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ARIZONA CITIZEN REVIEW PANEL  
Eleventh Annual Report



# ARIZONA CITIZEN REVIEW PANEL

## Eleventh 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

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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 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, 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.

This year was a transitional period as CABHP was awarded the contract for the administration of the ACRP program. CABHP developed a new approach to the coordination and support of the Panels based on interviews with key stakeholders (i.e. Panel members, advocates, representatives from other states, DCYF staff, and ADHS staff who formally administered the program); review of Panel member surveys and past reports; observation of Panel meetings; consultation from representatives from the National Citizen Review Panel Program at the University of Kentucky; and examination of the National Guidelines and Protocols created for ACRPs. Based on the information collected, a comprehensive work plan was developed which focused on the following four key goals:

**Goal 1:** Centralize responsibility for staffing, coordinating and supporting the ACRPs in meeting their legislative mandate.

**Goal 2:** Strengthen the ACRPs in order to fulfill CAPTA requirements.

**Goal 3:** Provide data from various sources to assist the ACRPs in making recommendations that improve the CPS system.

**Goal 4:** Enhance coordination, communication, and reporting of child welfare data to maximize public input and interagency collaboration.

The Eleventh Annual Citizen Review Panel Report summarizes the accomplishments, activities, findings, and recommendations of the three ACRPs (Northern, Central and Southern) in Arizona.

## **ACCOMPLISHMENTS**

Highlights over the past year are detailed below:

- Centralized logistical and staff support and instituted a process to strengthen the Panels (e.g. annual calendar of meeting, terms of membership, and new member application);
- Developed a program brochure that was distributed to over 500 people and also dispersed via various community list serves to solicit volunteer members;
- Increased membership by 47% statewide including recruiting family members and youth formerly served through the child welfare system and providing supports for continued participation (i.e. mileage reimbursement);
- Provided orientation to new members;
- Created an intranet site to provide meeting materials and other pertinent information (e.g. reports, presentations, information from the National Coordinating Center, etc.);
- Developed a public web site for public information and public comment;
- Developed a structured protocol for conducting case record reviews and a process for facilitating case record presentations during Panel meetings;
- Execution of a data sharing agreement between CABHP and DCYF;
- DCYF designated a Practice Improvement Specialist to two of the three regional Panels;
- DCYF designed a DCYF Central Office liaison to each of the three regional Panels; and
- Established ongoing coordination meetings between DCYF and CABHP.

## **PANELS' RECOMMENDATIONS**

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Each of the three Panels developed recommendations for improvement of the child welfare system in Arizona based on policy review, case record presentations, materials distributed and updates provided by representatives from the ADES/DCYF (see Appendix G). Recommendations are combined, prioritized, and then divided into four categories based on input from DCYF and Panel members. The first category is the recommendations that require a formal written response from DCYF as required by the CAPTA. Recognizing the ongoing efforts of DCYF to improve the 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 includes recommendations that are currently being addressed through practice improvement activities. DCYF has dedicated Practice Improvement Specialists in all districts. Practice Improvement Specialists in the districts lead case reviews, provide data

and performance information to district management and the DCYF's Quality Improvement Manager, facilitate district action planning, and monitor and lead district practice improvement activities. The Panels want to avoid duplication and monitor progress in these areas in the upcoming year.

The third category is recommendations that require further monitoring. Due to the limited sampling of case records, caution was used to avoid making inferences based on a limited amount of information. These items will continue to be monitored and explored to assess whether there are system trends. DCYF Practice Improvement Specialists will also assist the Panels in determining whether observations are rare occurrences or if there could be a possible trend that requires additional attention.

Recognizing that the child welfare system is not solely the responsibility DCYF, the final category includes recommendations for system improvement that are directed toward system partners. Panel members and DCFY staff are encouraged to advocate and promote collaborative efforts with system partners to incorporate these recommendations.

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

#### **RECOMMENDATIONS FOR AGENCY RESPONSE**

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.
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.
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 conviction would prevent a person from becoming a safety monitor.
4. The ACRPs recommend that DCYF reinforce current policy and documentation requirements on cases involving criminal conduct allegations. The ACRPs 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.

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

1. Chronic neglect continues to be a significant concern identified by the Panel. DCFY is currently examining this issue for future policy development. CABHP will work with DCYF to examine differences in substantiation rates by demographic factors and geographic location. Mechanisms to evaluate, track, and report on chronic neglect and abuse should be explored, including reporting on number of unsubstantiated prior investigations in cases, as well as, those cases in which repeated reports have been received from multiple sources (e.g. school, juvenile probation, neighbors, and police).
2. Information on evidence-based practices related to behavioral health, including how to work with family members who are receiving medication assisted treatment (e.g. methadone) and co-occurring disorders and medications used for pain management should be incorporated into current training curricula provided to CPS caseworkers. CPS caseworkers should be provided continued training opportunities on how to effectively work with families with substance abuse issues. This will also enable CPS staff to address clients' addiction disorders and develop case plans that address behavior changes necessary to resolve safety threats for the children.
3. Training and ongoing supervision should emphasize skills needed for CPS staff to identify ongoing services and mobilize resources prior to case closure. In addition, the importance of ensuring referrals are followed through by families prior to case closure should be re-enforced. For example, if a child is suspected or identified as having a developmental disability, CPS should make efforts to refer the family to the Division of Developmental Disabilities.
4. Training and ongoing supervision regarding DES Policy Chapter 2 Section 4-*Safety Assessment When There Has Been Three or More Prior Reports*, should continue in order to educate workers to properly document in the Safety Assessment detailed information, including the evidence to support the previous findings, information on out of state reports (including dates, whether records were received or if there were barriers to obtaining records), behavior changes that resulted from previous services provided, and circumstances surrounding a child's death (e.g. unusual sleep patterns, signs of neglect, failure to thrive, etc.).
5. DCYF should continue to focus on improving the quality of the documentation and the transparency of the decision-making for determining whether reunification is viable.



6. The Panels identified the need to improve concurrent case planning. The Division recently trained all CPS staff to strengthen Concurrent Planning Practice.

7. CPS staff should continue to provide each family under investigation with a child one year or younger with the “Safe Sleep for Your Baby” pamphlet. DCYF will send out reminders to CPS staff to distribute these to all families involved with CPS who have a young child in their home.

8. The Panels recommend that CPS enhance its current training to assist staff in improving assessments related to substance exposed newborns and those related to developmental disabilities.

### **THE FOLLOWING AREAS WILL BE LOOKED AT BY THE PANELS TO IDENTIFY POTENTIAL TRENDS**

1. Given budget cuts and proposed additional reductions, the Panels will monitor and request updates from DCFY in the upcoming year on the following:

- a. The Panels expressed concern that mandatory reporters will be discouraged from making reports.
- b. The number of foster families that adopt children statewide and any reduction in system capacity.
- c. The availability of resources, including substance abuse treatment in rural areas. The Panels expressed concern that the state budget crisis is affecting organizations across the board, including donations that support non-profit organizations.
- d. The number of joint investigations including the number of cases where there is a disagreement between DCFY and law enforcement as to whether or not a joint investigation should occur.

2. The District Speakers Bureau should continue to visit schools, community providers and other community stakeholders to educate them on the function of CPS, and process of reporting child abuse and neglect, etc.

### **RECOMMENDATIONS FOR CHILD WELFARE SYSTEM PARTNERS**

1. Medical and behavioral health providers should educate parents on the possible side effects of drugs prescribed including the dangers of co-sleeping with infants when under the influences of substances that inhibit responsiveness (e.g., prescription drugs and alcohol).

2. As DCYF has no authority to conduct follow-up checks to families once a case is closed, it is important that community service providers are trained in identifying families who are in distress and at-risk of abusing or neglecting their children. This also should include conducting follow-up on families where a CPS case has been closed and there are known future risk factors (e.g. mothers who are pregnant with histories of confirmed substance abuse and spouses that have child abuse or neglect perpetrators being released from the criminal justice system). In situations in which the provider suspects child abuse or neglect, mandatory reporting requirements must be adhered to. It is not the role or responsibility of the service provider to submit or evaluate evidence to determine if abuse has occurred.

## **ARIZONA CITIZEN REVIEW PANEL OVERVIEW**

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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.

***The promise of Citizen Review Panels is realized when vulnerable children are better protected as a result of new perspectives on old problems.***

**-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 such as 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 annually and make them available to the public no later than December 31<sup>st</sup> of each year. 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 2008 Citizen Review Panel Report is included in Appendix A.

## **ARIZONA CITIZEN REVIEW PANEL PROGRAM STRUCTURE**

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The CABHP centralized responsibility for staffing, coordinating and supporting the ACRPs to improve communication across Panels and with DCYF.

At the state level, the CABHP administers and supports the three regional Panels located in Phoenix (Central), Tucson (Southern) and Flagstaff (Northern). Previously each of the Panels was coordinated by separate organizations. In addition, there were two regional Panels (Pima County and Yavapai County) and a statewide Panel (Maricopa County). The statewide Panel had a dual role as it was responsible for both the central region and also the entire state. Each of the Panels represent specific DCYF district(s) and counties (see

Figure 1) and CABHP staff are responsible the coordination and sharing of information across the three Panels.

## QUARTERLY ACTIVITIES

**Figure 1**

Panel	DES Districts	Counties
Northern	III IV	Apache, Coconino, La Paz, Mohave, Navajo, Yavapai Yuma
Central	I	Maricopa
Southern	II IV VI	Cochise, Greelee, Gila, Graham Pima, Pinal, Santa Cruz

The three ACRPs met quarterly in 2009 as required. An annual schedule of meetings was developed and consistent meeting locations were established (Appendix B). Each of the existing Panel members were contacted personally and engaged in discussions regarding what was needed for their continued participation. The DES Assistant Director also sent out letters to each Panel member thanking them for their continued support. Monthly coordination meetings with DCYF and

CABHP were established to monitor the implementation of the new contract.

During the first quarter the emphasis was on establishing structures and processes for expanding the activities of the Panels. Consensus guidelines were developed and adopted by each Panel for decision making and signed confidentiality statements were obtained from each member. All meetings were digitally recorded and formal meeting minutes were prepared. CABHP also created an intranet site to provide meeting materials and other pertinent information (e.g. reports, presentations, information from the national coordinating center, etc.) to Panel members. Panel members stressed the need to receive materials prior to the meetings.

Previously, Panel meetings focused primarily on conducting case record reviews and annual recommendations were based on these findings. Because of the inordinate amount of time needed to complete and discuss the cases, only a limited number could be examined each year (e.g. 22 cases were reviewed in 2007 and 13 cases in 2008). New processes have been instituted and CABHP staffs are now responsible for the review and presentation of case records. Panel member input was obtained on thematic areas of focus (e.g. chronic neglect, substance use, and history of multiple reports) and a structured meeting agenda was established for the year that included the provision of information and data from various sources including speakers and presentations, and case record and policy reviews.

