Center for Applied Behavioral Health Policy

ARIZONA STATE UNIVERSITY

2010

ARIZONA CITIZEN REVIEW PANEL
Twelfth Annual Report

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Points of view represented in this report are those of the Arizona Citizen Review Panels and do not necessarily represent the official position or policies of the Arizona Department of Economic Security or Division of Children, Youth and Families.

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Executive Summary

The Center for Applied Behavioral Health Policy at Arizona State University (CABHP), through an interagency service agreement with the Arizona Department of Economic Security (ADES), began administering the Arizona Citizen Review Panel (ACRP) Program in December of 2008. The Arizona Department of Economic Security/Division of Children Youth & Families (DCYF) is the state agency responsible for the provision of child protection services. Working in conjunction, DCYF and CABHP are responsible for meeting all federal requirements specified in the Child Abuse Prevention and Treatment Act (CAPTA) regarding Citizen Review Panels. Panels develop recommendations for improvement of Arizona's child welfare system, including Child Protective Services (CPS), through independent, unbiased system reviews. The panels are composed of citizens; social services providers; child advocates; adoptive and foster care parents; legal, medical, education, and mental health professionals; and faith-based representatives.

Citizen Review Panels review CPS state policies, current practices, pertinent data, and case record information on child fatalities and near fatalities due to maltreatment. In addition, the panels evaluate the CPS relationship with foster care, adoption, and other related agencies. The panels make recommendations to CPS for system changes and improvements through the submission of the annual report.

The 12th Annual Citizen Review Panel Report summarizes the accomplishments, activities, findings, and recommendations of the three ACRPs (Northern, Central and Southern). Areas for recognition included CPS Specialists' positive qualities such as maintaining a good rapport with families, linking families with helpful services, and taking actions early to establish permanency. In addition, areas for improvements are included in both the case record review section and the panel's recommendations.

ACCOMPLISHMENTS

Throughout the past year the panels have continued to refine their operations as well as observed the many strengths of the Arizona child welfare system. The panels witnessed the dedication and many achievements of the CPS field staff, including a CPS Specialist who substantiated an abuse finding despite the reluctance of law enforcement to move forward with criminal charges against the perpetrator; and a CPS Parent Aide determination to obtain medical records despite the medical provider's reluctance to release the documents. In addition, the panels observed system partners working collaboratively in order to quickly establish permanency for child(ren) and provide a multitude of services from across various organizations to support reunification.

Additional highlights identified over the past year are detailed below:

- The panels found that case record documentation indicated that reports taken by the CPS Child Abuse Hotline were complete, accurate, and timely;
    - the timeframe for the initial response by CPS, law enforcement, or other emergency personnel were within the allotted times determined by levels of risk (high, moderate, low, potential); and

    - the investigative findings were supported in all 24 investigations reviewed;
- The panels formally recognized and sent letters of acknowledgement to CPS staff who exceeded expectations, and a community leader who exemplified collaboration efforts across the child welfare, criminal justice, and service delivery systems;
- The panels recognized the achievements of the Arizona Court Teams ("Best for Babies") as the cases reviewed showed CPS and the courts worked collaboratively to move the case forward and achieve permanency for the child within nine months of custody;
- Increased the number and expanded the diversity of panel membership, including recruiting foster and adoptive families along with youth formerly served through the child welfare system;
- Augmented the orientation process provided to new members;
- Enhanced the structured protocol for conducting case record reviews and the case record presentations during panel meetings; and
- Established a strong linkage with the National Citizens Review Panel Coordinating Center at the University of Kentucky, and participated in the Ninth Annual National Citizen Review Panel Conference.

PANEL'S RECOMMENDATIONS

Each of the three panels developed recommendations for improvement of the child welfare system in Arizona based on policy review, case record reviews, presentations, materials distributed and updated provided by representatives from the ADES/DCYF. Recommendations are combined, prioritized, and then divided into four categories based on input from panel members and DCYF. The first category (*Recommendations for Agency Response*) is the recommendations that require a formal written response from DCYF as required by the CAPTA. Recognizing the ongoing efforts of DCYF to improve practices and services, only those areas not currently addressed, or those which panels identified as benefiting from additional enhancements were included in this category.

The second category (*Observations In Alignment With Current Performance Improvement Plans Or Areas Being Addressed By The Child Welfare Training Institute*) includes recommendations that are currently being addressed through practice improvement activities. DCYF has dedicated Practice Improvement Specialists in all regions. Practice Improvement Specialists in each region lead case reviews, provide data and performance information to regional management and the DCYF's Quality Improvement Manager, facilitate regional action planning, and monitor and lead regional practice improvement activities. The panels want to monitor progress in these areas in the upcoming year. Updates on the result of these activities, including new initiatives, are provided annually to panel members.

Recognizing that the child welfare system is not solely the responsibility of DCYF, the final category (*Recommendations for Child Welfare System Partners*) includes recommendations for systems improvement that are directed toward system partners. Panel members and DCYF staff are encouraged to advocate and promote collaborative efforts with systems partners to incorporate these recommendations.

The following are the recommendations made by the regional panels in an effort to improve the CPS system:

RECOMMENDATIONS FOR AGENCY RESPONSE

1. DCYF should seek opportunities with collaborative partners to evaluate outcomes and systems collaboration, and explore expansion of the Arizona Court Teams ("Best for Babies") model throughout all regions of Arizona.

2. DCYF should review policies related to medically fragile children and their families/ caregivers and ensure that supervisors receive training related to this population (e.g., gathering, assessing and documenting key medical information; identification of high risk medical conditions and identifying needed services; accessing consultation from CMDP; expectations for service coordination with medical providers including Children's Rehabilitation Services; and providing clinical supervision to staff working with medically fragile children). DCYF should encourage and assist families of children with complex medical needs to invite their health care provider or an identified health care coordinator to interdisciplinary meetings (e.g., case staffings, care plan coordination meetings, and/or Child and Family Team Meetings) so they may assist with case planning, link families with resources, educate families/caregivers on the child's needs, and coordinate ongoing services. Alternative methods for participating in these meetings that maximize the use of technology should continue to be explored (e.g., teleconferencing and web-based applications).

3. Expand to all regions the remedial training for proper documentation that was initially piloted in one region of the state.

4. Clarification should be provided to CPS staff regarding the need to complete a safety assessment when an infant is born to a parent with an open case.

OBSERVATIONS IN ALIGNMENT WITH CURRENT PERFORMANCE IMPROVEMENT PLANS OR AREAS BEING ADDRESSED BY THE CHILD WELFARE TRAINING INSTITUTE

1. Child Safety Assessments must document all safety threats, not just those identified in the report and case plans; should identify how each of the safety threats and risk factors are being addressed in the case plan; documentation not meeting CPS policy standards for quality and timeliness, including clearly indicating services offered to families, as well as services declined; CPS investigations must include interviews with all members of the household and/or other persons known to have knowledge of the abuse or neglect or could confirm or deny a safety threat to the child victim, or any other child in the home where the abuse or neglect occurred, such as school personnel, medical providers, child care providers, relatives, other adults living in the non-custodial parents home, neighbors); and joint investigations protocols not being adhered to.

2. It is critical that CPS field staff have ample and timely clinical supervision to guide staff in decision making process and to identify and address ongoing and emergent training needs; enhance skills and improve documentation in the case record; ensure the quality of assessments and services; and address performance issues.

3. Key areas that the panel identified for continuing education of supervisors are medically fragile/complex youth, trauma and grief, identifying and addressing children's safety threats and risk factors.

RECOMMENDATIONS FOR CHILD WELFARE SYSTEM PARTNERS

1. It is critical that funding for DCYF and other Child Welfare partners not be reduced to ensure safety and maintain services of our children. Arizona's workforce continues to be challenged as CPS Specialists were reportedly working 65.6% above caseload standards.[1] The majority of the cases reviewed involve complex problems including substance use, mental illness, children who are medically fragile, parental criminal justice involvement, and inadequate day care funding. Reductions to other health and human service agencies will negatively impact the entire child welfare system.

2. The medical community needs to provide parents/caregivers with education and instructions for care and medications in their primary language.

3. Children with complex medical needs should be assigned an advocate by the medical community and would benefit from better coordination with medical services.

4. Emergency room physicians and other emergency personnel should continue to receive training in identifying and reporting child abuse and neglect. DCYF records reviewed and anecdotal reports from panel members identified several instances in which reports to CPS should have been made. Education to clarify that it is not the medical personnel's responsibility to report only when they are able to determine abuse has occurred. They are to report when there is a reasonable belief that a minor is or has been the victim of physical injury, abuse, child abuse, not just when abuse is confirmed. Additional training could also enhance the skills of medical staff to identify potential maltreatment such as when a child is seen repeatedly or is taken to multiple medical providers for similar injuries.

5. As child protection and safety involves ongoing collaboration and coordination across multiple systems, joint investigation protocols are crucial for clarifying expectations and agency roles. The panels identified that delays in obtaining autopsy reports impeded criminal investigations. Concerns were also expressed when the cause of death was undetermined, yet there appeared to be injuries (e.g., old fractures) noted in the CPS report that are highly suspect of maltreatment. Opportunities for all involved parties to improve collaboration and timely exchange of information during the investigation process should be examined, including expansion of joint protocols to include the Medical Examiner's Offices.

[1] Child Protective Services Bi-Annual Financial and Program Accountability Report (CPS Report), August 2010, Arizona Department of Economic Security.

6. AHCCCS and other medical facilities should continue to explore electronic medical records that would allow access to and sharing of medical records. Emergency rooms do not always have vital medical history information that would aide them in identifying children who are being abused and neglected.

7. Criminal Justice Coordinators, who play an important role in ensuring that joint investigation protocols are followed and resolve system issues that arise, are not available in every region. Counties should apply for the Children's Justice Grant funds available through the Office for Children, Youth and Families, Division for Children. Based upon a review of a case in Colorado City, the panel strongly recommends that the Criminal Justice Coordinator position in Mohave County that has remained vacant for a significant time period be re-established to address the concerns with investigation processes and joint investigation protocols.

8. Hospitals throughout Arizona are providing education and information to mothers of newborns on Shaken Baby Syndrome (SBS) prior to their discharge. The panels recommend that both parents and other caregivers participate given the number of incidents involving perpetrators of SBS who are fathers and caretakers. Pediatricians during well checks should also provide information and education to families on SBS.

Arizona Citizen Review Panel Overview

The ACRP was established in 1999 in response to the 1996 amendment to the Child Abuse Prevention and Treatment Act (CAPTA) requiring states to develop and establish Citizen Review Panels. The purpose of ACRP is to determine whether state and local agencies are effectively discharging their child protection responsibilities. Panel members develop recommendations for improvement of CPS through independent, unbiased case record and data reviews.

> "I think we should be really proud of ourselves, all of us. It really shows that it's important for everybody to be involved, to make recommendations and try to stand behind them the best we can and get them moving, because nobody will get them moving for you… a lot has been done (by the Panels)."
>
> ***-Judy Gideon, Foster Parent Northern Panel Member***

The creation of the ACRP Program is an acknowledgment that protection of our children is the responsibility of the entire community, not a single agency. Although the primary focus of oversight is ADES/DCYF, the ACRP takes into consideration the impact of other entities and assesses whether they support or hinder the state's efforts to protect children from abuse and neglect.

