the problems and needs being addressed with the actions the title IV-E agency will take to achieve desired outcomes. This overview might include an outcomes chain that consists of a series of "if-then" or "so that" statements that address the logical results of an action and illustrate the conceptual linkages between the identified problems and potential solutions. An example of an outcomes chain for one component of a hypothetical waiver demonstration is provided below:

Intervention: We implement standardized trauma-informed child assessments:

So That

Case managers have increased knowledge and awareness of the emotional and developmental needs of child welfare-involved children

So That

1) Case managers refer children and families to appropriate trauma-focused behavioral health treatments

and

2) Child welfare agencies make better decisions regarding the allocation of resources to provide behavioral health treatments

So That

1) Children have improved emotional health

and

2) Caregivers have improved coping and parenting skills

So That

1) Children are safe from future abuse and neglect

and

2) Children avoid out-of-home placement

Note in this example that it is possible to have more than one outcome associated with each "link" in the chain. It may be helpful to develop separate, more detailed outcomes chains for each major demonstration component, along with a main chain that articulates the theory of change for the waiver demonstration as a whole. As with the IDIR itself, outcomes chains should be revisited and adapted as necessary as the title IV-E agency's understanding of the waiver demonstration evolves and the linkages between discrete interventions and desired outcomes are refined.

Sharing the theory about why a program or intervention is proposed to work will be a worthwhile activity as the first step in the waiver demonstration's initial design and implementation because it provides all stakeholders with a chance to understand one another's thinking and to clearly identify what outcomes the title IV-E agency will be using to measure its success.

The Children's Bureau (CB) welcomes drafts of this section and is able to facilitate the provision of technical assistance to support a title IV-E agency in its theory of change development. The title IV-E agency may want to consider submitting its theory of change to CB for review and discussion in advance of developing the remaining sections of the IDIR.

Arizona's Title IV-E waiver demonstration project will seek to reduce length of stay in congregate care settings, and length of stay in out-of-home care overall, for children who are placed in congregate care settings at the start of the demonstration or who enter congregate care during the demonstration. To do so, the Arizona Department of Child Safety (DCS or the Department) will improve engagement with these children and their families by enhancing family/fictive kin search and engagement activities and by expanding its Team Decision-Making (TDM) process to target this population. In addition, Arizona will support the action plans created in partnership with the family/fictive kin by enhancing the availability of in-home reunification, placement stabilization or other needed services. Recognizing congregate care can be an important time-limited therapeutic service for some children, the intention of the demonstration project intervention is to reintegrate children into a family setting as soon as appropriate. In consideration of each child's safety and well-being, this may include reunification with a parent, placement with kin or fictive kin, or placement with a licensed foster family. Arizona will present in this Initial Design and Implementation Report (IDIR) the reasons for focusing on congregate care and for selecting these target interventions.

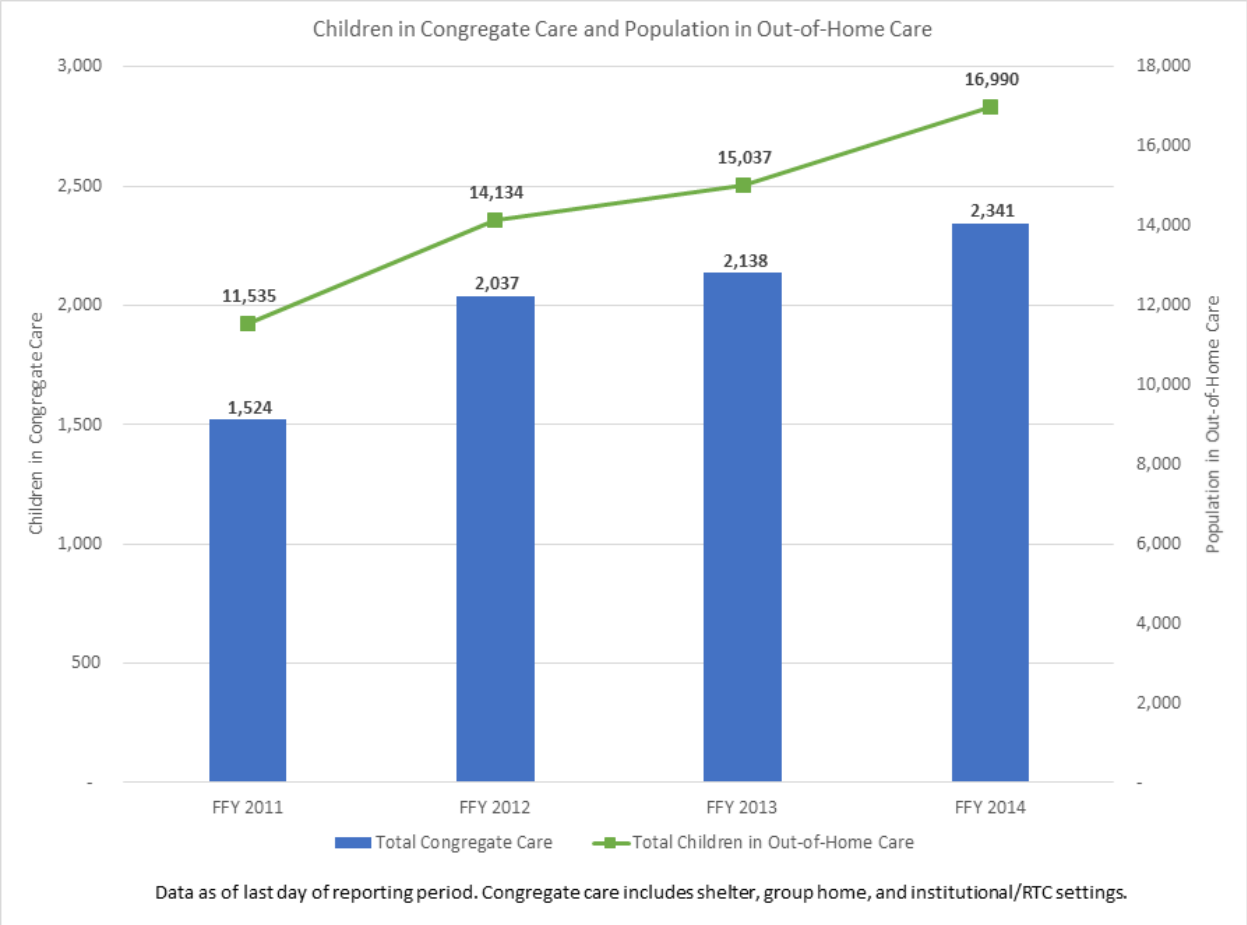
Why Congregate Care?

Arizona experienced a 47 percent increase in the number of children in out-of-home care from federal fiscal year (FFY) 2011 (11,535) through FFY 2014 (16,990). Although the percentage of children placed in congregate care in Arizona was the same as the national percentage in 2013[1], the increase in total care days of congregate care has caused substantial increases in the total cost of out-of-home care. As shown in Figure 1 using data from DCS' Statewide Out-of-Home Care report, the number of children placed in congregate care has increased over the last four years. The large number of children served in congregate care caused DCS to identify reduction in

[1] The Annie E. Casey (2015). *Every Kid Needs a Family: Giving Children in the Child Welfare System the Best Chance for Success.* Baltimore, MD. Retrieved from: http://www.aecf.org/resources/every-kid-needs-a-family/

congregate care as the problem to address for the waiver demonstration project. DCS is working to more quickly identify foster or kinship homes for children placed in out-of-home care. Often times, there are other placement options available, but they are not being identified early on in the child's custody episode.

Figure 1: Children in Congregate Care and Population in Out-of-Home Care



As noted in the graph, and for the purposes of the Title IV-E waiver demonstration project, congregate care placement types are defined as: emergency shelters, group homes, and institutional/residential treatment centers (RTCs), which includes behavioral health, juvenile justice, or medical type placements.

These types of restrictive placements do not create a family-like experience where children thrive and are most successful. Over 90 percent of children living with foster parents report that they "like who they are living with" and "feel like part of the family." Those children placed in congregate care type placements report the lowest rate of positive experiences. Congregate care placements often leave children without a family-like setting, which is imperative for a child's healthy brain and social development throughout life. In addition, children placed in congregate

care placements were more likely to test below children placed in a family-like placement setting, to drop out of high school, and less likely to graduate from high school.[2]

Another important consideration is the cost to Arizona of having such a large number of children in congregate care. The average monthly cost of congregate care increased from $3,429,605 in FFY 2009 to $6,856,877 in FFY 2014. The cost of group placement is roughly seven to ten times the cost of placing a child in a family-type setting.[3] With the extremely high cost of care per day in congregate care facilities, preventing or shortening these placements will create large cost savings that can fund earlier intervention and prevention efforts.

Understanding the Problem

Prior to submitting the Second Quarterly Report in May 2015, Arizona gathered and analyzed data to gain a deeper understanding of the reasons for congregate care use in Arizona and the characteristics of children placed in congregate care. This included:

- A review of data from Arizona's statewide information system (CHILDS) on the characteristics of children, such as the age, ethnicity, gender, length of stay, and number of prior placements;
- A review of Arizona's statewide qualitative case review results, which include findings that child and family engagement in case plan development, case worker contacts with parents, and comprehensive kinship search are areas for improvement in Arizona's child welfare system;
- A case record review conducted by Arizona's contracted evaluator, Arizona State University (ASU), of 17 cases of children with congregate care placement histories; and
- Focus groups to explore the needs of the congregate care population: five with DCS staff, eleven with children in care, two with statewide congregate care providers, and five with DCS involved parents.

The focus groups were especially informative about the needs of the children and families in the target population, and helpful toward identifying potential interventions and refining the theory of change. One major finding across all of the focus groups was that Arizona can, and should, do more to improve family engagement throughout a family's involvement with DCS, including engaging with the family to identify safety plans and services that would allow the children to reunify with their parents, and to gather thorough information about relatives and fictive kin as potential placement resources. Results of these focus groups are detailed in Section II.

Analysis of the focus groups, case review, and administrative data revealed that the majority of children placed in congregate care do not have behavioral health or other special needs that are distinct from other children served in out-of-home care. The information has consistently indicated that Arizona is over-utilizing congregate care for children where placement in such

[2] The Annie E. Casey (2015). *Every Kid Needs a Family: Giving Children in the Child Welfare System the Best Chance for Success.* Baltimore, MD. Retrieved from: http://www.aecf.org/resources/every-kid-needs-a-family/

[3] Wiegmann, W., Putnam-Hornstein, E., Barrat, V. X., Magruder, J., & Needell, B. (2014). *The invisible achievement gap, part 2: How the foster care experiences of California public school students are associated with their education outcomes*. Cited in State of California, Department of Social Services. (2015). *California's child welfare continuum of care reform* (p. 10, ref. 2). Sacramento, CA: Author. To retrieve a copy of reference 2, visit www.stuartfoundation.org/docs/default-document-library/IAGpart2.pdf?sfvrsn=4

restrictive environments is not necessary due to behavioral, medical, or juvenile justice requirements.

The Department's conclusions from this analysis are consistent with the 2014 report from the Arizona Office of the Auditor General, which attributes the increase in congregate care utilization to an inadequate supply of foster homes, inadequate access to evidence based practices, and Department practices, such as inadequate permanency planning.[4] This report also includes recommendations for DCS to reduce congregate care use, stating:

> "The Department should continue to assess what actions it can take to reduce the number of children entering out-of-home care, and develop and implement a comprehensive approach to reduce the use of congregate care. In doing so, the Department should consider various strategies, such as those used in other jurisdictions, and the reasons for the increased use of congregate care in Arizona."[5]

Research Solutions

In the months prior to the submission of the Second Quarterly Report, Arizona researched best practices of other states that have experienced success in congregate care reduction. Arizona gathered information from 27 states that have engaged in initiatives to reduce their congregate care populations. In addition to information publicly available, DCS staff communicated directly with staff in six states to gather additional information about program design and implementation, policy changes, engagement work that contributed to the state's initiative and any lessons learned.

Arizona sought advice from Casey Family Programs, specifically with staff members who have previously worked with states that have successfully reduced their congregate care usage, in order to identify states to research or contact. Arizona also engaged with its partners at Public Consulting Group, Inc. (PCG) to identify states with attempted and/or successful congregate care reduction initiatives.

DCS also conducted a literature review of more than 50 source documents, and identified seven common intervention themes that were found in initiatives across the country: 1) Family Engagement; 2) Trauma Informed Care; 3) Community Engagement; 4) Standardized Assessments; 5) Contracts and Performance Management; 6) Policy and Practice; and 7) Alternative Placements and Supports. From these identified themes, DCS then organized the interventions based on the following criteria: 1) Purpose of Service/Description; 2) Goal of Service; 3) Target Population; 4) Frequency/Duration of Service; 5) Known Cost Information; 6) Evidence-Based Practice Rating (as rated by the California Evidence-Based Clearinghouse for Child Welfare); and 7) Congregate Care Pathway Targeted.

Select Interventions and the Target Population

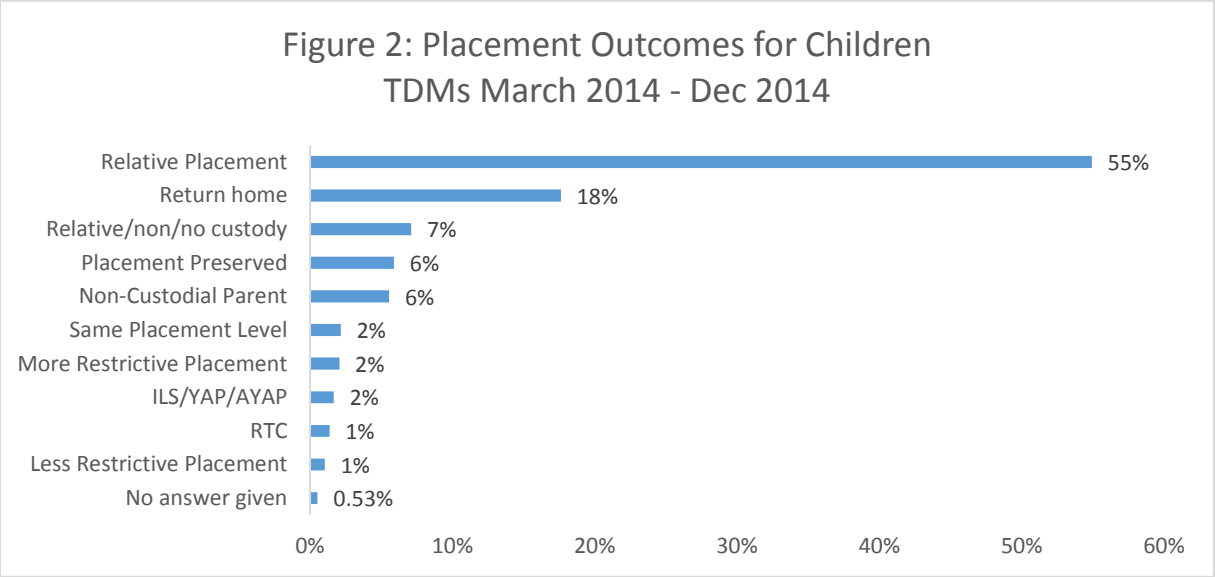
Arizona considered the information gathered through the data analysis and best practice research to narrow the list of potential interventions. Initially, the Department proposed Motivational Interviewing, peer parent support, and trauma-informed therapies as the demonstration project

[4] Arizona Office of the Auditor General (2014)
[5] Arizona Office of the Auditor General (2014)

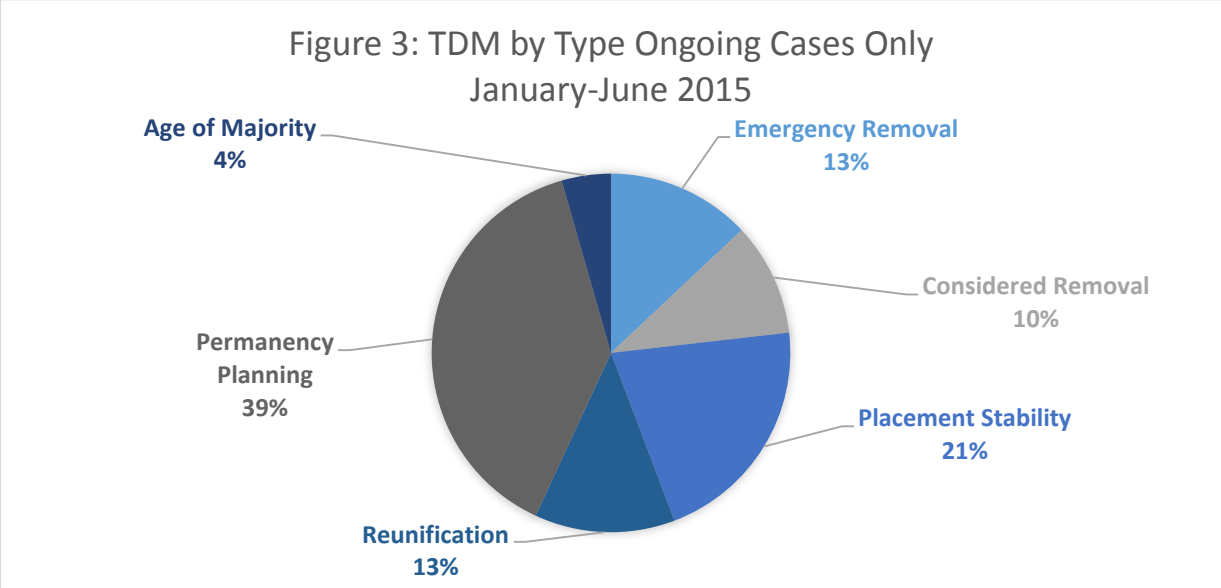
interventions. Following the May 2015 quarterly report, the Department continued to examine the viability of the proposed interventions and considered input from the Children's Bureau, Department employees, and community partners. In early August 2015, the Department engaged with Department staff, the Children's Bureau, James Bell Associates, and the National Capacity Building Center for States to vet the initially proposed and additional interventions being considered. DCS understands that the most effective waiver interventions are those that align with efforts already underway; are realistic given the timeframe and requirements for cost neutrality; will achieve agency, family, and stakeholder buy-in; and will build agency and community capacity for sustainable change. Through this process, Arizona selected the intervention of expanding the TDM process to target children in congregate care, together with providing family/fictive kin search and engagement activities and enhancing the availability of in-home reunification, placement stabilization or other needed services (will be referred to as the waiver intervention throughout the report).

The selected intervention is supported by the Department's analysis of the target problem and the characteristics of children in congregate care, has community and agency support, and can be developed more quickly and less expensively by expanding upon the existing Department programs and contracts that are not currently targeting children in congregate care. In addition, the intervention approach fully aligns both with the Department's strategic plan for SFY 2016 that was released in July 2015, and the Department's forthcoming practice model. Further development of the practice model and will take place in 2016. Following the development of the systematic foundations of the practice model, the Department will outline a plan to embed the model as standard practice. The previously proposed interventions continue as tactics within the Department's strategic plan. The Department will continue to support the current development and expansion of Motivational Interviewing, peer parent support programs, and trauma-informed therapies within the behavioral health system. In addition, the Department will develop DCS employee knowledge about the effects of trauma, trauma informed care, Motivational Interviewing, and when and how to access peer parent support and trauma-informed therapy services.

Between March 1, 2014 and December 31, 2014 Arizona held 5,409 Team Decision Making meetings of which 81 percent were *Emergency TDMs* or *Considered Removal TDM*s. Even though most TDMs during this time period were held during the emergency removal or considered removal phase of a case, the placement outcomes support the application of TDMs to reduce the use of congregate care because the majority of children were placed with a relative or returned home (Figure 2).



Arizona plans to use this demonstration project to increase TDMs that focus on children and youth already in congregate care through the development of a TDM type called *Life Long Connections TDM* that is a blend of *Placement Stability*, *Permanency Planning/Reunification*, and *Age of Majority TDM* types. Looking at a subset of only ongoing cases that receive TDM reveals that, although fewer TDMs are occurring for ongoing cases than new investigations, they are more likely to be *Placement Stability*, *Permanency Planning*, or *Reunification TDM* types (Figure 3) than other types.



The Department has selected a target population of children who are in congregate care settings at the start of the demonstration project or who are placed in congregate care during the demonstration project, excluding children in residential treatment, hospitals, or correctional facilities due to medical, juvenile justice, or behavioral health needs. The Department's analysis

found that children are often placed in congregate care settings due to lack of less restrictive placement options rather than due to therapeutic or medical needs that warrant such care. The tendency has been that once children are placed in congregate care, overburdened DCS Specialists' lack of time to work on cases, and parents' lack of understanding of the child welfare agency coupled with their perceived inability to positively affect it, have resulted in further delays making timely reunification less likely. There is evidence that the Department can improve outcomes for children and achieve cost savings by targeting these children with the selected interventions.

Develop Hypothesis

It is hypothesized that through the waiver intervention, the following outcomes will be achieved:

Short Term	Long Term
• Increased number of family/fictive kin available • Improved engagement and connections fostered to support the children • Enhanced involvement of family/ fictive kin in decision making • Expedited identification of needs and strengths for children/family • Increased children and family/fictive kin supports through natural and in-home services	• Increased percentage of children in congregate care settings who are placed in family settings • Decreased length of stay in congregate care • Increased rates of exit from congregate care • Increased reunification and legal permanency • Improved stability with life-long supports and connections • Improved child social/emotional well-being

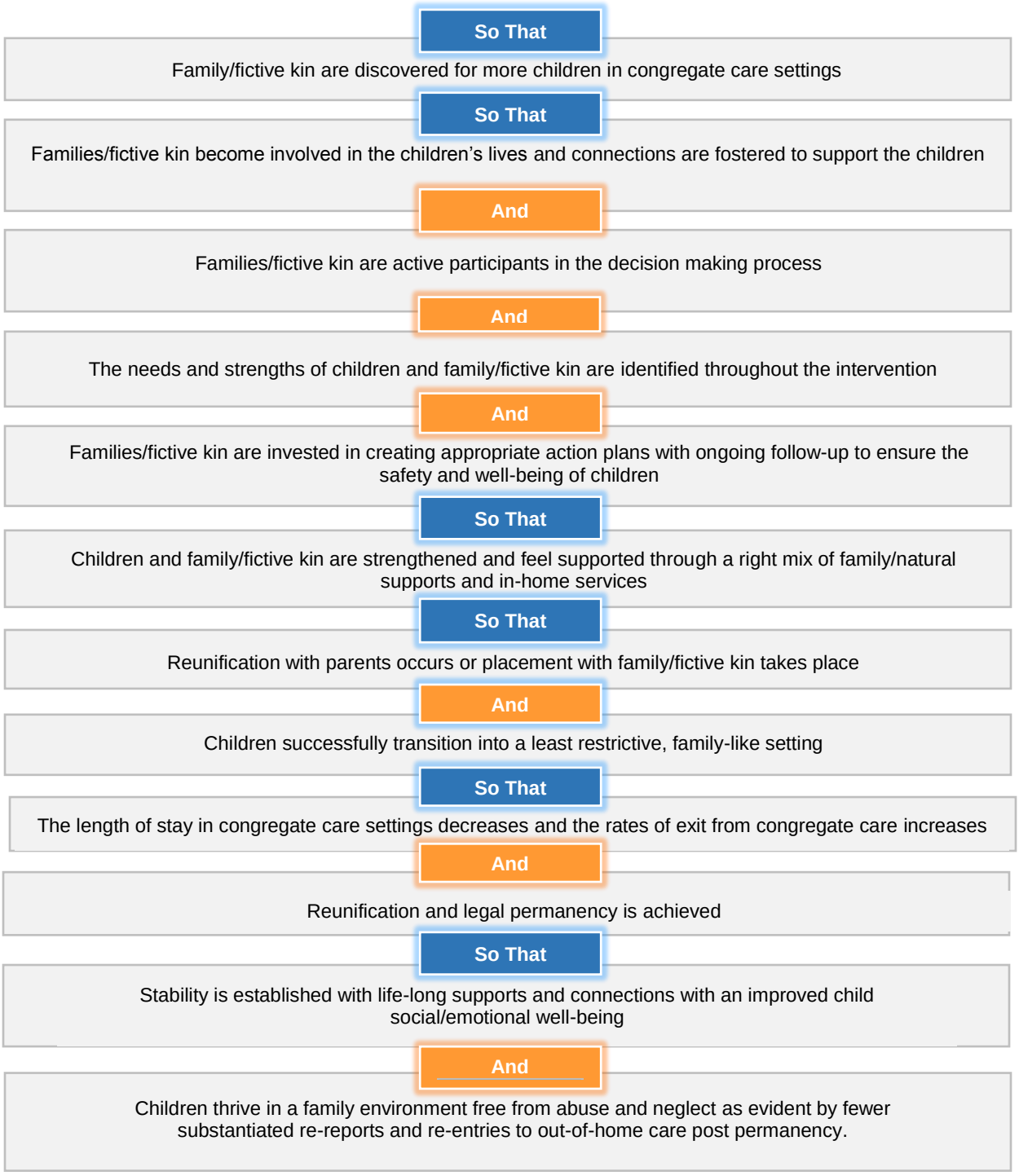
Outline Theory of Change

The Arizona TDM model is a collaborative, strength-based meeting of a team comprised of a DCS Specialist, a TDM Facilitator, family members, the child (if age appropriate), and other key stakeholders in the child's life, to provide input and develop action plans that can end unnecessary out-of-home placements, expedite reunification for those in out-of-home care, and ensure children's permanency, safety, and well-being. It is hypothesized that the waiver intervention will result in better safety, permanency, and well-being outcomes for the target population of children and families.

The theory of change is as follows:

Intervention: Improve engagement with children in the congregate care setting and their families through

1. DCS Family Engagement Specialists, in collaboration with the DCS Specialists, performing family/fictive kin search and engagement activities;
2. TDM Facilitators conducting TDM meetings to identify needs/strengths and develop action plans in partnership with the family/fictive kin; and
3. Providing in-home reunification, placement stabilization or other identified services when needed:



Completed and Next Steps

Arizona has used implementation science to select the intervention and target population. The progress and plan for each phase of implementation is shown in summary in the chart below, and explained in detail throughout this IDIR:

Completed Tasks	In Progress Tasks	Next Steps
✓ CHILDS data review ✓ Case record review ✓ Conducted focus groups for DCS staff, providers, youth and parents ✓ Researched states' best practices ✓ Reviewed similar/ current initiatives ✓ Selected and defined the intervention and process flow ✓ Develop hypothesis and updated theory of change ✓ Team Decision Making (TDM) data review ✓ Review In-Home Services Program performance data ✓ Conducted survey and focus groups with DCS Specialists, TDM Facilitators, and in-home services and congregate care providers ✓ Completed cost analysis on intervention ✓ Reconvened the Waiver Implementation Team ✓ Determined criteria for selecting initial office sites for implementation ✓ Create Communication Committee	○ Develop an Evaluation Plan ○ Develop a logic model ○ Update policy and practice materials for intervention model ○ Develop initial roll out plan for implementation ○ Select initial implementation sites ○ Develop intervention referral criteria	○ Develop initial based site implementation teams ○ Create communication plan for internal/external partners ○ Provide readiness activities for initial implementation sites ○ Develop training curriculum with coaching plans ○ Create training schedule and provide training ○ Roll out implementation to initial sites and monitor activities ○ Develop assessment to measure initial implementation ○ Develop implementation phase-in plan

In the last quarter, Arizona has defined the specific intervention design and process flow that will be implemented under the demonstration project. Further research was conducted, including a survey and focus groups with DCS Specialists, TDM Facilitators, and in-home services and

congregate care providers to understand the barriers, gaps, and possible solutions around family/kin search practices, the current TDM process, and in-home services array. How the current in-home services array can be enhanced through improved communication, coordination, and contract expansion (if needed) was explored. Additionally, Arizona researched the Family Finding kinship search methods and compared the results to current practice in Arizona. These activities assisted Arizona to further define the intervention model. Strategies through the intervention model will provide options for reintegrating children into family settings safely as soon as appropriate, as well as achieving legal permanency for children in congregate care.

A cost analysis on the intervention model was completed during this past quarter. Furthermore, the Waiver Implementation Team who is overseeing the design, readiness assessment, and implementation actions reconvened in October 2015. The team is charged with ensuring the major activities required to install and implement the waiver intervention are completed in order to maximize success. One major action item completed, was determining the criteria for selecting the initial office sites for implementation. This will assist Arizona to develop an initial roll out plan for implementation during the next quarter, as well as the creation of the initial site implementation teams. The criterion is detailed further in the report under section *IV - Assessing Readiness to Implement the Demonstration*.

Since the intervention model has been finalized, Arizona has started working with the evaluation partners at ASU to create and design the evaluation plan which includes evaluation design, process, outcome, and cost analysis components for the demonstration project. The Interagency Service Agreement (ISA) with ASU to conduct the evaluation of the demonstration project was signed on April 15, 2015. ASU and DCS will collaborate to develop an evaluation plan for the demonstration project due 90 days prior to the proposed implementation date of April 1, 2016. ASU has attended meetings with the Department to understand the intervention process and highlight areas of consideration in respect to the evaluation. ASU will be conducting an evaluation with a longitudinal, comparison design to examine changes in safety, permanency and well-being outcomes. There has been discussion about developing comparison groups using retrospective case matching techniques including propensity score matching. ASU has encouraged the use of the largest sample size available for the evaluation. Further details regarding the evaluation will be outlined in the Evaluation Plan.

II. Clearly Defined Target Population(s)

Section II should describe the target population(s) for <u>each</u> of the demonstration's interventions, noting exclusions, geography/locations, or eligibility criteria as appropriate. The target population(s) should reflect the group(s) of children and/or families whose safety, permanency, and well-being outcomes the title IV-E agency intends to impact through the waiver demonstration. In this section, the plan should:

A. Describe the characteristics and needs of the identified target population(s).

- ***Characteristics are generally related to demographics or past experiences that are not readily changeable (e.g., age, race, ethnicity, or placement history).***
- ***The needs define the circumstances and conditions that are amenable to change (e.g., difficulty dealing with past and present trauma, loss of connection to family members, lack of parental skills and abilities to manage behavior).***

Some helpful data sources for defining the target population may include the title IV-E agency's administrative data, quality assurance data, Court Improvement Program data, targeted case reviews, surveys, focus groups, and stakeholder feedback. Title IV-E agencies may also wish to partner with their evaluator (if currently under contract) or other university partners to engage in the "data mining" activities that will yield a comprehensive understanding of the waiver demonstration's target population(s).