- Quarter 1-** CABHP presentations on CPS System Overview, Process to Conduct a Comprehensive Review of CPS and Prioritizing Chapters, Proposed Revisions to Case Record Review Protocol and Sampling Criteria, Child Welfare Reporting Requirements Semi-Annual Report 2007/2008, Arizona Child Fatality Review Program 2009 Annual Report; and DCYF program report on 2009/2010 CAPTA plan and DCYF budget.

- **Quarter 2-** CABHP presentations on Adverse Child Experiences (ACE) Study, Characteristics of Substantiated vs. Unsubstantiated Reports for Children Under the Age of Five, Chronic Child Neglect, Case Record Review Process, Substance Exposed Newborns; and case theme on child fatalities and near fatalities under the age of two and related policies.
- **Quarter 3-** High Intensity Drug Trafficking Areas (HIDTA) Representatives provided information on joint protocols and drug endangered children and families, joint investigations and statutory mandates, DCYF program report on IV-B Safety Outcomes; and case theme on children affected by methamphetamine abuse.
- **Quarter 4-** Director of the Legislative Office of Family Advocacy and the Assistant Ombudsman for Citizen's Aid presented on the Grievance/Complaint Processes; CABHP presented on Key Constituent Groups and Role of Panels in Outreach and Education, DCYF program report on CAPTA Implementation Plan and Update on Panels' Recommendations; and case theme on children with physical, emotional and/or developmental disabilities.

During the transition it became apparent that formal feedback mechanisms must be developed to improve communication; facilitate collaboration; increase Panel member satisfaction; identify opportunities for innovation; and increase accountability by tracking and reporting on progress made on ACRP recommendations. There is now a standing agenda item at each meeting for DCYF representatives to provide a program report to ensure that the Panels receive information on the status of ACRP recommendations, process improvement initiatives, new policies and procedures, budget updates, and other relevant information. CABHP is in the process of developing a tracking system for monitoring the implementation of ACRP recommendations and will provide updates on a routine basis as many of the proposed changes span multiple years.

## **PANEL MEMBERSHIP**

Panels are comprised of 10 to 20 volunteers of diverse backgrounds and experience. Appendix C provides a listing of the ACRP members for each region with the type of agency and discipline represented. Terms of membership were agreed upon by the Panels, and training materials and an orientation processes established. Volunteer Panel members can request compensation such as reimbursement for mileage costs.

During the past year significant efforts were made to expand not only the number of individuals on each of the Panel, but also the composition of the Panels' membership to ensure both community representation and diversity. The membership growth in each individual region Panel, as well as the Panel as a whole, has increased significantly over the past year. The Central Region ACRP increased by 18% percent, while the Southern and Northern Regional Panels had a membership increase of 73% and 67%, respectively. The overall growth for the three Panels was 47%.

Many of the new members in each Panel now play or have played very important roles in Child Protective Service cases and/or law enforcement agencies, and know first-hand the many facets of the program. Approximately nine citizens who have joined the Panel were once served, or are family members to an individual, served by CPS. In addition, the ACRP welcomed six individuals from different law enforcement departments throughout Arizona. Each Panel has increased its diversity, with members representing a variety of schools, hospitals, non-profit organizations, and government agencies.

## **PANEL MEMBER SURVEY**

A survey of the Panel members was conducted in July of 2009 to provide CABHP staff information on Panel member's level of satisfaction and suggestions for improvement. Nineteen (19) Panel members completed the survey with 6 responses from Central (31.6%), 11 from Southern (57.9%) and 2 from Northern (10.5%) Panels. Overall, the majority of the respondents reported being satisfied as indicated by noting that they "agreed" or "somewhat agreed" as indicated below:

- 88% understood their role as a Panel Member
- 94% understood the mission of the ACRP
- 88% indicated that their regional Panel was comprised of members with diverse community representation
- 87% indicated that CABHP provides effective administrative support for the Panel
- 82% reported understanding the current case record review process

Suggestions for improvement focused on: case record review and case presentation process; desire to have County Attorney's represented on the Panel; need to trend data and compare Arizona's performance on indicators with other states; removal of members from the Panels who do not regularly attend; and the need for additional meetings/time. The complete survey results are included in Appendix H.

## **CAPTA REQUIREMENTS OF CITIZEN REVIEW PANELS**

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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; case record reviews of child fatalities and near-fatalities; and conducting outreach to communities. All of the findings and Panel recommendations were based on one or more of these activities.

## **REVIEW OF STATE PLAN**

CABHP and DCYF staff worked together to establish a process for each of the Panels to review and provide input into the state CAPTA plan prior to the federal submission. 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. During this review period, CABHP distributed and presented on the DCYF Semi-Annual Report including: the number and type of maltreatment reports; substantiation rates; out-of-home placements (e.g. race/ethnicity and reasons for removal) and number of foster homes.

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*. This instrument was created by the U.S. Department of Health and Human Services/Administration for Children and Families used to conduct the federal Child and Family Services Reviews (January 2007). See below for a description of the process and instrument.

## **COORDINATION BETWEEN STATE AND LOCAL FOSTER CARE AND ADOPTION SYSTEMS**

Although the case record review process addresses foster care and adoptions as related to the specific situation under review, this is an area that will be prioritized for 2010. A review of the coordination between state and local foster care and adoptions systems during our next review period will include examination of the implementation and outcomes of Arizona Court Teams.

## **PUBLIC OUTREACH AND SOLICITING PUBLIC COMMENTS**

Currently, 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. CABHP also developed an ACRP Program brochure (Appendix F) for distribution at events to inform the public, stimulate interest in the ACRP program and solicit volunteers. The brochure and CPR program information has also been distributed throughout Arizona by multiple community and advocacy email listservs (e.g., Council for Human Services Providers, RBHA, etc.)

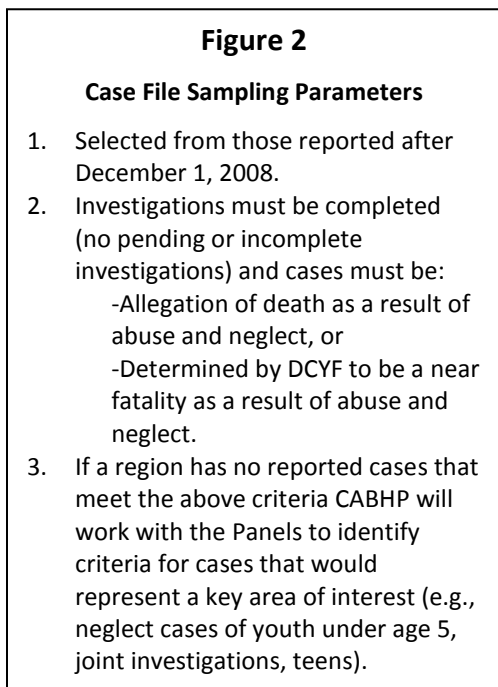
## **CASE RECORD REVIEW PROCESS**

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Over the past year, CABHP has worked with DCYF staff and Panel representatives to revise the case record review process and instruments. CABHP staff reviewed tools from other ACRPs across the United States and also incorporated recommendations from the *Citizen*

*Review Panels for Child Protective System: Guidelines and Protocols* (October 2001.)

Feedback from Panel members was obtained and incorporated into both the proposed process and tools. Restructuring the case record review process included: establishing



criteria for case selection; strengthening validity by standardizing the tool and developing comprehensive instructions; and aligning the tool with the DCYF Practice Improvement Instruments. Reviewed cases included both those in which children remain in the family's home and those in which children have been removed by CPS. The cases selected for review are not meant to be representative of all CPS cases, but rather an examination of cases of fatalities and near-fatalities and the specific steps followed during the course of open cases.

Previously, the case record reviews had been completed by Panel volunteers or one of the program coordinators. In order to reduce the burden on Panel members, streamline the process, and promote consistency across Panels, CABHP staff are now responsible for conducting the reviews.

CABHP have received training and have full access to the CPS electronic records (CHILDS) and are able to access needed information directly.

DCYF provides quarterly lists of all investigative reports which include allegations of fatalities and near-fatalities determined by CPS to be due to maltreatment. From this list, the CABHP Program Coordinator selects cases for review that meet the sampling parameters (Figure 2) and are consistent with the quarterly meeting themes. CPS staff provides a "hard" copy file to CABHP that contains information (e.g., autopsy reports, law enforcement records and service provider progress reports) that is not accessible through the CHILDS.

As previously noted, the case record review process is guided by the DCYF Practice Improvement Case Review Instruments (PICR), DCYF Quality Improvement Systems Procedures, and any relevant DCYF policies and procedures. An additional tool is completed on cases involving in-home or out-of-home placement. The period under review is for the last 12, except when prior history of CPS involvement is relevant to the case. CABHP utilize the DCYF PICR instruments to extract the information from CHILDS and as needed from the "hard" copy files.

The Panels are provided with ACRP Case Summary Forms (Appendix D), timeline of key events, and genograms of individual cases in advance of meetings to assist members in preparation for discussion. In addition, Panel members receive redacted copies of the



actual Safety and Risk Assessments completed by DCYF for each case. Information collected and discussed includes the following sections:

- 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 CPS Specialist (CPSS) made concerted efforts to gather and analyze sufficient and relevant information to accurately assess child safety including: decision on 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 gather to sufficient information about each of the 6 questions to confirm or exclude safety threats from the 17 safety threats listed in CSA; and if the CPSS analyzed all information gathered and accurately applies safety decisions.
- 3) Safety Planning to Protect Children in Home and Prevent Removal- information on whether CPSS took sufficient and least obtrusive actions to control present or impending danger (through protective action and safety plan) and ensure child(ren)'s safety in-home and prevent child(ren)'s entry into foster care or re-entry after reunification.
- 4) Initial Strengths and Risk Assessment and Provision of Services to Reduce Risks- information on whether CPSS 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; 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.
- 5) Determine Whether Maltreatment Occurred- information on whether CPSS made concerted efforts and gathered sufficient information and accurately applied legal and applied definitions of abuse and neglect including: determination if maltreatment occurred; if CPSS accurately applied substantiation guidelines and identified report as substantiated, proposed, unsubstantiated, or unknown for each report allegation.
- 6) Aftercare Planning- information on whether an aftercare plan was developed with input from family, and family was provided with adequate information on services and supports to address continuing or foreseeable needs including: if CPSS meet with parents or other caretakers and the child, if age 6 or older, to obtain their comments

and recommendations in regard to aftercare services; and if parents and children were provided sufficient information on community or other supports.

The DCYF Practice Improvement Case Review Instrument for In-Home or Out-of-Home section is completed for cases when in-home or out-of-home placement has occurred. The applicable information and criteria discussed by the Panels may include:

- ongoing safety and risk assessment and management
- permanency goal for child
- concurrent permanency planning
- independent living services
- 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 (reviewed only if allegations involve foster family placement)

The Panel recommendations and comments section focuses on precipitating factors that may have led to the case record event which may include:

- suspected event triggers
- family risk factors addressed and resolved
- factors that may have contributed to death
- joint investigation protocol
- instances of inadequate CPS supervision and communication
- potential policy issues or issues not addressed
- exemplary CPS practices that should be noted

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 and included in the recommendations section of this report.

