State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

DEPARTMENT OF ECONOMIC SECURITY, DIVISION OF CHILDREN, YOUTH AND FAMILIES

Report to the Arizona Legislature
By Douglas R. Norton
Auditor General
November 1997
Report Number 97-18

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

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DEPUTY AUDITOR GENERAL

November 10, 1997

Members of the Arizona Legislature

The Honorable Jane Dee Hull, Governor

Dr. Linda J. Blessing, Director
Department of Economic Security

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Department of Economic Security, Division of Children, Youth and Families. This report is in response to a May 29, 1995, resolution of the Joint Legislative Audit Committee.

The report addresses several aspects of the Division's oversight of child protective services, including its ability to: investigate reports of abuse or neglect, measure and manage its CPS workload, monitor problem group and shelter homes, provide sufficient out-of-home placements, and provide necessary management information to analyze its services and other needs. The report also acknowledges several major efforts the Division has undertaken in recent years to improve its ability to provide comprehensive child protective services. These efforts include the implementation of a statewide child abuse hotline, development of a case weighting system, and development and implementation of a comprehensive information system.

Regarding the Division's investigative process, our review found that the Division is unable to investigate all child maltreatment reports and thus cannot ensure that the children involved are safe. Therefore, to ensure the Division can investigate all its cases, additional staff will be needed. While the Division is currently in the process of developing staffing estimates, it could not provide auditors with the historical data needed to independently determine the extent to which additional staff are needed. In addition, a review of nearly 200 investigative case files in Maricopa County revealed that nearly 40 percent of investigations were not initiated within the required response time. Furthermore, some investigations were poorly documented, with some cases remaining open for extended periods when no further investigative activity was needed. Additional problems identified in the file review included investigative cases not receiving supervisory review and missing case files.

Regarding the Division's ability to measure its workload and staffing needs, our review found that although the Division recently implemented a case weighting model to better determine its CPS workload, further improvement of the model is needed. Specifically, the time study that was conducted to develop the case weighing model collected information from too few cases, did not consider the differences between types of caseworkers and excluded several important factors that can impact a caseworker's ability to manage caseloads. Regarding the Division's oversight of group and shelter homes, a review of 16 group care agencies that have exhibited problematic supervision and care of children revealed that the Division did not adequately document or resolve the problems occurring within those agencies. Regarding the current availability of foster homes, our review found that more children who are removed from their homes are being placed in temporary shelter care, for longer periods, because it is difficult to find appropriate placements for them. Specific problems often encountered in attempting to find more permanent placements include the inability or unwillingness of many homes to accept certain children, difficulty in finding placement for children with special needs and an overall shortage of foster homes located in the metropolitan areas. Finally, the report addresses the Division's need to continue to monitor data integrity after the implementation of its new information system.

As outlined in its response, the Department of Economic Security agrees with all of the findings and recommendations.

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

This report will be released to the public on November 12, 1997.

Sincerely,

Douglas R. Norton
Auditor General

Enclosure

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SUMMARY

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Economic Security, Division of Children, Youth and Families, pursuant to a May 29, 1995, resolution of the Joint Legislative Audit Committee.

During fiscal year 1997, the Division of Children, Youth and Families (Division) received 55,645 calls regarding suspected child abuse, neglect, or exploitation of Arizona children. Based on information callers provided, the Division determined that 38,063 of these calls (involving 62,839 children) required a Child Protective Services (CPS) investigation. The Division is responsible for ensuring these cases are investigated and that the children involved are safe from imminent danger.

To improve its efficiency and effectiveness in providing child protective services (CPS), the Division, over the last three years, has undertaken a number of major initiatives. Specifically, it has successfully implemented a statewide child abuse hotline, and it has developed a case weighting system for managing its CPS workload. Additionally, Arizona is a lead state in developing and implementing a comprehensive information system that is intended to capture information on the entire CPS process. The Division expects to complete implementation of this system, the Children's Information Library and Data Source (CHILDS), by the end of 1997.

The Division Is Unable to Investigate All Child Maltreatment Reports (See pages 9 through 14)

The Division is required to take calls regarding suspected child abuse and investigate those it deems appropriate. Such calls are referred to as CPS reports. Although the Division is mandated to investigate 100 percent of CPS reports, its fiscal year 1997 statewide investigation rate is 84 percent. Without conducting investigations in all cases deemed appropriate for investigation, the Division cannot ensure that the children involved are safe. Despite this, the number of uninvestigated reports increased between fiscal year 1996 and fiscal year 1997. Specifically, during fiscal year 1996, more than 1,500 cases went uninvestigated, and approximately 5,900 cases went uninvestigated during fiscal year 1997.

To ensure the Division can investigate all its cases, additional staff will be needed. Although the Division is developing staffing estimates, it could not provide auditors with historical information regarding workload because its workload measurement methods have recently changed. Although this Office's audit work does not dispute the need for additional staff, without this historical data, it was not possible to determine how reasonable the Division's estimates are. In addition, other factors may influence the need for additional staff and

resources and should be studied. For example, the Division should analyze whether the 34 percent increase in CPS reports during fiscal year 1997 will continue. Similarly, the Division should continue to review the process it uses to classify reports, since the Division received fewer calls regarding suspected child abuse in fiscal year 1997 than in 1996 (55,645 vs. 59,145), but determined that a much higher percentage of these reports required investigations (70 vs. 49 percent). Another factor the Division should review is the impact of the recently approved Family Builders Pilot Program, which is expected to provide services to families whose cases might otherwise remain uninvestigated. The Division anticipates that, over time, this program will reduce the number of staff it needs, so the Division will need to continually assess how many cases this program will handle once it is implemented in January 1998.

The Division's Investigations Are Not Always Timely or Thorough (See pages 15 through 21)

A review of 196 randomly selected District I (Maricopa County) investigative files found that nearly 40 percent of these investigations were not initiated within the required response time. In addition, some investigations were poorly documented, some cases were left open for extended periods when no further investigative activity was needed, and only about 40 percent of the investigated cases were reviewed by a supervisor in some manner prior to closure. Moreover, 6 percent of the case files were missing, so it was not possible to determine if any investigative activities were performed for these files.

The Division's problems with investigation timeliness and thoroughness are likely to continue because there were more reports requiring investigations during fiscal year 1997. While the Division is currently developing plans that would increase the number of investigative staff, it should make changes now in two other areas. **First**, the Division should develop additional training for its investigators covering both the basic investigative tasks required as well as specific investigative policies and procedures. **Second**, the Division should increase its oversight of investigations by ensuring that supervisors review cases prior to closure, and that Division management conduct random case file reviews to help assess the quality of its investigations.

Workload Measurement Model Needs Further Improvement (See pages 23 through 28)

Although the Division has recently implemented a better method for determining its CPS workload, the Division's case weighting model needs further improvement. Recognizing that case counts are not the best measure of workload, in 1994, the Division sought to implement

a more accurate means for assessing workload. The Division hired a consultant to design a case weighting model that measures workload by considering some of the complexities involved in handling a case, including the number of children and type of case plan established. However, when conducting the time study necessary to design the model, the Division collected information from too few cases, did not consider the differences between types of caseworkers, and excluded several important factors that can impact a caseworker's ability to manage caseloads, such as cases involving delinquent children or substance abuse, and children needing behavioral health services. To improve its case weighting model, the Division should increase its sample size so that it can gather more information for analysis when it conducts its next time study, scheduled for 1998.

The Division's Oversight of Group and Shelter Homes Is Inadequate (See pages 29 through 33)

The Division should improve its oversight of group and shelter homes. A review of 16 group care agencies' licensing files (chosen because they had been the subject of at least 2 child abuse and neglect reports during 1996) revealed that the Division did not adequately document or resolve the problems occurring at these agencies. Specifically, the Division did not adequately document all of these reports in the agencies' licensing files, and did not document whether it considered them during the agencies' licensing renewal process. Some agencies were allowed to alternate between regular and provisional licenses without adequately addressing the problems that originally caused them to receive a provisional license.

To help improve the Division's oversight of group and shelter homes, the Legislature should consider providing the Division with the authority to impose civil penalties. In the meantime, the Division should use its current authority to suspend or revoke the licenses of agencies that continually fail to adhere to licensing requirements.

Current Foster Homes Unable to Meet Certain Placement Needs (See pages 35 through 40)

More children who are removed from their homes are being placed in temporary shelter care, for longer periods, because it is difficult to find appropriate placements for them. Placement specialists and caseworkers cited three primary reasons for this problem: the inability or unwillingness of many homes to accept certain children, such as teenagers or large sibling groups; difficulty in finding placements for children with special needs; and the overall shortage of foster homes located in the metropolitan areas. Placement delays are not only costly, they are not in the child's best interest.

To ensure there are enough foster homes to meet placement needs, the Division needs to centralize foster home recruiting oversight and coordination, and expand its efforts to retain current foster families.

Data Integrity Should Remain a Continuous Priority for the Division's New Information System (See pages 41 through 44)

The Division should continue to monitor data integrity after the implementation of its new information system, the Children's Information Library and Data Source (CHILDS). During CHILDS' planning and implementation phases, the Division ensured that the system contained quality control features that would help address the previous data systems' problems identified in two prior Auditor General Reports (Nos. 91-6 and 94-L9). To ensure the Division remains committed to monitoring data integrity, it should continue with its development and implementation of a formal, written quality assurance program.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Arizona Department of Economic Security, Division of Children, Youth and Families, pursuant to a May 29, 1995, resolution of the Joint Legislative Audit Committee.

Division's Mission Is to Protect Child Abuse Victims

The Division's mission is "to protect children, to ensure their on-going safety, and to provide children in need and their families with an array of services that are accessible, appropriate, and which promote independence and self-sufficiency." During calendar year 1995, 43,762 children in Arizona required the Division's intervention. According to the National Center on Child Abuse and Neglect, in that year, the rate of children alleged to be victims of maltreatment in the U.S. by state ranged from 8 to 108 per 1,000 children younger than 18. Arizona ranked 33rd out of 49 states reporting, with a rate of 37 children per 1,000 being the subject of child abuse and neglect reports. Since 1995, the number of Arizona children involved in suspected maltreatment cases has grown. During fiscal year 1996, the Division received 28,445 child abuse and neglect reports involving approximately 47,000 children. In fiscal year 1997, the Division received 38,063 reports appropriate for investigation that involved 62,839 Arizona children.

Children are referred to the Division through its statewide toll-free child abuse hotline. Although any person can report suspected abuse, about half of the calls are made by teachers, doctors, and other health care professionals who are mandated by law to report such incidents. The hotline worker who responds to the call determines whether the situation warrants an investigation. During fiscal year 1997, the hotline received 55,645 calls, and about 70 percent of these met the Division's investigation criteria. In addition to determining which calls require a CPS investigation, the hotline worker also determines how quickly an investigation must be started. The Division uses four categories to prioritize investigations, and the standard response time for these investigations ranges from two hours for Priority 1 reports to seven days for Priority 4 reports (see Appendix A, pages a-i through a-iv, for more specific information about the priority classification system).

When an investigation is necessary, the Division must assess the child's safety, the validity of the allegations, and the risk of future harm to the child. Depending on the investigation results, the Division's involvement in any case can range from:

- **Investigation only—**When the Division concludes that there are no risk factors severe enough to warrant continued involvement, a case may be closed after investigation without

the Division providing further services. Alternatively, a case may be closed if a family refuses Division services and the risks to the child's safety are not severe enough to warrant legal action. Although the Division has no legal authority to compel families to cooperate or receive services, in every case closed after investigation, the Division still refers families to community resources that could provide assistance.[1] The Division estimates that the majority of cases are closed after investigation; however, it currently lacks a means for determining precisely how many cases fall into this category.

- **Investigation and short-term services—**When the Division determines that a child is at risk of maltreatment, it may offer families services such as counseling and parenting skills classes that could allow the child to live safely at home. Families participate in these services voluntarily. Voluntary services aimed at strengthening and stabilizing families last from several weeks to several months. As with the previous category, the Division lacks a mechanism for determining the number of families receiving short-term services, and whether these services improved the families' situations.

- **Investigation, state custody, and ongoing services**—When the Division believes a child is in imminent danger of abuse or neglect, the child may be removed from the home and placed in temporary protective custody. When this happens, the Division must file a dependency petition with the local Juvenile Court within 48 hours. If the Court determines the child to be dependent, it awards custody to the State. An ongoing caseworker must develop a case plan and monitor the family's progress with the case plan objectives while arranging for services such as medical and dental care, counseling, parenting skill classes, and transportation to and from services. Additionally, the caseworker must visit the child and family at least once a month and review and revise case plans every six months. The Division estimates that approximately 10 percent of the cases it investigates will fall into this category.

Overview of the Division's Organization and Budget

To carry out its mission, the Division employs 1,312 full-time staff, and is organized into four sections:

1. **Administration for Children, Youth and Families (ACYF)—**ACYF is the Division's primary unit, and is responsible for providing child protective services, including investigations and ongoing case management. It also offers in-home services, family preservation

[1] Per A.R.S. §8-546.02, the Division has no legal authority to compel families to cooperate with the investigation, nor to receive services. However, it can proceed with the investigation, and if necessary, take temporary custody of the child and / or file a dependency petition.

services, and foster home recruitment, training, and licensing services. To serve the entire State, ACYF's programs are provided through more than 98 local Child Protective Services (CPS) units located in 6 geographic districts, as follows (see Figure 1, page 4):

District I:	Maricopa County	District II:	Pima County
District III:	Apache, Coconino, Navajo, and Yavapai Counties	District IV:	LaPaz, Mohave, and Yuma Counties
District V:	Gila and Pinal Counties	District VI:	Cochise, Graham, Greenlee, and Santa Cruz Counties

The ACYF section contains 1,156 of the Division's 1,312 employees. The majority of these employees are located in the districts and local offices and perform direct case management activities. For example, approximately 600 employees are dedicated to providing investigative and ongoing case management services. Other employees perform administrative functions, such as the District Program Managers, or offer support services to the direct caseworkers, such as teaching parenting and household management classes, providing transportation, and supervising child / parent visitations.

2. **Financial and Business Operations—**This section contains various units that provide budget and financial information and technical assistance, including Information Systems Management, Evaluation and Statistics, Licensing, Personnel, Contracts, and Adoption Subsidy and Eligibility determination.