Developed description of a target population:

The target population for this project is children ages 0-18 who are in congregate care or at risk of entering congregate care. Approximately 70% of those in congregate care are over the age of 14; 80% have four or more placements; 53% are African American, 29% Hispanic, 4% Native American, and 19% white. As defined by State statute, children in or at risk of entering congregate care exhibit one or more of the following behaviors: fire setting, sexual acting out, harm to self/others, untreated substance abuse, and hallucinations. In 2011, of all children in congregate care settings, in the most recent six month period 45% reported a history of school expulsions, 64% expressed suicidal ideation, and 32% attempted suicide. The reason for referral for 68% of these cases was neglect, 23% physical abuse, 5% sexual abuse, and 35% Child In Need of Services.

Undeveloped description of a target population:

The target population for this project is all children statewide ages 0-18 who are in care, at risk of entering care, or have recently exited care. 52% are male and 48% are female; and African American children are disproportionately represented in the foster care population.

B. Provide an estimate of the number of children/families who will initially be enrolled in the demonstration.

The "Target Population Template" is available to assist title IV-E agencies in thinking through the above elements. The template is not a required deliverable but instead is provided as a resource to support the development of this section of the IDIR.

The waiver intervention will be provided to families with children ages birth to 18 years of age who are currently placed in congregate care, or who enter congregate care during the period of the waiver, but who do not require behavioral health, juvenile justice, or medical placements for their safety. Individuals that require behavioral health, juvenile justice, or medical placements are grouped together under the behavioral health congregate care placement type category. This category (that represents three percent of the overall out-of-home care population upon first placement and two percent upon second placement) will be excluded from the target population.

Characteristics of Arizona's Congregate Care Population

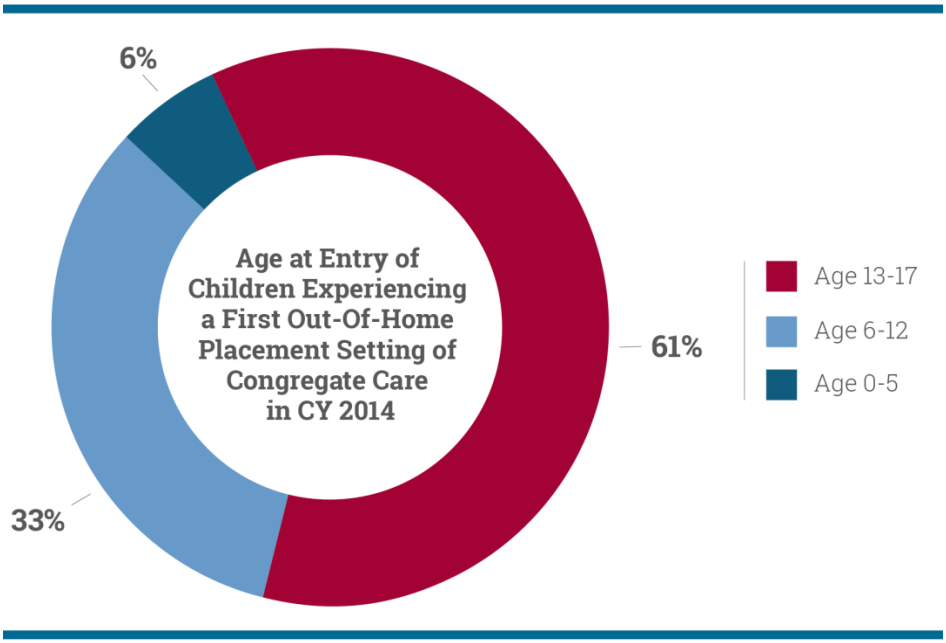
On July 1, 2015, there were 2,260 children and youth in the custody of the Department and placed in congregate care (defined as shelter, group home, or behavioral health group care). Of all children who entered out-of-home care in calendar year (CY) 2014, there were 2,444 (19 percent) initially placed in a congregate care setting. DCS has examined data on children placed in congregate care as of July 1, 2015, as well as cohorts of children and youth who entered care in CY 2013 and 2014, in order to learn the characteristics of the target population as a whole. Based on DCS' data review, results of staff and youth focus groups, and case reviews conducted since October 1, 2014, Arizona has determined that the congregate care population exhibits the characteristics described in the remainder of this section.

Arizona's large urban counties – Maricopa, Pima, and Pinal – encompassed 95 percent of children in congregate care as of July 1, 2015, with the remaining five percent of children in congregate care spread across the state's 12 rural counties.

Children in congregate care are most likely to be ages 13 through 17. As referenced in Figure 4 on the following page, children ages 13 to 17 make up the largest portion of children who were initially placed in congregate care upon entering out-of-home care in CY 2014, and constitute a still greater portion of the congregate care population on July 1, 2015. Of all children who entered care in CY 2014 and were initially placed in congregate care, 47 percent were ages 13 to 17.[6] Twenty percent were ages birth to five, and the remaining 33 percent were ages six to 12. As of July 1, 2015, youth ages 13 to 17 made up 61 percent of the total congregate care population.

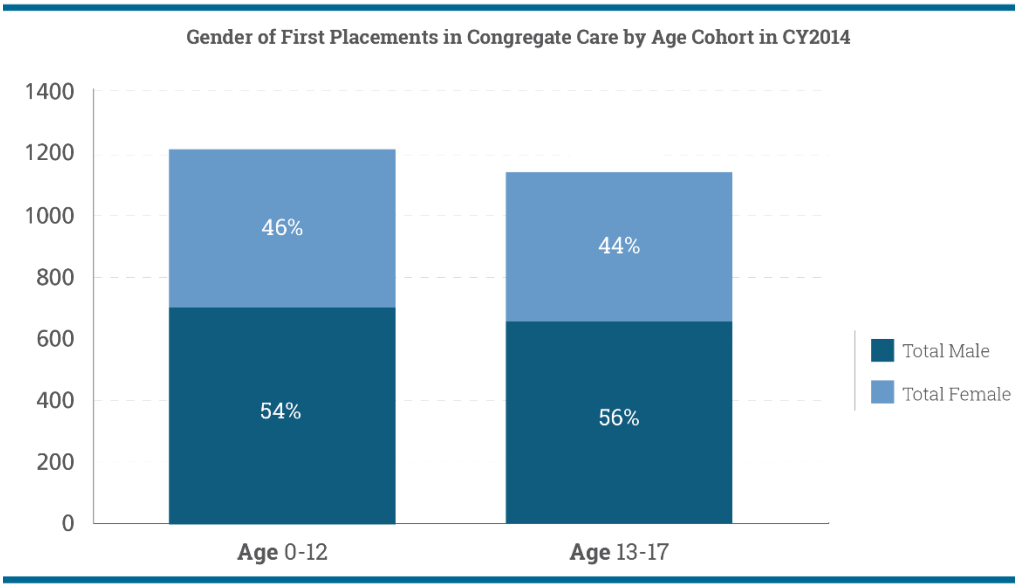
[6] The notation "*N*", when capitalized, refers to the total number of children or youth in the population being described. The notation "*n*", when lowercased, refers to the number of children in the sub-population of the sample being described.

Figure 4: Age at Entry of Children Experiencing a First Out-Of-Home Placement Setting of Congregate Care in CY 2014



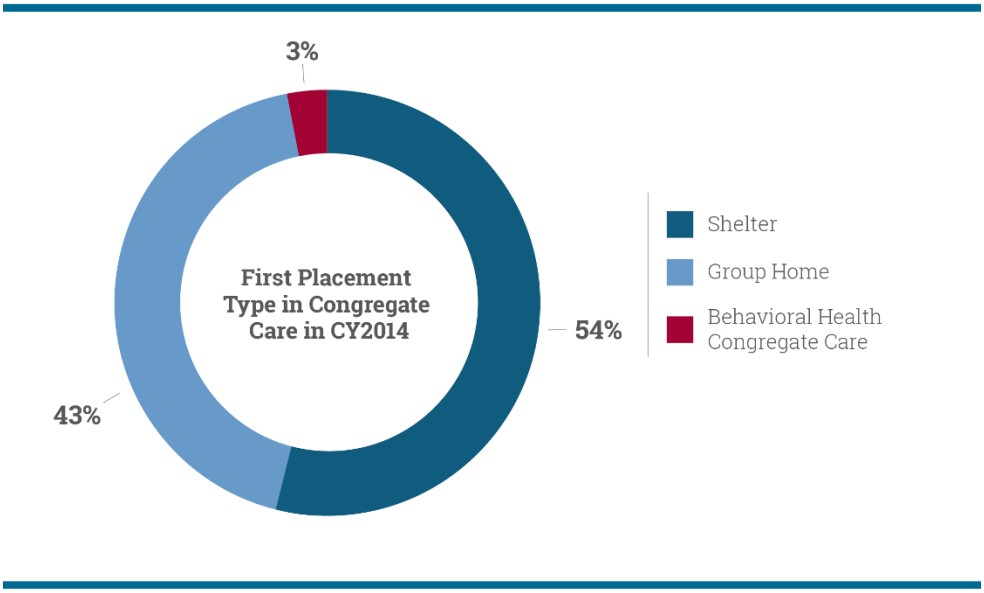
Children in congregate care are more likely to be male than female. Of children who entered care in CY 2014 and were initially placed in congregate care, 55 percent were male and 45 percent were female. As illustrated in Figure 5, this gender split holds generally true across the three age cohorts, with male children making up 54 percent of children ages birth to 12, and 56 percent of children ages 13 to 17.

Figure 5: Gender of First Placements in Congregate Care by Age Cohort in CY 2014



Children who are initially placed into congregate care upon removal are most likely to be placed in a group home and are unlikely to be placed in a behavioral health congregate care setting. Figure 6 indicates, of the 2,444 children who entered out-of-home care in CY 2014 and were initially placed in congregate care, 54 percent were placed in a shelter, 43 percent were placed in a group home, and the remaining three percent were placed in a behavioral health congregate care setting.[7] The fact that shelter and group homes comprise 97 percent of initial placements into congregate care suggests that these placements are not made because of the child's needs. Rather, this data suggests a lack of foster or kin care options, or an insufficient process to identify foster or kinship placements immediately upon a child's removal.

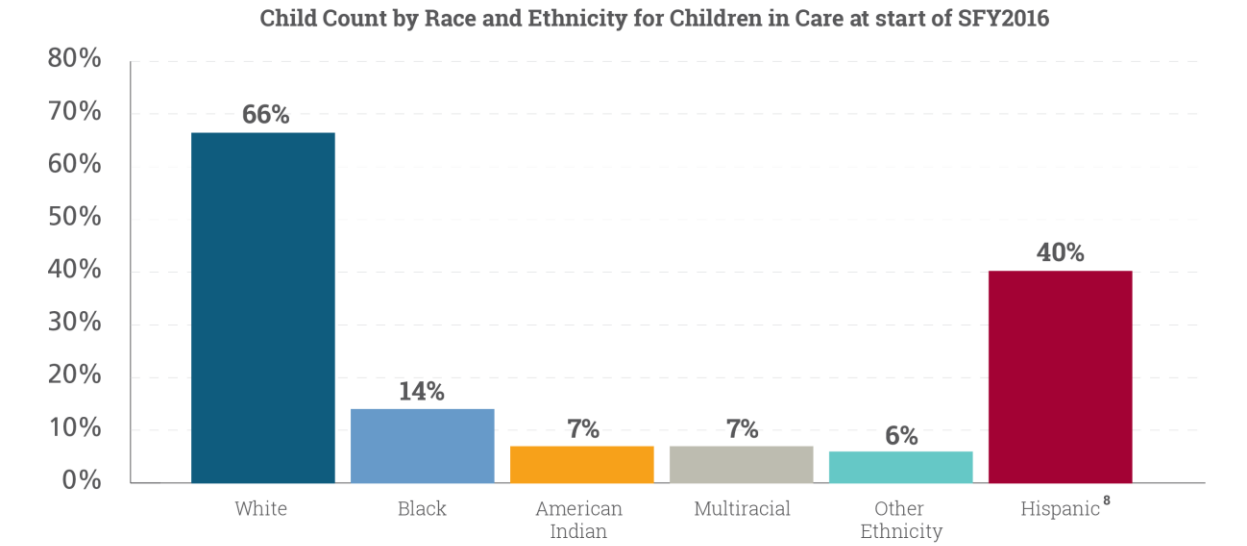
Figure 6: First Placement Type in Congregate Care in CY 2014



Nearly seven of every ten children in congregate care are white, but black children are overrepresented compared to the general out-of-home care population. Figure 7 on the next page illustrates that, of the 2,260 children in congregate care on July 1, 2015, 66 percent were identified as white, 14 percent as black, seven percent as American Indian, seven percent as multiracial, and six percent as other ethnicity. Forty percent of children were also identified as Hispanic in addition to either white, black, American Indian, multiracial, or other.[8] Compared to the population of black children in the general child population statewide (4.1 percent[9]), black children are overrepresented as a percentage of children in congregate care.

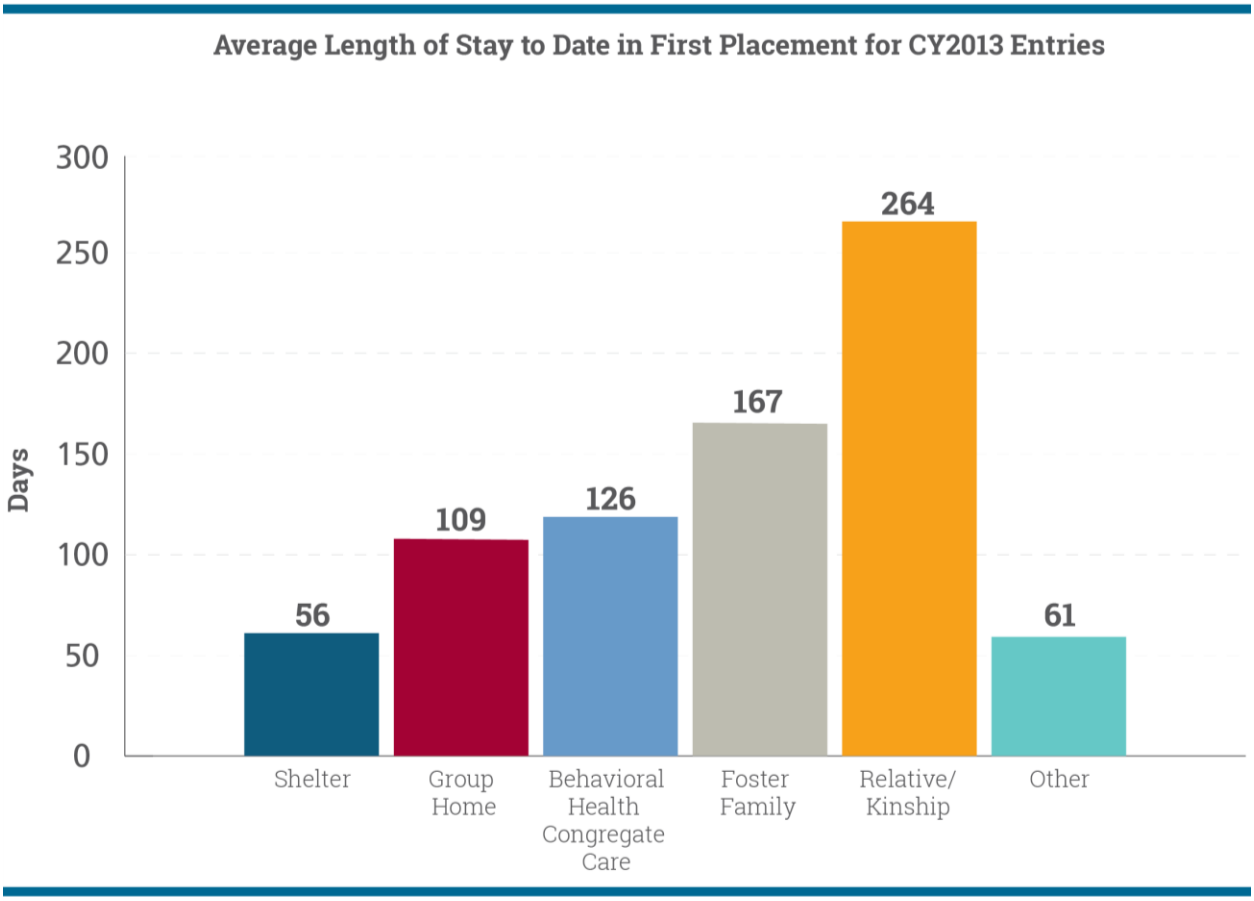
[7] Behavioral health congregate care category includes residential treatment centers, therapeutic group homes, and behavioral health homes.
[8] As the Hispanic indicator co-occurs with other races, totals add to greater than 100 percent.
[9] Kids Count Data Center (2015)

Figure 7: Child Count by Race and Ethnicity for Children in Care at start of SFY 2016



The average length of stay in the first out-of-home placement is shorter for children who are initially placed in congregate care compared to foster family or kinship care, which indicates that initial placements in congregate care are often temporary and do not provide stability equal to family-like settings. Related factors to the short say may be something the Department will explore further in the future. The average length of stay for children who entered care in CY 2013 varied by the initial placement types: from 56 days for shelter care, 109 days for group home, 126 days for behavioral health congregate care setting, 167 days for licensed foster family, and 264 days for kinship care. This data is the average length of stay as of December 31, 2014, and is not the final average length of stay for these children. As of December 31, 2014, one percent of children initially placed in shelter during CY 2013 were still in their first placements, as were six percent of children initially placed in group homes, three percent in behavioral health congregate care, 12 percent in foster family homes, and 24 percent in kinship care. As illustrated in Figure 8 on the next page, children in shelter placements who have exited care experienced average lengths of stay in their first placement of 61 days. In conjunction with the data illustrated in Figure 6, this indicates that the first placement in shelter and group home is a temporary placement, and does not necessarily indicate a therapeutic placement to meet specialized needs.

Figure 8: Average Length of Stay in First Placement for CY 2013 Entries (as of Dec. 31, 2014)



Characteristics of Children and Youth Placed in Congregate Care

Arizona's case reviews indicate that some children who enter congregate care have been the subject of multiple prior reports of abuse and neglect, and removal could have been prevented if adequate assessment, support, and resources had been provided to the family earlier in their involvement with the agency.

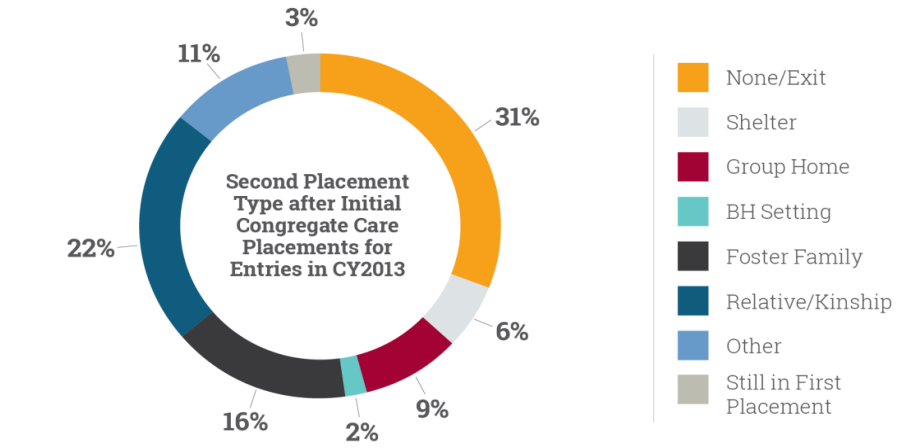
For children in congregate care on July 1, 2015, the most common removal reason was neglect. National Child Abuse and Neglect Data System (NCANDS) data indicates that families of children in congregate care commonly experience parental substance abuse, insufficient economic resources, inadequate housing, and domestic violence, and that these risk factors are associated with child removal. It should be noted that these risk factors are not substantially distinct from those associated with children in other out-of-home care placements. Focus groups with DCS staff, children, parents, and congregate care providers also indicated that the needs of children who enter congregate care upon first entry into Departmental custody are not markedly distinct from those of children who enter Departmental custody into foster care.

With adequate in-home services and resources, and engagement of the family to identify these issues and needs prior to removal, these risk factors in and of themselves would not necessitate placement in Departmental custody, let alone in congregate care, or might not lead to the

children developing co-occurring risk factors that necessitate congregate care placement. Additionally, there is an identified lack of supports for kinship and fictive kin placements (particularly financial supports since non-licensed providers only receive allowances as opposed to maintenance payments); all of which contribute to an overreliance on congregate care placements.

Figure 9 below shows the second placement type for children whose initial placement was congregate care. Of these children, 31 percent subsequently exited congregate care by the end of CY 2014 without experiencing a second placement setting. For these children, many exited Departmental care to reunification, which points to an opportunity for the Department to look at a safe reunification more quickly through the waiver intervention. The fact that collectively 69 percent of second placements were categorized as "none" (indicating an exit with no second placement, primarily reunification), foster care, and relative or other kinship, points to an area of potential for reducing congregate care if families are engaged and adequate in-home services and resources to meet assessed needs are provided.

Figure 9: Second Placement Type after Initial Congregate Care Placements for Entries in CY 2014

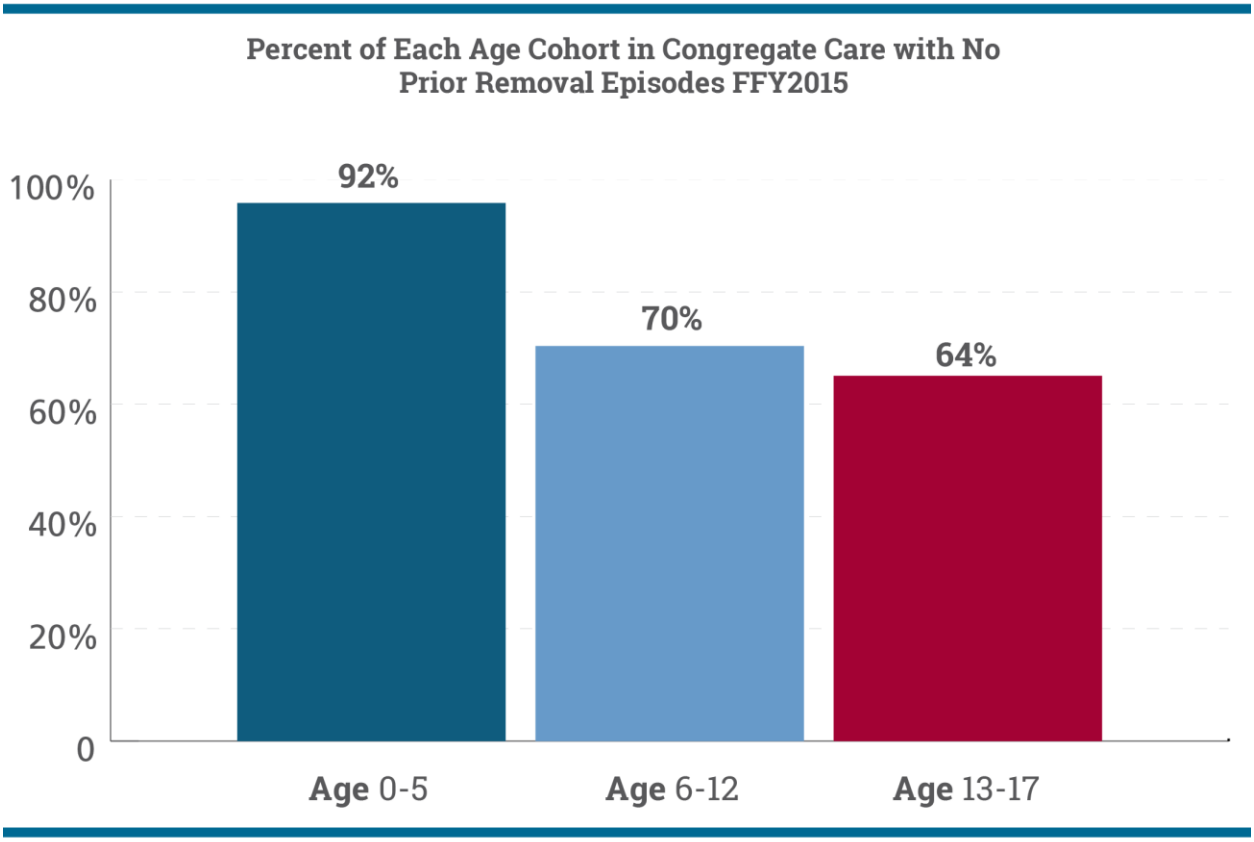


Characteristics of Children and Youth who need to be placed in Out-of-Home Care

Some children and youth require out-of-home placement, but may not require placement in restrictive congregate care settings. CHILDS data illustrated by age cohort in Figure 10 indicated that 68 percent of all children in congregate care placements on July 1, 2015 had no prior removal episodes. Consensus from DCS staff focus groups concur with this data, and further informs DCS that these children may be placed in congregate care due to a shortage of appropriate foster family or other kin/fictive kin homes for sibling groups or for children with unique needs, and not specifically due to the need for restrictive placements. This was also confirmed in the case reviews conducted over the last few months, which identified that at times,

children were placed in shelters to keep siblings together when first entering care.[10] DCS believes that the interventions implemented in this waiver will assist DCS Specialists with identifying additional family supports, which may lead to an increase in kin/fictive kin placements and allow sibling groups to remain together.

Figure 10: Percent of Each Age Cohort in Congregate Care on July 1, 2015 with No Prior Removal Episodes



Anecdotal reports from DCS staff focus groups also indicated that children who are placed in shelter and group home placement settings do not exhibit remarkably different risk factors or maltreatment types than those who are placed in foster families or kin/fictive kin homes, indicating that risk factors and maltreatment types may not be the leading cause of placement in restrictive congregate care settings.

Characteristics of Children and Youth Experiencing Long Stays in Congregate Care

Many children and youth experience long stays in congregate care that could be served by implementing interventions to move them into less restrictive care. DCS data indicated that only 13 percent of children in placement at the start of SFY 2016 were in congregate care. Of that, only 19 percent were in care longer than 24 months, or three percent of the total out-of-home care population. Furthermore, 59 percent of children in congregate care at the start of SFY 2016

[10] Source: Case Review Content Analysis Synthesis, 1/6/2015. The case review included 17 cases, eleven with child's current age 13 to 17 years, five with children currently aged six to 12 years, and one case involving birth to five years of age. The cases were chosen from those reviewed in the previous four years (2011 to 2014) from the Citizen Review Panel.

had been in care less than 12 months. Case record reviews indicate that those children who experienced long stays in congregate care demonstrated highly complex needs – medical, juvenile justice and behavioral – that indicated that congregate care was determined to be in the best interest of the child due to the risk of harm to self and others.

With this limited and highly specialized population, Arizona has selected to not focus on children who present a risk of harm to self or others as a specific target of the demonstration project.

Estimate of the Target Population

During the first six months of the initial implementation, the Department projects to serve approximately 30 children in the congregate care setting each month. Once the intervention is underway, the Department projects to serve an additional 60 children or more per month throughout the life of the demonstration project. Initially, the intervention will be provided in Maricopa County, which has the largest congregate care population in Arizona. The intervention will then be implemented in the remaining counties statewide.

III. Clearly Defined Demonstration Components and Associated Interventions

Section III should describe each of the waiver demonstration's interventions and associated components for the identified target populations.

Depending on the scope of the demonstration, State projects may have one intervention or several; similarly, some projects may have a broad systems focus, while others may be more discrete. All interventions must be sufficiently addressed in this section.

In this section, the plan should describe:

1. ***The waiver demonstration interventions planned for each target population, including a clear description of the interventions' core components;***

2. ***Who will receive demonstration programs and services (e.g., child, parents, foster parents, caseworkers);***

   It is possible that the recipient of an intervention may be different from the target population whose outcomes the title IV-E agency is trying to improve. For example, the title IV-E agency may want to improve the social and emotional well-being outcomes of children and youth with identified behavioral and mental health needs due to trauma. One intervention may be the implementation of a new trauma-informed training model for caseworkers. In this instance, the target population is still the children and youth with identified behavioral and mental health needs due to trauma, but caseworkers are the recipient of this particular intervention.

3. ***How the waiver demonstration's interventions will address the various needs of the target population(s) as identified in Section II;***

4. ***The specific outcomes expected for each intervention (which should link back to the overall theory of change for the waiver demonstration outlined in Section I);***

5. ***The existing evidence linking each intervention to the identified safety, permanency, and well-being outcomes the demonstration is supposed to address (i.e., research and evaluation findings and other data demonstrating support for the application of the chosen intervention(s) to the defined target population(s) in order to achieve the intended outcomes of the waiver demonstration);***

6. ***The program development and/or adaptation work that needs to be done to prepare each intervention for implementation.***

The "Intervention Template" is available to assist title IV-E agencies in thinking through the above elements. The template is not a required deliverable but instead is provided as a resource to support the development of this section of the IDIR.

Intervention Overview

Arizona's Title IV-E waiver demonstration project will seek to reduce length of stay in congregate care settings, and length of stay in out-of-home care overall, for children who are placed in a congregate care setting at the start of the demonstration or who enter congregate care during the waiver project. To do so, the Department will improve engagement with these children and their families through the waiver intervention as described throughout this section.

Family/Kinship search is currently conducted by DCS Specialists with support from the Department's Family Locate Unit with access to search technology, but there is no comprehensive program for kinship or fictive kin search (such as Washington D.C.'s Kin First or Kevin A. Campbell's Family Finding model). TDM currently exists throughout the state, but is underutilized and does not currently target children who are in congregate care. Similarly, the Department's reunification or placement stabilization in-home services and behavioral health in-home services are available statewide, but these services are also underutilized. By pairing TDM with accessible family/fictive kin search and engagement strategies through the Family Finding model with available in-home and/or other needed services as the waiver intervention, Arizona will be able to use flexible IV-E funding to expand current capacity of services for children in congregate care settings. In addition, effective implementation of the waiver intervention will result in and solidify the intervention model as routine case practice and demonstrate positive outcomes for children and families.

Team Decision Making Overview

TDM is an agency meeting where parents, children ages 12 or older (if appropriate), family members, extended family and other support persons, foster parents (if child is in placement), service providers, community representatives, the DCS Specialist of record and the supervisor come together when critical decisions regarding placement must be made as listed below. The meeting is a sharing of all information relating to child safety and protection, and the functioning of the family. The goal is to reach consensus on a decision regarding placement and to create a plan which protects the children in the least intrusive, least restrictive environment.

The process is strength-based with a focus on providing a forum for meeting participants to share and hear the worries about a child's safety, as well as what is working well with the family. TDM provides families and the community an opportunity to participate in the decision-making process regarding a child's placement, and allows participants to understand reasons decisions are made. For the full policy describing TDMs in Arizona, see the *Arizona Department of Child Safety: Policy and Procedure Manual Chapter 2 Section 8.*[11] .

