STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

February 9, 2017

The Honorable Bob Worsley, Chair
Joint Legislative Audit Committee

The Honorable Anthony Kern, Vice Chair
Joint Legislative Audit Committee

Dear Senator Worsley and Representative Kern:

Under contract with the Office of the Auditor General, the Chapin Hall Center for Children at the University of Chicago completed an initial followup of the Arizona Department of Child Safety regarding the implementation status of the 26 audit recommendations presented in the *Independent Review of Arizona's Child Safety System and the Arizona Department of Child Safety* released in June 2015 (Auditor General Report No. 15-CR1). As the attached grid indicates:

- 1 has been implemented;
- 24 are in the process of being implemented; and
- 1 has not been implemented.

Unless otherwise directed by the Joint Legislative Audit Committee, this concludes the follow-up work on the Arizona Department of Child Safety's efforts to implement the recommendations from the June 2015 Independent Review.

Sincerely,

Dale Chapman, Director
Performance Audit Division

DC:ka
Attachment

cc: Gregory McKay, Director
Arizona Department of Child Safety

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Ms. Debra K. Davenport
Auditor General
Arizona Office of the Auditor General
2910 N. 44th St., suite 410
Phoenix, AZ 85018

February 3, 2017

Dear Ms. Davenport:

The Chapin Hall Center for Children at the University of Chicago is pleased to submit the attached report, which provides an assessment of the progress made by the Arizona Department of Child Safety in implementing recommendations issued in our previous Independent Review. To complete the assessment, we conducted interviews with staff of the agency including leadership, model office managers, supervisors, and case carrying staff members. We also conducted an extensive review of documents made available to us by the Department.

Regarding our overall impressions, we would like to highlight several overarching themes. First, it is clear the Arizona Department of Child Safety has undertaken a concerted and strategic effort to implement the recommendations found in our earlier report. This was evident in the documents we reviewed, the strategies articulated by the members of the leadership team, and the change in practice and policy reported by front-line staff.

Second, the strategy undertaken by the Department has been deliberate and intentional. Best practice suggests that a large and complex system cannot address all challenges simultaneously; consequently, DCS has clearly established a set of priorities that are well-thought out. This has included the prioritization of certain problems (the hotline, CPS investigations, child safety, and the so-called backlog) as well as certain locations (i.e., those where the challenges facing the Department were most acute). The Department is also making better use of evidence to guide decision-making and to understand when adjustments to strategies are warranted.

DCS has a long way to go in bringing change to scale – both geographically and substantively. Progress made to date is reflective of the priorities set by the Department, as well as the "locus of control" – that is, change has taken hold first in the areas that are under the Department's purview, whereas other areas (collaboration with the courts) will require more complex solutions.

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Given these observations, we commend the Department for making good use of the Independent Review as a guide to transformation. Please don't hesitate to contact us if you have additional questions about the follow-up assessment, and thank you for the opportunity to engage in this work.

Sincerely,

Fred Wulczyn
Senior Research Fellow

Dana Weiner
Policy Fellow

Independent Review—Arizona's Child Safety System and The Arizona Department of Child Safety
Auditor General Report No. 15-CR1
Initial Follow-Up Report

Recommendation	Status/Additional Explanation
Finding 1: Investigation/Entries	
1. Establish and use clear safety assessment protocols and better standardize processes at the hotline and investigations.	**Implementation in process** The Department continues to utilize the SAFE Model as its safety assessment protocol, which was in place during the 2015 Chapin Hall review. The Department is receiving technical assistance from Action for Child Protection to update policies, procedures, and forms for its safety assessment protocol and has begun the field-testing aspects of the updated SAFE Model within three field offices. The Department has created new decision-making guides and produced new material (including infographics and flowcharts) to assist with the technical understanding of the SAFE Model. The Department holds meetings to discuss these policy revisions. Monitoring the SAFE Model is ongoing. The Department also indicated that it will work to address staff training and coaching to integrate the SAFE Model into the judicial review process and ensure fidelity to the SAFE Model. The Department set a fiscal year 2016 strategic goal of improving objective decision making at the hotline and during investigations. It has taken significant steps to improve standardization of call screening and prioritization at the hotline, particularly through changes to the hotline categorization and the implementation of a new decision-making guide. This guide contains clarified definitions, detailed explanation and classification of various types of harm, and a specific protocol for situations where information is insufficient. Dedicated audit staff have also been put in place at the hotline to ensure quality and standardization. Overall, the Department provided data on inter-rater reliability to document that hotline call goals are now met 88 percent of the time, as compared to 57 percent in 2014. The Department implemented detailed supervision guides based on the child safety protocol for investigations and ongoing cases; these guides inform and help staff with safety assessments and decision making. They cover multiple discussion areas, list specific safety threshold criteria and risk factors, and differentiate between in-home and out-of-home cases.

