A REPORT
TO THE
ARIZONA LEGISLATURE

Performance Audit Division

Performance Audit

Department of Economic Security—

Division of Children, Youth and Families—Child Protective Services—Congregate Care

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STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

Debra K. Davenport
Auditor General

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STATE OF ARIZONA
OFFICE OF THE
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June 25, 2009

Members of the Arizona Legislature

The Honorable Janice K. Brewer, Governor

Mr. Neal Young, 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—Child Protective Services—Congregate Care. This report was prepared pursuant to and under the authority vested in the Auditor General by Arizona Revised Statutes §41-1966.

As outlined in its response, the Department of Economic Security agrees with the findings and plans to implement 5 of 6 recommendations as outlined. It will handle one of the recommendations in a different manner.

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

This report will be released to the public on June 26, 2009.

Sincerely,

Debbie Davenport
Auditor General

Attachment

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SUMMARY

Our Conclusion

The Division can take steps to better ensure the safety and well-being of children living in group settings known as congregate care including shelters, group homes, and residential treatment centers (RTCs). Specifically, the Division should improve the timeliness of its investigations of CPS reports alleging abuse and neglect of children in group homes and shelters so that threats are mitigated promptly. The Division should also seek a statutory amendment that would clarify that CPS has authority to investigate allegations of abuse and neglect in RTCs. This will ensure information on substantiated instances of abuse is entered into the State's central registry and is considered when conducting background checks of prospective congregate care employees having direct contact with children. Finally, the Division should implement changes to increase the effectiveness of outcome monitoring as a means to help ensure quality congregate care services.

Agency Comments

The Department agrees with the findings and will implement 5 of the 6 recommendations as outlined. It will handle one of the recommendations in a different manner.

This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes §41-1966.

Congregate Care

The Department of Economic Security's (Department) Division of Children, Youth and Families (Division) oversees Arizona's Child Protective Services (CPS) program. The CPS program is designed to protect children alleged to have been abused or neglected by their parents, guardians, or custodians.

Sometimes, to protect a child from abuse and neglect, CPS staff will remove the child from his/her home, and the court will order that the child be placed temporarily in out-of-home care. In accordance with child welfare best practices, federal law requires that when a child is removed from his/her home, the child must be placed in the least-restrictive setting available consistent with his/her best interests and needs.[1] In some cases, this may be with a relative or licensed foster family. However, some children have needs that require the structure and services provided in a group setting, referred to as congregate care.

In Arizona, there are three types of congregate care settings available for children who have been removed from their homes by CPS: group homes, shelters, and residential treatment centers (RTCs). All congregate care facilities are licensed and paid staff provide 24-hour care and supervision of the children. Further, all congregate care is provided through contracted service providers. Although the need for congregate care remains, the Division continues to reduce its use and expenditures for this type of care.

Improvements needed in congregate care investigations (see pages 5 through 13)

The Division can better ensure the safety of children living in group homes and shelters by promptly investigating CPS reports alleging abuse and neglect of the children by facility staff. Prompt investigations facilitate the Division's ability to quickly mitigate threats and provide needed services to the children, but auditors found that many of the investigations involving children in these facilities were not being completed, documented, and closed in a timely manner.

The Division can also help protect children in congregate care by seeking a statutory amendment clarifying that CPS has authority to investigate reports alleging abuse and neglect of children in RTCs by facility staff. CPS investigates allegations of child abuse and neglect in group homes providing behavioral health services that are licensed by the Arizona Department of Health Services,

1 42 U.S.C. 675(5)(A)

which also investigates these allegations as part of its licensing responsibilities. However, CPS does not investigate allegations of child abuse and neglect within RTCs because the Division does not believe that it has authority to do so. CPS can only investigate allegations of abuse and neglect involving children's parents, guardians, or custodians, and the Division does not believe that RTC staff have a custodial relationship with the children. Rather, only the Department of Health Services investigates these allegations as part of its licensing responsibilities and it uses different procedures and standards than are required for CPS investigations. Statute and department policy require that staff providing direct care to children in contracted congregate care facilities undergo both criminal and central registry background checks. The central registry is an automated repository of information on CPS-substantiated reports of child abuse and neglect committed by parents, guardians, and custodians. However, only CPS-substantiated reports may be included in the central registry. Therefore, vital information regarding allegations of abuse and neglect in RTCs is not available for the central registry background checks.

To address these issues, the Division should:

- Implement the Division's action plan to improve the timeliness of investigations of alleged abuse and neglect in congregate care settings by more effectively tracking investigation activity, updating investigators on upcoming investigation completion dates, and increasing supervisor communication with investigators about ongoing investigations.

- Review and prioritize the responsibilities of the specialized investigation unit that investigates reports of alleged abuse and neglect in family foster homes, group homes, and shelters to ensure tasks critical for ensuring child safety, such as completing investigations within 21 days, are performed.

- Monitor and ensure that the Division's policy that requires staff to document case activity within 10 days of its occurrence is met in order to improve the availability of investigative information for management's use in monitoring investigation thoroughness, workload, and productivity.

- Seek a statutory amendment that would clarify that CPS has authority to investigate allegations of abuse and neglect in RTCs to improve the completeness of the central registry information used to conduct congregate care employee background checks.

Division should improve congregate care outcome monitoring (see pages 15 through 18)

Monitoring congregate care providers' performance using outcome measures helps ensure that children are well served and tax dollars are effectively spent. The Department's contracts with the congregate providers each include several outcome measures for assessing provider performance. Both the providers and the Division share responsibility for gathering and reporting data on the various outcomes. However, the Division has not been enforcing the reporting requirement, nor using the outcome data to assess providers' performance. Further, some of the outcome measures are inadequate. Division officials reported that limited staffing hinders its ability to evaluate the outcome data and use it to monitor the providers' performance. The Division should review and revise the outcome measures within its congregate care contracts according to established criteria, enforce the requirement that outcome data be gathered and reported to the Division, and use the information to monitor providers' performance, including using the data as additional criteria for yearly contract renewal and as the basis for helping providers identify problems and correct deficiencies.