CHILD ABUSE PREVENTION AND TREATMENT ACT

The Child Abuse Prevention and Treatment Act (SEC.106 [42 U.S.C. 5106a]) was enacted in 1974 to provide grants to states to support innovations in state child protective services and community-based preventive services, as well as research, training, data collection, and program evaluation. CAPTA requires states receiving a Basic State Grant to establish no less than three Citizen Review Panels. Panels are comprised of volunteer members who are broadly representative of their community, including members who have expertise in the prevention and treatment of child abuse and neglect. Each panel must meet at least once every three months and evaluate the extent to which the state agency is effectively fulfilling its child protection responsibilities in accordance with the CAPTA state plan. In addition, panels are required to review child fatalities and near-fatalities, and examine other criteria important to ensure the protection of children (i.e., the extent to which the state child protective services system is coordinated with the foster care and adoption programs).

Section 106(c)(5)(A) of CAPTA requires states to provide each Citizen Review Panel with access to information on cases that the panel chooses to review if the information is necessary for the panel to carry out its functions under CAPTA. Report language clarifies that congressional intent was to direct states to provide the panels with necessary information to carry out these functions.

Section 106(d) of CAPTA requires that Citizen Review Panels develop reports and make them available to the public annually. These reports should contain a summary of the panel's activities, as well as the recommendations of the panels based upon their activities and findings.

Citizen Review Panel members are bound by the confidentiality restrictions in section 106(c)(4)(B)(i) of CAPTA. Specifically, members of a panel may not disclose identifying information about any specific child protection case to any person or government official and may not make public other information unless authorized by state statute.

The Keeping Children and Families Safe Act of 2003 amended CAPTA to include the following requirements:

1. Each panel shall examine the practices (in addition to policies and procedures) of the state and local child welfare agencies.

2. Panels shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community.

3. Each panel shall make recommendations to the state and public on improving the child protective services system.

4. The appropriate state agency is required to respond in writing no later than six months after the panel recommendations are submitted. The state agency's response must include a description of whether or how the state will incorporate the recommendations of the panel (where appropriate) to make measurable progress in improving the state child protective services system. The ADES response to the 2009 Citizen Review Panel Report is included in Appendix A.

Arizona Citizen Review Panel Program Structure

At the state level, the CABHP administers and supports the three regional panels located in Phoenix (Central), Tucson (Southern), and Flagstaff (Northern). Each of the panels represent specific DCYF regions and counties, and CABHP staff are responsible for the coordination and sharing of information across the three panels. In July of 2010, ADES/DCYF was realigned from six districts to five regions.

QUARTERLY ACTIVITIES

The three ACRPs met quarterly in 2010 as required by CAPTA. Each meeting was scheduled for three (3) hours. Panel members were sent agendas with case record summaries and other meeting materials prior to each regional meeting. Orientation sessions were held one hour prior to the start of each meeting for new and continuing panel members. All meetings were digitally recorded and formal meeting minutes were prepared and emailed to respective panel members for review and comment.

At the 4th quarter meeting of 2009, panel members suggested thematic areas of focus for 2010 (e.g., cultural diversity, foster care, team decision making, advocacy centers, safety planning, Hotline process, and chronic child neglect). Based on these suggestions, the 2010 annual schedule of meetings was developed and distributed to each ACRP member (Appendix B). This structured meeting agenda included review of data collected from various sources, speakers,

case record presentations, and policy reviews. Panels continue to have access to an intranet site that contains meeting documents and other pertinent information (e.g., minutes, reports, presentations, journals articles, and links). Additionally, CABHP routinely sent panel members informative news items from the National Citizen Review Panel at the University of Kentucky, and links to teleconferences and publications.

Monthly coordination meetings occurred between DCYF and CABHP staff. DCYF representatives provided quarterly meeting program reports to ensure that the panels received information on the status of ACRP recommendations, process improvement initiatives, new policies and procedures, budget updates, and other relevant information. A focus on continuous formal feedback mechanisms served to improve communication, facilitate collaboration, increase panel member satisfaction, identified opportunities for innovation. CABHP and DCYF each maintain internal tracking systems for monitoring the implementation of ACRP recommendations. DCYF will continue to provide updates to the panels on a routine basis as many of the proposed changes span across multiple years.

Below are highlighted topics from each of the quarterly meetings:

- **Quarter 1-** Guest speaker presentations on *Practices for Diverse Cultures (Understanding Integration, Assimilation and Multiculturalism)* and Team Decision Making; reviewed the CAPTA Implementation Plan and Back to Basics (2010-2014 Activities); and the CPS policy on Special Immigrant Juveniles.

- **Quarter 2-** Guest speakers presented on the *Babies, Infants, and Toddlers in Foster Care Program (Arizona Best for Babies Project);* revisions to the Child Abuse Hotline; Safety Planning and Safety Monitors were presented to the panel; and the CPS policy on Voluntary Consent for Foster Care Placement for a Native American Child was reviewed.

- **Quarter 3-** Guest speakers presented on *Regional Advocacy Centers* and highlighted the multidisciplinary and collaborative approaches to case investigations. Arizona legislative updates were discussed, including the impacts of the changes to the DCYF budgets effective July 29, 2010. Information was distributed on the 9th Annual Arizona Citizen Review Panel Conference. The CPS policy review was on SB 1091, which expands the scope of CPS duties to include investigation of child abuse and neglect reports in licensed behavioral health residential settings. The case record theme was on joint investigation protocols.

- **Quarter 4-** CABHP presented and discussed the draft of the 12th Annual Report of the Arizona Citizen Review Panel, and identification of priorities and agenda topics for 2011. Updates were provided to the panels on ADES/DCYF activities resulting from CRP Recommendations from 2007-2009.

PANEL MEMBERSHIP

Panels are comprised of 9 to 26 volunteers of diverse backgrounds and experience. Below is a chart of the panel membership from each region showing their agency or discipline representation. During the past year significant efforts were made to expand not only the

number of individuals on each panel, but also the composition of the panels' membership to ensure both community representation and diversity. The membership in two of the regional panels, as well as the panel as a whole, increased again this past year. The Central and Northern Regional ACRPs increased by 53% and 29% respectively, while the Southern Region ACRP deceased slightly by 16%. (See Appendix C).

The panel members have a wealth of knowledge and experience in child and family serving systems. Nine citizens who joined the panel in 2010 were involved, or have family members who were involved with CPS in the past. Each panel has increased its diversity with members representing a variety of schools, hospitals, faith-based organizations, non-profit organizations, law enforcement, courts, government agencies, as well as private citizens and adoptive/foster care parents (Figure 3).

Figure 1

Panel Member Representation

***Representational Area**	**Central** ***n=26***	**Southern** ***n=21***	**Northern** ***n=9***
Private Citizens	4	2	1
Educators	4	6	1
Mental Health	4	2	1
Legal	5	5	1
Law Enforcement	2	2	2
Health Care	3	3	0
Social Services	5	7	4
Child & Family Advocates	8	2	2
Adoptive Parents	2	3	1
Adoptees	0	0	0
Foster Parents	3	3	1
Foster Care Alumni	1	0	0
Faith Based	0	1	0
Tribal	1	2	0

**n= as of December 2010. Members may belong to more than one representational area.*

PANEL MEMBER SURVEY

The annual survey of the panel members was conducted between November 19 and December 6, 2010, to provide CABHP staff with information on panel members' level of satisfaction and suggestions for improvement. Twenty-one (21) panel members completed the survey; 12 responses were from Central (57%), 6 from Southern (29%) and 3 from Northern (14%). Overall, the majority of the respondents reported satisfaction as indicated by noting that they "agreed" or "somewhat agreed" as indicated below:

- 71% indicated that their regional panel was comprised of members with diverse community representation.
- 95% indicated that CABHP provides effective administrative support for the panel.

- 67% reported they were satisfied with the case record review presentation.
- 81% were satisfied with the content of information provided at panel meetings.
- 81% reported they shared information about the Citizen Review Panel with community members and other organizations.

The survey also provided panel members with an opportunity to provide their suggestions or comments on what type of training would be helpful to become more effective as a member, meeting topics or themes for 2011, and ideas that would make meetings more productive. A few examples of members' suggestions included: shadowing a CPS Specialist to better understand their responsibilities; adding a theme on adopted youth returning to the child welfare system; and expanding the quarterly meeting times. The complete survey results with all of the comments are included in Appendix E.

CAPTA Requirements of Citizen Review Panels

The ACRP program evaluates the degree that CPS is effectively fulfilling its child protection responsibilities through several means including: the review of the state plan; examining compliance with federal child protection standards; looking at coordination between agencies and child welfare systems of care; conducting outreach to communities; and case record reviews of child fatalities and near-fatalities. All of the findings and panel recommendations were based on one or more of these activities.

Review of the State Plan

During the first quarter, the federal prescribed activities for which the CAPTA Basic State Grant may be used were reviewed with each of the panels. The panels' suggestions for utilizing the funds were collected and are included in the recommendations section of this report.

Compliance with Federal Child Protection Standards

Compliance with federal child protection standards is examined through a review of the DCYF semi-annual reports and information provided through DCYF updates or presentations. Additionally, the ACRP case record review instrument (Appendix D) and process examine compliance with federal child protection standards. The DCYF Practice Improvement Case Review Instruments (PICR) and the ACRP case record review instrument were both modeled after the *Child and Family Services Review: Onsite Review Instrument and Instructions (2007).*

Public Outreach and Soliciting Public Comments

The CABHP website hosts a link to the ACRP Program website to inform the community about the ACRP Program and to solicit public comments. Questions regarding specific cases are directed to the appropriate state agency for assistance. Over the past two years, only a few comments have been received and the panels will need to explore alternative methods for conducting public outreach and soliciting public comments. Information was collected from other Citizen Review Panels across the country and this information was shared with the panels to examine the initiatives currently underway and aids in identifying effective methods of collaboration.

The ACRP Program brochure continues to be distributed at events to inform the public, stimulate interest in the ACRP program, and solicit volunteers. The brochure and CPR program information have also been distributed throughout Arizona by multiple community and advocacy email listservs (e.g., Arizona Association for Foster and Adoptive Parents, Arizona Council for Human Services Providers, RBHAs, Governor's Office of Children, Youth & Families, and contacts in the faith-based community).

Case Record Reviews

Panel members reviewed twenty-four cases in 2010. Although the case record review process addresses foster care and adoptions as related to the specific situation under review, further examination of coordination across agencies was completed this year. The Court Teams for Maltreated Infants and Toddlers project, known as Best for Babies in Arizona is focused on improving collaboration between the courts, child welfare agencies, and related child-serving organizations to work together, share information, and expedite services for young children age zero to three who are placed in out of home care. The program relies on judicial leadership to ensure that such infants and toddlers are receiving the resources and supports they need to foster optimal physical and mental health.

Panel members were provided with information on the implementation and outcomes of the Arizona Court Teams ("Best for Babies") and a special sample was selected for case file reviews. The case file review tool was modified and examined:

- Safety- protected from further maltreatment
- Well-being- received needed services including pediatric care and developmental screening/services
- Reasons for removal
- Health needs at intake- exposed to parental substance abuse that contributed to poor health and substance exposed newborn
- Services received to alleviate maltreatment and meet developmental needs
- Family contact
- Foster care placements and placement stability
- Absence of and repeat of maltreatment
- Achieving timely permanency

Even though there was a limited sample size and no specific conclusions or trends could be drawn, several areas of interest were noted. The protocols for coordination and the checklists completed appeared to aide in the assessment of the infants and ongoing service delivery. All involved parties were held accountable by the courts and there were more frequent and thorough reviews. Additionally the checklist was reviewed at court proceeding. Key areas of interest were that permanency appeared to be achieved more rapidly, and evidence of coordinated efforts by CPS, community providers, and juvenile courts were well documented in the small sample of cases reviewed.