Recommendation	Status/Additional Explanation
2. Examine available child safety risk assessment protocols and consider reverting back to the standardized form that was previously in use OR implement a new, standardized safety assessment protocol selected from one of the many models in place in other jurisdictions.	**Implemented** The Department reviewed its options and decided to continue using the same protocol it had during the Chapin Hall review, bolstering its effectiveness with training and tools to support the reliable, comprehensive use of the protocol rather than implementing a new one or making significant changes.
3. The safety assessment selected should include standardized items, yield quantifiable data, and direct decisions clearly and transparently.	**Implementation in process** In a report to the Joint Legislative Budget Committee, the Department described its decision-making process. It made the argument that good safety decision making is not accomplished through implementing a specific assessment model; instead, the Department argued that the true focus should be on providing staff with adequate training, time, and guidance to "go beyond the tool" in making safety decisions. Furthermore, the Department has engaged Action for Child Protection for technical assistance to update the SAFE Model, which will now include metrics around fidelity. The SAFE Model already includes standardized items. The Department intends to replace the current automated child welfare information system, known as CHILDS, and is concentrating its resources on developing a new system called Guardian. Guardian is an incremental replacement that will start with the mobile solution in fiscal year 2018; that version will address safety and risk assessment in investigations. The contract for the mobile solution has already been awarded and is scheduled for implementation in the summer of 2017. The Department is delaying modification of the existing Child Safety and Risk Assessment (CSRA) tool that is currently incorporated into CHILDS until it can incorporate the changes into the new system. The SAFE Model Family Functioning Assessment will be integrated into Guardian in a way that will yield quantifiable data about the assessed safety threats and protective capacities. The Department will use this data in fidelity monitoring and outcome monitoring, and to inform service array development.
4. Workers and supervisors should receive significant support and oversight during its implementation to ensure that the protocol is being administered with fidelity and that the results of the assessment are being used to inform decision-making.	**Implementation in process** The Department implemented detailed supervision guides based on the child safety assessment protocol for investigations and ongoing cases; these guides inform and help staff with safety assessments and decision making. They cover multiple discussion areas, list specific safety threshold criteria and risk factors, and differentiate between in-home and out-of-home cases. In addition, administrative case record review checklists have been created for department supervisors' use to ensure that child safety specialists are administering the protocol correctly and with fidelity.

Recommendation	Status/Additional Explanation
	The Department is updating policies, procedures, and decision-making guides used in relation to the SAFE Model. To help direct workers' actions, the Department will integrate the new decision-making guides into the new information system when it is developed and will produce them in hard copy for state-wide use in the meantime. The Department is updating the training curriculum and developing staff to serve as coaches. The Department has standardized the process of having a safety decision discussion between a child safety specialist and a supervisor. The Department created a new *Safety Decision Guide* for this process. The Department provided state-wide training around this new process in September 2016. According to the Department, weekly meetings also occur with the five regional program administrators and their regional program managers. Data reviews occur at the deputy director/program administrator and program administrator/program manager meetings. The Department plans to continue this work at the program manager/supervisor huddle board discussions. As the Department continues to make safety assessments and decisions that align with best practice, it will be important to make sure that communication with the field is clear and well understood. Our interviews suggest that adjustments related to the distinction between "present" and "impending" danger are underway in order to clarify previous confusion among staff. Specifically, the Department is taking steps to clarify both the distinction and the implications for action. New strategies to encourage the documentation of safety decision making have clarified the protocol and streamlined the decision-making process, enhancing consistency and the speed with which cases may be dispositioned, according to interviews with department staff. Staff also recognize a newfound focus on the difference between safety and risk and consider themselves to now have a better understanding of this distinction. According to the Department, updated, standardized decision-making guidelines for field operations are being implemented in the Pima, central, and southwest regions. This process extends beyond simply rolling out the revised SAFE Model and includes an expedited case transfer process, visual management, and implementation of leader standard work. The Department projects the timeline for finalizing guides, scheduling and conducting trainings, and completing implementation to extend into 2018.

Recommendation	Status/Additional Explanation
5. To address the backlog of cases that has accumulated at the front door of the system, consider implementing multiple strategies. In the short term, these may include the engagement of community providers, retired case workers, or private companies to provide the capacity to conduct a large number of investigations and disposition cases in a timely manner. This must happen in conjunction with clear and consistent decision-making protocols and available service pathways for different levels of need (as described elsewhere in the report).	**Implementation in process** The Department has implemented tailored strategies to reduce the backlog of cases at the front end. Each of the five state-wide regions has developed and implemented a plan to address the backlog by closing more investigations than are opened each month. Weekly meetings between field operations leadership and regional program administrators focus on reviewing the objectives, progress, and effective practices of backlog reduction, and scorecards quantify the degree of improvement. The Department has also dedicated an unspecified but small number of full-time positions to the backlog reduction effort and has paid approximately 70 staff a stipend or overtime to complete investigations. In addition, data dashboards have been created to aid in backlog-reduction efforts by allowing for triage and prioritization of open investigations for response, as well as monitoring the progress on ongoing investigations. Training is provided to help staff use the data dashboards, although details were not provided regarding the training or the proportion of the staff who have been trained to use the data dashboards. According to staff interviewed, the Department has also implemented an improved case transfer process in some of its field offices (around 16 or 17 out of 55 offices) so that cases can move more quickly from investigation staff to ongoing case management staff. Staff interviewed indicated that there is now a standardized protocol of holding the first court hearing within 5 to 7 days of a child's removal. By improving the clarity and transparency with which cases are transitioned to ongoing case management and applying strategic capacity enhancements to reduce the number of open investigations, the Department has lowered caseloads to some extent and, according to investigators Chapin Hall interviewed, allowed investigators to devote more time to engage families in services, thus expediting the resolution of their cases (see status of Finding 4, Recommendation 3, for more specific caseload information). The success of this strategy depends upon support staff's capacity to help expedite the necessary documentation. In implementing these strategies, the Department has prioritized the regions/counties experiencing the highest backlog and investigative caseloads, and in these sites the strategies tested appear to have been successful. According to information provided by the Department, as of November 2016, more reports have been closed than received in 19 of the 21 months since March of 2015. In addition, the total number of open reports was reduced from a high of 33,245 in April 2015 to 10,536 in November 2016. This represents a

