Performance Audit Division

Special Report

Arizona Department of Child Safety

Department Assesses Child Safety and Risk Using Common Factors or Accepted Approaches, but Needs to Improve Critical Aspects of Its Child Safety and Risk Assessment Process

September • 2015
Report No. 15-118

The **Auditor General** is appointed by the Joint Legislative Audit Committee, a bipartisan committee composed of five senators and five representatives. Her mission is to provide independent and impartial information and specific recommendations to improve the operations of state and local government entities. To this end, she provides financial audits and accounting services to the State and political subdivisions, investigates possible misuse of public monies, and conducts performance audits of school districts, state agencies, and the programs they administer.

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Arizona Department of Child Safety

Transmitted herewith is a report of the Auditor General, *A Special Report of the Arizona Department of Child Safety—Child Safety, Removal, and Risk Assessment Practices*. This report is in response to Laws 2015, Ch. 18, §6, and was conducted under the authority vested in the Auditor General by Arizona Revised Statutes §41-1279.03. I am also transmitting within this report a copy of the Report Highlights for this audit to provide a quick summary for your convenience.

As outlined in its response, the Arizona Department of Child Safety agrees with all of the findings and plans to implement all of the recommendations.

My staff and I will be pleased to discuss or clarify items in the report.

Sincerely,

Debbie Davenport
Auditor General

Attachment

Arizona Department of Child Safety—Child Safety, Removal, and Risk Assessment Practices

REPORT HIGHLIGHTS
PERFORMANCE AUDIT

Our Conclusion

This report addresses the Arizona Department of Child Safety's (Department) child safety and risk assessment practices, including its approach for determining whether to remove a child from his/her home. Similar to other child welfare agencies, the Department uses three common factors to assess child safety. Agencies' risk assessment processes are more varied, and the Department uses multiple factors and relies on caseworker judgment to assess risk. However, the Department's child safety and risk assessment tool does not sufficiently guide caseworkers in making child safety decisions. Insufficient training has also limited caseworkers' ability to conduct child safety and risk assessments. The Department needs to modify or replace its child safety and risk assessment tool, provide adequate training for caseworkers and supervisors, and improve safety planning.

Department, like other child welfare agencies, considers three common factors to assess child safety, but agencies' risk assessment processes are more varied

Department uses common factors to assess child safety—Assessing child safety and risk is a primary department responsibility. As such, and similar to other child welfare agencies, the Department assesses child safety based on threats of danger to the child, child vulnerabilities, and the ability of the caregiver to protect the child. If a child is determined to be unsafe through the assessment of these factors, a safety plan must be implemented. The safety plan describes actions the Department will take to mitigate current safety threats, which may include removing the child from the home. The safety planning process involves Team Decision Making (TDM), which is a meeting of caseworkers, family members, and other stakeholders to address the safety and placement of the child. Appropriately assessing child safety and risk is critical because the removal of a child can have a significant impact on the child and family. In Arizona, child removals have been increasing.

Annual number of Arizona child abuse and neglect reports responded to compared to number of children removed
Federal fiscal years 2010 through 2014

Number of reports responded to: 2010: 33,455; 2011: 36,623; 2012: 39,687; 2013: 40,375; 2014: 46,597
Number of children removed: 2010: 7,946; 2011: 8,509; 2012: 10,684; 2013: 10,803; 2014: 12,162
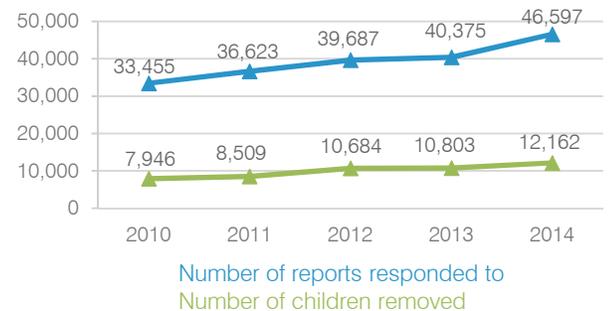
Department uses multiple risk factors and caseworker judgment to assess risk to children—In addition to evaluating child safety, child welfare agencies gather and assess information about families to determine whether children are at risk for future maltreatment so that action may be taken to prevent it, such as providing services to improve family functioning. Child welfare agencies' risk assessment models encompass similar overarching components, such as using forms or tools to capture and record information. However, despite sharing similar components, child welfare agencies vary in how they assess risk, including variation in the specific risk factors used. In addition, child welfare agencies generally use two distinct risk assessment approaches, an actuarial-based or a consensus-based risk approach. The Department uses a consensus-based risk approach, whereby department staff rely on their professional judgment, experience, guidance documents, and training to determine what risk factors are present and what actions would best address a particular situation.

Department has inadequately implemented critical components of its child safety and risk assessment process

Deficiencies in the child safety and risk assessment process impact effectiveness—The Department's child safety and risk assessment (CSRA) tool lacks the

structure to guide caseworkers in documenting and assessing child safety and risk. The CSRA tool does not effectively tell caseworkers what specific information should be considered or documented, which could lead to poor and inconsistent decision making. We found that department staff did not consistently document information in the CSRAs and did not always meet the Department's documentation requirements. Other reviews have identified similar concerns regarding how the structure of the Department's CSRA tool can affect documentation and decision making around child safety and risk.

Further, although critical to a determining whether to remove a child, the CSRA tool does not require case-workers to explicitly list and explain the safety factors. Consequently, the Department cannot identify how frequently a specific factor or set of conditions affects the decision to remove a child and does not have this data available to make improvements to its child safety and risk assessment process.

The Department's safety planning practices may also be inadequate. The Department uses a TDM meeting to consider the safety plan for a child, which may include removal from the home. Participants can all discuss their safety concerns for the child. Although caseworkers and supervisors should come to these meetings with open minds, some indicated that they come with their decision already made regarding the child-removal decision and may not adequately engage with families during the meeting. This approach is counterproductive and may result in unnecessary child removals. Although a TDM facilitator manages the meeting, the ultimate decision of whether to remove a child rests with the caseworker and supervisor. In addition, services that could mitigate child removal, such as parenting education and crisis intervention, have long waiting lists in some parts of the State.

Mentoring and coaching are also an important part of caseworker and supervisor preparation to properly conduct safety and risk assessments. Between fiscal years 2013 and 2015, the Department hired about 1,550 new caseworkers. Part of new caseworker training includes accompanying a mentor to do investigations and attend TDMs. However, because of the lack of access to mentors, some of these caseworkers may not receive critical mentoring opportunities. In addition, the Department does not provide formal mentoring or coaching to new supervisors as part of their training to oversee caseworkers.

Department plans to improve some child safety and risk assessment practices—These plans include revising the CSRA tool to be more structured and better guide caseworkers through the safety and risk assessment process. The Department is also in the early stages of piloting a field guide, which supplements the CSRA and contains checkboxes describing the information needed and narrative responses to improve answers' details. Additionally, the Department plans to reduce the time families will have to wait for services.

Department could learn from other agencies' child safety and risk assessment practices—The Breakthrough Series Collaborative is a program that involved 21 public and tribal welfare agencies aimed at improving the way they assessed child safety and risk. For example, the Carver County, Minnesota, child welfare agency has focused on further engaging children and families in safety and risk assessments and safety planning by adopting age-appropriate interviewing tools; using family safety networks comprising relatives, friends, and neighbors; and engaging families to identify safety concerns and family strengths, which lead to more accurate safety assessments.

Recommendations

The Department should:
- Review other agencies' efforts to improve safety and risk assessments and determine whether these actions would improve its practices;
- Continue efforts to modify or replace its CSRA tool to better guide caseworkers in assessing child safety and risk;
- Reduce waitlists for in-home family services to improve safety planning; and
- Ensure caseworkers and supervisors have adequate training and mentoring.

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As required by Laws 2015, Ch.18, §6, the Office of the Auditor General has completed a special report that addresses the Arizona Department of Child Safety's (Department) methods and decision-making approach for determining whether a child should be removed from his/ her home. The report includes a review of the Department's child safety and risk assessment practices, including the factors that are considered in determining whether to remove a child and a comparison of these practices to other states' practices and best practices (see Chapter 1, pages 5 through 12), as well as recommended improvements to the Department's implementation of its safety and risk assessment tool, including modifying or replacing its tool and improving caseworker and supervisor training practices (see Chapter 2, pages 13 through 25).

This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §41-1279.03.

Assessing child safety and risk

Child welfare agencies across the U.S. use various models to assess safety and risk

Assessing child safety and risk is a primary responsibility of child welfare agencies, including the Arizona Department of Child Safety (Department). The Department and other child welfare agencies assess child safety and risk throughout various stages of the child welfare system, such as when a call alleging abuse or neglect is received or when the decision to close a case is made. One critical point-in-time in this assessment process takes place when child welfare agencies respond to a report of abuse or neglect by meeting with the family who is the subject of a report, typically by visiting the family's home, to evaluate the safety of and risks to children in the home. If the children are determined to be unsafe as a result of this assessment and the safety concerns cannot be mitigated, the children may be removed from the home.

Child welfare agencies have increasingly adopted formal models, or approaches, to assess child safety and/or risk. The three most common formal safety and risk assessment models used in the U.S. are (1) ACTION for Child Protection SAFE, (2) Signs of Safety® and (3) Structured Decision Making® (see textbox, page 2, for more information on these specific models). Formal safety and risk assessment models are broad frameworks that typically consist of tools that aid caseworkers in carrying out tasks and decisions associated with assessing the safety and risk of a child, such as the decision to remove a child from the home or provide services to a family.[1] The Department's approach for assessing child safety is based on the ACTION for Child Protection model. As part of its approach, the Department uses a tool called the Child Safety and Risk Assessment (CSRA) to aid caseworkers in investigating a report of abuse or neglect in the home (see Chapters 1 and 2 for more information on the Department's approach for conducting safety and risk assessments and the need to improve this approach, including its safety and risk assessment tool).

