

Arizona Department of Child Safety
Independent Review

Submitted To:

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

Submitted By:

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June 26, 2015



DEBRA K. DAVENPORT, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

MELANIE M. CHESNEY
DEPUTY AUDITOR GENERAL

June 29, 2015

The Honorable Andy Biggs, President
Arizona State Senate

The Honorable David Gowan, Speaker
Arizona State House of Representatives

Members of the Arizona Legislature

The Honorable Doug Ducey, Governor

Mr. Gregory McKay, Director
Arizona Department of Child Safety

Transmitted herewith is an independent review of Arizona's child safety system and the Arizona Department of Child Safety. This review was conducted by the Chapin Hall Center for Children at the University of Chicago under contract with the Office of the Auditor General and was in response to the requirements of Laws 2014, 2nd S.S., Ch. 1, §159.

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

The report will be released to the public on June 30, 2015.

Sincerely,

Debbie Davenport
Auditor General

Attachment

ChapinHall at the University of Chicago
Policy research that benefits children, families, and their communities

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

Dear Ms. Davenport,

Chapin Hall Center for Children at the University of Chicago is pleased to submit our final report for the Independent Review of the Arizona Department of Child Safety. The report was commissioned pursuant to legislation passed in 2014 (Laws 2014, 2nd S.S., Ch. 1, Sec. 159). We appreciate the opportunity to conduct the review on behalf Arizona's children and families. We trust our report will in some measure be useful.

If you have any questions, please do not hesitate to contact me.

Best regards,

Fred Wulczyn
Dana Weiner
Clare Anderson
Krista Thomas
Molly Mayer
Kelly Crane

Arizona Department of Child Safety
Independent Review

Chapin Hall Center for Children

June 26, 2015

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Executive Summary

In Arizona today, there are more than 17,000 children living in foster care, which is more children than reported at any time in the last fifteen years. To a large extent, the increase in foster children is the result of a dramatic increase in the number of abuse and neglect reports, particularly since 2009. In that year, reports of maltreatment totaled slightly more than 33,000; by the end of 2014, the number of reports had increased to 48,000, an increase of 44 percent in six short years. Increases in child protection caseloads of this magnitude, over a relatively short period of time, put considerable strain on public child welfare agencies. Arizona was and is no exception.

In response to the challenges facing the state, then Governor Brewer and legislative leaders put in motion a very deliberate plan intended to improve child safety within Arizona. Among the steps taken, legislation passed in 2014 (Laws 2014, 2nd S.S., Ch. 1, Sec. 159) and signed by the Governor created a new **Department of Child Safety** by pulling the existing child welfare agency out of the umbrella Department of Economic Security (DES). The actions taken were done with the specific goal of improving public accountability in mind.

As part of the effort to increase public accountability, the legislation creating the new Department also contained provisions directing the Office of the Auditor General (OAG) to procure an independent report focused on the **implementation challenges** facing the new Department. The legislation specifically targeted four such challenges:

- Developing a strategic direction
- Creating accountability mechanisms
- Engaging communities and other stakeholders such as families, youth, and service providers
- Providing for regular, periodic performance evaluations

When it issued the Request for Proposals (RFP), the OAG asked that additional attention be paid to the following:

- Consider evidence-based and best practices . . . to evaluate whether the current strategic direction . . . ensures child safety and establishes appropriate protocols for services after an investigation.
- Consider evidence-based and best practices . . . and review DCS' accountability mechanisms to ensure they have the capacity to a) produce accurate data, b) use data for performance management, c) use continuous quality review, d) review qualitative reviews of system functioning, e) assess outcomes for children, f) include external

oversight, g) ensure the submission of timely and accurate data, and h) ensure parental rights and involvement in the system.

Chapin Hall Center for Children at the University of Chicago (Chapin Hall) was selected to prepare the independent review. A summary of our findings follows below.

Background

When we asked stakeholders around the state to explain why the child welfare caseload grew so quickly, most of the people we spoke with pointed to rising demand for child welfare at a time when state services for vulnerable families were being scaled back. In our review of the available data, we found considerable evidence to support this point of view:

- The number of children, along with the number of poor children living in the state, was growing.
- There were cut backs in childcare subsidies.
- The size of the state workforce (caseworkers and supervisors) working for the child welfare agency was reduced during the economic downturn.

During this critical period, we also found that reports of maltreatment increased dramatically. According to the Department of Child Safety's own data, between 2010 and 2014, the number of maltreatment reports grew by 44 percent, to more than 48,000. The most notable increase involved allegations of neglect. Whereas physical abuse was trending downward between 2004 and 2012, there was a dramatic surge in the number of neglect reports.

The increase in maltreatment reports was made more complicated by the fact that a larger fraction of maltreatment reports were being substantiated, which is the term used to indicate that a report of maltreatment was verified. Prior 2009, substantiation rates statewide were approximately six to eight percent of reports. By 2014, that figure was roughly 12 percent. Importantly, the data also indicate that Arizona places proportionately more children into foster care than other states, given a substantiated allegation of maltreatment. As a result, pressure on the foster care system grew at a nearly exponential rate. Time spent in out-of-home also increased. By our estimate, the median time spent in out-of-home care increased by almost fifty percent.

In the midst of these trends, the data also show a substantial decline in funding for childcare subsidies as well as changes in the size of the child welfare workforce. All in all, reductions in system capacity in the midst of rising demand set off a cascade of issues the Department is still addressing.

Stakeholders also described weak accountability mechanisms due in part to the fact the child welfare agency was embedded within the larger Department of Economic Security. Although it is difficult to say whether accountability was weak because the child welfare services were housed within a larger human services agency, the evidence does suggest that mechanisms of accountability such as public reporting of data about service use had changed little in fifteen years. Reports made available to the public were largely descriptive as opposed to analytical.

In addition to issues of demand, service capacity, and accountability, we also found a number of other concerns. For example, the evidence we examined suggested that basic processes were not operating as intended, particularly those processes used to manage the system's front door: reporting and investigation. We also found that although decision-making protocols were/are in place, the actual use of those protocols is not routine. With regard to service pathways, stakeholders pointed to a limited supply of services and poor alignment with assessed need.

Remedies

The problems confronting Arizona's child protection system led then Governor Brewer and the Legislature, in 2014, to take a series of steps in an effort to strengthen the system and improve child safety. Chief among the steps taken was the decision to pull the child welfare agency out from under the DES. The decision to create a new child welfare agency reflected a certain perspective as to the problems facing the state and the steps needed to solve them.

The accountability issues were addressed by creating a new, separate Department of Child Safety. The Director of the Agency reports directly to the Governor. With regard to specific responsibilities, the legislation creating the Department emphasized these core functions:

- An Oversight Committee is established
- Quality assurance (QA) is required
- Research and statistical reporting is required
- An Inspections Bureau charged with monitoring compliance with policy and procedures is established
- Data-driven decisions are required as part of a new QA process

The legislation also requires, on or before September 1, 2016, recommendations to the Governor, the President of the Senate, and the Speaker of the House on whether to consolidate into one comprehensive report numerous child welfare related accountability reports currently produced.

To address the capacity shortfall, lawmakers infused the system with fiscal resources at a rate exceeding prior periods (i.e., 2004 to 2008). The state budgeted \$736 million in 2011. Since then, through 2014, appropriations have averaged about \$74 million more per year, with the largest increase - \$84 million - coming in 2014. Lawmakers also increased the size of the workforce. From 2007 through 2012, except for a short-lived increase in the number of authorized positions for state fiscal year 2009, the authorized number of caseworker and supervisor positions held steady at 1,218. Thereafter, lawmakers authorized additional staffing levels, from 1,281 in January of 2013, to 1,374 in July of 2013, to 1,520 in February of 2014. That said, the size of the actual workforce is below authorized levels.

The Governor and Legislature addressed weaknesses within the system of care by establishing the Department's primary purpose as protecting children. The law also reinforced working relationships between the courts, law enforcement, social service agencies, faith-based organizations, other public agencies, and Tribal child protection agencies. Cooperative work includes the sharing of information.

On-going Systemic Risks

The RFP issued by the OAG asked the contractor to assess system risks and then rank and prioritize those risks in relation to the Department's strategic direction. To do so, we focused on core functions and structures including those connected to investigations of child safety and related concerns; the continuum of care with reference to the assessed needs of families; and accountability mechanisms.

Fundamental to a child protection system is the ability to identify and act on cases of child maltreatment. There has to be (1) a clear referral process, (2) a clear assessment process, and (3) clear service pathways once the needs have been established.

The **referral** and **assessment processes**, encompassing the hotline call center and the assignment of priority levels, is an area of on-going *high* risk for the Department. Although response rates have increased and response times have been reduced (due to improvements in both the processes and technology), the ambiguity about the assignment of priorities once a call is taken creates ongoing vulnerability.

With regard to the continuum of care and service pathways, almost every stakeholder reported that the **lack of available in-home services** results in a higher rate of removal and longer times until permanency. If parents are unable to receive parent training, substance abuse treatment, or mental health services *while their children remain in their home*, valuable time in a child's life is spent in foster care waiting for parents to complete services and achieve treatment goals. Once parents are referred for services, wait times are often extremely long (3-8 months), resulting in more delays in permanency proceedings. The

long-term financial and psychological cost of placing children relative to viable service alternatives is significant for children and families and for Arizona.

We also found relatively **less attention being paid to permanency and length of stay**, legal representation, and the accuracy and timeliness of court information. In particular, the number of cases assigned to attorneys likely limits the quality of legal representation for parents and children alike.

When we asked Department leadership about their accountability processes, we focused on continuous quality improvement (CQI), with specific reference to the CQI process, the capacity to produce accurate data, and the capacity to conduct qualitative case reviews. In response to our questions, the Department indicated that presently there are approximately nine FTEs assigned to reporting and business intelligence. Data about the performance of the agency is reported widely but there is no systematically compiled data pertaining to the performance of the private sector. Reporting has been expanded to include hotline calls, date and time of call, and type of call, all of which are basic reporting functions.

Data accuracy and completeness was weakest in the area of child safety. Safety threats, risks, and service needs are either missing from the electronic records or not collected. Caseworkers are not required to check any of the seventeen possible safety threats as part of data entry. As these data connect to core functions of the agency, the failure to collect that data represents an on-going risk.

In the area of qualitative care reviews, we found mixed results. The Department has a qualitative case review process for initial assessment, in-home service, and out-of home cases called the Practice Improvement Case Review (PICR). The PICR is designed to identify strengths, areas needing improvement, and underlying factors contributing to quality child welfare practice in Arizona. Although the Department has an electronic dashboard for tracking the timeliness of service response, neither the case review instrument nor the initial assessment review guide requires an assessment of the timeliness of the initial response to the family. This is notable because it is inconsistent with the federal child welfare case review instrument, which has consistently included this practice area as the first item in its protocol through three rounds of federal Child and Family Services Reviews (CFSR).

In addition to Departmental practices, we also surveyed Department staff at all levels of the organization. With regard to the use of evidence to support decision-making, staff reported a willingness to use evidence but that data are not always available. Staff were neutral with respect to whether the agency places a value on the use of evidence-based practices. Staff also indicated that evidence-based interventions are not widely available.

Recommendations

Our report concludes with recommendations targeting the systemic risks. In summary form, the recommendations include but are not limited:

- Solve the problems at the system's front door. The front-door problem has two dimensions: workforce and clarity of purpose. Workforce issues are being addressed, although more will need to be done, especially given the number of children in foster care. The hotline and investigative processes will need further clarification. Keeping children safe requires sound assessment, decision-making and referral processes to provide services that meet the needs of children and families. If these processes continue to be a source of uncertainty progress will be difficult to sustain.
- **Strengthen the service continuum.** Unless service alternatives are developed, foster care will be overused. If the service array is not expanded or strengthened to prevent entry into foster care and reduce the amount of time children are in foster care, better front-door assessments will become moot because services suited to the assessed need are not available.
- **Strengthen the placement system.** The Department of Child Safety, along with its partners, has to make 17,000 permanency decisions. A bottleneck has already formed at considerable cost to the taxpayers, not to mention the children and families involved. Without adequate resources for the Department and the Courts, at a minimum, it will be hard to avoid a long-term burden. It is very much a pay now or pay later proposition.
- **Introduce evidence-based interventions cautiously.** With so many challenges, evidence-based interventions are a way to reduce the uncertainty behind any given service investment. That said, evidence-based interventions have to be carefully selected relative to the problem leaders want to solve. They have to be targeted to the populations and places in the state most likely to benefit. Evidence-based interventions are not a panacea; great care has to be taken when taking interventions to scale otherwise the payoff will be less than expected.
- **Strengthen CQI processes.** As focal points of a reform agenda, carefully selected and targeted initiatives have to be launched within a rigorous CQI process that uses evidence to support decision-making. The connection between problems, for lack of a better term, and proposed solutions has to be carefully articulated. Without that connection, distinguishing what works from what does not is that much more difficult.
- **Deepen the commitment to accountability and transparency.** Accountability and transparency are core functions and capacities. Without accountability, deeply woven into a CQI culture, progress will not be possible. Stakeholders will have to engage accountability processes. Without that, public trust in the agency cannot be restored.

Introduction

In Arizona today, there are more than 17,000 children living in foster care, which is more children than reported at any time in the last fifteen years. To a large extent, the increase in the number of children in foster care is the result of a dramatic increase in the number of children reported for abuse and neglect, particularly since 2009. In that year, reports of maltreatment accepted for investigation totaled slightly more than 33,000; by the end of 2014, the total number of reports was 48,000, an increase of 44 percent in six years.

Increases in child protection caseloads of this magnitude, over a relatively short period of time, put considerable strain on public child welfare agencies. Arizona is no exception. In response to the challenges facing the state, Governor Brewer and legislative leaders put in motion a very deliberate plan intended to improve child safety within Arizona. Among the steps taken, legislation passed in 2014 (Laws 2014, 2nd S.S., Ch. 1, Sec. 159)¹ and signed by the Governor created a new **Department of Child Safety** (hereafter referred to as DCS, the Department, or the agency) by pulling the existing child welfare agency out of the umbrella Department of Economic Security (DES). These actions were taken with the specific goal of improving public accountability in mind.

As part of the effort to increase public accountability, the legislation creating the new Department also contained provisions directing the Office of the Auditor General (OAG) to procure an independent report focused on the **implementation challenges** facing the new Department. The legislation specifically targeted four such challenges:

- Developing a strategic direction
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When it issued the Request for Proposals (RFP), the OAG asked that additional attention be paid to the following:

- Consider evidence-based and best practices . . . to evaluate whether the current strategic direction . . . ensures child safety and establishes appropriate protocols for services after an investigation.

¹ Hereafter Laws 2014, 2nd S.S., Ch. 1, Sec. 159 is referred to as the law or as the legislation.

- Consider evidence-based and best practices . . . and review the DCS' accountability mechanisms to ensure they have the capacity to a) produce accurate data, b) use data for performance management, c) use continuous quality review, d) review qualitative reviews of system functioning, e) assess outcomes for children, f) include external oversight, g) ensure the submission of timely and accurate data, and h) ensure parental rights and involvement in the system.

Chapin Hall Center for Children at the University of Chicago (Chapin Hall) was selected to prepare the independent review, which follows.

Organization of the Report

The report is organized into four main sections that follow the introduction. In the first section after the introduction, we put forward what we learned about the child welfare system in Arizona as reflected in basic data about the use of child protection services, the need for child protection services, and the capacity to deliver child protection services. The narrative that emerges is one most if not all stakeholders already understand. From 2009 through to the present, the child protection system has been under considerable strain, owing largely to the fact that the number of families and children coming to the Department's attention has grown dramatically.

The next section reviews the legislation passed by the Legislature and signed by the Governor in 2014. This section has two parts. As a solution to circumstances in the state, the legislation was, in our view, prompted by a specific perspective as to the nature of the problem and what should be done. We address this perspective when we discuss the Theory of Change. We go on to describe how the new child protection system was shaped by the legislation. Our intent here is to explore the parts of the system the Legislature targeted in order to gain a sense of priorities relative to the Theory of Change and how one thinks about child protections systems as systems designed to accomplish certain goals.

In the section that follows we present the results of our risk assessment. Although the legislation establishes a clear vision for the Department, it is equally clear that implementation challenges remain. Through interviews with stakeholders, document review, and data analysis, we tried to align the steps the Department is taking or has taken with what we learned about the lingering challenges facing the Department. In doing so, we adopted the view that success is contingent on core functions and process the Department has to get right. We follow this analysis with our recommendations.

Guiding Frameworks

As articulated in our response to the RFP, we sought to understand the Arizona child welfare system in light of the systems framework advanced by the Institute of Medicine (hereafter referred to as IOM or “system framework”) in its report *New Directions in Child Abuse and Neglect Research* (IOM (Institute of Medicine) and NRC (National Research Council), 2014) and Continuous Quality Improvement (CQI) (O'Brien et al., 1995; RWJF, n.d.; Wulczyn, Alpert, Orlebeke, & Haight, 2014). We explain how we use both frameworks in the sections below.

From an organizational perspective, strategic direction involves connecting goals and action. The Department has a clear mandate: keep children safe. The work that remains involves choices about where and how to commit resources so that the goal of keeping children safe is realized.

As organizing frameworks for our work, the system and CQI frameworks offer two advantages. On the one hand, the frameworks provide a guide to gathering and interpreting evidence as to the challenges facing the new DCS. On the other hand, CQI and the system framework are themselves best practices in that they rationalize how one sets strategic direction and implements a change agenda.

IOM Framework²

The IOM framework views the work of systems through the lens of *functions* and *capacities*, at a minimum. System *functions* are organized processes that promote the achievement of system goals. With reference to child welfare systems, core or mission-critical goals emphasize child wellbeing with specific reference to safety and permanency, so the functions and associated processes promoted by the Department must align with those goals.

System *functions* within the child welfare system have been described as falling into one of two categories: those related to case decision-making (e.g., assessments, gate-keeping, investigation, service referral, placement, etc.) and those designed to support system performance (e.g., capacity building, research and evaluation, allocation of resources, cross-sector coordination, etc.).

Capacity refers to the facilities, material resources, skilled personnel, service continua, and the funding needed to operate the system. These capacities also have to be allocated in relation to system goals and the demand for those services.

Per the RFP and our response, we define the key services and the risks associated with those services with reference to the functions and capacities that most closely align with the core goals

² Details of the IOM and CQI frameworks are provided in the Appendix.

of the agency. Moreover, we define systemic risk in relation to functions and capacity as the potential gains (or losses) that arise when the system operates properly. Because child *safety* is a core outcome for the Department, systemic risks associated with decision-making protocols are, for example, particularly important because the failure to assess the risk of maltreatment accurately leads to a misalignment between the services offered (if any) and the needs of children and families.

To organize the findings, we again draw on the IOM's system framework, paying particular attention to the continuum of care, the process of care, and system capacity. The continuum of care refers to the different types of services Arizona makes available to children and families that come to the attention of the Department. Often the child welfare system is described as having a *front* and *back door*, with reporting, investigation, and preventive services arrayed at the front door and permanency services (e.g., reunification, adoption, independent living) and aftercare organized at the back door. Foster care is between the doors: services at the front door are used to prevent placement; services at the back door are meant to find children a family to live with outside the placement system, whether through reunification, adoption, or guardianship. When child protection systems are under strain it is often because the number of children and families coming into contact with system, at each point along the continuum, is too large to serve given the available resources. There is ample evidence, as we show, that this is what happened in Arizona.

The process of care refers to what caseworkers are asked to do when working with families. The process of care is typically where one finds the use of protocols to guide decision-making and action on the part of workers. Processes of care are particularly important because the decisions made link children and families with the services most likely to support children's safety. If the decision-making protocols lack clarity then workers will have a hard time matching needs and services, especially during times when the system itself is under stress. Based on what we found, the processes that link investigations to service referrals need to be strengthened, a point we highlight in this section.

Capacity refers to the available resources given the process and quality standards adopted by the state. We use two basic, interrelated measures of capacity to understand the situation in Arizona: workforce and funding. In both cases, available capacity dropped between 2008/9 and 2010 when the dramatic surge in child abuse and neglect first started.

Continuous Quality Improvement

As noted, CQI is a cyclical process of problem-solving activities that requires the deliberate use of evidence (Alexander & Hearld, 2011; Berwick, 2008; Wulczyn et al., 2014). In our work, we referenced CQI in two ways. First, as a framework for organizing change processes, CQI relies heavily on a clear problem statement that is then linked to a Theory of Change. The problem is the condition stakeholders want to change whereas the Theory of Change represents a formal statement of what stakeholders think it will take to resolve their shared concerns. In our work, we sought to understand the problem as well as the alignment between the actions taken and the Theory of Change.