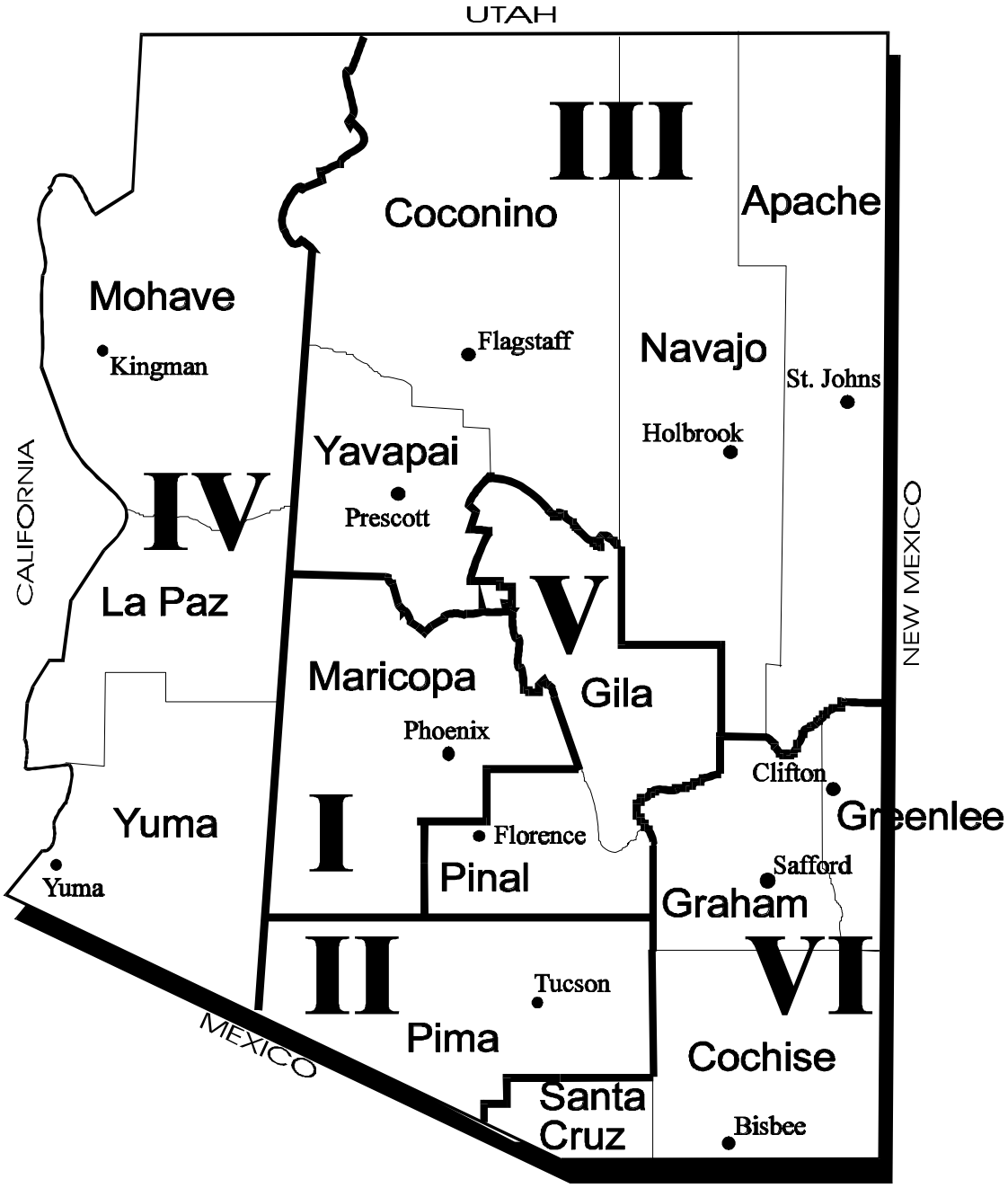
3. **Comprehensive Medical and Dental Program (CMDP)—**This program provides comprehensive medical and dental care to court-adjudicated children placed in out-of-home care under the custody of the Department of Economic Security, the Department of Juvenile Corrections, or the Administrative Office of the Courts / Juvenile Probation Offices. CMDP serves approximately 7,500 children annually and provides a full scope of services ranging from immunizations and prescriptions to surgery and medically necessary orthodontia.

4. **Legal Services—**This section comprises Assistant Attorneys General, housed at the Attorney General's Office, who provide the Division with legal representation for dependencies, severances, etc.

The Division receives its funding in virtually equal proportions from both the federal and state governments. As illustrated in Table 1 (see page 6), in fiscal year 1997, the Division received an estimated $246 million in federal and state monies to operate its programs and provide services

Figure 1

Location of ACYF Districts



to children and families. The State supported 46 percent ($114 million) of the Division's operations and services, while federal monies made up the remaining 54 percent ($132 million).

Approximately 23 percent of this money (nearly $56 million) was used to administer the Division's programs, with the remaining 77 percent (nearly $190 million) used to pay for direct services such as contracted services, foster care maintenance payments, and adoption subsidy payments.

Major Initiatives Implemented in Recent Years

The Division has undertaken a number of initiatives in recent years to address major operational issues. For example, the Division has successfully implemented a centralized report intake process with its statewide child abuse hotline. The hotline, which has been in effect since November 1994, receives all calls alleging child abuse and neglect and identifies which calls warrant an investigation. A set of specific cue questions was developed to ensure that hotline operators ask the same questions during every call received. This most recent review found the hotline was operating as intended and that Division staff were regularly monitoring its operation to ensure continued consistency in report screening and prioritization.

The Division has also taken steps to address workload management by developing a case weighting system to use in allocating staff. In fact, few states have devoted the time and resources necessary to design a comprehensive time study needed to provide information on workload and caseload complexity. While the Division's case weighting model is a step in the right direction, this review found that the model needs further refinement in order for the Division to use it as an effective workload management tool. (See Finding III, pages 23 through 28, for further information on the Division's case weighting model.)

Finally, the Division continues its efforts to provide statewide automated information about its child welfare activities. The Division is nearing the completion of its Children's Information Library and Data Source (CHILDS), which is intended to capture information on the entire CPS process. Similar to its efforts to develop a case weighting system, the Division is ahead of many other states in its development of a statewide automated system. However, to ensure the accuracy and reliability of information maintained on the new system, the Division needs to continue with its plans to establish a quality assurance program that will provide regular data monitoring and identify system-training needs. (See Finding VI, pages 41 through 44, for further information on the status of current management information systems.)

Table 1

Arizona Department of Economic Security
Division of Children, Youth and Families
Statement of Revenues and Expenditures
Years Ended June 30, 1995 through 1997
(Unaudited)

	1995 (Actual)	1996 (Actual)	1997 (Estimated)[2]
Revenues			
General Fund appropriations	$106,942,300	$109,958,500	$114,284,100
Federal grants and reimbursements	97,359,200	115,623,700	131,592,300
Total revenues	$204,301,500	$225,582,200	$245,876,400
Expenditures			
Operating expenditures:			
Personal services	$ 33,937,600	$ 36,073,700	$ 37,862,300
Employee related	7,848,500	8,549,000	8,342,100
Other operating	8,389,500	7,473,800	9,743,100
Total operating expenditures	50,175,600	52,096,500	55,947,500
Program expenditures:			
Children's services	65,719,800	75,916,800	87,185,800
Childcare programs	55,652,800	60,443,900	61,206,300
Adoption services	15,699,800	18,163,600	21,062,200
Comprehensive medical and dental care program for foster children	7,702,300	8,611,300	9,468,900
Other	6,390,900	8,988,000	11,005,700
Total program expenditures	151,165,600	172,123,600	189,928,900
Total expenditures	$201,341,200	$224,220,100	$245,876,400
Revenues over expenditures [1]	$ 2,960,300	$ 1,362,100	$ 0

[1] Any revenues in excess of expenditures consist of unexpended legislative appropriations that are subject to reversion to the state general fund.

[2] Amounts are based on legislative appropriations and estimates for nonappropriated monies.

Source: The Arizona Department of Economic Security Legislative Report II (BG35A) for the years ended June 30, 1995 through 1997.

Audit Scope and Limitations

This audit focused on the Division's ability to investigate all CPS reports of abuse or neglect, conduct investigations in a timely and thorough manner, measure and manage its CPS workload, monitor problem group and shelter homes, provide sufficient out-of-home placements for dependent children, and provide necessary management information to analyze its services and other needs.

However, the auditors' ability to comprehensively review two areas was impeded by a lack of data and/or inaccurate data. First, the audit initially set out to determine the extent to which services for children and their families were available and how adequately the Division met the identified needs. This audit objective could not be completed because the Division lacked data regarding children's and families' needs. Specifically, auditors were unable to compile complete information on service needs and services actually provided. Further, while some districts maintained or collected information manually, others did not. Therefore, auditors were unable to identify or determine the extent of problems with service provision, such as lags between the time a service was requested and the time it was actually provided.

Second, comprehensive compilation and analysis of the Division's management information for the purpose of assessing compliance and effectiveness was not possible because of various data problems within the Division's two primary data systems. As discussed in Finding VI (see pages 41 through 44), both systems suffered from incomplete, inaccurate, and untimely data inputs. As a result, it was difficult to determine how well the Division complies with statutory requirements, as well as its own policies, such as the requirement to meet with clients on a monthly basis.

Methodology

Some of the major methodologies used to conduct this audit included:

- Reviewing a judgmental sample of 16 agencies' licensing files chosen because they had been the subject of at least 2 child abuse neglect reports in 1996;

- Conducting a random sample of 196 CPS case files from District I involving investigations that were initiated in fiscal year 1996 to assess the timeliness and thoroughness of investigations;

- Observing both the investigative and ongoing case management processes through 62 hours of ride-alongs with caseworkers in Districts I and III;

- Conducting a total of 4 small group discussions with: (1) six CPS unit supervisors and 14

caseworkers to identify factors affecting their ability to manage CPS caseloads, and (2) eight children's services providers and child advocates to obtain their input on current service needs, barriers, and strategies for improving service delivery;

- Interviewing various other parties involved in the dependency process, including several Foster Care Review Board members, Court Appointed Special Advocates, Attorney General representatives, and Court personnel;

- Attending numerous meetings of the Ad Hoc Committee on CPS Issues and legislative hearings, in addition to reviewing the Division's proposed and passed legislation;

- Surveying seven other states to obtain comparative information on investigations, caseloads, licensing, and training and services; and

- Reviewing multiple reports and standards from national organizations such as the Child Welfare League of America and the National Center on Child Abuse and Neglect.

This report presents findings and recommendations in six areas, addressing the Division's need to:

- Investigate all reports of abuse and neglect deemed appropriate for investigation;

- Improve investigation timeliness and thoroughness;

- Improve oversight of group and shelter homes;

- Increase the availability of family foster homes;

- Enhance the current case weighting model in order to more effectively measure and monitor workload; and

- Continue with its plans to implement a quality assurance program to monitor data integrity on its new computer system.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Director of the Department of Economic Security as well as the Division of Children, Youth and Families' management and staff for their cooperation and assistance throughout the audit.

FINDING I

THE DIVISION IS UNABLE TO INVESTIGATE ALL CHILD MALTREATMENT REPORTS

The Division is unable to investigate all reports of child maltreatment even though statutorily required to do so. Without conducting an investigation in every case, the Division cannot assess a child's safety. To ensure the Division can investigate all its cases, additional staff will be needed. However, the Division should also consider how other factors, such as the recent increase in reports, the recent Family Builders legislation, and its report classification system, have or will impact its need for additional staff and resources.

Investigations Needed to Assess Children's Safety

Statute requires Child Protective Services (CPS) to take calls regarding suspected child maltreatment and investigate those it deems appropriate. However, the Division currently does not investigate all of those calls that it determines should be investigated (referred to as CPS reports). During fiscal year 1996, the Division never assigned an investigator to more than 1,500 cases that its centralized intake process determined should have been investigated.[1] Specifically, the Division assigned investigators to only 26,930 of 28,445 reports (or 94.67 percent) deemed appropriate for investigation. As illustrated in Table 2 (see page 10), none of the six districts were able to investigate 100 percent of the cases referred during fiscal year 1996, and District I (Maricopa County) had the lowest investigation rate.

Further, as shown in Table 2, most districts experienced a decrease in investigation rates during fiscal year 1997, with 5,899 cases being uninvestigated (see Appendix B, page b-i, for more specific details on the uninvestigated cases).[2] The largest decrease in investigation rates occurred in District I in its Priority 4 cases. However, statewide, 151 high-to-moderate risk cases (Priority 1 and 2) were not investigated. While most of the uninvestigated cases were of lower priorities, and theoretically involved children considered to be at low risk for immediate harm, even lower priority cases may contain instances of serious harm to children that should be

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[1] The number of uninvestigated cases does not include pending cases (i.e. those cases that the Division had not yet determined whether or not to assign an investigator to). There were 31 cases pending in the fiscal year 1996 data analyzed for this report.

[2] The number of uninvestigated cases does not include 57 cases that were pending in the fiscal year 1997 data analyzed for this report.

Table 2

Arizona Department of Economic Security
Division of Children, Youth and Families
Number of Reports Requiring Investigation
and Percentage Actually Assigned for Investigation [a]
Years Ended June 30, 1996 and 1997

	Priority 1 High risk 2-hour response		Priority 2 Moderate risk 48-hour response		Priority 3 Low risk 72-hour response		Priority 4 [b] Potential risk 7-day response		Total	
District I										
1996	2,078	99.42%	2,862	98.92%	7,402	88.58%	3,496	84.78%	15,838	91.03%
1997	3,021	99.77	3,740	97.46	10,072	70.64	4,432	59.27	21,265	77.13
District II										
1996	654	99.69	809	99.51	2,493	98.68	1,171	97.52	5,127	98.67
1997	873	98.85	1,102	96.37	3,685	86.05	1,665	79.04	7,325	87.54
District III										
1996	353	99.72	348	100.00	1,044	99.52	607	99.51	2,352	99.62
1997	506	98.22	403	98.76	1,464	98.36	716	98.88	3,089	98.51
District IV										
1996	322	99.69	310	100.00	896	99.55	477	99.16	2,005	99.55
1997	377	99.73	421	99.05	1,241	97.66	576	83.33	2,615	95.03
District V										
1996	229	99.56	259	99.23	734	99.73	411	99.16	1,633	99.57
1997	326	100.00	357	100.00	921	99.89	420	100.00	2,024	99.95
District VI										
1996	248	100.00	200	99.50	669	100.00	373	99.73	1,490	99.87
1997	291	100.00	255	100.00	810	99.75	389	100.00	1,745	99.89
Statewide										
1996	3,884	99.56	4,788	99.21	13,238	93.28	6,535	91.26	28,445	94.67
1997	5,394	99.50	6,278	97.71	18,193	80.61	8,198	72.46	38,063	84.35

[a] Does not include any cases pending final disposition.