BACKGROUND

Federal law requires that a child removed from home is placed in the least-restrictive setting, meaning one that is most like a family, consistent with the child's best interests and needs. Some children have needs that require the structure and services provided in group settings, referred to as congregate care. Congregate care includes group homes, shelters, and residential treatment centers. The Division is moving toward its goal of reducing the number of children in congregate care, and related costs.

Congregate care used to meet children's specific needs

The Department of Economic Security's (Department) Division of Children, Youth and Families (Division) oversees the State's Child Protective Services (CPS) program, which is designed to protect children alleged to have been abused and neglected. In some instances, to protect a child from further abuse and neglect, CPS staff will remove the child from his/her home, and the court will order that the child be placed temporarily in out-of-home care. In accordance with child welfare best practices, federal law requires that when this occurs, the child be placed in the least-restrictive setting available consistent with his/her best interests and needs, such as with a relative or licensed foster family. However, some children have needs or circumstances that require the structure and services provided in a group setting, referred to as congregate care.

Three types of congregate care settings available to CPS—Three types of congregate care settings are available for children who are removed from their homes by CPS—group homes, shelters, and residential treatment centers.[1] Although all of the settings are licensed and paid staff provide 24-hour care and supervision of children, they still vary in a number of ways.[2] Specifically:

- **Group homes** tend to be smaller than other types of congregate care settings, typically capable of housing between five and ten children of a specific gender and age group. Group homes are considered staff-secured as opposed to being a locked facility, and the children typically attend local schools. Additionally, some group homes provide behavioral health treatment services. According to a 2008 study, children placed in group home settings are typically older, more likely to be male, and a minority, and experience a range of socio-emotional and behavioral problems as compared with children living in family foster homes.[3] Division personnel indicated that group homes may also be used to keep siblings together when no family foster home is available to take them. Division management reported that as of May 2009, the daily cost for group home care ranged from $54 to $185 per child depending on the level of care provided.

1 In addition to caring for children referred through the child welfare system, these facilities may care for children referred through the Arizona juvenile court system, the Arizona Department of Juvenile Corrections, and the state behavioral health system.

2 Division officials reported that in addition to paid staff, some of the larger shelter facilities may also use volunteer staff.

3 Ryan, J.P., Marshall, T.M., Herz, D., & Hernandez, P.M. (2008). Juvenile delinquency in child welfare: Investigating group home effects. *Children and Youth Services Review,* 30(a), 1088-1099, doi:10.1016/j.childyouth.2008.02.004

- **Shelters** differ from group homes in that they are used on an emergency or temporary basis. For example, a child may be placed in a shelter temporarily if a family foster placement is not available when the child is removed from his/her home. Shelters vary significantly in the number of children they are capable of housing, ranging from as few as 2 to more than 40, and may serve both boys and girls of different ages. Children in shelters are enrolled in school. Although children in all congregate care settings may be transported to medical and dental appointments, some shelters have on-site medical and developmental services for children who require special care. Division management reported that the daily cost for shelter care ranged between $79 and $130 per bed.

- **Residential treatment centers** (RTCs) are generally larger than group homes and shelters, housing between 20 and 87 children, and may serve both boys and girls of different ages. RTCs can be locked or staff-secured facilities and on-site schooling is usually provided. The major difference between RTCs and group homes and shelters is that RTCs provide intensive care, supervision, and psychiatric oversight of children who have moderate to severe emotional, behavioral, and/or substance abuse problems. Services include individual, group, and family therapy; schooling; recreation; and living skills training. The severity of a child's behavioral or mental health problems is the primary factor in determining whether to place the child in an RTC instead of a group home that provides behavioral health services. Division management reported that the daily cost for RTC care ranged between $235 and $265 per child.

As of April 2009, the Department contracted with 200 congregate care facilities to care for children removed from their homes by CPS (see Table 1 on page 3). The majority of facilities are located in District I (Maricopa County) and District II (Pima County), the two most populated of the CPS program's six geographical districts. If a district does not have a facility within its boundaries that meets a child's needs, CPS may place the child in a facility in a nearby district.

Division's use of congregate care decreasing—In keeping with its efforts to place children in the least-restrictive setting possible consistent with their needs, the Division has been working to reduce the number of children it places in congregate care. As illustrated in Figure 1 (see page 3), the percentage of children removed from their homes by CPS who were living in a congregate care setting on June 30, 2005, 2006, 2007, and 2008 declined from 22 percent to 15 percent. The Division attributes this trend to reasons such as its increased success in placing children with relatives and licensed foster families and greater availability of and attention to placement data, which has improved staffs' ability to monitor children's progress toward a less-restrictive setting.

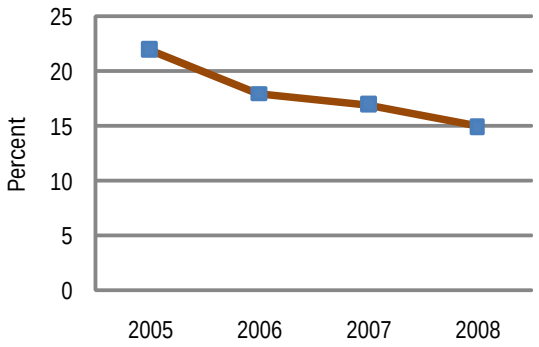
Although the number of children living in group homes and shelters is decreasing, as shown in Table 2 (see page 4), the number of children in RTCs has increased since fiscal year 2006. Typically, if a child is placed in an RTC, it is because the court has

Table 1: Number of Congregate Care Facilities Contracted for Placement of Children Removed by CPS by District As of April 2009

District (County)	Group Homes	Shelters	Residential Treatment Centers	Total
1 Maricopa	83	24	6	113
2 Pima	53	5	0	58
3 Apache, Coconino, Navajo, Yavapai	8	3	1	12
4 La Paz, Mohave, Yuma	2	1	0	3
5 Gila, Pinal	6	1	1	8
6 Cochise, Graham, Greenlee, Santa Cruz	3	2	1	6
State-wide	155	36	9	200

Source: Auditor General staff summary of a division-prepared spreadsheet of contracted congregate care facilities as of April 2009.