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[1]   Many agencies use tools from more than one formal model, and some develop their own model for carrying out assessments without the use of formal tools.

> **Formal models for assessing child safety and/or risk**
>
> **ACTION for Child Protection SAFE** model focuses strictly on determining whether a child is safe through the assessment of danger threats, child vulnerability, and caregiver protective capacities. The safety focus of this model is maintained throughout various decision-making points such as screening, reunification, or case closure.
>
> **Signs of Safety®** was designed to give child welfare workers a broad framework for engaging everyone involved in a case including professionals, family members, and children to assess safety and risk. The assessment approach guides professional judgment and is based on caseworker-family interaction.
>
> **Structured Decision Making®** provides standardized assessments for decision-making points throughout the life of a case. A distinguishing feature of this model is a risk assessment tool that incorporates criteria that have been found through statistical analysis to be associated with recurrences of maltreatment and that generates a score based on data input that corresponds to a prescribed course of action for the child protection agency.
>
> Source: Auditor General staff summary of child welfare literature.

At the time of this report, auditors' review of literature suggests that there is no academic or professional consensus regarding the efficacy of one model over another for assessing child safety and risk. Additionally, auditors interviewed three recognized experts on the subject of safety and risk assessments in child welfare who indicated that regardless of the model in use, an agency's success in conducting safety and risk assessments will depend on how well the model's practices are implemented.

Increasing number of child removals in Arizona

The increasing number of child removals in Arizona highlights the importance of using sound safety and risk assessment practices to help make this decision. The decision to remove a child from the home as a result of assessing safety and risk is one that can have a lasting impact on both the child and the family. In Arizona, the number of child removals has steadily increased since federal fiscal year 2010. Specifically, there were 7,946 removals in federal fiscal year 2010, compared to 12,162 removals in federal fiscal year 2014, an increase of more than 4,000 removals (see Figure 1, page 3). This increase in removals may be in part attributable to the increasing number of reports that the Department has responded to, as both the number of reports responded to and the number of removals have increased between federal fiscal years 2010 and 2014.[1]

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[1] Number of reports responded to refers to the total number of reports received by the Department that have a response time indicated in the Department's electronic database.

Figure 1: Annual number of Arizona child abuse and neglect reports responded to compared to number of children removed from the home
Federal fiscal years 2010 through 2014
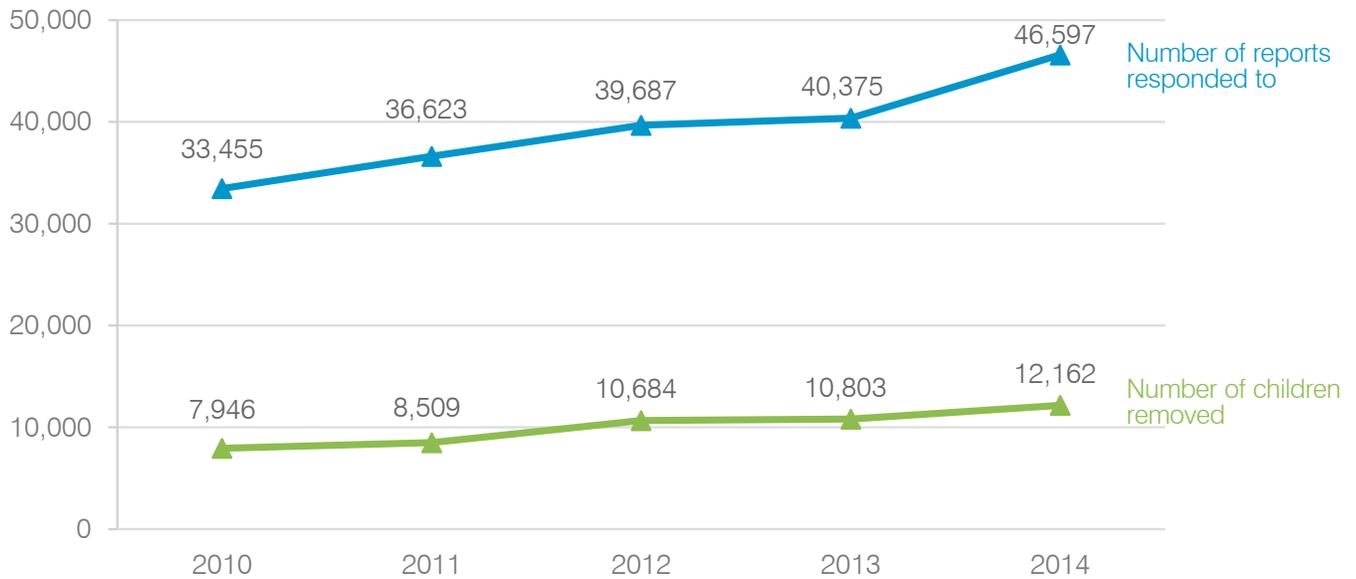
Source: Auditor General staff analysis of information from the Department's semi-annual child welfare reports for federal fiscal years 2010 through 2014.

Department, like other child welfare agencies, considers three common factors to assess child safety, but agencies' risk assessment processes are more varied

The Arizona Department of Child Safety (Department) assesses child safety similar to other child welfare agencies by using three common factors, but the risk assessment process varies across agencies. Arizona and child welfare agencies nation-wide generally assess safety using three common factors: threats of safety, child vulnerability, and protective capacity. The Department uses a tool called the Child Safety and Risk Assessment (CSRA) that is designed to gather sufficient and relevant information regarding a child's safety based on the three common factors. If a child is determined to be unsafe, the Department must put a safety plan in place to mitigate the threats, which may result in removing the child from the home. In addition, the Department uses its CSRA to assess the risk of future harm to a child. Although risk assessment approaches used by child welfare agencies share common components, the risk criteria used vary. In addition, two distinct methods for assessing risk exist; an actuarial-based approach or a consensus-based approach. The Department employs a consensus-based approach to assess risk, which relies on caseworker judgment.

Child welfare agencies use common factors to assess child safety

As indicated in the Introduction, child welfare agencies in the U.S. use various models to assess child safety (see pages 1 and 2). Safety assessments are used to help evaluate whether a child is safe or not

As required by Laws 2015, Ch.18, §6, this chapter includes a review of the Department's safety and risk assessment practices, including the factors that are considered in determining whether to remove a child, and a comparison of these practices to other states' practices.

safe in the immediate or near future, a determination which may lead to the removal of a child from his/her home.[1] Although the specific terminology used to assess safety may differ, and different tools may be used by various child welfare agencies, literature indicates that agencies gather safety information around three common factors, regardless of the model used.[2] Specifically, agencies consider the following three general factors when assessing child safety:

- **Threats of danger**—A threat of danger is a specific family situation or behavior, emotion, motive, perception, or capacity of a family member that is specific and observable, out of control, immediate, or likely to happen soon, and can cause severe consequences;

- **Child vulnerability**—Child vulnerability involves knowing about the child's ability to protect and care for him/herself. Vulnerability is not judged by degree, but rather a child is either vulnerable or not vulnerable; and

- **Protective capacity**—Protective capacity means being protective toward one's children and refers to cognitive, behavioral, and emotional qualities that support a parent's vigilant protection of children. If a threat(s) of

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[1] Lund, T., & Renne, J. (2009). *Child safety: A guide for judges and attorneys.* American Bar Association and ACTION for Child Protection, Inc.; Rycus, J. S. & Hughes, R. C. (2008). Assessing risk throughout the life of a child welfare case. In Lindsey, D. & A. Shlonsky (Eds.), *Child welfare research: Advances for practice and policy* (pp. 201-213). New York, NY: Oxford University Press; and Rycus, J. S. & Hughes, R. C. (2003). *Issues in risk assessment in child protective services*. Columbus, OH: North American Resource Center for Child Welfare.

[2] Lund & Renne, 2009; Rycus & Hughes, 2008; Rycus & Hughes, 2003; and Pecora, P.J., Whittaker, J.K., Maluccio, A.N., Barck, R.P., & DePanfilis, D. (2009). Child protective services. In Pecora, P.J. (Ed.) *The child welfare challenge: policy, practice, and research* (pp. 312-337). New Brunswick, NJ: Transaction Publishers.

danger is present and the child is deemed vulnerable but the child's caregivers demonstrate sufficient protective capacities, a child can still be deemed "safe."

Department's approach to assessing child safety incorporates the same three factors that other agencies consider

The Department uses the three common factors to assess child safety and has established rules and policies that guide caseworkers in obtaining the necessary information to assess child safety against these factors. Specifically, similar to other child welfare agencies, the Department's approach for assessing the safety of children in the home includes identifying and evaluating threats of danger, child vulnerabilities, and protective capacities. Additionally, Arizona Administrative Code and department policies direct the information caseworkers should obtain to help assess child safety.

Department uses three common factors to assess child safety— Similar to other child welfare agencies, the Department's approach for assessing child safety involves identifying and evaluating threats of danger, child vulnerabilities, and protective capacities. As previously mentioned (see Introduction, page 1), as part of its child safety assessment approach, which is based on the ACTION for Child Protection SAFE model, the Department uses a tool called the Child Safety and Risk Assessment (CSRA) to aid caseworkers in investigating a report of abuse or neglect in the home (see Chapter 2, pages 13 through 25, for information on how the CSRA should be improved).[1] The purpose of the CSRA is to gather sufficient and relevant information to make an informed decision about whether a child is safe.[2,3] In Arizona, children are considered unsafe, and may be removed from the home, when situations of present danger or impending danger are occurring. Specifically:

- **Present Danger**—Department policy defines present danger as an immediate, significant, and clearly observable family condition occurring in the present that has resulted in or is likely to result in serious harm or threat of harm to a child. For example, present danger could include a child who is abandoned and not capable of caring for him/herself, or a child who is actively endangering him/herself or others and the caregiver cannot control the child's behavior. Department staff reported that determining present danger is rare, but if it occurs, immediate protective action must be taken to ensure child safety. Protective action could involve various options, such as keeping the child in the home with an individual who is able to monitor and help ensure the safety of the child. However, if no other protective action is viable, the Department should immediately remove the child from the home.[4]

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[1] A report refers to an allegation of abuse or neglect that is received by the Department and is assigned for investigation.