Second, CQI processes focus on investments in process, quality, and capacity as the manifestation of how stakeholders expect to change outcomes. Put simply, changing outcomes for children and families means that individuals within the system (e.g., caseworkers, supervisors, managers, leaders, and service providers) have to change what they do (*process*) and/or how well they do it (*quality*). Individuals working in the system also need the resources necessary to do the work differently (*capacity*). Because change without investments (or redirected investments) is unlikely, strategic direction is tied to how the Department conceptualizes the process, quality, and capacity investments it needs to make in order to strengthen the agency's core functions.

A key component of the CQI process is the Theory of Change. The Theory of Change, and the evidence used to justify the Theory of Change, relates the problem statement to the strategic choices made in an effort to solve the identified problems. In order to assess the Department's strategic direction in the first instance, we set out to understand the problem stakeholders were trying to solve, place that strategy within the larger system framework, and then judge, based on our understanding and the work that remains to be done, whether systemic risks remain. We align our recommendations with what we see as the key vulnerabilities, using the system framework to pinpoint the next wave of choices facing the Department.

Data Collection

In order to assess the Arizona DCS from the perspectives of all system stakeholders, we utilized a multi-dimensional data collection approach, including:

- *Administrative Data.* Administrative data were obtained from the Department and pulled from the Foster Care Data Archive (Archive) housed at Chapin Hall, for the purpose of understanding trends over time, the current distribution and volume of cases, and the degree to which Arizona is similar to or different from

other jurisdictions. To ensure comparability between states, the Archive relies on common definitions of both entry into and exit from foster care.

- *Policy Data.* We obtained documentation of current and recent policy changes, which were compared to the historical foundational policy framework in Arizona to understand planned changes and identify areas in which policy and practice diverge. Our policy analysis can shed light on the manner in which the new agency is going about fulfilling its child protection mandate, and the likelihood of success of various strategies being employed.
- *Interviews and Focus Groups.* The Chapin Hall team spent considerable time speaking with individuals including agency management and front-line staff, foster parents, birth parents, attorneys, legislators and legislative staff, and other stakeholders with knowledge about the history and current functioning of the Department. Sometimes individually and sometimes in groups, these conversations were extremely helpful in revealing the realities of day-to-day practice. Given the issues that brought the Department substantial media and legislative attention, particular attention was paid to understanding referral mechanisms and assessment processes for front-line decision-making.
- *Fiscal Data.* Data on spending and budgets over the last ten years were examined to understand the fiscal trends that paralleled the growth in system size and vulnerability.
- *Survey Data.* An online survey was sent to all non-clerical staff to obtain information about organizational characteristics, including openness to innovation and research evidence use, including evidence-based practices, leadership and culture, and available services. The response rate for the survey was in excess of 50 percent.

Arizona in Context

The central issue facing Arizona's child protection system is the significant upswing in the number of families served at each point along the continuum of care, from reporting through placement in foster care and permanency for children. Simply put, the number of children and families coming into the system outstripped the available capacity. The strain these changes placed on the system caused a series of cascading problems that ultimately led the Governor and Legislature to pull the child welfare agency out from the DES.

According to the stakeholders with whom we spoke, the increase in demand for services was to a large extent due to rising poverty rates in Arizona, especially among children. Another explanation offered by stakeholders centered on changes in the supply of services used by families. Stakeholders pointed to cuts in funding for daycare as an example of how support for families was pulled back at a time of rising need. At the same time, resources available to the Department in the form of staff and funding were also scaled back. In sum, from 2009 to the

present, Arizona went through what might be usefully described as a perfect storm comprised of economic uncertainty triggered by the recession that started in 2007, rising demand for the services needed by families, and shrinking service capacity in the face of rising demand.

Reports of Maltreatment

To keep children safe, the Department has to first respond to reports of child maltreatment. Viewed through the IOM lens, there is no more important function given the goals of the system. Whether real or perceived, a failure to keep children safe costs the agency public confidence and is therefore an area of considerable risk. To restore public confidence, the Department must investigate reports of maltreatment, assess safety and risk, and then link families to appropriate services.

In Arizona, the principal challenge facing the Department is meeting the service demand generated by the large number of reports coming in.

- In 2004 there were slightly fewer than 40,000 reports of maltreatment accepted by the Department.
- By 2009, the number of reports had dropped to 33,228, a decline of 15 percent.
- Since 2010, the number of reports has increased by about 8 percent per year, resulting in a cumulative increase of 44 percent. In part, this increase may have been the result of changes to the screening tools that expanded the criteria to include behaviors and conditions within the home.
- In 2014, total reports reached 48,032.

Substantiation Rates

In addition to rising numbers of reports, the Department began to substantiate a larger percentage of the reports coming in, thereby compounding the pressure on the Department.

- Historically, across the state, between 6 and 8 percent of the cases reported went on to be substantiated. By 2014, that figure was roughly 12 percent.

Types of Maltreatment

The U.S. Department of Health and Human Services collects maltreatment data from nearly all states. Using these data we can better understand the reasons behind the sharp increase in substantiated reports in Arizona.

- In Arizona, substantiated reports of physical abuse declined between 2004 and 2012 (the most recent year for which national, comparative data are available). The same is true for the U.S. as a whole.

- In the U.S. from 2004 to 2012, reports of substantiated neglect also trended downward. However, in Arizona, there was a sharp increase in the number of children reported and then substantiated by the Department for reasons of neglect.

Arizona in a National Context

So as to more fully understand the demand for child protective services, we examined reporting rates and substantiation rates in a collection of thirty-four other states with comparable data. To carry out the comparison, we calculated average rates over seven years. The results show the following:

- Relative to its size and the socio-economic wellbeing of the population, the number of maltreatment reports in Arizona falls close to the national average.
- However, when compared with those same states, Arizona actually substantiates a much smaller percentage. In fact only two other states substantiate fewer maltreatments per 100 reports received.
- Even though Arizona receives an average number of reports, the number of victims per 1,000 children is actually relatively low.

Foster Care Placements

The front door of the child protection system functions to connect children and their families with the services they need. Sometimes, this means placing children into foster care. When rising maltreatment reports are coupled with rising substantiation rates, an increase in the number of foster care admissions is a predictable outcome. Indeed, multi-state comparisons suggest that a higher percentage of substantiated maltreatment victims are placed in Arizona than in other comparable states, even after controlling for the socio-economic status of the population living in the states.

- Placement trends in Arizona are best understood within three periods:
 - From 2000 to 2006, the number of children in foster care grew by about 20 percent, from 5,850 to 7,001.
 - From 2007 to 2009, the caseload increased to 7,326, or an additional 4.5 percent.
 - Since 2009 the foster care population has grown to more than 17,000. In the most recent period, year-over-year growth in the foster care population has approached 20 percent.
- As a fraction of children who are substantiated for maltreatment, Arizona places more children into out-of-home care than all but one of the nineteen states we reviewed.

Time Spent in Foster Care

The number of children in foster care is a function of both admissions and discharges.

Admissions are higher today than they were in 2000. Nevertheless rising admissions alone do not account for the substantial growth in the foster care population. Indeed, fast rising populations are almost always the result of rising admission and slower discharges caused by longer lengths of stay, which is what happened in Arizona.

- Of children admitted to foster care for the first time between 2006 and 2009, half left placement in less than 309 days.
- Of children admitted to foster care for the first time between 2007 and 2013, half left in 457 days, an increase of about 50 percent in the median length of stay.
- In part the longer length of stay is attributable to the fact that children in Arizona are much more likely to be adopted than reunified compared to children in other states. Adoptions cannot proceed until reunification is ruled out, so the process of moving children to permanency inevitably takes longer.

The Population at Risk

There is no single factor that accounts for the increase in the number of children served by Arizona's child protection system. As we will point out later, decision-making protocols used at critical points in the decision-making process are ambiguous and often not applied, problems that weaken the system's ability to respond appropriately during times of high demand. Furthermore, in the aftermath of a child fatality that attracts widespread attention, uncertainty in decision-making processes can cause the decision-making thresholds to change as workers look to manage the risk of error. Even a small shift in risk tolerance/risk aversion can lead to a contagion of changes throughout the system. The data suggest this is what happened in Arizona over the period from roughly 2008 through the present.

Nevertheless, it is important to consider the larger context in which these changes played out: the number of children in Arizona has been increasing; the number of poor children living in Arizona is substantially higher than it was ten years ago, and there have been cutbacks in core services.

Number of Children

All things being equal (i.e., reporting rates, substantiation rates, placement rates), if a state's population of young people under the age of eighteen is growing, then one should expect a steady increase in the demand for child welfare services.

- Between 1994 and 2012 the population of children increased by 45 percent; between 2000 and 2012, the population grew by 17 percent.

- The number of children born in Arizona increased each year from 1994 to 2007, from 70,896 to 102,687 for an increase of 44 percent. After 2007, annual births declined.

Number of Children in Poverty

The well-being of children is tied generally to poverty because families without material resources often struggle to raise children without assistance. In Arizona, the socio-economic status of families suggests that more and more children were living in vulnerable circumstances. Even if there were no specific increase in risk, a simple increase in numbers would predict a rising demand for services from human service systems, including the child welfare system.

- The number of zero to five year olds living in poverty increased from 113,000 in 2000 to 148,000 in 2013. Because zero to five year olds are the children at greatest risk of coming in contact with the child welfare system, this increase is an important contextual factor in Arizona.
- Poverty among six to seventeen year olds also increased, rising from 200,000 in 2000 to 273,000 in 2013.

Core Capacity

Supports for Families – Daycare

The economic recession that started in 2007 hit Arizona families hard. At the same time, the supply of services and supports families would have otherwise relied on were scaled back. Internal and external stakeholders interviewed across the state said repeatedly that families no longer had access to the level of support from the state and from their communities that was once available to them. Evidence suggests this did happen.

- The number of children receiving childcare subsidies peaked in 2009 at about 45,000. By 2014, that number was down to under 25,000.
- Total state expenditures for subsidies dropped from \$193.7 million in 2009 to \$136.2 million in 2010.
- By 2014, total state expenditures for child care subsidies stood at \$100 million.

Capacity in the Child Protection System

In the face of rising demand, new capacity in the form of staff and funding for services has to be allocated if the Department is expected to meet the demand. Unfortunately, in hindsight, just as the demand for services was rising, Arizona reduced staffing levels and spending for child protection services. That being said, staffing levels are again on the rise and funding for the new Department is above what it was in 2011.

- From 2004 through 2008, spending for child protective services was increasing at an average annual rate of 14 percent per year, or about \$54 million per year.
- From 2008 through 2011, there was a net decline in funding of about 7 percent.
- The state budgeted \$736 million in 2011. Since then, through 2014, appropriations have averaged about \$74 million more per year, with the largest increase - \$84 million - coming in 2014.
- The number of filled caseworker and supervisor positions fell sharply between 2008 and 2010, from 1,018 to 923, which is a decline of almost 15 percent.
- Relative to the number of authorized positions, there was a shortfall in the workforce of about 25 percent.

Key Processes and Services

In many respects, a child protection system is relatively simple in its design. There are (or should be) processes in place to a) receive, investigate, and substantiate reports of maltreatment, b) link families and children to the services needed, including foster care, and c) secure a stable, permanent family for children. When these processes operate smoothly, children are kept safe in a family context. When the processes are not working properly, problems with keeping children safe emerge, particularly during times of high demand.

With regard to Arizona, the evidence suggests that basic processes are not operating as intended, particularly those processes used to manage the system's front door. For example, the child safety priority matrix used to guide decision-making at the hotline uses four priority levels (see Table 1). However, the distinctions between priority levels are not clear. Consider the distinction between present (Level 1) and impending (Level 2) danger. Present danger refers to a condition that has or is likely to result in serious or severe harm. Impending danger refers to danger that is not occurring but is likely to occur in the near future and will result in . . . harm to the child. Given the relatively limited information available to the individual taking the call, the distinctions between present and impending may be too nuanced to reliably distinguish one type of case from another, even though doing so determines how the case will be handled going forward.

In addition to the priority level, cases may also be categorized by the degree of perceived vulnerability. For example, very young children (ages zero to three) may be assigned a higher priority level than circumstances would warrant, simply because of their age. Otherwise similar cases may be prioritized differently based on the type of reporter, with reports from mandated reporters and law enforcement prioritized over reports from members of the general public. Although selective or differential attention is to be expected, the application of a standardized

protocol is necessary to ensure that case assignments are valid, reliable, and consistent, given the risk and safety profile of the family.

Table 1: Child Safety Priority Levels

Priority Level	Expected Response Time	Description
1	2 hours	<i>Present Danger:</i> refers to an immediate, significant, and clearly observable family condition present now which has resulted in or is likely to result in serious or severe harm requiring an immediate initial response.
2	48 hours	<i>Impending Danger:</i> may not be occurring in the present but is likely to occur in the immediate to near future and will result in serious or severe harm to a child.
3	72 hours	Reports that do not rise to the level of present or impending danger but there is an incident of abuse or neglect that has happened in the past 30 days. This includes a current minor injury to the child.
4	1 week	Reports that do not rise to the level of present or impending danger but (1) there is an incident of abuse or neglect that happened more than 30 days ago or (2) the date of last occurrence is unknown and there is no current physical indicator of maltreatment or (3) there is unreasonable risk of harm to the child’s health or welfare.

In practical terms, these operational ambiguities mean that consistent thresholds are not applied when making decisions about investigations, service referrals, and placements. As a consequence, other influences may drive decision-making; in the current climate of apprehension, evidence suggests that decision-makers may err on the side of caution and make conservative decisions. At the hotline, this could mean assigning a higher Priority Level than the case warrants. At investigation, this may mean removing children from their parents’ care when the level of risk may not warrant removal. At either decision point, the absence of clear guidance plus the overuse of the most intensive responses adds to the backlog of cases waiting for responses. By tolerating higher rates of false positives (assessing cases as high risk when that is not the true condition), the Department further strains the capacity needed to provide appropriate responses and services to assist children and families.

At investigations, decision-making is similarly ambiguous. Though a protocol is available (Child Safety Risk Assessment – CSRA), its actual use is not routine. Moreover, the ability to track trends was compromised by changes to the CSRA. In its initial implementation, while not yielding a clear removal decision recommendation, the CSRA provided quantifiable guidance for

identifying risk in a home or a family. It was automated and required boxes to be “checked” in an online application, so that investigators were required to complete all fields and data could be tracked to identify trends. In recent years, the automation was disabled and the tool was modified to replace checkboxes with narrative fields, asking investigators to “tell a story” rather than to quantify elements of risk. While this shift may allow for more nuanced reporting in cases where it is still used as intended, the removal of automation allowed implementation drift, and the tool is now not completed in the same consistent, structured way in which it once was. Department leadership and staff identified this trend as one that has contributed to ambiguity around decision-making during investigations. As with the hotline, decision-makers are left to make decisions based on other factors. In the current climate, one of those factors is the fear of failing to remove a child who is in danger.

The failure to systematically evaluate, classify, and respond to cases according to their level of risk has led to a system in which distinct pathways of care for mild, moderate, or severe cases are poorly defined. In fact, even the delineation between the investigations process and ongoing case management is unclear, with transitions of responsibility happening at various points in the process. Pervasive role confusion, paired with urgency and reactivity around the need to address high-risk cases, results in an inefficient system that does not benefit from specialization, clear guidelines, or streamlined processes.

In addition to the lack of clarity around roles and risk, poorly defined pathways also arise out of the inadequacy of the current service array. Because current funding levels and practice protocols do not provide programming for families with mild to moderate needs, because in-home services (for parental substance abuse and other issues) are generally not available, and because long waiting lists are pervasive among service providers, many families who might benefit from these services fail to receive them.

Theory of Change and Remedies

The problems confronting Arizona’s child protection system led then Governor Brewer and the Legislature, in 2014, to take a series of steps in an effort to strengthen the system and improve child safety. Chief among the steps taken was the decision to pull the child welfare agency out from under the DES. Viewed through a CQI lens, the decision to create a new child welfare agency reflected a certain perspective on the problems facing the state and the steps needed to solve those problems. We describe what others told us about the Theory of Change below.

Viewed through the lens of the IOM's system framework, the changes adopted by Arizona were all designed to strengthen the child protection system. That is, the changes were designed to strengthen core functions by improving the process and quality of care, reinforcing mechanisms of accountability, and building (or restoring) the capacity to deliver services with fidelity to process and quality standards. After we describe the Theory of Change, we examine the ways in which the legislation creating the new Department set out to strengthen the child protection system. In doing so, we focus on the mission clarity (i.e., system goals), accountability, the process of care, the continuum of care, and capacity measured as human capital (number of workers) and funding levels.

Theory of Change

The steps taken to address problems within the Department reflect a collective Theory of Change that prioritizes visibility and accountability for promoting the safety of children and the wellbeing of their families. The Theory is predicated on assumptions about system deficits and the solutions needed to effectively address them. There are two key elements to the Theory of Change as described to us by Arizona system stakeholders:

The *Visibility Theory* postulates that the previous Child Protective Services operated with a lack of transparency when it was housed under the DES. While the integration of child protective services within DES allowed for certain synergies (physical co-location of Mental Health and child welfare services, more seamless transitions, efficient and flexible funding for infrastructure and services), some believe it also allowed problems to arise and go unnoticed. This Theory calls for a structural response: the new, stand-alone DCS was created to allow heightened visibility of Department operations and functioning, in order to prevent future mishaps.

The *Capacity Theory* attempts to explain the increasing rates of child neglect cases over the last five years, during which time volume exceeded capacity and many cases went uninvestigated. This Theory suggests that cuts to entitlements during the financial crisis led to undue stress on families as well as high turnover in the child protection workforce. Lay-offs, furloughs, and cuts eroded both the quantity and qualifications of front-line staff. Families were unable to meet the needs of children in their care, resulting in rising rates of neglect. The smaller workforce did not effectively manage the volume of cases generated by this increase in cases. This Theory required a fiscal response: new funding was allocated to increase the workforce to meet increasing demands on the Department, and funding was allocated to establish a new Division of Prevention within the Department.

Building a Stronger Child Protection System

The process of changing the child protection system in Arizona started when Governor Brewer signed an executive order (2014-01) establishing an independent, stand-alone organization, named the Division of Child Safety and Family Services. Per the order, the new agency head would report directly to the Governor and assume responsibility for the functions previously located within the DES' Division of Children, Youth, and Families. The *functions* relocated into the new agency included child protective services, foster care, adoption, and the comprehensive medical and dental program, as well as its Office of Child Welfare Investigations (OCWI), which was charged with investigating criminal conduct allegations of abuse and neglect. Subsequent to the executive order, the State Legislature, in a May 2014 special session, passed legislation supporting the executive order and established the DCS. With respect to the Theory of Change, the new Department increased both *visibility and capacity* inasmuch as the Director was now a direct report to the Governor (a change in structure). At the same, actions by the Governor and the Legislature added new capacity in the form of approximately \$60 million in new funding on top of a similar amount provided earlier in the year (approximately \$54 million). The funds were allocated to increase the number of workers, reduce the supervisor-to-worker ratio, and to fund additional services to children and families. All told, the budget for the Department increased to approximately \$848 million.

In addition to visibility and capacity, the legislation touched other functions and processes tied to how well the system protects children. Those functions and processes include the following:

Increase Accountability

Accountability is a central focus of the new legislation. As spelled out, the following (Departmental) responsibilities are articulated:

- An Oversight Committee is established
- Quality assurance (QA) is required
- Research and statistical reporting is required
- An Inspections Bureau charged with monitoring compliance with policy and procedures is established
- Data-driven decisions are required as part of a new QA process
- Fidelity with process and quality requirements is included as part of the QA process

In addition to these provisions, the legislation established a Community Advisory Committee to analyze current law and policy and to make recommendations to the Department. The membership of the committee, which is to meet quarterly, is established and a report is to be filed annually of its activities and recommendations.

Separately, the Child Safety Oversight Committee remains from previous legislation, and a representative of a Native American Tribe or Nation is added to its roster of mostly external stakeholders. This committee is to identify the responsibilities and scope of the Department and identify areas for improvement as well as monitor Department program effectiveness.

The legislation also requires, on or before September 1, 2016, recommendations to the Governor, the President of the Senate, and the Speaker of the House on whether to consolidate into one comprehensive report numerous child welfare related accountability reports currently produced.

Clarify Core Functions

The general provisions of the legislation established that the “primary purpose of the Department is to protect children.” To achieve this purpose, the Department is to focus equally on the following:

1. Investigate reports of abuse and neglect
2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect
3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations
4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family, and provide prevention, intervention, and treatment services.

Establish Structures and Functions

System structure refers to how parts of the child protection system relate to one another and to other systems that serve children and families (e.g., courts, the police, community-based agencies). Separating child protection functions from the DES was the primary structural change. Others include:

- Reinforcing relationships with courts, law enforcement, social service agencies, faith-based organizations, municipal agencies, and other public agencies/departments.
- Supporting cooperative work, including information sharing.