Arizona's TDM meetings follow a six step process based on the Annie E. Casey *Family to Family Initiative*:

1. Introduction
2. Identification (*Why are we here?*)
3. Assessment (*Concerns & Strengths*)
4. Brainstorming Ideas
5. Consensus Decision/Recommendation

[11] https://extranet.azdes.gov/dcyfpolicy/

6. Evaluation/Recap/Closing

There are five types of TDMs currently held in Arizona described as follows:

An *Emergency Removal TDM* occurs when:

- A child has been physically removed from the custody of the parent, guardian or custodian and a Temporary Custody Notice (TCN) has been served; or
- The Department requests a court ordered pick-up due to present danger or impending danger.

A *Considered Removal TDM* occurs when:

- The results of the assessment of child safety threats and risk indicate the child is unsafe due to impending danger; or
- Voluntary services have been initiated and the safety threats and risk factors have not been sufficiently remediated and no safety plan can be implemented to ensure the child's safety in the home.

A *Change of Placement Disruption/Placement Preservation TDM* occurs when:

- There is a potential placement disruption; or
- An unplanned placement change occurs.

A *Permanency Planning TDM* occurs when:

- There may be a recommendation for a change in the permanency goal; or
- A child will begin the reunification transition to their family.

An *Age of Majority/Program Disruption/Discharge TDM* occurs when:

- A youth in care is within six months of turning 18;
- A youth is in voluntary foster care for Independent Living and wants to exit or is in non-compliance with the program (scheduled no later than 72 hours from youth's request); or
- A youth is in voluntary foster care for Independent Living and is within 30 days of turning 21.

There are currently special circumstances when one of the listed five TDM meetings is not required or circumstances differ from those described above. For example, a TDM will not be held if a child is returned home due to no safety threats or a private dependency petition has been filed and the Department agrees with the allegation, placement and/or court orders. In addition, at an emergency or considered removal TDM a meeting is not held when only DCS staff and community providers attend, but the family is not present.

Another example is when a child is in out-of-home care and the child will begin the reunification transition to their family or the child's placement may disrupt and an existing Child and Family Team (CFT) meeting is in place. The CFT process is part of the behavioral health system with the objective to focus on the behavioral health needs of the child and family. When a child comes into care, either in an unlicensed licensed or placement including congregate care, an emergency assessment is completed by a contracted behavioral health provider. If mental health services are identified then a referral is submitted to a provider agency that is in the geographic location of

the placement and a CFT established. CFT meetings are facilitated by a behavioral health service provider, typically occur monthly, and focus on the behavioral health needs of the child and family; though the size, scope and occurrence of these meetings depend upon the needs of the child and family. Thus, if the child is beginning to transition home or the child's placement may disrupt, the CFT can address the placement needs rather than through the TDM process.

As part of the demonstration project a targeted TDM called *Life Long Connections TDM* will be introduced for the congregate care population even if an established CFT is in place for the child. Children in the congregate care setting will be selected for the waiver intervention based on case related data. Data elements include:

- Name and age of child
- Other demographic information about the child
- Type and name of placement
- Length of placement
- Region, unit and name of DCS Specialist

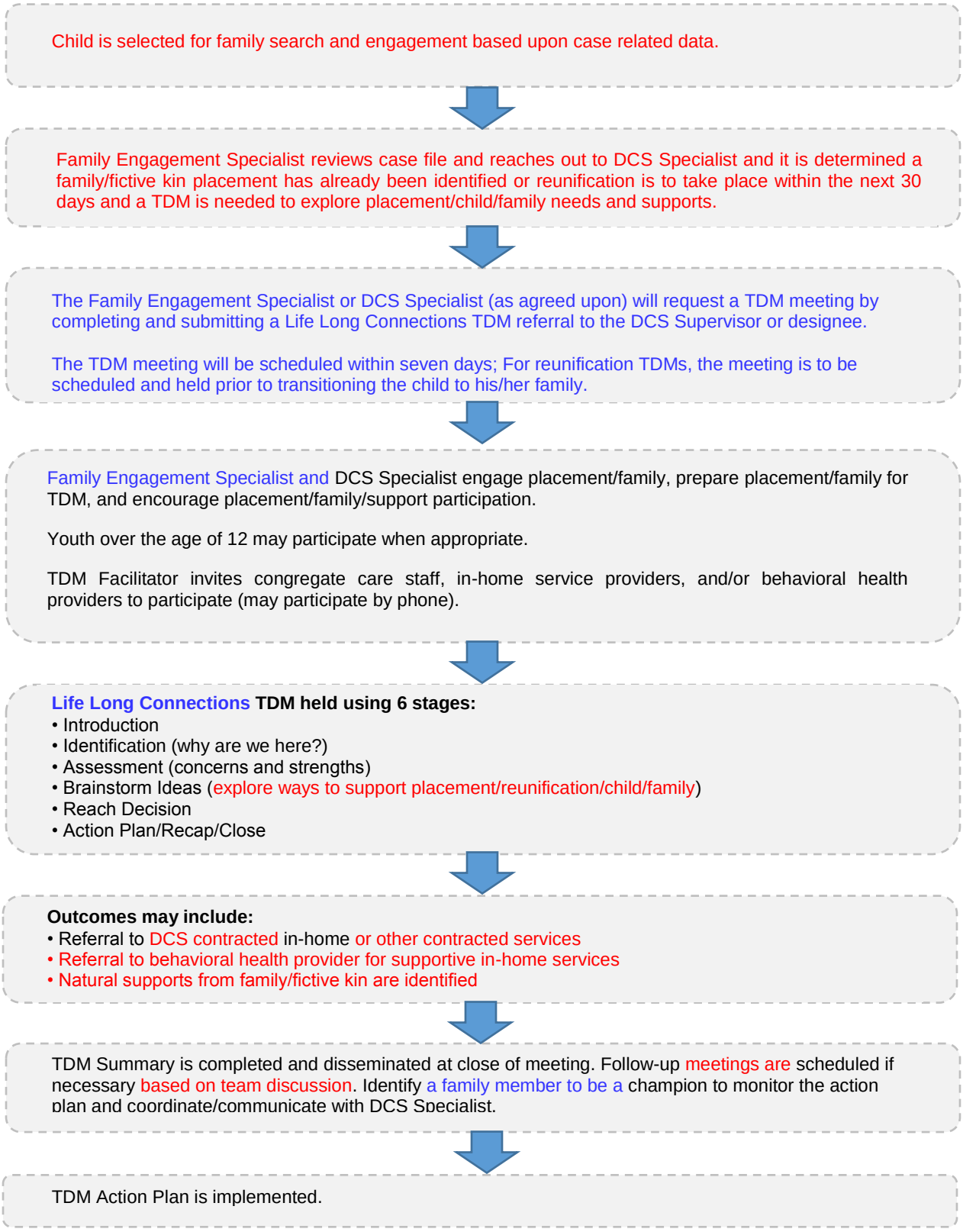
Prioritization criteria will be set by DCS leadership for the initial implementation sites during the week of March 14, 2016. The criteria will be based on the type of placement and length of time the child has been in the identified placement. As the roll-out plan is applied the prioritization criteria will be used and assessed on an ongoing basis.

Once selected, there will be two points of entry for children in the congregate care setting to the targeted TDM process:

1. The child has a family/fictive kin placement identified or reunification is scheduled to take place in the next 30 days, and a TDM is needed to explore needs/supports for the placement/child/family.
2. If placement with family/fictive kin is not identified or reunification is not occurring within 30 days, family/fictive kin search and engagement activities will be conducted and the family will be prepared for a TDM meeting.

On the following pages are two flowcharts of how a *Life Long Connections TDM* will occur for children in congregate care for each point of entry. This process combines elements of the current *Change of Placement Disruption/Placement Preservation*, *Permanency Planning*, and *Age of Majority TDMs*. They also incorporate the family/fictive kin search and engagement activities and the increased use of in-home and/or other support services for child/family.

Life Long Connections TDM Process, Entry 1



Life Long Connections TDM Process, Entry 2

Child is selected for family search and engagement based upon case related data.

Family Engagement Specialist reviews case file and reaches out to DCS Specialist to determine family search and engagement efforts to be made which may include:

- Finding ruled-out relative contact information to find other relatives
- Conduct internet searches
- Interviewing the child (if age appropriate), family members and supportive adults*
- Interviewing congregate care and treatment/service providers

*Interviewing through in-person interviews, phone conversations, written letters and email correspondence

Upon the Family Engagement Specialist making contact and engaging the family/fictive kin and in coordination with the DCS Specialist, determine if a Blended Perspective Meeting is needed prior to a Placement Options TDM. Criteria to determine if a Blended Perspective Meeting is to occur are:

- Family found, but placement not identified
- Disconnected family or family members who do not know the child or haven't had recent contact

The Family Engagement Specialist or DCS Specialist (as agreed upon) will request a TDM meeting by completing and submitting a Life Long Connections TDM referral to the DCS Supervisor or designee.

The TDM meeting will be scheduled within seven days; For reunification TDMs, the meeting is to be scheduled and held prior to transitioning the child to his/her family.

Family Engagement Specialist and the DCS Specialist prepare family for TDM.

Youth over the age of 12 may participate when appropriate.

TDM Facilitator invites congregate care staff, in-home service providers, and/or behavioral health providers to participate (may participate by phone).

Life Long Connections TDM held using 6 stages:

- Introduction
- Identification (why are we here?)
- Assessment (concerns and strengths)
- Brainstorm Ideas (explore placement options, ways to support placement/reunification/child/family)
- Reach Decision
- Action Plan/Recap/Close

Outcomes may include:

- Placement with family or fictive kin
- Placement in foster home
- Reunification
- Referral to DCS contracted in-home or other contracted services
- Referral to behavioral health provider for supportive in-home services
- Natural supports from family/fictive kin are identified

TDM Summary is completed and disseminated at close of meeting. Follow-up meetings are scheduled if necessary based on team discussion. Identify a family member to be a champion to monitor the action plan and coordinate/communicate with DCS Specialist.

Action Plan implemented; Family Engagement Specialist monitors the action plan and coordinates/ communicates with the identified family champion and DCS Specialist

As noted in the flowcharts, the Life Long Connections TDM process can be supported through the family/fictive kin search and engagement activities. Additionally, as family/fictive kin are actively participating in the decision making process, family/fictive kin will be strengthened and feel supported through the right mix of family/natural supports and in-home services.

Family/Fictive Kin Search and Engagement Overview

Arizona DCS currently has search procedures to identify kinship and foster homes for children placed in out-of-home care. However, DCS believes that these practices can be enhanced to increase family engagement, in conjunction with the TDM process and in-home services array. The Department consistently places children with kinship or foster families at rates higher than the national average. This has been verified through DCS data, as well as the work done this past quarter in understanding kinship search practices in Arizona. Due to caseload burden, as well as some gaps/barriers identified in the current kinship search practice, this has led to children being placed in congregate care settings rather than in family-like settings, oftentimes directly upon removal. In order to improve the kinship search practices in Arizona, the Department decided to adopt the Family Finding model founded by Kevin A. Campbell[12] . The Family Finding model was chosen due to success in at least 13 other states in past years. Additionally, the Family Finding model was selected due to the Department's past success and experience with Seneca Family Agencies, which the Department utilized from October 2012 through September 2013. The project initiative was discontinued in 2013 due to a need to redirect Department resources.

With the Family Finding model in mind, the Department explored kinship search models to find the right fit for the demonstration intervention. This included consideration of DCS contracted in-home services providers and congregate care providers. Learning from past experience when using the Family Finding model, the Department desires to build the Department's program infrastructure in order to embed the model into practice; thus, a decision was made to have existing DCS staff complete this work. They will be known as Family Engagement Specialists and will be non-case-carrying positions. In order to achieve this, the Department searched current vacancies or positions doing similar work that will be trained to provide the family/fictive kin search and engagement activities.

Using the Family Finding model, the Family Engagement specialist will: collaborate with the assigned DCS Specialist to mine the electronic and hard-copy case; engage the child currently in a congregate care placement along with congregate care/group home staff; encourage the child (age allowing) to talk about important people in his/her life; and reach out to identified relatives and fictive kin found to encourage their emotional support of the child. DCS believes that, once reconnected with family, the chances of a relative becoming a placement or reunification will greatly increase.

Depending on the response of family members and their commitment to supporting the child, there may or may not be a need for a Blended Perspectives Meeting, which originates within the Family Finding model. This is a meeting for family/fictive kin that have been disconnected from and/or do not know the child. It will be facilitated by the Family Engagement Specialist in the hope of reintroducing and connecting the child/family with each other. One of the objectives of the meeting is for the family/fictive kin to explore how they can support the child/family. The

[12] National Institute for Permanent Family Connectedness: http://www.familyfinding.org/

Family Engagement Specialist will also help prepare the family/fictive kin for the Life Long Connections TDM meeting where decisions will be made about placement, ways the family/fictive kin can support the child/family, and what services are needed for the placement/child/family/fictive kin. In addition, the Family Engagement Specialist will assist the DCS Specialist with obtaining the needed services while working with the identified champion to monitor the action plan created in the TDM meeting. This may include monitoring the progress of the formal/informal supports that are put in place for transitioning the child to the new placement and ensuring the child's needs are being met. The Family Engagement Specialist will further assist the DCS Specialist with evaluating the needs after placement, to ensure placement stability can be achieved until permanency.

Timeframes from when the child is identified to receive the intervention, the Family Engagement Specialist mining the case file to identify family/fictive kin, the family being engaged to participate in any planning meetings and the Life Long Connections TDM meeting, and other points of the intervention will be established during the initial implementation phase of the intervention. As the Family Engagement Specialists receive hands-on training and coaching during the initial phase, they along with the site-based teams will identify the triggers and establish timeframes within the process. This will assist with as the Department rolls-out the intervention to additional sites.

In Home Services Array Overview

In order to assist parents to either have their children return to their care or transition to a family/fictive kin placement, the availability of in-home and other supportive services is a key component to the waiver intervention. There are several avenues available services through the community, state contracts, and the behavioral health system. Such services include, but are not limited to:

- **Community Resources/Services**:
  Employment opportunities, job training
  Domestic violence support services and programs
  Housing services
  Tangible resources and food banks
  Respite services
  Disability services
  Vocational rehabilitation services
  Navigating community-based services and resources
  Family resource centers
- **Parent Training and Assistance (Parent Aide) -** state contract and also available through behavioral health system
  Purpose of Service: To provide a range of support services, instruction, and assistance to parents or caregivers of children involved with DCS to improve their skills and abilities to fulfill parenting roles and responsibilities. Services can be intensive or moderate and include: parenting skills, home management skills, education on accessing community resources, and arrangement and supervision of visitation.
- **Substance Abuse Treatment - Arizona Families F.I.R.S.T. (AFF) -** joint partnership with the behavioral health system

Purpose of Service: Assist in the recovery from substance abuse issues that affect a parent's ability to care for a child including both drugs and alcohol. Services can be intensive or moderate and include: educational, outpatient/intensive outpatient, residential treatment, and recovery maintenance services.

- **Counseling/Psychological Services -** state contract and also available through behavioral health system
  Purpose of Service: To provide psychiatric and psychological assessments to determine the mental status and behavioral health needs of clients including physical, emotional, educational, and social needs, and facilitate appropriate treatment/interventions, often through counseling.
- **Transportation -** state contract and also available through behavioral health system for treatment purposes only
  Purpose of Service: Available to allow families to meet court-ordered or other necessary obligations in order to expedite the resolution of the case and help move children to reunification or other permanency.
- **Prevention Services, Healthy Families -** several funding sources
  Purpose of Service: A nationally credentialed home visiting program that provides services that are voluntary and free to the public designed to strengthen families during the first five years of a child's life.
- **In-Home Services Program (IHSP) –** state contract and also available through behavioral health system
  Purpose of Service: Assist in supporting and preserving the family unit through a continuum of family-centered services that are coordinated, community-based, accessible, and culturally responsive. Services can be intensive or moderate and include: parent education, counseling, communication skills, behavioral management/ modification, and home management skills.

The intent of Arizona's contracted In Home Services Program is to be provided to families/fictive kin when the child/family/fictive kin does not qualify for services through the behavioral health system or other community services. The In Home Services program is to provide short term, time-limited services for approximately 60 to 120 calendar days. The length of service is based on the level of service to which the family is referred. The level of services provided are based on the needs, concerns and stressors of the child and the family, and address the safety and risk factors and behavioral changes identified by the Department in their referral. Included in the referral is the Department's Child Safety and Risk Assessment (CSRA), which is a tool used to assess the safety and risk of a child. It is initiated during initial contact with the family and is continued throughout the investigation, which is included in an Emergency Removal or a Considered Removal TDM process. The purpose of the CSRA is to gather sufficient and relevant information to make an informed decision about whether the child is safe or unsafe, and whether there are risk factors that necessitate the Department's ongoing involvement. The DCS Specialist must assess risk factors by engaging the parent, guardian or custodian to identify relevant information about the family's history in each of 14 risk domains. Further, the assessment of risk must include the identified risk factors, strengths of the family that can be built upon to reduce the risk level, and determine whether intervention (family, community resource or DCS intervention) is needed to address the risk factors.

A Continuous Child Safety and Risk Assessment (C-CSRA) is required whenever major changes in family circumstances occur and at key decision points during the life of a case, which will assist with any of the TDM meetings, including the Life Long Connections TDM. The C-CSRA should be completed for the following reasons:

- Case Plan reassessment and revision, minimally every 6 months, including changing the permanency goal
- Changes in household composition (additions or departures of individuals from the household)
- Indication that a child may be unsafe
- Considering unsupervised visits
- Considering reunification
- Considering case closure

(See Appendix A and B for the CSRA and C-CSRA practice guides)

The In Home Services Program also provides transitional supports from higher level of care placements to family homes, stabilization services of a child in relative/kin or adoptive placements, and possible services to a community based family that has no DCS involvement. Currently, in-home services are provided by 14 contracted agencies that serve families across Arizona. There are five levels of services to the In Home Services Program that are detailed in the following chart:

Five Levels of Services within the In Home Services Program

1	Clinical Family Assessment – an assessment conducted by a master's level clinician to assist in identifying the nature of the problem the treatment needs and services that might best be utilized to address the child's and/or family's problems. *Length of service – one time for the length of time it takes to conduct assessment
2	Family Support – short-term family supportive intervention services where conditions represent potential or low risk of abuse and/or neglect, in order to allow those children to safely remain in their home. This service may be provided to DCS referred families, community families or self-referrals. *Length of service – maximum of 120 days (45 days extension upon approval)
3	Moderate – services where conditions represent no safety threat, but a high to moderate risk of abuse and/or neglect in order to allow those children to safely remain in their home. *Length of service – maximum of 90 days (45 days extension upon approval)
4	Intensive – provide crisis-oriented activities where conditions represent a threat to child safety and whose children are at significant risk of out-of-home placement due to abuse and/or neglect in order to allow those children to safely remain in their home. *Length of service – maximum of 120 days (45 days extension upon approval)

5	Family Reunification and Placement Stabilization – Safely expedite the return of children who are in out-of-home placement or in voluntary foster care back to their family, and transition a child from a more restrictive placement back to the community, such as from a residential treatment center to a foster or family home or from a foster home to a family home. Family Reunification and Placement Stabilization may also assist in the stabilization or safe maintenance of a child in a relative/kinship or adoptive home. *Length of service – maximum of 120 days (45 days extension upon approval)

Any level of service within the In Home Services Program may be provided to the target population depending on the need of the family and availability of services. The Department anticipates the levels that will be utilized more frequently during the demonstration will be family reunification and placement stabilization. The In Home Services Program is provided to the entire family and is delivered in the family's home, or in the case of reunification or placement stability services, in the child's current and transitional placement, which may include a foster, kinship, or adoptive home. The service is currently paid through non-Title IV-E funds and is intended to improve the safety and well-being of children and families. Flexible funding under the waiver will allow for in-home services to be provided to the target population. Services are initiated rapidly – between 12 hours and five working days from referral depending on the intensity of services and the team is available 24/7 to families for crisis support. For a full description of these services and the appropriate cases for referral see Appendix C.

DCS has observed that these services, particularly the family reunification, placement stabilization level, and the family support level of services are underutilized in DCS cases. In addition, services through the behavioral health system are underutilized when the child/family/fictive kin may qualify. As noted from DCS staff and in-home providers, contributing factors are lack of staff knowledge of program availability both with the In Home Services Program and in-home behavioral health programs/services. Additionally, lack of appropriate referrals to the service level needed at the right time is a contributing factor. DCS Specialists may not ensure appropriate match between case and referral due to challenging demands of caseload size. As part of this readiness waiver effort, DCS will train and coach staff and supervisors, update policy and procedures, and create practice guides to assist staff in their decision-making. It is anticipated that staff knowledge will increase and appropriate referrals will be made with the addition and assistance of Family Engagement Specialists and the Life Long Connections TDMs.

Further, during the demonstration project DCS will engage with in-home providers to ensure that they are full partners in proving services to children who have been identified by DCS to move to a family setting or home. This will be done through the site implementation teams, as well as with the statewide in-home coordinator. DCS anticipates that this engagement may help in-home providers more fully participate in TDM planning and part of the solution to the overutilization of congregate care. This will increase the use of in-home family reunification and placement stabilization services and other noted state contracted and community services, as well as services through the behavioral health system for the target population through this waiver.

Target Population for Interventions

The primary recipients of the interventions described in this waiver are the families and children served by DCS. The target population, as described in Section II of this IDIR, includes children

and youth already placed in congregate care, or who enter congregate care during the waiver period, but who do not require behavioral health, juvenile justice, or medical placements for their safety. The family/fictive kin search and engagement activities, including the Family Finding process, works equally well for younger and older children, though more input will need to be provided by parents and/or close relatives of very young (non-verbal) children. The intervention will be available to all children/youth in group home placement regardless of the length of time in that placement. Data will be collected separately for children in placement less than 30 days versus more than 30 days, as part of the demonstration project evaluation in order to measure the effectiveness of using the intervention on both short-term and longer-term placements. Other states have successfully used Family Finding in both situations. There may also be circumstances when a child/family may receive Family Finding; however, not the Life Long Connections TDM meeting. The circumstances may vary depending on the needs of the family and will be coordinated with the Family Engagement Specialist, the DCS Specialist and the family.

Addressing the Needs of the Target Population

The target population of children in congregate care is not substantially different than other children placed in other types of out-of-home care. In essence, these children and youth are placed in congregate care without having a need for behavioral, juvenile justice, or medical specific treatment services with an intensive group care placement. Many of these children could have been placed in a family setting or remained in the home with appropriate support and safety planning. Using the chosen family/fictive kin search and engagement process, Family Finding, Arizona believes the child will be able to feel the family's support through increased contact and planning with family members for the child's future, which may include a Blended Perspectives meeting. Extended family will be brought into the decision-making process, including participating in the Life Long Connections TDM meeting, making for better decisions focused on the child's best interest. Older youth, who felt they had no supports, will realize there is family that cares, which could affect the youth's sense of self, self-esteem and well-being, all desired outcomes of the intervention. Negative behaviors often decrease as a result of having committed family members active in a youth's life. Anxiety levels that come from getting closer to age 18 lacking emotional supports with which to leave foster care successfully also may decline.

In addition to the Family Finding activities, increased utilization of TDMs with identified in-home supports through contracted or behavioral health services will address the needs of the target population by increasing family engagement to include the family's voice in these meetings and permanency planning in general, identifying and delivering needed services and informal resources within the family, and establishing clear action plans. Having clear action plans hold parties responsible for taking steps to move children towards reunification or placement in a family setting while ensuring their safety and well-being.

Desired Outcomes

By utilizing flexible funding to improve engagement with children in the congregate care setting and their families through the waiver intervention, Arizona anticipates the following outcomes for children served in congregate care:

- Increased number of family/fictive kin available;
- Improved engagement and connections fostered to support the children;

- Enhanced involvement of family/fictive kin in the decision making process;
- Expedited identification of needs and strengths for children/family;
- Increased children and family/fictive kin supports through natural and in-home services;
- Increased percentage of children in congregate care settings who are placed in family settings;
- Decreased length of stay in congregate care;
- Increased rates of exit from congregate care;
- Increased reunification and legal permanency; and
- Improved stability with life-long supports and connections
- Improved child social/emotional well-being

Existing Evidence

An internal evaluation of the TDM process was conducted in July 2011. The study found that the revised process helped DCS staff members identify child safety concerns and behaviors that contributes to an unsafe environment. The revised process also led to a mild increase in the number of fathers participating in TDMs.

General research on both TDMs and kinship search has yielded some mixed results due to the rigor of the studies executed, the degree to which agencies adhere to a model, and the buy-in of staff across the agency. However, research on TDM has yielded some positive results including increased exits from foster care to reunification or relative placements[13] and greater reductions in the use of congregate care and entries into out of home care.[14] Family Finding has been found to have positive impacts on both legal and emotional permanency, the identification and/or engagement of connections, finding permanent placements for children, and increased identification of family members.[15]

Evidence suggests that family engagement has many benefits, including promoting family buy-in. A qualitative analysis of findings from the three top-performing metro sites in the 2007-2008 Child and Family Services Reviews (CFSRs) found that child and family involvement in case planning was correlated with (1) active engagement of noncustodial and incarcerated parents, (2) family-centered and strength-based approaches (e.g., team meetings, mediation) effective in building working relationships, and (3) strong rapport developed between workers and parents.[16]

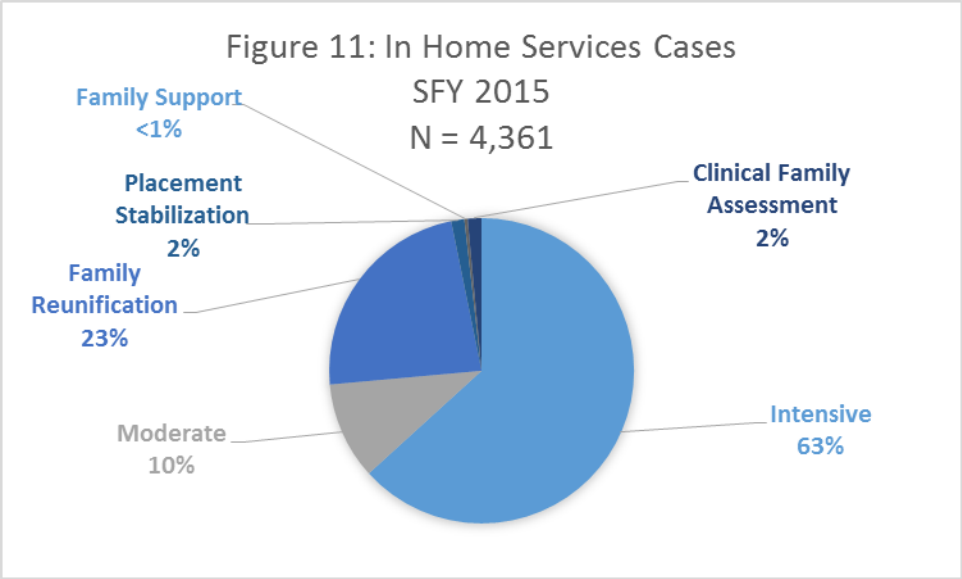
Family engagement also assists in increasing placement stability. The CFSRs found that states with high ratings for developing case plans jointly with parents and youth also had high percentages of children with permanency and stability in their living situations.[17] Research on Family Group Decision-Making (FGDM) also points to improvements in creating stability and

[13] Crampton, D. S., Usher, C. L., Wildfire, J. B., Webster, D., & Cuccaro-Alamin, S. (2011). Does community and family engagement enhance permanency for children in foster care? Findings from an evaluation of the family-to-family initiative. *Child Welfare*, *90*(4), 61-78.
[14] Puckett, A. (November 2012). Brief summary of research evidence for use of family engagement strategies in child welfare. Casey Family Programs.
[15] Vandivere, S. and Malm, K. (January 2015.) Kinship search evaluations: A summary of recent findings. *Child Trends.*
[16] Children's Bureau. Administration for Children and Families. DHHS. (2009) Results of 2007 and 2008 Child and Family Services Reviews. URL: http://www.acf.hhs.gov/sites/default/files/cb/agencies_courts.pdf
[17] Children's Bureau. Administration for Children and Families. DHHS. (2004) Results of 2001-2004 Child and Family Services Reviews. URL: http://www.acf.hhs.gov/sites/default/files/cb/findings_from_the_initial_cfsr.pdf

maintaining family continuity.[18] Research also suggests that parental involvement is linked to quicker reunification and other forms of permanency.[19] In addition, working collaboratively, caseworkers and families are better able to identify a family's unique needs and develop relevant and culturally appropriate service plans that address underlying needs, build on family strengths, and draw from community supports. A better fit in services often leads to a more effective use of limited resources.[20]

A study on the effectiveness of intensive in-home services in Arizona during 2007 found that the majority of families (75 percent) who received in-home services felt that they were stronger after their services, many of these families (82 percent) attributed part of their success to their involvement with the service, and most families perceived the services as helpful. In addition, of the families measured, 50 percent measured at a higher functioning level.[21] Recommendations from this study, review of literature, evidenced informed practices and other jurisdictions, provider outcome data, and feedback from providers and DCS staff guided the current design of the In-Home Services Program model.

Figure 11 on the following page shows the number of in-home services cases by type of service provided by contracted agencies during SFY 2015 totaling 4,361.



In-home services providers are required to report on a number of performance measures as well as how successfully they are at engaging families and continuing cases through completion of services. One target performance indicator is for 90 percent of families referred to the In Home Services Program for the intensive, reunification and placement stabilization or moderate level of

[18] Merkel-Holguin, L., Nixon, P., & Burford, G. (2003). Learning with families: A synopsis of FGDM research and evaluation in child welfare. *Protecting Children*, *18*(1-2), 2-11.
[19] Bossard, N., Munson, S., Braxton, A., Conway, D., Muhammad, B., & Mallon, G. P. Nothing about us, without us: Meaningful youth and family engagement in child welfare. *The Children's Bureau.*
[20] Doolan, M. (2005). The family group conference: A mainstream approach in child welfare decision-making. URL: http://www.americanhumane.org/assets/pdfs/children/fgdm/pc-fgdm-conf-fgc2004.pdf
[21] Lietz, C. A. (2009). Examining families' perceptions of intensive in-home services: A mixed methods study. *Children and Youth Services Review*,*31*(12), 1337-1345.

services have signed the initial interim plan and agreed to services. During the SFY 2015, 92.3 percent of families referred to all levels signed the initial interim plan and agreed to services, whereas 93.1 percent of families referred to the reunification level of services and 88.5 percent referred to the placement stabilization level signed the plan and agreed to services.