[2] A CSRA is not conducted for foster, relative, adoptive, or noncustodial parent homes unless the caregiver or any member of the household is identified as an alleged perpetrator in a new report.

[3] Department caseworkers are required to complete a CSRA for all cases where a field investigation is completed. The CSRA and its associated documentation is maintained in the Department's Children's Information Library and Data Source data system.

[4] Removal from the home can involve the caseworker taking legal custody of the child through a temporary custody notice. A temporary custody notice allows the Department to take custody of a child without consent for a maximum of 72 hours. After the 72-hour period, the Department must either return the child to his/her home, or file a petition with the courts for permanent custody.

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- **Impending Danger**—If a child is not in present danger, the Department must determine if the child is unsafe due to impending danger. Department policy defines impending danger as a family situation or a behavior, emotion, motive, perception, or capacity of a household member that is determined to be out of control and will likely result in serious harm to a child within the near future. In order to determine impending danger, department policy requires that caseworkers use the following five safety criteria:

  1. **Vulnerable child**—Is the child victim unable to protect him/herself or seek protection from others, regardless of the child's age? Is the child defenseless, or exposed to behavior, conditions, or circumstances the child is powerless to manage?

  2. **Out of control**—Is there an adult in the home who is able to control the identified safety threat to the child victim? Will the safety threat continue without outside intervention?

  3. **Severity**—Could the threat cause or result in serious or severe harm (pain, injury, suffering, terror or extreme fear, impairment, or death)?

  4. **Specific time frame**—Is the threat to the child's safety occurring now or likely to occur within the next 30 days? Could it happen just about any time within the near future—today, tomorrow, or during the upcoming month?

  5. **Observable family condition**—What is the specific behavior, emotion, attitude, perception, or situation by the parent, guardian, or custodian that can be seen and described and makes the child victim unsafe?

  In assessing whether the five criteria for impending danger are met, department caseworkers should compare the criteria against various safety factors that raise concern for safety, such as whether the parent leaves the child alone, whether there is domestic violence among adults in the house, or if physical conditions in the home are hazardous to the child (see textbox on page 9 for a fictional example of determining impending danger). If all five safety criteria apply to one or more of the safety factors, the child is determined to be unsafe and a safety plan must be put into place.

  A safety plan comprises actions the Department takes in coordination with the family to mitigate safety threats in the short term. For example, an in-home safety plan may be enacted if a safety monitor, or nonoffending adult caregiver, is able and willing to provide supervision of the alleged perpetrator and child victim. As part of this safety planning process for a child determined to be in impending danger, department policy requires a Team Decision Making (TDM) meeting be held to consider removal of the child.[1] The TDM is a meeting involving the Department, family members, community members, and other stakeholders, as applicable, to address the safety and placement of the child (see Chapter 2, pages 13 through 25, for more information about how the Department's TDM practices could be improved). However, if an in-home safety plan is not viable, the Department may decide that an out-of-home safety plan is necessary and remove the child from the home.

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[1] There are five circumstances for which the Department will hold a TDM: when an emergency removal of a child has occurred; the removal of a child is being considered; there is potential for disruption or an unplanned placement change occurs for a child in out-of-home placement; the permanency case goal may need to change or a child may begin the reunification transition to his/her family; or when a youth is in need of a discharge plan upon his/her exit from care.

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The Department gathers and reviews information from various sources to assess safety and risk—In order to assess the safety and risk factors for a family as part of an investigation of child abuse or neglect, caseworkers are required by both Arizona Administrative Code (AAC) and department policy to gather background information from various sources (the Department's process for assessing the risk of child maltreatment in the future is discussed in more depth below). Specifically, AAC R6-5-5508 indicates that when conducting an investigation, caseworkers must collect multiple pieces of information to determine whether any child in the home has suffered maltreatment or is at risk of maltreatment in the future. To do this, caseworkers should use various methods, such as interviewing the alleged victim, the caregiver alleged to have committed the abuse, and other adults and children in the home, as well as reviewing available documentation such as medical reports, police reports, and school records.

The Department's policy further details the information-gathering process that caseworkers follow in order to concurrently assess both safety and risk in the home. Specifically, department policy indicates that caseworkers must gather any relevant background information on the family, such as reviewing and documenting medical and school records, as well as any prior reports of abuse or neglect the family may have with the Department to determine if there is any pattern of maltreatment, increasing severity of allegations, or changes within the household composition. Caseworkers should also conduct background checks to see if there have been any arrests or charges against adults in the home. According to department policy, caseworkers also observe the behavior of infants, toddlers, children, and adults in the home where the alleged maltreatment occurred. Caseworkers then use the information obtained from reviewing background information, conducting interviews, and observations as a basis for the assessment of safety and risk, including the decision to remove a child from the home. (See textbox on page 9 for a fictional example of assessing child safety.)

Fictional safety assessment case example

Incident—There was a domestic violence incident between Mr. Newman against Mrs. Newman, which resulted in injuries to their two children, Mark (age 5) and Jennifer (age 4). The caseworker assigned to the family checked for prior reports of abuse or neglect history with the Department and ran background checks on both parents to see if there had been any arrests or charges against them. Based on that review, the caseworker determined that this was the first alleged maltreatment or legal issue with the parents.

However, through interviews with family members, the caseworker learned that Mr. Newman has a history of alcohol use and domestic violence against his wife and children, and during this incident threw a glass at Mrs. Newman as she was attempting to flee their home with her children. The glass hit a wall, and shards of glass hit and cut Jennifer on her face. Mark reported to the caseworker that he attempted to protect his mother and sister, but was punched and pushed by Mr. Newman, which resulted in Mark falling and hitting his head on the tile floor. Mark reported the incident to a school counselor the next day, who acted as the reporting source for the maltreatment.

The caseworker also reviewed the children's school records and found that Mark was having difficulty concentrating in school and Jennifer would show fear and hide after hearing loud noises in daycare, and is experiencing difficulty with her speech and pronouncing words. The caseworker's review of the children's medical records indicated that Jennifer's injuries were not treated in a timely manner and that Mark was dizzy due to dehydration and lack of sleep caused by stress from the family's situation.

Safety Factor—Domestic violence among adults living in or having access to the home impairs necessary supervision or care of the child and may result in serious or severe harm to the child.

Safety Criteria

1. **Vulnerable child**—Both Mark and Jennifer are vulnerable due to their ages, making them dependent upon their parents for their basic needs, protection, and guidance.

2. **Out of control**—Mrs. Newman has reported a history of domestic violence toward her by Mr. Newman. She is not able to defend or remove her children from the domestic violence situation.

3. **Severity**—During the incident, Mark was punched and pushed by Mr. Newman, causing him to fall and hit his head. He later showed signs of dizziness and nausea. Jennifer was struck by glass, which hit and cut her cheek.

4. **Specific time frame**—Without intervention by the Department, it is expected that another incident of physical maltreatment toward Jennifer and Mark could happen within the next 30 days, due to Mr. Newman's increasing history of violence.

5. **Observable**—Both children were injured.

Result—Based on evidence learned from a review of background information and interviews and observations of the family, the caseworker determined that all five safety criteria are indicated for the safety factor. The children are determined to be in impending danger and unsafe. A safety plan is put in place, which in this case involves the removal of the children from the home and their placement in a licensed facility.

Source: Auditor General staff summary of a fictional safety assessment from the Department's training materials.

Risk assessment models incorporate common components, but vary in their criteria and approaches

Risk assessment models employed by child welfare agencies encompass similar overarching elements, but the specific measures and approaches used to assess risk differ across these agencies.[1] Broadly speaking, risk assessment models are frameworks to help child welfare agencies gather information about families to determine whether children are at risk for future maltreatment so that action may be taken to prevent it, such as providing services to improve family functioning.[2] Risk assessment models encompass common components, including the criteria to be assessed, procedures for determining risk level, and forms to capture and record information.[3]

However, despite sharing similar components, there is variation in how child welfare agencies implement these components. Specifically, child welfare literature indicates that there is a lack of standardization in the criteria for assessing risk.[4] One study indicated that no single risk measure was common across all risk assessment models.[5] In addition, risk assessment models have wide variations in the number of criteria they use to assess risk, ranging from about 6 to about 50 (see page 11 for the risk criteria used in Arizona).[6] Auditors' review of literature suggests there is no consensus that any specific criteria, or groups of criteria, are better than others to guide caseworkers in assessing and addressing risks to children.[7]

In addition to the variation in criteria, child welfare agencies generally use two distinct approaches for assessing risk. These two approaches are known as actuarial-based and consensus-based.[8] The actuarial approach assesses risk using an instrument that has been developed based on an empirical or statistical study of cases and future abuse or neglect outcomes.[9] Based on the information gathered and documented by caseworkers, the actuarial instrument scores and/or determines a family's risk level for future maltreatment. In comparison, under the consensus approach, caseworkers assess the presence of specific characteristics identified by social work research or experienced practitioners as contributing to the risk of future maltreatment, such as a history of substance abuse or violence, and then use their own judgment about the risk of future child abuse or neglect to inform the decision about how to address the risk factors, such as the provision of services.[10] Although some research indicates that actuarial tools are better for the

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[1] Pecora, J.P., Chahine, Z., & Graham, J.C. (2013). Safety and risk assessment frameworks: Overview and implications for child maltreatment. *Child Welfare*, 92(2), 143-160.; Rycus & Hughes, 2003; Rycus & Hughes, 2008.