## **SUMMARY OF CITIZEN REVIEW PANELS' CASE RECORD REVIEW FINDINGS**

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During this reporting period, ACRPs completed reviews of 18 cases of child maltreatment that occurred between December 1, 2008 and November 30, 2009. Eleven (11) of these cases were fatalities and seven (7) were near-fatalities. It is important to note that findings are based on the information available to the CABHP reviewers and presented to the Panel members.

Case record review findings summarized below are consistent with the state's process by which report 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**

DES received a total of 54 reports on the 18 cases reviewed by the Panel during the 2009 period. The number of reports received ranged from 1 to 9 with an average of three (3) reports per case. Seven (7) of the reviewed cases had no previous reports. Of the eleven (11) records with a previous CPS case, the number of prior substantiated cases ranged from 1 to 3. One-third or 33% of the cases with prior abuse and/or neglect allegations were substantiated.

### **INTAKE AND SCREENING**

The case record reviews identified this stage as a strength of the child protection system. The Panels found that reports taken by the CPS Child Abuse Hotline were complete, accurate, and timely in all 18 cases (100%). The timeframe for the initial response by CPS or law enforcement or other emergency personnel were within the allotted times determined by levels of risk (high, moderate, low, potential).

### **CRISIS INTERVENTION AND INITIAL CHILD SAFETY ASSESSMENT**

In 11 out of 18 investigations reviewed, the Panels concluded that CPS adequately fulfilled its role of assessing child safety. The Panels determined this stage to be an area that needs improvement. The Panels expressed concern about CPS' lack of thorough assessment of safety in 8 of the investigations reviewed including: information on interviews of persons in the home were either unclear or not included in 3 cases; the Child Safety Assessment safety threats and factors were not complete in 3 cases; and CPS staff did not assess safety of other children in the home in 2 cases.

### **FAMILY RISK FACTORS**

Panel members review specific family risk factors addressed by CPS during the initial investigation. Panels are able to determine if CPS adequately assessed, identified and resolved risks contributing to child maltreatment. The most prevalent family risk factors identified during the reviews were substance abuse (72.2%), lack of parenting skills (55.5%), mental health issues (44.4%), and domestic violence (44%). Methamphetamines (44.4%), alcohol (22.2%), and prescription drugs (22.2%) were the most prevalent types of drugs identified in 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 1 to 10 with an average of 5 risk factors identified per case.

Below are the risk factors identified (more than one factor may have been identified in a single case) in the 18 fatality and near fatality cases reviewed:

<i>Risk Factor</i>	<i>Frequency of cases (N=18)</i>
Lack of Parenting Skills*	10
Teen Parent	2
Substance Abuse	13
Mental Health Problems of Parent(s)	8
Domestic Violence	8
Lack of Anger Control	7
Lack of Physical/Mental Ability to Provide Adequate Care	1
Lack of Motivation to Provide Adequate Care	5
Lack of Resources for Adequate Food/Shelter/Medical/Child Care	5
Prior Child Death	0
Prior Removals by CPS/Severance of Parental Rights	6
Prior Unsubstantiated Reports	8
Prior Substantiated Reports	3

**\*Parenting skills should demonstrate an ability to provide for a child's basic needs and the capability to guide, educate, and discipline in a way that facilitates a child's positive social and emotional development.**

### **INVESTIGATION STAGE**

During case record reviews, Panel members discuss various aspects of each investigation, identifying areas of strength and needing improvement, as well as exemplary practices, within the CPS system. The Panels determined this stage as needing improvement in a number of areas. Panel members concluded that thorough investigations were completed on 13 out of the 18 cases reviewed (72.2%). Concerns noted included missing medical records in 3 cases, psychological evaluations in 3 cases, autopsy reports in 3 cases, law enforcement reports in 3 cases, school records in 2 cases, immunization records in 2 cases, safety monitor paperwork 1 case, and home studies in 1 case where it was determined by the Panel as pertinent to the investigation. Custody and visitation orders and results of drug tests were also absent from some of the records. In 2 cases, CPS failed to interview all relevant persons in home, and safety assessments did not address other children in home or documentation was incomplete. Background checks, absent from 3 cases, should have been completed on all adults in home.

## **INVESTIGATIVE FINDING/DETERMINATION**

The Panels concluded that documentation did not support the investigative findings in 7 of the 18 investigations reviewed. The Panels identified concerns regarding the inability of CPS to substantiate allegations of abuse and neglect, in spite of strong supportive evidence. In 4 of the 18 cases, there was evidence of prenatal exposure to substance abuse, but still no allegations of neglect were substantiated. Concerns were also noted in 1 case in which there were unsubstantiated reports despite multiple sources (e.g. school, juvenile probation, neighbors and police) alleging incidents of abuse or neglect. In 2 cases, the Panels found that inadequate information was gathered in the record and failure-to-thrive was not taken into consideration.

## **CASE PLANNING AND IMPLEMENTATION**

The Panels determined that in 10 of the 18 cases, case planning and ongoing case management activities were appropriate and timely. Concerns included refusal by parents or guardians to participate in services and inability of CPS to enforce case plans, as well as failure to include all family members in case plans. Additionally, Panels were concerned that in 2 of the reviews the case plans focused on the deceased child and did not fully address other siblings in home; and case plan did not address substance abuse.

## **FOSTER FAMILY SECTION**

There were no reports of child abuse or neglect involving an out-of-home caregiver.

## **CASE CLOSURE**

Panel members concluded that 6 of the 18 cases appeared to be closed prior to adequately resolving all safety issues. Concerns noted by Panel included lack of law enforcement involvement and repeated unsubstantiated reports from multiple sources (school, juvenile probation, neighbors and police); reunification plans that were premature considering the potential safety issues; and Medical Examiner findings that cause of death was undetermined ended further investigation of the case.

## **POLICY ISSUES**

At the conclusion of case reviews, Panel members determine if state and federal policies were followed. During this reporting period, the Panels concluded that state and federal policies were followed in 10 of the 18 cases. In cases, where policies were not followed, the Panels identified the failure to obtain pertinent records during the investigation in 2 cases, failure to obtain background checks on all family members in 3 cases, and failure to complete summary and review of prior reports and case histories on cases that involve three or more prior reports in 4 cases, failure to update documents in 1 case and lack of identification of child's failure-to-thrive.

## **POLICIES, PROCEDURES AND PRACTICE REVIEW**

Initially, CABHP proposed implementing a formal review schedule to review DCYF policies and procedures using a "staged approach" whereby the Panel would review policies associated with key functions and activities undertaken by CPS (e.g. Hotline, Intake & Screening; Investigation &

Assessment; Case Disposition; etc.). Panel members did not view that such an approach to be a productive use of their time and requested that more flexible review method be developed. The Panels decided to look at specific policies where practice deficits occurred as identified through case file reviews. A matrix that outlines the policies and procedures that were examined in each component of the case record review process is included in Appendix E. The Panels agreed to focus on policies related to themes discussed each quarter. DCYF staff also agreed to alert Panels to upcoming legislative policy changes. A hyperlink to the ACRP website for Panel members and the community to access CPS policies and procedure was created.

## **AREAS OF FOCUS FOR 2010 AND UPCOMING ENHANCEMENTS**

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CABHP is committed to providing Panel members with the information they need to fulfill the program requirements as outlined in the CAPTA and to make certain that 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 have been identified over the past year. Due to resource limitations, priorities must be established. Suggestions identified by DCYF representatives, CABHP staff and Panel members have included the following:

- 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.
- 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.
- Explore opportunities to utilize technology for enhancing participation and communication for Panel members and across Panels (e.g. video conferencing and cross Panel trainings).
- Continue to update the ACRP Program Manual and augment Panel member orientation.

- Identifying opportunities to recognize Panel members and their contributions to the CPS program.
- Explore means of data extraction to identify trends and develop comparisons across districts and construct matched comparisons (fatalities/no fatalities) to test for differences (e.g. case characteristics, procedures, etc.).
- As recommended by the ACRPs, CPS and Arizona State University will explore how graduate students can be utilized in the DCYF evaluation process.

CABHP and the Panel will work with the DCYF Practice Improvement (PI) Specialists in each of the State's six districts. The PI Specialists conduct case reviews, provide data and performance information to management and the Quality Improvement Manager, facilitate district action planning, and monitor and lead district practice improvement activities. District and Central Office staff review a random sample of initial assessment, in-home services and out-of-home cases from each district to measure the rate of outcome achievement and gauge current practice related to the Division's safety, permanency and well-being goals. Review of initial assessment cases focuses on implementation of the integrated CSA-SRA-Case planning process. In the upcoming year PI Specialists will attend at least one quarterly ACRP meeting to learn from the ACRPs' reviews and observations about cases. PI Specialist will also assist the Panel by filling gaps in case information, explaining relevant policies or practice standards, and identifying trends from their case reviews. This collaboration will assist the Panel in understanding whether or not a strength or need seen in a single case is part of a trend. Annual updates will be provided to the Panel on the priority practice improvement areas and activities. The ACRP Annual Report will be distributed to all the PI Specialists and the DCYF Management Team by the DCYF Policy Manager.

As noted previously, strategic planning with each of the Panels will occur to prioritize areas to focus on in upcoming years will be conducted during 2010. For example, this may include researching the needs of the teenage population as teens may have endured long-term neglect and at risk of being overlooked in the child welfare system. A copy of the strategic plan will be included in next year's report.

**APPENDIX A:**

**AGENCY RESPONSE  
TO  
CITIZEN REVIEW PANELS' 2008  
RECOMMENDATIONS**



## APPENDIX A

**Recommendation 1:** The Citizen Review Panels recommend that Child Protective Services and law enforcement agencies develop strategies to improve compliance with the established joint investigative protocols for all applicable cases. Particular attention should be paid to enhancing prompt communication and information sharing between Child Protective Services and law enforcement agencies. A similar recommendation was made in the 2007 annual report, and Child Protective Services has addressed these concerns through enhanced monitoring processes and measures (see Appendix A). Also, in 2008, legislation was passed to strengthen and clarify the development of joint investigation protocol procedures (HB 2455). The effects of these actions will be applicable to Panel case reviews beginning with the 2009 annual report.