Case Record Review Process

Throughout the past two years, CABHP staff has continued to refine the case record review process with the assistance and input of DCYF staff and panel members. Feedback from panel members continues to be an important part of the design and quality of the case review tool. The standards for case reviews established in 2009 (i.e., criteria for case selection, tool standardization, and adherence to established instructions) have resulted in a comprehensive and consistent method for case review preparation, presentation, and a procedure for obtaining and organizing feedback from panel members during the interactive case review process at quarterly meetings.

Figure 2
Case Record Sampling Parameters

1. Child fatality/near fatality cases were selected from those reported in 2009 – 2010.

2. Established criteria for case selection require that CPS investigations must be completed. Cases with pending or incomplete investigations are not considered for review; however, cases which remain open for ongoing services may be selected.

3. Panels identified themes or particular areas of concern they wanted to highlight in 2010. DCYF staff worked with the CABHP to provide a list of cases representative of specific quarterly themes.

Twenty-four cases were selected for review in 2010. Two cases were presented at each panel region (Northern, Southern, and Central) quarterly. Reviews included cases that involved allegations of fatalities and near-fatalities determined by CPS to have resulted from child maltreatment (neglect and/or physical abuse). Selected cases included both in-home and out-of-home placements of children. A CABHP staff member with a background in child welfare serves as the primary case reviewer. The case reviewer is responsible for case selection, writing case reviews, and presenting cases to the panels. The CABHP reviewer is authorized for access to the CPS electronic records (CHILDS) system. The reviewer also works with CPS Practice Improvement Specialists and other key persons in each region to obtain additional information, including clarification regarding specific cases or policies, as necessary. A preliminary review of the case summary is conducted by the case reviewer and Program Manager to ensure the information is comprehensive and thorough. The CABHP staff are available one hour prior to each meeting, affording panel members access to hard copies of the CPS case files.

DCYF provides the case reviewer with a list of all investigative reports involving allegations of maltreatment that resulted in child fatality/near fatality. From this list, the CABHP case reviewer selects cases for review that meet the sampling parameters (Figure 4) and are consistent with the quarterly meeting themes. The case records are requested eight to ten weeks prior to the first scheduled meeting each quarter. CPS staff provides a “hard” copy file to the CABHP that contains additional information (e.g., autopsy reports, medical records, law enforcement records, and service provider progress reports) that is not accessible through CHILDS. Cases arrive at the DCYF Central Office and are transported by designated staff to the CABHP offices at

Arizona State University. Upon receipt of the cases, the case reviewer organizes the case record information and documents the information in the review tool. If information relevant to the case review is not in the case record, the case reviewer contacts a designated key contact person at DCYF to request further assistance in obtaining the information.

In an effort to prepare and assist panel members for each case review, they are provided with ACRP Case Summary Forms (Appendix D), a timeline of key events, and a genogram (a pictorial display of family relationships and key information including ages and medical history) in advance of each meeting. Panel members also receive redacted copies of the actual Child Safety Assessments (CSA), Family Safety and Risk Assessments (SRA), case plans, and aftercare plans (when applicable) completed by DCYF staff for each case. Key areas in which information is examined and discussed by the panels include:

1) Timeliness of Initiating Investigation of Reports of Child Maltreatment-Information on whether responses to every child maltreatment report received was initiated within timeframes established by policy including: identification of risk level; allegation of maltreatment; mitigated timeframes; accuracy of Hotline reporting procedures; whether law enforcement or other emergency personnel was notified; CPS confirmation of child's safety; and CPS Specialist's attempts at face-to-face contact with alleged victim(s).

2) Initial Child Safety Assessment-Information on whether the CPS Specialist made concerted efforts to gather and analyze sufficient and relevant information to accurately assess child safety including: decision whether any child in the home is unsafe due to present danger was consistent with observations at initial contact with child and family; if concerted efforts were made to interview or observe all relevant persons and to gather sufficient and relevant information to identify potential safety threats. CPS Specialist made correct safety decisions based on analysis of information gathered in the CSA.

3) Safety Planning to Protect Children in Home and Prevent Removal- Information on whether the CPS Specialist took sufficient and least intrusive actions to: control present or impending danger (through protective action and safety plan), ensure child(ren)'s safety in-home, and prevent child(ren)'s entry into foster care or re-entry after reunification. The panel determines if the actions taken by CPS to manage and control safety threats.

4) Family Strengths and Risk Assessment and Provision of Services to Reduce Risks-Information on whether CPS Specialist made concerted efforts to assess the risks that were of sufficient severity to necessitate CPS services including: gathering sufficient and relevant information about each domain in the Family Strengths and Risks Assessment (SRA); identify consistency of risk indicators and protective behaviors; necessity of intervention; and case opening and closure with information gathered during the assessment and documented in the case record. The SRA provides the panel with an overview of the number and type of risk factors identified in the family/caregiver constellation. Identified risk factors include: parental substance abuse; physical/mental/emotional limitations of caregivers; parental history of abuse, family violence, and inter-partner violence; parental history of trauma and mental illness; observed parental nurturing, bonding and empathy; recognition of the problem and willingness to change; child vulnerability and special needs.

5) Determine Whether Maltreatment Occurred- An analytical and evidentiary process carried out by the CPS Specialist which involves synthesizing pertinent case information and applying the legal definitions of abuse and neglect to determine if maltreatment has occurred. Panels utilize the evidence presented in the CPS case file, police investigation, and medical and autopsy records to determine if the statement of maltreatment reflects the severity and type of child maltreatment documented.

6) Aftercare Planning- Panels review information to determine if aftercare planning was developed with input from family, and if parents/caregivers were provided adequate information on services and supports to address whether the safety and risk factors necessitating department involvement have been adequately addressed or needs that may improve family functioning. When applicable, the panel determines if the CPS Specialist met with parents/caregivers and the child; assessed their needs and preferences with regard to aftercare services; and if parents/caregivers and children were provided with sufficient information on community or other supports.

The ACRP case review instrument, adapted from the In-Home/Out-of-Home section of the DCYF Practice Improvement Case Review Instrument, is completed on each case presented to the panel. In 2010, the applicable information examined and criteria discussed by the panel included:

- ongoing safety and risk assessment and management
- permanency goal for child
- concurrent permanency planning
- visiting with parents and siblings in foster care
- relative placement
- needs and services of child, parents and foster parents
- case plan development
- worker visits with child
- educational needs of child
- mental/behavioral health of child
- foster homes

The panel recommendations and comments section focuses on the following information:

- precipitating events or triggers
- f amily risk factors addressed and resolved
- factors that may have contributed to death
- joint investigation protocol
- potential policy issues or issues not addressed
- exemplary CPS practices that should be noted
- CPS supervision and communication

In addition to cases of child fatalities/near fatalities, cases representing specific themes or particular areas of interest were reviewed by the panels. As highlighted in the chart below, these topics included: cultural diversity; potential barriers impacting families; coordination of services to meet the unique needs of infants and toddlers placed in foster care; and the joint investigation process.

Figure 3 **2010 ACRP Case Review Themes/Special Topics**	
Quarter 1 **Cultural Diversity**	Cases were selected for review based on identified issues related to diversity factors and opportunities for culturally competent practices. **Example:** A language barrier existed between healthcare providers and the parents of a chronically ill teenager, resulting in medication non-compliance and subsequent reports of neglect. **Panel Recommendations and Comments:** The panel recommended CPS to review their policies related to medically fragile/complex children and their families/caregivers and ensures that supervisors receive training related to this population. The medical community needs to ensure that parents/caregivers receive education and instructions for care and medications in their primary language. Children with complex medical needs should be provided an advocate by the medical community to improve coordination with medical and other services providers. Interdisciplinary meetings for families of children with complex medical needs should include a healthcare provider with training and background in disease management to assist with identifying helpful resources.
Quarter 2 **Infants in Foster Care**	Cases were selected from two regions that have implemented Best for Babies procedures targeting children (ages 0 to 3) placed in foster care. In these regions, teams comprised of CPS, health/developmental service providers, and the juvenile court coordinate services to assure timely and thorough provided medical care, developmental assessments and services, and other needed services within established timeframes. Monthly status reviews are conducted by the juvenile court to review the child's health needs and to establish permanency for the child within the shortest timeframe possible. The panel also reviewed cases selected from a region that has not yet adopted a specific protocol coordinated for infants and toddlers in foster care. **Example:** An infant was removed from her family due to chronic neglect. The CPS Specialist and service providers coordinated medical and developmental assessments for the child, and follow-up appointments were documented in the CPS case record. Attempts to engage the birth family in appropriate services were well documented in the case record. Upon judicial review, it became evident that the birth parents lacked the motivation to engage in services. The case goal was changed from family reunification to adoption in order to establish permanency for the infant. **Panel Recommendations and Comments:** The panel recognized that CPS and the courts worked collaboratively to move the case forward and achieve permanency for the child within nine months of custody.

Figure 3 **2010 ACRP Case Review Themes/Special Topics**	
Quarter 3 **Joint Investigation**	Cases that involved joint investigation by law enforcement and CPS were examined for the following factors: adherence to written protocols; access and utilization of forensic services for children; issues with jurisdiction; challenges faced; lack of consensus in determining the presence of child maltreatment; and lack of resources and/or training for law enforcement officers and CPS Specialists responsible for conducting forensic interviews with children. **Example:** An investigation was conducted related to the death of a toddler. The toddler and his two sisters were in the care of Mom's significant other when he sustained a blow to his head by a blunt object and later died from his injuries. The primary language of the siblings was Spanish, and an interpreter was used to assist in the forensic interviews conducted with the young girls. No forensic physical exam was conducted and the criminal investigation dropped. **Panel Recommendations and Comments:** The panel believed that the siblings should have had skeletal surveys to determine if they had any old or healing injuries. A forensic specialist on the panel stated that the younger of the two siblings was still within the age range for a full skeletal survey even though the injuries may have occurred months earlier.
Quarter 4 **Fatalities and Near Fatalities**	Cases involving CPS investigation of fatalities and near fatalities were reviewed by the panel. Panel members adhered to the established review processes: reviewing a summary of the information reported to and documented by CPS; determining if all risk factors were identified, assessed, and addressed; reviewing the joint investigation conducted; noting clinical supervision and exemplary practices of CPS staff; identifying potential policy issues; determining and documenting any action that could have prevented the event; and recommendations related to policies, services, and practices. **Example:** The case described a family with multiple risk factors, including very young parents and three children under the age of 5 with identified moderate to severe developmental disorders. Multiple services were implemented; however, coordination of needed services was left up to the overwhelmed parents. The parents were very slow to respond to the assistance offered. A lack of family resources and support were identified as potential barriers to parental engagement to services. **Panel Recommendations and Comments:** The panel proposed that the case be used as a CPS training example for review by the National Resource Center for Child Protective Services (NRCCPS). The National Resources Center provides onsite training and technical assistance to local CPS offices.

Upon completion of each review, the panel asks the key questions of whether state and federal policies were followed and whether the panel recommends any changes in policies and procedures. Panels also comment on actions they believe could have been taken to prevent or avoid the event and their overall recommendations on the case. The results of each review are entered into a database that is maintained by the CABHP.

The case record reviews encompass all aspects of the child welfare system, and throughout the year resulted in a variety of recommendations or actions taken by individual panel members, DCYF staff, and system partners. The table below highlights some of the recommendations or actions which resulted from the panel case reviews.