[b] The Priority 4 category also includes cases for which a priority code was not recorded.

Source: Auditor General staff analysis of Child Protective Services Central Registry data.

investigated. Moreover, the Division is statutorily required to investigate all cases it deems appropriate for investigation regardless of the risk. Without conducting an investigation, the Division cannot assess the safety of the children involved.

The Division Needs to Address Several Factors Impacting Investigation Rates

The Division should take the necessary steps to ensure it investigates all appropriate child abuse reports. In addition to providing the Division with additional staff, other factors that may affect investigation rates should be studied.

Additional staff—Information obtained during the course of the review suggests that the Division needs additional staff to improve its investigation rates. Department and Division officials contend that the underlying cause of the increased number of uninvestigated reports is inadequate resources. Specifically, the Division maintains that it has not received sufficient funding to investigate 100 percent of its cases. Additionally, group discussions held with supervisors, investigative staff, and service providers confirm that inadequate resources have negatively affected investigation rates. Finally, the number of reports requiring investigations rose 34 percent during fiscal year 1997 from 28,445 reports (fiscal year 1996) to 38,063 reports.

To address this increase in reports, the Division is currently pursuing various staffing plans that would enable it to increase its investigation rates to 100 percent, as well as provide the necessary ongoing case management and support services. The Division's plans seek to increase staff and also expand the use of a new program established by the Legislature during 1997. This program, known as Family Builders, will focus on families with children who have low or potential risk for abuse and neglect. Therefore, when the Division's supervisors determine that a Priority 3 or 4 case will go uninvestigated, under certain circumstances, they may transfer that case to a local service agency. Within 48 hours of report receipt, the families and children who wish to participate will receive an assessment (instead of an investigation). In addition, within 30 days, the local service agency will design a service plan to meet the family's needs. The Division plans to implement this pilot program during January 1998, in at least two locations in the State. Further, under the Division's proposed staffing plans, this program would be implemented and expanded over a three-year period, and would serve approximately 1,100 children, or about 475 families, during the first 6 months of operation. During the second year, the program will reach about 1,800 families, and finally, during the third year, the program is expected to serve about 4,300 families.

Although the Division anticipates that over time the Family Builders Program can reduce the number of caseworkers needed, the Division is seeking additional staff for the remainder of fiscal year 1998 and for fiscal year 1999. The estimated number of additional staff needed ranges from 21 to 75 each year, depending on whether or not a 5 percent caseload growth is assumed. However, because the Division is still in the process of developing these plans, it has

not yet settled on a specific estimate. While the results of audit work do not dispute the need for additional staff, it was difficult to establish a sound estimate. The Division recently changed the methods it uses to measure workload (see Finding III, pages 23 through 28) and could not provide auditors with any historical workload data. Therefore, without adequate historical data, auditors could not reach conclusions about how reasonable the Division's estimates are.

Several other factors may influence the need for additional staff—Although the Division needs additional staff to help improve its investigation rates, it should also study several other factors that may affect its investigation rates, including:

- **The recent increase in number of cases requiring an investigation**—As mentioned previously, the number of reports requiring investigations during fiscal year 1997 increased 34 percent. While the Division attempted to keep pace with this increase by investigating more cases in 1997 (32,107 vs. 26,930), its investigation rates were negatively affected because it was unable to match the 34 percent increase in reports. However, because the number of child abuse reports was fairly stable over fiscal years 1994 through 1996 at about 28,500, it is not clear whether the Division can expect this type of increase to continue, whether the number of reports will stabilize at current levels, or whether the number of reports will be reduced to previous levels. Nevertheless, the Division's current staffing plans are based on the number of reports determined appropriate for investigation in 1997, which is 34 percent higher than the previous year. Therefore, the Division will need to continue to assess the number of reports requiring investigations to determine whether this dramatic increase in reports will continue, and adjust its staffing plans accordingly.

- **The Family Builders Program**—This Division will also need to continue to assess the impact of the Family Builders Program. As previously mentioned, this Program is slated to begin in January 1998. Therefore, as the Program progresses, the Division will need to carefully monitor this program's ability to handle the number of cases the Division is currently projecting, and adjust its staffing alternatives accordingly.

- **The report classification system**—The Division should also review the process it uses to determine which reports require an investigation so that only those reports needing an investigation are assigned to an investigative caseworker. Although the Division regularly reviews this system, several items discovered during the audit suggest further review is warranted. First, the total number of calls concerning suspected child abuse received by the Division's Child Abuse Hotline has gone down, but the number of reports referred to local offices for an investigation has increased. Specifically, as noted in Table 3 (see page 13), the hotline received a total of 59,145 calls during 1996, and 55,645 during 1997. While workers determined that only 49 percent of the calls needed an investigation in 1996, the percentage of calls requiring an investigation in 1997 increased to 70 percent. Second, CPS supervisors (in a group discussion held during the audit) suggested that the Division review and consider revising the report screening processes because, in their opinion, some reports that did not require investigations were being assigned. Finally, although the Division contends that it appropriately screens hotline calls because its validation rates (i.e., the number of re-

ports that are found valid upon investigation) have remained stable, it has not had a sound means for historically determining these rates. Specifically, in June 1997, the Division revised its validation rates previously reported for fiscal year 1996, after auditors pointed to the lack of data in the Child Protective Services Central Registry (CPSCR) regarding investigation findings. Based on its efforts to input the findings for more than 2,500 cases investigated over a year ago, the Division has shown a 13 percent increase in the number of valid reports compared to the figure previously reported in its annual report. However, since the Division does not have sufficient CPSCR data to compare validation rates for previous years, it is not clear that the validation rates have remained stable over time.

Since the Division regularly reviews its report classification system, with the next review scheduled for the end of 1997, it should consider these factors and modify its screening tool if necessary.

Table 3

Arizona Department of Economic Security
Division of Children, Youth and Families
Disposition of Child Abuse Calls
Years Ended June 30, 1996 and 1997

	1996	1997
Number of calls received concerning suspected child abuse	59,145	55,645
Number of calls referred to local offices [1]	29,070	38,699
Percentage of calls referred to local offices	49.2	69.5

[1] This number is higher than the number of reports requiring investigation in Table 2 (see page 10), because after a call is referred to a local office, it may be determined that it is not within the Division's jurisdiction or that it is a duplicate report.

Source: Auditor General staff analysis of Central Intake Monthly Report data from July 1, 1995 to June 30, 1997.

- **Characteristics of reports not investigated—**Similar to analyzing the report classification process, the Division should analyze the characteristics of uninvestigated reports. Although all reports referred to the local offices have been deemed appropriate for investigation and are required to be investigated per A.R.S. §8-546.01, the Division has a policy that allows supervisors the discretion to not assign a case for investigation under certain circumstances. Specifically, Priority 2 through Priority 4 cases can remain uninvestigated as long as the report does not involve a child in CPS custody, a family member involved in an open CPS case, or a facility licensed by either the Division or the Department of Health Services.[1] In

[1] Priority 2 cases must be approved for noninvestigation by the District Program Manager.

addition, interviews with supervisors revealed that other case-specific characteristics, such as age of the child, could impact the order in which they assign cases, regardless of priority. While the Division assumes that cases are not investigated only due to a lack of resources, supervisors may not be assigning cases to investigators for other reasons, such as the inability to locate the child involved. However, because the Division's policy does not require supervisors to document the reason why a case is not assigned for investigation, it is unable to track which factors lead supervisors to not assign cases for investigation.

Because this policy is in direct conflict with the Division's statutory mandate to investigate all reports it deems appropriate for investigation, the Division should eliminate or revise this policy. Recognizing that there may be legitimate reasons why a case goes uninvestigated, such as the inability to locate the child or family involved, if the Division maintains this policy, it should be revised to require supervisors to document the reasons why cases are not investigated. This information will help the Division determine what actions should be taken when investigation rates fall below 100 percent.

Recommendations

1. The Legislature should consider providing the Division with additional staff so that it can investigate all child abuse reports as required per A.R.S. §8-546.01.

2. The Division should assess the recent increase in the number of reports requiring investigations to determine whether it is likely to continue, and revise its request for additional staff and resources accordingly.

3. The Division should continue to assess the impact of the Family Builders Pilot Program and the number of families it will be able to serve.

4. The Division should continue to review and refine its report classification system to ensure its child abuse hotline more thoroughly screens calls.

5. The Division should eliminate its investigative policy that is in direct conflict with statute, or revise the policy to require supervisors to document the reason why a case is not assigned to an investigator.

FINDING II

THE DIVISION'S INVESTIGATIONS ARE NOT ALWAYS TIMELY OR THOROUGH

In addition to striving to investigate all child maltreatment reports, the Division should ensure that its investigations are timely and thorough. A review of the Child Protective Services (CPS) investigation process raised concerns about the timeliness and adequacy of some investigations. Because the Division is faced with an increasing number of child abuse reports, it needs to take steps now to improve the quality of its investigations. Therefore, the Division should provide specialized investigative training and improve its oversight of the investigation process.

Timely and Thorough Investigations Are Important

The lack of timely and thorough investigations can actually increase families' risk of abusive or neglectful behavior. According to a 1990 U.S. Advisory Board on Child Abuse and Neglect report, *Child Abuse and Neglect: Critical First Steps in Response to a National Emergency*, being the subject of an unresolved investigation creates and sustains uncertainty about the future. This uncertainty causes anxiety within families, and may stall children's development. Further, mandated reporters (i.e., teachers, doctors, etc.) may begin to doubt the system and fail to continue to report suspected cases of abuse, thus placing children at greater risk of continued abuse or neglect. The risk is even greater for families who are not offered or do not accept services following an investigation.

Because CPS investigations are so important in the child welfare process, a file review was conducted to assess the quality of investigations the Division performed. Auditors' examination of the CPS investigation area included a review of a statistically valid random sample of 196 child maltreatment reports referred for investigation in District I during fiscal year 1996. Files were chosen specifically from District I because it receives more child maltreatment reports than any other district, and it has the lowest investigation rate statewide. (See Appendix C, page c-i, for further details on the methodology applied in this case file review.)

Review Identifies Concerns Regarding Quality of Investigations

The review of District I investigative files identified several areas of concern regarding investigation timeliness and thoroughness. **First**, not all investigations were conducted within the time frames established by the Division. **Second**, some investigation files were missing, while others lacked documentation, raising doubts about the thoroughness of investigations. **Finally**, not all files were closed in a timely manner, nor were the results of those investigations recorded timely.

CPS does not always begin investigations promptly—Although A.R.S. §8-546.01(C)(3) requires the Division to conduct a "prompt" investigation, the file review and computer data identified several timeliness problems. First, the Division does not always conduct investigations within the time frames established by policy. While the required response times vary by report category, the Division must investigate even the lowest priority case within 7 days of its receipt. However, the Division did not respond timely in over 40 percent of the investigated cases auditors reviewed. As shown in Table 4 (see page 17), 71 of the 167 cases that were assigned for investigation began after the required response time.[1] While 4 of the investigations began within 1 hour after the response time had passed, 25 others did not start until more than 1 week afterward, often without explanation of the delay. For example, 1 case had no documented investigative activity until 47 days after receipt of the report, 2 additional cases did not begin until after the receipt of subsequent reports weeks later, and in 2 other instances, investigators left for vacation before investigating cases, delaying response times by as long as 30 days.

The file review also revealed that the Division does not always accurately record response times, which raises concerns about the reliability of investigation data recorded on the Division's computer. In fact, discrepancies between computer data and caseworker notes regarding response times occurred in 63 (or 38 percent) of the 167 investigated cases reviewed. In some instances, the times were recorded incorrectly in the computer. However, more than a quarter of these cases were recorded as timely even though file documentation shows the investigation did not meet the Division's time frames for response. For example:

> *A Priority 3 report alleged a mother's boyfriend had sexually abused her seven-year-old child in the past. Although the computer indicates CPS responded within two days, implying a timely response, file documentation shows no case activity took place until five days after report receipt, when an investigator scheduled a visit with the family. Therefore, computer records indicate a*

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[1] Of the 196 child maltreatment case files chosen for the sample, 182 were recorded as being investigated. However, only 167 files were reviewed. The District could not locate 11 of the 182 files, and 4 files were eliminated for other reasons.

timely response, when in fact, no one began working on the case until two days after the response time frame.

Table 4

Arizona Department of Economic Security
Division of Children, Youth and Families
Delayed Response Times for District I Sample of
CPS Investigations by Priority Category
Year Ended June 30, 1996

	Priority 1 (2 hours)	Priority 2 (48 hours)	Priority 3 (72 hours)	Priority 4 (7 days)	Total
Number of reports assigned for CPS investigation	16	32	83	36	167
Number of delayed investigations	5	16	41	9	71
Range of delayed response times	1 to 24 hours	5 hours to 47 days	1 hour to 44 days	1 to 6 days	

Source: Auditor General staff analysis of a random sample of Child Protective Services fiscal year 1996 investigation files from District I.

Lack of documentation raises concerns about thoroughness—In addition to concerns regarding investigation timeliness, missing file documentation raised concerns about investigation thoroughness. A.R.S. §8-546.01(C)(3) requires CPS to conduct a "thorough" investigation of every report. Accordingly, for every investigation, Division policy requires investigators to document their actions and decisions regarding families, as well as the information they collect. However, for 11 of the cases reportedly investigated in the sample, the Division could not provide case files to document that an investigation took place. In another instance, the Division recreated a case file from an investigator's memory more than one year after the investigation took place. Overall, missing and recreated files constituted 6 percent of the statistically valid file sample.

While most of the 167 investigation files reviewed clearly outlined the steps taken during an investigation and sufficiently documented the outcome, nearly all lacked documentation regarding why investigators did not follow policy for some aspect of the investigation. Specifically, files lacked documentation for:

- **Why the investigation deviated from protocol—**More than 20 of the 167 investigative

files (13 percent) lacked documentation explaining why the investigation was not conducted according to Division standards. For example, although investigation protocol calls for investigators to interview the victim first, in at least a dozen instances, it appeared children were not interviewed until after the case manager had discussed the report with their parents. In 9 other cases, it could not be established from the file documentation whether the child was interviewed at any point during the investigation.

- **The importance of prior investigations on the current case—**Although the Division requires caseworkers to review prior contacts with CPS as part of every investigation, little documentation was found to indicate the extent to which prior investigations are reviewed. According to the 1992 manual *Child Protective Services, A Guide For Caseworkers*, developed by the National Center on Child Abuse and Neglect, the existence of previous reports is one factor that aggravates the risk of imminent harm to children. In fact, approximately one-half of the families involved in the cases reviewed had at least 1 prior contact with CPS, while 3 had 30 or more. However, in only 1 instance did an investigator summarize the outcome of previously conducted investigations.