**Response:** *The Department agrees with this recommendation and has taken appropriate measures to address this concern.*

*In response to 2008 legislation (HB 2455), the Governor's Office, in collaboration with the Department of Economic Security and the Attorney General's Office, organized and held a statewide two-day Joint Investigation Protocols Convening on August 12 and 13, 2008. The purpose of the Convening was to develop consensus around the basic fundamental principles that provide the foundation for county-specific protocols to "guide the conduct of investigations of allegations involving criminal conduct". Participants included representatives from each County Attorney; the County Sheriff; the chief law enforcement officer for each municipality in each County; CPS leadership (local, District and State); the Attorney General and other representatives of the Attorney General's Office; and other strategic stakeholders (such as schools, medical, mental health, child advocates, etc.)*

*To ensure a prompt and thorough investigation of an allegation involving criminal conduct, the joint investigation protocols include:*

- 1. The process for notification of receipt of criminal conduct allegations.*
- 2. The standards for interdisciplinary investigations of specific types of abuse and neglect, including forensic medical examinations.*
- 3. The standards for interdisciplinary investigations involving Native American children in compliance with the Indian Child Welfare Act.*
- 4. Procedures for sharing information and standards for the timely disclosure of information.*
- 5. Procedures for coordination of screening, response and investigation with other involved professional disciplines and notification of case status and standards for the timely disclosure of related information.*
- 6. The training required for the involved Child Protective Services workers, law enforcement officers and prosecutors to execute the investigation protocols, including forensic interviewing skills.*

7. *The process to ensure review of and compliance with the investigation protocols and the reporting of activity under the protocols.*
8. *Procedures for an annual report to be transmitted within forty-five days after the end of each fiscal year independently from Child Protective Services and each County Attorney to the Governor, the Speaker of the House of Representatives and the President of the Senate. This report shall include:*
  - a. *The number of criminal conduct allegations investigated and how many of these investigations were conducted jointly pursuant to the investigation protocols.*
  - b. *Information from each County Attorney regarding the number of cases presented for review, the number of persons charged in those cases, the reasons why charges were not pursued and the disposition of these cases.*
  - c. *The reasons why a joint investigation did not take place.*

*The Convening, facilitated by Theresa Costello and Emily Hutchinson from the National Resource Center for Child Protective Services, provided an opportunity for participants to discuss, assess, and draw conclusions about:*

- *challenges surrounding the joint investigation protocols;*
- *roles and responsibilities;*
- *strategies to improve compliance with the established joint investigative protocols for all applicable cases;*
- *problem resolution for the joint investigative protocols and procedures statewide; and*
- *protocol development.*

*The results from this Convening were distributed in September 2008, and include key joint investigation principles and mutual commitments for Child Protective Services, Law Enforcement, and the County Attorney of how criminal conduct allegations and investigations would be handled. Prompt communication and information sharing between Child Protective Services, law enforcement agencies, and other professionals involved in the investigation was a key area of focus. All the representatives from the Convening were encouraged to utilize strategies to strengthen their county joint investigation protocols and to clarify any local variations in procedures which may create confusion.*

*In September 2008, the Department strengthened and clarified the following in policy:*

- *joint investigation protocols will guide the investigation of child abuse or neglect involving criminal conduct allegation;*
- *the CPS Specialist must notify and coordinate with the appropriate law enforcement agency when a report alleges criminal conduct;*
- *the CPS Specialist must consult the appropriate county joint investigation protocols when developing a strategy to initiate and complete the investigation including who should be interviewed; the sequencing of interviews; who should participate in the interviews; arranging medical examinations of child victims; frequent and open communication to discuss the status of the case; obtaining and sharing information in a timely manner; identifying actions needed to ensure child safety, etc.;*

- *when law enforcement is not able to respond jointly within the Department's response timeframes, the CPS Specialist should explain to the law enforcement agency that the Department must proceed with the investigation in order to ensure the child's safety; then proceed with the investigation; and*
- *CPS staff must protect the child's rights as a victim of crime by not allowing the alleged abusive person or any other person to threaten, coerce, or pressure the child victim, or to be present during interviews, family meetings, or other Departmental actions with the child victim.*

**Recommendation 2:** The Citizen Review Panels recommend that Child Protective Services more closely review its decisions when determining investigative findings. In cases where additional information has been received after a finding has been made to comply with statutory timeframes, Child Protective Services should review and amend the finding as necessary. A similar recommendation was made in the 2007 annual report, and Child Protective Services has addressed these concerns through improved quality assurance processes and measures (see Appendix A). The effects of these actions will be applicable to Panel case reviews beginning with the 2009 annual report.

***Response: The Department agrees with this recommendation and has taken appropriate measures to address this concern.***

*The Department has addressed this concern through implementation of a quality assurance program. The quality assurance process includes a thorough review and evaluation of the evidence collected to support or not support the finding, and whether concerted efforts were made to gather pertinent information to determine if an allegation of child abuse or neglect should be substantiated.*

*The quality assurance of practice continues to occur at all levels of the Department as follows:*

- *The review instrument includes an assessment of whether the agency made a concerted effort to gather sufficient information to determine whether maltreatment occurred, and whether the field unit accurately applied the substantiation guidelines to the information obtained to identify the report as substantiated or unsubstantiated.*
- *Each month, the outcome of each review is discussed with the District Program Manager or Assistant Program Manager and the assigned Supervisor and CPS Specialist. If the review found this to be an area needing improvement, the CPS Specialist and Supervisor are provided information about the specific practice standards relevant to the case, the substantiation guidelines, and/or resources for consultation about investigation findings, according to the Specialist's identified needs. Practice areas needing improvement are identified and a worker specific performance improvement plan may be developed and implemented.*
- *Each district's aggregated case review findings are provided in monthly reports to the District Program Managers and Central Office leadership. Program Managers distribute the findings within their districts, and discuss the results at monthly district leadership meetings.*
- *Statewide aggregated case review findings are provided in quarterly reports to the*

*District Program Managers and Central Office leadership. Program Managers distribute the findings within their districts, and discuss the results at monthly district leadership meetings. Central Office leadership reviews the results to identify necessary additional program or practice improvement actions. These reports are also provided to the Child Welfare Training Institute so that identified needs can be addressed in initial, refresher, or advanced training.*

- *If the review identifies a case in which a finding is not supported by the evidence, the Practice Improvement Manager consults with the Protective Services Review Team and subsequently recommends to the Supervisor and CPS Specialist that the finding be amended accordingly.*

*The Protective Services Review Team continues to provide training to unit field staff regarding the evidence required to substantiate child abuse and neglect. Evidence required and documentation “tips” are accessible under public folders where all staff can refer to for clarity.*

*Implemented in February 2008, the Division’s revised Critical Incident Review process continues to include an assessment of the evidence collected to support or not support the finding, and whether concerted efforts were made to gather pertinent information to make a finding. This process includes a thorough review of the facts regarding a critical incident. If the review indicates that the decision to substantiate or not to substantiate an incident of child abuse or neglect was not supported by the evidence, the District is directed to revise the finding accordingly.*

*In September 2008, the Department clarified and strengthened its policy regarding obtaining and reviewing information when determining investigative findings. The following areas of policy were reinforced:*

- *Fatality and Near Fatality: Guidance was provided to assist the CPS Specialist in gathering information from a medical professional (physician, doctor of osteopathy, physician’s assistant, or licensed nurse practitioner) when documenting whether a child fatality or near fatality was the result of abuse or neglect.*
- *Collection and Review of Records: Clarifies under what circumstances medical, behavioral health and educational records should be obtained and reviewed during the investigation process.*

**Recommendation 3:** The Citizen Review Panels recommend that Child Protective Services caseworkers be more diligent in consistently documenting all steps of their investigations. The Panels recognize that large caseloads and staff turnover affect Child Protective Services caseworkers’ ability to document consistently all investigative activities.

**Response:** *The Department agrees with this recommendation. The Practice Improvement Unit has developed a number of tools and guides to inform and assist staff in their documentation of all steps of their investigation. These tools, guides, and tips are distributed to district field staff and reinforced through the case review process. The case record review instrument utilized by the Program Improvement Specialist targets all areas of the investigation. Direct feedback is provided to field staff when a specific practice area is lacking documentation and also when there is outstanding documentation.*

*In October 2008, the “Keys to Documenting a Comprehensive Initial Assessment” guide was also developed as an additional tool for staff to reference and utilize in improving their documentation skills.*

*In 2008, the Child Welfare Training Institute developed a documentation curriculum to aid staff in improving case record documentation. The main areas of focus include how staff should notate relevant and complete information in the case record. This training was initially delivered in District IV in January 2009. Additional district trainings have been suspended due to budget constraints, but will continue once this suspension is lifted.*

*In February 2009, the Program Improvement Specialists, Child Welfare Training Institute staff, and Policy staff developed a “model case example” for use as a training tool for documenting the Child Safety Assessment and Strengths and Risks Assessment. This case example was disseminated to district field staff. The Department will continue to assist staff in strengthening documentation by providing ongoing feedback, training and developing additional “model case examples” for staff use.*

**Recommendation 4:** The Citizen Review Panels recommend that Child Protective Services develop protocols to identify, assess, and intervene in cases of chronic neglect. Cases of chronic neglect can extend over many years and involve multiple caregivers. These cases require complex strategies and a high level of coordination among many agencies and stakeholders.

**Response:** *The Department agrees with this recommendation. The Department acknowledges the need to augment its policy and practice to provide more informed direction to staff regarding the identification, assessment, and intervention in cases of chronic neglect.*

*The Department will complete a thorough review of the literature concerning chronic neglect including national child welfare data to determine “best practice” standards regarding:*

- *identification of chronic neglect—how it differs from poverty,*
- *thorough and comprehensive assessment of chronic neglect in child welfare,*
- *fundamental impact of neglect,*
- *the cumulative harm effect of chronic neglect, and*
- *evidence-based practice intervention.*

*Once this review has been completed, the Department, in collaboration with designated stakeholders and with the technical assistance via the U.S. Department of Health and Human Services, will develop and/or augment its policy and procedures concerning chronic neglect.*

*It should be noted that in May 2008, the Division of Children, Youth and Families (DCYF) and the Division of Developmental Disabilities (DDD) joined efforts to develop a protocol to collaborate in cases involving children who have suffered abuse due to chronic neglect and who are involved in both service delivery systems. The goal of the protocol is to improve the Department's response, assessment, collaboration, and intervention in cases involving special needs children. The draft protocol focuses on the following primary scenarios:*

- *How DCYF will respond to a report when a child(ren) has an open DDD case.*
- *How DCYF will respond when a child was not initially known to have been involved with DDD, but, through the course of an investigation, it is determined DDD is involved with the family.*
- *How DCYF and DDD will respond, when during the course of an investigation, DCYF determines the child may be in need of DDD services.*
- *How DCYF and DDD will collaborate to serve children involved in in-home intervention and dependency cases.*

*The joint Divisional workgroup developed policy, procedures, and training for designated staff. The changes strengthen and clearly define how the coordination between Divisions and other stakeholders should look when working with these children. The draft protocols are pending final approval. Implementation of these protocols has been suspended due to budget constraints, but will move forward once this suspension is lifted.*

**Recommendation 5:** The Citizen Review Panels recommend that Child Protective Services develop strategies to address complex, interconnected families. These strategies should address staff communication and consistent decision-making. Due to the increasing complexity of family relationships (e.g. kin placements, divorces, remarriages, live-in significant others, extended families), Child Protective Services caseworkers need the ability to better assess and address child safety when an adult or child is involved in more than one case, household, or family.