Recommendation	Status/Additional Explanation
	68 percent reduction in open reports. Further, there was a reduction of the backlog of inactive cases from 16,014 to 3,470 as of November 2016, which is a 78 percent reduction since March 2015. Going forward, the Department should continue to engage community providers and former department employees to assist with the backlog and help with the investigation and disposition of cases.
6. In the long term, the state should consider the regular engagement of providers in a performance-based contracting arrangement that is geared toward focusing agencies on achieving desired outcomes and incentivizing best practice and outcomes through contractual agreements.	**Implementation in process** The Department has taken steps to develop a clear and standardized procurement process that will clearly establish desired outcomes, performance standards and metrics, and the needs of the end users. A flowchart was created to show the process for developing contracts and setting evaluation criteria, with distinct workflows reflected for different levels of staff. In addition, according to the Department, it is applying for technical assistance from Harvard University on performance-based contracting. Going forward, the Department should establish and incentivize best practices.
Finding 2: Service Array	
1. Using services to reduce pressures at the system's front door will require a thoughtful, resourced answer. At the current pace, over the longer term, Arizona could expand in-home services and pay for the expansion with savings that accrue from reductions in foster care caseloads.	**Implementation in process** Office of Prevention staff are attending the Statewide Quarterly In-Home Service Provider Meetings to provide ongoing education on available services such as the Care Portal, Building Resilient Families, In-Home Community Based Resources such as Newborn Intensive Care Program, Safe Sleep, Regional Prevention Councils, and Fast Pass Initiatives. In the offices we visited, staff at all levels appeared to have increased awareness of in-home service options to alleviate the need for placement and indicated they are disseminating more information and referrals for these options. In-home service referrals have increased by 12-15 percent, according to the Department. Because fiscal year 2017 is still open, it is difficult to carry out an exact comparison with fiscal year 2016 referral figures. However, the stated increase in referrals appears to have taken place for in-home intensive and moderate services. In mid-2015, the Department launched Building Resilient Families, a community-based intervention program where families who were identified as being low risk can receive support and assistance from agencies contracted with the Department. This partially addresses the recommendation to cater more to families who come to the Department's attention but whose needs are not severe enough to warrant a removal. Building Resilient Families is a frequently accessed resource available to low-risk families in Maricopa

Recommendation	Status/Additional Explanation
	County during investigation, which can provide help with a wide array of issues to reduce risk and restore family functioning. The Department stated that the program has served over 1,600 families since its inception, and the Department is conducting an evaluation to measure the impact it has had on improving family functioning. Additionally, the Department is expanding the criteria for Building Resilient Families to allow more families to participate. The Department has also changed the billing process that allows providers more flexibility in how many hours they can spend with a family each month to meet the family's needs in the program. The program will continue through June 30, 2017, with possible subsequent extensions to the contract. While it may take time to scale up Building Resilient Families so that it is available for referrals across the State, this strategy's success in offices with the most serious and severe backlogs suggest that it will be a useful addition to the service continuum. In addition, the Title IV-E Waiver Demonstration project, Fostering Sustainable Connections, was implemented on July 1, 2016, to identify and support family connections for youth in group care with the goal of reducing the length of stay in congregate care settings when a kinship caregiver is located and supported to care for a youth. This initiative targets youth who are already living in out-of-home care settings—specifically, in congregate care. Results from the empirical evaluation of this effort, underway by partners at Arizona State University, are not available at this early stage. According to the Department, it is making efforts to reduce the waitlist for in-home services. The Department's September 2016 report to the Joint Legislative Budget Committee states that the Program Development Unit's waitlist reduction plan involves tracking and monitoring weekly referral numbers that contracted service providers submit. Moreover, service supply and demand is now managed at the regional level so that each region can address waitlist tracking and resolution in a way that is specific to that region's particular needs. In September 2016, the Department also issued contracts to five different in-home providers to increase capacity for in-home services, but the launch was too recent for any outcomes to be clearly determined. Despite these efforts, the Department acknowledges that in some parts of the State, the waitlist of in-home services is "still very long."
2. Healthy Families Arizona should continue to receive support, and other in-home services should be installed to meet the needs of families that come to the Department's attention but do not require a removal.	**Implementation in process** The Department continues to offer the Healthy Families Arizona (HFA) program to families at the community level. According to department figures, in fiscal year 2016, the program served 4,625 families state-