- Strengthening relationships with Tribal child protection agencies or programs.
- Clarifying the relationship between child safety workers and child welfare investigations workers is clarified so that cooperation and coordination occur as parts of the child protective services investigation process. These workers are also directed to cooperate with the rest of the Department as well as with the new Inspections Bureau, created as part of this legislation.

The functioning of the new Department receives the majority of attention across the new legislative language. How the new Department is to be governed and how it is to govern and manage are primary legislative concerns, which are reflected most heavily in the sections related to powers, duties, and Department organization. The functioning of the centralized intake hotline and the investigative functions are outlined in specific terms. The service coordination function is also detailed to include the provision of services that achieve and maintain permanency, strengthen the family, and provide prevention, intervention, and treatment for abused and neglected children.

Strengthen the Continuum of Care

The continuum of child welfare services starts with primary prevention and extends to foster care and post-placement services. Each point along the continuum receives attention in the legislation, but not in equal measure. Child safety and keeping children safe is the primary focus, as suggested by the name of the new agency and the phrases used throughout the legislation that refer to child safety, as in “without compromising child safety.” The law does reference services to “maintain permanency on behalf of the children, strengthen the family, and provide prevention, intervention, and treatment services . . .,” provided said services do not compromise child safety. New language targeting primary prevention (i.e., promotion in the IOM framework) and child wellbeing is more limited. The Healthy Families program, which targets young children, was kept but language authorizing the Family Builders program was weakened, by changing the bill language from “shall implement” to “may implement.” Family group decision-making was repealed, although group decision-making was not a practice model in use when the law was changed. However language related to “cooperating with other public and private agencies for the prevention and treatment of conditions giving rise to public welfare and social security problems” and in assisting the development of community programs “to meet prevention, treatment and other service needs” was left intact.

Language targeting case identification and investigation is robust by comparison. New language clarifies the definition of criminal conduct allegations and lays out how criminal conduct investigations are to be implemented. The legislation requires investigators to make prompt and

thorough investigations in order to determine whether a child has experienced abuse and/or neglect. A centralized hotline is to be maintained and the new legislation outlines how reports are to be accepted and what is to occur with these reports as it relates to recording communications, reviewing prior reports, providing information to law enforcement as indicated, and determining priority levels.

New language outlines the role and responsibilities of the hotline worker for preparing reports and the circumstances under which the report is to be completed. The process for referring a report from the hotline to investigations within the Department is also outlined. There is relative emphasis in the new language on the role and responsibilities of the investigators in their efforts to determine whether a child is a victim of abuse or neglect. To determine if the case should be open for on-going services, the Department is to consider present or future risk of harm to a child and if services can mitigate those risks. Across the Department, reasonable efforts are to be made to provide assistance that is least intrusive and least restrictive and provided in a culturally specific manner as close to the home community as possible.

As it relates to assessment, treatment, and follow-up in the process of care, there is more focus on assessment relative to treatment and follow-up, and much of the assessment requirements relate to assessment during the intake and investigation components of the system. The Department is required to develop and train hotline workers to use uniform risk assessment tools. New language requires investigators to determine whether a child needs child safety services. The investigation and risk assessment are to inform decision-making on whether to close the case, offer voluntary child safety services, or open a case for on-going services. As it relates to assessment in prevention, the Department is to develop a risk assessment for newborns as part of its Healthy Families program. New language related to family assessment protocols requires the Department to examine the necessity of and requirements for protocols for not conducting a full investigation when measures to prevent future harm can be taken and when there is a reasonable belief the child is currently safe.

Treatment and follow-up are also attended to in the new legislation. Specifically, the Department is directed to assess, promote and support the safety of a child in a safe and stable family or other appropriate placement. Services may be arranged, provided, or coordinated by the Department to protect children as well as to achieve and maintain permanency. The Department is directed to coordinate, without compromising child safety, services to achieve permanency, strengthen the family, and provide prevention, intervention, and treatment services as noted previously.

Follow-up language relates to the requirement that the Department is to coordinate services to maintain permanency. While this requirement is set forth in the preamble, there is limited language throughout the legislation clarifying the intent. For families having a case plan, the case plan is to articulate the time limits of services provided. Again, there is little legislative specificity. Interestingly, there is no directive to use evidence-based and promising practices within the legislation. Separately, but relatedly, within the requirement that a consultant be selected to conduct an external review (this review being conducted by Chapin Hall) is embedded an interest in understanding the consultant's knowledge of evidence-based and promising practices as part of the selection process.

Capacity – Human Resources

As it relates to capacity, human resource considerations are a focus of the legislation. Language regarding the hiring of a Director and his or her qualifications are outlined. Training for investigators is specifically outlined to include training in forensic interviewing, use of safety and risk assessment tools, due process protections, child and family rights, and the use of a checklist or other mechanism to assist in the investigation. Additionally, there is a requirement that one representative each from the OCWI and the Inspections Bureau be embedded within the Centralized Intake Hotline, which also relates to accountability and transparency.

The development of a data system that houses information about abused, neglected, and abandoned children is required as part of capacity/infrastructure building in the new Department. Funding and contracting are also addressed. The legislation clarifies that monies saved by the Department can be reinvested for the benefit of the Department rather than being returned to the state General Fund, a best practice. Authority for contracting and grant-making is provided along with the ability to accept grants for conducting programs that are consistent with the overall purpose of the Department. The ability to pay for the cost of care, inclusive of youth up to age twenty-two, (also considered a best practice and promoted by the federal government), is provided. Authority is provided for infrastructure building as it relates to the formulation of policies, plans, and programs.

Elected officials also increased the size of the workforce. From 2007 through 2012, except for a short-lived increase in the number of authorized positions for state fiscal year 2009, the authorized number of caseworker and supervisor positions held steady at 1,218. Thereafter, lawmakers authorized additional staffing levels, from 1,281 in January of 2013, to 1,374 in July of 2013, to 1,520 in February of 2014.

Capacity – Funding

In addition to creating a new Department, the Governor and the Legislature faced the realization in 2010/2011 that funding for the Department, old or new, was well below what was needed. According to the Department's financial reporting, from 2005 through 2008, spending for child protective services was increasing at an average of 14 percent per year, or about \$54 million.

From 2008 through 2011, there was a net decline in funding of about 7 percent. In historical context, the cuts to the child protection system were not as sharp as those that affected childcare subsidies. Nevertheless, in the face of rising numbers of children in poverty, the decision to cut the budget, which may have been necessary at the time, does appear to have contributed to the challenges facing the state today.

To address the capacity shortfall, lawmakers infused the system with fiscal resources at a rate exceeding prior periods (i.e., 2004 to 2008). The state budgeted \$736 million in 2011. Since then, through 2014, appropriations have averaged about \$74 million more per year, with the largest increase - \$84 million - coming in 2014.

Assess, Rank, and Prioritize Risk

The RFP issued by the OAG asked the Contractor to assess service risks and then rank and prioritize those risks in relation to the Department's strategic direction. To guide our assessment of risk and strategic direction, we relied on the IOM framework as a way to identify core functions and components within child protection systems. On that basis, the core components we examined included those connected to investigations of child safety and related concerns; the continuum of care with reference to the assessed needs of families; and accountability mechanisms. In this section, we describe our findings with regard to the risks. In the section that follows, we offer recommendations.

Process of Care

We focus our assessment of systemic risk on core processes linked to what child protection systems have to accomplish in order to provide effective services to children and families. Over the past fifteen years, operational ambiguities having to do with referral mechanisms, assessment protocols, and service pathways contributed in important ways to the situation on the ground today. Our emphasis on the process of care grows out of this perspective.

Fundamental to a child protection system is the ability to identify and act on cases of child maltreatment. There has to be (1) a clear referral process, (2) a clear assessment process, and (3)

clear service pathways once the needs have been established. With respect to the initiatives underway, we sought to identify the agency's response to this issue.

Child Safety – Referral, Assessment, and Service Pathways

The **referral process**, encompassing the hotline call center and the assignment of priority levels, is an area of *high risk* for the Department. Although response rates have increased and response times have been reduced (due to improvements in both the processes and technology), the ambiguity about the assignment of priorities once a call is taken creates ongoing vulnerability. In the absence of a clear, revised priority assignment system that is informed by a routine screening procedure and transparent to both staff and the system at large, the decision to abstain from investigating lower priority cases may create additional risk of harm for children. While child age and reporter characteristics inform the assignment of priority level, the circumstances surrounding the allegation of abuse or neglect are not assessed in a transparent and standard process at the hotline.

The current system is unable to respond to the number of **investigations** that receive prioritization from the hotline. Instead of adhering to guidelines that provide expectations for response times, investigators, overwhelmed with a number of cases far in excess of national standards, *complete* a response only to those cases that they perceive to be at greatest risk. However, in the absence of a standardized protocol for assessing risk, investigators are left to rely on instinct or experience in making decisions about whether to remove a child from the parents' home. Given the high degree of turnover and the recent shift toward filling new positions with less highly qualified staff, the ambiguity around investigative decision-making is also an area of *high risk* for the Department. In some parts of the state, this results in rates of removal that are higher than national averages. However, this is not the case in every region; a focus on regional data should inform the Department's strategies to stem the tide of new placement cases.

One area of concern expressed by staff across the state is the number of cases throughout the care continuum that are "inactive." Although the legislation and media attention resulted in a prohibition against "non-investigated" cases, this prohibition may be only semantic, and not a meaningful practice change. That is, there are still "dead-end" pathways into and throughout the Department, in the form of unassigned cases, inactive cases, and abandoned cases (i.e., cases in an unknown state of completion). These cases, added to the initial backlog of cases that were not investigated, have resulted in a very high demand for attention and resources that is unlikely to be met using the current capacity. Robustly addressing this backlog is critical to bringing the

Department back into stability. Recommendations in the final section will suggest strategies for addressing this backlog.

One approach that was implemented to address the backlog is the collaboration with law enforcement through pathways both external (between Agencies) and internal, with the formation of the OCWI, previously run by now-Director Greg McKay. Proponents of the law enforcement approach to child welfare highlight the more definitive nature of the determination of guilt in the criminal justice system, calling it more “black-and-white” in contrast to child welfare’s “grey.” Proponents also highlight the preparedness of law enforcement officers for handling difficult and possibly volatile family situations, and the streamlined pathways for prosecuting criminal child endangerment. On the other hand, law enforcement has historically approached its work with alleged perpetrators from a more adversarial, less family-centered paradigm than child welfare. The intention is often to determine if there is the presence or lack of criminal behavior rather than whether there is a need for assistance to support and stabilize a family. As such, an over-reliance on law enforcement in the investigative process may result in some loss of opportunity to successfully engage families as partners in the initial risk and safety assessment.

As the Department moves forward, it will be important to accurately and transparently assess: (1) the need for and value of law enforcement involvement; (2) the risks introduced by sharing the responsibility for child protection with the criminal justice system; and (3) the strategies that may be employed moving forward to maximize the positive impact of the collaboration. To this end, a clear understanding the number of reports that have a criminal conduct allegation and their pathways through the system, as distinct from other allegation types, would be helpful to understanding how best to collaborate with the criminal justice system.

Almost every system stakeholder reported that the **lack of available in-home services** results in a higher rate of removal and longer time until permanency can be achieved. If parents are unable to receive parent training, substance abuse treatment, or mental health services *while their children remain in their home*, valuable time in a child’s life is spent in foster care waiting for parents to complete services and achieve treatment goals. Once parents are referred for services, wait times are often extremely long (3-8 months), resulting in more delays in permanency proceedings. While new funding for “prevention” services is intended to provide some in-home services, procedurally these can only be provided subsequent to DCS involvement, often depend on a long provider waitlist, and are only available for moderate- to high-risk cases. More importantly,

based on what we heard during interviews, front-line staff, supervisors, and regional leadership remain unaware of the availability of services and the pathways for obtaining them.

Permanency and Length of Stay

Compared to the Department's focus on the system's front door (i.e., investigations) much less attention is paid to what happens once a child is placed in foster care. However, to the extent the current situation is defined by the rapid growth in the foster care population, the processes most likely to affect placement decisions and whether a child leaves foster care cannot be ignored. Length of stay is on the rise. Moreover, a significant number of children – more than at any time in recent history – require the attention of the Department and the courts.

Legal Representation and the Accuracy and Timeliness of Court Information

Among the many things a child protection system has to do well, making decisions about the proper care of young people is both the most important and the most difficult. Because of how profound child safety decisions are, child protection systems rely on the courts to oversee many of the decisions on a case-by-case basis. To perform their oversight effectively, courts depend on the flow of accurate, timely information and sufficient resources to ensure the rights of children and parents are being protected. The courts are also the mechanism of last resort for parents who want to exercise their rights. Government agencies can and sometimes do over-reach when trying to protect children. When and where this involves removing children from their homes, courts are the venue for parents to be heard. Federal policy requires that reasonable efforts be extended to parents before the state acts against their wishes, as in the case of removal and adoption. Upholding the rights of parents often requires that services be provided in the home, so that parents can learn what it takes to raise their children; the law is designed to extend them that opportunity. Doing so reinforces the idea that parents are in the best position to do what is best for their children, if given the chance to do so.

In the short term, with so many children now living in out-of-home care, the courts together with the Department play a critical role in how each of nearly 17,000 children will spend the rest of their childhood. Because effective collaboration depends on the flow of accurate information and the proper protection of parental rights, the RFP issued by Auditor General requested an examination of these two aspects tied to the courts.

The Court represents a vital partner in any child welfare system. Judges, children's and parents' attorneys, guardians ad litem, and court-appointed special advocates are all critical players in the child welfare case process, and the timeliness and quality of court hearings contribute to the

achievement of positive outcomes for children and families. The quality of legal representation for children and families as well as the timeliness and accuracy of the information provided to the Court are significant factors within these proceedings. Yet, with the exception of the Safe Reduction Workgroup, this arm of the larger child welfare system appears to have received little attention in the State's reform efforts.

The inability of caseworkers to effectively protect children and serve families, given their increasingly high caseloads and lack of resources over the past few years, has been universally recognized as a contributing factor to the problems leading to the creation of the new Department. As a result, significant investments were made in hiring and retaining new staff in an effort to create more reasonable workloads for caseworkers and supervisors.

However, a parallel dimension of the same concerns exists for the number of cases assigned to attorneys and advocates and the number of hearings that need to make it onto the judicial docket. Without reasonable workloads for attorneys and thoughtful scheduling of court calendars, it is unreasonable to expect that attorneys are as prepared as they need to be to effectively represent their clients. Similarly, judges are not in a position to ensure their hearings are of desired length and quality. There is no evidence that similar efforts and investments have been made to create more reasonable workloads for attorneys and ensure that judges have sufficient time on their court calendars to provide hearings of the necessary depth and quality. Furthermore, the State does not appear to have a mechanism for systematically tracking the number of cases assigned per attorney, an infrastructure problem that makes it difficult know whether caseloads and supports are appropriate for the legal representation assigned to children and families and how those numbers are shifting over time.

Although quantitative data were not available to assess the amount of time parents' and children's lawyers have to spend per assigned case, several stakeholders spoke to the harried nature often accompanying court hearings in Arizona's larger counties and the quick attorney-client meetings occurring just before participants were called before the judge. This suggests that attorneys often do not have sufficient time to brief and prepare their clients before court appearances.

Furthermore, while the expectation is that case information is provided to the Court by the Department five to ten days before the scheduled hearing depending on the type of case, stakeholders reported that common practice is closer to one day before and that the information provided is often duplicative, confusing, or otherwise hard to understand. As such, time is often taken during hearings to apprise all parties of current facts related to the case as opposed to

substantively addressing the issues impacting permanency achievement for the child(ren) in question.

Rule 40.1, which amends rules governing the juvenile court, details the expectations for counsel and guardians ad litem appointed for children.³ The rule includes such requirements as the timeliness and quality of lawyer-client meetings; expectations for contact with caseworkers, caregivers, and parents; as well as the counsel's expected contributions to important elements of the case process like staffings and child and family team meetings. Many elements of Rule 40.1 are consistent with the Best Practice Model put forward by the National Quality Improvement Center on the Representation of Children in the Child Welfare System (QIC-ChildRep).⁴ The ability to successfully fulfill each of these requirements requires that attorneys have sufficient time to devote to each of their cases. While no national standard exists for an ideal caseload for attorneys, and appropriate numbers may vary based on factors like case complexity and geography, a reasonable expectation is somewhere between sixty and seventy child clients annually.⁵ Conversely, some stakeholders reported that attorneys in Maricopa County managed caseloads upwards of 250 clients. It is likely not possible for attorneys to successfully meet their mandated requirements with the caseloads many attorneys appear to maintain. Moreover, Chapin Hall is not able to provide precise information about attorney caseloads by county because the State currently does not have the capability to track that information.

Given the large and growing number of children in foster care, the ability to protect the rights of both parents and children is a significant systemic risk.

Accountability Mechanisms

The swift upswing in the number of families served by Arizona's child welfare system exposed, in the minds of many, fundamental weaknesses in the mechanisms of accountability. At the macro level, the image of a child welfare agency buried in a larger umbrella agency came to symbolize the broad sense that accountability was compromised and problems disguised; the swift surge in demand for child welfare services might have been better managed had proper accountability mechanism been in place. At the micro level, the problem of uninvestigated reports came to represent a failure to accurately ascertain whether children are safe. Investigating child safety is the most basic function child protection systems must do well. In Arizona's case,

³ See <https://www.azcourts.gov/Portals/20/R110013.pdf>

⁴ National Quality Improvement Center on the Representation of Children in the Child Welfare System. (2011). QIC Best Practice Model of Child Representation. Retrieved from: <http://www.improvechildrep.org/DemonstrationProjects/QICChildRepBestPracticeModel.aspx>

⁵ Personal communication, Frank Cervone, Esq., Support Center for Child Advocates, Philadelphia, Pa.

the agency's stakeholders came to believe even that most basic functions were not being carried out and the agency lost the public's confidence. Logically, as the DCS pivots away from the DES, the Legislature has asked whether the basic mechanisms of accountability are in place and ready for use.

The recession, in combination with a number of other changes, set off a series of events that fundamentally weakened the child protection system in Arizona. Whether the impact of decisions made could have or should have been forecast is unclear. What is clear is the desire on the part of stakeholders to improve the mechanisms of accountability. There are three basic questions we put to agency staff when asking about their accountability system: Do you have a CQI process? Do you have the capacity to produce accurate data? Do you have the capacity to conduct qualitative case reviews?

CQI Process

Because leadership at the new Department is focused on CQI, when asking questions about the CQI capacity, we opted to look forward rather than backward in terms of the Department's approach to CQI.

First, the Department does produce a number of reports, for both internal and external use. According to Department officials, there are 7.5 FTEs allocated to the Reports and Statistics Unit plus another 1.5 FTEs dedicated to the Business Intelligence Dashboard. The group publishes various reports including the Financial and Accountability Reports. There are regional liaisons that produce reports at the regional level, among other functions.

Broadly, the reports produced, in particular the Financial and Accountability Reports, cover the range of important indicators: worker positions, reports accepted, placements, and so on. The reports do not cover staff compliance with laws and regulations. The agency does collect and report data on visitation and investigation timeframes. The agency does not report on the performance of its private sector partners. With regard to duties performed by legal counsel, the agency does not produce reports targeting that performance area.

The dashboard used by the agency has been expanded and now includes calls received by the hotline, date and time of call, and the type of call. These are basic capacities one would expect to find.

From a structural perspective, the agency has assigned lead workers to each phase of the CQI cycle. These individuals are charged with guiding the CQI process and reinforcing fidelity to the

process throughout the agency. Importantly, in conversations with leadership there is an understanding that CQI is as much a culture as it is simply process and structure.

Capacity to Produce Accurate Data

The capacity to produce accurate data has two dimensions. The first is relatively simple: Are the data accurate? The second is more nuanced: Are the data used to produce an accurate picture of the system's performance?

With regard to the first question, the feedback from officials within the Department suggests that the answer is mixed. Data about children (e.g., demographic information) in foster care is generally good.⁶ Other data are less reliable. Permanency goals are not routinely maintained in the electronic system. As a consequence children with an adoption goal show up as reunification on the case plan summaries because information has not been updated.

The weakest area appears to be data on child safety. Safety threats, risks, and service needs are either missing from the electronic records or not collected. Caseworkers are not required to check any of the seventeen possible safety threats as part of data entry. There are some fields for listing a child's needs and the Department relies on the comprehensive medical and dental program (CMDP) to capture some information. Special needs are not captured through these mechanisms, unless there is a CMDP payment. There are opportunities with CHILDS to fill special needs in but it is reported that this happens rarely. Importantly, parent special needs are not captured within the CHILDS system.

As for whether the data are used to develop the evidence needed to operate a child protection agency, we found a number of interrelated weaknesses. First, the routine reports produced for public consumption are almost entirely descriptive. There is very little analysis that accompanies the reports. Second, the format of the reports is unchanged over many years even though the standards for reporting performance data have changed. Finally, the indicators are treated as unrelated. There is no narrative, for example, that connects changes in the number of reports to the number of placements.