- **The findings of the investigation—**Due to a lack of documentation, it was unclear whether all the allegations of abuse or neglect were validated in 13 (or 8 percent) of 167 cases assigned for investigation. Additionally, in 2 instances, the investigator's written notes differed from the case outcome recorded in the Division's computer, thereby affecting the accuracy of the information retained on these families.

- **The number and type of services offered to families—**In 15 (or 9 percent) of 167 investigated case files, it was difficult to ascertain what services had been offered to families who came into contact with CPS. For example, while the caseworker indicated a referral to community services for the family, the caseworker did not specifically list the services recommended, nor the problems the services were intended to address.

- **Notification of families regarding the investigation outcome—**Fewer than 30 files contained documentation that families had received written notification regarding the investigation findings and services offered.

Thorough and accurate documentation of CPS investigations is important for at least two reasons. First, other entities involved in the child welfare process, such as the juvenile court and the Foster Care Review Board, depend on the caseworker's documentation of events to help make important decisions about children involved in the child welfare process. Accordingly, incomplete or inaccurate information regarding a family can impact the decisions other individuals involved must make. In addition, recent legislation allows parents to appeal investigative findings, thereby increasing the importance of complete and accurate documentation of investigators' actions and findings.

Cases not always closed promptly after investigation—While case closure is also an important aspect of the investigative process, some cases were not closed out promptly or recorded on

the computer in a timely manner. For example, 1 investigation lasted only 3 days, yet the case was not closed until 83 days after the investigation. In another instance, an investigation lasted only 1 day, but was not closed until 63 days after the investigation. Likewise, the investigation findings (i.e., whether the allegations were validated) are not always entered in a timely manner. Statutes require the Division to enter investigation findings into the Child Protective Services Central Registry (CPSCR) within 21 days of report receipt. Moreover, Division policy requires cases to be resolved within 30 days of report receipt. However, a review of CPSCR data indicates that more than 2,600 cases received between July 1995 and April 1997 were still missing information regarding the investigation findings as of June 1997.

In addition to statutory compliance issues, closing investigations in a timely manner is important for several reasons. **First**, as mentioned earlier, unresolved investigations increase the risk of abusive and neglectful behavior within the families involved. **Second**, unresolved investigations can potentially impact workload assignments within investigation units. Specifically, supervisors may not be able to differentiate between completed cases and those actively being investigated. As a result, workloads may appear higher than they actually are, which may discourage supervisors from assigning more reports for investigation.

Increasing Number of Reports May Also Impact Quality of Investigations

While it is uncertain how workload factors impacted the quality of investigations conducted in District I during fiscal year 1996, the increased number of child abuse reports during fiscal year 1997 could negatively impact future investigations. Specifically, the number of child abuse reports requiring investigations remained fairly stable over fiscal years 1994 through 1996 at about 28,500. However, as noted in Finding I (see pages 9 through 14) reports increased by 34 percent during 1997, from 28,445 to 38,063. This increase in reports will likely impact investigators' ability to handle all assigned cases in a timely and thorough manner. Discussion groups held with investigators and supervisors in District I revealed that the number of reports they receive impacts their ability both to begin investigations on time and to methodically investigate all cases. Some staff also worried that increased pressure regarding investigation rates could lead to less-thorough investigations.

To ensure that the Division can improve both investigation rates and investigation quality, additional staff will be needed. Although the Division is developing various staffing plans to increase the number of caseworkers, as mentioned in Finding I (see pages 9 through 14), the Division also needs to continue to analyze how several other factors, such as its report classification system and the characteristics of uninvestigated reports, influence the need for additional staff.

Division Should Develop Specialized

Training and Improve Its Oversight

In addition to assessing its investigative staffing needs, the Division should make changes in two other areas. **First**, the Division will need to develop additional specialized training for its investigators. **Second**, the Division will need to improve its oversight of the investigation process to ensure investigations are conducted promptly and appropriately.

Specialized training for investigators needed—The Division should develop specialized training for its investigators. In discussions with investigators and supervisors, several commented that the core training curriculum was deficient in teaching investigative policies and procedures. Since 1993, the Division has used a national training model requiring all case managers to receive 22 days of core training. Although the training model is endorsed by the Child Welfare League of America and is used by 29 other states, it includes only one day of material regarding investigations, and does not cover the Division's specific investigation policies and procedures. According to the training guide, the investigation training is intended only as an introduction to the CPS investigation process, requiring investigators to obtain additional individual training with their supervisors. However, staff agreed that little time is devoted to developing new investigators, due to the growing number of reports.

Therefore, to help improve the quality of investigations, the Division should develop a specialized investigative training curriculum. In auditors' discussions with investigators and supervisors, several topic items were suggested. First, investigative staff indicated a need for basic training on how to conduct an investigation, such as how to interview a child and what indicators of abuse to look for when investigating certain types of cases. Second, investigators identified a need for policy-oriented training to help them better comply with statutory and policy requirements.

Investigation oversight needs to be improved—In addition to providing specialized investigative training, the Division will need to improve its oversight of the investigation process. Although the Division's Uniform Case Practice Record used on each investigation since June 1, 1996, requires supervisors to review all investigations, auditors' file review indicates that many supervisors were not reviewing cases in a timely manner or ensuring that investigations were thoroughly conducted. Only 70 of the 167 investigated files (or 42 percent) had been reviewed in some manner by a supervisor prior to closure by the investigator. Among the remaining 97 files, approximately one-third were not reviewed for 1 month or more after closure, while 8 cases contained no documentation indicating a supervisor had ever reviewed the case. Therefore, in line with national CPS standards, the Division should require supervisors to review all cases prior to closure and in a timely manner. To help ensure this takes place, the Division should establish a policy that will provide guidance to supervisors on how quickly they should review cases. Because the Division is statutorily required to enter investigative findings into CPSCR within 21 days of report receipt, the policy should require supervisors to review cases close to that time frame.

Additionally, according to the National Center on Child Abuse and Neglect, in their 1994 manual, *Supervising Child Protective Services Caseworkers*, supervisors should monitor investiga-

tion outcomes on a case-by-case basis. In particular, the Center recommends that supervisors monitor critical casework activities and their outcomes, such as whether investigators conduct interviews in the proper order, gather complete and accurate information, thoroughly analyze the information collected, and correctly resolve the case. Therefore, the Division may want to expand its case review guidelines to incorporate similar factors. The Division should also require supervisors to document investigative activities that do not meet Division protocol and the corrective actions taken to rectify those discrepancies.

Finally, as it has done in the past, the Division should routinely conduct random case file reviews to assess investigation thoroughness and the accuracy of information entered on the CPSCR. The Division should also consider collecting additional information to better monitor the investigation process, including:

- Length of time to initiate investigations;
- Length of time cases remain open in investigation; and
- Reason for case closure.

Recommendations

1. To improve the timeliness and thoroughness of investigations, the Division should develop a specialized investigation curriculum that includes training on investigative techniques, as well as Division policies and procedures.

2. The Division should require supervisors to review all cases prior to closure and in a timely manner. To do so, the Division should consider establishing a policy that requires supervisors to review cases within a time frame close to when investigative findings are required to be entered (i.e., within 21 days).

3. The Division should also consider revising its file review guidelines to include additional critical casework activities and their outcomes as suggested by the National Center on Child Abuse and Neglect.

4. The Division should require supervisors to document in the file any investigative activities that do not meet the Division's standards and how they will be resolved.

5. The Division should routinely conduct random case file reviews to assess investigation thoroughness and the accuracy of information entered into its information systems.

6. The Division should collect additional information to better monitor the investigation process, including length of time to initiate investigations, length of time cases remain open in investigations, and reasons for case closure.

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FINDING III

WORKLOAD MEASUREMENT MODEL NEEDS FURTHER IMPROVEMENT

The Division should improve the system it uses to measure its child protective services workload. In an attempt to devise a better method of determining caseworker workloads, the Division recently implemented a case weighting model that accounts for the level of difficulty involved in handling the various types of cases rather than just counting the number of assigned cases. Although a step in the right direction, the model contains several problems that hinder its ability to adequately portray the amount of work caseworkers perform. Therefore, the Division should continue with its plants to refine its case weighting system.

Case Weighting Model Established to Improve Workload Management

In 1994, the Division developed a case weighting model to better measure and manage its child protective services workload. Prior to case weighting, the Division, like many other child welfare agencies, used case counts (the number of cases each caseworker handles) as a means of measuring workload and determining staffing needs. However, case counts are not the best measure of actual workload due to the differences between types of cases and their complexity. For example, a caseworker handling a case with only one child will likely be able to complete case management tasks more quickly than a caseworker handling a case with more than one child. Similarly, a long-term foster care case plan will likely require less intensive oversight than a case plan of return home or adoption. Recognizing this, the Division sought to implement a more accurate means of assessing workload and hired a consultant to design a case weighting model. The concept behind case weighting is to measure the effort workers expend when managing cases and assign "weights" to cases based on those measurements.

Weaknesses in Current Case Weighting Model

Although the Division's case weighting model can provide some valuable information, its ability to serve as an effective workload management tool is limited for several reasons. First, the underlying methodology used to design the model contains many flaws, including an inadequate number of cases by which to establish standards, wide variation in information caseworkers reported, and no consideration of the differences between types of caseworkers.

Additionally, the Division excluded several important factors that impact a caseworker's ability to manage his or her caseload.

***Case weighting model based on time studies*—**In designing the case weighting model, the Division's consultant conducted two time studies. The purpose of conducting the time studies was twofold: 1) to create a mechanism for more equitable case assignments, and 2) to determine the number of caseworkers needed to manage the current workload. These studies were an essential step in capturing the amount of time workers spend conducting actual casework. In conducting the time studies, caseworkers from across the State were asked to record, in 15-minute intervals, the specific tasks they were performing. This information was then compiled to determine a time estimate to adequately complete tasks for the various case types. Although both time studies used the same basic methodology, there were some significant differences between them:

- **1994 study —**The Division's first attempt to design a case weighting model involved a sample of 200 workers over a one-week period. The study categorized CPS' cases into 6 types: investigation, in-home care, substitute care, purchased care, adoption, and family resource development. Substitute care cases, requiring an average of 5.8 hours per month of caseworker time, was the category chosen to represent the standard by which all other case types were compared and was given a case weight of 1. Case categories that took longer would be given a higher weight, while case types that took a lesser amount of time were given a lower weight. The Division determined that, based on the amount of time available in a month, caseworkers could handle a caseload weight of 19.

- **1996 study**—This study was conducted to incorporate the effects of casework practice changes, such as the addition of a computer-based case recording form. This study also sampled approximately 200 caseworkers, but was conducted over a 1-month period. In addition, to better capture the variation in case work, the consultant expanded the case type categories from 6 to 16.[1] Because of the expanded case type categories, the 1996 time study identified licensed foster home cases, a form of substitute care, as the most common case type. While substitute care cases (the standard to which other cases were compared in 1994) took an average of 5.8 hours per month, licensed foster home cases required an average of 8.9 hours per month. However, because the Division wanted to maintain a caseload weight standard of 19, to determine the new weight of 1, the Division took the total number of hours available for casework in one month (i.e., 121 hours) and divided it by 19. This resulted in increasing the value of a caseweight of 1 from 5.8 to 6.37.

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[1] The 16 categories used in the 1996 time study were basic investigation, investigation with placement, court-ordered / private investigation, in-home services (non-court related), in-home services with dependency, shelter care, unlicensed relative care, licensed foster home, unlicensed non-relative care, group home / residential, independent living, Title XIX out-of-home care, adoption, family resource development, interstate compact, and runaway.

Time studies suffered from methodological problems—Both time studies contained methodological flaws that hinder the usefulness of the case weighting model. An analysis of the methods used to construct the studies revealed the following problems that ultimately impact the Division's ability to rely on the case weighting model as an accurate measure of workload:

- **Too few cases used to establish standards—**The primary methodological problem was that the number of cases included in the study was not sufficient. The sampling method did not produce enough workers from the rural districts and did not produce enough cases to accurately set standards for many of the 16 case type categories. Case weights for 9 categories were developed using data from 20 or fewer cases, with 3 categories using as few as 10 to 12 cases.

- **Too much variation in data resulted in nonrepresentative standards**—Because there were wide variations in data collected between districts, the consolidation of the data into averages may have resulted in some nonrepresentative standards. For example, the average time recorded by caseworkers to handle "investigation with placement" cases was 14.3 hours per month, but actual times ranged from 6 hours to almost 24 hours per month.

- **Differences between types of workers not reflected**—Although the time study established separate case categories to capture investigative work, a separate analysis was not conducted between investigators and ongoing caseworkers. However, duties vary sufficiently between the two, with investigative workers conducting more tasks per each case in a shorter period of time. Because of this, the Director of Standards from the Child Welfare League of America suggests that investigative workers should handle fewer cases than ongoing workers. Thus, case weights for investigative workers should be analyzed separately.

Several factors not considered—After completing the time study and developing the case weights, the Division overlooked several factors that can significantly impact caseload complexity. Discussions with investigative and ongoing caseworkers across the State revealed the following factors that currently impact the amount of time required to handle certain cases:

- **Increased number of delinquency cases**—In addition to being assigned court-ordered dependency cases, more and more juvenile court judges are placing children determined to be dually adjudicated (i.e., dependent and delinquent) under the Division's protection. According to caseworkers, these children have a tendency to run away and/or present behavioral problems that can require an extensive amount of their time.

- **Cases involving substance abuse**—Many of the children in foster care have been removed from their homes due to their parents' substance abuse problems. Because the Division must make efforts to reunite families, caseworkers must try to find treatment for the parents.

- **Children needing behavioral health services**—According to caseworkers, many cases involve children with behavioral health problems. As with delinquent children, these children are often difficult to place and need services that are difficult to obtain in a timely manner, if at all. Therefore, caseworkers can spend a significant amount of time trying to identify services and find appropriate placements for these children.

- **Cases involving multiple children**—In cases with multiple children, siblings are often located in separate placements, requiring caseworkers to coordinate multiple visits with each child as well as allowing visits among the siblings and their parents. Currently, the Division allows for an additional case weight for cases with multiple children. However, a case with three or more children receives the same weight as a case with only two children.