Another target performance indicator is that 82 percent of cases referred for family reunification services who are in out-of-home placement shall return to their home within 30 days of the Order of Physical Custody or if in voluntary foster care, from the time of the referral. During SFY 2015, there were 1,013 families referred and 525 (52 percent) had been returned within the targeted timeframe of 30 days. With respect to children referred to placement stabilization services, the targeted performance indicator is that 85 percent of children referred are to be safe and stabilized in the identified placement at the end of the 120 days from the time of the referral. There were only 34.4 percent at the end of SFY 2015 who were safe and stable at the end of the service.

DCS is aware that many in-home providers appear to be underperforming based on current targets. It is important to note that many of the cases referred to in-home services may be carried over from SFY 2014 and similarly, the outcomes may not be reported until SFY 2016. Further, the Department anticipates using the waiver as an opportunity to ensure that the right kind of cases are referred for in-home services and that families are matched with an appropriate level of service to ensure their engagement and success. Additionally, the timeframes for these indicators may need to be revised to meet more realistic demands and challenges of in-home services. This will be accomplished through the supports of the TDM process, TDM Facilitators, and Family Engagement Specialists ensuring that the right referral is being made at the right time to meet the individualized needs of the child/family. Moreover, the Department has established a matrix to monitor the utilization of services and referral process, which is outside of the waiver demonstration project. This will be continued throughout the demonstration project and other supports will be established through the Department's continual partnership, collaboration, and communication with the in-home and other services providers.

Additional Program Development and Adaptation

The major program development changes required for the waiver intervention was a key focus during this last quarter. The current capacity of the TDM Facilitators was identified and it was discovered that many are performing other duties outside of their TDM responsibilities. These ancillary duties are in the process of being reassigned to ensure that the targeted TDMs for children in congregate care are prioritized. Moreover, the TDM process requires Facilitators to collect information on each TDM they facilitate and enter it into an Access database. Data collection includes the number of meetings, participants by type, number of children discussed, and the legal and placement outcomes for the children discussed. As part of this waiver the TDM database will be revised to ensure that it adequately captures data necessary for the evaluation of the waiver's success. In addition, the in-home services providers are required to submit quarterly data to DCS and this will be explored and revised as needed for the evaluation of the waiver.

Regarding the Family Finding model, a tool developed from concepts from Judy Smith-Davis's *Instrument for Screening New Practices for Adoption* was discussed with the Family Finding training purveyor to determine whether the Family Finding model could be adapted to meet the needs of the Arizona intervention. It was determined that overall the Family Finding model is a

good fit for Arizona. The training purveyor expressed that they will work closely with Arizona to meet the Department's needs in adapting the model where needed to serve the target population. One example of an adaptation may be only searching/finding ten family/fictive kin members instead of finding 40 members like the model calls for. Another example is conducting the Blended Perspectives Meeting as needed, based on criteria the agency establishes and not in every case as the model calls for. The family in partnership with the Family Engagement Specialist and DCS Specialists will determine if a Blended Perspective Meeting is needed. In addition, the Life Long Connections TDM will be convened utilizing TDM Facilitators following the established TDM process in Arizona, rather than Family Engagement Specialists facilitating a decision meeting as outlined in the Family Finding model. The training purveyor was in agreement with Arizona using Family Engagement Specialists to complete the family/fictive kin search and engagement activities through the Family Finding model. The adaptations will be applied consistently in practice and there will be clear standards or criteria to guide the decision making.

The Department recently underwent a rapid process improvement session to address the service referral and approval process. It is anticipated that the standard work and process that will exist in Maricopa, Pima, and Pinal counties will have an impact on the waitlist by clarifying readiness for services as well as a standard approval process for services. At this time, there will be no contract changes, only areas of clarification around items that aren’t clearly defined in the existing contracts.

Additionally, the Department conducted a survey and held several focus groups with DCS Specialists and Supervisors, TDM Facilitators, and in-home and congregate care providers in order to understand the barriers/gaps and what is working well with the current kinship search practices, TDM process, and in-home services array. Information gathered from the survey and focus groups will be used to develop procedures, practice guides, and training curriculum for the waiver intervention.

IV. Assessing Readiness to Implement the Demonstration

Section IV should include an analysis and overview of the requirements for the child welfare system, related organizations, and community partners in implementing each demonstration intervention as intended, as well as specific activities to be completed prior to implementation. This includes:

A. Describing the fit of each demonstration intervention with community values, culture, and context, and how this was or will be assessed.

B. Describing the title IV-E agency and/or local jurisdiction's capacity to implement the demonstration, including available training and technical assistance resources and capacity, and how this was or will be assessed. Assessments of the capacity to implement should focus on:

1. Organizational and Systems Capacity, including a description of:
- ***a) Leadership support (i.e., the current status of state, county, and local leadership buy-in and where further engagement may be necessary);***
- ***b) Staff characteristics. Please describe the staff requirements for each demonstration intervention (e.g., number of staff, roles in the demonstration, qualifications in terms of education and experience) and compare that to the child welfare agency's current staff characteristics;***
- ***c) Availability of technical and financial resources to implement the program as intended (e.g., required hardware, required software, access to certain curricula or intervention manuals, start-up funding to aid in the initial implementation of the waiver intervention(s) prior to the accrual of title IV-E savings);***
- ***d) Availability and quality of linkages to and support from community organizations.***

2. Current processes and service system functioning that need attention because they are incompatible with or not aligned to ensure the successful implementation of the demonstration's key components and therefore will not facilitate the achievement of the demonstration's desired goals and outcomes (e.g., union agreements that may impact staff selection processes for new programs, current levels of coordination and cooperation between community service providers and what may be needed for successful implementation of waiver interventions).

3. Implementation supports (e.g., infrastructure enhancements, policy changes) that need to be developed to ensure that demonstration components are able to be executed as intended.

Congregate care reduction is a shared vision that includes the collaborations of broad internal and external support including congregate care and in-home providers, who coupled with DCS, recognizes that abused and neglected children and youth are best served in the least restrictive

environment possible. Furthermore, if out-of-home placement is necessary, children and youth should live in family-like settings, such as a relative or licensed foster home. Through the demonstration project, the Department will take steps to meet this shared vision of decreased congregate care usage in Arizona by better engaging families and increasing the availability of supported services array. As mentioned in Section I, the Auditor General Special Report clearly articulated that DCS needs to continue its efforts to reduce the use of congregate care. The report pointed out that from September 2009 to March 2014, congregate care usage increased by 73 percent. The report cited an inadequate supply of foster homes, various Departmental practices, and issues connecting to behavioral health services as root causes of the increased use of congregate care. The comprehensive approach to addressing this issue, as recommended in the report, is entirely consistent with the demonstration project's focus on decreasing congregate care.

The work of the demonstration project is also being done in the context of the Department's strategic plan.[22] The strategic plan aims to refocus attention and resources to the safety, permanency, and well-being of children in Arizona. The plan is made up of five key goals that address several of the most pressing departmental challenges:

Goal One: Improve Objective Decision-Making at the Hotline and Investigations
Objectives outlined specific to goal one are 1) increase the accuracy of referral categorization at the Hotline; 2) increase the accuracy of safety and risk assessments in investigations; and 3) increase utilization of the dashboard to better define workloads, develop action plans, and accommodate volumes. When the Department achieves goal one objectives, it is expected the total number of Hotline reports, the re-report rate, and the re-victimization rate will decrease. Further, it is anticipated that the entry rate and in-care rate per 1,000 children in Arizona will decrease and the percentage of children removed within thirty days of being reported and the re-entry rate will decrease.

Goal Two: Improve Performance and Quality of Service through Employee Retention
The rate of turnover within Arizona creates a significant challenge when serving families and DCS is committed to pursue a variety of strategies to improve staff retention including 1) create manageable workloads by addressing factors that contribute to the inactive backlog; 2) reduce the number of inactive cases; 3) improve job fit using behavioral characteristic analysis of applicants; 4) develop a compensation plan to recognize performance of all Department employees; and 5) increase advanced training opportunities for DCS Specialists and managers. Upon attaining goal two objectives, DCS expects all of the indicators described for Goals one through five will improve.

Goal Three: Reduce Length of Stay for Children in Out-of-Home Care
Improving timely permanency requires a multipronged approach of facilitating successful engagement with families, targeted staffings, internal case transitions, and collaboration with the local courts and other partners. This can be achieved through the goal three objectives, which are 1) improve timeliness of reunification, guardianship, and adoption; 2) improve casework transitions and division of labor to increase efficiencies; and 3) increase frequency of clinical supervision. When the Department achieves these objectives it is expected the in-care rate per

[22] Arizona Department of Child Safety, State fiscal Year 2016 Strategic Plan.

1,000 children in Arizona and the re-entry rate will decrease. In addition, of the children who enter or are in care at the start of the year, the percentage who reaches permanency in twelve months will increase.

Goal Four: Reduce Reoccurrence of Maltreatment by Improving Service Delivery

Families that come into contact with DCS have varying levels of risk that result in the need of Department intervention. Goal four objectives include 1) expand the availability of in-home services to prevent reports for investigation and foster care re-entry; 2) reduce waitlists for in-home and parent aid services; and 3) implement targeted prevention strategies to reduce the need for Department intervention. Upon accomplishing these targets DCS anticipates the total Hotline reports, the re-report rate, and the re-victimization rate will decrease. It is also expected that the entry rate and in-care rate per 1,000 children in Arizona, the percentage of children removed within 30 days of being reported, and the re-entry will decrease and permanency within 12 months will increase.

Goal Five: Improve Capacity to Place Children in Family Environments

The Department is committed to engaging kin and fictive kin sooner, increasing the capacity of the foster home network, and evaluating ways to improve stability and retention of foster placements. This can be attained through objectives 1) increase the number of foster homes and the availability of foster home placements; 2) increase the time that children are placed within a kinship caregiver; and 3) improve retention of existing license foster homes. When the Department achieves these objectives it is expected the rate of placement moves per 1,000 days of out-of-home care will decrease. It is also expected that of the children who enter care, the percentage initially placed in congregate care will decrease, as will the percentage of total care days spent in congregate care.

Of these five goals, three goals directly relate to the demonstration project:

1. Goal number three: Reduce length of stay for children in out-of-home care.
   In order to reduce the length of stay for children in out-of-home care the Department is actively working on improving the timeliness of reunification, guardianship, and adoption. This comprises several tactics including increasing the availability and utilization of Permanency TDM meetings, which the Department has identified as the Life Long Connections TDM process for the target population under the demonstration project.

2. Goal number four: Reduce recurrence of maltreatment by improving service delivery.
   To reduce the recurrence of maltreatment by improving service delivery, the Department has begun to implement the listed strategies including approaches to reduce waitlists for in-home and parent aid services. One such approach as noted earlier is the Department's rapid process improvement session that recently took place to address the service referral and approval process. It is anticipated that the work and process that was established to standardize will have an impact on the waitlist by clarifying readiness for services, as well as a standard approval process for services. As the waitlist is reduced timely services will be provided to both the waiver target population and other children/families served by the Department.

3. Goal number five: improve capacity to place children in family environments.

In order to improve capacity to place children in family environments, the Department is looking to engage kin and fictive kin sooner, increase the capacity of the foster home network and evaluate ways to improve foster placement retention and stability. This is being accomplished through process improvements on the licensure application/approval process. While this is being completed outside of the waiver demonstration, the strategic deliverable of increasing the use of Placement Coordinators in Maricopa County to identify available kinship placements upon removal has been implemented and will have a direct correlation to the demonstration project. In addition to current searches being conducted upon a child's initial removal, these same types of search activities will take place for the demonstration target population. This objective and other strategic goals/objective deliverables are directly linked to strategic plan objectives with the goals of the demonstration project to decrease congregate care by providing family/fictive kin search and engagement activities, expanding TDMs, and ensuring available services are in place for children/families/fictive kin when needed.

These objectives and other strategic goals/objective deliverables are directly linked to the goal of the demonstration project to decrease congregate care. In addition, some of the following values were identified through the development of the Child Welfare Practice Model and confirmed through the strategic planning process[23]:

- *Child-Centered*: Children belong with families – their own when it is safe to do so and when it's not, with a safe, permanent family who can meet their unique needs and will maintain their supporting, meaningful connections to continue positive values, beliefs and their cultural legacies.
- *Family-Focused:* Families have the primary responsibility for raising their children and keeping them safe. Families are the experts regarding their own strengths and needs and will have a voice and decision-making role regarding decisions that affect them and their children.
- *Successful Engagement:* Children, youth, and families are best served when child welfare staff respect the family, actively listen to them, and invite participation in decision-making to achieve positive outcomes.
- *Partnerships and Community:* The entire community shares the responsibility of keeping children safe and protected from abuse and neglect.

Assessing Fit

As outlined within the Department's strategic plan, Arizona is building a culture of accountability founded on the principles that child safety is non-negotiable, strategic planning is predicated on thoughtful analysis and research, and engagement with families and the community to prevent child maltreatment is crucial. Over the last two years, DCS has worked collaboratively with families, providers, and other community stakeholders to assist in the design of Arizona's forthcoming more detailed practice model that articulates the values, best practices, and overall approach that will drive the work and engagement with children, youth, and families. This process has built the foundation for the congregate care reduction model that continues to align the Department's and community values with the needs of families.

[23] IBID

The community recognizes and regularly communicates the importance of engaging children, youth, and families in service interventions and in the development and strengthening of child welfare programs. As a recent example, in May 2015, DCS conducted four public meetings statewide regarding another initiative, the proposed Family Assessment Response protocols. Family engagement is the foundation of the Family Assessment Response, which is in alignment with the demonstration project interventions. During these meetings, the community discussed the importance of strengthening the child welfare agency and its programs by focusing on social work values of being family-focused and strength-based. It was emphasized that this would be accomplished by better engagement with families and the community. The community also recommended engagement training for DCS staff and improved clinical supervision training and techniques to embed engagement strategies into every day practice.

Congregate care providers reiterated the importance of improved family engagement during DCS' March 2015 focus group. This diverse cross-section of 25 statewide providers recommended that DCS would benefit greatly from more active family engagement and recommended the development of protocols and practices that support strong and consistent engagement with families. Arizona's strategic plan and proposed waiver intervention would directly address community recommendations for increased engagement, as well as improved training and techniques.

DCS is committed to ensure the sustainability of the reduction of congregate care by incorporating the waiver intervention to ensure that families receive the support they need to expedite reunification and promote legal permanency for children in congregate care. The community has also expressed support in interventions that will increase family involvement of parents/caregivers, kin, and fictive kin in interventions designed to preserve and reunify families and promote the parents'/caregivers' own personal investment in change. For instance, in-home providers currently promote family involvement through their engagement and assessment process by being family centered and solution focused. Furthermore, as learned through the focus group with the congregate care providers, most congregate providers promote family involvement inviting parents/caregivers to special dates and events as long as their case plan allows for it. Most are also performing visitation services for parents and sibling groups when it is appropriate. One provider has parenting classes on-site as an engagement effort whereas another actively pursues kin when time allows. Such efforts will be considered in the demonstration evaluation while the Department standardizes the waiver intervention. Providing Family Finding activities and expanding the TDM engagement model with available in-home services aligns with the community's value of engaging families at a deep level and provides families with a sense of hope by supporting and empowering them to create positive change.

At the same time, many TDM Facilitators currently have other responsibilities assigned to them. In order to ensure model fidelity and capacity to provide TDMs to all eligible children and families, DCS will ensure that the current TDM Facilitators are fully utilized, having any additional responsibilities re-assigned. A utilization study was performed during this last quarter to understand the capacity of the TDM Facilitators. With that and the other responsibilities assigned to the facilitators in mind, the Department is in the process of identifying resources for the facilitators so they can dedicate their time to additional TDM meetings. Resources include community partners, contractors, and dedicated teams to assist with casework related activities. Other resources include the Family Engagement Specialists, as well as the Department's practice

improvement team assisting with targeted case reviews in offices with high volume of cases. These resources, coupled with implementation of the Department's strategic plan initiatives, will help ensure that TDM Facilitators will have the capacity to provide Life Long Connections TDMs as identified.

In addition to community and departmental supports, readiness to address reducing the use of congregate care at all phases of the system, with emphasis on the "front door" preventative measures and sustainability, can be demonstrated in current Department efforts along three main dimensions: Organizational and System Capacity; Current Process and System Functioning; and Implementation Supports.

Organizational and Systems Capacity

- *Leadership Support*
  Arizona maintains a strong commitment to the Title IV-E waiver demonstration project and the reduction of children and youth in congregate care. As evidence of this commitment, demonstration project leadership are highly involved in the Maricopa County Safe Reduction Workgroup, a group established by Judge McNally, presiding juvenile court judge of Maricopa County Juvenile Court, and Director McKay with the Department of Child Safety. This inclusive group will address issues facing Maricopa County and impacting children and families to create long-term sustainable change.

  The work of the Safe Reduction Workgroup will help to inform the ongoing direction of the demonstration project and will create a natural collaboration and communication point between these two projects. The Safe Reduction Workgroup developed several sub-groups to further their work: Data Analysis (which will serve all aspects of the workgroup and sub-groups), Family Engagement, Community Engagement, Consistent Decision Making, and Targeted Services. As the work of the demonstration project continues, demonstration project team members involved in the Safe Reduction Workgroup will continue to ensure that these initiatives maintain a positive collaborative relationship focused on congregate care reduction.

  Also related to the demonstration project is Arizona leadership's commitment to consistent and accurate use of DCS' safety and risk assessment tool by all staff to guide DCS Specialists' decision-making. Arizona recognizes that an effective assessment requires intentional strategies for improving the quality of family engagement practices with the children and families served and is actively enhancing this process through several tactics outlined within the strategic plan. Accurate use of DCS' CSRA and consistent decision-making will be further enhanced with the waiver intervention.

  Another component to the organizational and systems capacity is the establishment of an Inspections Bureau (known as the Office of Quality Improvement) within DCS as required by A.R.S. § 8-458, to include quality assurance and quality improvement functions. Arizona's new leadership team supports this office's goals of instilling a culture of continuous quality improvement throughout the Department and maintaining a Department-level strategic plan with ongoing input from DCS staff, community, and child welfare stakeholders, including the courts.

This office has the following components: Program Development, Practice Improvement (Child and Family Services Reviews and qualitative case reviews), Ombudsman and Family Advocacy, and Multidisciplinary Child Fatality Review Team. Members of the Office of Quality Improvement will provide technical assistance in implementation science, change management, strategic planning, project management, and a lean process improvement methodology throughout different components of the Department so that improvement strategies are coordinated, effective, efficient, and sustained.

The Office of Quality Improvement's Program Development team, which is responsible for the oversight of the demonstration project, will provide a structural support to allow demonstration project team members to have direct knowledge and ability to support other Department initiatives that are in alignment with reducing the utilization of congregate care.

- *Staff Characteristics*
  Arizona continues to actively address staffing needs across the state. In a July 30, 2015 report from Director McKay to the Arizona Governor, the Department reported that 1,263 of 1,406 (or 90 percent) of DCS Specialist positions are filled with active case-carrying specialists or those in training. The Department has continued to develop new units including 22 in Maricopa County and eight in Pima County.

  In addition, one of the Department's top priorities is to actively review the caseload and backlog issues. DCS is seeking community input from Casey Family Programs on how best to address this problem, since easing this burden will help to better engage staff in implementing the demonstration project intervention and increase their willingness to partner with the Family Engagement Specialists, as well as participated in TDMs. The waiver intervention will not create additional work for specialists, but will instead support the Department's efforts to reduce caseloads and change the way DCS approaches its work with children and families, leading to increased efficiency and accountability in case plans.

  DCS currently has 41 of the 43 appropriated TDM Facilitator positions filled. Following the Annie E. Casey *Family to Family Initiative*, the TDM Facilitators may have up to three meetings per day. However, in practice the typical TDM Facilitator has 1-2 meetings per day and is assigned to other responsibilities by the Regional Program Manager. TDM Facilitators must have at least one year experience as a DCS Specialist III in Arizona state service; or a Master's or Bachelor's Degree from an accredited college or university and three years of child welfare experience.

  The job functions of the TDM Facilitator include:
  - Conducting TDM meetings on a full-time basis;
  - Scheduling and arranging time-limited, outcome-focused meetings to include youth, family, extended family, caregivers, community representatives, service providers and agency staff;

- Guiding participants through discussion of concerns, identification of strengths, and development of ideas to reach consensus regarding the least restrictive, best possible placement-related decision while in care and post care;
- Giving assistance and support to family members, assigned specialists and others to achieve honest, respectful and constructive meetings;
- Ensuring meetings comply with agency's mission, values, policies, and best practice standards to protect children and preserve families;
- Documenting details accurately and sharing with participants summaries at the conclusion of every meeting; entering meeting statistics into TDM automated database timely;
- Participating in regular self-evaluations of the TDM process; and
- Providing regular feedback while advocating for system improvements that support best practice and policy development.

Successful Team Decision Making facilitators have the following characteristics:

Knowledge of:	group process and ability to respectfully lead diverse and multi-cultural groups toward resolution in an emotionally charged environment; traditional and non-traditional services; child welfare programs; demonstrating commitment to agency's mission, values and core beliefs.
Skill in:	oral and written communications; assessing risk, safety planning, and case planning with the goal of providing protection and safety, preserving families and promoting timely permanency; negotiation, collaboration and conflict management; understanding of agency policies, laws, and best practice principles in child welfare; strengths-based, solution-focused and family-centered practice.
Ability to:	interpret and apply agency policies, procedures, rules and regulations; establish and maintain effective working relations with individuals, groups, and representatives of other organizations; explain to participants, decision making tools, agency policies, laws, court process, etc.; model professional interactions, provide leadership and guidance, and share constructive feedback to ensure continual quality improvement.
Special Selection Factor	One (1) year as a Child Safety (DCS) Specialist III in Arizona state service; or Master's or Bachelor's Degree from an accredited college or university and three (3) years of child welfare experience.

Family Engagement Specialists should also have similar competencies as the TDM Facilitators, with an emphasis on interpersonal skills and effective engagement aptitudes. The job functions of the Family Engagement Specialists will include:

- Work/partner with DCS Specialists to understand what has been done already around kinship search and family involvement;
- Review CHILDS, hard-file, and other documentation to understand who is involved in the child's life and identifying needs for the child/family;
- Conduct internet and other search engine functions to find family/fictive kin;

- Reach out and engage family members through letters, calling, texting, email, and social media to help find other family members/fictive kin;
- Reach out to youth (age appropriate) to find names/relationships;
- Explain DCS involvement, discover needs, prepare youth/family/fictive kin for meetings and ways to be involved in the child/family's life while being a support;
- Communicate with the child's placement to find out names/relationships, gain their perspective, and have them be a part of the transition plan;
- follow up on action plans to ensure services (informal or formal) are getting/have been put in place; facilitate Blended Perspective meetings when needed; and
- Coordinate with TDM Facilitators and DCS Specialists for the Life Long Connections TDM meetings and any follow-up meetings established.

It is beneficial to the intervention that the staffing and training for the TDM Facilitators already exists, setting a model on which to build. Once selected and hired, the TDM Facilitators are trained over five days by the Department's Child Welfare Training Institute and experienced facilitators. Additional booster sessions or advanced training occurs on an as needed basis as determined by Regional managers or supervisors of the TDM Facilitators. TDM Facilitators were initially supervised centrally, but in 2010 they were dispersed and are now supervised regionally by their regional office. Although all facilitators are initially and periodically trained together, DCS reports that there is some model drift and that the practices in each region vary depending on the facilitator. For new DCS Specialists, the facilitators conduct one hour and 30 minutes training as part of the core training for new workers. Training materials for both DCS Specialists and TDM Facilitators are available upon request.

Training regarding the Family Finding model will be conducted with assistance from the Family Finding training purveyor who is flexible with timeframes that will work best for Arizona. Training will be hands-on with technical assistance and coaching built into the curriculum. In addition, the training purveyor, in partnership with the Department and ASU, will design a fidelity tool that will meet Arizona's need. Upon implementation of the waiver intervention, Family Engagement Specialists will begin with two to three cases each, increasing to ten to 15 cases once staff members are fully trained. In addition, building staff knowledge regarding available services to support family/fictive kin will be incorporated into the waiver intervention training.

The Department understands that as the waiver intervention strategies are developed, the expansion of appropriated positions and staff education will be critical. This will allow for room to readjust to the specific needs of children placed in congregate care. It is also recognized that as congregate care strategies are developed, the inclusion of staff in the development of policies, practice, and training initiatives, including the expansion of the TDM model, in-home services and kinship search activities, will be critical to successful implementation. During this last quarter, the Department has had DCS Specialists and Supervisors, TDM Facilitators, and in-home and congregate care providers assisting in research and development regarding the family/fictive kin search and engagement piece of the waiver intervention. In addition, the Department conducted a survey of DCS Specialists, Supervisors, and TDM Facilitators regarding the TDM process, kinship

search practices and the services array availability within the Department. Focus groups were also conducted with selected DCS Specialists and Supervisors, TDM Facilitators, and in-home and congregate care providers to further gather details regarding gaps/barriers and what is working well with the TDM process and services array. Moreover, another focus group is scheduled to occur on January 12, 2016 with the behavioral health provider networks to gather their feedback regarding services available through the behavioral health system, as well as how to navigate through the system. Information gathered through these different forums assisted with the development of the waiver intervention model, draft procedures, and draft process guides.

In addition to the activities that have taken place within the last quarter, a waiver intervention workgroup has been established and is charged with drafting procedures for the waiver intervention. The group began their work on January 7, 2016 and finished their work by January 31, 2016. The workgroup included DCS Specialists and Supervisors, TDM Facilitators, in-home and congregate care providers, and a representative from the behavioral health system. Furthermore, another workgroup with other selected staff, providers, and behavioral health representatives began to meet in order to develop process guides and tools for DCS staff. These procedures and process guides are assisting to inform the waiver training curriculum.

(See Appendix D for the waiver intervention draft procedure and Appendixes E through L for the draft process guides).

- *Technical and Financial Resources*
  TDM data points are currently managed on a database which outlines the type of TDMs that are occurring and within each office and Region. It further captures data around the number of meetings that are occurring, and what the recommendations are for custody and placement options for child(ren) coming into care. Further, the TDM summary is placed in Arizona's case management system, CHILDS.

  In-home data points are also managed on a database outside of CHILDS. Data gathered is around the in-home providers' targeted performance indicators, outcome data and satisfaction surveys. Program reports such as the providers' assessment and families' service plans are entered into CHILDS by the providers in order for the assigned DCS Specialist to review how families are doing with services.

  DCS is preparing to replace CHILDS in order to improve access to case management information and tools. A Request for Proposal is in the process of being drafted and released for vendors to propose specifications for a new case management system. The development of the replacement system will be completed in a modular component model with the first modular being implemented in FY 2017. The vision for this new system will allow DCS to manage TDMs and service planning internally, creating better access to data and notes from past TDMs and service notes for better planning for future TDMs and services. In the meantime, it is anticipated that the TDM and in-home databases will need to be updated to capture any performance measures and evaluation components for the waiver demonstration.

In addition to Arizona's commitment to update data components for the demonstration project, Arizona has a strong project team committed to a demonstration project focused on congregate care reduction. The demonstration project team is comprised of experienced DCS staff including seven individuals with a range from 18 years to 6 years of child welfare experience. Team members' experience has consisted of prevention services, investigations, front-line Hotline duties, reunification and permanency case management, supervision, facilitation of family and team meetings, parent aid services, foster parent training, and program development for statewide programs. The Department has supported this team from a resource perspective and will continue to fund these activities as necessary.

Moreover, Arizona has strong technical support from national child welfare experts in its ongoing relationships with Casey Family Programs, PCG, and ASU. ASU is currently collaborating with the Child Welfare Training Institute to strengthen DCS' core curriculum training and advance training resources statewide.

Examples of these trainings include:

- Basic Forensic Training (8 hours provided in DCS Specialist Core training);
- Advanced Forensic Training (40 hours);
- Sex Trafficking Training (delivered as a part of a National Sex Trafficking Grant; a computer-based training will be developed to sustain the fidelity of this training for future staff);
- Partnering with Foster Parents (developed in partnership with ASU) was recently piloted and will be rolled out into DCS Specialist Core training;
- Certified Public Manager course has been delivered to assistant program managers and supervisors by ASU for the past three years;
- Series of seven supervision courses for Supervisors; and
- PS-MAPP training (there is a section currently in development that will be dedicated to trauma informed care).

Arizona has also engaged the Child Welfare Capacity Building Center for States with an assessment in early June 2015. The center began working with the Program Development team in September 2015 providing training and coaching around implementation science. Additionally, the center and DCS has identified other areas on which the center offered, and will continue to provide, assistance to the Department.

- *Quality Community Linkages*
  Arizona has a strong history of community involvement in Departmental initiatives. As previously mentioned, focus groups were held with youth placed in congregate care and parents of children who were placed in congregate care, where they commented on issues related to congregate care settings, needed services and supports, and engagement. Ongoing engagement with parents and youth will be vital as implementation planning continues. The expansion of in-home services and kinship search practices will build off of these community linkages. A focus group was also conducted with the congregate care providers and an initial meeting has been held with in-home providers from across the state. Ongoing engagement with these providers will occur as part of the implementation.

The Congregate Care Implementation Team that had met in the past has included DCS staff, parents, youth, child welfare stakeholders, and community members. DCS will continue to engage subject matter experts within behavioral health, in-home providers and the community to determine how to enhance the existing TDM model to meet the needs of the congregate care population, identify strategies to build on existing in-home services and ensure they are fully utilized, and identify kinship search practices that can be successfully implemented to achieve legal permanency.

In addition to the implementation team and reconvening of workgroups, there are community providers that currently have programs in place that supports the demonstration project. For example, Arizona's Children Association hosts a PS-MAPP (Partnering for Safety and Permanence – Model Approach to Partnerships in Parenting) course for kin caregivers at the KARE Family Center, a resource center in Tucson for families raising their relative's children. Increasing the number of alternative placements, including kin placements, will help to reduce the use of congregate care. To reduce barriers to licensing kin as foster parents, the course is offered during evening and weekend hours to better accommodate kin caregivers' schedules and child care is provided. Although the content is the standard PS-MAPP course, additional information can be provided to meet the needs and experiences of kin caregivers. Further, kin caregivers learn in a supportive environment of peers with shared life experiences.

Furthermore, the Department's Office of Licensing and Regulations (OLR) is currently in the process of revising the training for potential foster parents. The goal is to decrease the length of time it takes to become trained and licensed, increase learning and retentionof the material presented. The design of the training is to focus on the most essential needs of foster parents during the first year of licensing, only. OLR will be holding focus groups in February 2016 with foster parents, licensing agencies, and DCS Specialists around the state to gain their input regarding the basic knowledge needed by foster parents. This will assist in the design of the new training curriculum which is expected to be complete by December 2016 and rolled out in 2017.