With regard to format of the reports and the developing standards for reporting performance data, the state relies almost exclusively on cross-sectional data as opposed to data that captures how

⁶ The accuracy of the basic data is certified as part of the federal certification process. The CHILDS system was deemed compliant in 2006. Basic information passes federal checks, with accuracy rates in excess of 95 percent for dates of entry, exit, and birth. Other vital information – race, permanency goal, and most recent placement were accurate at an 83 percent rate or higher.

children move through different parts of the system over time. Snapshots of activity tend to distort what is happening in ways that adversely affect the agency's ability to respond to changes as they unfold. For example there is no apparent effort made to distinguish between first reports (i.e., new families) versus families returning to the system having been served previously. As important, there is no apparent attempt to understand whether services provided to a family following a substantiated allegation depend on the type of allegation. These reports may be available internally as dashboard screens, but this information is important to external stakeholders if those stakeholders are to be placed in the position of helping the agency meet the needs of families and children.

In sum, it appears challenges facing the agency are three-fold. There is some useful data but it is clear the agency does not make full use of these data. Second, some basic data are not currently available, including core data about safety and needs. This is an important deficiency. Finally, the use of evidence – the process by which meaning is made of the available data and then applied to decision-making – is an area where greater focus is required. Without evidence use, improvements in the underlying data are less likely. Responses from the survey reinforce this point. The workforce generally needs a stronger set of skills if stakeholders expect to get the most of the data that are available.

Capacity to Conduct Qualitative Reviews

A fundamental component of any child welfare CQI system is a sound qualitative case review process.⁷ The Department demonstrates that it has a qualitative case review process for initial assessment, in-home service, and out-of-home cases called the Practice Improvement Case Review (PICR).⁸ The PICR is designed to identify strengths, areas needing improvement, and underlying factors contributing to quality child welfare practice in Arizona. Reviews of initial assessment cases are designed to focus on the Child Safety and Risk Assessment whereas reviews of the in-home and out-of-home cases are geared toward areas of practice not readily assessed through administrative data reporting and analysis because the electronic records lack the necessary detail.

Random samples of cases in all three categories are reviewed annually from each region throughout the state, including at least two cases from each DCS field unit. In-home cases are

⁷ Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2012). ACYF-CB-IM-12-07. <http://www.acf.hhs.gov/sites/default/files/cb/im1207.pdf>

⁸ Department of Child Safety. (2014). *Quality Improvement System Procedures and Training Manual*.

reviewed at a rate akin to which they are represented in the State's overall caseload, and the Department is purposeful about ensuring that cases involving youth over the age of sixteen and cases involving youth legally free for adoption are adequately included in the sample. Regions that possess a higher proportion of the State's overall child welfare caseload are represented to a greater extent in the overall annual case sample.

The Department has instituted detailed procedures for ensuring that case samples are extracted in a timely manner and that case eligibility for review is verified. For the most part, exclusionary criteria are reasonable with one noted exception. In-home cases eligible for review include only those with an authorization within CHILDS for a service referral or an authorization for at least one service. This exclusionary criterion may prevent the opportunity to identify and evaluate cases where service needs have been identified for families but no services have been provided.

The period under review for all cases is limited to the three-month period between the month the sample is pulled and the month that the case review commences. Although this approach provides for a rapid review of practice, as noted by the federal government in their assessment of the Department's quality assurance processes, this short period under review may present challenges in meaningfully assessing the quality of child welfare practice in a case over time.⁹

Protocol dictates that case reviewers undertake a complete review of the case file and put forth diligent efforts to communicate with caseworkers, service providers, and other information sources to fill in gaps that may be present in the documentation. Reviewers must also make concerted efforts to conduct interviews with out-of-home care providers, at least one parent, and youth fourteen years or older in both in-home and out-of-home cases.

The in-home and out-of-home case review instrument is comprised of fifteen items spanning the traditional domains of child safety, permanency, and well-being.¹⁰ Although the Department has a dashboard measure for tracking the timeliness of response, neither the case review instrument nor the initial assessment review guide requires an assessment of the timeliness of the initial response to the family.¹¹ This is notable for several reasons. First, this is inconsistent with the federal child welfare case review instrument, which has consistently included this practice area as the first item in its protocol through three rounds of federal Child and Family Services Reviews (CFSR). Second, and more importantly, this oversight seems particularly critical in Arizona

⁹ Department of Child Safety. (2014). *Child and Family Services Plan Fiscal Years 2015-2019*.

¹⁰ Department of Child Safety. (2015). *Practice Improvement Case Review Instrument – In Home or Out of Home*.

¹¹ Department of Child Safety. (2015). *Practice Improvement Case Reviewer's Guide – Initial Assessment*.

given the challenges the State has experienced in recent years in completing investigations in a timely manner. It is interesting to point out that this practice area is mentioned in the reviewer's guide to the initial assessment; however, the item is not required as part of the case review process.

The Department's efforts to assess child well-being focus on the items of physical health, mental health, and education. While this approach is consistent with items traditionally assessed through the CFSR process, best practice in this area would include efforts to gain a deeper understanding of children's social and emotional well-being and functioning.

Case reviewers may be practice improvement specialists or other professionals approved by the practice improvement managers. The Department has instituted case review training requirements and mandates that all reviewers have direct child welfare practice experience that is consistent with best practice in this area. The Department also maintains processes for ensuring inter-rater reliability and case review accuracy, with protocols in place to provide quality assurance and second level reviews of a sufficient number of cases each month to ensure confidence in case review findings.

With respect to how these data are used, the feedback suggests that more could be done. Some one-on-one review meetings are said to be productive. A newsletter is used to distribute results. However, more frequent production of the reports is hampered by capacity.

Although the data point to significant variation in regional and county performance, there are no regional improvement plans, largely because interest in those plans waned over time. Root cause analysis is weak and oversight of improvement efforts could be strengthened.

Table 2: Summary of Systemic Risks

Basic Function/Inventory	Risk Rank
<u>Safety</u>	
Front door processes	High risk: Arizona lacks a clear, standardized, data-driven approach to front-end decision-making. This is an area of high risk <i>and</i> high priority for the Department.
Preventive services	High risk: Budget cuts have resulted in an inadequate array of interventions and few of the services available are evidence-based.
Pathways/continuum of care	High risk: Pathways/continuum of care are not well connected to needs as assessed, and the pathways are not well mapped with clear designations for roles, transitions, and milestones.
<u>Placement</u>	
Permanency services	High risk: Attention continues to be focused on the system’s front door at the expense of a focus on promoting permanency.
Weak evidence-based interventions	High risk: The infrastructure needed to improve the quality of foster care interventions is not yet a sharp focus.
Court processes	High risk: The courts provide basic protections to both children and families, but information put in the hands of courts and attorneys is not timely nor is it necessarily accurate.
<u>Accountability</u>	
Capacity to generate evidence	Medium risk: Arizona has substantial CQI capacity in that the state can generate the evidence needed to make basic improvements, but this information needs to be integrated into the processes of providing care to children and families.
Capacity for evidence use	Medium risk: The Department lacks, but is developing, processes for incorporating evidence into decision-making and service provision.
Stakeholder engagement	High risk: Stakeholder trust in the Department has been shaken by a growing awareness of areas of risk, as well as some failures of accountability. According to survey responses, the Department lacks clear mechanisms for bringing service recipients into its feedback processes.

Evidence-Based Practices

This section provides the results of a survey of front-line staff to gauge the openness and readiness of the system to implement Evidence-Based Practices, as well as a review of Evidence-Based Practices and Best Practice Models that may be appropriate and helpful for addressing Arizona’s challenges.

Readiness to Implement Evidence-Based Practices: Survey Results

We surveyed state employees with four areas in mind: leadership, culture, research evidence use, and evidence-based interventions. The first two topics touch on what it takes to build and sustain a strong, effective child welfare system. Success of any agenda depends on leadership's ability to cultivate a culture committed to excellence and learning. The survey responses, generally reported on a five-point Likert scale from Agreement to Disagreement, indicate how much work is needed in these areas.

The survey also asked about research evidence use and evidence-based practices. High performing public child welfare agencies are increasingly reliant on evidence for decision-making. The acquisition, processing, and use of research evidence is a core capacity. Our questions help to establish the current capacity for research evidence use. The use of evidence-based practices is also on the rise within high-performance agencies. For this part of the survey we asked about staff familiarity with various service types, including evidence-based practices as a gauge of readiness and service infrastructure.

Fifty-eight percent of the survey recipients responded. Over half of the respondents were either caseworkers (36.1%) or investigators (19.6%). Other respondents included program directors and coordinators, case aides, research and evaluation staff, licensing staff, and supervisors. There was also fairly good regional representation, with respondents coming from all five regions.

Leadership and Culture

Ratings of leadership qualities tended to average somewhat below the midline when it came to leadership support for evidence-based practices, general cultural openness to innovation, and the tendency to challenge commonly held beliefs in order to identify and address problems. That said, survey respondents tended to think that staff are valued for openness and flexibility, individual ideas are welcome and they feel encouraged to think creatively about ways to approach problems. Almost everyone responded that staff are overly stressed; this theme is consistent with the trends observable through administrative data and focus group responses. Survey responses also suggested that staff believe training may not be adequate to prepare them for their role in the system, and opportunities for consultation with service recipients or expert consultants are scarce. However, responses regarding helpful, encouraging behavior by supervisors and managers was generally positive. The picture that emerges is a system that, while lacking in effective decision-making and the infrastructure to implement new protocols, is populated with people who are motivated and dedicated to using effective approaches to solving problems.

Research Evidence Use

The majority of staff report that the Department collects and uses data to understand its functioning and performance. However, staff report feeling that data is not available on a regular basis to staff and managers to assist with decision-making. This suggests that the capacity for using research evidence in decision-making is present, but that it is not necessarily accessible to front-line staff or their supervisors. Staff gave particularly low ratings to questions about the availability of resources (e.g. technology) to facilitate the use of data in their jobs.

Service Array – Evidence-Based Interventions

We looked at two different elements of service array: the value of evidence-based interventions, and staff knowledge of services in place, including evidence-based practices. Staff were relatively neutral when it came to their agreement or disagreement around the value and importance that the DCS places on using evidence-based practices (3.46 on a 5-point scale), the importance the DCS places on implementing evidence-based practices (3.50 on a 5-point scale), and the support and training provided by the DCS on evidence-based practices (3.08 on a 5-point scale).

When asked about the knowledge, implementation planning, and support of the DCS leadership on evidence-based practices, staff responses varied from agreeing with the statements to a slight extent to agreeing with the statement to a moderate extent (averaging a response rate of 2.91 on a 5-point scale).

Lastly, staff were asked about the service array at the DCS. Responses to the types of practices and interventions available and/or being implemented to serve families in the DCS suggest that case management, outreach, referral, and education are the most widely available services in the state, with 80 percent of respondents indicating those service were available to them. With respect to evidence-based interventions, we asked staff about the availability of Multisystemic Therapy (MST), Cognitive Behavioral Therapy (CBT), and Positive Parenting Program (Triple P), all of which are well known evidence-based interventions. In each case fewer than 40 percent of the respondents said those service were available in their area. Only 42 percent of respondents said that Healthy Families America (HFA) was available, even though HFA is a legislatively authorized primary prevention program. At the low end, only 10 percent of the workers surveyed said the Solution-Based Casework was in use in their area.

Evidence-Based Interventions

The use of evidence-based interventions in child welfare can provide a more rigorous approach to service delivery and help a state more effectively achieve specified outcomes. Chapin Hall was

asked to review the set of evidence-based interventions used and provide guidance on those to consider adding to its service array. Importantly, from a policy standpoint, there is no requirement in the enacting legislation for the DCS to consider, explore, implement, or use evidence-based interventions.

In qualitative interviews across the state and in the surveys conducted, there was little indication that evidence-based interventions are being used robustly. One exception to this is the use of Healthy Families Arizona, an evidence-based home visiting program that has consistently received funding from the Legislature via the child welfare system. This primary prevention program is designed to support new parents to reduce the risk of child abuse and decrease the likelihood of entries into foster care.

In addition to Healthy Families, the DCS staff indicated during focus groups that evidence-based interventions are in use by the Regional Behavioral Health Authority (RBHA), but the names and purposes of the interventions were not known by those attending the focus groups. There was little to no awareness of how, and to what end, the interventions are designed to work in the context of a Theory of Change, but rather these interventions are thought to sit outside of child welfare and are the responsibility of the behavioral health system. There was also general agreement that a high functioning feedback loop does not exist between the RBHAs and the DCS to help caseworkers and administrators understand whether progress is being made by those receiving the services and the implications for case level and system level decision-making.

Exploration and Adoption of Evidence-Based Interventions

Currently, the best examples of evidence-based intervention usage in child welfare are within the title IV-E waivers. Twenty-seven states, Arizona among them, were approved between 2012 and 2014 to receive flexible use of IV-E and IV-B dollars, with a sunset date in 2019. The federal waiver application process requested that states identify a particular area of need, a target population, screening and assessment tools, and evidence-based or evidence-informed interventions.¹²

Best practice regarding the insertion of an evidence-based intervention is accomplished through a rigorous selection process similar to what was requested by the [federal government in its](#)

¹² It is important to note that the Department followed these procedures pursuant to its application for and approval of its IV-E waiver.

[guidance](#) to states that recently received a Title IV-E waiver.¹³ This selection process also tracks closely with the CQI framework described earlier in the report. This requires the identification of a specific area of focus and target population through systematic data analysis and then giving meaning to the data as evidence for a Theory of Change to ameliorate the problem.

A Theory of Change makes transparent the identification of a specific problem to address, a hypothesis about why the problem is occurring, a well-defined target population, a screening and assessment approach to better understand the needs of the target population, one or more evidence-based interventions to address the problems/needs, and an approach to tracking and analyzing progress to determine if the interventions are having the anticipated effect. All of the waiver states have undergone (or are undergoing) this process to determine how best to proceed. Proceeding without this process can result in ill-informed decision-making and potentially poor investment strategies.

In addition to developing a Theory of Change that describes the problem to be addressed and for whom an intervention will be deployed, Arizona must also assess the expense and resource requirements of an intervention relative to the anticipated gains, the capacity of the system to implement a particular intervention, and the supports that will be needed for implementation and fidelity monitoring. Many of the waiver states have collaborated with university partners, evaluators, other experts, and peer consultants to conduct these assessments and make data driven selection decisions. An example of this selection process, although not within the waiver context, can be found in a brief commissioned by the Children's Bureau: [A Case Example of the ACYF's Well-being Framework](#), which describes the work of the Kansas Intensive Permanency Project, a grantee of the Permanency Innovations Initiative.

Table 3 below provides a sample of evidence-based interventions being used in child welfare waivers. A Casey Family Programs brief provides a more comprehensive description of the evidence-based interventions being used in the waivers, for which target populations, and with what screening and assessment tools to understand needs and for progress monitoring. The original brief was completed in 2014 ([Casey, 2014](#)) and is under revision to update it with the interventions selected by the waiver states during the past year. While there are numerous useful evidence-based intervention databases, this brief organizes the interventions using the [California Evidence-based Clearinghouse for Child Welfare's](#) evidence level categories of Promising

¹³ Children's Bureau. (2013). Initial Design and Implementation Report Guidance Document. Retrieved from: <http://www.acf.hhs.gov/programs/cb/resource/idir-guidance>

Research Evidence, Supported by Research Evidence, and Well-Supported by Research Evidence.

Table 3: Evidence-based Interventions in Child Welfare Waivers

Promising Research Evidence	Supported by Research Evidence	Well-Supported by Research Evidence
<ul style="list-style-type: none"> • Nurturing Parenting Program • Parents as Teachers • Parent Child Assistance Program • Sobriety Treatment and Recovery Teams • Strengthening Families • Wraparound • Circle of Security • Cognitive Behavioral Intervention for Trauma in Schools • Family Connections • Project KEEP • Parents as Partners • Project Connect • Family Finding • Family Group Decision Making 	<ul style="list-style-type: none"> • Functional Family Therapy • Healthy Families America • Homebuilders • SafeCare • Brief Strategic Family Therapy • Child-Parent Psychotherapy • Matrix Model Intensive Outpatient Program • Parenting with Love and Limits 	<ul style="list-style-type: none"> • Cognitive Behavioral Treatment • Trauma-focused Cognitive Behavioral Treatment • Incredible Years • Nurse Family Partnership • Parent Child Interaction Therapy • Multi-dimensional Family Therapy • Multi-dimensional Treatment Foster Care • Multi-systemic Therapy • Parent Management Training – Oregon Model • Triple P • Coping Cat • Eye Movement Desensitization and Preprocessing • Motivational Interviewing

Areas of Risk and Evidence-Based Intervention for Consideration

As described previously in the report, there are a number of areas of risk that are driving the increased number of children in substitute care in Arizona. Each of these risk areas could be an area for consideration in selecting an evidence-based intervention. In some instances, this might be the same intervention targeted to different families with different Theories of Change, while it is also possible to consider distinctly different interventions depending on where within the system and for what families they will be deployed. A few examples are provided below in relation to reducing admissions and length of stay (i.e., increasing discharges), both of which drive increased numbers of children in care.

Example 1: Need to Reduce Admissions

Number of Child Victims in Arizona is Increasing

The number of child victims has been increasing. Targeting an evidence-based intervention for families with young children who are at risk of entry into foster care may reduce the likelihood of entry. The first step would be to develop a hypothesis about why this increase is clustered among very young children, then determine the characteristics and needs of this cluster of families, and where geographically it is happening most frequently. Then, determine which age appropriate intervention (e.g., Incredible Years, Parent Child Interaction Therapy, Triple P) can be tested to ameliorate the concerns identified and whether it is the best fit given family needs, system resource availability, and overall feasibility. (As noted in Arizona's Child and Family Service Plan (2015-2019) submitted to the federal Children's Bureau, the Department has been participating in a consortium of community stakeholders to bring Triple P to Arizona. Outcome data about Healthy Families Arizona contained in the CFSP suggest that it is being used to good effect.)

Example 2: Need to Reduce Length of Stay/Increase Discharges

Time to Exit Has Increased Dramatically

The length of stay in care increased nearly ten-fold in the time needed to discharge 25 percent of the children admitted between the 2006-2009 entry cohort and the 2010-2013 entry cohort. For the same entry cohort, the time needed to discharge 50 percent of the children increased from 308 days to 457 days. The lengths of stay among children above the 50th percentile tend to be consistently long. This information can inform evidence-based intervention selection. Selecting an evidence-based intervention that can be deployed quickly when a child enters foster care in an effort to increase the likelihood and speed of reunification would be appropriate given these dynamics. Parent Management Training – Oregon Model, Nurturing Parenting Program, Strengthening Families, and Triple P are among the options for consideration.

It is also important to consider contextual information when selecting an evidence-based intervention. The increases in poverty rates and decreasing supports for families (i.e., child care subsidies) create a challenging environment for families. An evidence-based intervention can go a long way toward supporting families to increase nurturing and attentive behaviors, decrease harsh parenting practices, and improve the overall family climate, but it should be coupled with a review of the overall array of supports necessary to help families be successful and meet their children's needs.

Exploration and Use of Structural Best Practices

In addition to exploring and adopting evidence-based interventions, it is important to understand structural best practices from other states thought to have driven reductions in the number of children in care in individual state systems. While it is difficult to make a direct link between these practices and reductions in the number of children in care as randomized control trial studies have often not been completed, the use of specific structural enhancements can support safe reductions, which in turn may further stabilize the Arizona child welfare system.

As previously discussed, the implementation of any structural best practice (or evidence-based intervention) is ideally situated within the context of a well-defined Theory of Change *and* tracking and monitoring to determine if the new practice is having the desired effect. Sacramento County, California undertook this kind of planning and tracking approach to reduce the entries of children into foster care and saw a reduction of over 50 percent between 2006 and 2010 using both evidence-based interventions and structural best practices. A visual depiction of their Theory of Change and a description of their approach can be found at this link:

<http://sofs.s3.amazonaws.com/news/sacramento-care-entry-reduction.pdf>

Example 1: Subsidized Guardianship

The use of subsidized guardianship allows relatives and others to finalize permanency arrangements and continue to receive a financial subsidy to support the child(ren) in their care. Congress recognized the link with permanency achievement when it included additional federal funding to support a Guardianship Assistance Program in the Fostering Connections to Success and Increasing Adoptions Act of 2008. Applying for and implementing the Guardianship Assistance Program with additional federal dollars could establish a more robust pathway for families to achieve permanency. The historical guardianship program in Arizona, funded through TANF, provides a subsidy less than the general foster care payment, thereby creating a financial disincentive for foster/kinship parents to achieve permanency for the children in their care. Generally, children in kinship care have longer lengths of stay; a well-funded Guardianship Assistance Program can strategically reduce time in care and increase permanency. Among many resources providing additional information about subsidized guardianship, this link gives a good general overview:

(<http://www.grandfamilies.org/SubsidizedGuardianship/SubsidizedGuardianshipSummaryAnalysis.aspx>)

Example 2: Performance-based Contracting

Many states provide some child welfare services, including in-home and out-of-home care, via contracts with not-for-profit organizations. In states with rapidly rising caseloads, the private sector has helped the public sector meet new service demands by expanding capacity. However, expanding private sector capacity has to be approached carefully. Predictive analytics can be used to chart future demand so that supply does not drive demand. For out-of-home care providers, as the population returns to historical levels, performance-based contracts can provide the means to rebalance investments in community-based services, which helps reduce the demand for foster care. Performance-based contracts focused on outcomes prioritize service quality as the basis for managing change in capacity.