Figure 4
Actions Resulting from Case Record Reviews

Region	Issue	Action Taken
Northern Panel	Family with three moderate to severely developmentally disabled children under the age of three with multiple complex needs.	Recommendation was made to use the case as a training example with the National Resource Center for Child Protective Services.
	Investigation of potential neglect with an infant whose sibling died from Shaken Baby Syndrome approximately one year prior.	Based on the panel's concerns, a new investigation ensued and the child was taken into CPS custody.
	Conflicts concerning law enforcement jurisdictions and investigation protocols impeded the proper investigation of a child maltreatment report. The child interview was also not audio recorded as the equipment was broken.	A critical incident review was requested to examine the case, review policy and procedures, and identify barriers in the investigation. DCYF administrators began holding meetings with local law enforcement to resolve issues with jurisdiction and joint investigation protocols. New recording equipment was purchased for field staff. Panel members researched the lack of a Mohave County Criminal Justice Coordinator.
Southern Panel	Case record documentation indicated that CPS Specialist maintained their professionalism when working with antagonistic parents.	The panel sent a letter of commendation to the CPS Specialist involved in this case acknowledging their professionalism in a difficult situation.
	A case that involved a parent taking his child to the fire station to be "checked" led to questions about how "walk-ins" at fire	Panel members visited their local fire stations and/or discussed the issue with EMT personnel and provided

Figure 4 **Actions Resulting from Case Record Reviews**		
Region	**Issue**	**Action Taken**
	stations are documented, and if non-medical firemen receive mandatory reporter training.	information at the subsequent panel meeting.
Central Panel	A new child was born to a mother who had recently been substantiated for physical abuse of her two year old. A safety assessment had not been completed by CPS on the newborn.	The panel requested that CPS conduct a safety assessment with the newborn. Policy requires new CSA is completed when household composition changes.
	Hospital documents revealed that the child had been treated only a few weeks prior for a similar injury. No x-ray was taken, although medical documentation indicated that the child's arm was swollen. Both times the child was seen at the ER, he had multiple minor injuries in addition to significant injuries.	The panel recommended that CMDP Medical Director conduct an internal review to determine whether mandatory reporting requirements were followed. DCYF also conducted a critical incident review.
	A toddler with cystic fibrosis was regularly followed by a specialty clinic. When the child was taken into CPS custody for non-accidental blunt force trauma to her abdomen, she was observed to have decaying front teeth and her weight/height rate was at the 10^{th} percentile for her age, yet no referral for neglect had been received.	A DCYF panel member who had been attending a collaboration meeting with the clinic volunteered to request that a peer review of the case be conducted, and also recommend that Children's Rehabilitation Services (CRS) review their procedures for mandatory reporting and obtaining assistance from the CPS liaison for CRS.
	A juvenile court judge has worked toward assuring that foster children ages 0 to 3 are provided with all services necessary to reduce vulnerability and promote health and permanency.	The panel sent the juvenile court judge a letter of support and commendation for efforts to implement the Best for Babies guidelines in Maricopa County.

Summary of Citizen Review Panels' Case Record Review Findings

During this reporting period, 24 cases of child maltreatment that occurred between June 25, 2008 and April 21, 2010 were reviewed. Each of the three ACRPs completed reviews of two cases each quarter. Seven (7) of these cases were fatalities, seven (7) were near-fatalities, and ten (10) cases had allegations of maltreatment (ranging from physical abuse/high risk to neglect/low risk). Eighteen (18) cases selected for review were representative of specific themes; of these cases, five (5) were fatalities and four (4) were near fatalities.

Case record review findings summarized below are consistent with the state's process by which reports of child abuse and neglect are received and addressed. Examination of the operations of the CPS system at each of these stages as outlined below are also recommended in the *Citizen Review Panels for Child Protective System: Guidelines and Protocols* (October 2001.)

Prior Child Protective Service History

Of the cases selected in 2010, 15 (63%) had no prior CPS reports. CPS received a total of 28 reports in the nine (9) cases with prior report histories. Of the nine cases with prior reports, the number of reports ranged from one (1) to six (6) with an average of four (4) reports per case. Of the nine (9) cases with a total of 28 previous CPS reports, three (3) previous reports were substantiated; two of the three substantiated prior reports were made on the same case.

Intake and Screening

The panels identified the initial intake information gathering process as a strong component of the child protection system. The panels found that reports taken by the CPS Child Abuse Hotline were complete, accurate, and timely in all 24 cases (100%). The timeframe for the initial response by CPS, law enforcement, or other emergency personnel were within the allotted times determined by level of risk (high, moderate, low, potential).

A new CPS intake hotline process was put into effect in July, 2010. The new procedure was implemented to align the report allegations received at hotline with the child safety assessment completed in the field by CPS investigators. A primary goal of the new intake process is to use an assessment tool to family functioning as opposed to incident-based data collection. Two major changes to the hotline procedures include: 1) hotline staff have the option to contact collateral resources in instances when the person making the report does not give adequate information to determine the child's safety; and 2) prioritizing report based on child safety.

Crisis Intervention and Initial Child Safety Assessment

The panels concluded that CPS adequately fulfilled its role of assessing child safety in 14 (58%) of the 24 investigations reviewed. This finding is similar to the finding of 61% in 2009. In ten (10) cases, the panels found that various critical safety factors were not identified or thoroughly addressed in Child Safety Assessments. The agency recognized that many of the cases had multiple safety factors, as noted in the next section. However, panel members agreed that Child Safety Assessments should reflect all identified safety factors, as this assessment process drives the intervention for the removal of safety threats.

Of the ten (10) cases in which the panel identified the lack of action in response to a thorough safety assessment:

- One (1) case no safety monitor was present in the home;
- Three (3) cases had prior substantiated reports that were not factored into the Child Safety Assessment tool's safety threats analysis;
- Four (4) cases the Child Safety Assessments were not thorough and/or were completed outside of required timelines; and
- Two (2) cases the CPS staff did not document assessment of the safety of other children in the home.

DCYF staff reported that CPS Specialists are provided Child Safety Assessment training at the time of hire, and ongoing monitoring and training is provided through refresher training and clinical supervision. The panels' findings are consistent with the case record reviews completed by DCYF practice improvement specialists, and the agency recognizes that this is a critical area for performance improvement, and continues to be a primary key goal of ongoing performance improvement activities.

FAMILY RISK FACTORS RELATED TO THE CASE RECORD REVIEW

Panel members review specific family risk factors addressed by CPS during the initial investigation. Based on this information, panels determine if CPS adequately assessed, identified and resolved risks contributing to child maltreatment. The most prevalent family risk factors identified during the reviews were lack of parenting skills (87.5%), lack of motivation to provide care (75%), lack of anger control (66.6%) and domestic violence (62.5%). Methamphetamines (33.3%), alcohol (33.3%), and marijuana (16.6%) were the most prevalent types of drugs identified in case record reviews. The predominant risk factors identified are consistent with the findings from 2009 case record reviews. It is important to note that looking at individual risk factors does not take into consideration cumulative risk. The number of risk factors per case ranged from 3 to 12 with an average of approximately eight (8) risk factors identified per case. Three factors appeared to be prominent issues in cases reviewed by the panel in 2010: the case had the death/ injuries occur to young children while in the care of the mother's significant other; the children had multiple caregivers; and the children were medically fragile/medically complex.

Below are the risk factors identified in the 24 cases reviewed (Please note: More than one factor may have been identified in a single case):

Figure 5 ***Risk Factors***	***Frequency of cases (n=24)***
Lack of parenting skills	21 (88%)
Very young parents (19 to 22 years)	7 (29%)
Parental substance abuse	13 (54%)
Parental mental illness/trauma	14 (58%)

Figure 5 ***Risk Factors***	***Frequency of cases (n=24)***
Domestic violence	15 (63%)
Lack of anger control	16 (67%)
Lack of physical/mental ability to provide adequate care	13 (54%)
Lack of willingness/motivation to provide adequate care	18 (75%)
Lack of resources for adequate food/shelter/medical/childcare	13 (54%)
Prior child death	1 (4%)
Prior removals by CPS/severance of parental rights	5 (21%)
Prior unsubstantiated reports	6 (25%)
Prior substantiated reports	5 (21%)
*Medically complex/medically fragile child	8 (33%)
Developmentally delayed child	6 (25%)

***Children with health issues including premature birth, physical and developmental disabilities, failure to thrive, liver failure, cystic fibrosis, and substance exposed newborns.**

In addition to the risk factors listed in the table, the CABHP staff started tracking the following risk factors in 2010 as requested by the panels:

- Language/cultural barriers
- Child in the care of significant other
- Parent in prison
- Chronic neglect
- Prior abuse not detected/
- Lack of supervision reported by healthcare provider
- Parent did not seek medical treatment for child
- Multiple caregivers
- Parent(s) who are developmentally disabled
- Household with 3 or more children under the age of five
- Lack of coordination/cooperation across law enforcement jurisdictions

These additional risk factors will be compiled and incorporated into the 2011 annual report.

INVESTIGATION STAGE

When examining each case investigation process, the panel identifies the strengths of the investigation and exemplary practice of CPS case staff. The panels noted CPS Specialists' positive qualities including, maintaining a good rapport with families, linking families with helpful services, and taking actions early to establish permanency. For example, the Southern Panel recognized two CPS Specialists for maintaining professionalism in difficult circumstances with a particular family. Letters of commendation, signed by panel members, were sent to the Specialists and their supervisors. The Southern Panel also noted the professionalism of a CPS investigator who

recognized and reported a foster care licensing violation. The Central Panel noted that a CPS investigator substantiated findings of abuse and neglect in a fatality case in which law enforcement did not pursue, despite evidence of child abuse. The Northern Panel recognized the professionalism and diligence of a CPS case aide who obtained medical records, despite barriers confronted with a healthcare provider who was reluctant to release the information.

Panels also identify aspects of the investigation process where barriers hindered investigation, determination of findings, and/or case closure. Panels concluded that thorough investigations were completed on 15 out of the 24 cases reviewed (63%). The following issues with case investigation were identified:

- previous medical issues/injuries were not addressed in five (5) cases;
- no documentation of medical/development assessments in four (4) cases;
- no immunization records were obtained in four (4) cases;
- missing medical records (other than immunization records) in four (4) cases;
- background checks on household members were absent in four (4) cases;
- case information of interviews conducted with persons in the household were either unclear or not documented in three (3) cases;
- safety assessment documentation was incomplete in three (3) cases;
- autopsy reports were missing in three (3) cases;
- CPS did not interview all relevant persons in home in two (2) cases;
- child victim interviews were not conducted according to CPS procedures in two (2) cases;
- law enforcement reports were absent in two (2) cases; and
- safety monitor agreements were missing in two (2) cases.

INVESTIGATIVE FINDING/DETERMINATION

The panels found that case record documentation supported the investigative findings in all of the 24 investigations reviewed. The Central Panel identified one case in which a finding of neglect, in addition to the finding of physical abuse, should have been added post-investigation. In this case, the juvenile court judge ruled that there was no persuasive evidence that the perpetrator identified by CPS was responsible for the physical abuse (near fatality) of the child. The testimony of expert witnesses concluded that the injury was due to non-accidental trauma, but stopped short of identifying the perpetrator. The panel believed that the neglect had been disregarded as the emphasis appeared to be on determining who caused the physical injuries.