**Response:** *The Department agrees with this recommendation. The Department policy and procedures requires CPS staff to collect and thoroughly review and consider all available information in the assessment of child safety and provision of services. Prior CPS history pre-populates the background section of the Child Safety Assessment template, and the CPS Specialist is directed to complete an analysis of this information and determine its impact upon child safety.*

*In September 2008, the Department revised its policy to clearly identify all persons that must be interviewed and included in the assessment of child safety and risk of harm during the course of an investigation. The following policy revisions were made to strengthen and guide decision-making:*

*Unless case specific circumstances indicate otherwise, the following individuals should be interviewed. The timing and sequencing of interview, who conducts and/or participates in the interviews, and the circumstances upon which the interview is conducted may be affected by the respective county's joint investigation protocols for criminal conduct allegations.*

- *the reporting source;*
- *alleged victim of child abuse or neglect;*
- *siblings and other children in the home where the child victim resides;*
- *siblings and other children in the home where the alleged abuse or neglect occurred, if different from the child's primary residence;*
- *custodial parent;*
- *the spouse or partner or significant other (boyfriend, girlfriend, etc.) of the custodial parent;*
- *all other adults living in the home where the alleged abuse or neglect occurred;*
- *non-custodial parent of the child victim when the identity and whereabouts can be reasonably determined, and such contact would not be likely to endanger the life or safety of any person or compromise the integrity of a criminal investigation or the CPS investigation;*
- *the alleged abusing or neglecting person.*
- *other persons known to have knowledge of the abuse or neglect, or who could confirm or rule-out 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.*

*Once an assessment of present danger is complete, proceed with the initial child safety assessment to determine whether any child is unsafe due to impending danger. The following individuals must be included in the Child Safety Assessment:*

- *alleged victim of child abuse or neglect;*
- *siblings and other children in the home;*
  - *If a child who does not reside within the child victim's primary residence provides information that indicates he/she has been or may be abused or neglected, a report on that child's household must be made to the Child Abuse Hotline. Do not include this child in the assessment for the current report.*
- *the alleged abusing or neglecting person;*
- *other adults (including the spouse, partner, or significant other including a boyfriend, girlfriend, etc.) who have caregiving responsibilities for the child; and*
- *the non-custodial parent who:*
  - *has parenting time with the child; or*
  - *is being considered as a placement for the child.*

*Currently, Child Abuse Hotline staff searches multiple databases including CHILDS to identify demographic data and any child welfare information that may assist in the child safety assessment. When known, associated cases are linked to the primary report or case prior to field assignment.*

*The Department will review and revise as applicable its policy, procedures and practice to clearly articulate the expectation and requirement that the CPS Specialist will review and consider information about a case participant that is available in another case in the assessment of child safety and future risk of harm. Department policy will require, at a minimum, case consultation between involved CPS Specialists and their Supervisors when a case participant appears in more than one open case.*



**APPENDIX B:**  
**2009 ANNUAL MEETING CALENDAR  
AND AGENDAS**

## APPENDIX B

	<b>SOUTHERN REGION</b>	<b>CENTRAL REGION</b>	<b>NORTHERN REGION</b>
	<b><u>9:00 – 12:00</u></b>	<b><u>9:00 – 12:00</u></b>	<b><u>1:00 – 4:00</u></b>
<i>1<sup>st</sup> Quarter</i>	March 16	March 13	March 23
<i>2<sup>nd</sup> Quarter</i>	June 15	June 12	June 22
<i>3<sup>rd</sup> Quarter</i>	September 21	September 11	August 31
<i>4<sup>th</sup> Quarter</i>	December 7	December 11	November 30

### **1<sup>ST</sup> QUARTER MEETING AGENDA**

Welcome and Introduction  
CABHP Data Presentation “CPS System Overview”  
DCYF Program Report -2009-2010 CAPTA Plan and DCYF Budget  
Policy Review - Process to Conduct a Comprehensive Review of CPS/ Prioritizing Chapters  
Discuss Proposed Revisions to Case Record Review Protocol and Sampling Criteria  
Recommendations from 1st Quarter Meeting  
Identify Requests for Next Meeting

### **2<sup>ND</sup> QUARTER MEETING AGENDA**

Welcome and Introduction  
Review of 1<sup>st</sup> Quarter Meeting Minutes  
Data Presentation “Characteristics of Substantiated vs. Unsubstantiated Reports -Arizona Data Under the Age of Five”  
Chronic Child Neglect and Discussion  
Case Record Review Presentation “Child Fatalities and Near Fatalities Under the Age of Two” and Related Policies  
DCYF Program Report-IV-B Safety Outcomes  
Recommendations from 2<sup>nd</sup> Quarter Meeting  
Identify Requests for Next Meeting

### **3<sup>RD</sup> QUARTER MEETING AGENDA**

Welcome and Introduction  
Review of 2<sup>nd</sup> Quarter Meeting Minutes  
Data Presentation “Joint Investigations and Statutory Mandates” and “Methamphetamine and Drug Endangered Children Protocols ”  
Case Record Review Presentation and Related Policies/Data Presentation  
DCYF Program Report - Joint Investigations of Criminal Conduct Allegations and IV-B Safety Outcomes  
Recommendations from 3<sup>rd</sup> Quarter Meeting  
Identify Requests for Next Meeting

### **4<sup>TH</sup> QUARTER MEETING AGENDA**

Welcome and Introduction  
Review of 3<sup>rd</sup> Quarter Meeting Minutes  
Data Presentation “Key Constituent Groups & Role of Panel in Outreach and Education”  
Case Record Review Presentation and Policies Related to Case Record Review/Data Presentation  
Internal Quality Assurance and Grievance/Complaint Processes  
DCYF Program Report - CAPTA Implementation Plan and Update on Panels’  
Recommendations  
Recommendations from 4<sup>th</sup> Quarter Meeting  
Identify Requests for Next Meeting and Identify Priorities for 2010

## Arizona Citizen Review Panel 2009 Meeting Locations

### SOUTHERN REGION

La Paloma Family Services  
870 West Miracle Mile  
Building A  
Tucson, AZ 85705  
(520) 750-9667  
<http://www.lapalomakids.org>  
Free parking located on site.

### 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/>  
Free parking located at Valley Youth Theater at the southeast corner of Fillmore and 1st Street.

### NORTHERN REGION

Catholic Charities Community Services  
460 North Switzer Canyon Drive  
Suite 400  
Flagstaff, AZ 86001  
(928) 774-9125  
<http://www.catholiccharitiesaz.com/coconino.aspx>  
Free parking located on site.

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

Lisa Moen  
Program Coordinator, Sr.  
Phone: (602) 496-1480  
Email: [lisa.moen@asu.edu](mailto:lisa.moen@asu.edu)

**APPENDIX C:**  
**CITIZEN REVIEW PANEL MEMBERS**

## APPENDIX C

### CENTRAL REGION CITIZEN REVIEW PANEL MEMBERS

Beth Rosenberg  
Children's Action Alliance

Cindy Copp  
ADES/Administration for Children,  
Youth & Families

Gary Brennan  
Quality Care Network

Ivy Sandifer, M.D.

Jo Fuhrmann  
CHEERS, Inc.

Joelle Minitti  
ADES/Administration for Children,  
Youth & Families

Kara VanHise  
Ombudsman's Office

Linda Madrid  
Arizona State University

Lisa Barrientos  
Mesa Police Department

Mikayla Bailey-Null  
Citizen

Minerva Gant  
ADES/Administration for Children,  
Youth & Families

Nancy Logan  
Social Security Administration/  
Office of Disability

Natalie Miles Thompson  
Crisis Nursery

Pamela Fitzgerald  
Citizen

Pamela Ruiz  
Hospice of the Valley

Princess Lucas-Wilson  
ADES/Division of Developmental Disabilities

Roger Marshall  
Maricopa County Sheriff's Office

Roy Teramoto, M.D  
Indian Health Services

Samantha Nordvold  
Madison School

Simon Kottoor  
Sunshine Group Home

### CITIZEN REVIEW PANEL MEMBERS REPRESENTATION - CENTRAL

Private Citizens	Educators	Mental Health Care	Legal Professionals	Law Enforcement	Health Care Professionals	Social Services	Child & Family Advocates	Adoptive Parents	Adoptees	Foster Parents	Foster Care Alumni	Faith Based	Tribal	District Rep DCYF	DCYF
							X								
														X	
		X													
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					X										
	X														
						X									

**SOUTHERN REGION  
CITIZEN REVIEW PANEL MEMBERS**

Amy Gomez  
Pima County Attorney's Office

Anna Binkiewicz, M.D.  
Citizen

Barbra Quade  
Jewish Family Services

Carla Hinton, Ph.D.  
Amphitheatre Public Schools

Christie Kroger  
ADES/Administration for Children, Youth &  
Families

Cindy Graupmann  
Citizen

Cynthia Killion  
Amphitheatre Public Schools

David Reynolds  
Sunnyside High School

Gloria Bernal  
Sycamore Elementary School

Jaymie Jacobs  
Office Pima County School Superintendant

Joan Mendelson  
Citizen

Joanne Karolzak  
Casa de los Ninos

Joy Subrin  
Northwest Medical Center

Karen Harper  
Southern Arizona Children's Advocacy Center

Laurie San Angelo  
Office of the Arizona Attorney General

Linda Johnson  
AZDES/Administration for Children,  
Youth & Families

Lisa Jacobs  
Casa de los Ninos

Lynn Kallis  
Pilot Parents of Southern Arizona

Martha McKibben  
Northwest Medical Center

Marty Fuentes  
Tohono O'Odham Police Nation Department

Sandy Guizzetti  
Arizona Supreme Court/Foster Care Review  
Board

Scott Gamble  
Tohono O'Odham Police Nation Department

Stacy Meade  
Citizen

Susan Anderson  
UPH Hospital

Susan Eazer  
Pima County Attorney's Office

Susie Huhn  
Casa de los Ninos

Tish Kleiman  
Citizen

Yariet Camarena  
ADES/Administration for Children,  
Youth & Families

### CITIZEN REVIEW PANEL MEMBERS REPRESENTATION - SOUTHERN

Private Citizens	Educators	Mental Health Care	Legal Professionals	Law Enforcement	Health Care Professionals	Social Services	Child & Family Advocates	Adoptive Parents	Adoptees	Foster Parents	Foster Care Alumni	Faith Based	Tribal	District Rep DCYF	DCYF
			X												
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	X	X													
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**NORTHERN REGION  
CITIZEN REVIEW PANEL MEMBERS**

Beya Thayer  
Citizen

Gene Shantz  
Coconino County Sheriff's Office

Jill Sanchez  
Coconino County Superior Court

Judy Gideon  
Citizen

Julie Wood  
Arizona's Children Association

Mary Ellen Sandeen  
Yavapai Regional Medical Center

Maura Cluff  
Catholic Charities Community Services

Sandra Lescoe  
ADES/Administration for Children,  
Youth & Families

Suzette Vigil  
ADES/Administration for Children,  
Youth & Families

## CITIZEN REVIEW PANEL MEMBERS REPRESENTATION - NORTHERN

Private Citizens	Educators	Mental Health Care	Legal Professionals	Law Enforcement	Health Care Professionals	Social Services	Child & Family Advocates	Adoptive Parents	Adoptees	Foster Parents	Foster Care Alumni	Faith Based	Tribal	District Rep DCYF	DCYF
						X									
															X
				X											
			X												
								X		X					
						X									
					X										
							X								
X															
														X	