- **Travel time**—Caseworkers also report that a great deal of time is spent on travel related to their caseloads. For example, the best placement for a child may not be close to the worker's office or the parents' home. Therefore, the worker may have to drive across town or even out of the county to visit a child.

When one or more of these factors are present, case complexity increases, yet it is not reflected in the case weight. The following example illustrates the inequity that can result in case weights when certain case complexity factors are not considered:

- This case involves four children suffering from the effects of neglect. One child, with severe medical and behavioral problems, was hospitalized for an extended period. Meanwhile, his three siblings were placed in two separate foster homes on the opposite end of town from the caseworker's office. Further, both parents were substance abusers who failed to stop using drugs while the caseworker was making efforts to reunite the family. To manage this case, the caseworker had to attend weekly meetings for the hospitalized child, search for a placement for him upon discharge, and drive across town to conduct home visits with his siblings. Meanwhile, the caseworker also had to arrange various services for the family to ensure that diligent efforts were made to reunite them. However, this case received a case weight only slightly higher than a case with two children in a stable foster care home with no complexity factors present.

Case Weighting Model Needs Further Refinement

The Division needs to continue to refine its case weighting model to ensure that it can effectively manage its workload. When the Division conducts its planned updated time study, it needs to overcome methodological problems and consider other case complexity factors for analysis. Additionally, the Division should consider reinstituting the use of case counts to

provide additional insight into workload.

Updated time study can improve utility of case weighting model— Because the Division's case weighting model was initially developed as, and can still be an effective workload management tool, the Division should follow through with its plans to conduct a revised time study. The Division, recognizing the need to periodically review and update its case weighting model, plans to conduct another time study in 1998 to reflect the changes resulting from implementation of its new automated case management system. Therefore, when conducting its next time study, the Division should take into consideration the methodological concerns identified during this audit. First, the Division should increase the number of caseworkers sampled and the corresponding number of cases reviewed. This improvement alone will provide the Division with the information it needs to analyze the differences between rural and urban districts as well as between caseworker types. To ensure an adequate number of cases are reviewed, the Division should attempt to have at least 25 cases, and ideally 50 or more cases, in each of the 16 case type categories. Additionally, the Division should ensure that its sample includes sufficient representation from both investigative and ongoing caseworkers. Moreover, the Division should seek to analyze why any wide variations in data occur, and consider using a statistic other than an average (such as the median or mode), as a basis for case weights if the wide variation cannot be explained.

Although increasing the sample size alone will offer a significant improvement over the existing case weighting model, the Division should also consider analyzing other factors that may increase case complexity. As mentioned earlier, several factors, such as the increased number of delinquency cases, cases involving substance abuse, and children needing behavioral health services, may affect caseload complexity. If the Division incorporates such factors into the time study, it can analyze how these factors affect workload. If the time study proves these factors increase case complexity, the Division should consider (as it has done with the number of children in a case) providing additional allowances to its case weights.

Case counts can aid in analyzing workload—The Division should resume case counts for use in conjunction with case weights. In August 1996, Division officials decided to stop collecting case count information since they believed case weights were a sufficient measure of workload. However, case count data can give the Division a clearer picture of its workload by providing the actual number and type of cases currently in the system. Further, the Division can use case counts to determine whether changes in case weights are due to an increased number of cases or increased case complexity. Additionally, combining case counts with case weight information when reporting to outside groups may provide a more meaningful description of caseworkers' workload.

Recommendations

1. To ensure that its case weighting model more accurately portrays caseworker workload, the Division should fulfill its plans to conduct another time study.

2. When conducting its next time study, the Division should select a large enough sample to allow it to analyze differences that may occur due to geographic location or caseworker type. If wide data variation continues to exist in each case type category, the Division should also consider using a statistic other than the average when calculating case weights.

3. The Division should also consider incorporating into its next time study additional factors affecting case complexity, such as those dealing with delinquent children, substance abuse and behavioral health issues, multiple children, and travel time.

4. The Division should consider using case counts in conjunction with case weight information to further enhance its workload analysis and reporting abilities.

FINDING IV

THE DIVISION'S OVERSIGHT OF GROUP AND SHELTER HOMES IS INADEQUATE

Despite its responsibility to license group and shelter homes, the Division currently does not provide adequate oversight of these facilities. A review of licensing files revealed that the Division allows some homes with licensing violations to continue operating, which may ultimately impact the safety of children placed in those facilities. Therefore, to ensure group and shelter homes correct licensing violations, the Legislature should consider granting the Division the authority to impose civil penalties. However, the Division should also use its current authority to suspend or revoke the licenses of agencies who are unable or unwilling to correct serious problems. In addition, the Division will need to develop policies and procedures and redirect its licensing staff activities to ensure that it provides adequate oversight.

Division Responsible for Licensing Group and Shelter Homes

As mandated by A.R.S. §8-505, the Division is responsible for licensing child welfare agencies that provide supervised care for children adjudicated as dependent or delinquent.[1] These agencies' facilities (often referred to as group and shelter homes) house not only children in CPS custody but also children under the custody of other entities, including the Department of Juvenile Corrections, the Supreme Court's Administrative Office of the Courts, or other states. Before issuing a license, the Division is required to investigate an agency's activities and standards of care, its financial stability, the character and training of its staff, and the agency's ability to safely care for children. If the agency meets licensing standards, the Division issues a regular license for a period of one year. The Division may also issue a provisional license for a period of six months to any agency whose services are needed but which is temporarily unable to conform to the established standards of care. The Division can also suspend, revoke, or deny a license if an agency fails to meet or maintain the established licensing standards.

As of April 30, 1997, the Division licensed approximately 64 agencies with a total of 183 facilities and approximately 2,935 beds available for child placement. These facilities provide shelter

[1] As of July 1995, the Department of Health Services assumed the responsibility for licensing those institutions that provide supervised mental health treatment to adults and children, including children who have been adjudicated as delinquent or dependent.

for approximately 1,000 children within the Division's custody as well as for additional children referred from other entities.

Group and Shelter Homes Inadequately Monitored

While many children are regularly placed in group and shelter care facilities, the Division's oversight of such facilities is inadequate and may ultimately impact the safety of those children. To assess the adequacy of the Division's oversight, a judgmental sample (that is, these agencies were not selected randomly, but were chosen because of concerns about their ability to care for children) of 16 agencies that had been the subject of at least 2 child abuse and neglect reports during calendar year 1996 was reviewed.[1] According to Child Protective Services Central Registry (CPSCR) records, combined, these agencies accounted for a total of 74 child abuse reports during 1996. Most of these reports involved allegations of neglect or physical injury due to children being inadequately supervised. Moreover, according to CPSCR data, 19 of these reports were found to be valid. The Division's oversight of these 16 facilities was inadequate for the following reasons:

CPS reports were not adequately documented—The Division did not adequately document concerns raised about the agencies' ability to safely care for children. Specifically, the Division did not adequately document in the licensing files all the child abuse reports received or the results of the CPS investigations conducted to assess the allegations of these child abuse reports.[2] Further, the 16 agencies' licensing files did not always contain documentation on how agencies should correct any safety issues that were identified in investigative reports, such as inadequate supervision or improper restraint techniques. Although memos to agencies noting a need for a corrective action plan were placed in some files, these corrective action plans were not routinely maintained in the files and it is unclear if the plans were ever established and monitored. Additionally, the Division did not document whether it considered these child abuse reports during the licensing renewal process. For example, none of the agencies' licensing renewal packages documented concerns about these CPS reports or investigations. While it may be appropriate to disregard reports that were determined to be invalid, it is unclear why valid reports are not considered when determining whether licenses should be renewed.

Provisional licenses issued inappropriately—The file review also revealed that, in some instances, the Division issued provisional licenses inappropriately. A.R.S. §8-505 indicates a provisional license may be issued to any agency whose services are needed but which is temporarily unable to conform to the established standards of care. However, the deficiency must be minor, correctable, and not potentially injurious to children in the agency's care. In

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1 As mentioned earlier, an agency may have several facilities. These 16 agencies had a total of 58 facilities.

2 Reports of agency child abuse and neglect statewide are investigated by two CPS investigators located in District I (Maricopa County).

addition, the provisional license may be issued only for a period of six months and may not be renewed. Nonetheless, the Division allowed two agencies to alternate between regular and provisional licenses without adequately addressing the problems that originally indicated a provisional license was necessary. In addition, some of the problems were potentially injurious to children. For example, two agencies' personnel files lacked documentation regarding staff medical examination results, reference checks, or fingerprinting and criminal records clearance. One of these agencies in particular seemed to be deficient in many areas, yet as demonstrated below, continued to maintain licensure:

- Agency A was placed on provisional status three times over a three-year period (between April 1994 and April 1997) for a variety of reasons, including lack of an annual financial audit and fire inspection, personnel and children's files lacking required documentation, and a facility in need of extensive repair. At the end of each of these provisional periods, the agency returned to regular status. However, little documentation appears in the agency's licensing file regarding what corrective actions, if any, were actually taken to address the violations that resulted in it being placed on provisional status. In addition, throughout this three-year period, several concerns were raised about the agency's ability to safely care for children. For example, during 1996, this agency was the subject of four child abuse reports ranging from a lack of supervision to physical abuse. Three of these reports were validated upon investigation. In addition, in 1995 a caseworker filed complaints with the licensing unit alleging that the agency kept a child without authorization, lacked supervision and structure, and allowed children to climb on the facility's roof.

Ultimately, the safety and welfare of children placed in these facilities is compromised when the Division allows problem homes to continue operating without addressing potential safety issues.

Division Should Improve Oversight of Group and Shelter Homes

The Division needs to improve its oversight of group and shelter homes. To help the Division in this matter, the Legislature should consider strengthening the Division's current enforcement authority by providing it with the authority to impose civil penalties. However, the Division may need to use its current authority to suspend or revoke some agencies' licenses. In addition, the Division should develop policies and procedures to help guide its monitoring activities, and should redirect the licensing staff's activities to ensure monitoring activities are performed.

Additional legislative authority may be needed—To ensure agencies comply with licensing standards, the Legislature should consider granting the Division additional authority under A.R.S. §8-506 to impose civil penalties against agencies that fail to address licensing problems.

The Division currently has the authority to issue provisional licenses for a period of six months when an agency is needed but is unable to conform to the established standards of care. However, as previously mentioned, in some instances, these provisional licenses have been issued inappropriately. In addition, it does not appear that placing an agency on provisional status provides it with adequate incentive to comply with licensing standards.

Therefore, to give agencies additional incentive to comply with licensing standards, the Division may need the authority to impose civil penalties similar to that provided to the Department of Health Services (DHS). As a part of DHS' responsibility to license health care institutions and child day care programs, it has the authority to impose civil penalties. For example, A.R.S. §36-891 provides DHS the authority to impose a fine of up to $100 per day for each day it documents a licensing violation has occurred at a childcare facility.

Some licenses may need to be suspended or revoked—Because the Division has a responsibility to reasonably ensure the safety of children in its care, it may need to suspend or revoke some agencies' licenses. While a licensing specialist indicated that the preferred method is to work with agencies to correct violations, some agencies may not fully resolve the licensing deficiencies. Therefore, the Division should use its licensing authority to suspend or revoke the licenses of those agencies that do not promptly correct violations that may endanger the safety of children in their care. For example, the Division should have suspended or revoked the license of one agency that displayed serious ongoing concerns from the time it was initially licensed in August 1994. Specifically, this agency was the subject of 14 child abuse reports and more than 50 incident reports during 1996 alone.[1] Although the agency had responded with some corrective action plans, it was never able to fully comply with the Division's licensing requirements. Due to the seriousness of the violations, the Division finally removed the CPS children from this facility and canceled its child placement contract with this agency. However, the Division never suspended or revoked this agency's license, so other entities, such as the Department of Juvenile Corrections or other states, may have continued to place children in the facility.

Policies and procedures needed—To further guide its oversight of shelter and group homes, the Division should develop policies and procedures. Although the Division has both statutes and administrative rules regarding the licensing process, neither provide specific guidance on how to conduct monitoring or how to follow up on licensing violations. Therefore, by establishing policies and procedures, the Division can better ensure its licensing staff provide adequate oversight. Specifically, these policies should address when provisional licenses can be issued and whether it is appropriate in any instance to place an agency on provisional status more than once. In addition, policies should provide specific guidelines regarding the type of licensing violations that warrant a suspension or revocation, what type of oversight the Division should provide, how and when monitoring activities should occur, and the level of docu-

[1] An incident report must be prepared by the agency when a child is injured or runs away.

mentation needed to demonstrate adequate oversight. These policies should also address how the licensing unit should handle reports of child abuse it receives concerning licensed agencies.

Division should ensure licensing unit's activities include monitoring—Ultimately, to ensure homes are adequately monitored, the Division should require that the licensing staff dedicate a sufficient amount of time to monitoring activities. This unit, consisting of a manager and 6 staff, is responsible for annually licensing the 64 agencies with their 183 facilities, as well as reviewing new applications, conducting on-site visits, and maintaining licensing files. While auditors did not evaluate the effectiveness and efficiency with which licensing staff perform their tasks, it appears that these 6 staff should be able to adequately monitor the 64 agencies. At a minimum, staff could focus their monitoring efforts on those agencies that continue to exhibit problems. For example, the Division's oversight could focus on agencies that have been the subject of one or more valid child abuse reports. With regular monitoring, the Division could assist agencies in correcting deficiencies more promptly, or revoke agencies' licenses more swiftly.

Recommendations

1. To strengthen the Division's enforcement authority, and to provide agencies with a further incentive to comply with licensing standards, the Legislature should consider granting the Division the authority to impose civil penalties under A.R.S. §8-506.

2. The Division should develop policies and procedures regarding monitoring, including those which:

   - Address when provisional licenses can be used and whether it is appropriate in any instance to place an agency on provisional status more than once;

   - Provide guidelines regarding the type of licensing violations that warrant a suspension or revocation; what type of oversight the Division should provide; how and when monitoring activities should occur; and the level of documentation needed to demonstrate adequate oversight; and

   - Address the steps needed when it receives reports that a group care home or shelter has abused or neglected children.

3. The Division should ensure that its licensing staff adequately monitor group and shelter homes by incorporating regular monitoring activities into their work schedules.

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FINDING V

CURRENT FOSTER HOMES UNABLE TO MEET CERTAIN PLACEMENT NEEDS

The Division needs to improve its efforts to recruit and retain foster family homes to ensure children are quickly moved from temporary placements into more permanent foster care settings. Currently, caseworkers have difficulty finding appropriate placements in certain areas of the State as well as for children with special needs. As a result, children are remaining in temporary shelters for longer periods, which is both expensive and potentially unsafe. To rectify these problems, the Division will need to establish mechanisms for assessing overall foster home demands and for helping local offices recruit and retain foster parents.