Sound multidisciplinary forensic collaboration is critical to investigation and evidence gathering in fatality/near fatality child maltreatment cases. Of the 24 cases reviewed by the panels, 15 cases (63%) involved joint investigation. As noted previously in the chart on page 23, a subset (6) cases involving joint investigation were reviewed by the panels, specifically to evaluate the following: 1) adherence to protocol; 2) barriers to thorough investigations; 3) multidisciplinary (CPS, law enforcement, medical, forensic experts) collaboration; and 4) factors that resulted in thorough, investigation. The panel found that one-third of the cases reviewed in 2010 were jointly investigated by CPS and law enforcement according to established protocols. A properly conducted joint investigation includes the following elements: CPS case record documentation; police, forensic, and/or autopsy reports; CPS observations; interviews conducted by law enforcement; utilized forensic services, including audio/video recordings of child interviews; child interviews conducted by a trained forensic interviewer in a child-friendly, safe environment; all evidence is

gathered by a multidisciplinary team; and CPS and law enforcement work cooperatively with county attorneys and the juvenile court.

The panels cite the following issues concerning joint investigation in ten (10) cases: interviews by CPS and law enforcement did not include all members of the household; law enforcement lacked cooperation across jurisdictions; the county where the case was investigated does not have a Children's Justice coordinator; audio recorders were broken or had no spare batteries on hand; child interview protocol was not followed; forensic services were appropriate, but not accessed; police did not report a child death to CPS; police detective focused on child death, but not of evidence of child abuse; CPS supervisor instructed CPS investigator not to attend police interview because of budget cuts (staff shortage and fewer travel approvals for staff); inside of the home of parents was not observed by responding officer; CPS was not allowed in the interview room during parent interviews conducted by police; and documentation of forensic interviews with children was provided to CPS by police.

CASE PLANNING AND IMPLEMENTATION

Seven (7) cases did not receive ongoing services because these cases were closed following investigation. The panels determined that in nine (9) of seventeen (17) cases, case planning and ongoing case management activities were appropriate and timely. Panels noted instances when parents or guardians refuse to participate in services voluntarily; in such instances, CPS is unable to enforce recommended case plans when safety concerns do not rise to the level that requires court intervention. Concerns were raised by panels regarding the ongoing education training and support needs of parents of children who were medically fragile and/or complex. The panels cited two instances in which one parent was not addressed in the case plan. In addition, the panel expressed concerns that siblings of a deceased child were not assessed for grief or trauma. In another case, the CPS case worker discontinued daycare services for three young, developmentally disabled children after only two weeks of service. A panel member from DCYF concluded the department had the discretion to provide the family up to a maximum of six months of daycare services. Finally, the panels voiced concern regarding the lack of services available to families who are undocumented.

FOSTER FAMILY

There was one case involving physical abuse of a young child in foster care. The CPS Specialist witnessed the abuse (a spank) while visiting the family, and immediately reported the incident, as this was a licensing violation. The incident was investigated and it was determined that the foster parents would attend additional training regarding appropriate behavioral techniques for disciplining young children.

CASE CLOSURE

Eleven cases (46%) were receiving services provided by CPS ongoing case management workers at the time of panel review. One (1) investigation remained open pending CPS's receipt of autopsy and medical record documentation. Three (3) cases had been transferred to the adoptions unit for further services. Of the nine (9) cases that were closed prior to review, three (3) involved child fatalities with no other children in the home.

Concerns noted by panels included: the lack of mental health services for persons who are undocumented; incomplete CPS case record documentation in case plans; case closures with no documented aftercare plan; minimal case record documentation of medical services for children;

referrals not made for needed services for child and family; a case plan that did not address the needs of a medically fragile child; Medical Examiner's findings that cause of death was undetermined ended further investigation of the case; a case that did not undergo a thorough investigation despite a prior child death and continued safety threats in the home; a safety plan not signed by safety monitors due to a language barrier; and a family that moved out of state was not linked with services to address the serious developmental needs of the child.

POLICY ISSUES

At the conclusion of case reviews, panel members determine if state and federal policies were followed. In addition, panels evaluate the impact of policies/actions of community service and healthcare providers as related to the identification, prevention, and treatment of child maltreatment. The following are policy issues identified by the ACRP in 2010:

Figure 6
Issues Identified by Panels

Specific to CPS	Community/Healthcare Providers
Cases with medically fragile children require intensive and frequent oversight in clinical supervision.	Court Appointed Child Advocates (CASA's) assigned to work with medically fragile children should have a background in pediatric healthcare.
The protocol for interviewing child victims was not followed.	A service provider conducted a developmental assessment by phone rather than through observation in the home, the protocol prescribed by agency guidelines.
Properly maintained audio/video equipment for recording interviews (when feasible) should be available to field staff when necessary.	Law enforcement did not report a child death to CPS.
Collateral informants were not interviewed during investigation.	Multiple instances when healthcare providers did not report suspected abuse/neglect.
The lack of a national database that interfaces with State CPS agencies results in delays in receiving and/or incomplete information during the investigation phase, which could increase the risk of further child maltreatment.	Multiple instances when prior injuries were not detected in x-rays; frequent ER visits involving serious injuries or multiple minor injuries are not often diagnosed as child maltreatment by the healthcare provider.
Workload negatively impacts the efficiency and expediency with which child maltreatment cases can be investigated and case managed.	Autopsy reports often delayed for months.
Case records and documentation not meeting CPS policy standards for quality and timeliness.	Barriers to coordinated healthcare caused by a lack of access to medical record across within the healthcare.

Figure 6 **Issues Identified by Panels**	
Specific to CPS	**Community/Healthcare Providers**
CPS needs access to resources which assist in effective time management and increased efficiency of workers in the field. The panel recognized that a pilot project in one region involves testing dictation software. If proven successful, the panel supports the efforts of CPS to expand and capitalize on this capability.	The homicide investigation concluded that an unknown perpetrator caused an infant's death. Witnesses reported observations of abusive behavior by the parent, and the Medical Examiner's report indicated that the infant had multiple minor injuries. Law enforcement did not pursue charges of child abuse against the parent.

In addition to identifying policy issues, the panel works to identify the appropriate agencies or persons for action. Such actions may be undertaken collaboratively or individually, immediately or through another process, such as a work group. The panel seeks and considers pertinent information about current CPS, law enforcement, and community provider policies. Actions are underway to investigate and address the aforementioned policy issues identified by the ACRP in 2010.

Areas of Focus for 2011

CABHP continues to be committed to providing panel members with the information they need to fulfill the program requirements as outlined in the CAPTA and to make certain the program is functioning in an efficient manner. To ensure that practices are employed consistently with a process for continuous quality improvement, several areas for enhancing the ACRP programs had been identified in the 2010 report. Due to resource limitations, not all of the activities proposed were able to be implemented. Below is an update on the suggestions identified by DCYF representatives, CABHP staff and panel members in 2010:

- Request technical assistance from the National Resource Center for Child Protective Services to sponsor a facilitator to conduct strategic planning with panel members to facilitate the development of actions steps and strategies to meet program requirements including:
  - the examination and evaluation of the coordination between state and local foster care and adoptions systems; and expansion of outreach activities.

  Status: A technical assistance application was drafted by CABHP and will be submitted by DCYF for consideration by Federal Children's Bureau.

- CABHP will begin tracking areas of concern identified in several of the case record reviews (e.g., perpetrators responsible for caretaking while mother working outside the home in two of the cases reviewed, parent(s) co-sleeping with infants in four cases and investigations completed by law enforcement and closed by CPS prior to safety factors being resolved in two cases) to determine whether these may constitute a trend requiring additional actions.

  Status: Completed

- Explore opportunities to utilize technology for enhancing participation and communication for panel members and across panels (e.g., video conferencing and cross panel trainings).

  Status Update: Due to changes in the CABHP video conferencing software/program this was delayed and is planned to start during the second quarter of 2011.

- Continue to update the ACRP Program Manual and augment panel member orientation.

  Status Update: The CABHP Program Manager is now providing orientations to panel members face-to-face prior to their first panel meeting. Orientation materials continue to be updated as needed.

- Identifying opportunities to recognize panel members and their contributions to the CPS program.

  Status Update: All panel members were provided sponsorship to attend a workshop featuring David Conrad who is a national expert on secondary trauma.

- As recommended by the ACRPs, CPS and Arizona State University will explore how graduate students can be utilized in the DCYF evaluation process.

  Status Update: A Master's level graduate student in the School of Social Work completed a summer internship with ACRP Program.

Strategic planning with each of the panels did not occur in 2010; however, priority areas of focus in 2011 were identified during the fourth quarter meeting and through the panel member annual survey. Areas identified by the panel members during panel meetings and in the survey results included:

- ***Presentations on:*** trauma informed care, the *Never Shake a Baby* program, and multiple placements and disruptions in foster care;

- ***Case record review samples that include:*** youth aging out of the CPS system; teen parents including those in foster care; adopted youth returned to CPS;

- ***Training for panel members on:*** the child welfare system, assessing strengths and risks; impact of blended families on child welfare and domestic violence, additional trauma training for foster parents and CPS supervisors and staff, shadowing CPS staff in the field, observe Hotline, foster care services and ethics, criteria for child abuse prosecution, child abuse prevention strategies/resources (healthy families, etc.);

- ***DCYF staff to provide updates on***: activities related to panel recommendations (e.g. national registry, chronic child neglect) and impact of economic downturn (e.g. budgets, referral and services);

- ***Areas for further inquiry include:*** an examination of the child welfare system to identify areas where child abuse victims are "falling through the cracks"; examine initiatives in other

states that intended to strengthen and support their child welfare system, child maltreatment attributed to the economic downturn, educational services/supports for kids in foster care, intergenerational child abuse and neglect, and opportunities to collaborate with the Medical Examiner's Offices;

- ***Continue recruitment efforts targeting:*** juvenile court/judge, legislators, court-appointed special advocates (CASA), concerned citizens, guardians ad litem, law enforcement, medical providers, faith-based representatives, adoptees and foster children.

Appendix A: Agency Response To The 2009 Arizona Citizen Review Panels' 11th Annual Report Recommendations

The following is a summary of the findings and recommendations by the Regional Citizen Review Panels in an effort to improve the CPS system:

> **Recommendation 1:** DCYF should seek opportunities to work collaboratively with the Arizona Attorney General's Office to expand the Office of Drug Endangered Children's programs across counties.

Response: The Division of Children, Youth and Families (DCYF) agrees with this recommendation. The Governor's Office for Children, Youth and Families is now providing administrative support for the Drug Endangered Children's programs (DEC). DCYF will continue to be supportive of expanding the DEC programs and will work collaboratively with Drug Endangered Children's Alliance to achieve expansion of this program statewide. DCYF will continue to be an active participant in the Alliance, which includes the Governor's Office for Children, Youth and Families, Attorney General's Office, the Law Enforcement Community, County Attorneys, and other key stakeholders. The focus of the Alliance is to:

- develop a statewide safety assessment tool for use by the law enforcement communities; this tool will be congruent with the Division's Child Safety Assessment model;
- develop and enter into a Memorandum of Understanding with all Alliance partners;
- review and revise as necessary existing DEC protocols; these protocols will be expanded to include children of incarcerated parents and Level 2 drug endangered children; and
- review, revise and expand current training.

> **Recommendation 2:** DCYF should explore opportunities to work in partnership with the Federal Regional Office to advocate for a national registry and central depository that would aid CPS efforts to access information in a timely manner on adults who have a history of maltreatment reports in other states, especially those with multiple allegations of chronic abuse and neglect.

Response: The Division of Children, Youth and Families (DCYF) agrees with this recommendation. The Adam Walsh Child Protection and Safety Act of 2006 required that the U.S. Department of Health and Human Services conduct a study to assess the feasibility of establishing a national child abuse and neglect registry and present the results in a report to Congress. The Interim Report to the Congress on the Feasibility of a National Child Abuse Registry (May 2009) describes key issues regarding the feasibility of establishing a national child abuse registry and concludes that implementation is not feasible under statutory limitations of the authorizing legislation. It would also require enabling state legislation including funding for a project of this magnitude.