Recommendation	Status/Additional Explanation
	wide—a decrease from 4,911 families in 2015. No reasons were identified for this change, but it does not appear to be a substantial enough reduction to merit concern. Department data indicates that the program appears to be meeting at least some of its goals. For example, over 95 percent of families receive their first home visit within 90 days, thus meeting the program's 80 percent minimum goal. The next step in the process is to connect HFA to reductions in admissions to care. Other in-home services include the Substance Exposed Newborn Safe Environment (SENSE) program, which creates a coordinated system of care for substance-exposed newborns, where multiple agencies can share progress and collaborate on a single service plan; and Care Portal, which draws upon local churches as a community resource to meet the needs of families, ranging from items like clothing to services like an exterminator and was piloted in Pima County in October 2015. SENSE has been in place in Maricopa County for 10 years and, according to the Department, is in the process of being expanded to Yuma, Mohave, Yavapai, and Pima Counties. Care Portal is also expanding both in Pima and Maricopa Counties. In addition, as stated earlier (see Finding 2, Recommendation 1), the Department launched Building Resilient Families in mid-2015.
3. Monitoring the use of prevention dollars, streamlining pathways for referral and receipt of services, and clearly articulating eligibility criteria will be important to address this deficit.	**Implementation in process** The Department is making use of the Title IV-E Waiver to flexibly reinvest federal funds toward in-home services, such as the Fostering Sustainable Connections program mentioned earlier (see Finding 2, Recommendation 1). The Department is also working on improving referral pathways, such as the Fast Pass for Urgent Child Care (Fast Pass), which began in November 2016. Fast Pass allows for urgent child care referrals outside of normal business hours and service referral to families state-wide. A Service Referral Approval Matrix was developed and implemented to ensure that families receive the right services at the right time. In addition, the Department has created informational material to explain the eligibility criteria for various prevention services. Specifically, new and expanded programs such as the SENSE program, Care Portal, and Building Resilient Families have clearly stated eligibility criteria and referral processes. In addition, the Department has given some thought to the optimal utilization of funding, although efforts to monitor the use of prevention dollars are still in the early stages of development. For example, the Office of Prevention, created in February 2016, is developing a Strategic Action Plan to track prevention funds. In addition, the Department plans to regularly review and evaluate most preventive initiatives and has assigned responsibilities for

Recommendation	Status/Additional Explanation
	monitoring progress and how prevention dollars are being used. According to the Department, the Legislature has clearly defined the budget delineation for fiscal year 2017 with a Prevention line item that accounts for Building Resilient Families and Healthy Families, as well as the new Baby Box Program, which is part of the Department's Safe Sleep Initiative, and an In-Home Mitigation line item that accounts for Moderate and Intensive In-Home Services under the In-Home contract.
Finding 3: Courts	
1. Develop strategies in collaboration with county courts to both increase the number of attorneys and examine the payment strategies to re-align incentives and improve legal representation. Work with the local courts to build the capacity to conduct ongoing monitoring of attorney caseloads and the timely and accurate submission of information to the courts. An electronic, state-wide court-based management information system is used in some states to track court processes. Given the large number of cases on the court dockets, an investment in management information would pay for itself in a few short years.	**Implementation in process** While several of the recommended strategies in this area are beyond the Department's direct purview, the courts remain an essential component of the efforts to improve outcomes among children and families involved with the Department. According to interviews with stakeholders, efforts made to partner with the Maricopa County Juvenile Presiding Judge have been successful in expediting court hearings and redistributing work among an augmented work force of attorneys. For example, Maricopa County has hired an additional Commissioner to exclusively hear Preliminary Protective Hearings, which will help to make space on the calendars of other judges to conduct more timely dependency and severance trials. The Department has taken steps to replicate this collaboration in other counties by holding regular meetings with judges in other counties. According to Chapin Hall's interviews with department leadership, these meetings between the Department and the judges have focused on the impact of judicial action on permanency outcomes and the specific issues affecting attorney caseloads. The meetings have resulted in more streamlined decision making that can facilitate quicker case resolution and/or permanency, as well as a sensitivity to the need to reduce attorney caseloads. Further, according to Chapin Hall's interviews with department leadership, there have been successful efforts to secure funding for attorneys to reduce caseloads. Implementing a court-based management information system is beyond the Department's purview. However, Maricopa County's proposal for a new Juvenile Access Exchange system, which will allow for real-time exchange and distribution of court reports and disclosures to all parties in a dependency matter, was approved. The courts will need to initiate other measures that might improve their processes.

Recommendation	Status/Additional Explanation
Finding 4: Permanency/Exits	
1. Continue to increase the size of the work force to bring staffing ratios back to pre-2009 levels, if not above those levels given the number of children now in out-of-home care. While resources have been allocated to increasing the work force, there have been barriers to expanding capacity, including the time it takes to adequately train new staff and delays in hiring.	**Implementation in process** As of October 2016, the Department reported that 1,341 child safety specialist positions (95 percent of the 1,406 appropriated full-time employee child safety specialist positions) were filled. It has set a goal of 60 new hires per month, has maintained an average of 60.5 new hires for the first 8 months of 2016 (according to department reports), and continues to focus its recruitment efforts in particular regions where hiring is low. The Department has made administrative improvements to reduce delays in hiring, such as bringing on additional staff members to expedite background reference checks. According to a department report (the Central Administrative Hiring Plan), 60 additional full-time employee positions were appropriated to the Department in fiscal year 2017, but most of these were central administrative positions, including budget, accounting, procurement, and contracts. For reference, at the end of 2015, the Department had 1,295 full-time child safety specialists. Recruitment and retention data is tracked and reviewed bimonthly, and exit surveys are administered to new hires who leave the Department within their first year. The Department's goal is to reduce all employee turnover from 26.7 percent to 25 percent by June 30, 2017. The Department also restructured child safety specialists' compensation to enable them to reach the maximum salary faster in the hopes of increasing retention. However, some positions, such as case aides, only received a change in grade and title without an accompanying salary increase. In addition, staff noted in interviews that the removal of retention bonuses has in fact reduced the incentive for experienced employees to stay. Concerns were also voiced in interviews that supervisors had not received a pay raise and were not eligible for overtime, and that more work needs to be done to retain supervisors. Staff training is being revised and is scheduled for rollout in April 2017. Newly hired child safety specialists will enter a 22-week training program incorporating a mix of field training, gradual case assignments, and supervision, with flexibility based on how well a trainee is doing. In addition, the Department launched the Advanced Investigations Academy and the Advanced Ongoing Academy in 2016. These trainings allow child safety specialists to engage in more in-depth learning of subjects that were not covered in detail in their General Core Training, with the goal of improving their proficiency and confidence in their job, and thus further improving retention. The Department should now focus on quantifying the extent to which this training has helped to reduce turnover and should also incorporate