Background

Pursuant to A.R.S. §8-223, CPS is required to take temporary emergency custody of a child if the child is "suffering or will imminently suffer abuse or neglect." Upon initial removal, a child is typically placed in a temporary emergency placement, which is generally a shelter care facility or receiving home. Within 48 hours of a child's removal, CPS reviews the case to determine if continued out-of-home placement is necessary. If so, once a juvenile court judge orders a dependency action, the child's caseworker is responsible for assessing the child's needs and attempting to provide a placement in the "least restrictive" setting available. The child typically remains in the initial temporary emergency placement until the caseworker can locate a more appropriate placement.

The number of children requiring placements is increasing. As of June 30, 1997, 6,686 children statewide resided in out-of-home care. This represents an 11 percent increase over the 6,014 children in out-of-home care on June 30, 1996, and a 19 percent increase over the 5,624 children recorded on June 30, 1995.

Shortage in Availability of Certain Types of Foster Homes

Although the Division may initially appear to have a sufficient number of homes to meet its placement needs, these homes often do not match the needs of children ready for placement. As a result, children are delayed from moving into less costly and more permanent placements that can better meet their individual needs.

The number of vacant spaces is deceiving—Although the number of licensed foster homes is

increasing and there are vacant spaces available, many children cannot be placed in those homes. During 1996, the total number of foster homes increased by 118, with 467 homes becoming newly licensed and 349 homes leaving the program. Similarly, the Division again increased the number of licensed homes by 47 between January and March 1997. However, despite the net increase in the number of licensed foster homes, the Division was unable to use many of these spaces to help meet its placement needs. For example, as of March 31, 1997, there were 1,902 licensed foster homes with more than 1,200 spaces vacant. Placement specialists and caseworkers noted three primary reasons why it is difficult to match children with available homes:

- **Many homes will not accept certain children—**A match between available spaces and children is not always possible due to the types of children foster families may be willing to accept. For example, many foster families are unwilling to accept teenagers and large sibling groups.

- **Difficulty finding placements for children with special needs—**Similarly, many foster families may be unable to adequately care for children with special medical or behavioral needs, which require the foster parent to have special training or skills. According to district placement specialists, placements for children with special medical and behavioral needs are needed the most, yet are the most difficult to find.

- **Too few homes where the demand is greatest—**Some communities do not have enough homes to meet the Division's placement needs. For example, foster home shortages are particularly acute in the State's two metropolitan areas. Specifically, as of December 31, 1996, 81 percent of out-of-home placements were within Maricopa and Pima Counties, while only 56 percent of the available spaces were located within these two districts.

Movement from shelter care to foster family home care often slow—Because the Division is not always able to match children with appropriate foster homes, the number of children in more restrictive temporary settings is increasing. As illustrated in Table 5 (see page 37), the average number of children in shelters or receiving homes during April to June 1997 was 50 percent higher than the year before. Moreover, children are remaining in these temporary shelter placements for longer periods of time, despite a statutory requirement that children cannot remain in these facilities more than 21 days without a juvenile court order.[1] For example, 52 percent of the children placed in shelter care facilities during the third quarter of fiscal year 1997 had been there more than 21 consecutive days. In many instances, these delays are not attributable to any special needs of the children. For instance, 36 percent of these children had no identified special placement needs. CPS placement specialists, child advocates, and Division service providers have noted that this trend is increasing.

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[1] Any juvenile court orders extending placements beyond the 21 days must be reviewed weekly, beginning one week from the date of the order.

Table 5

Arizona Department of Economic Security
Division of Children, Youth and Families
Quarterly Comparison of Average Number of Children in a Shelter or Receiving Home
Years Ended June 30, 1996 and 1997

Quarter	1996	1997	Percentage Increase
July 1-September 30	375	433	15%
October 1-December 31	395	491	24
January 1-March 31	356	492	38
April 1-June 30	383	574	50

Source: Foster Care Program Activity Report for years ended June 30, 1996 and 1997.

Delays in permanent placement have several consequences—In addition to the rising number of children remaining in shelter care, several other consequences can result when appropriate placements are not available in a timely manner. First, the Division incurs a significant cost when it must continue to place children in temporary shelter care. The Division pays an average of $17 per day per child for family foster home placements, compared to an average cost of $80 to $90 per day for group home or shelter care. Children also remain in inappropriate settings for longer periods. Caseworkers indicate that shelter or group home placements are more limited in the type of care provided and their ability to meet some children's special needs.

Finally, placing an increasing number of children in temporary settings can be potentially unsafe. Division personnel have indicated that these settings are often the only locations available to take children with behavioral problems or children who have been adjudicated as both delinquent and dependent. Consequently, dependent children remain in the same settings with individuals who may be dangerous. However, with the constant turnover of children in shelters and group homes, staff may not always be aware of potentially violent youth placed with younger dependent children. For example, a review of group care agencies' licensing files revealed an incident in which three children threw a blanket over three other children, hitting and kicking them. The victims received substantial injuries to the arms, back, chest, ribs, and head. Moreover, within months, this same shelter experienced a serious fire that was started by a child with a long history of arson. In both cases, the perpetrators were children who were dually adjudicated delinquent and dependent.

Division Must Strengthen Recruiting and Retention Efforts

To ensure children are moved promptly into appropriate permanent foster care settings, the Division will need to enhance its ability to recruit additional foster homes, assess and coordinate placement needs, and retain existing foster homes.

Better coordination of foster home recruitment efforts needed—The Division can do more to coordinate foster home recruiting efforts throughout the State. Currently, new foster home recruitment is centered largely on efforts at the district level with each individual district (or a contractor hired by the district) being responsible for recruiting homes to meet their placement needs. However, districts receive minimal support from the Division's central office. Without centralized recruitment oversight, districts lack knowledge about which recruitment efforts work best. For example, districts run advertisements using newspapers, billboards, and tee shirts, and they make presentations to groups, forums, and community fairs. Yet, the Division has not given anyone the responsibility for monitoring these approaches and determining which strategies are the most effective. Moreover, statewide recruitment efforts have been limited. Although the Division recently initiated a statewide recruiting effort, known as the "Clouds Campaign," implementation of the campaign was conducted at the district level rather than by the central office. As a result, the campaign has not been run in all districts and awareness of the campaign varies by district.

Due to the variations in how foster home recruitment is currently being conducted, the Division should gain a better understanding of overall recruitment needs. Both district and contracted recruitment personnel indicated a need for a centralized mechanism for exchanging information between districts concerning successful recruiting efforts. Because the Division is currently establishing a central office position to coordinate foster home recruiting, it should consider using this position for:

- **Building stronger recruitment programs—**Professionals believe that successful foster parent recruiting programs educate communities about foster care and involve the communities in supporting foster parents and recognizing the service they provide. Using foster parents as recruiters and supporting foster parent associations contributes to successful foster parent recruiting. Additionally, professionals emphasize a need to use positive recruiting themes that realistically portray the difficulties of foster parenting. Although the Division currently uses foster parents to provide some orientation and training classes, it can further increase foster parents' involvement by including them in Division foster care recruitment efforts.

- **Drawing upon additional sources of foster parents—**The National Foster Parent Association suggests two potential sources sometimes overlooked in recruiting efforts senior citizens and former foster children.[1] In addition, retired medical personnel could be par-

[1] U.S. General Accounting Office: *Foster Parents, Recruiting and Preservice Training Practices Need Evaluation*, August

ticularly helpful for foster children with special medical needs.

- **Sharing information about what works—**The Division should formalize and facilitate interaction between district recruiters. Additionally, the Division should monitor innovative efforts used by districts and should communicate the results of such efforts throughout the State.

Better tracking of foster home availability and needs—The Division should also do more to collect and analyze information about the needs of children entering the CPS system and the supply of foster homes available. The Division's current automated information systems do not contain information on the number of spaces available in each foster care home or facility, the services each provider offers, or the ages of children providers will accept. Moreover, other important information maintained on the systems is often incomplete. Although the Division is developing a new computer system that should be able to capture this type of information, the Division will need to ensure the data entered into the system is complete and accurate. (See Finding VI, pages 41 through 44.)

Once the Division can accurately compare the demand for placements to the supply available, it can use this information to focus recruitment efforts. For example, the Division could use this information to develop specific statewide recruitment goals, or the districts could use this information to target their recruitment efforts. The Division may be able to help in recruiting for these needs by establishing a 1-800 foster care inquiry line, or by paying for statewide media campaigns and public service announcements. This would then allow districts to focus on initiatives to recruit for special needs within their own areas.

Increased efforts to retain existing foster homes—A final step toward meeting placement needs is through expanded efforts to retain current foster families. Although districts collect information on the reasons why foster families leave the system, it does not appear that the Division uses this information to increase foster home retention. For example, during fiscal year 1996, the Division determined that adoption of the foster child(ren) was the primary reason Arizona foster families left the system. Although it is not clear why this is the case, it may be that, after adopting a child, families may feel they are unable to care for additional children. However, a national study found that many adoptive parents were still eager to take foster children into their homes.[1] In addition to adoptions, the president of the state Foster Parent Association

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1989.

[1] U.S. Department of Health and Human Services, *The National Survey of Current and Former Foster Parents*, August 1993.

indicates that many foster parents become frustrated with the lack of training and poor relationships with case managers and ultimately leave the system. Therefore, following the recommendations of the Child Welfare League of America, contained in their 1995 *Standards of Excellence for Family Foster Care Services*, the Division should seek to learn more from and about the families who are leaving the system, and use this information to establish retention goals and track actual retention rates.

Recommendations

1. The Division should do more to coordinate foster home recruitment efforts throughout the State by dedicating a central office staff person to help build a stronger recruitment program, draw upon additional sources of foster parents, and share information with the districts on what types of recruitment strategies work best.

2. The Division should also do more to collect and analyze information about the needs of children entering the CPS system and the supply of foster homes available, and use this information to develop specific statewide recruitment goals.

3. The Division should also increase its efforts to retain existing foster homes, including establishing annual retention goals and tracking actual retention rates.

FINDING VI

DATA INTEGRITY SHOULD REMAIN A CONTINUOUS PRIORITY FOR THE DIVISION'S NEW INFORMATION SYSTEM

As the Division continues with its implementation of a new comprehensive management information system, it should remain committed to ensuring the accuracy and reliability of the system's information. The Division's two previous systems suffered from numerous problems, including inaccurate entries, untimely inputs, and incomplete data, that limited their ability to provide reliable and complete management information. Therefore, to ensure the Division's new data system does not encounter similar problems, the Division should continue its efforts to monitor data integrity and identify system-training needs.

History of Division's Computer Systems

The Division has relied on two primary computer systems to record information about its child protective services program. Its first system, the Child Protective Services Central Registry (CPSCR), was brought on-line in 1985 to register all reports of child abuse and neglect. Information recorded for each report includes initial allegation(s), disposition (i.e., whether the report was investigated), and the result of the investigation (i.e., whether the child abuse report was found to be valid). In 1991, the Division established a new computer system, the Arizona Social Services Information and Statistical Tracking System (ASSISTS), to provide better management information about its child protective services function. Although this system includes some information on CPS children, such as age, sex, and case plan goal (e.g., return to family, adoption, etc.), it is primarily used as a payment processing system. Therefore, the system primarily records information on the services authorized and paid for by the Division for children and families with ongoing CPS cases.

The Division is currently implementing a new information system, the Children's Information Library and Data Source (CHILDS). This system is intended to capture information on the entire CPS process by incorporating the functions handled by CPSCR and ASSISTS. Additionally, this information system will capture data typically contained only in the caseworkers' files, such as case notes and the number and types of services offered to families. The Division anticipates it will complete system implementation by the end of 1997.

Data Problems Limited Usefulness of Systems

Numerous data problems have historically jeopardized the reliability and accuracy of the information contained on the Division's two primary data systems—CPSCR and ASSISTS. Specifically, a 1991 Auditor General study (Report No. 91-6) found that CPSCR data was improperly classified in some instances, and improperly coded in others. The report also cautioned the Division that similar data problems might affect the usefulness of its new information system—ASSISTS. In fact, a 1994 Auditor General review (Report No. 94-L9) found that many of the data problems identified in 1991 continued to exist, and also noted that the accuracy of the data contained on ASSISTS was suspect because workers were not required to input information into all data fields. Both systems continued to suffer from inaccurate coding, untimely inputs, and incomplete data at the time of the Auditor General's review. Although the Division acknowledged these problems, it may have chosen not to expend significant resources to rectify them due to its planned implementation of CHILDS.

However, the Division's ability to obtain important information has been affected because it did not resolve these problems. For example, the Division was recently interested in the number of children adjudicated both delinquent and dependent because these children may present needs the Division is unable to fulfill, and because these children can pose a threat to others (e.g., dependent children, foster families, and staff). Although ASSISTS has a data field to capture this information, caseworkers do not consistently complete it. Therefore, in its attempt to identify the number of dually adjudicated children, the Division had to obtain manual counts from each district. Additionally, the Division is currently unable to determine what services it has offered to families and whether these services have prevented further abusive situations.

Division Efforts to Ensure Data Integrity Should Continue

As the Division completes CHILDS' implementation, it should ensure that it continues to monitor data integrity. During implementation of CHILDS, the Division took several steps to address the problems encountered by CPSCR and ASSISTS. However, to ensure the Division continues to monitor data integrity following implementation, it should continue with its plans to develop and formalize a quality assurance program.

Division took steps to address previous causes of data problems—In designing the new system, the Division ensured that it contained several quality control features to help address the problems previously identified. One significant type of quality control is the use of on-line edits. For example, the system contains mandatory fields that require caseworkers to enter specific information before the case file can be saved, and validation checks that require caseworkers to enter only specified values or codes. These system edits will help prevent inaccurate

or incomplete data entries from occurring. In addition to on-line edits, the system also contains several security features that will limit individuals' access to the system and prevent data from being modified unless approved by a supervisor. Finally, the Division took several steps to ensure that the data entered into the system was accurate. During the data conversion process, caseworkers were asked to review all the case file data that would be entered into CHILDS. While conversion workers were entering the data into the system, caseworkers received three days of training on how to use CHILDS. After training, caseworkers were required to re-verify the case file data and only then was the data fully transferred onto CHILDS.