It should be noted that department policy provides guidance to staff regarding obtaining and use of prior CPS history in assessing child safety. Policy states that the CPS supervisor "will complete the review of prior reports and case history in the Child Protective Services Central Registry including out-of-state reports." Information (such as when CPS history was requested, whether records exist, barriers in obtaining the information, and a summary of the information, etc.) is documented in the

automated Child Safety Assessment. CPS staff are also required to contact other states when they learn a parent may have history in that state.

Recommendation 3: Additional guidelines should be provided to assist DCYF staff in strengthening and assessing the appropriateness of safety monitors. Provide staff with the types of charges on the Department of Public Safety background checks that would preclude someone from being a safety monitor. Currently, DCYF staff is expected to conduct background checks, but there is some discrepancy in how decisions are made and what type of criminal arrest, charge and/or convictions would prevent a person from becoming a safety monitor.

Response: The Division of Children, Youth and Families (DCYF) agrees with this recommendation. Current department policy provides guidance to assist CPS Specialist in identifying appropriate safety monitors. The CPS Specialist must consider the following in assessing the appropriateness of a safety monitor:

- current or prior CPS history;
- criminal history;
- whether the home is physically safe (if child will be staying there);
- an understanding of the safety threats and that the threats must be controlled;
- ability to prevent contact with those who pose threats;
- availability at times needed to ensure child safety;
- accessible when threats are or are likely to be present;
- ability to meet the child's basic needs;
- is physically able to protect child;
- is aligned with CPS in carrying out the safety plan; and
- any substance abuse, mental health or personal issues that may interfere with keeping the child safe.

The DCYF will ensure that the criminal history requirements for safety monitors are more closely aligned with the criminal history guidelines for unlicensed caregivers. These guidelines note the following:

- If the prospective relative caregiver including a person who has a significant relationship with the child or any adult household member is awaiting trial on or has been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more specific criminal offenses prescribed in A.R.S. § 41-1758.03, he/she is precluded from placement.
- If a criminal records background check or a self-disclosure statement reveals a conviction or indictment of any other criminal offense, the decision to place a child in that home will be based upon the safety threats presented by that crime. In assessing the safety threats, the CPS Specialist, in consultation with the CPS Supervisor, must consider the following:
    - the extent of the person's criminal record including whether the criminal offense was an isolated incident or indicative of a pattern of criminal activity;
    - the length of time that has elapsed since the offense was committed;
    - the nature of the offense;
    - any applicable mitigating circumstances including whether the victim was child or a vulnerable adult;
    - the degree to which the person participated in the offense;

- the extent of the person's rehabilitation, including:
  - ⇨ completion of probation, parole or community supervision,
  - ⇨ evidence of positive action to change criminal behavior, such as completing of drug treatment program or counseling, and
  - ⇨ personal reference attesting to the person's rehabilitation;

➢ The vulnerability of the child needing placement including the child's age and special needs.

Recommendation 4: The Arizona Citizen Review Panels recommended that DCYF reinforce current policy and documentation requirements on cases involving criminal conduct allegations. The Arizona Citizen Review Panels are concerned about the lack of adequate information gathered and/or documented which indicate a thorough safety assessment was completed for children remaining in the home when a criminal investigation has ended and a determination to close the case was made.

Response: The Division of Children, Youth and Families (DCYF) agrees with this recommendation. The DCYF will continue to reinforce compliance with the policy and documentation requirements for completing a thorough investigation including the assessment of child safety in all cases including reports alleging criminal conduct behavior through:

➢ instructional tips and model examples:
  - of documentation, and
  - on who to interview, what documents to review, review of criminal history information, and obtaining and reviewing court orders that restrict or deny custody, visitation or contact;

➢ case record reviews that evaluate whether or not the required interviews occurred, whether required documents were obtained and reviewed, whether sufficient relevant information was gathered to confirm the presence or absence of each of the 17 safety threats, and whether there is documentation of an analysis of the information in relation to 17 safety threats and the safety threshold;

➢ real-time feedback to staff about their documentation following each case review to clarify and reinforce the practice standards for staff at all levels in the district and to improve consistency and accountability;

➢ employee performance evaluation; and

➢ Case Manager and Supervisor CORE training, and refresher and advance training opportunities including development of seven-hour documentation training which focuses on the fundamental foundation for documentation (e.g., the importance of documentation, how to record important tasks and events in the life of a case, and who/what/when/where/how).

Appendix B: 2010 Agenda and Meeting Locations

	Northern Panel	***Southern Panel***	***Central Panel***
	Monday (1:00 – 4:00)	*Monday (1:00 – 4:00)*	*Friday (9:00 – 12:00)*
1st Quarter	*March 29*	*March 15*	*March 19*
2nd Quarter	*June 7*	*June 21*	*June 25*
3rd Quarter	*August 30*	*September 20*	*September 24*
4th Quarter	*November 1*	*November 15*	*November 19*

1st Quarter Meeting Agenda

Welcome and Introduction
Presentations: Practices for Diverse Cultures and Team Decision Making (TDM)
CPS Policy Review Related to Case Record Presentation
Case Record Review #1
DES Program Report: CAPTA Implementation Plan and Back to Basics
Case Record Review #2
Recommendations from 1st Quarter Meeting
Review Agenda and Identify Requests for 2nd Quarter Meeting

2nd Quarter Meeting Agenda

Welcome and Introduction
Review of 1st Quarter Meeting Minutes
Presentation: Babies, Infants, and Toddlers in Foster Care
CPS Policy Review Related to Case Record Presentation
Case Record Review #1
DES Program Report: Hotline Process; Safety Planning & Safety Monitors
Case Record Review #2
Recommendations from 2nd Quarter Meeting
Review Agenda and Identify Requests for 3rd Quarter Meeting

3rd Quarter Meeting Agenda

Welcome and Introduction
Review of 2nd Quarter Meeting Minutes
Presentations: Regional Advocacy Centers; Multidisciplinary Approach to Case Investigations
CPS Policy Review Related to Case Record Presentation
Case Record Review #1
DES Program Report: Legislative Updates
Case Record Review #2
Recommendations from 3rd Quarter Meeting
Review Agenda and Identify Requests for 4th Quarter Meeting

4th Quarter Meeting Agenda

Welcome and Introduction
Review of 3rd Quarter Meeting Minutes
Presentation**:** Annual Report
CPS Policy Review Related to Case Record Presentation
Case Record Review #1
DES Program Report: Agency Responses to CRP Recommendations 2007-2009
Case Record Review #2
Recommendations from 4th Quarter Meeting
Review Agenda and Identify Priorities for 2011

2010 Meeting Locations
Arizona Citizen Review Panel

Southern Region

La Paloma Family Services
870 West Miracle Mile
Building A
Tucson, AZ 85705
(520) 750-9667
http://www.lapalomakids.org

Central Region

School of Social Work
Arizona State University
Downtown Phoenix Campus
University Center (UCENT)
411 North Central Avenue
Suite 822A, 8th Floor
Phoenix, AZ 85004-0698
(602) 496-0800
http://ssw.asu.edu/portal/

Northern Region

United Way of Northern Arizona
1515 East Cedar Avenue
Suite D-1
Flagstaff, AZ 86001
(928) 773-9813
http://www.nazunitedway.org/

If you have questions or need additional information,
please contact:

Lisa Moen
Program Coordinator
Phone: (602) 496-1480
Email: lisa.moen@asu.edu

Appendix C: Citizen Review Panel Members Central Region

Allison Thompson
Maricopa County Adult Probation

Bernadette Chambers
Arizona State University
Prevention Research Center

Beth Rosenberg
Children's Action Alliance

Cindy Copp
DES/DCYF/CPS Southwestern Region

Darryl Bailey
DES/DCYF/CPS Central Region

Diana Yazzie Devine
Native American Connections

Gary Brennan
Quality Care Network

Gloria Sesma
Isaac Middle School

Janet Cornell
Scottsdale City Court

Janice Waggoner
Maricopa County Justice Court

Jennifer Mullins
Arizona State University
School of Social Work

Jo Fuhrmann
CHEERS, Inc.

Joelle Minitti
DES/DCYF Child Protective Services

Kara VanHise
Arizona Ombudsman's Office, Citizen's Aid

Kim Leggio
Maricopa County Justice Court

Kris Jacober
Arizona Association for Foster and Adoptive Parents

Linda Madrid
Arizona State University
Southwest Interdisciplinary Research Institute

Lisa Barrientos
Mesa Police Department, Homicide Unit

Marcia Stanton
Phoenix Children's Hospital

Minerva Gant
DES/DCYF Child Protective Services

Nancy Logan
Office of Disability Adjudication, SSA

Natalie Miles Thompson
Crisis Nursery

Pamela Fitzgerald
Citizen/Former Teacher

Pamela Ruzi
Hospice of the Valley

Princess Lucas-Wilson
Citizen

Roy Teramoto, M.D.
Indian Health Services

Samantha Nordvold
Madison School

Simon Kottoor
Sunshine Group Home

Stephanie Zimmerman, M.D.
Phoenix Children's Hospital

Tracy Sloat
Maricopa County Dept. of Public Health

Yariet Camarena
DES/DCYF Practice Improvement Specialist

Appendix C: Citizen Review Panel Members Southern Region

Anna Binkiewicz, M.D.
Retired Professor/Medical Director
Casa de los Niño's Crisis Nursery

Barbra Quade
Jewish Family Services

Carla Hinton, Ph.D.
Amphitheater Public Schools

Cheryl Brown
Pima County Attorney's Office
Juvenile Unit

Christie Kroger
DES/DCYF Practice Improvement Specialist

Comel Belin
Tucson Unified School District

Cynthia Killion
Amphitheater Public Schools

Darlene Moten
Amphitheater Public Schools

David Reynolds
Citizen/Special Education Teacher

Gloria Bernal
Sycamore Elementary School

Jaymie Jacobs
Office of Pima County School Superintendant

Scott Gamble
Tohono O'Odham Police Nation Department

Joan Mendelson
Citizen/Attorney

Joy Subrin
Northwest Medical Center, Social Work Department

Karen Harper
Southern Arizona Children's Advocacy Center

Karen Kelsch
Pilot Parents of Southern Arizona

Laurie San Angelo
Office of the Arizona Attorney General

Linda Johnson
DES/DCYF Child Protective Services

Martha McKibben
Northwest Medical Center, Social Work Department

Marty Fuentes
Tohono O'Odham Police Nation Department

Robin Gerard
Casa de los Niños Crisis Nursery

Sandy Guizzetti
Foster Care Review Board

Susan Peacock
Foster Care Review Board

Appendix C: Citizen Review Panel Members Northern Region

Beya Thayer
Northland Family Help Center

Carli Moncher
Safe Child Center/Flagstaff Medical Center

Cindy Trembley
DES/DCYF Child Protective Services

Dani O'Connell
DES/DCYF Practice Improvement Specialist

Erin Callinan
Northland Family Help Center

Dustin Wagner
Child and Family Support Services

Gene Shantz
Flagstaff Police Department

Jill Sanchez
Juvenile Court Services
Coconino County Superior Court

Judy Gideon
Citizen/Retired Foster & Adoptive Parent

Julie Wood
Arizona's Children Association

Kathi Raley
Victim/Witness Services for Coconino County

Sandra Lescoe
DES/DCYF Child Protective Services

Suzette Vigil
DES/DCYF Child Protective Services

Appendix D: CABHP Case Record Summary and Presentation

Arizona Citizen Review Panel
___ Quarter, ____, 20__
_____Region, Case # ___

Purpose: Highlight key data and findings extracted from CPS CHILDS system and other documentation to provide information to the regional Citizen Review Panels so that recommendations can be developed and areas of exemplary practice identified. Panel members will receive a copy of this document with copies of the Practice Improvement Case Review Instrument and the In Home or Out of Home (if applicable). All personal identifying information will be redacted from the materials before distribution. The period under review will be the last 12 months except for items that are related to history of CPS involvement and /or may be relevant to the current case being reviewed (e.g. substance use, criminal history, etc.)