Recommendation	Status/Additional Explanation
	feedback from trainees about the new training and whether they are finding it beneficial. Staff noted that they were usually given only a few weeks' notice of trainings, which sometimes made it difficult to accommodate the training into their schedules, and they would appreciate more advanced notice of the trainings.
2. Ideal caseload sizes should be calculated (using the information provided in this report and other jurisdictions as a reference point).	**Implementation in process** The Department recognizes the need to manage caseloads and is monitoring caseload sizes but has not made substantial progress in achieving consistently low caseloads. The Department has a scorecard target of 25 children per child safety specialist in ongoing cases and a target of 30 children per child safety specialist in in-home services. The investigations target varies by region as the Department works through the backlog. The Department should consider conceptualizing the size of its workforce in terms of staffing ratios (both for investigations and ongoing), as suggested in the recommendation, rather than in raw numbers. This will help track changes in capacity in terms of caseload management.
3. Funding should aim to stabilize caseload sizes for both investigations and placement workers at levels that will allow adequate attention to the needs of families, including sibling and parent visitation (which is now occurring at far below the rates specified in policy).	**Implementation in process** The Department's strategic plan has prioritized addressing the need to reduce the number of open reports. However, while this number has come down, the significant number of children now in the State's custody will require concerted efforts to achieve resolution. The Department has employed several strategies to promptly reduce the out-of-home population, including identifying ongoing cases in which the only outstanding issues are data or court related (cases in which children have been living at home with parents without incident for some time but are not marked "closed"). Investigation staff in one office noted that the situation with investigations has improved now that child safety specialists were being assigned no more than three new reports a week. For ongoing staff, if a new child safety specialist (i.e., staff who have been on the job less than 22 weeks) is counted as a 0.5 child safety specialist, the average ongoing caseload in Maricopa County is 43 children per child safety specialist, with some parts of Maricopa having as many as 50 children per child safety specialist. The Department recognizes that its caseloads are beyond capacity for the current workforce, leading to staff feeling overburdened by too many cases; it is monitoring and analyzing caseload data to equalize the distribution of cases across units and staff. For example, a GIS project was undertaken to realign the investigative service areas in Maricopa and Pinal Counties to deal with the disparity of reports each office received with the goal of balancing the reports assigned to each office.

Recommendation	Status/Additional Explanation
	The Department is shifting its efforts away from improving investigative workloads and is now adjusting assignments to provide more support for ongoing child safety specialists. Caseloads in some regions are still higher than the Department's goal, and the Department is prioritizing these—notably, out-of-home caseloads are significantly lower in Pima and southeast regions than the others, and the Department is therefore dedicating less attention to these regions. In addition, the Department reported a supervisor-to-child safety specialist ratio of one to six in August 2016. At the time of the audit, in 2015, the Department reported a supervisor-to-child safety specialist ratio of one to seven, showing improvement.
4. Decision-making has to become more efficient without being rushed, or vulnerable to the pressures of fear and reactivity.	**Implementation in process** There is some evidence that decision making is moving toward standardized protocols but not that it is less rushed and less susceptible to fear and reactivity. The Department implemented supervisory case progress reviews and case record review checklists in October 2015 to clarify the factors that should be considered in key decisions for both investigations and ongoing cases. Child safety specialists are mandated to consult with their supervisors when they assess that there is present or impending danger or a need for the Department to intervene; the checklists are used to guide and document these discussions between child safety specialists and their supervisors. However, while they help ascertain that all documentation and procedural requirements have been fulfilled, these reviews in themselves are not enough to improve consistent decision making unless staff are trained in how to use them well and are using them consistently. The Department is relying on reductions in caseload size to allow decision making to become less rushed. While interviews with staff suggest that decision making is naturally becoming more structured and thought-out as staff have more time to deal with individual cases, this change should be supplemented by the widespread adoption and fidelity of standardized protocols.
5. The workforce hired by the Department has to be distributed wisely along the continuum of care if the value of adding workers is to be realized.	**Not Implemented** The Department has not addressed the concern regarding the distribution of workers along the continuum of care, although there may be evidence of workers being redistributed once ongoing caseloads are reduced. The Department reported that it plans to pursue a more systematic approach to allocating workers along the continuum of care mid-2017, when it expects to have more data available and any statutory changes have been implemented.