Figure 1: Percentage of Children in Out-of-home Care Living in a Congregate Care Setting As of June 30, 2005, 2006, 2007, and 2008



Source: Auditor General staff analysis of division placement data on children removed from their homes by CPS and living in out-of-home care on June 30, 2005, 2006, 2007, and 2008.

ordered the placement and/or the Regional Behavioral Health Authority (RBHA) has approved the placement based on a documented need.[1] According to division officials, staff and the RBHA in District I initiated a joint evaluation process in 2006 that allowed some children to be placed in less-restrictive settings, such as group homes, with additional community supports. Although the joint evaluation process ended in less than a year when the Arizona Department of Health Services contracted with a new RBHA, District I staff are working with the current RBHA to reinstate it.

1 RBHAs are state-contracted, managed-care organizations that contract with service providers to provide behavioral health services in specific geographic areas.

Table 2: Number of Children in Congregate Care by Setting[1]
Fiscal Years 2005 through 2008

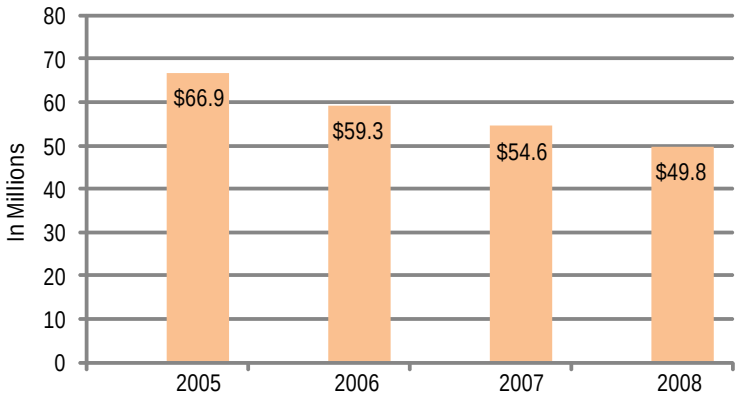
Facility Type	Fiscal Year 2005	2006	2007	2008
Group homes	3,925	3,675	3,284	2,788
Shelters	3,151	2,705	2,662	2,313
Residential treatment centers	311	271	319	367

1 A child may be counted in more than one facility type within the fiscal year if he/she was moved from one type of congregate care setting to another.

Source: Auditor General staff analysis of division congregate care placement data on children removed from their homes by CPS and living in a group home, shelter, or RTC at any point during the year for fiscal years 2005 through 2008.

Congregate care expenditures also decreasing—As shown in Figure 2, in line with the reductions in congregate care use, the Division's congregate care expenditures have also steadily decreased between fiscal years 2005 and 2008. Specifically, in fiscal year 2008, the Division spent approximately $50 million for contracted congregate care, which was 25 percent less than it spent in fiscal year 2005. Both State General Fund and federal monies such as Title IV-E (Foster Care and Adoption Assistance) and Title IV-A (Temporary Assistance for Needy Families) monies are used to fund congregate care. In addition to funding provided through the Division, other sources were used to pay for congregate care expenditures. For example, division management estimated that in December 2008, approximately 80 percent of the children removed from their homes by CPS and placed in RTCs and group homes licensed by the Arizona Department of Health Services were funded through the RBHAs using federal Title XIX (Medical Assistance Programs) monies. The Division pays the allowances for all the children, and room and board for children not eligible under Title XIX. In some instances, non-Title XIX placements for youth adjudicated both dependent and delinquent are cost shared with the Arizona Department of Juvenile Corrections or county juvenile probation agencies.

Figure 2: Annual Congregate Care Expenditures
Fiscal Years 2005 through 2008



Source: Auditor General staff analysis of division-prepared data on congregate care expenditures for fiscal years 2005 through 2008 obtained from the Division's Child Information Library and Data Source.

FINDING 1

Timely investigation of reports of alleged child abuse and neglect within congregate care is important to help ensure child safety and well-being. Oftentimes the Division has not met statutory and division timeliness requirements for investigating these reports, determining a finding, and closing the case. In addition, the Division has not documented investigation activities in a timely manner, which may impact accuracy and impacts management's ability to monitor workload and productivity. Therefore, to better ensure the safety and well-being of children in congregate care, the Division needs to improve congregate care investigation and documentation timeliness. The Division should also seek a statutory amendment clarifying CPS' authority to investigate allegations of abuse and neglect in RTCs to improve the completeness of the central registry information used to conduct congregate care employee background checks.

Improvements needed in congregate care investigations

Investigations help to ensure child safety

A vital part of Child Protective Services' (CPS') responsibility to promote the safety and protection of children is achieved by promptly investigating CPS reports alleging abuse and neglect. Timely investigation is critical because a delay may jeopardize a child's immediate safety and long-term well-being by failing to mitigate threats to the child and/or provide needed services.

Further, timely investigations also help ensure that congregate care staff members who have abused children do not continue to work in congregate care settings. During an investigation, an alleged perpetrator may still work for a congregate care provider, resign, or be terminated by the provider, but then be hired by another provider. However, statute requires that once the abuse or neglect allegation is substantiated, it must be recorded in the central registry.[1] The Department uses this automated system to record information on the perpetrators of substantiated incidents of child abuse and neglect committed by parents, guardians, and custodians.The information in the central registry is used to conduct background checks on prospective department employees and employees of their contracted service providers. If a job applicant is listed in the central registry because CPS determined that he/she was responsible for high- or moderate-risk abuse and neglect or the death of a child, he/she is not eligible for employment in a position having direct contact with children, thereby helping prevent abusive staff from moving to different congregate care facilities.

It is also important that CPS investigators document their actions in a timely manner in the Division's automated CPS case management system known as CHILDS (Children's Information Library and Data Source). This ensures that the information can be factored into the safety assessment and decision-making process if a subsequent report is received involving the same child, alleged perpetrator, or facility. The information is also available for management's use in monitoring investigation thoroughness, workload, and productivity. Additionally, CPS staff's delay in documenting their actions may negatively affect the accuracy of that information.