A. ***Narrative Overview of Case Description -*** allegation(s)/what trigger the call, age, gender and race/ethnicity of victim(s), reporter, perpetrator(s), summary of history of CPS reports and findings, relevant factors (e.g. substance use, mental illness, physical health, developmental disability), manner and cause of death (specify per medical report, autopsy and/or death certificate), relevant toxicology testing performed including results and any charges filed, summarize services received and/or needed but not received.

B. ***DES Practice Improvement Case Review Instrument Summary -*** review should use the directions in the tool also refer to the DCYF Quality Improvement System Procedures, Training Manual and any relevant DCYF policies and procedure**. Significant information** - summary of information reviewed in the copy of the DES record and/or collected from CHILDS. **Key Findings**-document findings of safety & risk assessment and investigations, plus any relevant decisions made by DES and the courts. **Comments-** additional information that would be beneficial to share with CRP members, DES Administration and/or CABHP staff.

Item	Significant Information, Key Findings & Comments

Item 1 **Timeliness of Initiating Investigation of Reports of Child Maltreatment** Consider also the relevance and sufficiency of the information gathered during current or prior CPS investigations and case planning	
Item 2 **Initial Child Safety Assessment**	***-ATTACHED COPY OF CSA FROM CHILDS-***
Item 3 **Safety Planning to Protect Child(ren) in Home and Prevent Removal**	***-ATTACHED COPY OF CSA FROM CHILDS-***
Item 4 **Initial Strengths & Risk Assessment and Provision of Services to Reduce Risks**	***-ATTACHED COPY OF SRA FROM CHILDS-*** *Document whether services offered and/or provided addressed the identified safety threats and risk factors and any outcomes as a result of services received. Also need to consider whether actions were taken in a timely manner to ensure the safety of other children remaining in the home.*
Item 5 **Determining Whether Maltreatment Occurred**	
Item 6 **Aftercare Planning**	

C. ***DES Practice Improvement Case Review Instrument-In Home or Out of Home- review -*** should use the directions in the tool and any relevant DCYF policies and procedure**. Key Finding-** should include information that justifies the rating. **Comments-** additional information that would be beneficial to share with CRP members, DES Administration and/or CABHP staff.

Item	Significant Information, Key Findings & Comments
Item 1 Ongoing Safety and Risk Assess. And Safety Management	***-ATTACHED UPDATES OF SRA FROM CHILDS-***
Item 2 Permanency Goal for Child	
Item 3 Concurrent Permanency Planning	
Item 4 Independent Living Services	
Item 5 Visiting with Parents & Siblings in Foster Care	
Item 6 Relative Placement	
Item 7 Needs &Services of Child, Parents and foster Parents	

Item 8 **Case Plan Development**	
Item 9 **Worker Visits with Child**	
Item 10 **Worker Visits with Parents**	
Item 11 **Educational Needs of the Child**	
Item 12 **Physical Health of the Child**	
Item 13 **Mental/Behavioral Health of the Child**	
Foster Homes *Complete only if allegations involve foster family placement. Identify any findings from foster care review board on their barriers.*	

D. Panel Recommendations and Comments

Precipitating Events and/or Suspected Triggers: ☐ Commission of Another Crime ☐ Family Violence ☐ Revenge ☐ Crying	☐ Disobedience ☐ Feeding Difficulty ☐ Toilet Training ☐ Other:

Family Risk Factors: ☐ Substance Use ☐ Mental Health Problems ☐ Domestic Violence ☐ Sexual Abuse ☐ Violence Outside the Home ☐ Lack of Physical or Mental Ability to Provide Adequate Care ☐ Lack of Motivation to Provide Adequate Care ☐ Prior Removals by CPS or Severance of Parental Rights ☐ Lack of Resources for Adequate Food/Shelter/Medical/Child Care ☐ Child(ren) with special needs: ☐ Medical ☐ Developmental ☐ Emotional/Behavioral Health	☐ Lack of Parenting Skills ☐ Teen Parent ☐ Prior Child Death ☐ Lack of Anger Control ☐ Co- sleeping with Infant ☐ Prior Substantiated Reports ☐ Other: ***Were all risk factors identified in the record?*** ☐***Yes*** ☐***No*** ***If not, specify additional risk factors identified by the panel members:***
Were all identified risk factors addressed and/or resolved? ☐***Yes*** ☐***No*** ***If No, describe:***	
Joint Investigation: r*eference the joint investigation protocol for the applicable region and note any areas in which the protocol was not followed.*	
Was a thorough investigation completed? ☐***Yes*** ☐***No*** ***If No, describe:***	
Supervision: *note any instances or documentation that indicates that there was inadequate communication (e.g. reporting facts, clear instructions) between the CPS worker and their supervisor. Also specify any decisions/findings were overturned.*	
Potential Policy Issues: *indicate whether there are any specific policy issues, concerns or recommendations. 1) Areas where policy not followed or quality concerns; 2) Policy followed but still bad outcome or concern identified (may need to re-evaluate or modify the policy); 3) Issue not addressed in the policy.*	
Exemplary Practices: *note any practices that should be shared to encourage the continued practice.*	

Other: *note any known circumstances that you believe may have impacted the outcome (e.g. lack of services, support services, case load size, training). Document any barriers outside the CPS agency that impacted the agency's ability to ensure a continuity of consistent, timely and adequate services.*
What actions does the panel believe could have been taken to prevent/avoid this event?
Recommendations:

Demographics

Age of Child: **Race:** **Hispanic/Latino:** ☐***Yes*** ☐***No***

Prior CPS involvement: **Number of prior complaints:** **Number of substantiated complaints:**

Age of Parents/Gender (e.g. 43F 51M): **Marital Status:**

Father History of Abuse: ☐***Yes*** ☐***No*** **Check Type:** ☐Physical ☐Sexual ☐Mental/Emotional ☐Neglect

Mother History of Abuse: ☐***Yes*** ☐***No*** **Check Type:** ☐Physical ☐Sexual ☐Mental/Emotional ☐Neglect

Does mother work out of the home? ☐***Yes*** ☐***No***

If *Yes*, was perpetrator primarily responsible for caring for Target Child during mother's absence? ☐***Yes*** ☐***No***

Birth Order of Target Child: **Number of Children Under Age 5:**

Was substance abuse a risk factor for this family: ☐***Yes*** ☐***No*** **Identify substance(s):**

Was Target Child identified as having a behavioral health disorder? ☐***Yes*** ☐***No*** **If *Yes*, specify:**

Time Line

Date	Significant Events for the Target Child	Notes

Appendix E: Citizen Review Panel Survey

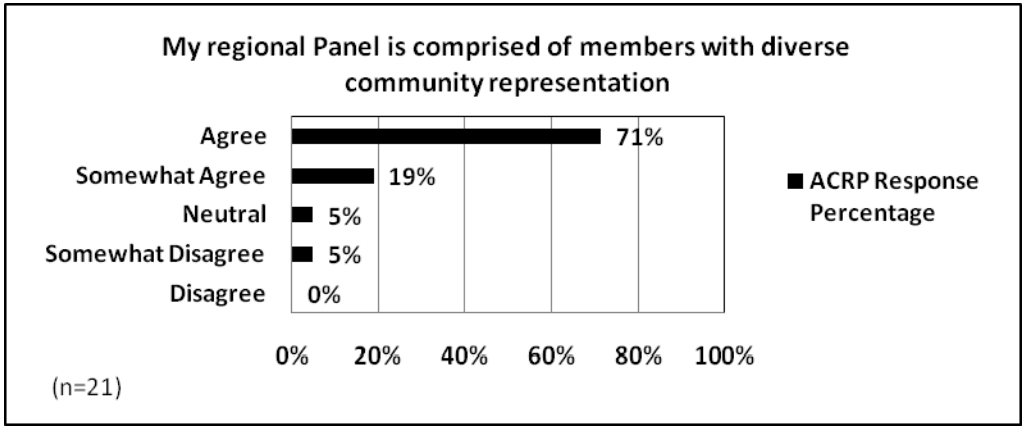
On November 19, 2010, Panel members received an email request from the Citizen Review Panel Program Coordinator requesting them to complete a 10 question survey by December 6, 2010 as a means to provide information on the level of satisfaction and suggestions for improvement of the program.

Question 1: I am a Citizen Review Panel member for (check one): Central, Southern or Northern Region. Twenty-one (21) Panel members completed the survey with 12 responses from Central, 6 from Southern and 3 from the Northern Panels.

Question 2: ***I have served on the Citizen Review Panel for: ___month(s) or ___year(s).*** Members who responded indicated they had served on Panels from 1 month to 8 years. The majority of the respondents were satisfied with the performance of CABHP administrative support, community diversity of Panel members, CPS case record presentations, and content of the meetings, e.g. guest speakers, policy reviews, and DES program reports. Panel members were asked for suggestions on areas of additional training or topics that they would like to learn more about, in addition to ideas on ways that Panel meetings could improve in the upcoming year. Panel members' comments generally reflect more confidence and enthusiasm about the program and their roles compared with last year's survey. The rest of the 2010 survey questions and results are summarized as follows:

Question 3: My regional Panel is comprised of members with diverse community representation.

Comments:

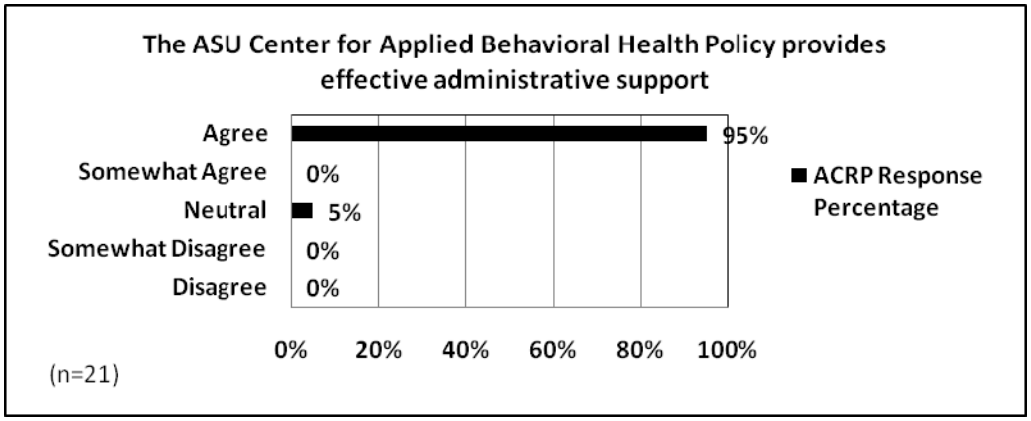


- Need law enforcement, former foster child, someone from the GAL/legal advocate office, a CASA; how about a judge? (Southern)
- I think that juvenile probation needs to send a worker. (Southern)
- Law enforcement not present.
- I know there is considerable effort put into finding people from diverse backgrounds.
- Panel has great diversity.
- Diversity can always be enhanced.
- I have previously stated that the citizen review panel seems more like the 'professional' review panel and that the opinions of the CPS members often make it feel like the "CPS reviewing CPS panel." We need more 'off the street' citizens to review the cases with an outsider's view. (Central)

Question 4: The ASU Center for Applied Behavioral Health Policy provides effective administrative support.