[2] Knoke, D. & Trocme, N. (2005). Reviewing the evidence on assessing risk for child abuse and neglect. *Brief Treatment and Crisis Intervention*, 5(3), 310-327.; Rycus & Hughes, 2003; Rycus & Hughes, 2008.

[3] Rycus & Hughes, 2003.

[4] Rycus & Hughes, 2003.

[5] Lyons, P, Doueck, H.J., & Wodarski, J.S. (1996). Risk assessment for child protective services: A review of the empirical literature on instrument performance. *Social Work Research*, 20(3), 143-155, as cited in Rycus & Hughes, 2003.

[6] Lyons, Doueck, & Wodarski, 1996; Cicchinelli, L.F., & Keller, R.A. (1990). *A comparative analysis of risk assessment models and systems*: *Final report*. Lakewood, CO: Applied Research Associates, as cited in Rycus & Hughes, 2003.

[7] Rycus, & Hughes, 2008; Lyons, Doueck, & Wodarski, 1996; Cicchinelli & Keller, 1990.

[8] Andrade, A., Austin, M., & Benton, A. (2008). Risk and safety assessment in child welfare: Instrument comparisons. *Journal of Evidence-Based Social Work*, 5(1), 31-56.; Baird, C. & Wagner, D. (2000). The relative validity of actuarial and consensus-based risk assessment systems. *Children and Youth Services Review*, 22(11), 839-871.

[9] Andrade, Austin, & Benton, 2008.

[10] Andrade, Austin, & Benton, 2008.; Baird & Wagner, 2000.; Rycus, & Hughes, 2003.

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specific purpose of predicting future maltreatment, there is no agreement that one approach is better than the other for the overall purpose of assessing risk factors to guide decision making throughout the life of a case and to take actions to prevent future maltreatment.[1]

Department uses multiple risk factors and relies on caseworker judgment to assess and address risks to children

The Department uses various risk factors to help guide caseworkers in determining what risks are present when investigating a report of abuse or neglect in the home. The Department uses the term "risk" to refer to a broad set of conditions that may predict a longer-term potential for abuse or neglect. However, a child removal cannot occur based solely on risk factors, but rather on the safety factors described previously. Caseworkers gather and evaluate information across various factors associated with the risk of future maltreatment, including:

- **Child risk factors**—Child vulnerability/self-protection; child's special needs (disability)/behavior problems (alcohol abuse, drug abuse);

- **Parent, guardian, custodian risk factors**—Parenting skills/expectations of child; parent substance abuse (alcohol abuse, drug abuse); parent mental, emotional, intellectual, or physical impairment; general history of violence by caregiver toward peers and/or children; domestic violence in family; protection of child by nonabusive caregiver; parent history of child abuse/neglect as a child; and

- **Family risk factors**—Economic resources of family; family social support system; and current family stressors.

In conjunction with assessing safety factors, the Department's CSRA tool is used to document and evaluate these risk factors, which can then be used to help determine how to address the family's situation. For example, based on a family's identified risks, a caseworker may decide to offer certain services to a family, including behavioral health services, a housing subsidy, or child daycare. Alternatively, a caseworker may close a case if the risks identified by the caseworker are not serious enough to warrant department involvement. Department staff rely on their professional judgment, experience, guidance documents, and training to determine what risk factors are present and what actions would best address a particular situation, as the CSRA does not calculate a specific score or prescribe specific action when evaluating risk. This approach is consistent with the consensus-based approach described previously. However, as detailed in Chapter 2 (see pages 13 through 25), the Department has not provided adequate training for its staff regarding the safety and risk assessment process, which could limit the effectiveness of the Department's risk assessment approach.

The Department reported that it has evaluated the merits of the two different risk assessment approaches and determined that continuing with a consensus-based approach would best meet Arizona's needs. In February 2015, the Department received a proposed scope of work for

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[1] Gambrill, E. (2008). Assessing risk throughout the life of a child welfare case. In Lindsey, D. & A. Shlonsky (Eds.), *Child welfare research: Advances for practice and policy* (pp. 175-193). New York, NY: Oxford University Press.; Pecora, Chahine, & Graham, 2013.

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implementing the Structured Decision Making (SDM)® model for safety and risk assessments, which includes an actuarial-based risk assessment component. However, after evaluating the proposal, the Department decided not to implement SDM because of cost and resource concerns related to implementing a new safety and risk assessment model. In addition, the Department reported that there would be no predictable benefit of adopting an actuarial-based risk approach, and that it would be more efficient for the Department to develop training, coaching, and other supports to improve its implementation of the existing consensus-based approach.

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Department has inadequately implemented critical components of its child safety and risk assessment process

Although the Arizona Department of Child Safety (Department) uses the same three common factors to assess child safety as other child welfare agencies, the Department has inadequately implemented key aspects of its approach to assess child safety and risk. Specifically, the Department's child safety and risk assessment tool is not sufficiently structured to document its safety and risk assessment findings and guide staff through the decision-making process. In addition, some safety planning practices may be leading to unnecessary removals and the Department has not provided sufficient mentoring and coaching to caseworkers and supervisors to help ensure they can appropriately conduct the safety and risk assessment. The Department plans to take some steps to improve its safety and risk assessment practices, but additional actions are needed, including modifying or replacing its tool for assessing safety and risk, working to improve its safety planning practices, and developing and improving caseworker and supervisor field training.

Increasing number of reports and removals reinforces the need for sound safety and risk assessment practices

The decision to remove a child from the home as a result of assessing safety and risk is one that can have a lasting impact on both the child and the family. As indicated in the Introduction (see pages 2 and 3), since federal fiscal year 2010, the Arizona Department of Child Safety (Department) has been responding to an increasing number of reports of abuse or neglect, which has contributed to an increase in the number of children removed from their homes. These increases highlight the importance of using sound safety and risk assessment practices to ensure that services offered to families align with families' needs and that children are removed from the home only when truly warranted.

As required by Laws 2015, Ch.18, §6, this chapter includes a review of the Department's safety and risk assessment practices and other states' practices, and recommends improvements to the Department's practices.

Various factors negatively impact Department's child safety and risk assessment process

The Department's approach for assessing child safety and risk incorporates the use of a formal safety and risk assessment tool, safety planning practices, and staff training; however, deficiencies in all three areas hinder the Department's ability to effectively assess child safety and risk. Specifically, the lack of structure in the Department's Child Safety and Risk Assessment tool contributes to poor documentation and subjective decision-making by caseworkers in their assessment of child safety and risk, and limits the Department's ability to track and analyze metrics related to child safety and risk. Additionally, safety planning practices regarding Team Decision Making (TDM) and a lack of available services for families may be contributing to unnecessary child removals. Finally, inadequate coaching and mentoring opportunities for caseworkers and supervisors may also contribute to inadequate safety and risk assessment practices.

Department's unstructured CSRA tool does not guide decision-making or documentation practices, and hinders data analysis efforts—As explained previously, the Department uses a tool called the Child Safety and Risk Assessment (CSRA) to aid caseworkers in assessing and documenting child safety and risk as part of investigating a report of abuse or neglect in the home (see Chapter 1, page 6). However, the CSRA tool lacks adequate structure to effectively guide caseworkers in assessing and documenting child safety and risk information, and hinders the Department's ability to capture and analyze safety and risk assessment data. Prior to its adoption of the CSRA tool in 2012, the Department used two automated tools to guide the assessment and documentation of child safety and risk, called the Child Safety Assessment (CSA) and Strength and Risk Assessment (SRA), respectively. The Department reported that it adopted the CSRA tool, which combines the safety and risk assessments into a single narrative-based assessment tool, because the CSA and SRA assessment tools were too time consuming to complete.

According to best practice literature, child safety and risk assessment tools should provide adequate structure to effectively organize risk and safety-related information. Further, the literature indicates that such structure helps to guide staff in their assessment of child safety and risk, and ensures consistency in the decision-making process, such as the decision to provide services or remove a child from the home.[1] However, the Department's CSRA tool is a narrative-based form that requires caseworkers to enter their findings in open textboxes using a story style of reporting, rather than a structured format that would more closely guide caseworkers' assessment and documentation of safety and risk. This format has resulted in two primary issues:

- **Inconsistent documentation of child safety and risk, which could lead to poor decision-making**—Although department policy and training provides guidance on the information that should be captured in the narrative boxes of the CSRA tool, the tool itself does not effectively indicate what specific information should be considered or documented during a child safety and risk assessment. For example, a textbox within the CSRA tool includes a field titled "Assessment of Impending Danger"; however, no additional guidance or reminders are given in the CSRA as to what specific factors or information a caseworker should consider in assessing impending danger. An assessment of impending danger requires caseworkers to apply five safety criteria to an identified safety factor (see page 7 for more information on these five criteria), such as domestic violence in the home, but the CSRA tool does not guide the caseworker through this and other parts of the assessment and does not indicate what information the caseworker should document. This lack of guidance within the tool itself can lead to inconsistencies between caseworkers regarding what information they consider and ultimately document during a safety assessment.

  Auditors reviewed a sample of nine CSRAs that were completed during fiscal year 2015 where a child (or children) was determined to be unsafe and found that department staff did not consistently document information in the CSRAs and did not always meet the Department's documentation requirements. For example, in the CSRA there is a textbox titled "Safety Plan" where caseworkers are required to document the names of children

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[1] Casey Family Programs & American Humane Association. (2009). *Safety and risk assessments: A project between Casey Family Programs and the American Humane Association*. Seattle, WA.