As of October 1997, the Division had converted approximately 55 percent of the statewide CPS offices to CHILDS. Although the Division plans to complete conversion by December 1997, ASSISTS is still handling provider payments. The Division is delaying conversion of the ASSISTS' payroll component in order to conduct additional data integrity testing. However, even when CHILDS is fully implemented, the Division will need to maintain both CPSCR and ASSISTS in "read-only" format for several years so historical information is available, as required by law.

The Division needs to follow through with its plans—The Division recently announced its plans to continue monitoring the integrity of the data entered and maintained on CHILDS. However, at this time the plan appears to be in the very early stages of development. The Division could not provide us with sufficient documentation outlining the specific monitoring activities it would conduct, or how frequently it would conduct these activities. Moreover, although the Division has indicated that its Evaluation and Statistics Unit would be involved in monitoring data integrity, the amount of time this unit will devote to this activity is not clear. The Evaluation and Statistics Unit was originally established as a quality assurance unit; however, this audit revealed that the unit had not regularly performed quality assurance tasks.

Therefore, to ensure quality assurance becomes an institutionalized process within the Division, the Division should develop a written formalized plan, and follow through with its plans to establish a quality assurance program. In the process of developing the plan, the Division should identify what activities will take place, how often the activities will occur, and who will conduct the activities. The Division should ensure that the quality assurance program will:

- **Monitor data integrity—**Regular monitoring is necessary to ensure that data entry problems are identified and rectified quickly. CHILDS has some built-in quality control features including built-in logic checks and drop-down menus that should help reduce data entry errors and incomplete entries. However, data reliability and validity will ultimately depend on those individuals responsible for entering the data into the system (e.g., caseworkers and central intake personnel). As such, the potential for data error still exists.

- **Identify system-training needs—**To ensure caseworkers and administrators appropriately use the system, periodic training should be offered. Although the Division has developed a comprehensive training program to meet the needs of new CHILDS users, continued monitoring of the system's data may assist the Division in identifying additional or subsequent training needs.

- **Identify necessary system changes—**Regular monitoring of the system's data would also ensure needed updates are identified and performed quickly. For example, the Division may need to update existing data fields and codes to adequately reflect changes in CPS clients, programs, and services.

Recommendation

The Division should continue the development and implementation of a formal, written quality assurance program to ensure CHILDS consistently contains accurate, reliable, and timely management information. Specifically, this program should:

- Provide regular monitoring to quickly identify and rectify data integrity problems;

- Help the Division identify additional training needs; and,

- Identify necessary system changes, such as data field and code updates.

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Agency Response

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
1717 W. Jefferson - P.O. Box 6123 - Phoenix, AZ 85005

Jane Dee Hull
Governor

Dr. Linda J. Blessing
Director

Mr. Douglas R. Norton, CPA
Office of the Auditor General
2910 North 44th Street, Suite 410
Phoenix, Arizona 85005

Dear Mr. Norton:

Thank you for the opportunity to respond to the recently completed performance audit of the Department of Economic Security's Division of Children, Youth and Families.

The thoughtful examination and analysis of the division by the audit team verifies needs which we have long recognized and provides support for our continued efforts to obtain the resources necessary to meet our statutory mandates. We concur with your assessment that additional staff will be needed to investigate 100% of all reports in a thorough and timely basis. As I am sure you are aware, increases in the investigation rate will likely lead to the need for additional family services and related funding.

I appreciate your acknowledgment of a number of recent significant achievements that included the development of the very complex and comprehensive CHILDS (Children's Library and Data Source) automated system, which will significantly enhance the management, oversight and day-to-day activities within the division; the development of a case weighting system for measuring Child Protective Services workload, and the implementation of the statewide Child Abuse Hotline, which is operating as intended.

We agree with all six findings contained in the report. The recommendations pertaining to each finding will be implemented as discussed in our accompanying response.

Finally, please accept our appreciation for the time and considerable effort invested in this critically important audit. We wish to specifically recognize Ms. Rinehart and Ms. Tremble for their hard work and insightfulness during the audit process.

Sincerely,

Linda J. Blessing

Enclosure

DEPARTMENT OF ECONOMIC SECURITY
RESPONSE TO THE
DIVISION OF CHILDREN, YOUTH AND FAMILIES PERFORMANCE AUDIT

FINDING I: The Division Is Unable To Investigate All Child Maltreatment Reports

The division agrees with the finding and shares the Auditor General's concern regarding the need to investigate all reports of child maltreatment. As indicated in the report, additional staff are needed to meet this obligation in addition to pursuing alternative responses to Child Protective Services (CPS) reports. The division supports the Auditor General's recommendation that the Legislature should consider providing the division with additional staff so that all reports of child maltreatment can be investigated.

The division agrees that the recent increase in the number of reports requiring investigations should be assessed to determine whether the trend is likely to continue. The division's request for additional staff and resources should be revised accordingly.

The division agrees to assess the impact of the Family Builder's Program and the number of families it will be able to serve. In fact, the legislation creating the Family Builders Program mandates that "an evaluation of the impact and effectiveness" of the program be performed and that an outcome evaluation report be produced by January 1, 2000. In addition, performance measures contained in the Request For Proposals for the Family Builder's Program will assure early and continuous evaluation of the impact of this important program.

The division also agrees with the recommendation for continued review and refinement of the report classification system to ensure that the child abuse hotline thoroughly screens calls. The division appreciates the acknowledgment of our previous and ongoing initiatives relating to the review and revision of the report classification system. The division currently reviews and revises its report classification system annually for appropriateness, consistency and accuracy. The next review is scheduled for the early 1998, following implementation of the CHILDS system. Further, quality assurance specialists were added to the staff at the Child Abuse Hotline during fiscal year 1996 to review and evaluate individual report classifications on an ongoing basis.

The "Policy and Procedures Manual" for Child Protective Services is presently scheduled for revision and publication during the early part of calendar 1998. The division agrees that policy regarding cases that are not assigned for an investigation should be revised to require supervisory documentation of the reasons for not completing an investigation.

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FINDING II: The Division's Investigations Are Not Always Timely Or Thorough

The division agrees with the finding. The division makes every effort to investigate reports of child maltreatment in a timely and thorough manner. However, as stated in the audit, in order "to ensure that the division can improve both investigation rates and investigation quality, additional staff will be needed."

In addition, the division agrees with the observation by the audit team that improving staff training should positively impact the skills and knowledge necessary to conduct thorough investigations. Development of a specialized investigation curriculum would benefit the division. The existing training curriculum is under ongoing review. As a part of this review, special attention will be given to strengthening the investigations component.

The division agrees with the recommendation to require timely supervisory reviews of all cases. As stated in the audit, the division's Uniform Case Practice Record, implemented in June 1996, requires supervisors to review all investigations to ensure they are conducted thoroughly. The division's ability to ensure that supervisors are conducting such reviews will be greatly enhanced with the full implementation of the CHILDS system.

The division strives for constant improvement and, therefore, readily agrees with the recommendation to review guidelines of casework activities established by the National Center on Child Abuse and Neglect. The division also agrees that routine random case file reviews should be conducted to assess the thoroughness of investigations and the accuracy of information contained in its information systems. Collection of additional data regarding the investigation process, as recommended, would also be of benefit to the division.

The division agrees with the recommendation that supervisors should document investigative activities that do not meet the division's standards.

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FINDING III: Workload Measurement Model Needs Further Improvement

The division agrees with the finding of the audit team that, although it is a step in the right direction, the workload measurement model requires further refinement.

The division agrees with the recommendation to follow through with plans to conduct a time study in 1998.

The division agrees with the recommendation that when conducting its next time study, a larger sample will be used. Moreover, the division will consider analyzing differences that may occur due to geographic location or caseworker type. If wide data variation continues to exist in each case type category, the division will also consider using a statistical measure other than the simple mean when calculating case weights.

Based upon the experience gained from the time study in 1994 additional factors affecting case complexity were incorporated into the 1996 study. The division agrees with the recommendation that consideration should be given to incorporating additional factors affecting case complexity, such as those dealing with delinquent children, substance abuse and behavioral health issues, multiple children and travel time when conducting future time studies.

The division also agrees with the recommendation to consider using case counts in conjunction with case weight information to further enhance its workload analysis and reporting abilities. With the implementation of the new CHILDS system, case count reports will be generated and utilized in conjunction with the workload measurement model.

FINDING IV: The Division's Oversight Of Group And Shelter Homes Is Inadequate

The division agrees with the Auditor General's recommendation that enforcement of licensing rules and regulations could be strengthened if the Legislature would include DES as part of ARS §8-506. Under this statute, which currently applies only to DHS, the licensing agency has the ability to impose civil penalties on licensed facilities. Additionally, if DES were allowed to enforce ARS §36-891, the division would have the ability to impose monetary fines up to $100 per day for each day the facility has a documented licensing violation. The division will support the legislature in amending the statutes listed to assist in the enforcement of corrective action plans and licensing violations.

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The audit team's study sample, which was used to determine the adequacy of monitoring group and shelter homes, was based upon agencies that had been the subject of two or more CPS reports as opposed to valid findings. Of the 16 DES licensed agencies reviewed, which included 58 separate facilities, only one agency had more than two valid CPS reports and this agency is now closed.

The division agrees with the Auditor General's recommendation that the guidelines surrounding the use of provisional licenses should be reviewed. The division will review existing guidelines surrounding the issuance of provisional licenses to agencies that previously operated on a provisional license basis. The division has developed new Group Care Rules, which were approved by the Governor's Regulatory and Review Council (GRRC) and became effective July 1, 1997. These rules provide improved guidelines for dealing with adverse licensing actions including, in part, the granting of provisional licenses or the denial of license. The division will continue to monitor the rules and regulations, which apply to licensing of Group and Shelter Homes, and request changes from GRRC where deficiencies are identified.

The division concurs that guidelines surrounding the types of licensing violations, which warrant suspension or revocation; type of oversight the division should provide; how and when monitoring activities should occur; and, the level of documentation needed to demonstrate adequate oversight, should be developed. As recommended, policies and procedures for dealing with licensing violations, which warrant the suspension or revocation of an agency's license, types of oversight the division will provide, and when monitoring should occur will be developed. As part of the revised Group Care Rules approved by GRRC, a revised monitoring tool was developed. This tool provides the division with necessary documentation regarding monitoring activities, helps enforce corrective action plans, and helps substantiate license revocations or denials.

The division agrees with the recommendation that the steps needed when the division receives reports that a group care home or shelter has abused or neglected children should be reviewed. The division will review existing procedures, which deal with the investigation of a CPS report that involves an agency licensed by the division, to insure that the safety and welfare of children placed with the agency is not compromised.

The division agrees with the recommendation concerning licensing staff adequately monitoring group and shelter homes by incorporating regular monitoring activities into their work schedules. As recommended, the division will review current licensing activities, and incorporate the recently revised monitoring tool as part of the normal work activities performed by licensing unit staff.

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FINDING V: Current Foster Homes Unable To Meet Certain Placement Needs

The division agrees with the finding of the Auditor General and with the recommendation that we should do more to coordinate foster home recruitment efforts throughout the State. We agree that the division needs to build a stronger recruitment program designed to draw upon additional sources of foster parents, and to share information with districts on what types of recruitment strategies work best. The recommendation of dedicating a central office staff person to perform these functions is a resource issue for which we are not funded. However, we do believe such support would benefit the recruitment and retention of foster parents and, as a result, we will make every effort to implement this recommendation with existing resources.

The recommendation that the division should also do more to collect and analyze information about the needs of children entering the CPS system and the supply of foster homes available is agreed to and will be implemented. We also agree to use this information to develop specific statewide recruitment goals.

We appreciate the acknowledgment by the audit team of the difficulty caseworkers face finding appropriate placement in certain areas of the state, as well as for the many children entering the system with special needs.

The division agrees and will implement the recommendation that the division should increase its efforts to retain existing foster homes, including establishing annual retention goals and tracking actual retention rates. Many potential foster families are unable to adequately care for children with special medical or behavioral needs, or are unwilling to accept certain placements, such as teenagers or large sibling groups. The division appreciates the report's acknowledgment of these very real barriers to successful foster home recruitment.

As stated in the report, the division is developing a new computer system (CHILDS) that should be able to capture relevant information concerning the special needs of the children in care and potential foster parents. This information will also be used in developing foster parent recruitment and retention activities.

FINDING VI: Data Integrity Should Remain A Continuous Priority For The Division's New Information System.

The division agrees with the recommendation of the Auditor General that the Division should provide regular monitoring to identify and rectify data integrity problems. As stated in the audit, the Division is committed to ensuring the accuracy and reliability of the system's information. The division will continue developing a formal written plan to ensure that data quality assurance becomes an ongoing process. This plan is being developed by the Evaluation and Statistics Unit in conjunction with the Information Systems Support Unit and CHILDS, and identifies what activities will take place, how frequently the activities will occur and who will conduct the activities. This plan provides for regular data monitoring, identification of system training needs and identification of needed system changes.

As the report indicates during the implementation of CHILDS the division has taken several steps to address the problems encountered by CPSCR and ASSISTS in an effort to avoid the same problems encountered during the implementation of these computer systems. During the development phase of CHILDS, the division took steps to ensure that quality control features would be included to address problems previously identified and to ensure that the data entered into the system would be accurate.

The regular monitoring of management reports, both production and ad hoc, as well as evaluation of Help Desk calls, assists with the identification of needed system changes. Enhancements and modifications will also be developed based on the refinement of policy and of new and modified legislation. The activities defined in the quality assurance plan identifies those changes need to produce and insure quality and valid data.

The Division concurs with the recommendation regarding identification of additional training needs. The Division has established a permanent CHILDS Training Unit which provides on-going training to all workers based on a number of factors, i.e., newly hired or job function change, identified by supervisor as needing additional training, or identified by the number of Help Desk calls made by the individual. The Help Desk has recently installed software, which provides data allowing trainers to identify which areas of the CHILDS application need more emphasis in training or areas that need specialized concentration. Additionally, individuals with specific problem areas can be identified and individualized remedial training can be offered.

The Division agrees with the recommendation to identify necessary system changes, such as data field and code updates. The Division is currently assessing changes needed to the system due to statutory changes, which occurred during the last legislative session. Additionally, the Division of Data Administration has a group of staff involved in training courses dealing with the software programs which will allow for needed system

modifications. The Division will also monitor changes in federal and state statutes, and assess the impact of these changes on the CHILDS system.

Appendix A

Child Protective Services
Child Abuse Hotline
Report Priority Classification System

Appendix A

Child Protective Services
Child Abuse Hotline
Report Priority Classification System

Priority 1—High Risk

Standard Response Time:
Within 2 Hours

Physical Abuse

Child death due to alleged abuse or neglect or suspicious death.