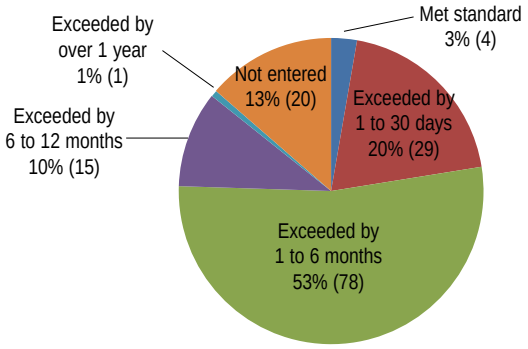
1 Before a person's name can be entered into the central registry, the individual must be afforded due process. If the outcome of due process is that probable cause exists to sustain the Department's substantiation finding, then the person's name will be entered into the central registry.

Division should improve timeliness of congregate care investigations and documentation

Although the Division is required to conduct and record investigations promptly, many CPS investigations of alleged child abuse and neglect in congregate care are not being completed, documented, and closed within statutory and/or division policy time frames. A.R.S. §8-802 and division policy require that CPS investigators enter a decision, or finding, into CHILDS for each allegation of abuse and neglect in a CPS report within 21 days of receiving the report. Entry of the finding(s) in CHILDS signifies that the investigation has been completed. Division policy requires that investigation documentation be completed and the investigation closed within 45 days of the unit's being assigned the report. These requirements apply to all CPS reports, not just those involving children in congregate care.

A specialized CPS investigation unit in District I conducts the investigations of reports alleging child abuse and neglect within group homes and shelters for the entire State. In addition, the unit investigates reports alleging abuse and neglect in family foster homes within Maricopa County. The unit consists of a supervisor and three investigators. It is the unit's responsibility to determine if there is evidence to substantiate or unsubstantiate that the alleged abuse and neglect occurred. According to auditors' review of CPS reports assigned to the unit, the unit conducted 74 investigations of alleged abuse and neglect in congregate care in calendar year 2007, and 73 investigations in calendar year 2008.[1]

Figure 3: Compliance with Entering Investigation Findings Within 21 Days of Report Receipt
Reports Received in Calendar Years 2007 and 2008



Source: Auditor General staff analysis of division data for 147 CPS congregate care investigations conducted in calendar years 2007 and 2008 from the Department's data warehouse.

Many congregate care investigations not completed in a timely manner—Although the Division is statutorily required to complete investigations within 21 days of report receipt, few of the congregate care investigations met the time frame. Promptly conducting investigations helps ensure children's safety and well-being by mitigating threats and/or providing needed services in a timely manner. However, auditors' analysis found that only 3 percent, or 4 of 147, of the investigation unit's 2007 and 2008 congregate care investigations had findings entered into CHILDS within 21 days (see Figure 3). Further, 11 percent, or 16 of 147, exceeded the time frame by more than 6 months.

Auditors conducted additional assessment to determine if it was only the documentation of the findings or the actual investigation activities, such as interviewing the alleged child victims and perpetrators and reviewing police and medical

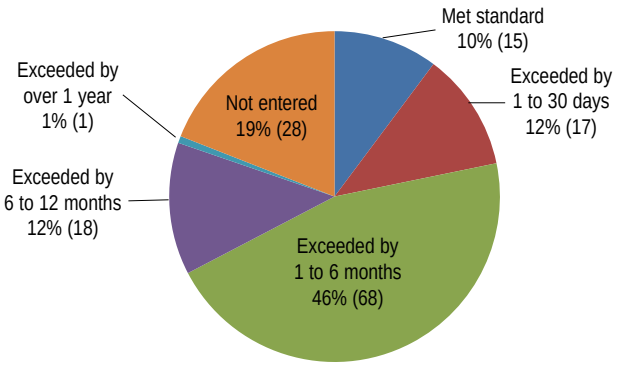
[1] In addition to the 74 investigations of alleged child abuse and neglect in congregate care in calendar year 2007, and the 73 investigations in calendar year 2008, the unit was assigned to investigate 194 CPS reports in non-congregate care settings in calendar year 2007 and 184 CPS reports in calendar year 2008.

reports, which were untimely. Specifically, auditors reviewed the documentation for 23 investigations conducted by the unit during the first half of 2008 that did not have investigation findings entered into CHILDS within 21 days. Seventeen of the 23 investigations had investigation activities that occurred beyond the 21-day time frame. For example, in 14 of the investigations, the investigator was still interviewing the alleged child victim, other children in the facility, or facility staff more than 21 days after being assigned the report and in three investigations, the investigator was still interviewing more than 3 months after being assigned the report.

Many congregate care investigations not documented and closed in a timely manner—Although division policy requires that the investigative unit document and close investigations within 45 days of a report's receipt, few congregate care investigations met the time frame.[1] It is important that investigations be documented in a timely manner because this ensures that the investigative information can be factored into the safety assessment and decision-making process if a subsequent report is received involving the same child, alleged perpetrator, or facility. It is also important to close investigations in a timely manner to facilitate management's ability to monitor and manage investigator workload and productivity by providing an accurate picture of the number of active investigations.

However, auditors' analysis found that only 10 percent, or 15 of 147, of the investigations conducted in calendar years 2007 and 2008 were closed within the required time frame (see Figure 4). Additionally, for 20 of the 23 investigations auditors reviewed that were conducted in the first half of 2008, the investigators did not even begin documenting the case in CHILDS until after the 45-day time frame expired. For 15 of the 23 investigations, investigators did not begin documenting the case in CHILDS until more than 3 months after the start of the investigation.

Figure 4: Compliance with Closing Investigations Cases Within 45 Days of Report Receipt
Reports Received in Calendar Years 2007 and 2008



Source: Auditor General staff analysis of division data for 147 CPS congregate care investigations conducted in calendar years 2007 and 2008 from the Department's data warehouse.

1 The investigator's supervisor may close the congregate care investigation after ensuring that the investigator took appropriate actions to address the alleged child victim's continued safety and well-being and reviewing the investigative documentation to ensure that it is complete, thorough, and accurate.

Several reasons cited for untimely congregate care investigations— Division management provided several reasons to help explain the specialized investigation unit's lack of investigation and documentation timeliness. First, at times the unit experienced delays in receiving police and medical reports and delays in gaining access to those involved in the case, such as alleged perpetrators, which contributed to some investigations remaining open for extended periods. Second, the unit assisted with some District I investigations, thus hampering its ability to complete its own investigations in a timely manner.[1] Finally, management indicated that changes the Division made to its comprehensive tool for assessing child safety and family strengths and risks in February and November 2007 required that investigators relearn how to navigate the automated system.