The use of performance-based contracting can provide clarity to private agencies contracted for foster care and other child welfare related services regarding to what end those services are to be provided. Too often, services provided under contract from public agencies lack strategic direction and a “pay for performance” approach. Providers (i.e., residential treatment centers, foster care providers, foster home recruitment agencies) can benefit from metrics, to include the establishment of baselines and targets, for performance. Accountability is increased across the entire system when performance expectations are clear and measurable. In systems without performance-based contracting, partners are, often inadvertently, incentivized to provide services rather than to achieve outcomes. As an example, Tennessee has made great strides using performance-based contracting to reduce the number of care days used and increasing the quality of services in a system that is partially privatized: https://fcda.chapinhall.org/wp-content/uploads/2012/10/2012_TN-PBC-case-hx2.pdf

Example 3: Legal Best Practices: Court Improvement Programs,

Court improvement activities across the country and in Arizona focus attention on the judicial and legal roles in both case oversight and ensuring timely permanency. Court improvement activities nationally have helped to engage the judiciary in understanding their role in system level performance including ensuring timely permanency for children in foster care. Improvement activities such as making explicit time to permanency and positive permanency outcomes across counties and individual judicial officers can promote reflective practice and motivate additional effort to ensure children achieve permanency quickly. In fact, states are now required to demonstrate that their Court Improvement Programs have strengthened their internal capacity around strategic planning, CQI and their ability to collect data and track the time that is needed to achieve key permanency outcomes. <http://www.acf.hhs.gov/sites/default/files/cb/pi1202.pdf>

The achievement of timely permanency was the focus of the Three Branch Institute on Adolescents in Foster Care: Increasing Permanency and Reducing Entries, a joint project began in 2011 of the National Governors' Association, the National Conference of State Legislatures, and Casey Family Programs, as it related to reducing entries into foster care and reducing length of stay for adolescents. The Wisconsin summary report provides an example of how stakeholders across the three branches of government came together to better understand the need to reduce entries and increase permanent exits for a specific population and the steps they took:

http://dcf.wisconsin.gov/children/foster/nga/pdf/summary_report.pdf.

Additionally, establishing an explicit set of metrics that are shared regularly with the court can spur dialogue and joint effort towards reducing time to permanency. The work in New York State provides a good example:

<https://www.nycourts.gov/ip/cwcip/Publications/2013NYSCWCIPMetrics.pdf>

Example 4: Legal Representation for Children

In Arizona, gaining a shared understanding across the Department and the courts/judicial officers of the information contained in this document could result in a rethinking of and development of next steps regarding the Departmental/judicial preference for adoption over reunification and the resultant increased time to permanency.

Lack of adequate legal representation for children in foster care was identified as a concern as part of this review. Increasing the number of attorneys and frequency of contact with their clients consistent with established policy would go a long way towards ensuring children receive solid advocacy in court and that the quality of their legal representation is consistent with the Best Practice Model put forward by the National Quality Improvement Center on the Representation of Children in the Child Welfare System:

<http://www.improvechildrep.org/DemonstrationProjects/QICChildRepBestPracticeModel.aspx>

Example 5: Court Teams for Infants and Toddlers

The use of court teams for infants and toddlers represents an expansion opportunity of a best practice in Arizona. This program provides additional judicial oversight, including accelerated court review schedules, of families when a child is an infant or toddler, and works to ensure more timely service delivery and reunification. Currently, all fifteen of Arizona's counties are implementing Best for Babies but there may be opportunities to consider expanding the program

to serve more families or to serve children a year or two older than is currently possible. Given the increasing number of children age zero to four who are confirmed victims of maltreatment, this could represent a solid investment of time and resources. Of important note is the need to keep these teams focused simultaneously on well-being and timely permanency so the length of stay in foster care continues to be reduced rather than lengthened for families receiving this approach.

Structural Strategies to Safely Reducing Entries into Foster Care

Example 1: Use of Standardized Decision-Making Protocols

The use of structured decision-making protocols at the intake/hotline as well as in investigations can make transparent and clear how the Department is to assess safety and risk and how/why it proceeds with families regarding provision of services and entry into foster care, as contemplated in Article 8-817 of the Arizona Revised Statutes. Standardized protocols, alongside clear definitions of child abuse and neglect, support better decision-making and action, provided they are *used*, which is part of challenge in Arizona. As noted elsewhere in the report, this work could include either reverting back to the standardized form/approach that was previously used by the Department or undertaking a thorough review of other protocols available to determine which tool(s) is a good fit. Ensuring solid training and sustainability efforts, along with developing data reporting mechanisms can promote long-term use of the chosen protocol. It is important to note that this training should be focused on cultivating solid assessment, decision-making, and judgment skills at the worker level to enhance the use of standardized tools. The Decision-making Tool Library from the National Center for Child Protective Services provides a wealth of information regarding how states are approaching decision-making:

<http://nrccps.org/information-dissemination/1249-2/> The Child Endangerment Risk Assessment Protocol in Illinois furthers the assessment approach by including the development of a safety protection plan:

http://cfrc.illinois.edu/pubs/rp_20010401_IllinoisCERAPImplementationEvaluationFY2001.pdf

Example 2: Alternative Response

Alternative response can be used to provide support and services to families where the safety concerns do not warrant a child removal but there are needs that, if addressed, could be managed so that the risk levels may be less likely to require future DCS attention. More than twenty states are using some form of alternative or differential response:

<http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/DR/qicdr/Documents/DR%20Map.pdf>

States using alternative response generally report that having a service or support to offer a family provides a mechanism for increasing engagement and reducing the adversarial approach inherent in child protective services. While the recent cross-site evaluation of three differential response systems through the Quality Improvement Center on Differential Response showed that differential response did not appear to impact, either positively or negatively, children's entry into foster care, there were positive findings as it related to increased service provision for differential response families relative to investigation families and improvements in engagement over time (<http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/QI-C-DR/Documents/Final%20Cross%20Site%20Evaluation%20Report.pdf>).

General Strategies

Example 1: Use of the Child Welfare Titles IV-E and IV-B Waiver

Arizona has been awarded a child welfare waiver from the U.S. Department of Health and Human Services to increase flexibility in spending federal funds under Titles IV-B and IV-E. This is a unique and important opportunity to support children and families in innovative ways. There are robust efforts underway within the DCS and the state to further refine the target population and interventions to be tested within the waiver demonstration project in an effort to “right-size and redesign” the use of congregate care with longer-term goals of reducing length of stay and increasing permanency. The HHS Children's Bureau requires the best practice of undertaking a structured process to define the target population, develop a Theory of Change, select evidence-based and evidence-informed interventions, and craft an “outcome chain” showing how the assessment processes and interventions are likely to impact child and family outcomes. The waiver demonstration projects are designed to safely reduce the number of children in foster care and improve child well-being. Supporting the work being undertaken in the Arizona waiver and assessing it against the desired outcomes will be important.

Example 2: Use of Team-based Decision-making at Critical Decision Points

As of mid-2005, the child welfare system in Arizona was using Team Decision-making Meetings (TDM), Family Group Decision Making (FGDM), and Child and Family Teams (CFT) – all considered best practices across the country. Related to the implementation of this strong array of family meetings, a “practice model” was developed that included “teaming” with families and

relevant stakeholders as a core component. Currently, the Arizona Department of Behavioral Health uses Child and Family Teams for planning and decision-making purposes (<http://www.azdhs.gov/bhs/guidance/cft.pdf>). Team-based decision-making is used in many states to ensure the engagement of parents and stakeholders, and to increase the involvement of parents in the child welfare system. Consistent deployment of family team meetings across the child welfare continuum, regardless of involvement with the Department of Behavioral Health, can promote enhanced decision-making and accountability among all stakeholders.

Example 3: Use of Continuous Quality Improvement

CQI provides a structured way to support the development of Theories of Change to address pressing needs by using evidence to make decisions about where and how to improve the DCS. The Plan, Do, Study, Act approach in CQI allows for a transparent accountability process to further the goals, strategies, and outcomes of the DCS. This process can and should occur within the Department and be shared broadly with the legislature and other external stakeholders. The use of specific measures related to child and family level improvements and system level performance across time can both inform and motivate the workforce and stakeholders. More detail about CQI and how it used to improve system performance can be found here: <https://feda.chapinhall.org/knowledge-in-action/continuous-quality-improvement/> and <http://www.nrcpfc.org/downloads/wu/ACYF-CB-IM-12-07.pdf>.

Summary and Recommendations

Arizona is not the first state to move its child welfare system out from under an umbrella human services agency. New Jersey and New York City did so in the mid-1990s. In the specific case of New York City, the historical narrative bears a striking resemblance to events in Arizona. The death of a child and ensuing outcry revealed structural problems within the child welfare agency that led then-Mayor Giuliani to create the freestanding Administration for Children's Services in 1996. A few years later, New Jersey did the same, moving the Division for Youth and Family Services out from under its umbrella state agency and into the Department of Children and Family Services. In both cases, the changeover has endured. Moreover, if one measures success as fewer children in out-of-home care, then arguably the examples of New York and New Jersey are reason for optimism. There were 45,000 children in out-of-home care when Mayor Giuliani made the change (1996); today there are fewer than 12,000. The changes in New Jersey are nearly as striking. From a peak of 12,000 foster children in 2004, when the agency was still embedded, the number has dropped so that there are fewer than 7,000 foster children today. That

said, a bureaucratic overhaul is neither a necessary nor a sufficient condition for a turnaround. In recent decades both Illinois and Tennessee, where the child protection agencies have always been freestanding, experienced a sharp upswing and subsequent decline in the number of foster children. In these jurisdictions, clarifying front-end safety and investigations protocols, and employing Performance-based Contracting strategies to effectively collaborate with private foster care providers have helped to restore stability and achieve reductions. It is clear, then, that simply moving a bureaucracy out from under a parent organization will not change outcomes if in making the move the same basic decision-making apparatus remains firmly in place.

Our analysis points to a set of systemic risks facing the agency as it pivots toward greater independence. As it thinks of how to mitigate these risks, the Department will have to extend its Theory of Change. There is already a new Department charged with all the critical functions, including a direct reporting relationship to the Governor; resources have been provided in the form of funds to support programs and workers to manage cases. How the agency and its stakeholders leverage these changes to improve the system depends on the management of the following systemic risks:

- 1) **Investigations/Entries:** Systemic risk at the system's front door and pathways of care (process). The data suggest that Arizona needs a clear articulation of need matched with a pathway of care that addresses the needs. The current priority system lacks the clarity needed to match service needs with a service pathway. When children and families are mismatched with the service pathway, child protection systems are less effective and cost more to operate than when services are in alignment.

Recommendation: Establish and use clear safety assessment protocols and better standardize processes at the hotline and investigations. Examine available child safety risk assessment protocols and consider reverting back to the standardized form that was previously in use OR implement a new, standardized safety assessment protocol selected from one of the many models in place in other jurisdictions. The safety assessment selected should include standardized items, yield quantifiable data, and direct decisions clearly and transparently. Workers and supervisors should receive significant support and oversight during its implementation to ensure that the protocol is being administered with fidelity and that the results of the assessment are being used to inform decision-making.

To address the backlog of cases that has accumulated at the front door of the system, consider implementing multiple strategies. In the short term, these may include the engagement of community providers, retired case workers, or private companies to provide the capacity to conduct a large number of investigations and disposition cases in a timely manner. This must happen in conjunction with clear and consistent decision-making protocols and available service pathways for different levels of need (as described elsewhere in the report). In the long term, the state should consider the regular engagement of providers in a performance-based contracting arrangement that is geared toward focusing agencies on achieving desired outcomes and incentivizing best practice and outcomes through contractual agreements.

- 2) **Service Array:** Systemic risk in the array, supply, and quality of services for families. The removal of family supports and the services that keep them together has created risks within families that fall within the purview of child welfare agencies. While legislation and budgets refer to funds allocated to “prevention,” the perception in the field (from the leadership level to front-line staff) is that these services are simply not available. The perception is that the few services that are available are only for families with severe needs, and have limited capacity and long waiting lists.

Recommendation: Using services to reduce pressures at the system’s front door will require a thoughtful, resourced answer. At the current pace, over the longer term, Arizona could expand in-home services and pay for the expansion with savings that accrue from reductions in foster care caseloads. To do that it will need a clear plan negotiated with the Department’s stakeholders. Healthy Families Arizona should continue to receive support, and other in-home services should be installed to meet the needs of families that come to the Department’s attention but do not require a removal. Monitoring the use of prevention dollars, streamlining pathways for referral and receipt of services, and clearly articulating eligibility criteria will be important to address this deficit.

- 3) **Courts:** Systemic risk in the relationships with and capacity of the courts.

Recommendation: Develop strategies in collaboration with county courts to both increase the number of attorneys and examine the payment strategies to re-align incentives and improve legal representation. Work with the local courts to build the capacity to conduct ongoing monitoring of attorney caseloads and the timely and accurate submission of information to the courts. An electronic, statewide court-based management information is used in some state to track court processes. Given the large number of cases on the court dockets, an investment in management information would pay for itself in a few short years.

- 4) **Permanency/Exits:** Systemic risk in the attention paid to permanency for children in care. When states absorb shocks to the system’s front door as a result of low worker capacity, the impact is usually measured as a sharp increase in the number of children placed in foster care. Inevitably the same forces that stripped the system’s front door of its capacity shift to the systems back door. As it stands, the DCS has to find permanency for 17,000 children. Five years ago that number was just 10,000.

Recommendation: Continue to increase the size of the work force to bring staffing ratios back to pre-2009 levels, if not above those levels given the number of children now in out-of-home care. While resources have been allocated to increasing the work force, there have been barriers to expanding capacity, including the time it takes to adequately train new staff and delays in hiring. Ideal caseload sizes should be calculated (using the information provided in this report and other jurisdictions as a reference point) and funding should aim to stabilize caseload sizes for both investigations and placement workers at levels that will allow adequate attention to the needs of families, including sibling and parent visitation (which is now occurring at far below the rates specified in policy).

Decision-making has to become more efficient without being rushed, or vulnerable to the pressures of fear and reactivity. The workforce hired by the Department has to be distributed wisely along the continuum of care if the value of adding workers is to be realized.

The Department should address the needs of the growing number of children in substitute care by reducing entries and decreasing time until permanency. This will involve taking a

broader view of the Department's purpose and function, developing a Theory of Change that identifies key decision points and levers for changing growth trends, and implementing and supporting Evidence-Based Practices. To meet these needs, the Department should proceed with and reinforce steps it has taken, including: the Safe Reduction Workgroup and Permanency Roundtables.

- 5) **Accountability.** With regard to basic data holdings and accountability mechanisms, we think the Department can (1) improve the quality of the data it collects and (2) learn to generate evidence from the data it produces. Data collected at investigations is incomplete, a problem that has been compounded by the overwhelming number of investigations to be completed, and data collected at other points in the process is not always recorded accurately. Under new leadership, the Chief Quality Improvement Officer has begun the installation of a CQI structure and has aligned functions within the structure. Middle management of the agency understands that CQI processes and structures only work if paired with a CQI-oriented culture. While they may not have all the data they need, the Department can make better use of what is available.

Recommendation: Refine and build on current improvements so that the CFSR, OAG reports, and Department-generated reports provide useful information at regular intervals. Build upon existing CQI capacity by developing enhanced reports (data presented herein can provide a beginning template) and producing them regularly to inform ongoing improvements. Develop baselines and targets for key outcomes to focus attention on improvement in the areas identified, and key reporting metrics to these outcomes. Content and frequency of reports should be refined, and transparency enhanced by developing a regular schedule of reports for use by internal and external stakeholders, allowing the federal CFSR, OAG reports, and Department-generated reports to provide useful information at regular intervals. With respect to outside reviews, integrating the CFSR and OAG oversight with a rigorous, well supported CQI process ought to provide the transparency stakeholders need in order to rebuild trust. The CQI structure can be mobilized to improve data compliance by providing regular internal submission reports to staff so that they can see whether the data reflect their work, and correct it accordingly. Additional assessment tools that collect data on child well-being should be incorporated so that this information can be a part of future reports.

- 6) **Evidence-Based Practices:** Systemic risk associated with the fact that evidence-based interventions cannot be installed in systems under high levels of stress. There are some evidence-based interventions the Department will have to take on because they will help reduce system instability. Nevertheless, with respect to improving services by installing evidence-based interventions, it will be some time before the system is ready to mount, at scale, a rich array of evidence-based interventions. This does NOT mean the Department should pull back from its efforts to do so. On the contrary, if over the next few years the system remains ill-prepared to mount evidence-based interventions it will be because the other systemic risks have yet to be resolved. In other words, it is the presence of other systemic risks limits the return on investment one would otherwise expect from at-scale implementation of evidence-based practices.

Recommendation: Develop partnerships with academic and other institutions to support the ongoing exploration, and then implementation, of evidence-based practices. The development of a Theory of Change, the refinement of Target Populations, the selection of Evidence-Based Practices, and the ongoing monitoring of the implementation of these practices will need to be informed by additional empirical data analyses, some of which may be beyond the Department's current capacity. These analyses would ideally be performed in

collaboration with an academic partner that can apply statistical expertise to understanding the needs of children at greatest risk for poor outcomes. Steps taken in this direction, as typified by the Department's work on the Title IV-E waiver, should be reinforced.

- 7) **Engagement:** Systemic risks are present within the Agency's relationship with stakeholders and other constituents. Generally, in our conversations with stakeholders during focus groups, were heard recurrent themes having to do with the basic mistrust, confusion, lack of transparency, and so on. In the survey of employees, respondents indicated low levels of meetings with experts from outside the organization and especially low levels of effort when it comes to meeting with and learning from service recipients. Closer connection to stakeholders lends legitimacy to the organization as it manages the difficult work of child protection. When transparency is low, frustration gives way to anger, especially during times of strain on the system.

Recommendation: Develop the infrastructure to promote regular communication and engagement of stakeholders among the foster parent, birth parent, foster youth, and advocacy communities that involve regular meetings, communication strategies (regular reporting or newsletters) and forums for the exchange of ideas.

- 8) **Collaboration with Law Enforcement:** Systemic risks are tied to the overlay of child protection with law enforcement. There are risks associated with using law enforcement officers for the routine investigation of parental behavior in alleged child abuse and neglect cases. In our conversations, advocates, lawyers, and judges highlighted these. First, across the range of parental behavior needing the Department's attention, a relatively small proportion falls within the narrow band of what might be called criminal behavior. In those few cases, the path forward from a public accountability perspective is clear. However, for the vast majority of other cases, parental behavior falls far short of criminal behavior yet the Department has an obligation to serve those families. In those cases clarity of purpose equal to but different from cases of egregious criminal behavior have to be present in the ways the Department serves those families. The different approaches pinpoint the vast cultural differences in how the work is approached. For the child welfare system and the people who are drawn to its work, balancing the rights of parents with the needs of children has more salience. In the criminal context, the presence of law enforcement officers in courtrooms imparts the family court processes with criminal implications. To avoid incriminating themselves, parents are often advised by attorneys to avoid acknowledging their needs or deficits. In doing so, there is a risk of losing the fundamental prospect of rehabilitation that is at the heart of child welfare policy aimed at getting parents back on their feet.

Recommendation: Because criminal behavior requires a criminal justice response, close collaboration requires a thoughtful and strategic approach, so that the involvement of law enforcement can be (1) targeted toward the highest risk situations in which criminal wrongdoing is a concern; (2) informed and sensitive to the impact of trauma and the manner in which cases should be handled to minimize further trauma; and (3) employed in a way that incentives are aligned to identify family needs without criminalizing parents in need of assistance.

Ongoing Evaluation

Once strategies are implemented, focused evaluations may assess the effectiveness of strategies for stabilizing or reducing the growth trends in the current system. A subsequent evaluation to

monitor the implementation of the recommendations highlighted here would inform the stakeholder community of the Department's progress. Ongoing monitoring of the attorney caseloads, as well as the timely and accurate submission of information to the courts, should supplement evaluations of the Department itself. Between the monitoring performed for the CFSR, the support for the Waiver Demonstration project performed by academic partners at Arizona State University, the Department's own quality assurance and CQI capacity, and the Office of the Auditor General, local capacity should be leveraged to provide informed and coordinated evaluation strategies.