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determined to be unsafe. However, there is no reminder on the CSRA that caseworkers should include the name of the unsafe child or children. Auditors identified four CSRAs where caseworkers did not enter the name of the unsafe child or children. Failing to list the specific names of children could lead to confusion regarding the determination of safety for a specific child, particularly if there are multiple children in the home. Additionally, there is a textbox in the CSRA titled "Assessment of Impending Danger" where caseworkers should document an analysis of how the neglect or maltreatment situation meets the five safety criteria for unsafe children. However, in two cases auditors reviewed, caseworkers did not provide a clear explanation as to how the five safety criteria were met. In fact, in one of the two CSRAs, the caseworker instead included information related to the safety plan.

Other department reviews have identified similar concerns regarding how the structure of the CSRA tool can affect documentation and decision making around child safety and risk. In its independent review of the Department's child safety and welfare practices published in June 2015, the Chapin Hall Center for Children (Chapin Hall) reported that the narrative format of Arizona's CSRA tool has resulted in less consistent and structured documentation than when it was two automated tools (see *Arizona Department of Child Safety Independent Review, Chapin Hall*, Report No: 15-CR1).[1] Chapin Hall also reported that without a standardized assessment protocol, staff are left to rely on their own instinct or knowledge for making decisions about whether to remove a child from his/her home during the child safety and risk assessment process. Further, one expert who auditors interviewed indicated that the CSRA's unstructured format could lead caseworkers to subjective conclusions in evaluating child safety and risk. Both department officials and staff reported that reiterating and reinforcing the numerous concepts and requirements of the safety and risk assessment within the CSRA tool itself would help reaffirm what caseworkers should consider and document during the child safety and risk assessment process.

- **Limited ability to analyze safety and risk data to assess performance on key measures—** The narrative and unstructured format of the CSRA also hinders the Department's ability to analyze its safety and risk assessment process. Specifically, the Department is unable to track overall department performance for meeting certain timeliness metrics, such as whether or not the Department has made initial contact with a child who is the subject of a report of abuse or neglect.[2] Because the Department's CSRA tool is narrative-based, assessing the timeliness of initial contact can only be accomplished by opening cases one by one and reading the narrative. This prohibits the Department from collectively tracking data and ensuring that response times are being met.

  Additionally, the narrative and unstructured format of the CSRA tool does not allow the Department to analyze safety and risk assessment data and improve its safety and risk assessment practices based on this analysis. Specifically, because caseworkers respond in a narrative format to document the assessment within the CSRA, the language and terminology used may vary from caseworker to caseworker, which makes it difficult to analyze the

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[1] Chapin Hall is a research and policy center at the University of Chicago which focuses on improving the well-being of children, youth, and families. Per legislation relating to the creation of the newly formed Department (Laws 2014, 2nd S.S., Ch. 1, §159), the Office of the Auditor General was required to select an independent consultant with experience in child-welfare practices to perform an independent review of the Department and Arizona's child welfare system. Chapin Hall was selected to perform this review and offer insight into implementation challenges and best practices on child safety and risk.

[2] The Department applies a priority ranking to reports at the hotline, which ranges from Priority 1 through 4. Each priority level corresponds to a required response time. Specifically: Priority 1 (2 hours), Priority 2 (48 hours), Priority 3 (72 hours), and Priority 4 (7 days).

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assessment data and results. For example, because policy does not require caseworkers to explicitly list and explain the safety factors within the CSRA, the Department is unable to see how frequently a specific factor or set of conditions affects the decision to remove a child. Without this type of data, the Department's ability to make informed improvements to its child safety and risk assessment process, including its decision-making process, is limited. One expert with whom auditors spoke reported that in order to assess an overall system to make improvements, child welfare agencies need to be able to analyze the criteria used to make decisions around child safety. Similarly, best practice literature states that child welfare agencies should use data and case analysis to support ongoing learning and practice improvement around assessment practices for staff.[1]

Inadequate safety planning practices may adversely affect child removal—

The Department's safety planning practices, including Team Decision Making (TDM) meetings and the provision of services to families, may be inadequate for determining or mitigating the need to remove a child from his/her home, potentially leading to unnecessary child removals.[2] The Department uses a TDM meeting when an emergency removal of a child has occurred or the removal of a child is being considered (see textbox). The TDM meeting is held to determine if the child can safely return home or remain in the home with the provision of a safety monitor and/ or services, such as behavioral health services to help ensure the safety of children.[3] However, TDM meetings may not be carried out as intended and the Department may not have an adequate availability of services for families to help children remain in the home. Specifically:

> **TDM**—A TDM meeting is a decision-making process to address the safety and placement of an unsafe child. Department policy outlines what should happen during a TDM, such as all participants providing perspective about the safety situation, brainstorming ideas as to what changes must be made to manage the identified safety threats, and reaching a decision about child safety, placement, and service recommendations.
>
> Source: Auditor General staff summary of the Department's policy and procedure manual.

- **TDM practices may not be appropriately implemented**—The Department's implementation of TDMs may be inadequate for determining the need to remove a child from his/her home. The Department utilizes TDMs as a part of its safety planning process for an unsafe child. TDMs are collaborative meetings that should include a child's family, community partners, such as behavioral health providers, and department staff, including caseworkers, supervisors, and TDM facilitators. A TDM facilitator is a department employee who manages the TDM meeting by ensuring that the child safety decision is discussed during the meeting and that the placement decision resulting from a TDM is the least intrusive to ensure child safety. The Department has designed TDMs so that all participants discuss the safety concerns of the child and any possible services that may be offered to the family in order to keep the child safely in the home. This approach is consistent with best practice literature, which states that multiple community stakeholders

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[1] Casey Family Programs & American Humane Association, 2009.

[2] An unsafe child may refer to a child in present or impending danger (see Chapter 1, pages 6 through 7, for more information).

[3] In the instance of an emergency removal, the child has already been removed from the home. The TDM is held to determine if the child should remain out of the home or return home.

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should be included as partners in increasing child safety and reducing the risk of child maltreatment, and that families should be actively engaged in the safety planning process.[1]

However, one TDM facilitator who works in Maricopa County and reported attending more than 200 TDM meetings between November 2014 and August 2015, and one department manager with responsibility for overseeing TDM practices across the State, reported that caseworkers or supervisors may not be approaching TDMs with the appropriate mindset, which may be leading to unnecessary child removals. Specifically, they both reported that some caseworkers and/or supervisors may come to TDM meetings with their decision already made about whether to remove the child from the home, and may not adequately engage with families during this meeting. In addition, one caseworker that auditors interviewed reported she generally had already decided whether or not to advocate for removal of a child before ever attending the TDM. However, this approach is counterproductive, as the purpose of TDMs is to reach a joint decision about child safety and placement during the TDM process itself. Although a TDM facilitator is able to provide input as to whether he/she believes the child should be removed or not, ultimately it is the decision of the caseworker and supervisor. When caseworkers approach TDMs in this manner, it can lead to unnecessary child removals because caseworkers are not considering all of the available safety planning options.

Although the Department provides initial training for caseworkers around the purpose and values of a TDM meeting, the stages of a TDM, and caseworkers' role in the TDM process, there is no continual training for department staff on TDMs. Best practice literature indicates that practices involving the families to ensure child safety, such as TDMs, should be promoted through initial and ongoing training.[2] Similarly, the TDM facilitator and manager reported that having continual training that highlights the importance of the TDM process as a way to mitigate against child removal may be beneficial in improving TDM practices.

- **Department may not have adequate services to implement in-home safety plans**—The Department's availability of services for families may be inadequate to keep a potentially unsafe child in the home. If a child is determined to be unsafe during the child safety and risk assessment, a safety plan should be developed to mitigate the safety threats, which may allow the child to stay in the home. In order to implement and maintain a safety plan, the Department may provide services to the child and family, such as crisis intervention services and other behavioral health services to address the identified safety threat(s) to the child. Best practice literature states that a broad range of services and support should be available for at-need families, and that these services should be put in place to control for and maintain safety, reduce the likelihood of future maltreatment, and stabilize families in times of crisis.[3] In addition, one expert stated that the provision of these services may allow a child to stay in the home, but if services cannot be provided, child removal may be the only option to keep the child safe.

Department staff reported that the services most important to mitigating child removal are in-home intensive family preservation services, such as parenting education, crisis intervention

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[1] Casey Family Programs & American Humane Association, 2009.

[2] American Humane Association & the FGDM Guidelines Committee. (2010). *Guidelines for family group decision making in child welfare.* Englewood, CO.

[3] Casey Family Programs & American Humane Association, 2009.

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services and/or counseling, family therapy, domestic violence treatment, and behavioral management. However, there are lengthy waiting lists for these services in some parts of the State. For example, as of August 2015, 81 families were on the Department's referral waitlist for intensive in-home services in Yuma County, La Paz County, and portions of Maricopa County. According to department staff, based on the number of families awaiting services in these areas, these families may have to wait approximately 4 to 6 weeks before receiving services.[1] Further, 32 families were on the Department's waitlist for intensive in-home services for the remainder of Maricopa County and Pinal County, and these families could potentially wait up to 2 weeks before receiving services.

All required field training opportunities may not be provided to some caseworkers and coaching and mentoring opportunities unavailable to supervisors

—Although the Department provides both classroom and on-the-job training—termed field training—to caseworkers for conducting safety and risk assessments, some caseworkers may not be receiving all of the necessary field-training opportunities required by the Department. The Department hired approximately 1,550 new caseworkers between fiscal years 2013 and 2015, and adequately preparing these new staff to perform safety and risk assessments is critically important. According to the Department's training materials, part of the field training activities for new caseworkers involves shadowing a mentor, who is an experienced caseworker. This shadowing should include activities such as observing a TDM meeting, accompanying their mentor on two investigations, and reviewing or helping complete the CSRA tool with their mentor. However, according to a department official, some caseworkers may not be receiving all of the required shadowing and mentoring opportunities outlined in the training curriculum because of a shortage of staff who are available to mentor and coach new caseworkers, particularly in areas with high caseloads. Not receiving these training opportunities can have a critical impact on caseworkers' ability to effectively conduct safety and risk assessments. For example, four caseworkers from various Arizona counties indicated that because of a lack of access to mentoring opportunities during field training, they did not feel fully prepared to make safety and risk assessment decisions.[2] Child welfare literature indicates that adequate training with mentoring and coaching is important so that caseworkers can reach accurate conclusions when conducting assessments.[3] In addition, two experts who auditors interviewed indicated that success in conducting assessments largely depends on an agency's ability to effectively train, coach, and provide support to workers.