**APPENDIX D:**

**CITIZEN REVIEW PANEL  
CASE RECORD SUMMARY FORM**

**APPENDIX D**

**CABHP Summary and Case 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 an /or may be relevant to the current case being reviewed (e.g. substance use, criminal history, etc.)*

***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.*

- A. ***DCYF 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 DCYF record and/or collected from CHILDS. **Key Findings**-document findings of safety & risk assessment and investigations, plus any relevant decisions made by DCYF and the courts. **Comments**- additional information that would be beneficial to share with ACRP members, DCYF Administration and/or CABHP staff.*

Item	Significant Information, Key Findings & Comments
<b>Item 1 Timeliness of Initiating Investigation of Reports of Child Maltreatment</b>	<i>Consider also the relevance and sufficiency of the information gathered during current or prior CPS investigations and case planning</i>
<b>Item 2 Initial Child Safety Assessment</b>	<b>-ATTACH COPY OF CSA FROM CHILDS-</b>
<b>Item 3 Safety Planning to Protect Child(ren) in Home and Prevent Removal</b>	<b>-ATTACH COPY OF CSA FROM CHILDS-</b>
<b>Item 4 Initial Strengths &amp; Risk Assessment and Provision of Services to Reduce Risks</b>	<i>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.</i>  <b>-ATTACH COPY OF SRA FROM CHILDS-</b>
<b>Item 5 Determining Whether Maltreatment Occurred</b>	
<b>Item 6 Aftercare Planning</b>	

**B. DCYF 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 ACRP members, DCYF Administration and/or CABHP staff.

Item	Significant Information, Key Findings & Comments
<b>Item 1- Ongoing Safety and Risk Assess. And Safety Management</b>	<b>-ATTACH UPDATES OF SRA FROM CHILDS-</b>
<b>Item 2- Permanency Goal for Child</b>	
<b>Item 3- Concurrent Permanency Planning</b>	
<b>Item -Independent Living Services</b>	
<b>Item 5-Visiting with Parents &amp; Siblings in Foster Care</b>	
<b>Item 6- Relative Placement</b>	
<b>Item 7- Needs &amp; Services of Child, Parents and foster Parents</b>	
<b>Item 8- Case Plan Development</b>	
<b>Item 9- Worker Visits with Child</b>	
<b>Item 10- Worker Visits with Parents</b>	
<b>Item 11- Educational Needs of the Child</b>	
<b>Item 12- Physical Health of the Child</b>	
<b>Item 13- Mental/Behavioral Health of the Child</b>	
<b>Foster Homes</b>	<i>Complete only if allegations involve foster family placement. Identify any findings from foster care review board on their barriers.</i>

**C. Panel Recommendations and Comments**

<b>Precipitating Events and/or Suspected Triggers:</b>	
<input type="checkbox"/> Commission of Another Crime	<input type="checkbox"/> Crying
<input type="checkbox"/> Family Violence	<input type="checkbox"/> Disobedience
<input type="checkbox"/> Revenge	<input type="checkbox"/> Feeding Difficulty
<input type="checkbox"/> Gang Activity	<input type="checkbox"/> Toilet Training
<input type="checkbox"/> Other: _____	
<b>Family Risk Factors:</b>	
<input type="checkbox"/> Substance Use	<input type="checkbox"/> Lack of Resources for Adequate Food/Shelter/ Medical/Child Care
<input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Lack of Parenting Skills
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Teen Parent
<input type="checkbox"/> Violence Outside the Home	<input type="checkbox"/> Prior Child Death
<input type="checkbox"/> Lack of Physical or Mental Ability to Provide Adequate Care	<input type="checkbox"/> Lack of Motivation to Provide Adequate Care
<input type="checkbox"/> Lack of Anger Control	<input type="checkbox"/> Co-sleeping with Infant
<input type="checkbox"/> Prior Removals by CPS or Severance of Parental Rights	
<input type="checkbox"/> Prior Substantiated Reports	
<input type="checkbox"/> Other: _____	
<b>Were all risk factors identified in the record? Yes ___ No ___</b> <b><i>If not, specify additional risk factors identified by the Panel members:</i></b>	
<b>Were all identified risk factors addressed and/or resolved? Yes ___ No ___</b> <b><i>If not, describe:</i></b>	
<b><i>Joint Investigation:</i></b> Reference the joint investigation protocol for the applicable region and note any areas in which the protocol was not followed.	
<b>Was a thorough investigation completed? Yes ___ No ___</b> <b><i>If no describe:</i></b>	
<b><i>Supervision:</i></b> 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.	

<p><b>Potential Policy Issues:</b> 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.</p>
<p><b>Exemplary Practices:</b> note any practices that should be shared to encourage the continued practice.</p>
<p><b>Other:</b> 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.</p>
<p><b>What actions does the Panel believe could have been taken to prevent/avoid this event:</b></p>
<p><b>Recommendations:</b></p>

**Demographics**

**Age of Child:** \_\_\_\_\_ **Race:** \_\_\_\_\_ **Hispanic/Latino:** \_\_\_\_\_

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

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

**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 the 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:**  
**POLICIES EXAMINED THROUGH**  
**CASE RECORD REVIEWS**

## APPENDIX E

<b>Practice Improvement Case Review Instrument</b>		
<b>Item</b>	<b>Chapter</b>	<b>Sections</b>
1-Timeliness of Investigation of reports of Child Maltreatment	1	Section 3 Prioritizing Reports and Response Section 4 Disposition of Reports Section 1 Interviews With The Child, Family And Collateral Contacts Section 3 Efforts To Locate The Child Victim And Family
2-Initial Child Safety Assessment	2	Section 2 Conducting The Child Safety Assessment
3-Safety Planning to Protect Child(ren) in Home and Prevent Removal	2	Section 2 Conducting The Child Safety Assessment Section 3 Safety Planning
4-Initial Strengths & Risk Assess. Provision of services to Reduce Risks	2 3 5	Section 13 Assessing the Risk of Future Harm: Using the Family Centered SRA Section 2 Providing Emergency Intervention Section 1 Determining Whether to Open the Case for Ongoing Services
5-Determining Whether Maltreatment Occurred	2 2	Section 12 Determining Whether Maltreatment Occurred Section 3 Efforts to Locate the Child Victim and Family Exhibit 11-Substantiation Guidelines
6-After Care Planning	9	Section 19 Accessing Services Required by the Case Plan: Provision of Aftercare Services
<b>In Home or Out of Home Tool</b>		
<b>Item</b>	<b>Chapter</b>	<b>Sections</b>
1-Ongoing Safety and Risk Assess. and Safety Management	2 2	Section 2 Conducting The Child Safety Assessment Section 13 Assessing the Risk of Future Harm: Using the Family Centered SRA
2-Permanency Goal for Child	9 11 12 15 15	Section 2 Determining the Permanency Goal for a Child Section 5 Changing the Permanency Goal from Family Reunification Section 3 Petitioning for Termination of Parental Rights Section 1 Selecting Guardianship as a Permanency Goal Section 8 Long-Term Foster Care as a Planned Permanent Living Arrangement

<b>Item</b>	<b>Chapter</b>	<b>Sections</b>
3-Concurrent Permanency Planning	9	Section 3 Developing and Implementing Concurrent Permanency Plan
4-Independent Living Services	16 6	Independent Living Services and Supports Section 20 Locating Children on Runaway Status
5-Visiting with Siblings in Foster Care	7	Section 1 Ensuring Visitation Between Children in Out-of-Home Care and Their Family Exhibit 26 Visitation Supervision Continuum
6-Relative Placement	6	Section 4 Assessing the Placement Needs of Children Who Require Out of Home Care Section 5 Selecting an out of Home Caregiver Section 6 Providing Kinship Foster Care Services Section 2 Finding Missing Parents, Relative, and Other Significant Persons
7-Needs and Services of Child, Parents, and Foster Parents	6 9 16	Providing Out-of-Home Services Under a Dependency Petition Developing the family-Centered Case Plans Independent Living Services and Supports
8-Case Plan Development	9	Developing the Family-Centered Case Plan Exhibit 27 Ensuring a Meeting with the Family is Family-Centered Exhibit 39 Cultural Competence: Starting Where the Family Is At
9-Worker Visits with Child	6	Section 8 Providing Supervision of Children in Out-Of-Home Care Exhibit 23 Supervision and Contacts with Children in Out-Of-Home Care
10-Worker Visits with Parents	9	Section 4 Planning and Implementing Services and Supports Necessary to Achieve the Permanency Goal
11-Educational Needs of the Child	6	Section 10 Meeting the Educational Needs of the Children in Out-Of-Home Placement
12-Physical Health of the Child	6	Section 11 Meeting the Medical Service Needs of the Children in Out-Of-Home Placement
13 -Mental/Behavioral Health of the Child	9	Sections 12-14 on accessing behavioral health services

**APPENDIX F:**

**ARIZONA CITIZEN REVIEW PANEL  
PROGRAM BROCHURE**

## OUR MISSION

The mission of the Citizen Review Panel Program is to assess the Child Protective Services system and make recommendations for continuous improvements that will help ensure the safety and well being of Arizona children and families.



This document was prepared by the Center for Applied Behavioral Health Policy (CABHP), College of Public Programs, Arizona State University, under contract number DE091156001 with the Arizona Department of Economic Security, Division of Children, Youth and Families (ADES/DCYF).

For more information about the  
**Arizona Citizen  
Review Panel Program**

visit  
[www.cabhp.asu.edu](http://www.cabhp.asu.edu)

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**Center for  
Applied Behavioral  
Health Policy**

ARIZONA STATE UNIVERSITY

# ARIZONA CITIZEN REVIEW PANEL PROGRAM



**CITIZEN VOLUNTEERS  
NEEDED!**

This is your invitation to become  
an advocate for the protection  
and welfare of children and  
families.

**Learn how to get involved.**



Are you interested in promoting positive change in the lives of abused and neglected children in your community and in Arizona?

Would you like to participate on a volunteer panel that addresses important issues related to Child Protective Services (CPS) and that develops recommendations for improvement?

Can you devote two hours for preliminary training and approximately three hours once every three months to participate in Citizen Review Panel meetings?



**“The promise of citizen review panels is realized when vulnerable children are better protected as a result of new perspectives on old problems.”**

— Panel Member

**BACKGROUND:** The Arizona Citizen Review Panel Program began in 1999 in response to a 1996 amendment to the Child Abuse Prevention and Treatment Act (CAPTA) that required states to establish Citizen Review Panels. The three regional panels are located in Phoenix, Tucson and Flagstaff.

**OBJECTIVES:** The objectives of the Citizen Review Panels are to review Child Protective Services state policies, current practices, pertinent data, and case file information on CPS-involved children and families. The panels evaluate the extent to which Child Protective Services is fulfilling its child protection responsibilities, including coordination with foster care and adoption programs. The panels make recommendations to Child Protective Services for system changes and improvements and submit annual reports of activities and goals.

**VOLUNTEERS:** Panels are comprised of 12 to 15 volunteers of diverse backgrounds and experience. Members may include private citizens or professionals such as: educators; child advocates; attorneys; law enforcement professionals; health care, mental health and social service providers; adoptive and foster care parents; and foster care alumni.