Despite the delays in completing and documenting congregate care investigations, unit staff maintain that child safety is ensured because often the child is removed, and/or the alleged perpetrator is put on leave or terminated when the unit notifies the group home or shelter that there will be an investigation. However, removing the child does not guarantee the safety of the remaining children in the group home or shelter, and terminating the alleged perpetrator does not guarantee the safety of children in other group homes or shelters. In one case reviewed by auditors, a child in a group home alleged that a staff person abused him prior to the group home terminating that person for an undisclosed reason. Investigation revealed that the terminated staff person went on to work at another group home and was under CPS investigation for allegedly abusing a child there. During that investigation, which was eventually substantiated, the staff person went on to work at a third group home.

Division should take actions to resolve untimely congregate care investigations, but may be limited by budget issues— To help ensure child safety and well-being in congregate care facilities, it is important that unit investigators adhere to statutory and policy time frames for completing, documenting, and closing investigation cases. Division officials indicated that in March 2009 an action plan was developed to address investigation and documentation timeliness issues in the investigative unit. The plan requires the unit supervisor to revise the unit's procedures to more effectively use manual and online systems to track investigation activity, to provide weekly updates to investigators on finding due dates, and to increase the frequency of supervisor contact with investigators to discuss the progress of ongoing investigations. Additionally, the Division can help facilitate staff compliance with the investigative time frames by ensuring that the unit remains adequately staffed and by not routinely using the unit to assist with other investigative units' workloads. Further, the unit supervisor should monitor and ensure that the division policy requiring staff to document case activity within 10 days of its occurrence is met.

Although division management agrees that maintaining adequate staffing and not assigning congregate care investigative staff to assist other investigation units would help with investigation and documentation timeliness, it cautions that this may not be

1 Investigation of alleged abuse by parents is the responsibility of district CPS specialists, but according to division management, staff shortages in District I have caused it to use the unit's investigators for this purpose. In 2008, the specialized investigation unit conducted 15 investigations for District I.

feasible right now because of the impact of recent budget cuts on staffing. However, the Division is planning to mitigate some of the impact of the reduced staffing by not investigating some of its potential risk CPS reports, meaning those reports where the alleged abuse and neglect are based on the potential to occur rather than actual occurrence, and by temporarily re-assigning non-investigative CPS specialists to the investigative function. Additionally, it should review and prioritize the specialized investigation unit's responsibilities to ensure that critical tasks affecting child safety are accomplished, such as completing investigations within 21 days.

Division should seek statutory amendment clarifying CPS' authority to investigate allegations of child abuse and neglect in RTCs

To help ensure the safety of children placed in congregate care settings, the Division should seek a statutory amendment that would clarify that CPS has authority to investigate allegations of abuse and neglect in RTCs. As indicated earlier, a specialized CPS investigation unit in District I conducts investigations of all reports alleging child abuse and neglect within group homes and shelters for the entire State, including group homes licensed by the Arizona Department of Health Services. However, CPS does not investigate or substantiate allegations of child abuse and neglect within RTCs because the Division does not believe that it has the authority to do so. Instead, the Division forwards these reports to law enforcement, if appropriate, and to the Arizona Department of Health Services' Office of Behavioral Health Licensing, which investigates these reports as potential licensing violations. Although the Arizona Department of Health Services investigates these reports as part of its licensing responsibilities, it uses different procedures and standards than those required for CPS investigations.[1] Further, because only CPS-substantiated reports may be included in the central registry, vital information is not available for the central registry background check that all staff providing direct care to children in congregate care facilities must undergo. This gap potentially leaves children at risk for abuse and neglect.[2]

1 Before an allegation of abuse or neglect can be substantiated, CPS must show probable cause, meaning facts that provide reasonable grounds to believe that abuse or neglect occurred. Additionally, the investigation must undergo review by an entity external to CPS to verify that the standard of evidence was met. Once this has been confirmed, the identified perpetrator must be informed that the allegation(s) will be substantiated and entered into the central registry, and offered an opportunity to provide additional information to refute the substantiation. Although the Arizona Department of Health Services' investigations of complaints alleging abuse or neglect of children in RTCs adhere to defined investigation standards, they are not required to show probable cause and the process for reviewing the investigation results and providing an opportunity for appeal differ from CPS' statutory requirements.

2 A.R.S. §8-804 requires the Department to maintain a central registry of substantiated child abuse and neglect reports. The central registry information is used for specific purposes, including conducting background checks, as one factor to determine qualifications for persons applying for employment with the State in positions that provide direct service to children or vulnerable adults and persons applying for contracts with the State and their employees who will provide direct service to children or vulnerable adults.

Examples of Criminal Offenses Precluding Receipt of a Fingerprint Clearance Card

- Sexual conduct, abuse, or exploitation of a minor
- Manslaughter or murder
- Kidnapping
- Arson
- Sexual assault
- Contributing to the delinquency of a minor
- Felony drug distribution offense
- Burglary or robbery
- Dangerous crimes against children as defined in A.R.S. §13-705
- Child abuse or molestation
- Aggravated assault

Source: A.R.S. §41-1758.03

Criminal and child abuse and neglect information used in congregate care employee background checks—Arizona statute and department policy require that employees who work for the Department's contracted congregate care facilities in direct contact with children undergo both criminal and child abuse background checks to ensure that they do not pose a threat to the children in the facilities. The Arizona Department of Public Safety conducts the criminal background check using the employee's fingerprints. As long as the employee is not awaiting trial on, or been convicted of, certain criminal offenses (see textbox for examples) he/she will receive a fingerprint clearance card. If the person is declined a fingerprint clearance card for certain crimes, he/she may appeal the decision to the Arizona Board of Fingerprinting. Staff in congregate care facilities who do not have a valid fingerprint clearance card may not work directly with children.