Comments:

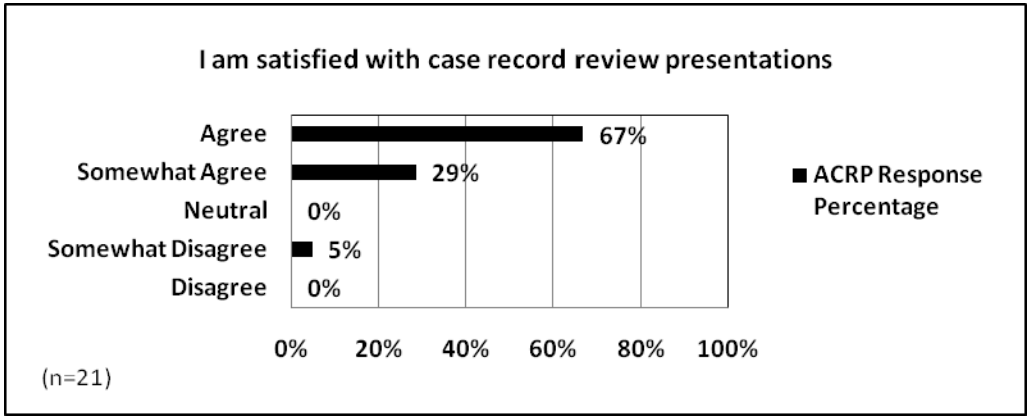
- I am VERY impressed with the administrative/ organizational aspect of this panel. The meetings are very well facilitated.
- They are great.
- The work of the ASU Center is thorough and informative.
- Exceptionally strong support and direction. It is very much appreciated.



Question 5: I am satisfied with case record review presentations.

Comments:

- The content of the reviews is good and the discussion is really good, but we often run out of time and have to move on from discussions to keep on schedule.
- Due to my newness, I am still learning best methods to review the case materials.
- There are times when reports from providers are given to panel members as part of the case history. These reports can be critical if the provider is not assisting the family in the way that CPS is requesting.



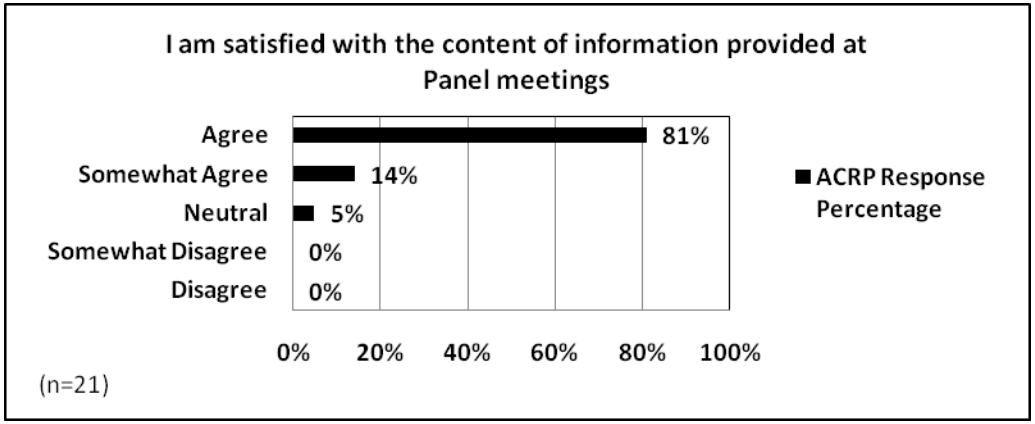
- Sometimes the rules and processes that are used by CPS and other institutions are unknown to a Board member. It takes time on the Board to pick up information about laws and regulations that are built into the process.

- The panel still tends to go off on tangents. This is to be expected with such a large group and Vicki does a great job of politely and diplomatically keeping us on task.
- Always seems like we do not have much time for the case reviews. The agenda is always very full.
- Not enough time!
- They are well synopsized and easy to work through.

Question 6: I am satisfied with the content of information provided at Panel meetings.

Comments:

- I think it is very difficult to go through files that have extensive information and that are dated. Problems with the information provided come from the originating source. Many of the questions the caseworkers fill in are cut and pasted; following dates and any changes over time becomes difficult.



Question 7: What information or training would be helpful for you to become more effective in your role as a Panel member?

Comments:

- I think a little more upfront information about the role/responsibilities of the panel would have been helpful as a new member. Maybe being paired with a seasoned member, to act as a mentor or someone to ask questions would be helpful.
- CPS policy and procedures for removal/investigations. Maybe not the 'whole book' but a flow sheet or some tool they use to guide their work.
- No specific training recommended. Suggest my continued panel participation will assist in becoming more effective.
- As meeting results are processed, I would like to know about follow-ups for information requested from the panel.
- Have been satisfied with the information provided.

- It may be helpful for a panel member to shadow a Case Manager to better understand the types of hurdles they must overcome to make the best decision possible to assist a family in need. It would also be helpful to learn how a family can be so inundated with services that they are set up to fail.
- You have already helped with offering training one hour prior to quarterly meetings and provided a listing of acronym definitions.
- Maybe training that includes how the various institutions that are typically involved with CPS work together. Flow chart form. That might be an overwhelming task. Unless you are already a little familiar with the relationships between institutions, it will be very confusing to figure out what each part plays to the whole.
- Over a period of time, it might be good to review the policies and processes for the various organizations from CPS to law enforcement to forensic pediatrics, etc.
- Trainings held in Tucson.
- Information provided at the end of each meeting on what recommendations/suggestions will be made to DES regarding the cases reviewed that day.
- It might help if non-DCYF staff had a strengthened understanding of CPS policy in determining child safety/risk, reasons for removal, and conditions for return/reunification.
- Agency policies and protocols.
- Case worker ride-along to understand the role of CPS caseworkers.
- The use of all the acronyms is sometimes frustrating when you don't know what they all stand for.
- An update on how CPS categorizes a child's case when it is presented to the agency.
- Update on the joint protocols between CPS and law enforcement, including a response from the police leadership and the County Attorney's Office.

Question 8: What additional themes or topics would you like to explore at Panel meetings in 2011?

Comments:

- Foster Care Ethics.
- Ineffective safety plans.
- Blended family dynamics and review of family history as risk factors.
- Domestic violence.
- The determining factors as to whether the case should be forwarded to the Attorney General's Office for a Dependency action.
- How information is able to flow or not flow between institutions, police, schools, hospitals, doctors, courts, etc.
- There was a good list of topics presented at the most recent meeting, but I would repeat the recommendation for general training on "systems."
- Discussion of follow up services arranged for families who have had a child removed from their care.
- Lack of good behavioral health services for the children and families.

- I'm wondering if the incidents of child fatalities and level of severity of child abuse in Arizona is increasing since the economic downturn and legislative budget cuts. I have an impression that it is, but I do not know if anyone is collecting data and/or reporting findings to citizens regarding this possible trend.
- Chronic neglect; prevention strategies; adopted youth returning to the system; and how lack of resources is affecting agency effectiveness.
- More information about what we need to do to get this state to improve CPS. What we need to do to make them able to do their jobs better! The idea is to save lives!
- Criteria for child abuse prosecution (seems as though few cases are actually pursued and prosecuted); child abuse prevention strategies/resources (Healthy Families, etc.); cases involving youth; -educational services/supports for kids in foster care; intergenerational child abuse.
- We need to comment on other state and public agencies that must interface with and coordinate with ADES/CPS, so we can better protect children, families and our communities.
- Information regarding prevention programs available in the community specific to cases evaluated.
- How does the educational system, including Arizona Department of Education, school districts, and schools (e.g., charter) support and/or participate in child protection?

Question 9: My Regional Panel meetings would be more productive if (please specify):

Comments:

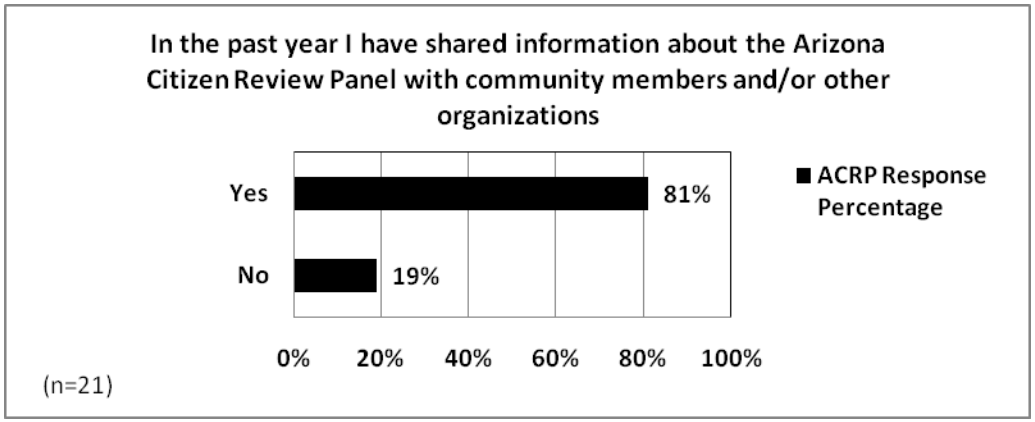
- All members should attend.
- No suggestions - it is quite productive as is.
- It appears that not everyone on the panel understands the criteria involved in the decision making process as to the services that are provided to each family. It may appear on the outside that each family presented to CPS needs services, but once the process is understood, the panel will then see that it is what is on the inside that CPS must work with to help the family.
- I believe adding more time to the quarterly meetings would not make things so rushed. We are rarely able to follow the agenda schedule because of so much discussion, which is beneficial and should occur.
- I think our panel and the ASU support does a great job and that we are unusually productive for such a diverse group.
- Less time was taken on "extraneous" topics. On the other hand, these are often valuable ideas/topics, and it is difficult to measure the value in terms of "productivity."
- They are well organized and they run very smoothly--staff support is excellent.
- I made more time to prepare between meetings.
- A Mohave DCYF representative could attend the Mohave case reviews.
- Members should not go off on tangents or philosophical ranting on parenting, the system, etc., and instead focus on what our objectives are.

- There should be more 'off the street' citizens and less professionals from the field, who sometimes can't look at cases as an outsider could.
- The meetings are very productive.
- Case overviews seem to be heavy in investigation and little information about the rest of the case. For example, more information is needed about what services were offered, completed, opinions, reports of those involved in order to get the full picture; who else was involved in the case, etc.
- I am wondering if others would agree that the number of meetings should be increased to 5 or 6 annually?

Question 10: In the past year I have shared information about the Arizona Citizen Review Panel with community members and/or other organizations.

Comments:

- Many people were not aware that there is such a panel and were very pleased to hear of its existence.
- I am working with the Pima County Juvenile Court Committee on education. Some of the areas of interest and concern overlap.
- Yes, with respect to confidentiality.
- I invited people from Pima County Juvenile Court.



To obtain further information, contact:

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Information about the Arizona Citizen Review Panel Program can be found on the Internet through the Center for Applied Behavioral Health Policy at:
http://www.cabhp.asu.edu/

This publication can be made available in alternative format.
Please contact the Arizona Citizen Review Panel Program at (602) 496-1470.

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