In addition, the Department does not provide formal mentoring or coaching opportunities for new supervisors as part of their training curriculum, which may affect supervisors' ability to effectively guide caseworkers. For example, one supervisor stated that the training she received as a new supervisor did not adequately prepare her to oversee caseworkers through the safety and risk assessment process. Another supervisor similarly indicated that she observed new supervisors struggling to manage and assist caseworkers in making sound safety and risk assessment decisions due to a lack of training and mentoring. Supervisor turnover may also aggravate the lack of mentoring and coaching for new supervisors. Specifically, the CARE Team Report published in 2014 indicated that the Department had

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[1] According to department staff, referrals involving extreme circumstances, as determined by caseworkers, are moved up in the waitlist and may not wait the full 4 to 6 weeks before receiving services.

[2] Two caseworkers work in Gila County, one in Pima County, and another in Maricopa County.

[3] Rycus & Hughes, 2003.

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experienced high supervisor turnover, which led to the promotion of staff members to supervisory positions who may not have been adequately prepared for the role.[1]

Together, the lack of sufficient shadowing and mentoring opportunities for both new caseworkers and supervisors may have a tiered effect, where some supervisors feel underprepared to help and oversee caseworkers make accurate safety and risk assessment decisions, and some caseworkers feel unprepared to conduct child safety and risk assessments.

Department plans to improve its child safety and risk assessment practices, but additional actions needed

The Department has planned to take some initial steps to improve its child safety and risk assessment practices; however, additional actions are needed. Specifically, in the Department's fiscal year 2016 strategic plan, the Department outlines several strategies for improving its safety and risk assessment practices, including plans to adopt a revised safety and risk assessment tool. In making these and any future changes, the Department should review and consider other agencies' experiences in improving their safety and risk assessment practices. Further, the Department should take additional steps to improve safety and risk assessment practices in Arizona, including improved safety planning practices and improved training for caseworkers and supervisors.

Department's strategic plan outlines steps to improve its safety and risk assessment practices—As part of its fiscal year 2016 strategic plan, which was released in July 2015, the Department has outlined its plans to improve performance in several key practice areas, such as the assessment of safety and risk. The planned improvements for safety and risk assessment practices include the following:

- **Revising its CSRA tool**—The Department plans to increase the accuracy of safety and risk assessments through the implementation of a revised CSRA tool. The Department reported that the new tool will be more structured than the current CSRA tool in order to better guide caseworkers through the safety and risk assessment process. For example, the tool will list the specific safety threats and risk factors so that caseworkers are prompted to consider and document each factor during their assessment. The Department estimates that the revised tool will be completed and implemented by the third quarter of state fiscal year 2016.

- **Incorporating a safety and risk assessment field guide**—As a supplement to the CSRA, the Department is in the early stages of piloting a field guide in two cities to enhance information collection as part of assessing safety and risk. The guide, which is carried into the field by caseworkers, contains a combination of checkboxes and narrative responses. The use of checkboxes is meant to provide additional guidance on what information caseworkers should gather and record, as they remind the caseworker to go through the safety and risk assessment process step-by-step while in the field. The inclusion of narrative response areas allows for caseworkers to explain in greater detail the answers provided in the checkboxes.

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[1] The CARE Team was created by the Governor in response to the revelation in November 2013 that department staff intentionally did not investigate nearly 6,600 child abuse and neglect reports. The CARE Team was tasked with overseeing the investigations of these cases; assessing department policies, procedures, and personnel; and making recommendations for change.

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As part of this pilot, the information collected by caseworkers is subsequently entered into the Department's CSRA by administrative staff in order to save time for caseworkers. According to its fiscal year 2016 strategic plan, the Department estimates that the field guide pilot will be completed by the second quarter of fiscal year 2016.

- **Reducing the waitlists for in-home services**—The Department indicated it plans to reduce the waitlists for in-home services, including intensive services that help mitigate removal. In reducing the waitlist for in-home services, the Department intends to use various strategies, including conducting a process improvement project to address factors contributing to the waitlist for services. According to its fiscal year 2016 strategic plan, the Department estimates that its process improvement project will be completed in the first quarter of fiscal year 2016.

Department could learn from other agencies to improve its safety and risk assessment practices—In addition to the Department's indicated actions for improving its safety and risk assessment practices, the Department should consider and review efforts other child welfare agencies have taken to improve their child safety and risk assessment practices. In 2008, Casey Family Programs and the American Humane Association jointly developed a Breakthrough Series Collaborative (BSC), an interactive program that involved 21 public and tribal child welfare agencies aimed at improving the way participating agencies assessed and made decisions related to child safety and risks.[1] Collectively, agencies that participated in the BSC and implemented reforms to their processes based on the best-practice framework experienced a 35 percent drop in their re-referral rates. The BSC defines a re-referral as a child who is referred to an abuse/neglect hotline twice within a 6-month period. The majority of the changes agencies piloted can be organized into five areas of practice improvement, specifically: (1) making sound decisions on safety and risk; (2) using safety and risk assessment tools; (3) respecting and responding to race, ethnicity, and culture; (4) engaging the child/youth and family; and (5) collaborating with cross-system and community partners. Table 1 on page 21 provides examples of changes that agencies piloted as a part of their participation in the BSC.

Auditors contacted Carver County, Minnesota's child welfare agency in order to follow up on changes piloted by this jurisdiction during its participation in the 2008 BSC. Additionally, auditors spoke with Vermont's child welfare agency, which did not participate in the BSC, but underwent a formal evaluation of its safety and risk assessment practices in 2014 by Casey Family Programs. Specifically:

- **Carver County, Minnesota, focused on child and family engagement as part of its safety and risk assessment process**—Changes made by Carver County during its participation in the BSC were aimed at further engaging children and families in safety and risk assessments and safety planning. Specifically, Carver County targeted the following:

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[1] The 21 jurisdictions included in the BSC included: Fresno County, CA; Pasadena, CA; Pomona, CA; San Francisco, CA; Stanislaus County, CA; Chippewa Cree Tribe; Larimer County, CO; Florida Circuit 18; Florida Circuit 5; Indiana; Carver County, MN; Olmsted County, MN; Navajo Nation, Shiprock; Navajo Nation, Southwest Region; Buncombe County, NC; Catawba County, NC; Oklahoma; Philadelphia, PA; Texas; Utah; and Wyoming.

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Table 1: Example practice improvement actions piloted by child welfare agencies as part of the BSC
As of December 2009

Practice improvement area	Example actions
Making sound decisions on safety and risk	• Immediate post-assessment conversation between caseworker and supervisor to discuss the presence of safety threats, family protective capacity, and the need for immediate protection. • Gather information about child safety and risk from collateral contacts identified by the family such as medical providers, educational institutions, or other individuals/systems with which the family has had contact. • Development of an immediate, written safety plan with the family, copies of which are left with the family and provided to the case supervisor.
Using safety and risk assessment tools	• Including questions about family strengths, resources, and support at the point of referral or at the hotline in order to enhance safety planning processes. • Supervisor training, worker think tanks, safety and risk discussions during supervision and agency meetings, and use of laminated cards with definitions in order to clearly define safety and risk and encourage consistent use of definitions.
Respecting and responding to race, ethnicity, and culture	• Initiation of conversation around race, ethnicity, and culture with the family. • Asking the family directly how they culturally and ethnically identify in order to gather more accurate data. • Development of a cultural broker program using community volunteers to assist the family through assessment processes, Team Decision-Making meetings, and to help agencies identify culturally appropriate services.
Engaging the child/youth and family	• Use of child-appropriate formal interviewing tools from the SOS model to actively engage children in order to obtain information for assessment and safety planning purposes. • Completion of assessment tools and creation of safety plans with the participation of families. • Calling families before initial visit to make an appointment and explain assessment process in order to better prepare families and establish a more cooperative working relationship. • Use of safety networks, such as relatives, friends, neighbors, and community members to whom the family has reached out and asked for a commitment to help, to aid in the development and implementation of safety plans.
Collaborating with cross-system and community partners	• Engaging community partners in a discussion about the agency's safety and risk definitions. • Sharing safety and risk assessment tools with family resource centers. • Developing a specialized caseworker with expertise in working with military families and coordinating with appropriate outside agencies.

Source: Auditor General staff summary of Casey Family Programs & American Humane Association. (2009). *Safety and risk assessments: A project between Casey Family Programs and the American Humane Association*. Seattle, WA.

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- ○ **Age-appropriate interviewing tools**—To incorporate children's perspectives, Carver County adopted age-appropriate interviewing tools from the Signs of Safety (SOS)® model to elicit and record a child's feelings about what makes him/her feel safe or not safe. According to staff in Carver County, this change resulted in an increased willingness on the part of children to participate in interviews.

- ○ **Family-developed safety networks**—During its participation in the BSC, Carver County shared information about its use of safety networks with other agencies. Safety networks comprise the relatives, friends, neighbors, and community members to whom the family has reached out and asked for a commitment to help. The safety network makes a commitment to the family and the agency that it will do specific things to support a safety plan and are expected to intervene if safety concerns arise after the agency is no longer involved. Carver County shared that it had found that families were more likely to follow a safety plan they had created themselves than a plan that the county had created for them, and that safety plans worked best when created by the safety network and the family together.