Appendix A: Study Design

The RFP sought guidance in three main areas: safety, permanency, and accountability. We were left to articulate an approach, which we outlined in our response to the RFP. Specifically, we used the IOM framework to focus on core functions with specific reference to basic processes, quality standards, and capacity. Our efforts to identify gaps in the current system are captured in the table below.

Appendix Table A.1: Study Design

Core functions/services	Data Gathered	Data Source
Safety	Key services are investigations and prevention services	
<u>Investigations</u>		
Process	What is the process of case disposition within the investigatory process?	Document review and stakeholder interviews
Capacity	How many caseworkers are there?	Official reports, stakeholder interviews
Quality	Is there a validated Safety/Risk Assessment?	Document review and stakeholder interviews
<u>Prevention</u>		
Process	What about referrals to In-Home Services?	Stakeholder interviews
Capacity	What about the supply of services?	Stakeholder interviews, survey responses
Quality	Are EBPs in use?	Document review, stakeholder interviews, survey responses
Placement	Key services are permanency related	
<u>Courts</u>		
Process	Movement of information is satisfactory?	Stakeholder interviews/document review
Capacity	Are parental right observed?	Stakeholder interviews
Quality	Are there special services in place?	Stakeholder interviews
<u>Private Providers</u>		
Process	Are performance-based Contracts used?	Stakeholder interviews, official documents
Accountability	Key services support a viable CQI process	
<u>Data & Evidence</u>		
Process	Is there routine production of reports	Stakeholder interviews, official documents
Capacity	What is the staffing pattern	Stakeholder interviews, official documents
Quality	Is there access to data	Stakeholder interviews, official documents
<u>CQI</u>		
Process	Is there and identifiable CQI process	Stakeholder interviews, official documents
Capacity	Is there dedicated staff and infrastructure	Stakeholder interviews, official documents
Quality	Is there training on use of use evidence	Stakeholder interviews, official documents,

Appendix B: Evidence-based, Evidence Informed, and Best Practices

Appendix Table B.1: Evidence-based and Informed Practices

Promising Research Evidence	Supported by Research Evidence	Well-Supported by Research Evidence
<ul style="list-style-type: none"> • Nurturing Parenting Program • Parents as Teachers • Parent Child Assistance Program • Sobriety Treatment and Recovery Teams • Strengthening Families • Wraparound • Circle of Security • Cognitive Behavioral Intervention for Trauma in Schools • Family Connections • Project KEEP • Parents as Partners • Project Connect • Family Finding • Family Group Decision Making 	<ul style="list-style-type: none"> • Functional Family Therapy • Healthy Families America • Homebuilders • SafeCare • Brief Strategic Family Therapy • Child-Parent Psychotherapy • Matrix Model Intensive Outpatient Program • Parenting with Love and Limits 	<ul style="list-style-type: none"> • Cognitive Behavioral Treatment • Trauma-focused Cognitive Behavioral Treatment • Incredible Years • Nurse Family Partnership • Parent Child Interaction Therapy • Multi-dimensional Family Therapy • Multi-dimensional Treatment Foster Care • Multi-systemic Therapy • Parent Management Training – Oregon Model • Triple P • Coping Cat • Eye Movement Desensitization and Preprocessing • Motivational Interviewing

(All can be found in the [California Evidence-based Clearinghouse for Child Welfare](#))

Best Practice Approaches

Practices for Reducing Length of Stay:

Subsidized Guardianship

<http://www.grandfamilies.org/SubsidizedGuardianship/SubsidizedGuardianshipSummaryAnalysis.aspx>)

Performance Based Contracting

https://fcda.chapinhall.org/wp-content/uploads/2012/10/2012_TN-PBC-case-hx2.pdf

Practices to Improve Legal Representation

Court Improvement Programs, Legal Representation for Children, and Court Teams for Infants and Toddlers (Best for Babies and Cradles to Crayons)

http://dcf.wisconsin.gov/children/foster/nga/pdf/summary_report.pdf.

<https://www.nycourts.gov/ip/cwcip/Publications/2013NYSCWCIPMetrics.pdf>

Practices for Reducing Admissions

Standardized Decision-Making Protocols

<http://nrccps.org/information-dissemination/1249-2/>

The Child Endangerment Risk Assessment Protocol in Illinois furthers the assessment approach by including the development of a safety protection plan:

http://cfr.illinois.edu/pubs/rp_20010401_IllinoisCERAPImplementationEvaluationFY2001.pdf

Alternative Response

<http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/DR/qicdr/Documents/DR%20Map.pdf>

<http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/pediatrics/subs/can/QIC-DR/Documents/Final%20Cross%20Site%20Evaluation%20Report.pdf>

Practices to Improve Quality of Care

Team-based Decision-making at Critical Decision Points

<http://www.azdhs.gov/bhs/guidance/cft.pdf>

Continuous Quality Improvement

<http://www.chapinhall.org/research/report/principles-language-and-share-meaning-toward-common-understanding-cqi-child-welfare;>

<http://www.nrcpfc.org/downloads/wu/ACYF-CB-IM-12-07.pdf>

Appendix C: Frameworks

The IOM and CQI Frameworks

As articulated in our response to the RFP, we sought to understand the Arizona child welfare system in light of two best practice approaches: the systems framework advanced by the Institute of Medicine (IOM) in its report *New Directions in Child Abuse and Neglect Research* (IOM (Institute of Medicine) and NRC (National Research Council), 2014) and Continuous Quality Improvement (CQI) (O'Brien et al., 1995; RWJF, n.d.; Wulczyn et al., 2014). We explain how we use both frameworks below.

IOM Framework

The IOM framework views the work of systems through functions, structures, and capacities. System *functions* are generally thought of as organized activities that promote the achievement of system goals. With specific respect to child protection systems, system *functions* have been described as falling into one of two categories: those related to case decision-making (e.g., assessments, gate-keeping, investigation, placement, etc.) and those designed to support system performance (e.g., capacity building, research and evaluation, allocation of resources, cross-sector coordination, etc. Although child protection systems typically serve a wide variety of functions, the effective and efficient operation of the system hinges, at least in part, on a clear statement of how functions and systems are related.

Capacity refers to the facilities, material resources, skilled personnel, and funding needed to operate the system. These capacities have to be allocated in relation to the purpose of the system. One important capacity is decision-making. At an organizational level, decision-making is used to allocate capacity to meet the purpose of the system. Procurement of capacity is another important aspect of what an organization has to do. Structures and capacity for monitoring, management, and decision-making are especially critical, particularly in view of the need to interact with and adapt to the operating context. Arguably, the extent to which a system is able to achieve its goals is more heavily dependent on capacity than any other factor.

Appendix Table C.1: Basic System Components
(adapted from the Institute of Medicine)

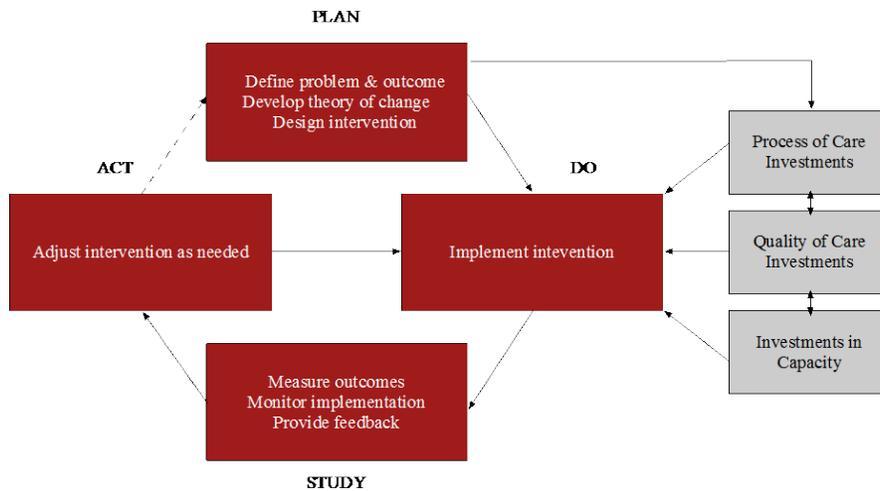
System Components	Component Detail
<u>Structures</u>	
Relationships between system components and actors	<ul style="list-style-type: none"> • Structure refers to the relationships between component parts of the system. Courts, the private sector, and other state agencies and their relationship with the Department of Child Safety reveal the system’s structure.
<u>Functions</u>	
Governance	<ul style="list-style-type: none"> • Child protection systems are organized to meet goals established by stakeholders. Governance of the systems is the process by which those goals and corresponding means are aligned. Management compels the use of resources toward the established ends; enforcement addresses fidelity to the manner in and ends to which resources are allocated. • Governance refers to the manner in which system goals are defined. Within the context of governance, leaders of the system articulate the means and ends towards which the agency is oriented.
Management	<ul style="list-style-type: none"> • Management refers to basic operations of the Department including the deployment of resources toward the purposes of the agency.
Enforcement	<ul style="list-style-type: none"> • Enforcement refers to the agency’s ability to compel compliance with the rules and regulations established in accordance with the goals of the agency.
<u>Capacity</u>	
Human resources/capital	<ul style="list-style-type: none"> • Capacity refers to the resources needed within the agency to carry out the core responsibilities. • Human resources include the workforce and their fundamental abilities (i.e., skills) to carry out the work.
Funding	<ul style="list-style-type: none"> • Funding is a basic measure of how much financial support the agency receives, given its primary goals. Funding supports basic functions such as investigations, services, and accountability.
Infrastructure	<ul style="list-style-type: none"> • Infrastructure refers to all other forms of capacity including buildings, technology, administrative support, transportation, and basic office supplies.
<u>Continuum of Care</u>	
Promotion	<ul style="list-style-type: none"> • To meet the goals of the new system – protect children and preserve families – an agency needs a continuum of care. Each part of the continuum has embedded within it sub-continua that address the unique challenges facing families with children and the range of needs presented. • Promotion refers to those services and other activities the Department takes on to promote the well-being of the general population. In public health terms, promotion refers to primary prevention.
Prevention	<ul style="list-style-type: none"> • Preventative services are those services that strengthen families

System Components	Component Detail
Placement and other treatment related services	<p>and their ability to raise children safely so that further involvement is unnecessary. Although the array of services that fulfill the prevention mandate is quite diverse, the services generally target at-risk families. Generally speaking, at-risk families are families that have been referred to the child welfare system through the reporting process, although families may seek services voluntarily.</p> <ul style="list-style-type: none"> • When families find themselves unable to fulfill their basic responsibilities, the state provides out-of-home care. Out-of-home care takes various forms including foster and kinship family homes, shelter care, group care, and residential care. Treatment services may fall along other points of the continuum, such as substance abuse treatment intended to prevent a child from coming into care.
<u>Process of Care</u>	<ul style="list-style-type: none"> • The continuum of care describes the services available; the process of care describes the steps taken when children and families are connected to services. • The process of care establishes how incoming reports are handled, when and how reports are investigated, how assessments are conducted, how treatment decisions are made, how referrals are processed, how treatment is delivered, and how follow-up is conducted. Where the processes involve protocols that guide what people do, the quality of service provided is tied to protocol fidelity.
<u>Accountability</u>	<ul style="list-style-type: none"> • Accountability mechanisms are the means by which the agency seeks to understand whether the goals set by governing bodies are being met. • Accountability is not possible without data. Data come in a variety of forms including both quantitative and qualitative. Data are gathered via electronic records systems, qualitative record reviews, and other means. For data to be useful, it must be accurate and pertinent to the question at hand. Increasingly, there are <i>best practices</i> that govern how data are acquired/generated, processed, and then used. • Quality refers to how well the agency performs its basic functions, with particular reference to the continuum of care and the process of care. Standards are benchmarks against which the system judges itself. Increasingly quality is defined by whether agencies are invested in evidence-based interventions. Standards are also expressed in policy, regulation, and best practices. • To be useful, accountability processes have to make meaning of the data collected. The meaning made has to be communicated internally so that adjustment to the continuum of care, the process of care, and the capacity to deliver care might be made. In time, the meaning made has to be communicated to external stakeholders so that governing bodies can take stock of how well the system is doing relative to the goals.
Data collection	
Quality standards	
Research, analysis, communication	

Continuous Quality Improvement (CQI)

To organize how we understand the changes underway, we draw on the Continuous Quality Improvement (CQI) framework that is increasingly relevant to the way human services are managed.¹⁴ At its core, CQI is a cyclical process of problem-solving activities that requires the deliberate use of evidence. The cycle has stages during which various analytic and decision-making tasks are executed: identify the problem; hypothesize as to its cause; develop, implement, and test a solution; and make decisions about future investments based on the results of those tests. CQI has been applied formally across fields for nearly a century. As a result, a number of different models exist that describe the process.¹⁵ All of them, however, involve a cycle that contains four fundamental phases: Plan, Do, Study, and Act (PDSA). Figure 1 below illustrates how these phases unfold within the child welfare context, with investments in process, quality of care, and capacity occurring during the “Do” phase.

Appendix Figure C.1: The Continuous Quality Improvement Cycle¹⁶



Appendix Table C.2 outlines how we used the basic CQI cycle to organize our data collection. In essence, we were interested in understanding the Theory of Change that has emerged during the PLAN phase. The Theory of Change articulates the investments Arizona was prepared to make

¹⁴ Alexander, J. A., & Hearld, L. R. (2011). The science of quality improvement implementation: developing capacity to make a difference. *Medical Care*, 49 Suppl, S6–20. Berwick, D. M. (2008). The science of improvement. *JAMA: the Journal of the American Medical Association*, 299, 1182–1184.

¹⁵ e.g., Pyzdek, T., & Keller, P. A. (2003). *The Six Sigma handbook: A complete guide for green belts, black belts, and managers at all levels*. New York: McGraw-Hill; Rubin, J. (2009). Front-line Practice: Define, Assess, Plan, Implement and Monitor. *Policy & Practice*, December 2009, 11-13.

¹⁶ Chapin Hall at the University of Chicago, The Center for State Child Welfare Data. (2014). The Four Phases of the CQI Process. Retrieved from: <https://fcd.chapinhall.org/>.

in its efforts to address the challenges facing the state. In other words, Arizona recognized that the system was not functioning in the way that it should. As a result, changes were made in attempt to address those problems. The Theory of Change simply tells the story of how and why the changes made were intended to address the identified problems.

Appendix Table C.2: The CQI Process¹⁷

CQI Process	What happens during this CQI phase?
Plan	The CQI cycle begins when the agency defines the problem it wishes to solve, usually by observing performance on an outcome of interest. Next, the agency identifies an intervention that is expected to improve that outcome. The intervention should (must) be grounded in a <i>Theory of Change</i> that addresses the causes driving performance and clarifies the mechanisms by which the intervention is expected to improve the outcome.
Do	To change outcomes, the agency has to invest in three major areas: the process of care, the quality of care and the capacity needed to deliver care. Changes to <i>process, quality and capacity</i> are linked closely to the Theory of Change.
Study	As change unfolds, the agency monitors the extent to which the interventions are being implemented. After an established period of time, the agency measures the outcomes of interest to determine whether the interventions are having their intended effect.
Act	The Act phase is when decisions about future investments are made. For example, to what extent do performance problem persist? Does progress toward the target outcome support the Theory of Change? Are adjustments to the intervention (i.e., the agency's process, quality, and capacity investments) required?

¹⁷ Chapin Hall at the University of Chicago, The Center for State Child Welfare Data. (2014). The Four Phases of the CQI Process. Retrieved from: <https://fcda.chapinhall.org/>

Appendix D: Crosswalk/Index to RFP Work Statement

Chapin Hall Center for Children at the University of Chicago (Chapin Hall) was asked to examine the current child safety system and consider best practices to improve the delivery of child welfare services in Arizona. In addition, Chapin Hall was to provide consultation on the effective establishment of the Department of Child Safety (DCS) with a focus on implementation challenges. Following is a summary of the five specific areas Chapin Hall was directed to review and their findings and recommendations in each of these five areas. More detailed information on each of these five areas can be found in the body of the report on the referenced pages.

1. Prepare a risk assessment of key services, rank and prioritize where improvements are most needed/critical, and how this risk assessment can be used going forward.

What are the key services DCS provides?

DCS provides services in the following three functional areas:

- Safety
- Placement
- Accountability

Within each of the above areas, the services Chapin Hall evaluated include:

Safety

- Front door processes (i.e., hotline screening, safety and risk assessment, investigations)
- Preventive services (i.e., in-home services aimed at strengthening families to prevent child removals)
- Pathways/continuum of care (i.e., service referrals at all levels of intensity appropriate to level of risk)

Placement

- Permanency services (i.e., services designed to facilitate case resolution and permanent outcomes such as adoption or reunification)
- Evidence-based interventions (i.e., services with research evidence of the production of specific outcomes)
- Court processes (i.e., judicial decision-making about case milestones and outcomes)

Accountability

- Capacity to generate evidence (i.e., data on effectiveness of services for addressing child or family needs)
- Capacity for evidence use (i.e., decision-making based on the results of data analyses)
- Stakeholder engagement (i.e., communication and relationships with youth, families, and other system participants)

See pages 20 through 43 for additional information.

What is the risk level associated with each service, where are improvements in services most needed/critical, and what steps can DCS take to improve these services?

Service areas presenting a *high* degree of risk:

- Safety
 1. Front door processes
 - Arizona lacks a clear, standardized, data-driven approach to front-end decision-making, (e.g., whether or not to remove a child).
 2. Preventive services
 - There is an inadequate array of interventions for families known to DCS and at risk of having a child removed from the home, and few of the services available are evidence-based.
 3. Pathways/continuum of care
 - Pathways/continuum of care are not well connected to child and family needs, and the pathways are not well mapped with clear designations for professional roles and case transitions.
 - The current backlog of inactive cases represents a high risk for the Department.
- Placement
 4. Permanency services
 - Attention is focused on the system's front door at the expense of a focus on promoting and facilitating permanency for the growing number of children now in state custody.
 5. Evidence-based interventions
 - There is development work needed to identify Theories of Change and target populations (i.e., groups that will receive the interventions) that will guide the selection of evidence based practices (EBPs). Infrastructure and additional implementation supports, such as commitment from leadership at multiple levels, equipped implementation teams, staff training, ongoing coaching and mentoring, and supportive data systems will be needed to promote the use of evidence-based interventions designed to reduce length of stay in foster care and increase permanency.

- Court processes
 6. The judicial process provides basic protections to both children and families but lack of adequate representation, due to high attorney caseloads, and lack of timely information sharing by the Department hinders this process.
- Stakeholder engagement
 7. Stakeholder trust in the Department has been shaken by a growing awareness of areas of risk (i.e., increasing numbers of children in care, the backlog of inactive cases, etc.), as well as some failures of accountability. According to survey responses, the Department lacks clear mechanisms for bringing service recipients and other stakeholders into their feedback processes.

Service areas presenting a low to moderate degree of risk:

- Accountability
 8. Capacity to generate evidence
 - Arizona has substantial Continuous Quality Improvement (CQI) capacity in that the state can generate the evidence needed to make basic improvements, but this information needs to be integrated into the processes of providing care to children and families. For example, reports related to the achievement of child safety, permanency, and well-being outcomes and associated process measures (e.g. frequency of caseworker visits, sibling visits, parent/child visits) for children in their area of responsibility should be made available at regular intervals and used to help inform the continuous improvement of practice of staff at all levels (e.g., caseworkers, supervisors, program directors).
 9. Capacity for evidence use
 - The Department lacks, but is developing, processes for incorporating evidence into decision-making and service provision. In other words, staff at all levels need to know how to understand and make appropriate use of the data contained in the reports they receive in order to make decisions.

In order of priority, recommendations for addressing areas of risk are listed below.

- Establish clear safety assessment protocols and better standardize processes at the hotline and investigations.
- Address the needs of the growing number of children in substitute care, and the backlog of cases, by reducing entries and decreasing time until permanency.
- Continue to increase the size of the work force to bring staffing back to pre-2009 levels, as a stable, competent workforce of an appropriate size is necessary to address all service areas and ensure the Department has the capacity to function effectively.

- Increase the use of in-home services that can stabilize families, treat service needs of parents, and prevent admissions into foster care.
- Develop the infrastructure to promote regular communication and engagement of stakeholders among the foster parent, birth parent, foster youth, and advocacy communities.
- Develop partnerships with academic and other institutions to support the ongoing exploration, and then implementation, of evidence-based practices.
- Build upon existing CQI capacity by developing enhanced reports (data presented herein can provide a beginning template), producing them regularly, sharing them with relevant leadership and staff to make meaning, and creating continuous quality improvement cycles.
- Develop strategies in collaboration with county courts to both increase the number of attorneys and examine the payment strategies (ensuring they do not conflict with the best interests of the children involved) and improve legal representation.
- Develop close collaborations with law enforcement to encourage identification of high-risk targets, employment of trauma-informed approaches, and alignment of incentives.