Current Process and System Functioning

After a thorough analysis of current practice, policies, and initiatives, Arizona has determined there is not an active practice, policy, or initiative that conflicts with the demonstration project, although there will be a need to update current policy to include the targeted Life Long Connections TDM process, as well as the Family Finding activities. All current processes and those under development align with the common agency-wide goal of reducing the use of congregate care placements for children when appropriate. Furthermore, the implementation of the intervention would address issues of miseducation and mistrust among providers, further strengthening the relationship between DCS and providers. Any congregate care reduction interventions currently in place are not considered in competition with the waiver project.

As noted in-home providers frequently have a wait list for services that results from their need to balance case referrals with a desire not to have excess staff capacity without a full caseload. Methods to address this throughout the waiver demonstration project include streamlining the referral process, ensuring the right referral is made at the right time, and continued collaboration

with the services providers on an individual case related basis and as a whole during quarterly statewide provider meetings.

Implementation Supports

Arizona has developed an ongoing governance structure for the demonstration project. The Waiver Implementation Team supports sound planning, executing, and monitoring of the implementation. In addition, the current project team is guiding the development of the IDIR, and as the project progresses, Site Based Implementation Teams in each office will be developed to manage the work of implementation. Implementation science will be used as guiding principles to all waiver initiatives. DCS will invite parents, youth, child welfare stakeholders, and community members to join the implementation team and other subgroups.

V. Work Plan

Section V should provide a plan and estimated timeline for activities associated with the implementation of each component of the demonstration. To the extent possible, this section should include a description of the key tasks, responsible parties, timeframes for beginning and completing activities, and products or benchmarks of progress that will serve as evidence of completing the activities, noting the phasing or staging of provider contracts, services, or other activities if there are multiple implementation locations. Title IV-E agencies may choose to include a Gantt chart to support the narrative. Activities that may be particularly time-consuming or require action or approval by those outside of the child welfare agency to complete (e.g., State legislation, contractual agreements) should be identified. This section should address the following areas:

A. Developmental Activities: A summary of the title IV-E agency's plan to develop the resources needed to support the waiver demonstration, including:

1. ***Cost estimates for interventions and activities associated with each demonstration component;***
2. ***Decisions on how title IV-E dollars will be allocated, including projections of how savings will be realized;***
3. ***Selection of and contracts with any partnering agencies;***
4. ***Expected processes and dates for hiring needed staff, and schedules for training staff;***
5. ***Developing supervision and coaching plans;***
6. ***Installing or modifying any required data systems[24];***
7. ***Plans for initiating service delivery (e.g., referral protocols that describe how families or children will be selected to participate in the demonstration, how these selections will be made, and how the suitability of services will be determined; selection of units/sites that will begin implementation of the demonstration; and when and how staff will begin providing services associated with the initiative/interventions);***
8. ***Development of proactive problem-solving protocols.***

B. Teaming and Building an Accountable, Collaborative Governance Structure: Detailed information should be included related to the teaming structure to manage implementation of the demonstration, including:

1. ***Identification and description of the lead agency, partner organizations, and collaborative partners and their respective roles and responsibilities, including financial commitments to the demonstration;***
2. ***Description of the standards of quality and safety and practice requirements identified by the title IV-E agency to be incorporated into any agreements with public and private providers that are expected to provide supports and services;***
3. ***Identification of implementation teams along with clarified purposes, core features,***

[24] Activities conducted as part of the demonstration that affect the Title IV-E agency's Child Welfare Information System may require the submission of an Advance Planning Document to ensure compliance. See http://www.acf.hhs.gov/sites/default/files/cb/pi1005.pdf for more information. Agencies are encouraged to contact the Division of State Systems within CB for further assistance.

functions of the teams, communication protocols that link teams, and teaming challenges or risks;

4. Identification and description of management procedures, positions, and functions;

5. Description of the processes for monitoring implementation progress, including ongoing identification of barriers or emerging implementation issues.

C. Communication Plan and Strategies: A description of the processes, procedures, and strategies for maintaining efficient and effective communication internally among all applicable partners, and externally with the public and policymakers.

D. Quality Assurance: A framework for continuous quality improvement and implementation and a description of the role of monitoring and evaluation in informing the implementation and refinement of the demonstration project's components.

E. Evaluation Schedule: A timeline illustrating the inter-relationship between demonstration and evaluation activities, including efforts to engage a third-party evaluator and the evaluator's expected hire date in relation to the proposed start date of the demonstration.

F. Phase Down Plan: A description of the plan for phasing down the demonstration so that case plans for children and their families can be adjusted, if necessary, for the post-demonstration portion of their placement, and to revert to traditional title IV-E claiming.

Developmental Activities

Over the course of the last quarter, Arizona took many actions to develop resources for successful implementation of combining TDM with accessible family/fictive kin search and engagement strategies through the Family Finding model with available in-home and/or other needed services as the waiver intervention. Such actions included conducting research on congregate care reduction strategies; analyzing data to understand the characteristics and needs of the target population; reviewing DCS policies, procedures and related materials on congregate care; reviewing and designing the waiver intervention; conducting a cost analysis regarding all components of the waiver intervention; and establishing a collaborative governance structure.

As the Department will initiate implementation in April 2016, there are several installation activities currently being completed. Activities currently being performed and accomplishments during this last quarter are outlined in the work plan on the following pages:

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
STAGE I: EXPLORATION						
A.1 Objective: Conduct research on congregate care reduction strategies						
1.1	Research other jurisdictions' congregate care reduction strategies	Sep-14	Jan-15	Nov-15	100%	Updated strategies were researched and summarized
1.2	Research articles on congregate care reduction strategies	Dec-14	Jan-15	Nov-15	100%	Updated strategies were researched and summarized
1.3	Research EBP's used to reduce congregate care	Dec-14	Jan-15	Nov-15	100%	Updated strategies were researched and summarized
1.4	Interview other jurisdictions that have reduced congregate care	Nov-14	Jan-15	Nov-15	100%	Updated strategies were researched and summarized
A.2 Objective: Analyze data to understand characteristics and needs of target population to identify possible interventions						
2.1	Gather and analyze child welfare data	Oct-14	Dec-14	Sep-15	100%	
2.2	Conduct focus groups with DCS Staff	Nov-15	Jan-15	Dec-15	100%	Conducted twice - February 2015 and again in December 2015 with DCS staff and TDM Facilitators regarding updated strategies
2.3	Conduct focus groups with parents	Nov-14	Jan-15	Jan-15	100%	
2.4	Conduct focus groups with youth	Dec-14	Jan-15	Jan-15	100%	
2.5	Conduct focus groups with congregate care providers	Dec-14	Jan-15	Jan-15	100%	
	Conduct focus groups with in-home and congregate care providers	Dec-15	Dec-15	Dec-15	100%	Conducted regarding updated strategies
2.6	Conduct case record review	Dec-14	Dec-14	Feb-15	100%	ASU reviewed 17 cases related to CGC

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
A.3 Objective: Review DCS' policies, procedures and related materials on CGC						
3.1	Review current DCS initiatives and collaboration strategies that could be built upon	Jan-14	Mar-15	Apr-15	100%	
3.2	Review Auditor General's report	Oct-14	Feb-15	Oct-14	100%	
3.3	Gather information from DCS' lessons learned from previous CGC reduction initiatives	Dec-14	Dec-14	Dec-14	100%	
3.4	Review policies and procedures that relate to CGC placement decisions	Jan-15	Jan-15	Apr-15	100%	
3.5	Review training materials related to CGC placement decisions	Jan-15	Jan-15	Apr-15	100%	
3.6	Review contracts for CGC providers	Dec-14	Jan-15	Sep-15	100%	
ADDITIONAL PROGRAM DESIGN STEPS OUTLINED IN INDIVIDUAL INTERVENTION WORK PLANS						
TEAM DECISION MAKING (TDM) WORK PLAN						
B1. Objective: Evaluate current TDM model in AZ						
1.1	Identify current TDM model in Arizona	Aug-15	Aug-15	Aug-15	100%	
1.2	Gather information on current performance evaluation tools being utilized in Arizona	Aug-15	Oct-15	Oct-15	100%	
1.3	Research different types of TDM meetings and purposes	Aug-15	Aug-15	Aug-15	100%	
B2. Objective: Evaluate potential barriers to TDM model						
2.1	Interview TDM Facilitators	Nov-15	Nov-15	Dec-15	100%	Survey and Focus Group setting
2.2	Interview DCS Specialists	Nov-15	Dec-15	Dec-15	100%	Survey format

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
B3. Objective: Evaluate current TDM population in AZ						
3.1	Gather number of children who were the subject of a TDM by region	Oct-15	Oct-15	Oct-15	100%	Summary of the number of children discussed at a TDM and their legal and placement outcomes by region
B4. Objective: Research on best TDM model/process for AZ and congregate care population						
4.1	Identify desired outcomes for TDMs focused on reducing congregate care	Oct-15	Nov-15	Dec-15	100%	
4.2	Determine costs associated with changing the model	Oct-15	Oct-15	Nov-15	100%	Cost analysis conducted for all waiver components
IN-HOME SERVICES WORK PLAN						
C.1 Objective: Evaluate current family support services available in AZ						
1.1	Determine what information is already available that can be utilized for this current project plan	Oct-15	Oct-15	Oct-15	100%	
1.2	Identify the current contracted services array available and utilized for each Region	Oct-15	Oct-15	Nov-15	100%	
1.3	Prepare data on current processes	Oct-15	Nov-15	Nov-15	100%	
C.2 Objective: Identify inefficiencies, barriers, or gaps in the in-home services array						
2.1	List barriers/limits/ gaps of current In Home service array	Oct-15	Nov-15	Dec-15	100%	Survey and Focus Group setting
2.2	Assess current referral process for In Home services	Oct-15	Nov-15	Dec-15	100%	Survey and Focus Group setting
C.3 Objective: Review policy and law regarding services to families						
3.1	Review current DCS Policy re: providing adequate services to DCS-involved families (Reasonable Efforts)	Nov-15	Nov-15	Nov-15	100%	

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
3.2	Review current Federal Law re: providing family support services	Nov-15	Nov-15	Nov-15	100%	
KINSHIP SEARCH WORK PLAN						
D.1 Objective: Evaluate what kinship search tools already exist in AZ						
1.1	Identify the kinship search practices existing throughout AZ, including % of success locating kin/referral process/ staff involved/ limitations of use	Oct-15	Oct-15	Oct-15	100%	
1.2	Discuss requirements and timeframes for new contracts for the chosen model	Oct-15	Oct-15	Nov-15	100%	
D.2 Objective: Review policy and law regarding locating/involving kinship members						
2.1	Review current DCS Policy re: kinship services	Oct-15	Oct-15	Oct-15	100%	
2.2	Review current Federal Law re: involving kinship members	Oct-15	Nov-15	Nov-15	100%	
D.3 Objective: Identify workgroup members						
3.1	Schedule and hold initial workgroup meeting to define the workgroup purpose, develop charter, goals, time commitment, duration, expectations, etc.	Oct-15	Nov-15	Nov-15	100%	Kickoff meeting 11/05/15
D.4 Objective: Evaluate potential barriers to kinship search models						
4.1	Research and list barriers/ limits/ gaps of current kinship search process in AZ	Nov-15	Nov-15	Dec-15	100%	Survey format
4.2	Research processes regarding kinship search for unique AZ populations	Nov-15	Nov-15	Nov-15	100%	
4.3	Determine possible solutions for unique AZ populations	Nov-15	Nov-15	Dec-15	100%	Tribal population; persons for DPS checks unable to be completed

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
4.4	Discuss in workgroup research/data found to date re: current AZ need by Region vs. resources available (i.e. challenge)	Dec-15	Jan-16	Jan-16	100%	
D.5 Objective: Evaluate current reach (need) of kinship search in AZ						
5.1	Interview with CHILDS to see if needed data is captured	Oct-15	Oct-15	Oct-15	100%	
5.2	Locate other data sources (non-CHILDS) available to obtain needed data	Oct-15	Oct-15	Oct-15	100%	
5.3	Determine data variables needed and if/where available including timeframe of data needed	Nov-15	Nov-15	Nov-15	100%	
5.4	Request CHILDS/other data sources on Federal kinship search compliance variables, if data is available, and locate other sources if needed	Nov-15	Dec-15	Dec-15	100%	
5.5	Research costs of all current search processes used	Nov-15	Dec-15	Dec-15	100%	
5.6	Calculate number of children impacted by kinship search process statewide	Nov-15	Dec-15	Dec-15	100%	
D.6 Objective: Decide on best kinship search models in AZ						
6.1	Research potential kinship search models to implement, including average success rates of each	Oct-15	Nov-15	Nov-15	100%	

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
STAGE II: INSTALLATION						
E.1 Objective: Establish collaborative governance structure						
1.1	Create Waiver Implementation Team	Nov-14	Jan-15	Sep-15	100%	Kickoff meeting with Waiver Implementation Team occurred on 10/21/15
1.2	Re-evaluate team membership as needed	Nov-14	Ongoing			
E.2 Objective: Develop initial roll out plan						
2.1	Determine criteria for initial office sites selections	Dec-15	Dec-15	Dec-15	100%	
2.2	Determine initial office sites for implementation	Jan-16	Jan-16	Jan-16	100%	
2.3	Create initial site implementation teams	Jan-16	Feb-16	Feb-16	100%	
2.4	Develop phase-in plan	Feb-16	Mar-16		50%	
2.5	Identify additional support needed	Feb-16	Mar-16		50%	
2.6	Assess office and community readiness	Mar-16	Ongoing		50%	Initial sites currently be assessed
E.3 Objective: Create a communication plan						
3.1	Form a communication committee	Dec-15	Jan-16	Jan-16	100%	
3.2	Create a communication plan for those involved in implementation process	Feb-16	Feb-16	Feb-16	100%	Kick off meeting to occur on 1/19/16
3.3	Create a communication plan for internal communication	Feb-16	Feb-16	Feb-16	75%	Currently drafting messages; est. completion 3/14/16
3.4	Create a communication plan for external communication	Feb-16	Feb-16	Feb-16	75%	Currently drafting messages; est. completion 3/14/16
E.4 Objective: Develop procedures						
4.1	Draft procedures	Jan-16	Jan-16	Feb-16	90%	Currently in review & approval process; est. approval 3/25/16

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
4.2	Draft statewide policies	Jan-16	TBD			When roll-out statewide
4.3	Draft tools and process guides	Jan-16	Feb-16	Mar-16	90%	Final approval process
E.5 Objective: Train staff on intervention model						
5.1	Charter training development team	Oct-15	Oct-15	Oct-15	100%	The Department has a partnership with Arizona State University to assist with the development of training curriculum
5.2	Design training curriculum	Feb-16	Mar-16		50%	Currently being developed; Family Finding training confirmed
5.3	Develop supervision and coaching plans for staff	Feb-16	Mar-16		50%	Currently being developed
5.4	Establish training schedule	Feb-16	Mar-16		75%	Initial sites set; additional sites will be established in roll-out plan
5.5	Implement training of staff	Mar-15	Apr-16			Set for the week of 4/11/16 for Family Engagement Specialists and initial implementation sites
E.6 Objective: Create continuous quality improvement processes						
6.1	Develop framework for continuous quality improvement	Feb-16	Jun-16			Partnership with ASU during initial implementation; embed into practice
6.2	Design quality assurance tools for field	Feb-16	Jun-16			Partnership with ASU during initial implementation
E.7 Objective: Create technological changes and supports needed for intervention model						
7.1	Determine CHILDS changes needed to support intervention model	Dec-15	Dec-15	Dec-15	100%	There are no changes needed to support the intervention

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
STAGE III: INITIAL IMPLEMENTATION						
F.1 Objective: Phase One - Roll out implementation to initial implementation sites						
1.1	Implement in initial implementation sites	Apr-16	Apr-16			
1.2	Initial implementation site teams monitor activities	Apr-16	Ongoing			
1.3	Review data and identify indicators to measure initial implementation	Apr-16	May-16			
1.4	Identify strategies to work through barriers/challenges	Jun-16	Jul-16			
1.5	Apply strategies to smooth out barriers/challenges	Jul-16	Jul-16			
1.6	Assess initial implementation, adjust approach as needed for phase two roll out	Jul-16	Jul-16			
1.7	Develop implementation guidance for upcoming sites	Jul-16	Jul-16			
F.2 Objective: Phase Two - Roll out implementation to next selected sites						
2.1	Implement in the next selected sites	Aug-16	Ongoing			
2.2	Site implementation teams monitor activities	Aug-16	Ongoing			
2.3	Develop assessment to measure initial implementation	Aug-16	Ongoing			
2.4	Identify strategies to work through barriers/challenges	Aug-16	Ongoing			
2.5	Apply strategies to smooth out barriers/challenges	Aug-16	Ongoing			

	Task Description	Est. Beginning	Est. Completion	Actual Date Completed	% Completed	Comments/Notes
STAGE IV: FULL IMPLEMENTATION						
G.1 Objective: Ensure sustainability for the model within the child welfare system						
1.1	Develop sustainability plan	Apr-17	Ongoing			
1.2	Codify and anchor sustainability into practice	Apr-18	Ongoing			
1.3	Ensure resources are available to maintain the practice	Apr-18	Ongoing			

As noted, much of the exploration phase has been complete and the Department began the installation phase in an effort to establish needed resources to support the waiver intervention. An important aspect for successful and sustainable implementation is having a thorough understanding of the cost associated with the waiver intervention. Thus, a cost analysis regarding the waiver intervention was completed. The analysis included a review of the average cost per month per child in congregate care setting and the cost savings that the Department expects to take place upon the waiver intervention. Further, an examination of the projected savings that may be accrued during the waiver took place, and discussions continue to occur regarding how any cost savings will be used for future child welfare services.

The Department has also established criteria for selecting the initial implementation sites. Criteria to consider include:

- Number of children in congregate care at particular sites
- Children's length of time in congregate care
- The rate of removals
- Age of children in congregate care
- Number and type of placements children have had (especially those previously disrupting from kinship placements)
- Case plan goals of the children in congregate care
- Case load size of DCS Specialists
- Experience of DCS Specialists

With this rationale, the Department has pulled data and identified potential sites within Maricopa County, which will be the initial implementation county. Maricopa County has 25 field offices with 14 offices having an average of 74 children in the congregate care setting. The remaining offices average 20 children in the congregate care setting. The Department has six Family Engagement Specialists that will begin the Family Finding activities upon initial implementation and will be supported with the site's assigned TDM Facilitators. The Department has identified the initial sites in Maricopa County; therefore, Site Based Implementation Teams have been established. The initial Site Based Teams has assisted in the development of the initial roll out plan while assessing office and community readiness to identify additional needed supports. In addition, the site based leadership has helped with developing the waiver intervention communication plan.

During the month of January 2016, DCS the Department drafted procedures regarding the waiver intervention. This includes outlining the intervention model with key roles and responsibilities of those performing waiver intervention activities. In February 2016, process guides were drafted that, together with the procedures, has informed and is assisting in the development of the waiver training curriculum.

The Department has established a Training/Coaching Committee to oversee the development of the training curriculum. The committee members are individuals from the Department's Program Development Team and Child Welfare Training Institute (CWTI) Administrator, ASU, and the Family Finding training purveyor. CWTI and ASU are currently writing the curriculum and will have this complete by March 25, 2016. Upon completion the training curriculum will be

submitted for Departmental approval with the tentative approval date of 4/1/16. There are four components to the training, which includes an awareness training regarding the Family Finding model, hands-on Family Finding practice techniques, on the Life Long Connections TDM process and on the waiver intervention model, which includes the service array. Participants for each component are as follows:

Family Finding Awareness

- Executive Leadership Team
- Regional Leadership
- All Family Engagement Specialists and Supervisor
- All TDM Facilitators
- Site Based Teams
- Program Development Team
- CWTI Administrator and Trainers

Hands-on Family Finding Training over the course of six months

- Family Engagement Specialists
- Family Engagement Supervisor
- Site Based Leadership
- Program Development Staff
- CWTI Trainers

Life Long Connections TDM Process

- Regional Leadership
- Site Based Leadership
- Family Engagement Specialists and Supervisor
- TDM Facilitators
- Program Development Staff
- CWTI Trainers

Waiver Intervention Model

- Regional Leadership
- Site Based Leadership
- Site Based Staff
- Family Engagement Specialists and Supervisor
- TDM Facilitators
- Program Development Staff
- CWTI Trainers

A training schedule outlines the initial training to occur during the week of 4/11/16 which will include the Family Finding Awareness workshop for the larger group of participants. The hand-on Family Finding practice techniques, together with the training on the Life Long Connections process and the waiver intervention model, will be done in stages. The initial sites will be trained during the week of 4/11/16, coupled with the Family Engagement Specialists receiving hands-on

training and coaching for six months. As the Department rolls out to additional sites, the TDM Facilitators, with the site-based teams/leadership and staff, will receive training specific to the Life Long Connections TDM process and the waiver intervention model.

(See Appendix D for the waiver intervention draft procedure and Appendixes E through L for the draft process guides).

Governance Structure

In October 2015 the Waiver Implementation Team reconvened and meets monthly. This team is made up of key individuals within DCS, as well as the behavioral health system and ASU. The following is a list of those on the implementation team:

Waiver Implementation Team		
Name	**Title**	**Organization**
Shalom Jacobs	Deputy Director, Field Operations	DCS - Program Operations
Mike Dellner	Deputy Director, Operations	DCS - Business Operations
Katherine Guffey	Office of Quality Improvement Officer	DCS - Office of Quality Improvement
Aaron Goldman	NARBHA, Director of Children's Services	Behavioral Health System
Alex Ong	Assistant Director, Business Operations	DCS - Business Operations
Alice Mclain	Contracts Manager	DCS - Business Operations
Amanda Kindle	Assistant Program Manager, S. Mtn	DCS - Program Operations
Amy Fox	Placement Assistant Program Manager	DCS - Program Operations
Beverlee Kroll	Permanency & Youth Services Manager	DCS - Program Operations
Casey Melsek	Central Regional Program Specialist	DCS - Program Operations
Christie Kroger	Practice Improvement Administrator	DCS - Office of Quality Improvement
Cynthia Ramirez	Behavioral Health Clinical Supervisor	DCS - Program Operations
Dawn Goulet	Northern Regional Program Manager	DCS - Program Operations
Deb Nishikida	Southeast Regional Program Manager	DCS - Program Operations
Deborah Fernandez-Turner	Mercy Maricopa, Children's Medical Director	Behavioral Health System
Gillian Vanasse	SW Regional Office Program Specialist	DCS - Program Operations
Illya Riske	Finance Manager	DCS - Business Operations
Jennifer Sismondo	OCWI Investigator	DCS - Office of CW Investigations
Joei O'grady	Investigative Supervisor, Tempe	DCS - Program Operations
Judy Krysik	Associate Director/Professor	Arizona State University
Karen Nelson-Hunter	Policy Administrator	DCS – Program/Business Operations
Kylah Ross	CWTI Program Administrator	DCS – Child Welfare Training Institute
Lyn Hart	Assistant Program Manager, Avondale	DCS - Program Operations
Monique Thomas	Assistant Program Manager, Thunderbird	DCS - Program Operations
Pauline Machiche	Pima Regional Program Manager	DCS - Program Operations

Name	Title	Organization
Ronald Copeland	Cenpatico Behavioral Health	Behavioral Health System
Susan Blackburn	Program Development Administrator	DCS - Office of Quality Improvement
Vanessa Bustillos	Statewide In Home Coordinator	DCS - Program Operations

The team is charged with:

- Ensuring the key installation activities are completed and oversee the effective implementation of the intervention;
- Ensuring resources are available to support the implementation;
- Problem-solve and address barriers to implementation;
- Review and utilize data to monitor the progress of implementation; and
- Make suggestions and endorse improvements to be made when needed to ensure success that is sustainable.

The initial Site Based Implementation Teams are as follows:

Initial Site Based Implementation Teams	
Avondale Office	**Positions**
	Assistant Program Manager
	Ongoing Supervisor
	Investigative Supervisor
	Ongoing DCS Specialist
	Investigative DCS Specialist
	Program Specialist
	TDM Facilitator
	Cross-over Juvenile Probation Officer
	Advocacy Center Specialist
Tempe Office	Assistant Program Manager
	Ongoing Supervisor
	Investigative Specialist (Seasoned)
	Investigative Specialist (New)
	3 Ongoing DCS Specialists
	Two TDM Facilitators
	Co-located Provider Specialist

Upon implementation, the initial Site Based Implementation Teams will monitor the activities with an established data set and program indicators to measure initial implementation. The data set and indicators will be developed by a Data/Evaluation Committee that is being co-led by the Department's Program Development Team and ASU. The Data/Evaluation Committee is also charged with identifying what data and information ASU will need for the demonstration project evaluation and ensuring that ASU obtains the information as outlined within the evaluation plan. The Data/Evaluation Committee will begin meeting on March 15, 2016 and will have established criteria by April 15, 2016.

Further, upon initial implementation, the initial Site Based Teams through the months of April-July 2016, will gather information, problem solve, and provide feedback to the Statewide

Implementation Team and leadership. This will allow for all to celebrate the successes, and identify and apply strategies to work through any barriers/gaps. This process will also assist in the development of an implementation guide for upcoming sites during additional roll-out activities.

As DCS rolls out to additional sites, individual Site Based Teams similar to those listed above will be established. This is done in collaboration with the regional and site based leadership.

Communication Plan and Strategies

On January 19, 2016 DCS had a kickoff meeting with the Waiver Communication Committee. Members of the committee include external partners, and internal staff, including the Department's Director of communications. The purpose of the committee was to develop a plan for internal and external communication with strategies that are aligned with the stages of implementation. There are seven key areas each plan focuses on:

1. Audience, such as service providers, the courts, DCS management and leadership, DCS staff, the public, and governor/legislature;
2. What is needed from the different audiences, specifically their awareness and understanding of the benefits of the waiver intervention, and support of implementation and embedding it into practice;
3. What matters to the different audiences or the impact the intervention may have on them;
4. Key messages to be delivered;
5. Best vehicle/forum to deliver the messages, such as the DCS website, emails, brochures, in-person meetings, presentations, and on-site meetings;
6. Date/estimated delivery; and
7. Messenger/person responsible who may include DCS leadership, contracts, fiscal team, general counsel or court liaison, program development team, or the communication team.

The communication plan also addresses the feedback loop from the Site Based Implementation Teams to the Waiver Implementation Team regarding implementation progress, including information regarding barriers, successes, and resource needs. The plan will also address pathways for how key decisions will be communicated, such as the next site selections, changing timelines, training plans, etc.

Quality Assurance

As noted in the waiver work plan, tasks to still be completed include the development and creation of the quality assurance process to monitor the progression of the waiver intervention implementation. In partnership with ASU, from March-June 2016 the Department will design a quality assurance process with fidelity tools and other performance instruments to measure initial implementation. This will include surveys, data gathered by the Site Based Teams, information tracked by the Family Engagement Specialists and TDM Facilitators, case reviews, and site visits being conducted by the Department and ASU. During the design and testing phase of the instruments and quality assurance process, ASU will gather information and report on initial implementation outcomes throughout July-September 2016.

Evaluation Schedule

An Interagency Service Agreement (ISA) with ASU to conduct the evaluation of the demonstration project was signed on April 15, 2015. ASU and DCS finalized and submitted the evaluation plan for the demonstration project on February 29. 2016. Included in the evaluation plan is a timeline for process evaluation, outcome evaluation, and the cost evaluation. The timeline outlines the tasks and the required reports.

Phase-Down Plan

For the wavier intervention that is implemented under the demonstration project, individuals who are receiving the intervention services at the close of the project may continue to receive the services. DCS does not anticipate phasing down the usage of the family/fictive kin activities and the Life Long Connections TDM process. The majority of new costs for these activities will be incurred during the implementation period. As the Department builds internal capacity to provide family/fictive kin activities while utilizing existing TDM Facilitators for the Life Long Connections TDM meeting, DCS will be able to embed the process into practice.

However, there may be a need to phase down in the area of in home reunification or placement stabilization services. Throughout the project, effort will be made to allocate some general funds for the contracted in home reunification or placement stabilization services, and not rely solely on flexible title IV-E funds. This will allow for some capacity to be maintained for these services on a reduced scale after the demonstration project has ended. If any services must be discontinued due to loss of flexibility of title IV-E funding, the service end date will be set after all children/families served under the project have been completed.

Title IV-E eligibility will continue to be determined for all children in out-of-home care throughout the demonstration project. Payments for eligible children in out-of-home care will continue to be processed as they are now, which enables title IV-E eligible maintenance payments to be identified. By maintaining eligibility determination and payment processes throughout the project, no changes will be required at phase down for children who are title IV-E eligible in out-of-home care.

VI. Training and Technical Assistance Assessment

Section VI should include a description of the training and technical assistance (T/TA) resources the title IV-E agency anticipates it will need in order to implement the waiver demonstration, making note of any strengths and gaps in those resources. This description should include federally supported and non-federally supported T/TA resources. The agency should consult with CB to determine the extent to which CB's T/TA Network can be used to support the implementation and evaluation of the demonstration.

Arizona is working in collaboration with ASU, Casey Family Programs, the Capacity Building Center for States, and other parties to finalize the intervention. Ongoing engagement of these partners will be integral to the Department's ongoing success in moving towards waiver implementation.

VII. Anticipated Major Barriers and Risk Management Strategies

Section VII should identify any anticipated major barriers to implementing the waiver demonstration's interventions and any planned strategies to address them.

Progress on Identifying Barriers and Risk Management Strategies
There are several anticipated barriers to the demonstration project that Arizona has considered at this stage of selecting a new intervention:

- Staff Capacity
    - *Risk Mitigation*: There is concern that increasing TDMs could add to the workload of DCS staff. However, once implemented, TDMs can alleviate DCS staff's workload by increasing reunification and permanency, maximizing efficiency during meetings, and holding parties accountable for the action plan.
    - *Risk Mitigation*: Currently TDM Facilitators have duties beyond facilitating TDM meetings, which impacts their ability to facilitate up to three TDMs per day. In order to address the increased demand for TDMs for congregate care populations, the responsibilities of facilitators must focus on TDMs and other duties re-assigned to other staff.

- Staff Understanding and Training
    - *Risk Mitigation*: Agency staff members are not aware of TDMs and how to utilize them with the congregate care population. In addition to the basic training offered to new specialists through the Child Welfare Training Institute, DCS will provide training and materials to support the use of TDMs to current agency staff, supervisors, and leadership.
    - *Risk Mitigation*: A good coaching plan is imperative to the success of this waiver project. Arizona is currently reviewing how to mitigate this risk by developing supervisory planning, a coaching plan, phased roll out of the demonstration project, and involving parents and others who have benefited from DCS services.
    - *Risk Mitigation*: Agency staff members are not aware of in-home services that can be useful. Additional training will help agency staff learn about the in-home services available, benefits, referrals, and collaboration with these providers.