Recommendation	Status/Additional Explanation
6. The Department should address the needs of the growing number of children in substitute care by reducing entries and decreasing time until permanency.	**Implementation in process** The Department is exploring various options to speed permanency, including policies that will facilitate guardianship, planning for independent living among youth 16 and older in foster care, and improving models of supervision to provide greater attention to the barriers to permanency. The Department has improved consistency in the procedures that lead to removal and reunification decisions, such as through developing a new *Child Safety Intervention Discussion Guide* and refining the timing, procedures, and oversight for team decision-making meetings. These improvements help limit removals to those cases the children cannot be safely served at home. Between January 2016 and October 2016, the number of entries into care per month ranged between 900 and 1,100, as compared to a range of 950 to 1,300 per month between a comparable period in 2015. The Department is also field testing updated policies and procedures for in-home safety plans to address present and impending danger. The Department stated that this should improve staff understanding of available in-home options and help ensure that an in-home safety plan is more likely to be considered as a viable option rather than being immediately rejected in favor of removing a child. The Department plans to disseminate these new supervisory guides and reviews, and other major policy revisions such as the *Child Safety Intervention Discussion Guide* through email messages and training sessions. According to the Department, all staff received training in September 2016 on the *Child Safety Intervention Discussion Guide.* The Department also reported that it is making efforts to reduce the waiting list for in-home services to allow for more timely reunification. However, these waiting lists are still considered too long. The Department is training family engagement specialists to find kinship placements for children in congregate care to safely exit children from out-of-home care into a foster or kinship family setting as part of the Fostering Sustainable Connections. In addition, the Department is developing procedures and collaborating with the courts to support more widespread use of guardianship, which typically takes a shorter time than adoption and therefore could reduce the length of time a child spends in care. Changes in the out-of-home care population coincide with these efforts. According to the Department, the number of children in out-of-home care has decreased from 19,044 children in February 2016 to 18,046 children in September 2016.

Recommendation	Status/Additional Explanation
7. This will involve taking a broader view of the Department's purpose and function, developing a Theory of Change that identifies key decision points and levers for changing growth trends, and implementing and supporting Evidence-Based Practices.	**Implementation in process** The Department has developed Theory of Change Models for the Hotline, Investigations, and Permanency as well as for the Title IV-E Waiver Demonstration project. There are plans to discuss these Theories of Change among the executive management for updates and next steps. The Theory of Change for investigations entails reducing caseloads at investigations to ensure that each employee can spend more time with the families they serve, such that fewer children have to enter care and more cases get closed. According to the Department, it is reducing caseloads at investigations through backlog reduction and improving the transparency and efficiency of the case transfer process, and changes in statutes and at the hotline improve communication screening. The Theory of Change for ongoing cases and permanency centers on instituting a better model of supervision. These Theories of Change are mostly understood at the leadership level; the employees interviewed were all aware that they now had fewer cases and knew that this was part of an effort to improve permanency through enhanced opportunity to engage with families, even though they did not necessarily label this as a "Theory of Change."
8. To meet these needs, the Department should proceed with and reinforce steps it has taken, including: the Safe Reduction Workgroup and Permanency Roundtables.	**Implementation in process** The Department continues to participate in the Safe Reduction Workgroup as part of the Maricopa County Safe Reduction Initiative. Department representatives meet quarterly with Maricopa County judges with high case volumes to address initiatives that impact the out-of-home care population. Partnerships with these judges have successfully obtained funding to reduce attorneys' caseloads and are working on legislative changes to facilitate guardianship. However, it is not clear how well-attended the workgroup is by other representatives from across the system, such as private providers. The Department should therefore try to specifically determine how effective this initiative is in connecting it to other stakeholders. The Department moved away from Permanency Roundtables because it preferred that these discussions be an internal process and because the required staff and community partner training was too time-consuming. Instead, the Department has developed and implemented Targeted Permanency Staffings. Targeted Permanency Staffings are meant to identify children with a goal of reunification who can safely return home and to discern the steps needed for timely permanency, thus decreasing the time for a child to achieve permanency.

Recommendation	Status/Additional Explanation
Finding 5: Accountability	
1. Refine and build on current improvements so that the CFSR, OAG reports, and department-generated reports provide useful information at regular intervals.	**Implementation in process** The Department has significantly revamped its use of data to focus attention on key outcomes and engage staff at all levels in the process of improving practice in all department offices. Innovative strategies to promote the dissemination and use of data on benchmarks, targets, and actual progress are in place and in use by managers. The Department has developed the Enterprise Risk Management (ERM) and Audit Management Services team, which coordinates and manages external audits and reviews from various entities, including the Arizona Office of the Auditor General and the U.S. Department of Health and Human Services. The teams examine, track, and monitor all recommendations and follow-up activities. Further, strategic activities have been developed with the Office of Quality Improvement and the Lean Practitioner from the Government Transformation Office.
2. Build upon existing CQI capacity by developing enhanced reports (data presented herein can provide a beginning template) and producing them regularly to inform ongoing improvements.	**Implementation in process** The reports being produced, including the quarterly benchmark progress reports and regional scorecards, are relevant and compelling for staff because they reflect not only the progress and output of work, but also the achievement of key departmental goals.
3. Develop baselines and targets for key outcomes to focus attention on improvement in the areas identified, and key reporting metrics to these outcomes. Content and frequency of reports should be refined, and transparency enhanced by developing a regular schedule of reports for use by internal and external stakeholders, allowing the federal CFSR, OAG reports, and department-generated reports to provide useful information at regular intervals.	**Implementation in process** The Department continues to regularly produce benchmark reports, strategic action plans, regional scorecards, and weekly wall charts to enhance reporting by providing baselines, targets, and improvement actions and progress. The Department has developed metrics for field offices, and dashboards allow for data-driven discussions. The Department will establish targets for performance metrics, and reporting to the regional level and department level will occur no less than monthly.
4. With respect to outside reviews, integrating the CFSR and OAG oversight with a rigorous, well-supported CQI process ought to provide the transparency stakeholders need in order to rebuild trust. The CQI structure can be mobilized to improve data compliance by providing regular internal submission reports to staff so that they can see whether the data reflects their work, and correct it accordingly.	**Implementation in process** The remobilization of the CQI structure is apparent to staff at all levels and, with the development of communication plans and appropriate venues, can be communicated to key stakeholders and system partners as well. The Department's work with stakeholders on matters having to do with public reporting is another step forward. The outputs from those efforts must include an expert's best practices review of the validity and reliability of the proposed measures and the reporting cycles.