### **DESIRED QUALITIES:**

- Compassion for children and families
- Ability to work, listen and cooperate with other team members
- Ability to think independently and impartially
- Sensitivity to ethnic, cultural, economic diversity and mental and physical disabilities
- A high standard of confidentiality
- Ability to participate in quarterly panel meetings
- Willingness to make a commitment of two years

**APPENDIX G:**  
**QUARTERLY ACTIVITIES**



## APPENDIX G

### CITIZEN REVIEW PANEL 1<sup>ST</sup> QUARTER ACTIVITIES

In early February 2009, the office of the Assistant Director of the Division of Child, Youth and Families mailed letters to all ACRP members introducing CABHP as the coordinators for the statewide Panels. The ACRP Program Coordinator followed up with personal phone call to members. CABHP staff centralized logistical and staff support of three regional Panels in Central, Southern, and Northern Arizona, and developed an annual 2009 calendar of meetings.

Meeting facilities were established at Arizona State University School of Social Work in Phoenix, La Paloma Family Services in Tucson, and Catholic Charities Community Services in Flagstaff. The 1st Quarter Panel meetings were held on March 13th, 16th and 23rd respectively. Agendas, policies, presentations and other materials were emailed to members prior to each meeting. Mileage reimbursement was offered to Panel members who are former CPS' clients, family members and family advocates. Attendance included 15 participants on the Central Panel, 11 on the Southern Panel, and 9 on the Northern Panel.

DCYF staff provided a program report on the CAPTA plan and the DCYF budget. CABHP presented an overview of CPS and engaged the Panels in discussion of case record and policy review procedures. Panels established terms of membership, training and orientation plans for new members and revisions to the ACRP Manual. The Panels were involved in redesigning the case record review tool. Initial considerations on how to examine coordination between state and local child protection systems and state and local foster care and adoption system was also introduced. Strategies were briefly discussed with Panels on how to develop collaborative relationships with the ACRP's and foster care, adoption and other related agencies. Recruitment to target a diverse community representation for each regional Panel was begun through Panel members' referrals, networking, and advertising.

The Panel meetings were tape recorded, formal meeting minutes were transcribed and posted, along with other meeting materials, to a newly created ACRP Intranet website.

CABHP staff began discussions with DCYF staff on collecting information in preparation for conducting data analysis activities, including the mining of informatics from the CHILDS and ADES CPS Child Fatality databases.

## **CITIZEN REVIEW PANEL 2<sup>ND</sup> QUARTER ACTIVITIES**

CABHP continued to centralize logistical and staff support for the three regional Panels. Members were notified in advance of the 2nd Quarter meeting via email, intranet and personal phone calls by the CABHP Program Coordinator. Members who were not in attendance at the 1st Quarter meeting were personally contacted. Meeting materials were emailed to members in advance and provided at the 2nd Quarter meetings held in Phoenix on June 12, Tucson on June 15 and Flagstaff on June 22. The Central Panel had 19 participants; the Southern Panel had 17 participants; and the Northern Panel had 11 participants. Recommendations from 1st Quarter meetings and Action Items were compiled and presented to the Panels for their comments.

CABHP staff meets once a week or more often, if needed, for planning and discussion around the ACRP. CABHP staff also attended a training workshop in April on the investigation of child physical abuse crimes and homicides offered by Childhelp Children's Center of Arizona. In addition, staff registered for a teleconference on evidence based practice in child welfare sponsored by the National Child Welfare Resource Center for Organizational Improvement in May.

CABHP staff held a meeting with DCYF data specialists to discuss CHILDS and other databases with information on child fatalities and near fatalities, as well as criteria for case selection and review. CABHP staff completed required DCYF computer based training and CHILDS training. CABHP staff also met with an ADES Child and Family Services Manager for instruction on CHILDS and Practice Improvement Case Review Instruments and other assessment tools. At each of the 2nd Quarter Panel meetings two cases were presented on child fatalities and near fatalities under age two, followed by Panels' discussions. Chronic child neglect data and characteristics of substantiated vs. unsubstantiated reports for children under age five were also presented and discussed. A refined case record review protocol was implemented with recommended mechanisms to examine current policies, procedures and practices of CPS.

A Confidentiality Agreement was signed by all Panel members. Consensus guidelines were provided in draft form at the Panel members' request. Recruitment efforts targeted at diverse populations in all three regions resulted in a gain of three new members to the Central Panel, six new members to the Southern Panel and three new members to the Northern Panel. An application form was made available, along with the ACRP brochure and orientation Power Point.

CABHP utilized the National Citizen Review Panel listserv to request information from other states' ACRP on their public outreach and education experiences. CABHP and DCYF also coordinate responses to the National Panel's requests for information that will be incorporated into various research projects and publications on Citizen Review Panels.

## CITIZEN REVIEW PANEL 3<sup>RD</sup> QUARTER ACTIVITIES

A meeting with DCYF was scheduled on July 10, 2009 to discuss policy development related to chronic child neglect which is an area of concern to Panels. CABHP offered a variety of resources to the CPS Policy and Program Development Specialist for research purposes including literature reviews, numerous articles, and pertinent websites.

Meeting materials were emailed to members in advance and provided at the 3rd Quarter meetings held in Phoenix on September 11, Tucson on September 21 and Flagstaff on August 31. The Central Panel had 12 participants; the Southern Panel had 14 participants; and the Northern Panel had 9 participants. Guest speakers from High Intensity Drug Trafficking Areas (HIDTA) program presented *Methamphetamine and Drug Endangered Children (DEC) Protocols*. A DCYF Child and Family Services Manager presented a report on *IV-B Safety Outcomes* and CABHP presented *Joint Investigations and Statutory Mandates*.

Two case records were reviewed at each Panel meeting with a focus on methamphetamine abuse. A case record document checklist was included in the request for case record copies to CPS. The checklist identifies the documents that CPS includes in the file copies and reasons that other documents are missing. Genograms clarifying complex family relationships in CPS case investigations were provided to Panels with copies of the seventeen safety factors and *Six Fundamental Questions for Information Collection and Assessment to Identify and Understand Possible Safety Threats*, to assist in following the case record review and safety assessments.

A survey link was emailed to Panel members on July 14, 2009 asking for comments on the ACRP and suggested areas for improvement. The survey closed on July 31st. Panel members who completed the survey were entered into a drawing to receive a copy of *Interventions for Children Exposed to Violence*. See Citizen Review Panel Survey section.

CABHP incorporated consensus guidelines requested and approved by the Panels. CABHP continues to explore opportunities to utilize faith-based and social service organizations to stimulate public outreach and the solicitation of public input. The National Citizen Review Panel Virtual Community provides a listserv, through the University of Kentucky College of Social Work, to request information from other states' ACRPs on their public outreach and education experiences. The National ACRP gathers information from states Panels that will be incorporated into various research projects and publications on Citizen Review Panels.

Arizona provider network listserves are utilized to promote the ACRP and recruit new volunteers and brochures are distributed at key meetings and local conferences.

## CITIZEN REVIEW PANEL 4<sup>TH</sup> QUARTER ACTIVITIES

The 4th Quarter Citizen Review Panel meetings were held on November 30, 2009 with the Northern Panel, December 7 with the Southern Panel, and December 11 with the Central Panel. The Northern Panel meeting location was changed to the United Way of Northern Arizona. The Southern Panel added a new member, while the Central Panel gained six new members representing education, health care, behavioral health and private citizenry.

Maria Hoffman, Director of the Legislative Office of Family Advocacy, and Kara VanHise, Assistant Ombudsman with Citizen's Aid (also a member of the Central Region Panel) presented information on grievance and complaint processes within their respective agencies. Ms. Hoffman provides a communication bridge between constituents, who have been referred by legislators, children and Child Protective Services. Ms. VanHise mediates solutions to complaints that her office receives from Child Protective Services' clients through various forms completed at the time of initial investigation of a report. Other sources are legislators, other agencies, the Governor's Office and Ms. Hoffman. Ms. VanHise and Ms. Hoffman work collaboratively in resolving multi-faceted issues. They offered to provide updates to the Panels every three months. CABHP will also chart the advocacy organizations for Panels.

Vicki Staples presented *Key Constituent Groups and Role of Panels in Outreach and Education*. Panel members discussed various ideas for outreach such as distributing the Arizona Citizen Review Panel Annual Report to statewide professional organizations, educational institutions, law enforcement, medical and behavioral health communities, court judges and the general public. Members suggested linking the Annual Report with the release of the Arizona Child Fatality Report, agencies concerned with child welfare. Other public outreach ideas included development of a program video and appearances on radio talk shows.

Two Child Protective Services case records were presented and discussed at each Panel meeting for a total of six cases. In response to Panels' requests to clarify the case record reviews, CABHP staff included redacted copies of the Child Safety Assessments, Safety Plans and Family Strengths and Risk Assessments from CHILDS. Genograms were improved to understand complex family relationships, and timelines of the target child's significant events were attached to each case summary. Members requested that future timelines also reflect any changes in CPS staff during investigation. In addition, a Medical Examiner with child maltreatment experience from the Maricopa County Forensic Science Center agreed to be a consultant to the Panels on questions regarding autopsy reports.

The Southern Panel requested that CABHP conduct a survey of agencies to gather information on types of training currently available regarding mandatory reporting. The Central Panel was interested in learning more about CPS' Team Decision Making

(TDM) process at a future meeting. The Northern Panel would like to invite a speaker from the Foster Care Review Board and obtain additional information on CPS reports around the Colorado City area of Arizona.

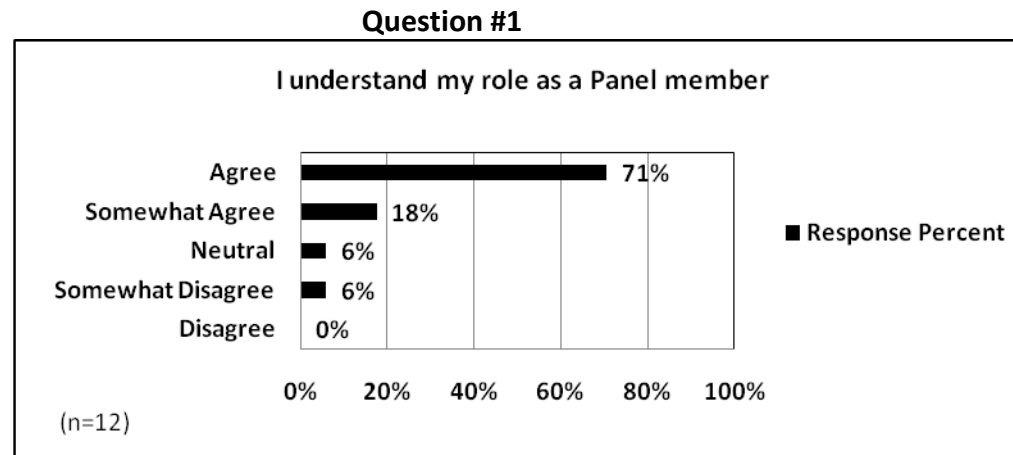
The DES Program Report on the CAPTA Implementation Plan and Update on Panels' Recommendations was rescheduled for the first quarter meeting in 2010 at the request of DES staff.