See pages 20 through 43 and pages 44 through 47 for additional information.

How can this risk assessment be used by DCS to help it improve most needed/critical services and ensure the effective establishment of the DCS?

The following recommendations, listed in order of priority, reflect the areas of risk identified in the report.

- Establish clear safety assessment protocols and better standardize processes at the hotline and investigations.

Examine available child safety risk assessment protocols and consider reverting back to the standardized form that was previously in use OR implement a new, standardized safety assessment protocol selected from one of the many models in place in other jurisdictions. The safety assessment selected should include standardized items, yield quantifiable data, and direct decisions clearly and transparently. Workers and supervisors should receive significant training, supervision, mentoring and oversight during its implementation to ensure that the protocol is being administered with fidelity and that the results of the assessment are being used to inform decision-making.

- Address the needs of the growing number of children in substitute care, and the backlog of cases, by reducing entries and decreasing time until permanency. This will involve:

Taking a broader view of the Department's function, from one that addresses child safety (with hotline calls and investigations) to one that is responsible for the full continuum of services that are delivered in the context of child welfare,

including prevention, in-home services, investigations, placement, monitoring, permanency, and post-permanency services. Use of the Institute of Medicine (IOM) framework for delineating the functions and structures in the system will be helpful in developing a better understanding of how these system components will work together.

Developing a Theory of Change that identifies key target outcomes (e.g., reduction in time to permanency achievement), the levers that are needed to achieve them, and the strategies that are likely to be effective (see Recommendation #5 below).

Implementing Evidence-Based Practices. To that end, we recommend supporting the current process underway at the Department and with stakeholders to explore Positive Parenting Program (Triple P), an evidence-based program. If chosen, it will be important to develop a Theory of Change that clarifies where, with whom, and to what end it is deployed to reduce new entrants, reduce length of time in substitute care, or both. Also underway at DCS is the exploration of evidence-based practices to reduce the use of congregate care as part of the federal Child Welfare Waiver Demonstration Project.¹⁸ Linking or framing this work as an effort to both reduce the use of congregate care and reduce the length of stay in foster care/increase permanency will be important as the Theory of Change for this effort is refined. We would also recommend continuing to support and perhaps bolstering the implementation of Healthy Families Arizona, which has demonstrated positive preliminary results in Arizona. Strategic expansion of this program, aimed at targeting families at greatest risk, could further help to stem the tide of new cases coming into care.

Providing sufficient resources to address the backlog of inactive cases. The backlog of inactive cases developed and continues to grow due to a variety of factors across the continuum of care, such as insufficient staff for the number of cases and inadequate attention to achieving timely permanency for children in foster care. Consequently, multiple strategies, many of which are noted here, such as increasing the size of the workforce, establishing clear decision making protocols, and using data and evidence for decision making, will be needed to reduce the backlog and restore confidence in the Department.

- Continue to increase the size of the work force to bring staffing back to pre-2009 levels.

While resources have been allocated to increasing the work force, there have been barriers to expanding capacity, including the time it takes to adequately train new staff, delays in hiring, and high rates of turnover. Ideal caseload sizes should be calculated (using the information provided in this report and other jurisdictions as a reference point) and funding should aim to stabilize caseload sizes for both investigations and placement workers at levels that will allow

¹⁸ The Child Welfare Demonstration Project is designed by the US Department of Health and Human Services to increase flexibility in spending federal funds under titles IV-B and IV-E in order to safely reduce the number of children in foster care and improve child well-being. Additional information on Arizona's Waiver Project may be found in the Report on pages 34 through 36 and page 42.

adequate attention to the needs of families, including sibling and parent visitation (which is now occurring at rates far below those specified in policy).

- Increase the use of in-home services to prevent the entry of children into foster care.

Stakeholders from the leadership level to front-line staff indicated that very limited services are available to families who come to the attention of the Department and are at risk of having their children removed. Family needs must be severe to trigger services to prevent removal, and the available services have limited capacity and long waiting lists. Increasing capacity of existing in-home services, expanding the range of offered and available services, streamlining pathways for referral and receipt of services to prevent removal, and clearly articulating eligibility criteria will be important to address this deficit.

- Develop the infrastructure to promote regular communication and engagement of stakeholders among the foster parent, birth parent, foster youth, and advocacy communities.

Develop the infrastructure to promote regular communication and engagement of stakeholders among the foster parent, birth parent, foster youth, and advocacy communities that involve regular meetings, communication strategies (regular reporting or newsletters) and forums for the exchange of ideas.

- Continue developing partnerships with academic and other institutions to support the ongoing exploration, and then implementation, of evidence-based practices.

The development of a Theory of Change, the refinement of Target Populations, the selection of Evidence-Based Practices, and the ongoing monitoring of the implementation of these practices will need to be informed by additional empirical data analyses, some of which may be beyond the Department's current capacity. These analyses would ideally be performed in collaboration with an academic partner (e.g., Arizona State University) that can apply statistical expertise to understanding the needs of children at greatest risk for poor outcomes.

- Build upon existing CQI capacity by developing enhanced reports (see Work Plan Item #3 below), producing them regularly and sharing them with relevant leadership and staff to inform ongoing improvements.

Develop baselines and targets for key outcomes to focus attention on improvement in the areas identified and on key reporting metrics to these outcomes. Content and frequency of reports should be refined, and transparency enhanced by developing a regular schedule of reports for use and tracking by internal and external stakeholders. The federal Child and Family Service Reviews (CFSR), Office of the Auditor General (OAG) reports, and Department-generated reports, which can be informed by and modeled on the analyses conducted by Chapin Hall as part of this review, can provide useful information at regular intervals. With respect to outside reviews, integrating the CFSR and OAG oversight with a rigorous, well supported, and internally-driven CQI

process ought to provide the transparency stakeholders need in order to rebuild trust.

The Department should also ensure that leadership at multiple levels have the capacity to understand and use data to inform decision making and provide learning opportunities to strengthen this capacity as needed.

- Develop strategies in collaboration with county courts to:

Increase the number of attorneys,

Examine the payment strategies to re-align incentives and improve legal representation, and

Improve timely information sharing with the courts and representing attorneys so that informed decision-making can take place on behalf of children and families.

This work will likely require both evaluation and engagement efforts targeted at understanding court practice and policies at the local level and monitoring key indicators (e.g., attorney caseloads, timeliness of information) to document improvements. Additionally, increasing the DCS workforce to stabilize caseloads would allow for more time and attention to the important case management task of documentation and information sharing within the judicial process.

- Develop close collaborations with law enforcement to encourage identification of high-risk targets, employment of trauma-informed approaches, and alignment of incentives.

Because criminal behavior requires a criminal justice response, close collaboration requires a thoughtful and strategic approach, so that the involvement of law enforcement can be (1) targeted toward the highest risk situations in which criminal wrongdoing is a concern; (2) informed and sensitive to the impact of trauma and the manner in which cases should be handled to minimize further trauma; and (3) employed in a way that incentives are aligned to identify family needs without criminalizing parents in need of assistance.

Further information and detail regarding the above recommendations may be found in the full report under “Summary and Recommendations” (p. 43 - 48).

What implementation challenges does DCS face?

- The complexity and inter-relatedness of the recommendations themselves create implementation challenges for the Department. Two specific potential barriers include:

Mistrust may make buy-in for innovation or new initiatives difficult, and will require the Department to develop clear communication with stakeholders and system staff and to persevere despite initial implementation challenges.

The volume of cases now in the custody of the Department creates capacity challenges, as the work associated with serving these cases must continue while

new strategies are implemented to address their needs *and* improve front-door processes. This requires that both the quantity and quality (competency) of the work force be restored to levels appropriate to the current caseload.

2. Evaluate strategic direction for child safety and protocols for services.

Is DCS's current strategic direction evidence-based and best practice and does it ensure child safety?

No. As noted previously, there are no standardized protocols in place at the hotline or during investigations to inform decision making. Having protocols in place is a best practice, and having best practices in place helps promote child safety.

Regarding the use of evidence based practices to promote child safety, Healthy Families Arizona is an evidence based primary prevention home visiting program in place across Arizona designed to reduce child maltreatment in at-risk families. Additionally, there are efforts underway within the Department and with multiple external stakeholders to explore Triple P. Triple P is a multi-level program that can be used for primary, secondary, or tertiary prevention of child maltreatment. The legislation requiring the establishment of the Department of Child Safety does not set forth as a vision or direction the use of evidence based practices. More can be done by the legislature and the Department to encourage, install, and implement evidence based practices. For example, providing a vision for the use of evidence based practices, increasing funding for EBPs, and partnering with agencies across the state to use EBPs to increase nurturing parenting practices and reduce maltreatment would be indicated.

See pages 31 through 43 for additional information.

Does DCS's current strategic direction establish appropriate evidence-based and best practice protocols for services after an investigation?

No. There are efforts underway within the department to explore, install, and implement evidence based practice to reduce the use of congregate care as part of the federal child welfare waiver demonstration project. As noted above, triple p, if chosen as an appropriate evidence based intervention, could be used to increase parenting capacity and decrease the risk of maltreatment after an investigation as part of a secondary or tertiary effort. The legislation requiring the establishment of the department of child safety does not set forth as a vision or direction the use of evidence based practices. More can be done by the legislature and the department to encourage, install, and implement evidence based practices. For example, providing a vision for the use of evidence based practices, increasing funding for EPBs, and partnering with agencies across the state to use ebbs to increase nurturing parenting practices and reduce maltreatment would be indicated. Evidence based practices to address substance abuse and mental health needs of parents along with ebbs to promote positive parenting would be indicated.

See pages 31 through 43 for additional information.

What implementation challenges are ahead of DCS?

Initial efforts to increase transparency and capacity will not be sufficient to reset the department's course. The narrow view of the system as a "child safety" system neglects many important functions necessary for youth to achieve positive outcomes as a result of

their involvement with the department, and will be a barrier to implementing broad systemic change.

The high volume of cases, inclusive of the number of cases that are unattended, creates implementation challenges for the department. Bringing a safety minded yet rationalized approach to reducing the number of children entering care, reducing length of stay in care, and increasing the number of children exiting care to their own homes or other positive permanency option are requisite for implementing broad systemic change and resetting the department's course.

See pages 6 through 14 for additional information.

What recommendations do you have to improve this area?

In order for best practice approaches to be identified and tested, a more comprehensive theory of change should be articulated that:

- Defines the entire child welfare system with its functions and purposes;
- Provides clarity in decision-making at key junctures;
- Incorporates evidence-based assessment approaches and services; and
- Identifies outcomes with specific and measurable targets.

Developing a theory of change to guide the new strategic direction will require (1) a data-driven examination of the risk factors for admission and length of time in foster care (2) consideration of the interventions that may address these risk factors (3) an inventory of the capacity to implement these interventions and (4) ongoing data monitoring of processes and outcomes.

Additionally, as mentioned above with regard to work statement #1, clear safety assessment protocols and better-standardized processes at the hotline and investigations need to be established.

See pages 33 through 43 for additional information.

3. Review DCS' accountability mechanisms. Evaluate the appropriateness and sufficiency of these accountability mechanisms, identify any implementation challenges associated with implementing these accountability mechanisms, and provide recommendations to improve each of the above areas, as necessary.

Does DCS have the capacity to produce accurate data on performance and outcome measures and is it using evidence-based and best practice measures? If not, what does it need to start doing in each area, what implementation challenges do you see in each area, and what recommendations do you have to improve its accountability mechanisms? (i.e. what does it have, what should it have?)

The Department does have the capacity to produce data that can inform the internal management and external monitoring of the system. However, while there have been some recent promising practices put in place at the leadership level, further work connecting these data with a rigorous CQI process for performance management,

compliance monitoring, or contract monitoring requires further attention. While several standard review mechanisms are intact and in place, these are not tightly aligned with outcomes for children, youth, and families. Information from case records is not being provided to the courts in a timely or comprehensive manner, which severely hampers both the quality of legal representation that children and families receive, as well as the courts' ability to make informed decisions that will promote the well-being of children in the department's care.

The Department might consider the development and use of a data dashboard that includes state performance on key outcome and process indicators relevant to child safety, permanency, and well-being. Decisions around which outcome and process indicators to include in the dashboard should be made in partnership with key internal and external stakeholders. The choice of outcome measures is dependent upon the changes undertaken as guided by the theory of change. Process measures should include fidelity to process, quality, and capacity guidelines. Performance on identified indicators should be measured carefully, monitored regularly (e.g., quarterly), and shared and discussed with leadership on an established basis (e.g., as part of regular meetings).

Best practice suggests that variation in observed outcomes (e.g., time to permanency achievement, re-entry rates) should be examined by population, child characteristics, and services received (e.g., age, kinship vs. Group care, urban vs. Rural areas). Reporting should emphasize process and outcome variation by administrative region and county and should highlight differences by age, service needs (to drive changes in resource availability) and services received (to understand the effectiveness of services).

See pages 15 through 16 and pages 25 through 31 for additional information.

Does DCS have accurate performance and outcome data (using evidence-based and best practice measures) to:

Ensure staff compliance with laws, regulations, and policies and procedures;

- No. Qualitative reviews may provide a limited view of the timeliness of responses in selected cases, but are not adequate in scope or representation to inform the Department on staff compliance across system functions.

See pages 29 through 30 for additional information.

Monitor contractors' and/or service providers' (including foster care providers) compliance with contract requirements and provisions, and laws and regulations;

- No. Department staff and leadership reported that data are not being used to monitor contract performance, and no performance-based contracting arrangements are currently in place.

See pages 26 through 28 for additional information.

Oversee legal counsel compliance with statutes, rules, and policies and procedures?

- No. The broadly reported failure of legal counsel compliance with statutes, rules, and policies suggest a lack of oversight in this area.

See pages 23 through 24 for additional information.

Implement mechanisms/tools or incentives/disincentives to address staff, contractor, service provider, and legal counsel noncompliance with laws, regulations, and policies and procedures?

- No. The Department does not appear to implement tools or incentives to address noncompliance, leaving problems to linger and intensify as caseloads continue to grow.

See pages 23 through 24 for additional information.

Do DCS accountability mechanisms:

Include processes for continuous quality review?

- Partially. The basic capacity for continuous quality review is in place. Reports cover a range of indicators but cross-sectional reporting strategies obscure the Department's ability to detect trends and changes over time. In addition, data contained in reports, if not incorporated into a narrative and a larger strategy to exploration and understand trends, do not become evidence on which decisions can be based.

See pages 26 through 28 for additional information.

Include mechanisms for qualitative review of system functioning?

- Partially. The Department has a process for qualitative case review and while one-on-one meetings and newsletters are reported to be helpful, more frequent production of reports integrating qualitative and quantitative data are hampered by capacity.

See pages 28 through 30 for additional information.

Assess outcomes for children, youth, and families?

- No. Qualitative reviews on small samples of cases incorporate some outcome measures, but these are not measured comprehensively for the broader population of children and families involved with the Department.

See pages 25 through 30 for additional information.

Include external oversight of the child safety system to help ensure laws and DCS policies are followed?

- No. With the exception of periodic audits by the Office of the Auditor General on particular practices or programs and the Federal Child and Family Services Review to assess compliance with federal laws and policies, there is not ongoing oversight to ensure compliance with state laws or agency policies.

See pages 25 through 30 for additional information.

Ensure all parties involved in the child welfare system:

Provide accurate and timely information to the courts?

- No. Accurate and timely information is not being provided to the courts, and there are currently not protocols in place to address problems in this area.

See pages 23 through 25 for additional information.

Ensure compliance with court orders and address noncompliance with these requirements?

- No. There are currently no mechanisms in place to address noncompliance with court orders.

See pages 23 through 25 for additional information.

Ensure parental rights and involvement in the child welfare system?

- No. There are not currently mechanisms in place to ensure that parental rights are not violated.

See pages 23 through 25 for additional information.

4. Evaluate the DCS' strategies for community engagement, including engagement with families, youth, and service providers including foster-care providers, and child welfare advocates. Comment on any implementation challenges and, as necessary, make recommendations to improve this area.

Systemic risks are present within the Agency's relationship with stakeholders and other constituents. Generally, in conversations with stakeholders during focus groups, recurrent themes were basic mistrust, confusion and lack of transparency. In the survey of employees, respondents indicated infrequent meetings with experts from outside the Department and especially low levels of meeting with and learning from service recipients. Closer connection to stakeholders lends legitimacy to the organization as it manages the difficult work of child protection. When transparency is low, frustration gives way to anger, especially during times of strain on the system.

Recommendations include:

- Development of the infrastructure to promote regular communication and engagement of stakeholders among the foster parent, birth parent, foster youth, and advocacy communities that involve regular meetings;
- Development of communication strategies (regular reporting or newsletters) and forums for the exchange of ideas; and
- Ensure regular child and family team meetings are occurring as part of routine case management practice.

See pages 21 through 28, 31, 42 through 43, and 47 for additional information.

Are DCS' strategies effective in engaging families? If not, what recommendations do you have for improving this area?

No. Families should be engaged through a variety of strategies, at the system and case level. For example:

- Efforts should be made to identify and engage family members who might be resources for family stabilization.
- Efforts should be made to inform and engage families through public relations campaigns that make families aware of preventive strategies and initiatives that may be available to them to provide needed support.
- All system actors should be made aware of and able to articulate the rights of biological and foster parents and foster youth, and communication about these rights with families should be part of regular practice.

See pages 21 through 28, 31, 42 through 43, and 47 for additional information.

Are DCS' strategies effective in engaging youth? If not, what recommendations do you have for improving this area?

No. Youth we spoke with reported feeling alienated and misjudged by a system that was not prioritizing their needs, respecting their rights, or acknowledging the impact of trauma on their lives. Efforts to improve this area might include:

- Improving trauma awareness among investigative workers who oversee the removal of children from their homes, as well as other staff and foster parents who come into contact with children.
- Efforts to improve sibling visitation among youth placed in foster care.
- Initiatives aimed at stabilizing school placements to avoid school disruption associated with foster care placement.

See pages 21 through 28, 31, 42 through 43, and 47 for additional information.

Are DCS' strategies effective in engaging service providers, including foster care providers? If not, what recommendations do you have for improving this area?

No. While the department engages providers through contractual arrangements, more work is needed to collaboratively address the challenges facing the entire child welfare system. Strategies might include:

- Intentionally seek service provider input, including foster parents, by providing regular opportunities for them to receive updates about the Department's

performance and provide their feedback on areas of strengths and challenges as relevant to their role in the child welfare case process.

- Include service providers, foster parents, and other relevant community stakeholders and advocates on CQI committees or implementation teams for evidence-based interventions or other performance improvement strategies.

See pages 21 through 28, 31, 42 through 43, and 47 for additional information.

Are DCS' strategies effective in engaging child welfare advocates? If not, what recommendations do you have for improving this area?

No. The advocacy community's trust in the Department has been shaken, so many groups that might in other circumstances work more collaboratively with the Department are now operating as "watchdogs," placing additional demands on the Department by requiring extensive data reports. Transparency, engagement, and accountability will improve outcomes but the approach taken with stakeholders must be strategic. Specific steps include the recommendations mentioned previously: build a rigorous CQI process that uses evidence to shape consensus, to establish system goals, and to monitor progress. These steps ought to link directly with periodic performance monitoring processes already in use and those developed by the Department going forward. To begin the process, the Department could, if it has not already started, conduct town hall-type meetings with stakeholders around the state. These meetings should begin with a "State of Child Protection" report so that each stakeholder group is working with a common understanding of the issues facing the Department.

See pages 21 through 28, 31, 42 through 43, and 47 for additional information.

5. Determine the need for and frequency of regular, periodic performance evaluations and identify recommended areas for future reviews of the DCS by an independent outside evaluator.

Is there a need for regular, periodic performance evaluations by an independent outside evaluator?

Yes. Periodic performance evaluations are necessary, but not necessarily by an external evaluator, and could be performed collaboratively with the department's CQI infrastructure. Evaluations should investigate:

- The needs and characteristics of children in foster care to assist in identifying appropriate Evidence-Based Practices to improve permanency outcomes;
- The effectiveness of changes to front-end processes on removal rates;
- The effectiveness of changes to front-end and other decision-making processes for providing service referrals; and
- The effectiveness of strategies for stabilizing or reducing growth trends in the current system;

- Attorney caseloads, and the timely and accurate submission of information to the courts.
- See page 46 for additional information.

If so, how frequently should these periodic performance evaluations occur?

Evaluations of outcomes in the designated areas should occur at least annually, and not necessarily by outside evaluators. Best practice would suggest that the timing of evaluations should occur in line with the changes being implemented. Reviews and analyses to facilitate strategic direction should occur as needed and in collaboration with the department's CQI infrastructure.