- ○ **Assessments of families with child maltreatment reports**—Carver County shared its practice of conducting assessments with the full participation of families who are subjects of a child maltreatment report. According to Carver County staff, the participation of families in the identification of safety concerns and family strengths has resulted in higher-quality information than approaches that do not fully engage families in the process, which in turn has led to more accurate safety assessments. This practice is a part of the SOS model for assessing safety and risk, which Carver County adopted in 2005. According to Carver County staff, the adoption of the SOS model has led to better rapport with families and better outcomes overall. For example, since 2005, the number of families determined to need ongoing services has decreased, the average number of children in out-of-home placements has declined, despite a rising number of assessments conducted, and since 2006, repeat maltreatment has declined, according to Carver County staff.

- • **Vermont focused on increased training for safety and risk assessment tools and safety planning**—The Vermont Department for Children and Families (Vermont Department) reported that it is in the process of revising its training around safety and risk assessment practices. In its evaluation of the Vermont Department, Casey Family Programs found that caseworkers needed increased training and guidance from the agency on the use of child safety and risk assessment tools and safety planning. Specifically, it recommended that the Vermont Department provide caseworkers with ongoing training and coaching, which should focus on general assessment skills as well as using tools for assessing safety and risk. In addition, it recommended the use of training and coaching for safety plans for cases in which significant safety threats or risks of future harm are identified and children remain in the home or are reunified following out-of-home placement, especially in families with issues of parental substance abuse, mental illness, or domestic violence. According to department staff, the Vermont Department formed a partnership with the University of California-Davis to have the University share its training program around coaching with the Vermont Department.

Because other child welfare agencies' reform efforts and experiences can provide valuable information to the Department, it should review the efforts that these other agencies have taken to improve their child safety and risk assessment practices and determine whether similar actions would improve the Department's child safety and risk assessment practices. In particular, the Department should evaluate the actions taken by agencies who participated in the BSC. Additionally, the Department should review Vermont's revised child safety and risk assessment training and coaching for caseworkers, which may help the Department improve its own mentoring and training practices.

Department should implement additional steps to improve safety and risk assessment practices—In conjunction with the actions identified in its strategic plan, the Department should take additional actions to improve its safety and risk assessment practices. Specifically, the Department should continue efforts to modify or replace its safety and risk assessment tool and ensure that the new tool effectively facilitates and guides caseworker safety and risk assessments and decision making through the use of a structured approach, standardizes information collected and documented by caseworkers, and results in usable data that the Department can analyze to assess its decision-making system and make informed changes for improvement. In developing a new safety and risk assessment tool, the Department should consider:

- Using automated and standardized checkboxes and/or prompts to ensure the appropriate level of detail, consistency, accuracy, and usefulness of safety and risk assessment data, and supplementing these checkboxes and/or prompts with narrative fields within the tool as necessary for caseworker use;

- Bulleting out the specific risk factors, safety threats, and safety criteria within the tool to help guide caseworkers in decision making by allowing them to go step-by-step through the assessment process and increase consistency in information gathering; and

- Including specific instructions and parameters within the tool itself on what type of information and level of detail is needed for areas where a narrative response would provide additional helpful information.

In addition to the revised safety and risk assessment tool, the Department should take action to address the other areas where improvements are needed, such as safety planning practices and staff training. Specifically:

- The Department should develop and implement policies and procedures that would direct and guide an analysis of safety and risk assessment data to identify trends, assess the appropriateness and results of decisions, and then revise any relevant child safety and risk assessment processes and protocols accordingly.

- The Department should reduce the waitlists for in-home services in order to improve safety planning by analyzing the availability of funding for in-home services, assessing whether it has contracted with sufficient providers, conducting a gap assessment to determine the level of services available and the level of services still needed, and identifying available funding and/ or resources to address this gap.

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- In addition to its initial staff training, the Department should develop and implement continual training on TDMs for all relevant department staff, including caseworkers, supervisors, and TDM facilitators to ensure that department staff are consistently and appropriately using TDMs. The continual training should reemphasize the core purpose of TDMs as a collaborative process to reach critical decisions regarding child safety, placement, and services.

- Finally, the Department should ensure that caseworkers and supervisors receive sufficient training related to assessing child safety and risk by:

  - Developing and implementing a plan that ensures new staff have access to mentors and are able to complete all of their training requirements, including those mentoring and coaching requirements indicated as part of field training, prior to conducting safety and risk assessments unsupervised;

  - Augmenting its training curriculum for supervisors by incorporating a field training component to allow for mentoring and shadowing opportunities for new supervisors regarding child safety and risk assessment;

  - Developing training on the new safety and risk assessment tool, once it is developed and implemented, to ensure that the tool is used correctly and consistently across the State; and

  - Ensuring that all relevant staff, such as caseworkers and supervisors, receive the new or revised training.

Recommendations:

2.1. The Department should review the efforts that other child welfare agencies have taken, including those agencies that participated in the BSC and Vermont's revised training program, to improve their child safety and risk assessment practices and determine whether similar actions would improve the Department's child safety and risk assessment practices.

2.2. The Department should continue its efforts to modify or replace its safety and risk assessment tool and should ensure the new tool effectively facilitates and guides caseworker safety and risk assessments and decision making through the use of a structured approach, standardizes information collected and reported by caseworkers, and results in usable data that the Department can analyze to assess its decision-making system and make informed changes for improvement. In developing a new safety and risk assessment tool, the Department should consider the following:

- Using automated and standardized checkboxes and/or prompts to ensure the appropriate level of detail, consistency, accuracy, and usefulness of safety and risk

assessment data, and supplementing these checkboxes and/or prompts with narrative fields within the tool as necessary for caseworker use;

- Bulleting out the specific risk factors, safety threats, and safety criteria within the tool to help guide caseworkers' decision making by allowing them to go step-by-step through the assessment process and increase consistency in information gathering; and

- Including specific instructions and parameters within the tool itself on what type of information and level of detail is needed for areas where a narrative response would provide additional helpful information.

2.3. The Department should develop and implement policies and procedures that would direct and guide an analysis of safety and risk assessment data to identify trends, assess the appropriateness and results of decisions, and then revise any relevant child safety and risk assessment processes and protocols accordingly.

2.4. The Department should reduce the waitlists for in-home services in order to improve safety planning by analyzing the availability of funding for in-home services, assessing whether it has contracted with sufficient providers, and conducting a gap assessment to determine the level of services available and the level of services still needed, and identifying available funding and/or resources to address this gap.

2.5. In addition to its initial staff training, the Department should develop and implement continual training on TDMs for all relevant department staff, including caseworkers, supervisors, and TDM facilitators to ensure that department staff are consistently and appropriately using TDMs. The continual training should reemphasize the core purpose of TDMs as a collaborative process to reach critical decisions regarding child safety, placement, and services.

2.6. The Department should ensure that caseworkers and supervisors receive sufficient training related to assessing child safety and risk by:

a. Developing and implementing a plan that ensures new staff have access to mentors and are able to complete all of their training requirements, including those mentoring and coaching requirements indicated as part of field training, prior to conducting safety and risk assessments unsupervised;

b. Augmenting its training curriculum for supervisors by incorporating a field training component to allow for mentoring and shadowing opportunities for new supervisors regarding child safety and risk assessment;

c. Developing training on the new safety and risk assessment tool, once it is developed and implemented, to ensure that the tool is used correctly and consistently across the State; and

d. Ensuring that all relevant staff, such as caseworkers and supervisors, receive the new or revised training.

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APPENDIX A

Methodology

This appendix provides information on the methods auditors used to meet the report objectives. The Auditor General and staff express appreciation to the Arizona Department of Child Safety (Department) Director and staff for their cooperation and assistance throughout the engagement.

Auditors used the following methods to meet the report objectives:

- Interviewed department management and staff and reviewed applicable state and federal laws and rules, department policies and procedures, department training materials, and other information obtained from the Department, including its fiscal year 2016 strategic plan;

- Reviewed two independent evaluations of the Department, including the 2014 CARE team report and the 2015 Chapin Hall report;[1,2]

- Analyzed information from the Department's semi-annual child welfare reports for federal fiscal years 2010 through 2014 regarding the annual number of Arizona child abuse and neglect reports the Department responded to compared to the number of children removed from the home;

- Conducted six observations of various components of the Department's child safety and risk assessment process to assess the Department's assessment methods and decision-making approach;[3]

- Reviewed documentation of completed child safety and risk assessments where children were determined to be unsafe to gain an understanding of the Department's assessment and documentation practices;

- Interviewed three child welfare experts regarding best practices in child safety and risk assessment;

- Reviewed literature related to safety and risk assessment in child welfare agencies to compare Arizona's child safety and risk assessment

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[1] *Arizona Department of Child Safety Independent Review*, Chapin Hall, Report No: 15-CR1 (2015). Chapin Hall is a research and policy center at the University of Chicago which focuses on improving the well-being of children, youth, and families. As required by Laws 2014, 2nd S.S., Ch. 1, §159, the Office of the Auditor General selected an independent consultant with experience in child welfare practices, Chapin Hall, to perform this review and offer insight into implementation challenges and best practices on child safety and risk.

[2] Governor Janice K. Brewer's Independent Child Advocate Response Examination (CARE) Team report (2014). The CARE Team was created by the Governor in response to the revelation in November 2013 that department staff intentionally did not investigate nearly 6,600 child abuse and neglect reports. The CARE Team was tasked with overseeing the investigations of these cases; assessing department policies, procedures, and personnel; and making recommendations for change.