In addition to the criminal background check, statute and department policy require the Department to review the central registry to see if the employee is identified as a perpetrator in a substantiated CPS report. The information contained in the central registry is used as one factor to determine qualifications for persons applying for positions that provide direct services to children. A person is disqualified from providing services to children in a direct service position if he or she is identified as the subject of a substantiated report involving the death of a child, high-risk physical abuse, sexual abuse or neglect, moderate-risk physical abuse, sexual abuse or neglect, and moderate-risk emotional abuse. Table 3 on page 11 provides examples of high and moderate abuse and neglect.

Children may be vulnerable to staff abuse because CPS does not investigate child abuse and neglect reports in RTCs—Although CPS investigates allegations of child abuse and neglect in group homes that provide behavioral health services and are licensed by the Arizona Department of Health Services, and it coordinates with the Arizona Department of Health Services, which also considers these same complaints as part of its licensing responsibilities, CPS does not investigate allegations of abuse and neglect in RTCs. Rather, only the Arizona Department of Health Services investigates these complaints as part of its licensing responsibilities. Because statute only allows information on child abuse and neglect reports substantiated by CPS to be entered into the central registry, information on similar complaints in RTCs investigated by the Department of Health Services as licensing violations is excluded from the central registry. This situation may potentially allow staff that abuse and neglect children in RTCs to be hired later at a different congregate care facility. Further, allegations of abuse and neglect investigated by the Arizona Department of Health Services may not rise to the level of criminal activity or be pursued for prosecution, and therefore may not appear in a criminal background check. This potential gap in reviewing staff qualifications underscores the importance of including reports of abuse and neglect in all congregate care facilities in the central registry.

Table 3: Examples of High- and Moderate-Risk Child Abuse and Neglect

Abuse Type	High Risk	Moderate Risk
Physical abuse	Severe or life-threatening injuries requiring emergency medical treatment and/or parent presents immediate, severe physical harm to a child. Physical abuse by a parent, guardian, or custodian who has a prior substantiated high-risk report.	Serious or multiple injuries which may require medical treatment and/or a child at risk for serious physical abuse if no intervention is received.
Neglect	Severe or life-threatening situations requiring emergency intervention due to the absence of a parent, or a parent who is either unable due to physical or mental limitations or is unwilling to provide minimally adequate care. Child 6 to 9 years of age is alone for 3 hours or longer or unknown when parent, guardian, or custodian will return. Imminent harm to child due to health or safety hazards in living environment which may include exposure to the elements.	Serious/non-life-threatening situations requiring intervention due to the absence of a parent, or a parent who is unable due to physical or mental limitations or is unwilling to provide minimally adequate care. Inadequate supervision or encouragement by parent, guardian, or custodian, sexual conduct or physical injury occurs between children. This includes a licensed or certified DES facility or a licensed DHS Level I, II, or III Behavioral Health Treatment facility (e.g. *Residential Treatment Center or Behavioral Health Group Home*).
Sexual abuse	Physical evidence of sexual abuse reported by a medical doctor or child reporting sexual abuse within the past seven (7) days.	Sexual behavior or attempted sexual behavior occurring 8 days or up to 1 year ago and/or child is exhibiting indicators consistent with sexual abuse.
Emotional abuse	Not applicable.	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.

Source: Auditor General staff summary of examples of high- and moderate-risk child abuse and neglect obtained from the Arizona Child Abuse Hotline Procedural Manual.

Division management, in consultation with their Assistant Attorney General representative, believe there is no clear authority in state law for CPS to investigate allegations of abuse and neglect in RTCs. CPS can only investigate allegations of abuse and neglect involving children's parents, guardians, or custodians, and the Division does not believe that RTC staff have a custodial relationship with the children. Although the Division does not believe it has the authority to conduct investigations alleging abuse and neglect in RTCs, auditors found cases where CPS had investigated such allegations in years past with results demonstrating the importance of such investigations.[1] For example, auditors found a case showing that CPS investigated and substantiated an allegation of continued sexual abuse inflicted by an RTC staff person on a child in 1998. The allegation and subsequent investigation resulted in the staff person being terminated from the facility.

In addition to the concern regarding CPS' authority to investigate child abuse and neglect reports in RTCs, division management indicated that conducting investigations in RTCs may place an excessive burden on CPS' investigative resources. Although the Arizona Department of Health Services does not specifically track the number of reports alleging abuse or neglect of children in RTCs referred to them from other sources, such as the Division or an RTC itself, Arizona Department of Health Services staff indicated that they believe the incidence of child abuse and neglect in RTCs is low.

Division should seek statutory amendment that clarifies CPS' authority to investigate in RTCs—To help ensure the safety of children and that vital information is available from all congregate care settings for child abuse and neglect background checks, the Division should seek a statutory amendment that would clarify that CPS has authority to investigate allegations of abuse and neglect in RTCs. By clarifying CPS' investigative authority, the Division would then be able to investigate allegations of abuse and neglect in RTCs and help to ensure that individuals who pose a threat are disqualified from providing direct care to children. Once the investigative authority is clarified, the Division should then coordinate its RTC investigations with the Arizona Department of Health Services, as it does for investigations of alleged abuse and neglect in other facilities licensed by the Arizona Department of Health Services.

Recommendations:

1.1. To help facilitate the timeliness of congregate care investigations, the Division should:

a. Implement the Division's action plan for the specialized investigative unit requiring the unit supervisor to revise the unit's procedures to more effectively use manual and online systems to track investigation activity, to update investigators weekly on upcoming investigation completion dates,

[1] Division management indicated that the investigations in RTCs found by auditors may have resulted from the Division's central intake unit, which receives reports alleging child abuse and neglect from across the State and forwards them to the appropriate entity for investigation, incorrectly forwarding the reports to CPS investigation units.

and to increase contact with investigators to discuss ongoing investigations; and

b. Ensure the specialized investigative unit remains adequately staffed and do not routinely use the unit's investigative staff to assist with other investigative units' workloads. If this is not possible due to staffing cuts, the Division should review and prioritize the specialized investigation unit's responsibilities to ensure tasks critical for ensuring child safety are performed; for example, completing investigations within 21 days.

1.2. To help ensure that information is available for management use in monitoring investigations' thoroughness, workload, and productivity, the supervisor of the specialized investigative unit should enforce division policy requiring staff to document case activity within 10 days of its occurrence.