- In-home Services Capacity
    - *Risk Mitigation:* Currently many contracted providers for in-home services maintain a waitlist for new referrals, which can delay access for families. DCS will address this problem by working collaboratively with the in-home providers to understand their concerns and develop processes to ensure that referrals are streamlined, appropriate, and timely. Additionally, DCS will improve DCS Specialist training to understand the different types of in-home services and how to make a referral that is individualized for each family's needs.
    - *Risk Mitigation:* Current contracts with in-home providers may need to be expanded to meet increased demand. DCS will work with the Department's contracts unit to

proactively plan for the use of new or revised contracts to increase access to in-home services.

- New Department of Child Safety
  The impact of operationalizing the new Department of Child Safety at the same time as other initiatives are being developed, including the Title IV-E waiver demonstration project, could be seen as a barrier, but DCS has strategies in place to mitigate these risks:
  - *Risk Mitigation*: The Auditor General's report identifies congregate care reduction as an issue within DCS highlighting the importance of the demonstration project goals as part of DCS optimal operations. The DCS project team will continuously monitor the inclusion of congregate care reduction as an agency priority and will further develop strategic planning efforts.
  - *Risk Mitigation*: One key initiative currently in process at DCS is the development of a practice model. Demonstration project leadership is also involved in the practice model initiative, creating a natural collaborative effort that will ensure the congruence of project goals. Arizona recognizes that effective congregate care reduction will need to include an approach to practice that involves the engagement of families, accurate assessments, and decision-making processes that ensure youth and families are provided the right services to maintain families whenever possible and, when necessary, place youth in the least restrictive and safest environment possible. It is anticipated that further development of the practice model and demonstration project outcomes will be consistent and highly inter-related. Discussion of practice model efforts and how this would ultimately support the demonstration project will take place.

VIII. Program Improvement Policies

Section VIII should include a description of the new program improvement policy(ies) the title IV-E agency will implement within three years of the submission of the proposal, as required by the authorizing legislation. Please include a summary of implementation activities and describe the title IV-E agency's progress towards full implementation of the proposed policies. If one or both of the new program improvement policies is included specifically as a waiver intervention and is fully addressed in the preceding sections, the information does not need to be repeated in this section.

The following items are the policies selected by Arizona with a current status update:

1. *Increase the number of siblings that are together in all placement settings.*
   This is a policy that Arizona has already implemented. The DCS' Policy and Procedure Manual was updated to reflect policies related to siblings. Arizona has committed to make all reasonable efforts to place a child with any or all of his or her siblings unless there is documented evidence that it is not in his or her best interest. The policy also covers visitation between siblings that are not in placement together. Lastly, the policy discusses an exception in the licensing process for overcapacity issues when efforts are being made to account for sibling placements. These changes were made in part due to state law change in 2013. Arizona will continue to monitor efforts, but these efforts are considered as completed for demonstration project purposes.

   Although placing siblings together is one reason why some children are placed into congregate care, it is a DCS policy to increase the number of siblings together in all placement settings. Any interventions and efforts Arizona will make to reduce congregate care will not ignore this policy. Arizona will need more placement resources that are outside of congregate care that can care for sibling groups, which is what the program improvement policy described below aims to address.

2. *Develop and implement a plan to improve the recruitment and retention of high quality foster family homes. Supports for foster families under such a plan may include increasing maintenance payments, expanding training, respite care, and other support services for foster parents.*

   DCS released the new contract for Home Recruitment, Study, and Supervision (HRSS) in March 2015. This contract, as well as the performance indicators included therein, was developed with the input of provider stakeholders. The service requirements are intended to increase the quality and quantity of family-based care providers and permanency resources, including licensed foster families, respite families, in-home respite providers, receiving foster families, and adoptive families. DCS staff members are currently developing the processes needed to fully implement and monitor the terms of the HRSS contract. DCS will also begin work on recruitment-related policies.

A critical change from previous HRSS contracts is the removal of training and child specific recruitment (CSR) and the establishment of these elements as stand-alone contracts. It is anticipated that separating out training will increase the quality and consistency of training statewide and increase training options for families. DCS will also look for agencies that specialize in CSR to improve this service and allow for improved coordination with the Central Office adoption staff. With these changes the HRSS contract will allow selected providers to focus solely on improved recruitment efforts for resource families.

Twenty-nine vendors were awarded HRSS contracts on May 6, 2015 and started on July 1, 2015. This represents an increase from 23 HRSS providers in the last contract cycle, and this expanded service capacity should result in increased recruitment of foster family homes. The training and CSR contracts were awarded in May 2015 and began on July 1, 2015.

Arizona is also involved with the National Resource Center for Diligent Recruitment at AdoptUSKids (NRC-DR) and is implementing several cutting edge strategies such as Geographical Information System (GIS) Mapping and Market Segmentation for the targeted recruitment of foster and adoptive homes. This project provides data that can be used to make better decisions for recruiting high quality foster and adoptive homes reflecting the needs of the children in out-of-home care and matching characteristics of families determined to be "successful" or "model" foster families. This new model was implemented in July 2015 with the new HRSS contracts. With on-site support from NRC-DR, DCS will provide training to the HRSS contractors on the use of GIS maps and market segmentation data.

Next Steps to Address in Ongoing Reporting

Outcome reports will be maintained to communicate the success of these efforts and summaries will be included with every applicable demonstration project progress report.

APPENDIX A

Arizona Department of Child Safety
Child Safety and Risk Assessment (CSRA)
Practice Guide

Effective Date: June 30, 2014
Revision History: July 1, 2013

Section I: Background Information (review priors and DPS history before the initial response whenever possible)

A. Prior History in Arizona or other states or jurisdictions:
- Document each report, including the current report, with the date, summary of allegations, findings, and service outcomes
- Document if there is a pattern of maltreatment, chronicity, increasing severity of the allegations, or a change in the household composition

B. Department of Public Safety (DPS) background checks and results:
- List any arrests, charges, and disposition for all parents of the child victim(s)
- List any arrest, charges, and disposition for each adult in the home where the maltreatment occurred
- Document each adults relationship to the child(ren)

C. Court Orders Limiting or Restricting Contact:
- Document a good faith effort was made to obtain the information: as part of this good faith effort, the Child Safety (DCS) Specialist must ask the parent, guardian, or custodian under investigation if a current Court order exists
- List any Court order that may restrict or deny custody, visitation or contact with the child(ren)
- Identify jurisdiction and involved parties
- Summarize any Court orders that indicate a potential safety concern

D. Joint Investigation and/or Police Involvement:
- Identify Law Enforcement agency, Detectives names, contact information, and DR# for the incident
- Document the status of the police investigation and outcomes
- Joint Investigation Detail (LCH 431) will still need to be completed for all reports containing the "Criminal Conduct" tracking characteristic

E. Documents Reviewed (if applicable):
- Police reports
- Other Criminal history
- Medical records
- School records
- Court orders
- Provider reports on services provided to the family

Section II: Interviews with all required parties – Document each interview in narrative form with the date, type, location and who was present, information

collected, or the concerted efforts to locate, contact, and interview all required parties

A. Reporting Source – The interview must gather information about:

- Any additional information the reporting source has related to current maltreatment, child functioning, adult functioning, parenting practices or disciplinary practices

B. Each alleged child victim – Children must be interviewed separately and the interview must gather information about:

- Who lives in the home and who are the child's caretakers
- Observations of the child (Infants, toddlers, non-verbal children) and the home
- Child functioning (Medical and dental health, mental/behavioral health, emotional well-being, education and/or development, special needs that would make the child vulnerable or unable to self-protect)
- Response to allegation(s)
- Assessment of all types of maltreatment
- Parent/caregiver functioning (Substance use, mental health, domestic violence or violence out of the home, intellectual and physical health or limitations)
- Family rules, chores and disciplinary practices
- Relationships among family members
- Whether child feels safe at home and with caregivers, why or why not?
- Is there anything the family needs?

C. All other children in the home where the child victim(s) reside (primary residence) and all other children in the home where the alleged maltreatment occurred - The interview must gather information about:

- Who lives in the home and who are the child's caretakers
- Observations of the child (Infants, toddlers, non-verbal children) and the home
- Child functioning (Medical and dental health, mental/behavioral health, emotional well-being, education and/or development, special needs that would make the child vulnerable or unable to self-protect)
- Response to allegation(s)
- Assessment of all types of maltreatment
- Parent/caregiver functioning (Substance use, mental health, domestic violence or violence out of the home, intellectual and physical health or limitations)
- Family rules, chores and disciplinary practices
- Relationships among family members
- Whether child feels safe at home and with caregivers, why or why not?
- Is there anything the family needs?

D. Custodial parent / Non-custodial parents of the child victim(s) - (If applicable and if the identity and whereabouts can be reasonably determined and contact would not be likely to endanger the life or safety of any person or compromise the integrity of a criminal investigation or the CPS investigation) – The interview must gather information about:

- Notification of rights and parent's response
- Both parents must be asked if there are any Court orders (Good faith effort)
- Who lives in the home/child's caretakers
- Location of each victim's non-custodial parent, if applicable
- Observations of the parent and the home
- Response to allegation(s)
- Assessment of all types of maltreatment
- Protection of child by non-abusing caregiver, if applicable
- Child functioning (Medical and dental health, mental health, emotional well-being, education and/or development, general perception and expectations of each child, and attachment to and nurturance of each child)
- Parent/caregiver functioning (Substance use, mental health, intellectual and physical health or limitations, domestic violence or violence out of the home, criminal involvement/history, history of abuse or neglect as a child, recognition of problems and motivation to change, economic resources, adequacy of housing, family social supports, family stressors, coping skills, current services and the need for additional services)
- Family rules, chores and disciplinary practices
- Relationships among family members
- Court orders that restrict or deny custody, visitation or contact between any parent or other adult in the home and any child in the home

E. Spouse/Partner/Significant Other of the custodial parent/Other adults living in the home where the alleged maltreatment occurred, if applicable – Interviews must gather information about any of the following that are applicable to the individual:

- Who lives in the home/child's caretakers
- Observations of the parent and the home
- Response to allegation(s)
- Assessment of all types of maltreatment
- Protection of child by non-abusing caregiver, if applicable
- Child functioning (Medical and dental health, mental health, emotional well-being, education and/or development, general perception and expectations of each child, attachment to and nurturance of each child)
- Parent/caregiver functioning (Substance use, mental health, intellectual and physical health or limitations, domestic violence or violence out of the home, criminal involvement/history, history of abuse or neglect as a child, recognition of problems and motivation to change, economic resources, adequacy of housing, family social supports, family stressors, coping skills, current services and the need for additional services)
- Family rules, chores and disciplinary practices
- Relationships among family members
- Court orders that restrict or deny custody, visitation or contact between any parent or other adult in the home and any child in the home

F. Alleged perpetrator, if someone other than listed above – Interviews must gather information about any of the following that are applicable to the individual:

- Who lives in the home/child's caretakers
- Observations of the parent and the home
- Response to allegation(s)
- Assessment of all types of maltreatment
- Protection of child by non-abusing caregiver, if applicable
- Child functioning (Medical and dental health, mental health, emotional well-being, education and/or development, general perception and expectations of each child, attachment to and nurturance of each child)
- Parent/caregiver functioning (Substance use, mental health, intellectual and physical health or limitations, domestic violence or violence out of the home, criminal involvement/history, history of abuse or neglect as a child, recognition of problems and motivation to change, economic resources, adequacy of housing, family social supports, family stressors, coping skills, current services and the need for additional services)
- Family rules, chores and disciplinary practices
- Relationships among family members
- Court orders that restrict or deny custody, visitation or contact between any parent or other adult in the home and any child in the home

G. Collateral contacts (other persons known to have knowledge of the maltreatment or who could confirm or rule-out a safety threat to the child victim or any other child in the home where the alleged maltreatment occurred):

- These may include but is not limited to other relatives not living in the home, school personnel, pediatrician and other medical professionals, law enforcement, tribal representatives, and out-of-state contacts
- Any additional information gathered related to the alleged abuse or neglect, child safety or risk of maltreatment

---

Section III: Analysis of information and conclusions about the presence of risk factors and/or safety threats and type of intervention needed:

A. Assessment of Present Danger – Narrative must include:

- Based on the initial contact with the child, was an immediate action required in order to ensure child safety before any further interviews or assessment could take place?
- If a protective action was required, describe the action.
- If the protective action includes a safety monitor, briefly describe how the safety monitor will manage the current safety threat to the child(ren)

B. Assessment of Risk Factor(s) for each child in the family and parents, guardian, or custodian and need for intervention:

- Identify and document risk factors based on information about the family's history and current functioning in each life domain which include the following:

Child Risk factors: Child Vulnerability/Self Protection; Child's Special Needs (disability)/Behavior Problems (alcohol abuse, drug abuse)

Parent, Guardian, Custodian Risk factors: **P**arenting Skills/Expectations of child; Parent Empathy, Nurturance, Bonding; Parent Substance Abuse (alcohol abuse, drug abuse); Parent Mental, Emotional, Intellectual or Physical Impairment; General History of Violence by Caregiver towards Peers and/or Children; Domestic Violence in Family; Protection of Child by Non-Abusive Caregiver; Parent History of Child Abuse/Neglect as a Child; Parent Recognition of Problem/Motivation to Change, Level of Cooperation

Family Risks factors: Economic Resources of Family; Family Social Support System; and Current Family Stressors

- Document protective factors (behaviors) by the parent, guardian, and custodian that mitigate the level of risk in the family.
- Document family strengths, positive qualities or resources the family can build upon to enable them to care for their child(ren), support case planning.
- Prior to closing a case, the family, CPS Specialist and other service team members should meet to obtain the thoughts of the parents and children about their unmet needs and develop a aftercare plan to address these needs and improve family functioning.

C. Assessment of Impending Danger – Narrative must include:

- All safety criteria **must** be met to identify a safety threat.
    a. **Vulnerable child**: Is the child victim unable to protect him or herself or seek protection from others, regardless of the child's age? Is the child defenseless, exposed to behavior, conditions, or circumstances the child is powerless to manage?
    b. **Out-of-control**: Is there an adult in the home who is able to control the identified safety threat to the child victim? Will the safety threat continue without external intervention?
    c. **Severity**: Could the threat cause or result in serious pain, injury, suffering, terror or extreme fear, impairment, or death of child?
    d. **Specific Time Frame**: Is the safety threat to the child's safety occurring now or likely to occur within the next 30 days? Could it happen just about any time within the near future- today, tomorrow or during the upcoming month?
    e. **Observable Family Condition**: What is the specific behavior, emotion, attitude, perception, or situation by the parent/caretaker that can be seen and described and makes the child victim unsafe? Observable does not include suspicion and gut feeling. It can be clearly described and reported.

D. Safety Decision:

- Safe - No child is in present or impending danger
- Unsafe - At least one child is in impending danger
    - List the name of each unsafe child

Safety Plan: If a child is unsafe, a safety plan is required. The safety plan must be the least intrusive/restrictive intervention to the family and sufficient to control the safety threats (in-home, out-of-home, or combination).

- If a child is placed in a licensed home or facility, a safety plan agreement (CPS 1030B and CPS 1030 C) is not required.
- Document DPS checks for all non- DES licensed safety monitors in a Key Issue case note type.
- Complete the hard copy safety plan agreement with the family and the safety monitor. Scan the document into a Key Issue case note type.

Reminder: CHILDS Windows still needing completion

- Report Detail (LCH031)
- Joint Investigation Detail (LCH431)
- Investigation Tracking Characteristics Findings (LCH049)
- Investigation Allegation Findings (LCH048)
- NCANDS
- Case Closure (LCH060) – Closures only

Section IV: Clinical Supervision Discussion

- Review the Child Safety and Risk Assessment to confirm enough information was gathered to make an informed decisions on child safety and family risk factors
- Review the Child Safety and Risk Assessment to confirm all required documents were obtained (the Child Safety Specialist must obtain or gather sufficient information to rule out the need or ability to obtain the following records: medical exam record, if one was required by policy; child medical records; child educational records; DCS history records from Arizona or other jurisdictions; DPS criminal history information on all victim's parents and adults in the home where the maltreatment occurred; court orders that restrict or deny custody, visitation or contact between any parent or other person in the home and the child victims; parent or child behavioral health records or other provider reports
- Review the Child Safety and Risk Assessment to confirm it demonstrates sufficient information was gathered during each interview (sufficient information confirms the presence or absence of each of the 17 safety threats and reveals the risk level in relations to each of the 14 risk domains)
- Discuss with the Child Safety Specialist the information gathered from all interviews and documents reviewed to determine the existence of child maltreatment, circumstances surrounding the maltreatment, adult functioning, child functioning, general parenting practices, and disciplinary practices. Analyze and determine if present danger, impending danger, or risk factors require DCS intervention. If no intervention is required, explain why. In addition, explain the level and type of aftercare planning required.
- When a DCS report alleges a criminal conduct allegation, review with the Child Safety Specialist the Criminal Conduct Investigation Practice Guide to ensure that all investigative tasks on a criminal conduct investigation have been completed.
- Discuss with the Child Safety Specialist and document if there was sufficient evidence gathered to draw a conclusion on findings for each allegation in the case.
- Document your Clinical Supervision Decision

APPENDIX B

Arizona Department of Child Safety
Continuous Child Safety and Risk Assessment (C-CSRA)
Practice Guide

Effective Date: June 27, 2014
Revision History: May 23, 2013

Section I. Purpose of Child Safety and Risk Assessment: A Continuous Child Safety and Risk Assessment is required and should be updated whenever major changes in family circumstances occur and at key decision making points during the life of a case.

A. Reason for Continuous Child Safety and Risk Assessment:

- Case Plan reassessment and revision, minimally every 6 months, including changing the permanency goal
- Changes in household composition (additions or departures of individuals from the household)
- Indication that a child may be unsafe
- Considering unsupervised visits
- Considering reunification
- Considering case closure

Section II: Analysis of information and conclusions about the presence of risk factors and/or safety threats and type of intervention needed:

Review the information gathered and documented to make an informed decision on child safety and family risk factors. This includes child's medical records; educational records; parent/ child behavioral health records; DCS history from other jurisdictions; criminal history; court orders restricting or denying custody, visitation or contact; and provider reports. Include the information gathered during monthly contacts with the parents, all children residing in and/or returning to the home, and out-of home care providers. If necessary, review additional information from extended family members, other significant persons, service providers, tribes (if applicable) and any other case participants.

A. Assessment of Risk Factor(s) for each child in the family and parents, guardian, or custodian and need for intervention:

- Review the previously identified risk factor(s) related to the child, parents, guardian, custodian, and family risk factors. Assess and document whether the risk factors are still present.
- Identify and document risk factors based on information about the family's history and current functioning in each life domain which include the following:
  Child Risk factors: Child Vulnerability/Self Protection; Child's Special Needs (disability)/Behavior Problems (alcohol abuse, drug abuse)

Parent, Guardian, Custodian Risk factors: **P**arenting Skills/Expectations of child; Parent Empathy, Nurturance, Bonding; Parent Substance Abuse (alcohol abuse, drug abuse); Parent Mental, Emotional, Intellectual or Physical Impairment; General History of Violence by Caregiver towards Peers and/or Children; Domestic Violence in Family; Protection of Child by Non-Abusive Caregiver; Parent History of Child Abuse/Neglect as a Child; Parent Recognition of Problem/Motivation to Change, Level of Cooperation
Family Risks factors: Economic Resources of Family; Family Social Support System; and Current Family Stressors

- Document protective factors (behaviors) by the parent, guardian, and custodian that mitigate the level of risk in the family.
- Document family strengths, positive qualities or resources the family can build upon to enable them to care for their child(ren), support case planning.
- Prior to closing a case, the family, Child Safety Specialist and other service team members should meet to obtain the thoughts of the parents and children about their unmet needs and develop a aftercare plan to address these needs and improve family functioning.

B. Continuous Assessment of Impending Danger: Narrative must include:

- Review the previously identified safety threat(s). Assess and document whether the safety threats are still present. For each safety threat, explain how all safety criteria are met.
  - Have the parents, guardians, or custodians made changes in their behaviors or home environments to resolve any or all of the safety threats that were previously identified?
  - If progress is not being made, what are the barriers?
- Review and analyze all current information and Safety Factors. Assess and document whether any new safety threat(s) are currently present and explain how all safety criteria are met.
  - Has any new information been received that reveals a safety threat, or has there been a change in a parent's behavior or home environment that created a new safety threat?
- All safety criteria **must** be met to identify a safety threat.
  - **Vulnerable child**: Is the child victim unable to protect him or herself or seek protection from others, regardless of the child's age? Is the child defenseless, exposed to behavior, conditions, or circumstances the child is powerless to manage?
  - **Out-of-control**: Is there an adult in the home who is able to control the identified safety threat to the child victim? Will the safety threat continue without external intervention?
  - **Severity**: Could the threat cause or result in serious pain, injury, suffering, terror or extreme fear, impairment, or death of child?
  - **Specific Time Frame**: Is the safety threat to the child's safety occurring now or likely to occur within the next 30 days? Could it happen just about any time within the near future- today, tomorrow or during the upcoming month?
  - **Observable Family Condition**: What is the specific behavior, emotion, attitude, perception, or situation by the parent/caretaker that can be seen and described and makes the child victim unsafe? Observable does not include suspicion and gut feeling. It can be clearly described and reported.

C. Safety Decision:

- Safe - No child is in present or impending danger
- Unsafe - At least one child is in impending danger

- List the name of each unsafe child

Safety Plan: If a child is unsafe, a safety plan is required. The safety plan must be the least intrusive/restrictive intervention to the family and sufficient to control the safety threats (in-home, out-of-home, or combination).

- If a child is placed in a licensed home or facility, a safety plan agreement is not required.
- Document DPS checks for all non-DES licensed safety monitors in a Key Issue case note type.
- Complete the hard copy safety plan agreement with the family and the safety monitor. Scan the document into a Key Issue case note type.

Section III. Clinical Supervision Discussion: Document Clinical Supervision discussion which should include the topics of child safety, permanency and well- being.

- Review the Continuous Child Safety and Risk Assessment to confirm enough information was gathered and documented to make an informed decision on child safety and family risk factors.
  - Child's medical records; child educational records; parent/ child behavioral health records; DCS history from other jurisdictions; criminal history; court orders restricting or denying custody, visitation or contact; and provider reports.
  - Include information gathered during monthly in-person meetings and other contacts with the parents, all children residing in and/or returning to the home, and out-of home care providers. If necessary, review additional information from extended family members, other significant persons, service providers, and other case participants.
- Do you agree with the risk factors and the safety threats that were identified? If the child is determined to be unsafe, does the documentation clearly support and describe how each safety threat meets the five safety criteria?
- Discuss how the family is progressing. Are the services working? Are the parents making behavioral progress in the current services? If not, why? Should the services continue, change, or stop?
- If a parent is missing or not participating in services or visits, what efforts have been made to locate, contact, and motivate the parent (this includes detained and incarcerated parent).
- Would the child be able to safely return home? Can the identified safety threats be managed and controlled through a sustainable in-home safety plan? If so, is there a plan to return the child home? If not, what would need to happen before this could occur?
- What efforts were and are being taken to locate and engage kin as placement or in supporting the family?
- Have the children, parents, extended family members, and anyone else who might have knowledge been asked, if the child is or might be an Indian child?
  - Review and ensure ICWA policy is discussed regarding child placement and active efforts are being made to comply with ICWA? Are there ongoing communication and/or involvement with the tribe?
- How is the child doing? If the child is in out-of-home care, what is the current visitation between the parent, guardian, custodian, siblings, family members, other relatives, friends, and any former placement and the child? Have any problems or concerns been noted during the visits?
- Discuss what contact is occurring or what efforts have been made to arrange parent-child visitation with detained or incarcerated parents (should occur unless it is contrary to the child's safety or emotional well-being of the child).

- Has the worker had regular contact with the out-of-home caregiver? Are the out-of-home caregivers providing for the child's needs? How is the worker supporting the out-of-home caregiver?

Case Planning:

- Discuss and document whether the family has been involved and/or what efforts were taken to actively involve the child, family, and other team members (including tribal social services) in case planning, reassessment, identifying needs, strengths, services, and progress.
- If the family has a poor prognosis of reunification within 12 months, has concurrent planning begun?
- How long has each child in the family been in out-of-home care? Considering the time in care and likelihood of reunification, should the permanency goal for each child continue or change?
- Does the documentation in the case clearly support that reasonable efforts were made to move toward a change in permanency goal?
- If the case plan goal is long term foster care or independent living: Have more permanent goals been considered and ruled out? What actions and activities are occurring to ensure life-long, supportive connections to kin, culture and community?
- For youth transitioning into adulthood, has the Child Safety Specialist discussed and provided services and supports for post-secondary education, employment, life skills training, and other services which would assist in transition into adulthood?
- If the permanency plan is adoption or legal guardianship, are services and supports in place to assist in the success of this plan?

Case Closure:

- Discuss and review the child safety and risk re-assessment to ensure the safety threats were eliminated or sufficient protective capacities exist within the home to keep the child safe and there are no high risk factors that warrant DCS intervention? **A case cannot be closed with an Unsafe Child or a Safety Plan in place.**
- Discuss and document how the Aftercare Plan was developed with the family? Was the family provided or connected to services and/or family supports that are sufficient to address why the family was involved with DCS?

APPENDIX C

In Home Services
Outline Grid

	Intensive	Reunification and Placement Stabilization	Moderate	Family Support	Clinical Assessment
CSA/SRA results	Safe with high risk or Unsafe with a Safety Plan in place	Safe with high risk and in Out of Home care	Safe with moderate risk	Potential or Low Risk	Any
Type of Cases	In Home Dependencies In Home Interventions Open DCS case with no court involvement	Expected reunification in 45 days (30 days target return date) during OOH dependency or Voluntary Foster Care Stabilization of relative/kin or adoptive placement Transition from more restrictive placement to less restrictive (residential to foster home or foster home to family home)	Open DCS case w/no court involvement	Short term supportive intervention DCS cases with no court involvement Community families – No DCS involvement or Open/closed DCS	All types
Team	Team Lead: Master's level professional (a Master's level intern may be used) or a Bachelor's level w/ 5 years experience; and, Fam Support Wkr: Bachelor's level professional or paraprofessional w/5 years of related work experience; or Peer Mentor: Qualifications are: 1) Parents that have been through the DCS system themselves; 2) DCS case must have been closed for at least a year; and 3) Have successfully achieved reunification. *Provider may choose to have a peer mentor serve as a paraprofessional (w/5 years of related work experience) team member or be in the peer mentor role if do not meet the paraprofessional standard.				Master's level professional only
Training Component	Minimum of 15 hours annual training to include: Evidence based or informed practices Mandated Reporter Law Therapeutic Intervention techniques/specialty training How to access Title XIX services Coordinate with DCS to receive training on CSA/SRA/CP process and other trainings as identified by DCS				
Supervision Component	Availability to staff 24/7 Weekly Team consultation, individually and/or in group setting Accompany the Team on home visits quarter to new staff and annually thereafter				
Response Time (Contact and inform DCS of receipt of referral w/in 2 hours of receipt)	Maximum of 12 consecutive hours	Maximum of 2 working days – Contact the referring DCS Specialist & arrange for a meeting with the family (if already established meeting – initial mtg can take place)	Maximum of 2 consecutive days	Maximum of 5 working days	Maximum of 5 working days to consult with DCS about the case, and meet with the family
	Response Time definition is conduct outreach with any adult family member through a face to face in home meeting (Exceptions to timeframe or face to face meeting can be made with DCS approval via phone, referral, or e-mail. Exception are based on need of family or due to a scheduled meeting)				
	An initial meeting will need to be set up within 48 hours of initial outreach and contact with the family, with as many family members as possible that are identified on the referral.				
	Unable to contact – immediately consult w/DCS to confirm contact information and/or get assistance, once confirmed the Contractor will have 3 additional home contact attempts to make w/in 72 hours at various times.				