CABHP drafted the Arizona Citizen Review Panel 11th Annual Report and reviewed it with the Panel members at the 4th quarter meetings and with DES staff on December 14, 2009. CABHP received responses to the recommendations in the draft report from DES. On January 13 and 19, 2010, CABHP will conduct meetings via telephone and in office to discuss the report with participating Panel members and DES staff. The final version of the report is due to DES on January 22, 2010.

**APPENDIX H:**  
**CITIZEN REVIEW PANEL SURVEY**

## APPENDIX H

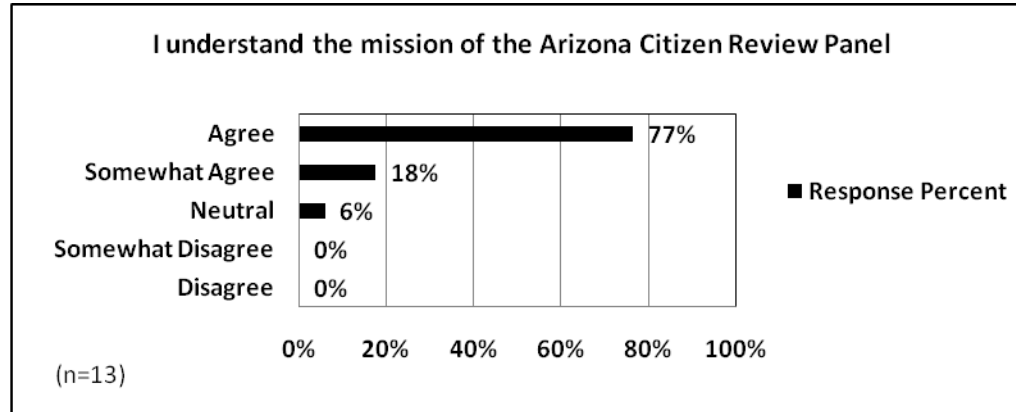
On July 14, 2009 Panel members received an email request from the Citizen Review Panel Program Coordinator asking them to complete a short Survey Monkey to provide CABHP staff information on Panels' level of satisfaction and suggestions for improvement in the program. Nineteen (19) Panel members completed the survey with 6 responses from Central, 11 from Southern and 2 from Northern Panels. The majority of the respondents were satisfied with the performance of CABHP administrative support and understood the Citizen Review Panel mission and members' roles. Most of the comments and/or recommendations concerned the case review process. The survey results are summarized as follows:



### **Comments:**

- I have a better understanding now. To my recollection, I had not had any orientation to the role until the ASU Center began conducting the meetings.
- As a member I have received written and verbal information about my role on the Panel.
- I was very impressed with the Panel and looking forward to working with the group.
- I want to be involved, however, I am not getting the information in enough time to participate.

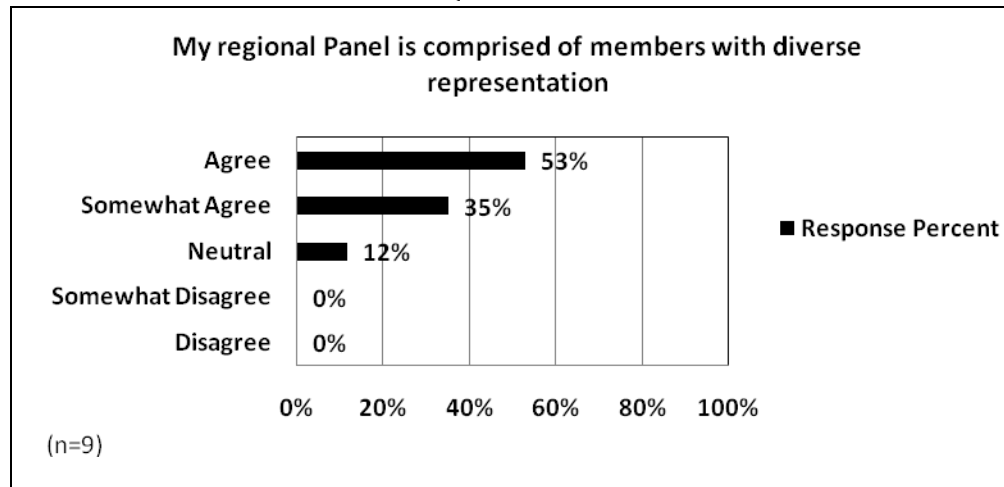
### Question #2



#### Comments:

- The mission of the Arizona Citizen Review Panel was made clear during my first meeting.
- I have been provided the mission information.

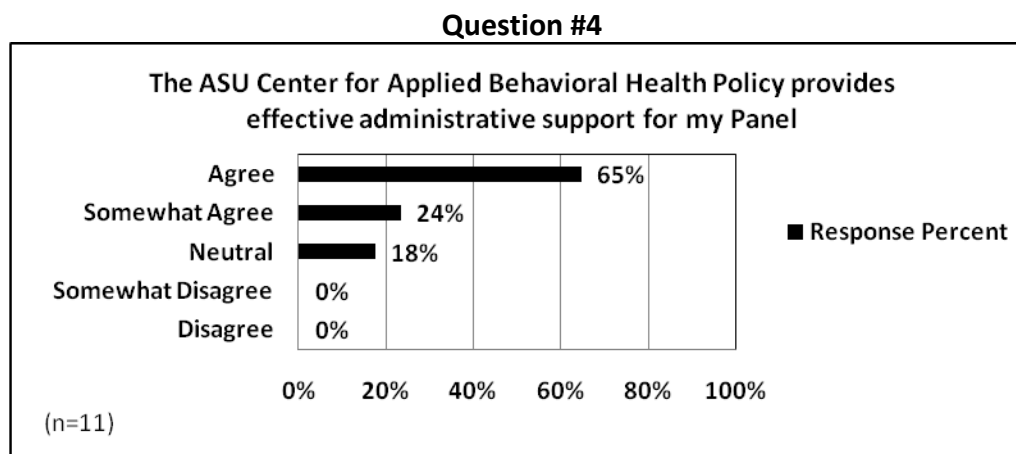
### Question #3





**Comments:**

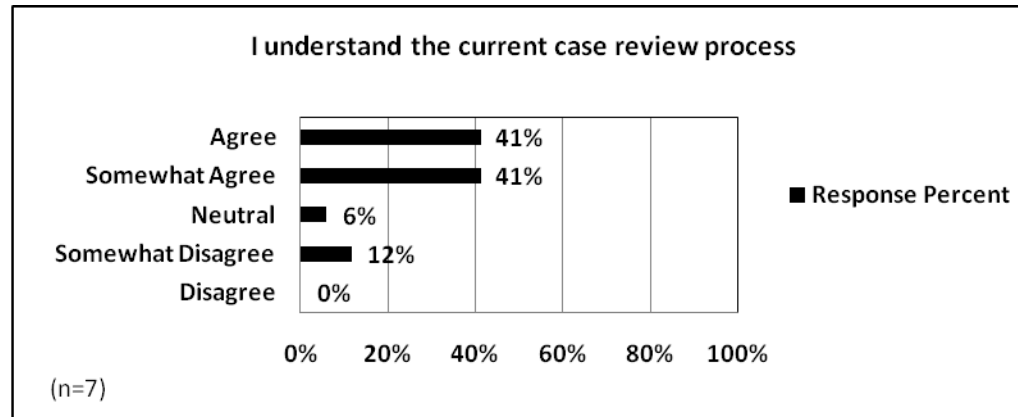
- The Panel needs more diversity from community agencies. Also, I would like to recommend an emancipated young adult/older adult who has been in Foster Care to be part of the Panel.
- I enjoy the diversity. However, the reliance on voluntary participation is a potential vulnerability.
- If everyone could attend the meetings, I would likely agree that there is enough diversity. In my limited experience, I am seeing little representation from many sectors, specifically because most of the committee does not attend the meetings.
- Not very diverse.



**Comments:**

- The administrative support has been excellent.
- In the brief time that they have been coordinating, the organization of the meetings has improved. I believe there are also less frequent meetings (which is appreciated, but it also can hinder some interactions among members and the “flow” of the meeting).
- I would like a year of support before making a final judgment.
- Since we have changed administration to the ASU Center, I have not been able to attend one meeting. I do feel as though I am waiting to see how ASU will administer our program.
- Certainly good administrative support, but I think that we are all learning through this new process.

### Question #5



#### Comments:

- As the process is new, we are still learning. However, I see a lot of potential regarding its effectiveness.
- In the past, one of the members reviewed the cases which was time consuming and also burdensome. On the other hand (in my opinion), it gave the person who reviewed the case a much better idea of the processes involved.
- I think it's still somewhat under development. There is always room for improvement in this time consuming and detail-oriented process.
- At the last meeting we did review a case. However, we had a number of gaps in the information that we needed to discuss the case fully.
- Certainly good administrative support (assuming you mean notifications, meeting, set-up, etc.). I think we are all learning through this new case review process.

### Question #6

#### What additional information would be helpful in the case review process?

- Times and dates of occurrences within the case, clarify regarding who made decisions and points in time when collaboration occurred with other entities, agencies, etc.
- Often times, very important information is not available, like medical records. In some instances, the records have not been provided or are not available. However, the more information available at the time of the review, the better the members can evaluate whether policies were followed and the quality of the process and documentation. However, information "gaps" also point out the constraints and conditions that the case workers often have to deal with.

- Better clarity on priors and family relationships.
- Basic information: police and pathology reports; a more detailed summary of the case.
- More time with each case. I'm confused on which part we are reviewing – the actions that lead up to the incidents or CPS' actions afterward.
- Input from County Attorney's Office.
- Review more cases.
- I can't think of any additional information I would want.
- No additional information is needed.
- None at this time.
- Getting the information on how to be involved.

#### Question #7

#### **My Regional Panel meetings would be more productive if (please specify):**

- I feel the meetings are very organized and productive.
- We could compare to other states' "best practices" and track trends either in Arizona or nationally.
- Definite improvements by ASU in bringing literature and evidence-based practices to the attention of members.
- Would like more frequent meetings to help us be more cohesive, more detailed summary of cases, and a more thorough presentation and better understanding of cases.
- We are getting off the ground with the new format but I believe it is more productive.
- I have a hard time committing 3 hours of time; condense the material into 2 hours. For reviews involving law enforcement or medical reports, have the reviewer consult with someone on the Panel before the meeting to make sure material is complete.
- Make sure that case documentation is complete before presentations.
- Reviewing the cases is rushed.
- Perhaps provide some of the case specific information prior to the meeting.
- Re-evaluate long-standing members and either have them re-commit to attending or allow them to be removed from Panels.
- I don't think enough meetings are scheduled to be able to review an adequate number cases.
- Review more cases and want to see the results or an update on the ones that were reviewed.
- I have no suggestions for increased productivity.

**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) 496-1480.

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