Recommendation	Status/Additional Explanation
5. Additional assessment tools that collect data on child wellbeing should be incorporated so that this information can be a part of future reports.	**Implementation in process** The Department is implementing more child well-being tools within the Title IV-E waiver evaluation in partnership with Arizona State University. The Department provided the following tools that may be a part of the evaluation: *Ages and Stages Questionnaire: the Social-Emotional 2nd Edition*, the *Behavioral and Emotional Rating Scale-2nd Edition*, and the *Youth Quality of Life Instrument-Short Form*. While there has been significant improvement in the capacity to generate evidence using data resources and engagement of the work force around what meaning should be made of the evidence generated, it is unclear to what degree the evidence is being applied to decision making at the practice level and to what degree evidence use is pervasive across all areas of the agency (see Finding 6, Recommendation 1). As a result, the Department should now turn its attention to ensuring the evidence is in fact being applied to decision making at the practice level.
Finding 6: Evidence-Based Practices	
1. Develop partnerships with academic and other institutions to support the ongoing exploration, and then implementation, of evidence-based practices. The development of a Theory of Change, the refinement of Target Populations, the selection of Evidence-Based Practices, and the ongoing monitoring of the implementation of these practices will need to be informed by additional empirical data analyses, some of which may be beyond the Department's current capacity. These analyses would ideally be performed in collaboration with an academic partner that can apply statistical expertise to understanding the needs of children at greatest risk for poor outcomes. Steps taken in this direction, as typified by the Department's work on the Title IV-E waiver, should be reinforced.	**Implementation in process** The Department currently engages with two divisions at Arizona State University: ASU Center for Child Well-Being and ASU's Morrison Institute for Public Policy (the Morrison Institute). The Department is aiming to improve the awareness of definitions of neglect, prevention, and the use of IV-E funding to implement evidence-based practices. Recent examples of evaluation projects where the Department partners with the Center for Child Well-Being include the Title IV-E Waiver Demonstration project evaluation, in which several evidence-based practices have been mobilized to reduce the length of time that children spend in congregate care settings. The partnership with the Morrison Institute has also helped to guide an understanding of the scope and nature of the State's neglect cases. The approach suggested by the Morrison Institute is one of collaboration and partnership between the Arizona Community Foundation, the Morrison Institute, the Department, and the community. Neglect accounts for 70 percent of the hotline calls, indicating that the Department should more comprehensively collect data on the prevalence and types of child neglect in Arizona. The Morrison Institute recommended that next steps include acquiring data on neglect cases, analyzing the data, identifying current prevention programs, and developing policy options for prevention programs based on the data. This is especially important for increasing prevention efforts; community and in-home services are key to preventing neglect, keeping families together, and

reducing the need for foster care. According to the Morrison Institute, the Department should also consider deepening its involvement with leadership forums (legislators, courts, agency representatives, child advocates, etc.) to inform and help develop a common understanding of prevention and decide upon next steps.

The Department is also engaged with Northern Arizona University (NAU), which is currently evaluating Building Resilient Families and SENSE. NAU is conducting these evaluations free of charge.

In the meantime, the Department supports and encourages the use of evidence-based practices by community and contracted provider agencies. The Department has made a good effort to develop solid theories based upon evidence from data. A Theory of Change Model has been developed and implemented for Removal & Placement & Permanency, Hotline & Investigations, and the Title IV-E Waiver Demonstration project. Examples of successful implementations of evidence-based practices are the Team Decision Making Processes and In-Home Services. The Department is making progress toward more accurate assessments of actual needs of children and families, which leads to more individualized case plans (and matching In-Home Services) to improve outcomes for children and families. Furthermore, procurement practices have been modified to encourage the use of evidence-based practices by private providers, particularly in delivering parent training and assistance services.

In addition, the Department has created a workgroup of department staff and In-Home Service Providers. Its task is to consider which evidence-based practices best fit the needs of families who require In-Home Services. In addition, the group developed an assessment of evidence-based practices for state-wide use. The group's reports are now available publicly.