In Home Services
Outline Grid

Service Provision	Intensive	Reunification and Placement Stabilization	Moderate	Family Support	Clinical Assessment
Initial Interim Plan *Enter into CHILDS w/in 10 working days	1) Set up & have initial mtg w/in 48 hrs of initial outreach/contact w/family 2) Inform about services and develop initial interim plan w/family during initial mtg 3) Outlines what to expect (address initial safety/risk factors & behavioral changes as outlined by DCS) during next 30 days to assess and develop service plan 4) Outlines frequency and contact w/family 5) Provides ER contact info 6) During the initial mtg, remain w/family as long as necessary to resolve initial crisis 7) Staff w/DCS w/in 7 working days (in person, via phone or email)	For Reunification cases, develop an initial interim plan which includes an accelerated Visitation plan, in conjunction with family, current caretaker, youth, and DCS, to include extended & overnight visits with a target date of completion w/in 30 days of services For Placement Stabilization, develop an initial interim plan as outlined for Intensive & Moderate For Voluntary Foster Care, develop an initial interim plan as outlined for Intensive & Moderate	1) Set up & have initial mtg w/in 48 hrs of initial outreach/contact w/family 2) Inform about services and develop initial interim plan w/family during initial mtg 3) Outlines what to expect (address initial safety/risk factors & behavioral changes as outlined by DCS) during next 30 days to assess and develop service plan 4) Outlines frequency of contact w/the family 5) Provides ER contact info 6) During initial meeting, remain w/family as long as necessary to resolve initial crisis 7) Staff w/DCS w/in 7 working days (in person, via phone or email)	N/A Explain purpose and begin assessment and service planning process	N/A Explain purpose and begin assessment process
Comprehensive Assessment *Enter into CHILDS w/in 10 working days	1) Complete w/in 30 days from time of initial mtg unless otherwise approved by DCS via phone, referral or e-mail 2) Will assist the contractor to: - determine level of family functioning & how to work w/the family - identify further strengths, needs & risks (incorporating the initial interim plan, CSA/SRA, behavioral changes outlined by DCS) - develop service plan 3) Ongoing process to assist in updating service plan as needed 4) Staff w/DCS w/in 7 working days (in person, via phone or email)				N/A Clinical Family Assessment to be complete w/in 30 days from time of referral. Exceptions approved by DCS.
Pre/Post Assessment	Conduct a pre and post assessment (Protective Factors Survey) with all families to measure family functioning at the beginning and end of services				N/A
Family Centered Service Plan *Enter into CHILDS w/in 10 working days	1) Complete w/in 30 days from time of initial mtg w/family 2) Include the following: - Overall goals w/the expected measurable outcomes - Incorporate comprehensive assessment, initial interim plan, CSA/SRA, behavioral changes as outlined by DCS - Frequency and location of contact - Tasks w/whom is responsible for completion - Strengths that will assist in accomplishing the overall goal(s) - Anticipated completion date of goal(s) 3) Staff w/DCS w/in 7 working days (in person, via phone or email) 4) Assess the progress of the family weekly regarding accomplishing overall goal, tasks and objectives 5) Provide an update to DCS in the monthly progress report (weekly for Reunification/Stabilization)				N/A

In Home Services
Outline Grid

Service Provision	Intensive	Reunification and Placement Stabilization	Moderate	Family Support	Clinical Assessment
Scope of Services	Follow evidence based strategies/curriculum for the listed services:				Clinical Family Assessment
	- Structured parenting education & child development; - Problem solving skills, stress management; - Job readiness training;				
	- Crisis intervention services &/or counseling; - Nutrition & home management; - Peer mentoring				
	- Individual, family &/or marital therapy (Utilizing all types of therapeutic interventions based on need) - Substance abuse – linkage to Arizona Families FIRST, community resources, etc. - Sexual abuse intervention				
	- Communication & negotiation skills; - Conflict resolution, anger management; - Systems of support				
	- Domestic violence treatment &/or education; - Linkages with community resources; - Coordinate with T-19 provider				
	- Behavioral management & modification; - Emergency financial assistance (to be approved prior by DCS) -				
	Obtain written consent from the parent/guardian of the family or the placement provider who chooses to accept services				
	Provide services to the family to decrease the risk of abuse and/or neglect within the home through behavioral changes by the parent/guardian as identified by DCS. Services shall also incorporate issues identified by the family				
	Visit with the family in their home at different times of the day and evening according to the needs of the family				
	Collaborate with other community agencies working with the family and participate in staffings when invited to do so, such as TDM meetings, CFT meetings, DCS Case Plan staffings, Adult Treatment meetings, Substance Exposed Newborn Safe Environment (SENSE) program staffings, etc.				
	If the family is involved in the SENSE program, establish or use existing collaborative partnerships to provide seamless, efficient and customer friendly services				
	Contact DCS twice monthly via phone, email or Monthly Progress Report to staff the progress/needs of the family & further coordinate service needs If Family Reunification/Placement Stabilization, contact DCS weekly via phone, email or Weekly Progress Report				
Length of Service	Maximum 120 days	Maximum 120 days	Maximum 90 days	Length of time specified by DCS or for self referred as agreed upon w/family. Maximum 120 days	One time, or length of time it takes to conduct assessment
	**If deemed services need to be extended – DCS must approve extension of 45 days, not to exceed one extension. Must be made 30 days prior to projected closure				
Frequency of Contact & by whom	Team Lead / Fam Support Wrkr/ Peer Mentor	Team Lead / Fam Support Wrkr/ Peer Mentor	Team Lead / Fam Support Wrkr/ Peer Mentor	Team Lead / Fam Support Wrkr/ Peer Mentor	As often as needed to complete the assessment
				2 x per month / 1 x per week	
1st 60 days	1 x per wk / 2 x per wk	1 x per wk / 1 x per week	1 x per wk / 1 x per week		
61-90 days	2 x per mth / 2 x per wk	2 x per mth / 1 x per week	2 x per mth / 1 x per week		
91-120days	Monthly / 1 x per wk	Monthly / 2 x per month.			
	**An exception to the number of visits by the Team may be granted by DCS based on need and must be received in writing via hard copy or email				

In Home Services
Outline Grid

Service Provision	Intensive	Reunification and Placement Stabilization	Moderate	Family Support	Clinical Assessment
Closing Out Procedure	When parent refuses or has not completed services: 1) There must be 3 re-engagement efforts made including written approval from DCS via hard copy or email prior to closing 2) When parent withdraws, notify verbally DCS w/in 1 business day and follow-up with written notice w/in 2 business days				N/A
	All families completing services: 1) Conduct home visit 7 calendar days prior to closure – document progress and observation of children 2) Invite DCS to be present at closure meeting. If DCS not present, document date when case was staffed with and approved by DCS 1) Discuss w/family during closure meeting: - Progress made and achievement (or lack of) toward original goals - Note therapeutic risks and recommendations; and create an aftercare plan				
	Discharge Summary is to be completed on each family who accepted services (excluding families referred to Clinical Family Assessment) 1) The report will summarize: - Contacts with the family - Progress made and achievement (or lack of) toward the original goals - Note therapeutic risks and recommendations, and Aftercare planning with the family - Should services result in ADCS custody, the summary will provide documentation of the family's lack of progress toward goals along with supporting information illustrating the recommendation of ADCS custody 2) Obtain written approval of the summary upon completion from DCS via hard copy or email 3 business days prior to closure 3) Enter a copy of the summary into CHILDS w/in 10 working days following termination of services				
	If parent moves outside of the original geographic service area: 1) Exceeds 50 miles outside the geographic area border, the provider can choose to continue w/the family or ask the case be closed and transferred 2) Less than 50 miles, the provider is to continue the service				
Outcome Goals	**90%** of families referred to In Home Services for the Intensive, Reunification/Stabilization or Moderate levels have signed the initial interim plan and agree to services. **90%** of families referred who have agreed to Intensive, Moderate, Family Support or Reunification/Stabilization levels of services have shown improvement in areas identified in the ADCS prescribed pre and post test. **82%** of cases referred for Family Reunification services who are in out-of home placement shall return to their home w/in 30 days of the Order of Change of Physical Custody or if in voluntary foster care, from the time of referral. **85%** of children referred for Placement Stabilization services shall be safe and stabilized in the identified placement at the end of 120 calendar days from time of the referral. **90%** of families successfully completing Intensive, Moderate or Family Support services shall not have any new substantiated abuse/ neglect reports, excluding reports made by the Contractor, during service delivery **90%** of families successfully completing Intensive, Moderate or Family Support services shall not have any new substantiated abuse/neglect reports w/in 6 months of case closure. **90%** of families successfully completing Intensive, Moderate or Family Support services shall not have a child in ADCS during service delivery. **90%** of families successfully completing Intensive, Moderate or Family Support services shall not have a child in ADCS custody w/in 6 months of case closure. **95%** of family satisfaction surveys returned shall express satisfaction with the Contractor's service delivery based on a survey issued at closure. **95%** of DCS Specialists involved with cases provided by the Contractor during the time period will express satisfaction with the Contractor's service delivery based on an annual survey. The Department will compile the results, which will be shared with the Contractor.				

In Home Services
Outline Grid

	Intensive	Reunification and Placement Stabilization	Moderate	Family Support	Clinical Assessment
Payment Points	**15%** Referral with successful outreach & interim plan or Referral with no successful contact & required attempts **70%** Completion of Comprehensive Assessment & Service Plan **15%** Discharge Summary **20%** Approved extension	**30%** Referral with successful outreach & interim plan or Referral with no successful contact & required attempts **60%** Completion of Comprehensive Assessment & Service Plan **10%** Discharge Summary **20%** Approved extension	**15%** Referral with successful outreach & interim plan or Referral with no successful contact & required attempts **70%** Completion of Comprehensive Assessment & Service Plan **15%** Discharge Summary **20%** Approved extension	**One Hour Family Support**: 50 mins of face to face in home and 10 mins write up Maximum can bill is 2 hours total per case to complete the Comprehensive Assessment and Service Plan **One Hour Consultation**: Actual time spent on consultation w/DCS & participation at staffings/other mtgs as requested by DCS. Billed in 15 mins increments	Completed Clinical Family Assessment
	** Emergency (flexible) funds – not to exceed $300 per family – written prior approval by DCS				
Reporting Requirements	Initial Interim Plan Comprehensive Assessment Pre/post test Service Plan Monthly Progress Reports Weekly Progress Reports (Reunification/Stabilization) Discharge Summary No Contact Form, if applicable Extension Approval Form, if applicable Emergency Funds Authorization Form Incident Reports Program Summary Report Financial documents				Clinical Family Assessment

APPENDIX D

DEPARTMENT OF CHILD SAFETY
CENTRAL REGION, TEMPE OFFICE
SOUTHWEST REGION, AVONDALE OFFICE
OPERATING PROCEDURE
DRAFT 2/4/2016

SUBJECT: **Fostering Sustainable Connections**
Effective Date: April 1, 2016
Prepared By: Enjoli Carter, DCS TDM Facilitator
Jane D'Amore, D'Amore Group Home
Reanne Gamet, DCS Program Development
Randy Grover, Mercy Maricopa Integrated Health
Cathryn Hasenberg, DCS Program Development
Nichol Houser, Cenpatico Integrated Health
Alexa Lang, Devereux
Sandra Lescoe, Arizona State University
Susan Blackburn-Love, DCS Program Development
Andrew Marioni, DCS Policy Administration
Kerri Rittschof, DCS Program Development
Nicole Roskens, Maricopa County Juvenile Court
Victoria Stevens, DCS Program Development
Amber Stohner, DCS Program Development
Tammy L. White, DCS Program Development
Melody Ann Wilks, DCS TDM Facilitator

Approved By: Shalom Jacobs, Deputy Director of Field Operations
Name, Title

Purpose: Positive outcomes for children in out of home care are more likely to be achieved when they are placed in safe family environments. The Department will improve family engagement by employing extensive family finding efforts for the purposes of family connections and placement. In addition, the Department will expand its Team Decision Making (TDM) program to target children in shelter and group home settings. The action plans created in the TDM meetings will be supported by available In-Home, behavioral health and/or other needed community services.

The purpose of this Operating Procedure is to specifically identify types of cases appropriate to refer for the implementation of Fostering Sustainable Connections. Additionally, the procedure will outline the step by step

process involved in arranging the participation in each of the identified strategies and the time frames for each.

OPERATING PROCEDURE:

I. INTERVENTION

FAMILY FINDING STRATEGY:

The Family Finding strategy is an intensive recruitment effort that includes family finding engagement activities. The goal of the strategy is to provide each child/youth with the lifelong connections that only a family can offer. Fostering Sustainable Connections will utilize the Family Finding strategy in order to increase the number of available family like homes and supportive connections for children in shelter and group home settings.

An activity to achieve this is a Blended Perspectives meeting, which brings together the family network, combined with other key participants, to connect or reconnect the child and family. The meeting provides an opportunity for the family to gain a greater understanding of the child, his/her experiences, and perspectives. The family will explore how they can provide ongoing support to the child that will serve as a foundation for planning to meet permanency for the child.

TEAM DECISION MAKING STRATEGY:

Team Decision Making (TDM) is a strength-based meeting where parents, the child or child's voice, kin, other support persons, out of home care provider(s), service provider(s), community representatives, and the assigned Child Safety Specialist (CSS) with the Supervisor come together to be active participants in the decision making process. The goal is to create an action plan to identify kin placement(s), services and supports. This action plan shall detail activities that protect the child in the least intrusive, least restrictive environment.

See DCS Policy and Procedural Manual Chapter 2: Section 8 Team Decision Making for more information.

SERVICES ARRAY STRATEGY:

A variety of In Home, behavioral health and community services are available to support children and families. These services will be identified throughout the Fostering Sustainable Connections process. Any services identified shall be timely and specific to meeting the needs of the child and family to facilitate successful connections and placement. If placement has yet to be determined, these services can assist in supporting the child and kin in other ways.

The Department provides contracted in home services through a continuum of family-centered services. The purpose of in home services is to provide interventions to assist in supporting and enhancing the family. Services may be provided in the family's home,

the child's current and temporary placement, or other locations. Services are based on the needs, concerns and stressors of the child and family, and may include, but not limited to: parent education, counseling, communication skills, behavioral management/modification and home management skills.

Children in out-of-home care have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment or services they need. Services are provided through the Regional Behavioral Health Authorities (RBHA) based on the child's location. Services can be delivered to the child, as well as their identified placement or family members based on the needs of the child.

Behavioral health services can assist the child for any meetings during the Fostering Sustainable Connections process, assist in reconnecting the child with family, or support any placement transitions. In addition, those working with the child shall be invited to any meetings to support the child and family.

Other community based services or resources may also be identified for the child and family during the Fostering Sustainable Connections process. Such services may consist of job training, vocational rehabilitation services, family resource centers, respite services, tangible resources, kinship navigation and resources, etc. See Arizona DCS Policy and Procedure Manual Chapter 4: Section 3 Kinship Care for more information.

II. SELECTION and REFERRAL:

A child age 0-17 who is a Court Ward, in the care and custody of the Department and in a shelter or group home placement setting is eligible to participate in Fostering Sustainable Connections. Data generated based upon the child's placement type will be used to select a child to participate in Fostering Sustainable Connections.

III. Process:

There are four stages to Fostering Sustainable Connections, which are:

1. Discovery and Engagement
2. Planning
3. Decision Making/Action Plan
4. Follow-up

Stage One: Discovery and Engagement
The goal of this stage is to discover and engage those who know the child best who have a historic or inherent connection in helping the child by sharing information and assisting in building a lifelong supportive network for the child.
Children in shelter and group home settings will receive Fostering Sustainable Connections based on case related data. Once identified, the following process will take place:

.

1. The Family Engagement Specialist (FES) will research CHILDS and hard file for information on the child/family and work that has already been completed regarding kinship searches.

2. The FES will track potential family members that have been considered for emotional support or as a placement option.

3. If a kinship placement has been identified or reunification is to occur within 30 days, the FES will assist with setting up a TDM, if needed, to begin transitioning the child into the home.

4. If a kinship placement or reunification has not been identified to occur within 30 days, the FES will:
    a. Meet (in-person or telephonically) with the CSS and discuss what family has been explored and if they know of other kin

    b. Meet with the child accompanied with the CSS and shelter/ group home provider for initial introductions, rapport building and explaining the role of the FES.

       Subsequent meetings with the child by the FES may take place based on the needs of child for discovery of kin, preparation of meetings, etc.

5. The FES will begin contacting identified kin through in-person interviews, phone conversations, written letters, email, and internet and other search engines with the objective of identifying/locating additional family members.

Stage Two: Planning
The goal of the planning stage is to have discussions and hold meetings when necessary with relatives and others important to the child to focus on planning for the child. This may include a meeting where family members/participants provide a blended perspective so kin who do not know the child or have not been in contact with the child for some time, can learn about the child. This will serve as a foundation to kin planning for the child and how they can be a support. The following are steps to be taken during the planning stage:

6. The FES and CSS will determine whether a planning (Blended Perspectives) meeting is needed. The Blended Perspectives Meeting is needed when:

    a. Inadequate family connections are discovered
    b. Kinship placement have not been identified
    c. Multiple kin have been identified for placement

7. If a Blended Perspectives Meeting is not needed, the FES and CSS will discuss whether a TDM is needed. The criterion for convening a TDM includes:

    a. Kinship placement needs to be identified
    b. Services and supports for the child and family need to be identified

8. Should a determination be made that a Blended Perspectives meeting is needed; the FES shall:

    a. Arrange and convene the meeting to explore how the family can emotionally support the child and if kin can be a placement option for the child
    b. Work with the CSS upon completion of the meeting to determine if a TDM is needed.

Stage Three: Decision Making/Action Plan
Within a few weeks of the planning discussions and/or meetings, the participants gather again to hone in on who will assume specific roles in the life of the child. Decisions will be made during a TDM meeting regarding placement and an action plan developed. The next steps will be taken:

9. The FES, CSS and TDM facilitator shall confer to arrange the TDM meeting in accordance with the family's availability. The TDM shall be convened timely and in collaboration with the family.

10. The FES will prepare the family for the TDM.

11. The TDM facilitator will convene the TDM, ensuring that there will be an identification of a kinship or least restrictive placement, services and supports that will sustain the placement and an action plan that details the transition of the child to the lesser restrictive placement.

State Four: Follow-up
A key component throughout the Fostering Sustainable Connections process is ensuring formal and natural supports are in place, accessible, timely, and meeting the needs of the child and family. The FES will assist the CSS with any follow-up actions needed by:

12. Ensuring necessary service referrals are made and tracking the progress of the referral.

13. Determining with the CSS and the family what type of follow-up contact is needed and at what intervals. This may include telephonic contact, as well as email correspondence or meetings, such as internal staffings, family meetings, Child and Family Team (CFT) meetings, case plan staffings, home visits, etc.

IV. KEY ROLES and RESPONSIBILITIES:

Child:

- Meet with the FES to learn and understand the FES involvement;
- Participate in the Blended Perspectives meeting and TDM, if appropriate;
- Identify potential placement options with relatives/fictive kin;
- Able to articulate/identify his/her strengths and needs, as well as for other family members; and
- Identify those with whom they have a significant relationship with.

Kin:

- Be open and honest regarding family and potential placement options;
- Identify how they can be a support to the child, parents, and other family members;
- Support the child/family during the child's transition to a least restrictive placement;
- Work with service providers if/when identified as a need;
- Provide feedback regarding services; and
- Support any plans that are developed during the Blended Perspective meeting and the TDM meeting.

Family Engagement Specialist:

- Partner with CSS and TDM Facilitator throughout the Fostering Sustainable Connections process;
- Collaborate with the CSS to engage with the behavioral health providers when needed;
- Build rapport with the child and family involved with Fostering Sustainable Connections;
- Provide an open avenue for each child's perspective, preferences, and feelings to be heard and regarded;
- Ensure the needs of the child and family are considered in every step of the process;
- Help build a Family Network that is fully committed to ensuring the needs of the child are met; and
- Honor the family as the most important and lasting source of connection and support to the child.

Team Decision Making Facilitator**:**

- Collaborate with the FES and CSS a time and place for the TDM meeting to occur that is conducive with the family's need.
- Discuss with FES and/or CSS any special considerations for the TDM (special accommodations, orders of protection, telephonic participation, etc.)
- Ensure information is presented in the families primary language;
- Confirm with FES and/or CSS the family and child (if appropriate) participation in the TDM;
- Send invites to service providers, if appropriate;
- Manage meeting logistics including meeting space, set-up and equipment;
- Facilitate the TDM meeting using the established six stage TDM facilitation structure;

- Ensure that a thorough discussion regarding the strengths and needs of the child and family is taking place while exploring placement options
- Ensure that critical discussions are held with all team members regarding safety, permanency and wellbeing;
- Establish a strengths-based discussion with all team members' voices being heard;
- Ensure that a consensus-based recommendation/decision is made regarding child placement;
- Identify services/support for child/family and placement
- Complete summary for all participants that will include the action steps for team members

Child Safety Specialist:

- Staff case with Supervisor;
- Partner with FES throughout the Fostering Sustainable Connections process;
- Determine with the FES what type of family finding search and engagement efforts are most appropriate for each case;
- Inform the FES of family members that have already been identified, what works needs to be done to transition the child, etc.
- Make the hard file and other documents available for FES to review;
- Collaborate with the FES to engage with the behavioral health providers when needed;
- Involve and invite any current service providers, i.e. CFT, additional service providers or community support;
- Participate in the Blended Perspective meeting and TDM meeting; and
- Notify the FES or TDM Facilitator if an interpreter is needed.

Child Safety Unit Supervisor:

- Staff case with CSS
- Attend the Blended Perspective meeting
- Attend the Team Decision Making meeting;
- Support the CSS during the meeting; and
- Encourage open and honest communication;

Contracted Service Providers:

- Representatives of contract agencies providing residential services (shelter, or group care) for the child will provide information about the child's current status, including emerging needs and treatment recommendations;
- Other providers who have been serving the family in the community will report on the status of current support services to the family and offer recommendations regarding treatment. Facilitate a smooth transition to new placement; and
- Support the child during the transition.

APPENDIX E

Fostering Sustainable Connections (FSC)
Child Safety Specialist (CSS)
Process Guide – DRAFT

What is a Life Long Connections (LLC) meeting?

- This is a new type of Team Decision Making (TDM) meeting.
- It is facilitated by a trained TDM Facilitator.
- It involves all of the individuals who support the child to decide on who will assume specific roles in the child's life in order to provide ongoing emotional support and to plan for the transition to a family-like placement for the child.

What is a Blended Perspectives Meeting (BPM)?

- This meeting brings together the family network and others who support the child to provide a blended perspective so kin that do not know the child or have not been in contact with the child for some time, can learn about the child.

What will a CSS do to help children placed in congregate care settings?

The CSS will be frequently collaborating with the **Family Engagement Specialist (FES)** to provide information on selected cases in which children are placed in a shelter or group home to help develop a permanency plan and supports for the child. This will be accomplished in the four stages of FSC: Discovery & Engagement, Planning, Decision Making/Action Plan and Follow-Up.

FSC is comprised of four stages, which include:

Stage 1: Discovery & Engagement

- Meet with the FES to provide the case history of the child. This includes:
  - Names and contact information of parents, caregivers, kinship, fictive kinship and any other important people in the child's life which can include teachers, coaches, therapists, counselors, etc.
    - This includes any adults who have been denied contact or placement of the child in the past.
  - Access to the case hard file.
- Facilitate a meeting for the FES to meet the child to develop rapport and trust.
- Inform the FES of any identified relative placement and the transition plan in place.
- Coordinate with the FES on any background checks that would need to be completed for any potential placements or supports to ensure child safety.
- Intervene if and when contact would be detrimental to the child.
- Continually strengthen rapport with the child's current placement provider.
- Continue to work on the ongoing case plan goals.
- Keep all involved parties updated on Family Finding efforts taking place.

Stage 2: Planning

- Staff with the FES, your supervisor and/or Assistant Program Manager (APM) and any others involved to determine if a **Blended Perspectives Meeting (BPM)** or any other meeting is needed.
  - If so, collaborate with the FES for meeting dates, times and locations which should be arranged with the family's schedule to maximize participation.
  - Assist with transportation, if needed.
  - Assist with referrals for services for the child and/or family, if needed.

Stage 3: Decision Making/Action Plan

- Staff with the FES, TDM Facilitator, your supervisor and any others involved to determine if a **Life Long Connections (LLC) meeting** is needed.

- The child's strengths and needs are identified to develop a greatest unmet needs statement that will serve as the foundation for permanency planning options.
- It is facilitated by the FES and lasts a maximum of 90 minutes.

What's my role at the BPM?

- Help explore the strengths and needs of the child.
- Be strengths-based.
- Listen to the family's perspective.
- Help brainstorm solutions.
- Focus on the safety of the child.
- Provide education around DCS policies and procedures, when needed.

- Assist in developing an action plan for how those involved are going to support the child(ren) throughout their life as well as help plan for the permanency of the child which may include creating a transition plan, determining a family-like placement, assessing the child and family's need for services, etc. This may also include connecting the family with DCS In Home Services, community services and/or kinship care to stabilize and retain placement.
    - For more information, see:
        - *Fostering Sustainable Connections In Home Services Program Process Guide*
        - *Fostering Sustainable Connections Community Services Process Guide*
        - *Fostering Sustainable Connections Kinship Care Process Guide*
- The action plan will also determine who will be responsible for completing and submitting referrals for services.
- Inform and update the Court and all involved parties on the results from the LLC meeting.
- For more information about LLC, see *Fostering Sustainable Connections Life Long Connections Meeting Process Guide.*

Stage 4: Follow-Up

- Collaborate with the child's support team to evaluate whether the adults caring for the child have adequate and lasting supports as identified in either the BPM or LLC meeting. If not, brainstorm solutions or initiate back-up plans.
- Address permanency options with relatives if reunification is not possible.
- Continue to attend any Child and Family Team (CFT) meetings or any other meetings as needed to help advocate for the child and family.
- Document all contacts and results by entering a case note in CHILDS.

APPENDIX F

Fostering Sustainable Connections (FSC)
Family Engagement Specialist (CSS)
Process Guide – DRAFT

There are a number of methods currently in use to obtain family history from children. Two of the most frequent discovery activities are:

- **Mobility Mapping**: A technique used with youth to help them uncover clues about missing family and to encourage discussion about their past by drawing pictures. It is a more relaxed and informal technique to explore the child's history.
- **Connectedness Mapping**: A technique used to illustrate and discover family members and adults in the community to whom the child feels connected. Once complete, it is used for engaging family members by highlighting the

What will a FES do to help children placed in congregate care settings?

The FES will provide kinship search and engagement activities to identify family and other close adults for children in a shelter or group home setting to assist the family to develop supports and plan for permanency of a child. This will be accomplished in the four stages of FSC: Discovery & Engagement, Planning, Decision Making/Action Plan and Follow-Up.

FSC is comprised of four stages, which include:

Stage 1: Discovery & Engagement

- Arrange a meeting (in person or via telephone) with the **Child Safety Specialist (CSS)** to obtain information regarding what efforts have been made regarding finding family for the child and determine what search and engagement efforts are needed.
- Discover family members and important people in the child's life through an extensive review of a child's case file (hard file and CHILDS), interviewing the child (if appropriate), any known family members and other supportive people, the use of search tools and speaking with behavioral health specialists, congregate care providers and/or staff.
- In partnership with the CSS, meet the child to build rapport and trust while encouraging child involvement and voice.
- Complete discovery activities (such as Mobility Mapping and/or Connectedness Mapping) with the child to explore connections. This may include meeting with the child on multiple occasions.
- Once individuals have been identified but cannot be contacted, begin searching the Internet, different search engines, social media, etc. to attempt to locate them.
- Start to engage with identified family members via telephone, e-mail, mail, text messages, in person, etc. to inform them of the child's involvement with the Department of Child Safety (DCS), explore how they can support the child, and identify other family members to make contact with.
- Coordinate with the CSS on any background checks on those who express interest in becoming potential placement and/or support for the child to ensure child safety.
- Reach out to internal and external stakeholders to inform them of the Family Finding efforts being made when needed. This includes: the CSS, Team Decision Making (TDM) Facilitator, placement provider, Guardian ad Litem (GAL), Court Appointed Special Advocate (CASA) and any others providing support for the child.

child's loneliness and the urgency of developing connections and supports for the child. It may help avoid recalling traumatic events from the past that may surface during mobility mapping.

The Family Engagement Specialist is the key to connecting families.

- Listen to each family member.
- Demonstrate respect and empathy for family members
- Develop an understanding of the family's past experiences, current situation, concerns and strengths.
- Establish the purpose of involvement with the family.
- Be aware of one's own biases and prejudices.
- Validate the participatory role of the family.
- Be consistent, reliable and honest.
- Hold meetings in a neutral and safe environment.
- Assist in the development of a transition plan for child and family.

Stage 2: Planning

- Staff with the CSS to determine if a **Blended Perspectives Meeting (BPM)** or any other meeting is needed.
- A BPM may be needed when family connections are unestablished or family members may not know the child, multiple family members have expressed interest in being a placement option and further discovery of the child is needed, or family members have been found however, no placement options have been identified.
- A BPM brings together the family network and others who support the child to identify the child's strengths and needs to develop a greatest unmet needs statement that will serve as the foundation for permanency planning options.
- To prepare the child, family, internal and external stakeholders for a BPM:
    - Inform them that the child will be the focus of the meeting.
    - Discuss what to expect and if family expectations are unrealistic, address any ongoing family conflict.
    - Develop an invitation list.
    - Solicit the family's preferences regarding location and time.
    - Schedule a phone conference line and/or Skype, arrange child's transportation and bring all necessary materials to the meeting.
- Facilitate a BPM:
    - During the meeting, identify the strengths and needs of the child to create the greatest unmet needs statement.
    - Determine and prioritize the next steps to prepare for further connections and visits.
        - Determine what needs to be considered;
        - How contacts have been thus far; and
        - Include relatives that are participating from a distance.
    - Keep the BPM to a maximum of 90 minutes.
- Within a few weeks after the BPM, determine if a **Life Long Connections (LLC) meeting** is needed and schedule the meeting with a TDM Facilitator.
    - Prepare the family for the LLC meeting.

Stage 3: Decision Making/Action Plan

- The LLC meeting is facilitated by a trained TDM Facilitator. The meeting identifies and develops plans regarding a family-like placement and/or lifelong connections for a child placed in a shelter or group home setting.
- Those involved develop an action plan for how they are going to support the child(ren) throughout their life and help plan for permanency which may include creating a transition plan, determining a family-like placement, assessing the child and family's need for services, etc. This may also include connecting the family with DCS In Home Services, community services and/or kinship care to stabilize and retain placement.
    - For more information, see:
        - *Fostering Sustainable Connections In Home Services Program Process Guide*
        - *Fostering Sustainable Connections Community Services Process Guide*
        - *Fostering Sustainable Connections Kinship Care Process Guide*

- The action plan will also determine who will be responsible for completing and submitting referrals for services.
- The result of the LLC will be an identification of a kinship or least restrictive placement, services and supports that will sustain the placement and an action plan that details the transition of the child to the lesser restrictive placement.
- For more information about LLC, see *Fostering Sustainable Connections Life Long Connections Meeting Process Guide.*

Stage 4: Follow-Up

- Prior to ending involvement with the family, follow up to ensure the adults caring for the child have adequate and lasting supports as identified in either the BPM or LLC meeting.
    - If identified services are not in place, follow up to initiate services as soon as possible.
- Evaluate with the child and family what additional services or supports are needed to maintain a successful placement and increase in the child's well-being.
- Document all contacts and results by entering a case note in CHILDS.

APPENDIX G

Fostering Sustainable Connections (FSC)
Life Long Connections (LLC) Meeting
Process Guide – DRAFT

Ten tips for Child Safety Specialists to an effective LLC meeting:

- Invite the right people.
- Schedule time for yourself to prepare.
- Be on time and share transportation resources with the family.
- Come organized to present a case summary in a professional manner.
- Explain the meeting's purpose to team members.
- Be sensitive and respectful regarding the nature of the meeting.
- Be honest, fair and strengths-based.
- Understand the goal and outcomes of the meeting.
- Assist with keeping the team focused and productive.
- If any team member from the Department of Child Safety (DCS) feels that the decision is not least restrictive and least intrusive, they can request a review by management.

What is a Life Long Connections meeting?

The Life Long Connections meeting identifies and develops plans regarding a family-like placement and/or lifelong connections for a child in a shelter or group home setting.

- It is one component of Fostering Sustainable Connections.
- The LLC's team members can include:
  - The Child Safety Specialist (CSS);
  - The supervisor or Assistant Program Manager;
  - The Family Engagement Specialist (FES);
  - The child (if appropriate);
  - The child's kinship (family and those who have a significant relationship with the child);
  - Caregivers including shelter and group home providers;
  - Service providers; and
  - Members of the child's community.
- The LLC is facilitated by a trained Team Decision Making (TDM) Facilitator.
- The LLC should occur in the least restrictive environment (i.e., at school, at church, at a community center) to meet the family's needs.
- Safety, permanency and well-being are paramount.
- The LLC meeting is NOT:
  - A Case Plan Staffing.
  - A Child and Family Team Meeting.
  - A Permanency Planning TDM Meeting.
  - An Age of Majority TDM Meeting.