1.3. To help ensure child safety by making certain complete information is available for conducting child abuse background checks on congregate care employees, the Division should seek a statutory amendment clarifying that CPS has authority to investigate allegations of abuse and neglect in RTCs.

FINDING 2

Monitoring congregate care providers' performance using outcome measures helps ensure that children are well served and tax dollars are effectively spent. The Department's contracts with the congregate providers each include several outcome measures for assessing provider performance. Both the providers and the Division share responsibility for gathering and reporting data on the various outcomes. However, the Division has not been enforcing the reporting requirement, nor using the outcome data to assess providers' performance. Further, some of the outcome measures are inadequate. Therefore, the Division should review and revise the outcome measures within its congregate care contracts according to established criteria, enforce the requirement that outcome data be gathered and reported to the Division, and use the information to monitor providers' performance.

Division should improve congregate care outcome monitoring

Outcome monitoring helps ensure child well-being and effective use of state resources

Monitoring congregate care providers' performance using outcome measures helps ensure that children are well served and tax dollars are effectively spent. Outcome monitoring is used to assess whether children benefited from the services they received. For example, the Division uses outcome monitoring to determine the extent to which services provided to children by behavioral health group home providers result in the children moving to and remaining in a less-restrictive environment, such as with a relative or licensed foster family. Additionally, monitoring outcomes enables the Division to ensure that the millions of dollars allocated annually for congregate care is directed to those providers meeting service expectations. Finally, monitoring outcomes enables the Division to identify providers that may be having performance problems. When this occurs, the Division can help the providers identify problems and correct deficiencies. Alternately, if the providers' performance fails to improve or worsens, the Division may choose not to renew the contract.

Outcome measures focus on the results of services that the contractor provides, as well as intermediate indicators of success.

Source: U.S. Department of Health and Human Services. (2008). *Ensuring quality in contracted child welfare services*. Retrieved on April 24, 2009 from http://aspe.hhs.gov/hsp/07/CWPI/quality/report.pdf

Division needs to address several deficiencies affecting outcome monitoring

Despite the importance of outcome monitoring for assessing the quality and effectiveness of congregate care providers' performance, several issues hinder the Division's ability to adequately implement outcome monitoring. The Department's contracts with the congregate providers each include between four and six specific outcome measures. For most of the measures, the provider is responsible for obtaining the outcome data and reporting it to the Division. For the remaining measures, the Division is responsible for obtaining the outcome

data.[1] However, regardless of which entity collects and reports the outcome data, there are problems with its quality, availability, and use. Specifically,

- **Outcomes unclear**—Literature on contract administration indicates that to help ensure quality contractor performance, the outcomes required of the contractor should be clear, and that the contracting entity should determine measurable factors to indicate the degree to which the provider is meeting expectations.[2] Auditors' review of the outcomes required in the Division's contracts with congregate care providers found that 5 of the15 required outcomes do not meet one or both of these criteria. For example, an outcome in the group home service provider contract regarding the children in the provider's care requires that "80% of the children will have improved community citizenship (e.g. significantly reduced rates of arrest, detention, incarceration and/or recidivism; increased positive measure of school, work attendance, and/or achievement)." This outcome does not clearly and specifically define how the provider should measure improved community citizenship using the indicators listed, including the degree of reduction or increase necessary to indicate the child's improvement.

- **Performance targets not established**—Contracting literature indicates that performance goals or targets should be established.[3] However, auditors determined that 6 of the congregate care providers' 15 required outcomes failed to meet this standard. For example, an outcome measure in the group home service provider contract requires submission of the "Number of youth admitted and number of youth successfully transitioned to live with their families, including foster families. Successfully transitioned means in stable placement for up to at least 3 months." This outcome measure does not have a specific target number that the provider should attain to achieve adequate performance.

- **Outcome data seldom available or used**—Contracting literature indicates that outcome data should be available to assess the degree to which contractors are achieving expected outcomes. However, the Division does not enforce outcome data submission by the providers, and as a result, some providers either infrequently submit the data or do not submit the data at all. For example, auditors' review of contract files for four congregate care providers found that two of the providers had not submitted any outcome data and one had submitted data only twice during its 5-year contract with the Department. The Division also does not obtain and/or compile data on some of the congregate care outcomes that the Division is responsible for tracking. For example, the

1 Although contracts with congregate care providers are issued by the Department's Office of Procurement, the Division develops the contract, including the outcome requirements.

2 Planning and Learning Technologies, Inc., & The University of Kentucky. (2006). *Literature review on performance-based contracting and quality assurance*. Retrieved August 8, 2008 from http://www.uky.edu/SocialWork/qicpcw/documents/QICPCWPBCLiteratureReview.pdf

3 McCullough, C. (2004). *Financing and contracting practices in child welfare initiatives and Medicaid managed care*. Retrieved April 1, 2009 from https://www.cwla.org/programs/bhd/mhpubfinancing.htm

group home service provider contract includes an outcome stating that "90% of case managers will express satisfaction with the contractor's service delivery based on a semi-annual survey conducted by the Division." However, the Division does not conduct the survey. Finally, the Division does not review or use the outcome data that it does receive in any meaningful way, such as to help providers identify and correct deficiencies, or as additional criteria when renewing providers' contracts.

Division management reported that staff hours are not available to evaluate outcome data and use it to monitor provider performance. Management indicated that as of May 2009, the Division had 3 contract manager positions and 13 contract administrator positions to develop and/or manage more than 2,800 family foster agreements, procurement contracts, purchase orders, and requests for developmental disabilities contracts.

Division should revise required outcomes and consider them in contract renewals

To help ensure effective, quality performance by congregate care providers, the Division should review and revise the outcomes required within the congregate care contracts to ensure they are clear and include measurable indicators of performance, and that they contain specific performance targets. The Division should also enforce the requirement that outcome data be gathered and reported, and compile the data it is responsible for tracking. Finally, as part of its ongoing efforts to reprioritize its responsibilities in response to budget cuts, the Division should determine the importance of using the outcome data to monitor provider performance, including using it as additional criteria for yearly contract renewal and as the basis for helping providers to identify problems and correct deficiencies, and assign staff accordingly.