[3] Auditor observations occurred in Gila, Maricopa, and Pima Counties.

practices to other states' practices and best practices.[1] As part of this literature review, auditors identified a 2008 Casey Family Programs and American Humane Association joint program entitled the "Breakthrough Series Collaborative", which involved 21 public and tribal child welfare agencies and was aimed at improving the way participating agencies assessed and made decisions related to child safety and risks;[2] and

- Contacted two agencies to obtain information regarding their safety and risk assessment practices, including information on actions that each agency has taken to improve its child safety and risk assessment processes.[3]

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[1] American Humane Association & the FGDM Guidelines Committee. (2010). *Guidelines for family group decision making in child welfare*. Englewood, CO.; Andrade, A., Austin, M., & Benton, A. (2008). Risk and safety assessment in child welfare: Instrument comparisons. *Journal of Evidence-Based Social Work*, 5(1), 31-56.; Baird, C. & Wagner, D. (2000). The relative validity of actuarial and consensus-based risk assessment systems. *Children and Youth Services Review*, 22(11), 839-871; Casey Family Programs & American Humane Association. (2009). *Safety and risk assessments: A project between Casey Family Programs and the American Humane Association*. Seattle, WA; Knoke, D. & Trocme, N. (2005). Reviewing the evidence on assessing risk for child abuse and neglect. *Brief Treatment and Crisis Intervention*, 5(2), 310-327.; Lund, T., & Renne, J. (2009). *Child safety: A guide for judges and attorneys.* American Bar Association and ACTION for Child Protection, Inc.; Lyons, P., Doueck, H.J., & Wodarski, J.S. (1996). Risk assessment for child protective services: A review of the empirical literature on instrument performance. *Social Work Research*, 20(3), 143-155, as cited in Rycus & Hughes, 2003.; Pecora, P. J., Whittaker, J.K., Maluccio, A.N., Barck, R.P., & DePanfilis, D. (2009). Child protective services. In Pecora, P.J. (Ed.) *The child welfare challenge: policy, practice, and research,* (pp. 312-337). New Brunswick, NJ: Transaction Publishers.; Rycus, J.S. & Hughes, R.C. (2008). Assessing risk throughout the life of a child welfare case. In Lindsey, D. & A. Shlonsky (Eds.), *Child welfare research: advances for practice and policy,* (pp. 201-213). New York, NY: Oxford University Press; and Rycus, J.S. & Hughes, R.C. (2003). *Issues in risk assessment in child protective services*. Columbus, OH: North American Resource Center for Child Welfare.

[2] Casey Family Programs & American Humane Association, 2009.

[3] Auditors interviewed staff from Community Social Services in Carver County, Minnesota, and the Vermont Department for Children and Families.

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AGENCY RESPONSE

September 24, 2015

Ms. Debra K. Davenport
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85018

Re: Auditor General Report on Child Safety Assessment and Removal

Dear Ms. Davenport:

The Arizona Department of Child Safety (Department) appreciates the opportunity to provide this response to the Auditor's General's report draft on Child Safety Assessment and Removal. The Department values the collaborative effort of the Auditor General's staff throughout this audit.

Enclosed is the Department's response to each individual recommendation. Thank you again for the opportunity to provide feedback, we believe that the information in the Auditor General's report will be constructive in helping the Department to better serve the children of Arizona.

Sincerely,

Gregory McKay
Director

Enclosure

cc: Shalom Jacobs, Deputy Director of Operations
        Katherine Guffey, Chief Quality Improvement Officer

**ARIZONA DEPARTMENT OF CHILD SAFETY'S RESPONSE
TO THE OFFICE OF THE AUDITOR GENERAL'S REPORT ON
CHILD SAFETY ASSESSMENT AND REMOVAL**

The Department's response to the Auditor General's recommendations is described below:

RECOMMENDATION 2.1:

The Department should review the efforts that other jurisdictions have taken, including those agencies who participated in the BSC and Vermont's revised training program, to improve their child safety and risk assessment practices and determine whether similar actions would improve the Department's child safety and risk assessment practices.

DCS Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Department recently formed a workgroup of field staff, subject matter experts, and community partners to recommend and implement methods that will increase workforce capacity to conduct high quality investigations and family assessments. These groups will review the efforts that other jurisdictions have taken, including jurisdictions that participated in the BSC and Vermont's revised training program.

RECOMMENDATION 2.2:

The Department should continue its efforts to modify or replace its safety and risk assessment tool and should ensure the new tool effectively facilitates and guides caseworker safety and risk assessments and decision-making through the use of a structured approach, standardizes information collected and reported by caseworkers, and results in useable data that the Department can analyze to assess its decision-making system and make informed changes for improvement. In developing a new safety and risk assessment tool, the Department should consider the following:

- Using automated and standardized checkboxes and/or prompts to ensure the appropriate level of detail, consistency, accuracy, and usefulness of safety and risk assessment data,

and supplementing these checkboxes and/or prompts with narrative fields within the tool as necessary for optional caseworker use;

- Bulleting out the specific risk factors, safety threats, and safety criteria within the tool to help guide caseworkers in decision-making by allowing them to go step-by-step through the assessment process and increase consistency in information gathering; and

- Including specific instructions and parameters within the tool itself on what type of information and level of detail is needed for areas where a narrative response would provide additional helpful information.

DCS Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

As noted by the Auditor General and outlined in the Department's strategic plan, the Department is already modifying its safety and risk assessment tool in the statewide automated child welfare information system (SACWIS, known as CHILDS in Arizona) so that it will include standardized checkboxes and prompts; the specific risk factors, safety threats, and safety criteria; and instructions.

RECOMMENDATION 2.3

The Department should develop and implement policies and procedures that would direct and guide an analysis of safety and risk assessment data to identify trends, assess the appropriateness and results of decisions, and then revise any relevant child safety and risk assessment processes and protocols accordingly.

DCS Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Department will analyze trend and outcome data to inform the continuous improvement of safety and risk assessment processes and protocols after the safety and risk assessment tool in CHILDS has been revised to allow extraction of data. The Department currently evaluates trends and outcomes through the Department's qualitative case review process.

RECOMMENDATION 2.4

The Department should reduce the waitlists for in-home services in order to improve safety planning by analyzing the availability of funding for in-home services, assessing whether it has contracted with sufficient providers, and conducting a gap assessment to determine the level of

services available and the level of services still needed, and identifying available funding and/or resources to address this gap.

DCS Response

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Department has been engaging with in-home service providers to identify service gaps and root causes for the current waitlist, and will continue to do so.

RECOMMENDATION 2.5

In addition to its initial staff training, the Department should develop and implement continual training on TDMs for all relevant department staff, including caseworkers, supervisors, and TDM facilitators to ensure that department staff are consistently and appropriately using TDMs. The continual training should reemphasize the core purpose of TDMs as a collaborative process to reach critical decisions regarding child safety, placement, and services.

DCS Response:

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

The Department's Strategic Plan for State Fiscal Year 2016 includes tactics related to the expansion of Team Decision Making. Support for this expansion will include staff training.

RECOMMENDATION 2.6

The Department should ensure that caseworkers and supervisors receive sufficient training related to assessing child safety and risk by:

a. Developing and implementing a plan that ensures new staff have access to mentors and are able to complete all of their training requirements, including those mentoring and coaching requirements indicated as part of field training, prior to conducting safety and risk assessments unsupervised.

b. Augmenting its training curriculum for supervisors by incorporating a field training component to allow for mentoring and shadowing opportunities for new supervisors regarding child safety and risk assessment;

c. Developing training on the new safety and risk assessment tool, once it is developed and implemented, to ensure that the tool is used correctly and consistently across the State; and

d. Ensuring that all relevant staff, such as caseworkers and supervisors, receive the new or revised training.

DCS Response

The finding of the Auditor General is agreed to and the audit recommendation will be implemented.

An advanced safety and risk assessment training will be developed as part of the Child Welfare Training Institute's advanced training curriculum. Staff will be enrolled in this training after they have been in the field for at least six months. In addition, the Department is developing supervision guides, including a guide for staffing with a supervisor and/or Assistant Program Manager when considering removal of a child. These guides are grounded in the Department's safety and risk assessment model. Initial implementation of these guides will include a coaching component.

Performance Audit Division reports issued within the last 12 months

14-107	Arizona Department of Child Safety—Children Support Services—Emergency and Residential Placements
14-108	Arizona Department of Administration—Arizona State Purchasing Cooperative Program
15-101	Arizona Department of Child Safety—Child Abuse or Neglect Reports, Substantiation Rate, and Office of Child Welfare Investigations
15-102	Arizona Department of Administration—State-wide Procurement
15-103	Arizona Medical Board—Licensing and Registration Processes
15-104	Arizona Department of Transportation—Motor Vehicle Division
15-105	Arizona Department of Revenue—Use of Information Technology
15-CR1	Independent Review—Arizona's Child Safety System and the Arizona Department of Child Safety
15-CR1SUPP	Supplemental Report to the Independent Review—Arizona's Child Safety System and the Arizona Department of Child Safety
15-106	Arizona State Retirement System
15-CR2	Independent Operational Review of the Arizona State Retirement System's Investment Strategies, Alternative Asset Investment Procedures, and Fees Paid to External Investment Managers
15-107	Arizona Sports and Tourism Authority
15-108	Arizona Department of Administration—Personnel Reform Implementation
15-109	Arizona Department of Administration—Sunset Factors
15-110	Arizona Foster Care Review Board
15-111	Public Safety Personnel Retirement System
15-CR3	Independent Operational Review of the Public Safety Personnel Retirement System Investment Strategies, Alternative Asset Investment Procedures, and Fees Paid to External Investment Managers
15-112	Arizona Commerce Authority
15-113	Arizona Department of Transportation—Transportation Revenues
15-114	Arizona Department of Transportation—Sunset Factors
15-115	Arizona Radiation Regulatory Agency, Arizona Radiation Regulatory Hearing Board, and Medical Radiologic Technology Board of Examiners
15-116	Arizona Department of Revenue—Security of Taxpayer Information
15-117	Arizona Department of Revenue—Sunset Factors

Future Performance Audit Division reports

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Information Briefs:
    Alternatives to Traditional Defined Benefit Plans
    A Comparison of Arizona's Two State Retirement Systems