Prior to the LLC meeting, both the FES and CSS will:

- Talk with the child about his/her wishes regarding placement and permanency.
- Discuss family and other important connections with the child.
- Discuss the meeting with the parents and with kinship**.**
- Staff the case with supervisor.
- Prepare the child, parents, family and other important individuals for the LLC meeting.
- Collaborate with the TDM Facilitator regarding team members and their roles.
- Be mindful of schedules when setting the date and time of the meeting – this could mean school hours for a child, CSS availability and/or work hours for team members.
- Discuss with the TDM Facilitator any logistical and special needs for the meeting including participation of team members by telephone, orders of protection, etc.

Ten tips for Supervisors or Assistant Program Managers to an effective LLC meeting:

1. Staff with CSS prior to discuss safety and risk factors, strengths, permanency and well-being of the child.
2. Attend as a support and participate in the process.
3. Model the Department's commitment to the values and principles of FSC.
4. Ensure that staff understand the purpose of the LLC meeting.
5. Ensure that staff are organized to present a case summary in a professional manner.
6. Keep the team focused and productive.
7. Help others understand the importance of consensus group decision making.
8. Ensure staff follow through on plans that are developed.
9. Solicit and provide feedback to staff regarding their presentation and interactions.
10. If any team member from DCS feels that the decision is not least restrictive and least intrusive, they can request a review by management.

During the LLC meeting:

- Share with the team the outcome(s) of any pre-planning meetings, such as a Blended Perspectives Meeting (BPM), if held.
- Provide information regarding the child's placement history.
- Provide information regarding services and supports provided to the child and the placement or kinship.
- Be open and honest regarding the strengths and needs of the child and how this will impact the placement.
- Be receptive to team ideas and strategies regarding the child's placement, services and supports, even if non-traditional.
- Be the content expert with regards to the case.
- Be knowledgeable regarding the Department policies and procedures regarding placement, services and case planning.
- Clearly articulate safety, risk, permanency and well-being.
- Collaborate with team members in reaching a consensus decision.
- Own the team's decision.

Outcomes of a LLC meeting include:

- Identifying the strengths and needs of the child and kinship.
- Team consensus regarding decision on a family-like placement for the child.
- Identifying the services and supports needed for a successful placement.
- Identification of tasks including who will be responsible to facilitate the family-like placement, services, supports and lifelong connections.

After the LLC meeting:

- Provide and be open to feedback from team members.
- Follow up with tasks assigned as an outcome of the meeting.
- Check in with the child and family to ensure that the meeting outcomes are clearly understood.
- Schedule follow up meetings to ensure ongoing communication between placement, services and supports are in place.
- Follow up with service providers to ensure the right services are in place.

APPENDIX H

Fostering Sustainable Connections (FSC)
In Home Services Program (IHSP)
Process Guide – DRAFT

The Child Safety Specialist (CSS) can help with family engagement.

Families are more likely to engage in services when the CSS:

- Thoroughly explains the services so that they know what to expect,
- Attends the first family meeting with In Home providers,
- Updates team members of contact information changes,
- Facilitates the collaboration of other service providers involved (i.e. RBHA providers), and
- Acknowledges family progress and strengths.

SENSE is available for families with substance exposed newborns.

Substance Exposed Newborn Safe Environment (SENSE)

How can the In Home Services program help my families?

The In Home Services Program assists in supporting and enhancing the family unit, and preserving and reunifying the family through family oriented services. These support services are designed to maximize family strengths and protective factors to families stay together, to minimize placement disruptions and to enhance healthy individual and family functioning. There are five components included in the program:

1. **Family Support level** - A family supportive intervention (up to 120 days) for families with potential or low risk of abuse and/or neglect to allow the children to safely remain within their homes. Good for open or closed DCS cases with no court involvement and community families (no DCS involvement).

2. **Moderate level** - A type of supportive service activities (up to 90 days) for families where conditions represent no safety threat, but a high to moderate risk of abuse and/or neglect. These services are intended to allow the children to safely remain in their homes. Good for open DCS cases with no court involvement.

3. **Intensive Family Preservation level** - A level of crisis-oriented service activities (up to 120 days) for families where conditions represent a threat to child safety and whose children are at significant risk of out-of-home placement due to abuse or neglect. Good for In Home Dependencies, In Home Interventions and open DCS cases with no court involvement.

4. **Family Reunification and Placement Stabilization level** - Assists to safely expedite the return of children who are in out-of-home placement or in voluntary foster care back to their family. Aides in the transition of a child from a more restrictive placement back to the community, such as a residential treatment center to a foster or family home or from a foster home to a family home; or in the stabilization or safe maintenance of a child in a relative/kinship or adoptive home. These services are up to 120 days. Good for cases where expected reunification in 45 days (30 days target return date) during Out of Home Dependency or Voluntary Foster Care, stabilization of relative/kin or adoptive placement, transition from more restrictive placement to less restrictive (residential to foster home or foster home to family home).

Home Services with a nursing component, Healthy Families, Arizona Families F.I.R.S.T. and drug testing. It is expanding to various regions. Consult with your supervisor if you are unsure about availability in your region.

Reunification Services

To accelerate the start of services, send referrals for reunification services as soon as possible. These services are intended to help expedite the return of children. Reunification services are not to be used if there is no intention of returning the child(ren).

Frequency of Contact

The frequency of contact by the assigned provider team can be adjusted upon agreement with DCS and the provider with consideration of progress in services. Monthly case staffings can help with decision making and keep DCS informed of progress and concerns

5. **Clinical Family Assessment** - An assessment conducted by a Master's Level Clinician to assist in identifying the nature of family issues, treatment needs and services that might be utilized to address the identified areas of focus. The completed assessment is sent to DCS within 30 days of the referral. Where available, a Unit Consultant can also be used to assess individuals. Good for all types of cases.

Eligibility - The CSS determines the type and level of service based on the needs, concerns and stressors of the child and family that are assessed (in the CSRA). If any safety and/or risk factors are in need of intervention, In Home Services is one of several services available to address behavioral changes as well as support the family.

Referrals - The CSS needs to complete the following forms:

- Request for Services (PS-067)
- In-Home Services Addendum (PS-06713)

After the above forms are completed, the CSRA and other relevant case documents should be included in the referral packet. Referral packets are sent to the regional referral units (may vary by region). Consult with your supervisor if you are not sure where to send the referral packet.

This program provides a wide range of services including but not limited to, the following:

- Crisis intervention counseling
- Clinical family assessment
- Goal setting and case planning in accordance with the safety and risk factors, and behavioral changes identified by DCS
- Individual, family, and marital therapy
- Communication and negotiation skills
- Structured parenting education and child development
- Problem solving skills and stress management
- Home management and nutrition
- Development of linkages with community resources to serve a variety of social needs

---

In Home Services Do's and Don'ts

Do's

- DO explain the program to families so they know what to expect.
- DO outline the expected behavioral changes for families as time limited, specific and achievable.
- DO include current contact information (for families and DCS) and all required documents in the referral packet.

Building Protective Factors

Protective factors are individual strengths that can help families deal with stressful events. In Home Services incorporate the protective factors into their work with the families. A pre- and post-test is used to measure improvements in each of the protective factors during service delivery. Protective factors include: parental resilience, nurturing and attachment, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children.

- DO respond quickly when contacted by assigned providers as services or critical information could be delayed if you don't.
- DO communicate with the family to discuss their engagement and progress in services.
- DO encourage collaboration by inviting all service providers to TDMs, CFTs, etc.
- DO refer to Moderate or Family Support instead of Intensive Family Preservation if there are only potential, low or moderate safety risks.
- DO send in Reunification or Placement Stabilization referrals sooner rather than later so services can start before a child is returned home or moved.
- DO refer to Clinical Family Assessment to assist in identifying the nature of family issues and for clinical recommendations.
- DO contact your supervisor if you have questions or concerns about services.

Don'ts

- DO NOT forget to follow up with submitted referrals (with families and providers).
- DO NOT forget to let the provider know of family changes such as relocation.
- DO NOT leave In Home Services open after behavioral changes have been achieved.

In Home Services are not intended to replace mental health/substance abuse treatment. The CSS or the family can complete a referral to the local Regional Behavioral Health Authority (RBHA) provider to address mental health issues. If substance abuse problems are present, a referral to the Arizona Families F.I.R.S.T. program can also be made.

APPENDIX I

Fostering Sustainable Connections (FSC)
Kinship Care
Process Guide – DRAFT

In CHILDS, use case note type RELATIVE INFORMATION for:

- Contact information about kinship;
- Kinship search efforts;
- Forms mailed to kinship;
- Discussion with kinship about placement and/or contact; and
- The date of criminal records requests and results of the search.

When placement has been selected, don't forget to:

- Complete the Motion for Change of Physical Custody (CT01700);
- Complete the Assessment for Kinship Foster Care or Significant Person Placement (CT01100);
- Submit both forms to the Juvenile Court; and
- Submit background checks under seal to the Assistant Attorney General's Office.

A kinship caregiver is an adult relative or person who has a significant relationship with the child and who is caring for the child under the care, custody and control of the department.

- When children are removed from their parents and placed into out-of-home care, being placed with and cared for by kin is preferred. The most important benefit of kinship care is for children to be able to live with someone who knows them, who loves them and who will provide the best care possible.
- Kinship caregivers can be licensed or unlicensed.

Once placement is selected, support to the kinship caregiver can be offered by answering questions and providing resources.

The following are resources and information that can be provided:

- Kinship Foster Care Relatives Caring for Children in DCS Custody (CSO-1047) pamphlet.
- At time of placement, provide and review the:
  - Notice to Providers (Out-of-Home Educational and Medical) (CSO-1035A);
  - Child Placement Summary/Agreement (CSO-1046A)
  - Safety Plan (CSO-1034B); and
  - Protective Action/Safety Plan Signature Page (CSO-1034C).
- Advise the kinship caregiver about:
  - CMDP and Behavioral Health Services available through the Regional Behavioral Health Authority (RBHA).
  - Kinship Information Session which is held monthly in Phoenix and Tucson. For dates, times and locations call (520) 323-4476.
  - Review the Kinship Placement Agreement and Notification of Resources (CSO-1129A).

An unlicensed kinship caregiver must:

- Be at least 18 years old;
- Have all adults in the household clear DCS Central Registry, criminal background and fingerprint checks;
- Be able to pass a home study using the Home Study Checklist for Kinship Foster Caregiver Household (CSO-1014);
- Be able to meet basic health and safety requirements; and
- Complete a Self-Disclosure Statement for Kinship Foster Caregiver Household (CSO-1130).

To become a licensed kinship foster parent one must:

- Be at least 21 years old;
- Be single, divorced or married; if married, your spouse must also apply to get licensed;
- Be fingerprinted for a criminal history records check and get a fingerprint clearance card (this applies to everyone 18 and older living in your home);
- Be a legal resident of the United States;
- Own, lease or rent your home, mobile home, apartment, condominium, or townhouse;
- Meet health and safety requirements and correct problems found during inspection of your home;

The Department provides non-financial services to kinship caregivers to meet the needs of the child such as:

- ✓ Child Care
- ✓ Respite Care
- ✓ Family Assessment
- ✓ Housing Search/Relocation
- ✓ Emergency Services
- ✓ Parent Aide
- ✓ Case Management
- ✓ Transportation
- ✓ Parenting Skills Training
- ✓ Supportive Intervention & Guidance Counseling

Additional services that the Department determines are necessary to meet the needs of the child and family. Complete the appropriate referral. See supervisor for more information.

There are also financial resources available for kinship caregivers to meet the needs of the child.

The Department provides:

- Personal and Clothing Allowances also known as Daily Allowances
- Auxiliary Payments and Special Allowances/Supplemental Financial Supports
- The kinship caregiver can become a licensed kinship foster parent to receive additional foster care maintenance payments.

Grandparents and great-grandparents may apply for the Grandparent Stipend Program.

- Provide and discuss the **Grandparent Stipend Eligibility** (CSO-1266A) form.
  - The benefit is $75 per month per child.
  - There is an income requirement for eligibility.
    - Kinship cannot receive this simultaneously with TANF Child-Only Cash Assistance or foster care maintenance payments, if licensed.
  - The stipend is funded on a yearly basis based upon legislative appropriation.
  - For assistance, contact a Kinship Specialist at +DCSKinship or DCSKinship@azdes.gov.

Kinship caregivers may apply for Child Only Cash Assistance (CA) Temporary Assistance for Needy Families (TANF).

- Provide and discuss the application for CA/TANF and encourage the caregiver to apply.
  - Kinship caregiver is to complete both the Application for:
    - Cash Assistance (CA) Temporary Assistance for Needy Families (TANF) (FA-001); and

- Have transportation available and a means of communication with emergency services, the Child Safety Specialist, police, etc.;
- Have a bed and storage space for the children;
- Be in good general health (a statement from a doctor is required);
- Have enough income to take care of your own family (aside from the children in out-of-home care);
- Give the names and contact information of at least five references;
- Attend 30 hours of training as an important part of getting licensed;
- Work with a foster home licensing worker to complete a study of your family and home; and
- Sign and agree to follow the DCS Discipline Policy.

    - TANF/CA Contact Form (FAA-1091AFORNA)

  They cannot use the online application process.
- Kinship caregiver provides the completed forms to the Child Safety Specialist.
- Note that the child's Social Security Number is on the FA-001 application.
- Write "KFC/DCS/P" on the upper right hand corner of the FA-001 application.
- Scan each page of the application (the application is two-sided) and e-mail the FA-001 application and FAA-1091AFORNA to +FAA CDS Kinship FC or FAACDSKinshipFC@azdes.gov.
- FAA will contact the kinship caregiver to schedule an in-person/telephonic interview to complete the interview requirement within **5** days of receiving the e-mail.
- Eligibility determination is made within **20** days of when FAA receives the e-mail.
- An EBT card will be mailed to the applicant within **5** days of the interview. If approved, the EBT card will be "loaded" the day following the approval date.

For more information regarding Kinship Care:

See the Arizona DCS Policy and Procedure Manual:

- Chapter 2, Section 6 Emergency Interventions and Removals
- Chapter 3, Section 3 Voluntary Placement
- Chapter 4, Section 3 Kinship Care

Contact a Kinship Specialist at +DCSKinship or DCSKinship@azdes.gov.

APPENDIX J

Fostering Sustainable Connections (FSC)
Community Services
Process Guide – DRAFT

Arizona 2-1-1 (Community Information & Referral Services)

- Transforms lives by linking individuals and families to vital community services throughout Arizona.
- Individuals and families should be connected to available health and human services in their communities.
- Community Information and Referral Services can assist you in guiding the family to obtain services.

Become familiar with the locations of community services in the areas you work to ensure the right service(s) is provided to the right family at the right time.

- Arizona 2-1-1 (Community Information and Referral Services) is just one resource to obtain community services.
- Research the 2-1-1 Arizona website www.211arizona.org, download the **FREE** 2-1-1 Arizona phone application or dial 2-1-1. Order FREE 2-1-1 Arizona Brochures and Cards from www.211arizona.org/secure/freestuff to provide to the family.
- Community services are listed by County or by service type.
- Click on the names of the agencies and programs that come up during your search, read their descriptions, eligibility requirements, intake process, and other information before contacting the service. Review the community provider's website(s).
- A DCS referral is NOT required to obtain services for a family.
- A referral can be made on an open or closed DCS case.
- Although not all listed services are guaranteed to be available some common community services are (but not limited to):
  - Food Banks
  - Shelters
  - Animal Services
  - Youth Services
  - Food Stamps
  - Transportation
  - Daycare Services
  - Bill Payment Assistance

Explore and identify the needed community services with the parent/caregiver.

- Talk and engage with the parent/caregiver.
- Ask the parent/caregiver about their needs and give them the opportunity to identify and discuss.
- Inform and notify the parent/caregiver about the website www.211arizona.org and/or provide other community services' pamphlets and brochures.
- Assist the parent/caretaker with navigating the website www.211arizona.org and obtaining the needed community services.

Discuss with your supervisor, the collaborative assessment and aftercare plan.

- Inform your supervisor of the agreed upon community services (and other needed services) discussed with the parent/caretaker.
- Provide information to your supervisor of how or the plan to obtain the community services for the parent/caregiver.
- Determine if continued community services are needed (staff with supervisor and parent/caregiver).
- Community referrals can be part of the aftercare plan. Ensure an aftercare plan has been created with the parent/caregiver and documented in CHILDS.

APPENDIX K

Fostering Sustainable Connections (FSC)
Title XIX Behavioral Health Services
Process Guide – DRAFT

Behavioral health services for children in out-of-home care are available.

The array of covered behavioral health services include:

- Outpatient Behavioral Health
- Treatment Services
- Rehabilitation Services
- Psychiatric Services
- Support Services
- Crisis Intervention Services
- Inpatient Behavioral Health
- Residential Behavioral Health
- Behavioral Health Day Programs

A comprehensive assessment will be completed and remain open for a minimum of 6 months.

- If a child is identified as having a behavioral health need at any time, a referral may be made by calling the local T/RBHA or calling an intake provider directly.
- The child's out-of-home placement (kinship, foster parent, etc.) can also make a referral.

The Department of Child Safety (DCS) shall seek to ensure that all children and families served by DCS receive the appropriate behavioral health services.

- DCS is NOT funded to provide behavioral health services for Title XIX eligible children.
- The Regional Behavioral Health Authority (RBHA) provides behavioral health services to Title XIX eligible children.
- Most children in out-of-home placement are Title XIX eligible.
- Services should be based on the child and/or family's needs, strengths and culture.
- Child and Family Teams (CFTs) are a platform for assessment, service planning and the delivery of services is based on the unique individual needs of the children and other family members.
- For more information about what services are covered by the RBHA, see Title XIX Covered Services.

All requests for behavioral health services for Title XIX eligible individuals MUST be made to the RBHA.

- Refer all children in out-of-home care to the RBHA for a Rapid/Urgent Response within **24** hours of removal.
- All referred children are to be seen within **72** hours of removal and an assessment be completed by the RBHA. The biological family's contact information should be provided so that engagement and inclusion of the assessment process can be done.
- Timeliness of the referral is crucial to assist in identifying the immediate behavioral health needs of the children and address the trauma of the removal itself.
  For more information, see Standards for Timeliness of Behavioral Health Services.
- The DCS Specialist should participate in the intake and assessment process in person to provide pertinent information (i.e. reason for the removal, any known supports and known needs) and to sign the consent to treatment document. The caregiver is encouraged to participate in the assessment process to provide pertinent information.
- Provide a copy of the initial assessment and behavioral health recommendations within five to seven days of the referral or prior to the Preliminary Protective Hearing, whichever is the latter.
- Collaborate with the RBHA providers to ensure the child(ren) is receiving the right services for their needs.

Each RBHA has a DCS Liaison to assist DCS staff and foster families with accessing necessary behavioral health services for children and families involved with child welfare:

Mercy Maricopa Integrated Care (MMIC)
DCS@mercymaricopa.org
RBHA Member Services:
1-800-564-5465

Cenpatico Integrated Care (C-IC)
DCS@cenpatico.com
RBHA Members Services:
1-800-495-6738

Health Choice Integrated Care
DCS@iasishealthecare.com
RBHA Member Services:
1-800-640-2123

- More information on Title XIX Covered Services is available in the DCS Policy and Procedures Manual, Chapter 3, Section 14, Related Information

Most children in out-of-home care are Title XIX eligible.

- Eligible children:
  - All children under Title IV-E or Supplemental Security Income (SSI).
  - If the child(ren) does not have substantial income and is in out-of-home care who are U.S. citizens or qualified non-citizens.
- To determine if a child in in-home or out-of-home placement is Title XIX eligible, refer to the Eligibility Directory window in CHILDS, or contact the DCS Eligibility Unit at (602) 235-9358.

Select the most appropriate RBHA.

- A court ward in out-of-home placement: Contact the RBHA serving the location of the child's court jurisdiction.
- A court ward on an in-home petition: Call the DCS Eligibility Unit to determine the child's Title XIX eligibility status, and if eligible, contact the RBHA serving the current residence of the child.
- Not a court ward: Contact the RBHA serving the current residence of the child's parent or legal guardian and/or the child's location.
- A child in a crisis situation who is not enrolled for Title XIX services: Contact the RBHA serving the area where the child is at the time of the crisis for emergency services.

Regional Behavioral Health Authorities by Region

Arizona Tribal and Regional Behavioral Health Authority (T/RBHA):	**County or Tribal Nation Served:**
Cenpatico Integrated Care (C-IC) RBHA 1-866-495-6735	Pima, La Paz, Pinal (part of), Yuma, Graham, Greenlee, Santa Cruz and Cochise
Gila River T/RBHA 1-800-259-3449	Gila River Indian Community
Mercy Maricopa Integrated Care (MMIC) RBHA 1-800-631-1314	Maricopa, Pinal (part of)
Navajo Nation T/RBHA 1-928-729-4466	Navajo Nation
Health Choice Integrated Care (HCIC) RBHA 1-877-756-4090	Apache, Coconino, Gila, Mohave, Navajo, Yavapai
Pascua-Yaqui T/RBHA 1-520-879-6060	Pascua Yaqui Tribe
White Mountain Apache T/RBHA 1-877-336-4811	White Mountain Apache Nation

Child and Family Team (CFT) Meetings.

- A CFT process is initiated when DCS makes a Rapid/Urgent Response referral and the assessment begins.
- Facilitated by the behavioral health provider.
- The CFT includes, at minimum, the child and his/her family, a behavioral health representative, DCS Specialist, placement and any individuals important in the child's life and who are identified and invited to participate by the child and family.
- The DCS Specialist is aware and collaborates with behavioral health providers for the strengths, needs, cultural consideration, clinical risks, symptoms, and behaviors of the child and family/placement.
- The DCS Specialist should participate and collaborate with the RBHA in the development of the Individualized Service Plan (ISP).
  For more information, see Twelve Principles to Develop the Individualized Behavioral Health Plan.
- See Child and Family Team Practice for the DBHS CFT Guide.

APPENDIX L

Fostering Sustainable Connections (FSC)
Non-Title XIX Behavioral Health Services
Process Guide – DRAFT

Some free or low cost support services:

- SOS Non-Title XIX Resource Hotline: (602) 759-8175
- MIKID AZ: Select your location and select "Support Groups"
- Teen Lifeline: 1-800-248-TEEN (8336)
- Substance Abuse and Mental Health Services Administration: 1-800-662-HELP (4357)

To access behavioral health services through CMDP for Non-Title XIX eligible children:

- Obtain prior authorization by contacting the CMDP Behavioral Health Coordinator.
- Monitor provision of services and program toward goals.

Children and families served by DCS will receive the appropriate Comprehensive Medical and Dental Plan (CMDP) behavioral health services.

- These behavioral health services are available through CMDP for eligible clients:
  - Inpatient hospitalization;
  - Psychiatric evaluation and diagnosis;
  - Laboratory and other services for medication regulation and diagnosis;
  - Psychotropic medication;
  - Psychological evaluations for eligible children in an inpatient hospital setting; and
  - Psychological evaluations, therapy and other services for eligible children residing outside of Arizona.
- For more information, see CMDP Behavioral Health Services.

Children who are Non-Title XIX eligible are still eligible to receive DCS contracted behavioral health services.

- These contracted behavioral health services include:
  - Individual therapy/counseling,
  - Group/family therapy/counseling,
  - Evaluation and diagnosis,
  - In-home moderate services,
  - In-home intensive services,
  - Substance abuse assessment, and
  - Substance abuse treatment.
- To access these DCS contracted behavioral health services, complete the "Request for Services (PSO-67)."
- Continue to request all other services through the Title XIX RBHA provider.
- For more information, see Non-Title XIX Behavioral Health Services.

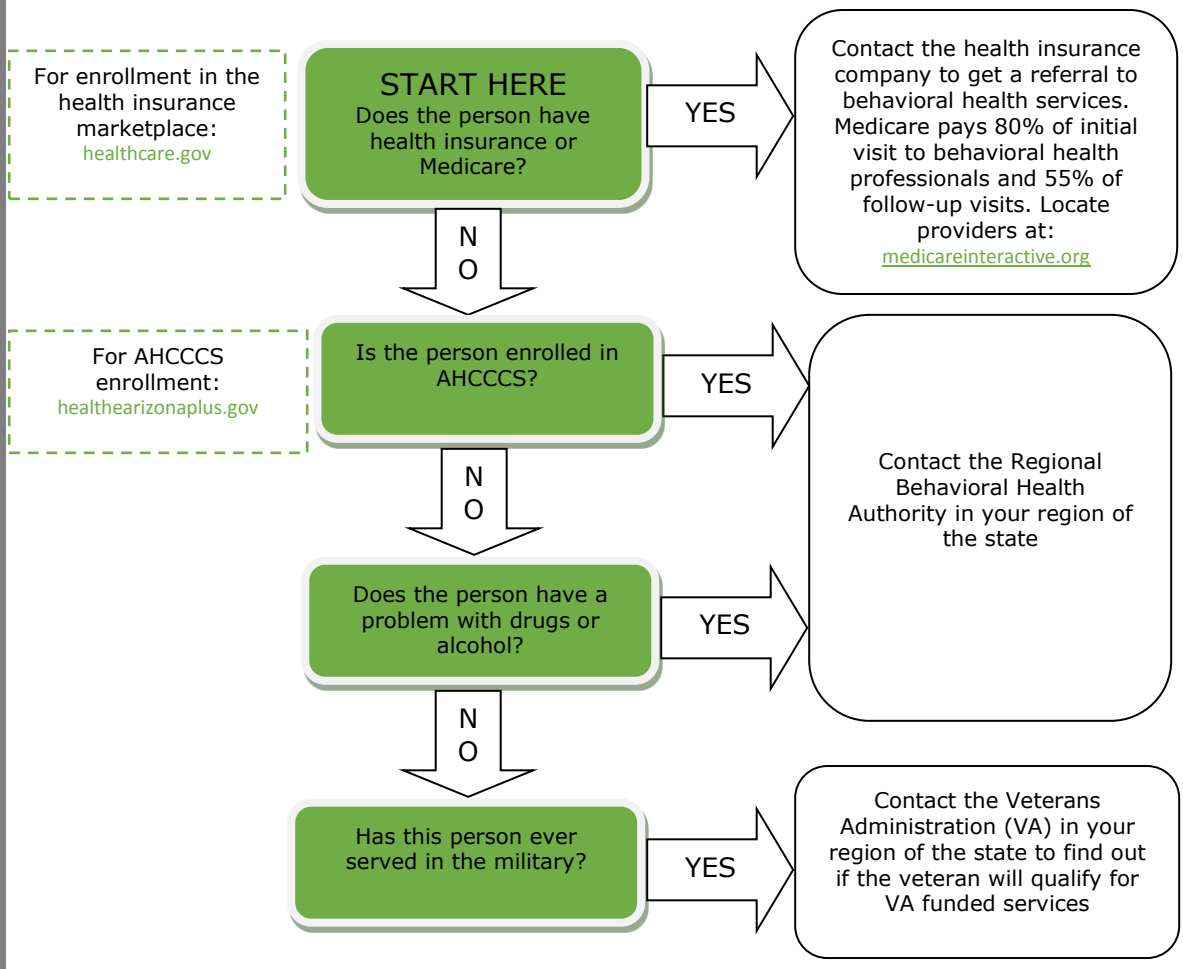
Parents may also benefit from behavioral health services.

- **Either in the treatment plan for the child or through separate enrollment in the adult behavioral health system.**
- **Adults served by DCS are eligible for adult behavioral health and substance abuse services.**
- Parents may need assistance in order to:
  - Learn how to better analyze and solve problems in relation to the safety needs of the child and other family members, and

- Make DCS case records available to CMDP and the service provider, as necessary.
- Notify CMDP of any changes that may affect the child's eligibility status.
- Notify the CMDP Behavioral Health Coordinator of the decision for a child to participate in extended foster care, prior to the child's 18th birthday.

When adults served by DCS are receiving Title XIX Behavioral Health Services:

- Maintain primary case management responsibility and make DCS records available to the behavioral health provider, complying with confidentiality requirements.
    - Be engaged (or possibly re-engaged) to participate in assessment, service planning, and delivery processes for their children and themselves.
- The Child Safety Specialist (CSS) will refer adults served by DCS to receive appropriate behavioral health and/or substance abuse treatment.
- For more information, see Adult Behavioral Health and Substance Abuse Services.



- Participate in all RBHA treatment staffings and Individual Service Plan (ISP) development.
- Participation may be telephonic if unable to attend in person.
- Follow the Case Management Hierarchy.

Monitor progress to ensure timely services.

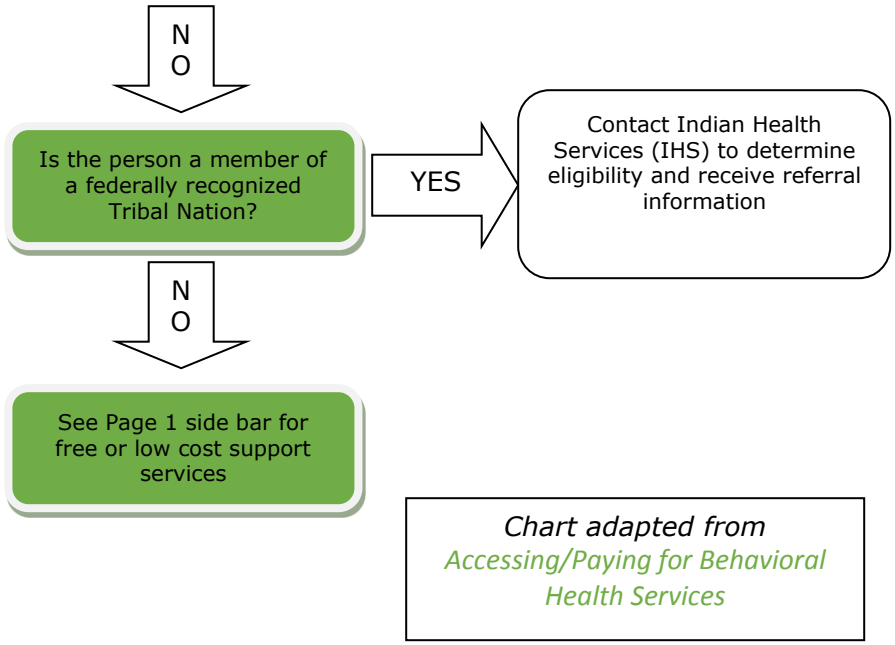


Chart adapted from
Accessing/Paying for Behavioral Health Services