Recommendations:

2.1. The Division should review and revise the outcomes within its congregate care contracts to ensure that they meet established criteria: they are clear, include measurable indicators of performance, and contain specific performance targets.

2.2. The Divisions should enforce the requirement that congregate care providers submit required outcome data to the Division. Additionally, the Division should ensure that it compiles the necessary outcome data for those congregate care outcomes it is responsible for tracking.

2.3. As part of its ongoing efforts to reprioritize its responsibilities in response to budget cuts, the Division should determine the importance of using outcome data to monitor congregate care provider performance, including using the data as additional criteria for yearly contract renewal and as the basis for helping providers identify problems and correct deficiencies, and assign staff accordingly.

AGENCY RESPONSE

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Janice K. Brewer
Governor

Neal Young
Director

JUN 22 2009

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

Dear Ms. Davenport:

The Department of Economic Security wishes to thank the Office of the Auditor General for the opportunity to respond to the recently completed audit of the Division of Children, Youth and Families—Child Protective Services—Congregate Care Performance Audit.

The Department agrees with and is currently implementing the recommendations. In regards to Recommendation 1.3, the Department agrees with the recommendation and a different method of dealing with the finding will be implemented.

If you have any questions, please contact Jakki Hillis, Acting Assistant Director, Division of Children, Youth and Families, at (602) 542-3598 or me at (602) 542-5757.

Sincerely,

Neal Young
Director

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ARIZONA DEPARTMENT OF ECONOMIC SECURITY'S RESPONSE TO THE OFFICE OF THE AUDITOR GENERAL'S REPORT ON CONGREGATE CARE

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

RECOMMENDATION 1.1:

To help facilitate the timeliness of congregate care investigations, the Division should:

a. Implement the Division's action plan for the specialized investigative unit requiring the unit supervisor to revise the unit's procedures to more effectively use manual and online systems to track investigation activity, to update investigators weekly on upcoming investigation completion dates, and to increase contact with investigators to discuss ongoing investigations; and

b. Ensure the specialized investigative unit remains fully staffed and do not routinely use the unit's investigative staff to assist with other investigative unit's workloads. If this is not possible due to staffing cuts, the Division should review and prioritize the specialized investigation unit's responsibilities to ensure tasks critical for ensuring child safety are performed; for example, completing investigations within 21 days.

DES Response:

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

A process has been developed to monitor investigative activities and the time frames for monitoring of these activities are being established.

RECOMMENDATION 1.2:

To help ensure that the information is available for management use in monitoring investigations' thoroughness, workload, and productivity, the supervisor of the specialized investigative unit should enforce division policy requiring staff to document case activity within 10 days of its occurrence.

DES Response:

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

A process has been developed to monitor investigative activities and the time frames for monitoring of these activities are being established.

RECOMMENDATION 1.3:

To better ensure child safety by making certain complete information is available for conducting child abuse background checks on congregate care employees, the Division should seek a statutory amendment clarifying that CPS has authority to investigate allegations of abuse and neglect in RTCs.

DES Response:

The finding of the Auditor General is agreed to and a different method of dealing with the finding will be implemented.

The Division will explore the advisability of seeking a statutory amendment that codifies that CPS has authority to investigate allegations of abuse and neglect in the residential treatment centers (RTCs). As discussed with the Office of the Auditor General, the Department of Health Services investigates these types of allegations in RTCs, as they are the licensing authority. Because the Division does not believe that it currently has statutory authority to investigate these allegations, the Division will explore potential legislation through the Department's protocol for developing its annual legislative agenda. This protocol includes an assessment of the impact upon the Department of each suggested legislative proposal. The Division's Child Protective Services is responsible for investigating allegations of child abuse and neglect by parents, guardians, or custodians. If the term "custodian" is expanded to include RTC staff, analysis of the potential consequences of this expansion will be required. During times of diminishing resources, the Department must carefully weigh the benefits, resource needs and unintended consequences before voluntarily proposing legislation that would increase the responsibility of Child Protective Services by adding more investigations to the current caseload.

RECOMMENDATION 2.1:

The Division should review and revise the outcomes within its congregate care contracts to ensure that they meet established criteria: they are clear, include measurable indicators of performance, and contain specific performance targets.

DES Response:

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

A process has been established to review and re-define the outcome measures for congregate care contracts as they are solicited.

RECOMMENDATION 2.2:

The Division should enforce the requirement that congregate care providers submit required outcome data to the Division. Additionally, the Division should ensure that it compiles the necessary outcome data for those congregate care outcomes it is responsible for tracking.

DES Response:

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

A process has been established to review and re-define the reporting of outcome measures for congregate care contracts as they are solicited.

RECOMMENDATION 2.3:

As part of its ongoing efforts to reprioritize its responsibilities in response to budget cuts, the Division should determine the importance of using outcome data to monitor congregate care provider performance, including using the data as additional criteria for yearly contract renewal and as the basis for helping providers identify problems and correct deficiencies, and assign staff accordingly.

DES Response:

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

CPS Reports Issued

Performance Audits

CPS-0501	CHILDS Data Integrity Process
CPS-0502	Timeliness and Thoroughness of Investigations
CPS-0601	On-the-Job Training and Continuing Education
CPS-0701	Prevention Programs
CPS-0801	Complaint Management Process

Questions and Answers

QA-0601	Substance-Exposed Newborns
QA-0701	Child Abuse Hotline
QA-0702	Confidentiality of CPS Information
QA-0703	Licensed Family Foster Homes
QA-0801	Child and Family Advocacy Centers
QA-0802	Processes for Evaluating and Addressing CPS Employee Performance and Behavior

Information Briefs

IB-0401	DES' Federal Title IV-E Waiver Demonstration Project Proposal
IB-0501	Family Foster Homes and Placements
IB-0502	Revenue Maximization
IB-0601	In-Home Services Program
IB-0701	Federal Deficit Reduction Act of 2005
IB-0702	Federal Grant Monies
IB-0801	Child Removal Process
IB-0901	Client Characteristics

Future CPS Reports

Performance Audits

Relative Placement

Questions and Answers

Adoption Program

INTEGRITY
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