Injuries requiring emergency medical treatment. For example, head injury, internal injury, multiple injuries, fractures, immersion burns, etc.

Child under the age of 6 observed or reported to be struck in the head, face, neck, genitals, or abdomen which could likely cause injury.

Child under the age of 24 months is shaken (shaken baby syndrome).

Physical abuse by a parent, guardian, or custodian who has a previous validated Priority 1 report.

Parent, guardian, or custodian threatens or presents serious bodily harm to a child now.

Priority 2—Moderate Risk

Standard Response Time:
Within 48 Hours

Physical Abuse

Injuries that may require medical treatment. For example, injuries to torso or extremities, fractures, injury to a child under age 1, etc.

Priority 3 injury to a child under the age of 6.

Child 6 years of age or older observed or reported to be struck in the head, face, neck, genitals, or abdomen which could likely cause an injury.

Parent, guardian or custodian fears or threatens to harm child if no intervention is received and he or she has previous validated report of physical abuse.

Priority 3—Low Risk

Standard Response Time:
Within 72 Hours

Physical Abuse

Injuries not requiring medical treatment. For example, first-degree or cigarette burns, injury to buttocks or scalp, single or small bruises, etc.

Parent, guardian or custodian fears or threatens to harm a child if no intervention is received.

Priority 4—Potential Risk

Standard Response Time:
Within 7 Consecutive Days

Physical Abuse

Home environment stressors place child at risk of physical abuse which may include domestic violence, mental illness, substance abuse, history of physical abuse with no current injury, etc.

Appendix A (cont'd)

Child Protective Services
Child Abuse Hotline
Report Priority Classification System

Priority 1—High Risk

Standard Response Time:
Within 2 Hours

Neglect

Untreated medical condition which is life-threatening or permanently disabling which includes comatose state or debilitation from starvation or possible nonorganic failure to thrive.

Child of any age who is alone and cannot care for self or for other children due to physical, emotional, or mental inability.

Child under the age of 6 who is alone now.

Child 6 to 9 years of age is alone for 3 consecutive hours or longer or unknown when parent, guardian, or custodian will return.

Imminent harm to child under the age of 6 due to inadequate supervision by parent, guardian, or custodian.

Neglect results in serious physical injury or illness requiring emergency medical treatment.

Imminent harm to child due to health or safety hazards in living environment which may include exposure to the elements.

Child diagnosed as suicidal by qualified mental health professional and parent, guardian, or custodian is unwilling to secure needed emergency medical treatment including psychiatric treatment.

Priority 2—Moderate Risk

Standard Response Time:
Within 48 Hours

Neglect

Child age 11 to 13 years of age caring for a child age 6 or younger for 12 hours or longer.

Living environment presents health or safety hazards to a child under the age of 6 which may include human/animal feces, undisposed garbage, exposed wiring, access to dangerous objects or harmful substances, etc.

Sexual conduct or physical injury between children due to inadequate supervision by parent, guardian, or custodian including a licensed or certified DES facility or a licensed DHS Level I, II, or III Behavioral Health Treatment facility.

History of extensive gestational substance abuse to child under 3 months of age or mother or child tests positive for nonprescribed or illegal drug or alcohol at time of birth.

Child under 2 months of age displays nonprescribed or illegal drug or alcohol withdrawal symptoms.

Priority 3—Low Risk

Standard Response Time:
Within 72 Hours

Neglect

Untreated medical problem causes child pain or debilitation that is not life-threatening and parent, guardian, or custodian is unwilling to secure medical treatment.

Child under the age of 9 who is not alone at the time of the report, but has been left alone within the past 14 days.

Parent, guardian or custodian demonstrates an inability to care for a child within the past 30 days including leaving a child with inappropriate or inadequate caregivers.

Living environment presents health or safety hazards to a child 6 years of age or older which may include human/animal feces, undisposed garbage, exposed wiring, access to dangerous objects or harmful substances, etc.

Food not provided and child is chronically hungry.

Significant developmental delays due to neglect.

Parent, guardian, or custodian is not protecting child from a person who does not live in the home and who abused the child.

Complaint by law enforcement or juvenile court officer alleging dependency due to a delinquent or incorrigible act committed by a child under age 8 [A.R.S. §8-546.(A)(c)]

Priority 4—Potential Risk

Standard Response Time:
Within 7 Consecutive Days

Neglect

Parent, guardian, or custodian has no resources to provide for child's needs (supervision, food, clothing, shelter, and medical care) and child's needs may be neglected.

Home environment stressors, which may include mental illness, substance abuse, etc., place child at risk of neglect.

Living environment is likely to present health or safety hazard to child.

Sexual conduct or physical injury between children and unknown if parent, guardian, or custodian will protect.

Child adjudicated dependent due to finding of incompetency or not restorable to competency pursuant to A.R.S. §8-201.

Appendix A (cont'd)

Child Protective Services
Child Abuse Hotline
Report Priority Classification System

Priority 1—High Risk

Standard Response Time:
Within 2 Hours

Sexual Abuse

Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within past 7 days.

Child reporting vaginal or anal penetration or oral sexual contact within past 72 hours and has not been examined by a medical doctor.

Priority 2—Moderate Risk

Standard Response Time:
Within 48 Hours

Sexual Abuse

Sexual behavior within past 8 to 14 days including sexual abuse, sexual assault, sexual exploitation of a minor, commercial sexual exploitation of a minor, incest, child prostitution, molestation of a child, and sexual conduct with a minor.

Priority 3—Low Risk

Standard Response Time:
Within 72 Hours

Sexual Abuse

Attempted sexual behavior when last occurrence is unknown or occurred more than 14 days and up to 3 years ago, including sexual abuse, sexual assault, sexual exploitation of a minor, commercial sexual exploitation of a minor, incest, child prostitution, molestation of a child, and sexual conduct with a minor.

Parent, guardian, or custodian suggests or entices a child to engage in sexual behavior, but there is no actual touching, including encouraging a child to view pornographic materials.

Child is exhibiting physical or behavioral indicators which are consistent with sexual abuse.

Priority 4—Potential Risk

Standard Response Time:
Within 7 Consecutive Days

Sexual Abuse

Parent, guardian, or custodian sexually abused a child in the past and is now living in a home with the child.

Attempted sexual behavior or sexual behavior when last occurrence was beyond 3 years including sexual abuse, sexual assault, sexual exploitation of a minor, commercial exploitation of a minor, incest, child prostitution, molestation of a child, and sexual conduct with a minor.

Appendix A (concl'd)

Child Protective Services
Child Abuse Hotline
Report Priority Classification System

Priority 1—High Risk	Priority 2—Moderate Risk	Priority 3—Low Risk	Priority 4—Potential Risk
Standard Response Time: Within 2 Hours	Standard Response Time: Within 48 Hours	Standard Response Time: Within 72 Hours	Standard Response Time: Within 7 Consecutive Days
Emotional Abuse	**Emotional Abuse**	**Emotional Abuse**	**Emotional Abuse**
N / A	Child diagnosed by qualified mental health professional as exhibiting severe anxiety, depression, withdrawal, or untoward aggressive behavior which could be due to serious emotional damage by parent, guardian, or custodian.	Parent, guardian, or custodian demonstrates behavior or child reports parent, guardian, or custodian behavior which is likely to have the effect of terror, rejection, isolation, humiliation, or debasement of a child.	N / A
Abandoned	**Abandoned**	**Abandoned**	**Abandoned**
No parent willing to provide immediate care for a child and child is with a caregiver who is unable or unwilling to care for the child now or child is left to his or her own resources.	No parent willing to care for a child and child is with a caregiver who is unable or unwilling to continue caring for the child for more than six days.	No parent willing to care for child and child is with a caregiver who is unable or unwilling to continue caring for the child more than 30 days.	N / A
Non-Sexual Exploitation	**Non-Sexual Exploitation**	**Non-Sexual Exploitation**	**Non-Sexual Exploitation**
N / A	N / A	Use of a child by a parent, guardian, or custodian for material gain which may include forcing the child to panhandle, steal, or perform other illegal activities.	N / A

Appendix B

Department of Economic Security
Division of Children, Youth and Families
Description of Uninvestigated Cases
Year Ended June 30, 1997

Appendix B

Department of Economic Security
Division of Children, Youth and Families
Description of Uninvestigated Cases
Year Ended June 30, 1997

Type of Abuse	Priority 1	Number of Cases
Physical	Injuries requiring emergency medical treatment which may include severe head injuries, internal injuries, severe facial bruises, fractures, or immersion burns.	1
Neglect	Child under the age of six left alone *now*.	1
Neglect	Neglect resulting in serious physical injury or illness requiring emergency medical treatment.	1
Sexual	Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past seven days.	1
Abandoned	No parent willing to provide immediate care for a child. Child is with a caregiver who is unable or unwilling to care for the child, or child is left to own resources.	10
	Total Uninvestigated Priority 1 Cases	14
	Priority 2	
Physical	Injuries that may require medical treatment including multiple injuries, injuries to the torso or extremities, injuries to a child under age 1, or fractures.	18
Physical	Injuries to a child under age six not requiring medical treatment including first-degree or cigarette burns, injury to buttocks or scalp, or single or small bruises.	19
Physical	Child six years of age or older observed or reported to be struck in the head, face, neck, genitals, or abdomen which could likely cause injury.	25
Neglect	Child age 11 to 13 years of age caring for a child age 6 or younger for 12 hours or longer.	2
Neglect	Living environment presents health or safety hazards to a child under the age of 6 including human/animal feces, undisposed garbage, or exposed wiring.	12
Neglect	Sexual conduct or physical injury between children due to inadequate supervision by parent, guardian, or custodian.	29
Neglect	History of extensive gestational substance abuse to children under 3 months of age or mother or child tests positive for illegal drugs or alcohol at time of birth.	15
Sexual	Sexual behavior within the past 8 to 14 days including sexual abuse, sexual assault, sexual exploitation of a minor, incest, or child prostitution.	9
Emotional	Child diagnosed by a qualified mental health professional as exhibiting severe anxiety or depression which could be due to serious emotional damage by parent or guardian.	1
Abandoned	No parent willing to care for a child, and child is with a caregiver who is unable or unwilling to continue caring for the child for more than 6 days.	7
	Total Uninvestigated Priority 2 Cases	137

Appendix B (cont'd)

Department of Economic Security
Division of Children, Youth and Families
Description of Uninvestigated Cases
Year Ended June 30, 1997

Type of Abuse	Priority 3	Number of Cases
Physical	Injuries not requiring medical treatment including first-degree or cigarette burns, injury to buttocks or scalp, injury to body parts, or single or small bruises.	1,136
Physical	Parent, guardian, or custodian threatens to harm a child if no intervention is received.	36
Neglect	Untreated medical problem causes child pain but is not life-threatening, and parent or guardian is unwilling to secure medical treatment.	157
Neglect	Child under the age of 9, who is not alone now, but has been left alone within the past 14 days.	190
Neglect	Parent or guardian demonstrates an inability to care for a child within the past 30 days including leaving a child with inappropriate or inadequate caregivers.	1,017
Neglect	Living environment presents health or safety hazards to child 6 years of age or older, including human/animal feces, undisposed garbage, or exposed wiring.	80
Neglect	Food not provided and child is chronically hungry.	70
Neglect	Parent or guardian is not protecting child from a person who does not live in the home and has abused the child.	44
Neglect	Complaint by law enforcement or juvenile court officer alleging dependency due to a delinquent or incorrigible act committed by a child under age 8.	2
Sexual	Attempted sexual behavior or sexual behavior when last occurrence is unknown or occurred more than 14 days and up to 3 years ago, including sexual abuse, sexual assault, or incest.	219
Sexual	Parent or guardian suggests or entices a child to engage in sexual behavior but there is no actual touching, including encouraging a child to view pornographic materials.	25
Sexual	Child is exhibiting physical or behavioral indicators which are consistent with sexual abuse.	173
Emotional	Parent or guardian demonstrates behavior or child reports parent or guardian behavior which is likely to have the effect of terror, rejection, isolation, humiliation or debasement to a child.	268
Abandoned	No parent willing to care for a child and child is with a caregiver who is unable or unwilling to care for the child more than 30 days.	23
Exploitation	Use of a child by a parent or guardian for material gain including forcing a child to panhandle, steal, or perform other illegal activities.	13
	Total Uninvestigated Priority 3 Cases	3,453

Appendix B (concl'd)

Department of Economic Security
Division of Children, Youth and Families
Description of Uninvestigated Cases
Year Ended June 30, 1997

Type of Abuse	Priority 4	Number of Cases
Physical	Home environment stressors place child at risk of physical abuse which may include domestic violence, mental illness, substance abuse, or history of physical abuse with no current injury.	1,202
Neglect	Parent or guardian has no resources to provide for child's needs including supervision, food, clothing, shelter and medical care and child's needs may be neglected.	126
Neglect	Home environment stressors including mental illness and substance abuse place child at risk of neglect.	553
Neglect	Living environment is likely to present a health or safety hazard to a child.	149
Neglect	Sexual conduct or physical injury between children, and unknown if parent or guardian will protect.	100
Sexual	Parent or guardian sexually abused a child in the past and is now living in the home with the child.	69
Sexual	Attempted sexual behavior or sexual behavior when the last occurrence is beyond 3 years including sexual abuse, sexual assault, sexual exploitation of a minor, or incest.	39
	Total Uninvestigated Priority 4 Cases	2,238
	Total Uninvestigated Cases	5,842 [a]

[a] The total number of reports not investigated is equal to 5,899, but 57 uninvestigated reports could not be included in this description because they lacked the appropriate abuse category code.

Appendix C

Department of Economic Security
Division of Children, Youth and Families
District I—File Review Methods

Appendix C

Department of Economic Security
Division of Children, Youth and Families
District I—File Review Methods

A random sample of 196 child maltreatment reports filed in District I during the first month of each quarter of fiscal year 1996 was chosen for review as follows:

- 40 reports were randomly selected among the 1,111 reports appropriate for investigation in District I during July 1995.
- 53 reports were randomly selected among the 1,423 reports appropriate for investigation in District I during October 1995.
- 45 reports were randomly selected among the 1,222 reports appropriate for investigation in District I during January 1996.
- 58 reports were randomly selected among the 1,552 reports appropriate for investigation in District I during April 1996.

Of these 196 reports selected for review, electronic records indicate that 182 were recorded as being investigated, and 14 were listed as not investigated. However, the Division could not locate files for 11 of the 182 investigated cases, and 4 other files had to be eliminated from the review for other reasons. Therefore, the review covered 167 investigated reports and 14 noninvestigated reports.