See page 46 for additional information.

What specific areas do you recommend these performance evaluations review?

To inform the external review process, it is recommended that the department develop baselines and targets for key outcomes to focus attention on improvement in the areas identified, and key reporting metrics to these outcomes. Content and frequency of reports should be refined, and transparency enhanced, by developing a regular schedule of reports for use by internal and external stakeholders, allowing the CFSR, OAG reports, and department-generated reports to provide useful information at regular intervals. With respect to outside reviews, integrating the CFSR and OAG oversight with a rigorous, well supported CQI process ought to provide the transparency stakeholders need in order to rebuild trust.

Based on the areas identified in the risk assessment portion of the review and in alignment with the CFSR, future performance evaluations should focus on key indicators for child safety, permanency, and well-being. Once a theory of change has been articulated, evaluators may focus on gaining a better understanding of the target population at greatest risk for unnecessary admissions or unnecessarily long stays in foster care, and identifying key predictors and characteristics among these populations to facilitate the identification and selection of strategies to address them. Once strategies are implemented, focused evaluations may assess the effectiveness of strategies for stabilizing or reducing the growth trends in the current system. A subsequent evaluation to monitor the implementation of the recommendations highlighted here would inform the stakeholder community of the department's progress. Ongoing monitoring of the attorney caseloads, as well as the timely and accurate submission of information to the courts, should supplement evaluations of the department itself. Between the monitoring performed for the CFSR, the support for the waiver demonstration project performed by academic partners at Arizona State University, the department's own quality assurance and CQI capacity, and the office of the auditor general, local capacity should be leveraged to provide informed and coordinated evaluation strategies.

See page 46 for additional information.

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Douglas A. Ducey
Governor

Gregory McKay
Director

June 19, 2015

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

Re: Chapin Hall Independent Review

Dear Ms. Davenport:

The Arizona Department of Child Safety (hereafter referred to as DCS or the Department) has reviewed the full review entitled *Arizona Department of Child Safety: Independent Review* conducted by Chapin Hall Center for Children, University of Chicago. The following constitutes the Department's response to each recommendation and its intent to implement the recommendations and/or to clarify any efforts already underway to address the issues identified in the recommendations.

RECOMMENDATION 1:

"Establish and use clear safety assessment protocols and better standardize processes at the hotline and investigations. Examine available child safety risk assessment protocols and consider reverting back to the standardized form that was previously in use OR implement a new, standardized safety assessment protocol selected from one of the many models in place in other jurisdictions. The safety assessment selected should include standardized items, yield quantifiable data, and direct decisions clearly and transparently. Workers and supervisors should receive significant support and oversight during its implementation to ensure that the protocol is being administered with fidelity and that the results of the assessment are being used to inform decision-making.

To address the backlog of cases that has accumulated at the front door of the system, consider implementing multiple strategies. In the short term, these may include the engagement of community providers, retired case workers, or private companies to provide the capacity to conduct a large number of investigations and disposition cases in a timely manner. This must happen in conjunction with clear and consistent decision-making protocols and available service pathways for different levels of need (as described elsewhere in the report). In the long term, the state should consider the regular engagement of providers in a performance based contracting arrangement that is geared toward focusing agencies on achieving desired outcomes and incentivizing best practice and outcomes through contractual agreements."

DCS Response:

The Department agrees with this recommendation. DCS utilizes a Child Safety Assessment model designed by Action for Child Protection. The Department is contemplating reverting back to a previously utilized, standardized assessment documentation form, which will make the protocol more clear to staff and produce quantifiable data. DCS leadership will oversee the redeployment to the standardized assessment form. This oversight will include utilization of a more precise means by which Child Safety Specialists document safety and risk factors, and the documentation form will allow for a more concise means to collect data. The Practice Improvement Unit (PIU) and Child Welfare Training Institute (CWTI) can work together to provide coaching and guidance during the redeployment of the standard assessment form.

In regard to the "backlog", the volume of DCS reports exceeds the capacity to respond, complete comprehensive investigations, initiate services quickly, and close or transfer cases within required timeframes. Because the number of new reports received has been greater than the number closed for several years, the Department has a large backlog of reports that have been open more than 60 days. Existing staff do not have the capacity to investigate and close all new reports within 60 days, and have no capacity to follow-up on the backlog. This capacity issue affects our ability to retain staff and leads to poor safety outcomes, such as repeat maltreatment and repeat reporting. DCS has outlined several interventions to address the backlog:

1. Clarify Hotline standards for categorizing information as reports, and improve application of the standards to increase consistency of decision-making.
2. Use evidence to identify the predictive characteristics of reports that do not receive substantiation, services, removal and have a low rate of re-report; and revise report definitions, Hotline prioritization procedures, and investigation procedures to better align the use of agency resources with family risk level.
3. Identify communities and locations with a high volume of reports, and collaborate with community partners to provide prevention services and community interventions to address risks before a report to DCS is needed.
4. Improve investigation processes in (1) the transfer of dependency cases to ongoing caseworkers, (2) use of case aides to complete administrative tasks, and (3) documentation.
5. Categorize the existing backlog of reports based on risk level and investigation completion stage, identify assessment and closure procedures for each category, and mobilize new personnel resources to implement the procedures and close reports.
6. DCS will provide ongoing training and support to field supervisors and Assistant Program Managers (APMs) in an effort to increase the use of the dashboard. The data is currently available to the supervisors and APMs; however, it is underutilized due to a lack of understanding for the use of the tool. The dashboard provides information regarding reports that remain open on a particular Specialist's directory. With this knowledge, the supervisors and APMs will be further equipped to clinically discuss barriers to closing the investigations. The dashboard can also be used to track key performance indicators such as timeliness of initial response to reports; timeliness of investigation finding data entry; the number of open and closed initial assessments;

in-person contacts with the children, parents, and out-of-home care providers; child removals and returns; time to reunification; and time to adoption.

7. A Request for Information (RFI) was issued in an effort to understand what community and private services exist to build statewide and regional capacity to respond to the DCS in-active cases. The responses are in the process of being reviewed.

DCS believes a multi-pronged approach concurrently addressing practice, policy, and legislative change, informed by data and guided by the goal of increased safety for children at risk of abuse or neglect, will reduce the current backlog while addressing the institutional barriers that have led to the lack of timely investigations.

RECOMMENDATION 2:

"Using services to reduce pressures at the system's front door will require a thoughtful, resourced answer. At the current pace, over the longer term, Arizona could expand in-home services and pay for the expansion with savings that accrue from reductions in foster care caseloads. To do that it will need a clear plan negotiated with the Department's stakeholders. Healthy Families Arizona should continue to receive support, and other in-home services should be installed to meet the needs of families that come to the Department's attention but do not require a removal. Monitoring the use of prevention dollars, streamlining pathways for referral and receipt of services, and clearly articulating eligibility criteria will be important to address this deficit."

DCS Response:

The Department agrees with this recommendation. The Department is already considering the re-implementation of the Family Builders program. Once the Department has investigated the report and determines that it meets the criteria for potential to low risk, the family may be referred to Family Builders, who will provide the family with ongoing services and supports. The anticipated outcomes are that 99% of families that receive services will have a reduction of risk at time of case closure on at least one risk scale, and less than 5% of the families that receive services will be re-referred to DCS with a similar substantiated report within a six month period after case closure.

The Department's title IV-E waiver application was approved and is intended to provide improved family engagement by way of Motivational Interviewing and Peer Parent Support Programs. In addition, trauma focused therapies and trauma informed care services will be developed. These interventions will be provided to families throughout the life of the case, but especially at the onset of the case. The anticipated outcomes of these interventions will be a reduction in the number of children in out-of-home care and an overall reduction of involvement with the child welfare system. Savings from reductions in out-of-home care will be invested in additional in-home services and supports.

In April 2015, the Department's Office of Prevention and Family Support facilitated a productive workgroup with Central and Southwestern Regional staff and providers about the Parent Aide and In-Home Services programs in order to develop a consensus proposal to reduce and ultimately eliminate the waitlist. Several objectives were identified to eliminate the wait list for these services: 1) regularly conduct collaborative meetings with providers, 2) continuously assess agency capacity and share updated data routinely with providers, 3) hire additional staff within the provider agencies, 4) ensure that Regional referral units maintain an up-to-date tracking system, and 5) continuously evaluate families who have been on the waitlist for more than three weeks to assess ongoing need for services. The Department recognizes that it will need to develop a clear and well defined plan with providers to reduce the number of families involved with DCS and to prevent removals.

RECOMMENDATION 3:

"Develop strategies in collaboration with county courts to both increase the number of attorneys and examine the payment strategies to re-align incentives and improve legal representation. Work with the local courts to build the capacity to conduct ongoing monitoring of attorney caseloads and the timely and accurate submission of information to the courts. An electronic, statewide court-based management information is used in some state to track court processes. Given the large number of cases on the court dockets, an investment in management information would pay for itself in a few short years.

DCS Response:

The Department agrees there is a need for more attorneys to represent families and children and supports efforts to re-align incentives and improve legal representation. While the authority to implement different payment strategies does not fall within the Department's purview, DCS does support improvements to these incentives. The Department with the support of Casey Family Programs has been involved in the Safe Reduction Initiative that began in October 2014 and is spearheaded by DCS and the Maricopa County Juvenile Court. The purpose of the initiative is to collaboratively address issues facing the County and impacting children and families involved with DCS and the Court. The initiative is structured into three workgroups: a multi-system stakeholder workgroup involving 35 public, private and community stakeholders; an attorney workgroup; and a judicial workgroup chaired by the presiding judge of the Maricopa County Juvenile Court. The multi-system stakeholder workgroup meets quarterly and has collectively decided on four focus group areas: family engagement, targeted services, consistent decision making, and community engagement.

The Arizona Administrative Office of the Courts, Court Improvement Program, conducts a Dependency User's Group (DUG) on a quarterly basis to discuss the data needs of dependency courts throughout the state. This group addresses issues with case processing standards. DUG meets with representatives from the courts in all 15 counties in Arizona. Casey Family Program's Judicial Engagement Team has been working with Maricopa County providing

technical assistance with real-time distribution of Judicial Orders and collaborating with the Clerk of the Court to improve calendaring.

RECOMMENDATION 4:

"Continue to increase the size of the work force to bring staffing ratios back to pre-2009 levels, if not above those levels given the number of children now in out-of-home care. While resources have been allocated to increasing the work force, there have been barriers to expanding capacity, including the time it takes to adequately train new staff and delays in hiring. Ideal caseload sizes should be calculated (using the information provided in this report and other jurisdictions as a reference point) and funding should aim to stabilize caseload sizes for both investigations and placement workers at levels that will allow adequate attention to the needs of families, including sibling and parent visitation (which is now occurring at far below the rates specified in policy).

Decision-making has to become more efficient without being rushed, or vulnerable to the pressures of fear and reactivity. The workforce hired by the Department has to be distributed wisely along the continuum of care if the value of adding workers is to be realized. The Department should address the needs of the growing number of children in substitute care by reducing entries and decreasing time until permanency. This will involve taking a broader view of the Department's purpose and function, developing a Theory of Change that identifies key decision points and levers for changing growth trends, and implementing and supporting Evidence-Based Practices. To meet these needs, the Department should proceed with and reinforce steps it has taken, including: the Safe Reduction Workgroup and Permanency Roundtables."

DCS Response:

The Department agrees with the recommendation to bring staffing ratios back to pre-2009 ratios. We recognize that the increase of children in foster care has created overwhelming caseloads. To address this need, the Department is actively strengthening case worker recruitment, retention, and training. In 2014, Arizona's legislature allocated funding, which increased the number of Child Safety Specialist positions by 212. The Department has been able to hire all of these positions. Additionally, the funding allowed for the creation of 36 additional supervisor positions, and those positions have been filled. This will assist in reducing caseworker to supervisor ratios and improve supervisor's availability for clinical supervision. The Department is also seeking to improve retention by improving resources and supports for Child Safety Specialists. For example, the Department has already begun providing caseworkers with laptops that have wireless capability. DCS was authorized to provide incentive bonuses for Child Safety Specialists who remain employed with the Department for a period of time. Funding additional contracted services for parent-child visitation allows caseworkers to focus on other core job functions, including case manager contacts with children and parents. This was deemed critical when the Department observed that due to high demand for parent-child visitation services,

Child Safety Specialists would often facilitate and supervise the visits, a task that can fill at least eight hours each week.

The Department is piloting a Talent Science software program to recruit top performers and develop current employees into top performers. The anticipated outcome is that the current turnover rate of 27.1% will be reduced by 25%. This product works by first developing a customized performance profile for case aides, specialists, and supervisors. These performance profiles are tied to the key performance indicators. Then, when candidates apply for a job, a report is generated that explains how the candidate differs from the ideal behaviors for the role. These reports also include a breakdown of overall fit compared to competency groups and key behaviors for the specific performance profile. The report compares fit to current positions and future roles to assess growth potential and career path. Finally, it guides role-specific customized insight for interviews, onboarding, coaching, and employee development.

To help improve decision-making at key points, reduce the number of children entering care, and decrease time spent in care, the Department is exploring the expanded use of Team Decision-Making (TDM) and other types of team meetings. By utilizing these mechanisms more efficiently and streamlining the various meetings Child Safety Specialists attend, the Department anticipates reducing children's time in care as well as Specialist's work load so more time can be spent on other value added duties. This will include conducting case reviews for children ages six to eleven years with a case plan goal of reunification who have been in care for a period of six to nine months. DCS would then identify which of these youth can be safely reunified with their parents/guardians. Additionally, the Department is considering the increased utilization of Permanency TDMs, incorporating effective processes from best practices such as Permanency Roundtables, and utilizing the existing facilitators to more efficiently implement the process. A key element to the success of these meetings is to continue meeting with team members to ensure follow-through on identified tasks and services, assess the ongoing need to modify services and supports, and determine whether the desired outcome is being achieved.

RECOMMENDATION 5:

"Refine and build on current improvements so that the CFSR, OAG reports, and Department-generated reports provide useful information at regular intervals. Build upon existing CQI capacity by developing enhanced reports (data presented herein can provide a beginning template) and producing them regularly to inform ongoing improvements. Develop baselines and targets for key outcomes to focus attention on improvement in the areas identified, and key reporting metrics to these outcomes. Content and frequency of reports should be refined, and transparency enhanced by developing a regular schedule of reports for use by internal and external stakeholders, allowing the federal CFSR, OAG reports, and Department-generated reports to provide useful information at regular intervals. With respect to outside reviews, integrating the CFSR and OAG oversight with a rigorous, well supported CQI process ought to provide the transparency stakeholders need in order to rebuild trust. The CQI structure can be mobilized to improve data compliance by providing regular internal submission reports to staff so that they can see whether the data reflect their work, and correct it accordingly. Additional

assessment tools that collect data on child wellbeing should be incorporated so that this information can be a part of future reports."

DCS Response:

The Department agrees with this recommendation. DCS is already engaged in the development of a continuous quality improvement structure, including enhanced reports and better integration of external reports into CQI processes. DCS is developing enhanced reports that include data similar to the Chapin Hall Independent Review, such as the report created by the Office of Quality Improvement for the state legislature's Child Safety Oversight Committee. The Child and Family Services Review process and its measures of safety and permanency outcomes are also well integrated into the new Office of Quality Improvement's structure. In addition, the Department, in conjunction with various legislative bodies, must make recommendation for the consolidation of child welfare reporting requirements into one comprehensive report. The Department currently generates numerous reports that are required by statute, accreditation standards, or upon request. While many of these reports generate data, they are not always meaningful as they do not focus on outcomes nor do they help drive policy. The Department is currently identifying key outcomes and measures to gather and report. DCS has received useful guidance and instruction on the development of meaningful data and a CQI structure from Chapin Hall in the past, and looks forward to additional support from Chapin Hall as we continue this work

RECOMMENDATION 6:

"Develop partnerships with academic and other institutions to support the ongoing exploration, and then implementation, of evidence-based practices. The development of a Theory of Change, the refinement of Target Populations, the selection of Evidence-Based Practices, and the ongoing monitoring of the implementation of these practices will need to be informed by additional empirical data analyses, some of which may be beyond the Department's current capacity. These analyses would ideally be performed in collaboration with an academic partner that can apply statistical expertise to understanding the needs of children at greatest risk for poor outcomes."

DCS Response:

The Department agrees with this recommendation. The Department acknowledges the challenges it faces to identify and implement evidence-based practices and to consistently and effectively monitor their ongoing implementation. DCS has already begun to implement practices to address the concerns noted. To this point, the DCS Office of Quality Improvement was established and is partnering with Arizona State University. DCS and ASU will develop and implement evidence-based practices and use implementation science to understand problems and sustain improvement. Additionally, ASU assists CWTI to develop training to improve the quality of our workforce.

RECOMMENDATION 7:

"Develop the infrastructure to promote regular communication and engagement of stakeholders among the foster parent, birth parent, foster youth, and advocacy communities that involve regular meetings, communication strategies (regular reporting or newsletters) and forums for the exchange of ideas."

DCS Response:

The Department agrees with this recommendation. DCS recognizes that the Department's success will require the combined understanding and alignment of multiple stakeholders. DCS and stakeholders have identified transparency as a key value. To achieve this, DCS, in partnership with Casey Family Programs and The Clarus Consulting Group, is developing a strategic plan that will serve as the framework for this communication. To help the Department communicate its goals, challenges, and progress in a manner that allows stakeholders to understand context, priorities, and data, Clarus and DCS have identified three tasks: 1) Development of a Strategic Communication Plan and DCS Message Encyclopedia, 2) Communication Coaching Sessions, and 3) Targeted Communication Support.

Additionally, the Department has identified the members of the Community Advisory Committee (CAC) and will coordinate the initiation of the Committee's work. The CAC provides an opportunity for the Department and community stakeholders to collaborate so Arizona can accomplish the mission of protecting vulnerable children and helping families at risk.

On May 27, 2015, the Department announced the commissioning of a multidisciplinary group of volunteers to reshape Arizona's foster care system. The Fostering Inclusion Respect Support Trust (FIRST) Advisory Commission consists of professionals and community partners with a depth of experience with Arizona's foster care system. The team will work with Director Greg McKay to use data-driven interventions that improve the consistency of quality when foster parents interact with the system, ensuring that foster families feel respected, trusted, and empowered. By anticipating the needs of foster families over time in multiple interactions, the agency can rebuild trust with foster families and increase the number of children in family environments. This will both provide better outcomes to children in foster care and potentially reduce taxpayer expenses.

RECOMMENDATION 8:

"Because criminal behavior requires a criminal justice response, close collaboration requires a thoughtful and strategic approach, so that the involvement of law enforcement can be (1) targeted toward the highest risk situations in which criminal wrongdoing is a concern; (2) informed and sensitive to the impact of trauma and the manner in which cases should be handled to minimize further trauma; and (3) employed in a way that incentives are aligned to identify family needs without criminalizing parents in need of assistance."

DCS Response:

The Department agrees with this recommendation. The Office of Child Welfare Investigations (OCWI) was established following the enactment of Arizona House Bill 2721, and derives its statutory authority from A.R.S. § 8-471. OCWI is charged with investigating DCS reports containing criminal conduct allegations of child abuse with the appropriate local law enforcement agency. The principal goal of OCWI is to protect children by conducting uniform investigations into allegations of criminal conduct child abuse. OCWI enhances the quality and efficiency of investigations by maximizing resources through a joint investigative process.

A.R.S. § 8-817 requires the Department to develop, establish and implement initial screening and safety assessment protocols in consultation with the Arizona Attorney General's office, county attorneys, local law enforcement agencies, medical experts, victims' rights advocates, domestic violence victim advocates and mandatory reporters. Each county has a multi-disciplinary protocol that governs and guides investigations involving both law enforcement and DCS. The protocols serve to ensure children are treated with dignity and respect, are protected from harassment, intimidation and/or abuse, and to minimize secondary trauma that can accompany criminal conduct investigations. OCWI developed a Criminal Conduct Screening Tool that is aligned with statutory definitions of crime, which garners greater law enforcement participation in joint investigations. This tool is utilized by the Arizona Child Abuse Hotline to help identify reports potentially involving criminal conduct.

OCWI's philosophy involving criminal conduct investigations is to ultimately ensure child safety and minimize any further trauma to child victims. OCWI works collaboratively with law enforcement while creating a sensitive team atmosphere with the family to identify any outstanding concerns that may need to be addressed through ongoing services.

Although DCS has no authority to enforce the police department's practice, the Department does agree with a close collaboration with law enforcement, taking a trauma-informed approach and targeting high risk situations for reports involving criminal conduct.

Sincerely,



Gregory McKay
Director

cc: Shalom Jacobs, Deputy Director of Field Operations, DCS
Katherine Guffey, Chief Quality Improvement Officer, DCS
Dana A. Weiner, Policy Fellow, Chapin Hall Center for Children, University of Chicago