Interviews with local leadership suggest that the Department has communicated a clear vision regarding the use of evidence-based practices. The Department now places more value on the use of innovation in evidence-based decisions to improve outcomes for children and families.

According to Chapin Hall's discussions with the Department, local leadership initiated conversations with office staff about quality, processes, and capacity. These conversations give staff the opportunity to discuss issues they have encountered and present data on different processes to assist them in their decision making. Our interviews with investigative staff also

Recommendation	Status/Additional Explanation
	suggest that critical thinking—about quality, processes, and capacity—is encouraged. In addition, staff are being trained, supported, and mentored in the use of data. The interviewed staff did note that while these improvements and opportunities are implemented within model sites (locations in which new strategies are being piloted and studied to understand their effectiveness for broader implementation), it might not be representative of all sites. Future steps should include moving from an approach of one-on-one or small group conversations about evidence-based practices and the use of data for decision making, at certain sites, to implementing these discussions systematically and at a structural level. The eventual incorporation of well-being measures may also provide additional guidance around the appropriate evidence-based practices to implement.
Finding 7: Engagement	
1. Develop the infrastructure to promote regular communication and engagement of stakeholders among the foster parent, birth parent, foster youth, and advocacy communities that involve regular meetings, communication strategies (regular reporting or newsletters) and forums for the exchange of ideas.	**Implementation in process** Interviews with department leadership, local leadership, and staff suggest that engagement with children and families receiving services through investigations has been greatly improved as a result of lowered caseloads and clarified protocols. According to several program managers, the decrease in caseloads—and the resulting reduced pressure and lower stress levels—has positively affected the time taken and willingness of workers to engage with families and children. At the time of this followup, investigators are supported in their work, grasp the importance of engaging with families, and care about this engagement. As a result of the quality time workers spend with families, several program managers noted that families' perceptions of the Department are also starting to change. In the meantime, the Department is developing practice guidelines for investigators. These guidelines are intended to teach investigators how to engage families from the first contact. These practice guidelines will include topics such as the initial contact with a family, developing a safety plan with the family, and gathering information about parent and child functioning. The Department expects to publish these guidelines within the next 6 months. The Department continues to engage in some initiatives and developed several additional initiatives to engage with certain groups of stakeholders (especially children and families receiving services):

Recommendation	Status/Additional Explanation
	• To increase engagement with birth parents, a Birth Parent Advisory Board (Board) has been formed. The Board now includes four parents who successfully completed services through the Department. These parents are working with the Office of Quality Improvement to define the Board's role and responsibilities. The Department realizes the importance of an organized framework for the Board to play a meaningful role in the Department. • For foster parents, the following efforts continue or have been developed: Arizona Statewide, a statewide quarterly newsletter for foster, kinship and adoptive placements; Warm Line for support, information, and complaint resolution; the Fostering Inclusion Respect Support Trust (FIRST) Advisory Commission; and the Arizona Family Resources website, http://www.azfamilyresources.org/. • For foster youth, a Youth Advisory Board continues to be in place. • The Department continues to engage with advocacy communities, including a Community Advisory Committee (CAC). • The Department funds Regional Prevention Councils. Part of the contract requires the councils to promote and educate communities about the effects of Adverse Childhood Experiences and Protective Factors, including encouraging families to participate in local resources. Going forward, the Department should develop a more formal and coordinated structure or network within which communication about department initiatives and feedback can be exchanged.
Finding 8: Collaboration with Law Enforcement	
1. Because criminal behavior requires a criminal justice response, close collaboration requires a thoughtful and strategic approach, so that the involvement of law enforcement can be (1) targeted toward the highest-risk situations in which criminal wrongdoing is a concern; (2) informed and sensitive to the impact of trauma and the manner in which cases should be handled to minimize further trauma; and (3) employed in a way that incentives are aligned to identify family needs without criminalizing parents in need of assistance.	**Implementation in process** As of January 2016, the Office of Child Welfare Investigations (OCWI) provided additional staff to address capacity issues to supplement the Department's ability to manage cases with criminal involvement throughout the investigations process. OCWI is working with Maricopa, Pima, Pinal, and Gila Counties to update their respective county multidisciplinary protocols to include OCWI revisions, such as its response to criminal conduct reports. OCWI also provides an Advanced Joint Investigations Training as part of the Advanced Investigations Academy. The Advanced Joint Investigations Training is an instructor-led classroom training, which includes lectures, exercises, and case studies about

Recommendation	Status/Additional Explanation
	actual joint investigations and practices identifying criminal conduct using case narratives and the Criminal Conduct Decision Making Tool. The training is provided to all investigators state-wide. In addition, OCWI conducts periodic criminal conduct training with the Department's hotline personnel, which provides hotline personnel with a better understanding of what types of hotline reports meet criminal conduct criteria. OCWI continues to develop a collaborative relationship with its law enforcement partners to build a sensitive team approach to better serve families. Additionally, OCWI attends and participates in various meetings with its law enforcement partners, including monthly Multidisciplinary Team Meetings, monthly law enforcement Person Crimes squad briefings, and weekly Child Protection team meetings, among other regularly scheduled meetings. However, the differences in responsibility for decision making and report submission can challenge the strength of these collaborations. For this reason, changes are underway to allow OCWI workers to file court reports in cases with criminal wrongdoing. That said, the Department continues to work to leverage this resource in ways that improve efficiency and service delivery.