Arizona Citizen Review Panel

THIRD ANNUAL REPORT

DECEMBER 2001

Arizona Department of Health Services
Community and Family Health Services

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Program Background and Purpose

Arizona's Citizen Review Panel Program was established in response to the 1996 amendment to the Child Abuse Prevention and Treatment Act requiring states to develop and establish Citizen Review Panels as oversight to the states' child protective services systems. The purpose of this program is to develop recommendations for improvement of child protective services through independent, unbiased reviews by Panels composed of citizens, social service, legal, medical, education and mental health professionals in Arizona. The creation of the Citizen Review Panel Program is an acknowledgment that protection of our children is the responsibility of the entire community, not a single agency. As such, the child protection system is the interaction of numerous agencies and individuals. While the primary focus of oversight will be the Arizona Department of Economic Security/Division of Children, Youth and Families (ADES/DCYF), the Citizen Review Panels shall take into consideration the impact of these other entities and assess whether they support or hinder the state's efforts to protect children from abuse and neglect. The entire community has a stake in protecting the safety of its children.

Program Structure

The Arizona Department of Health Services (ADHS), through an interagency service agreement with ADES, administers Arizona's Citizen Review Panel Program. During the planning stages it was determined that location of this program outside of ADES would be critical to achieve the independence necessary for an effective, objective program. The Citizen Review Panel Program Manager provides administrative support and oversees the operation and organization of the program at the state level.

Arizona maintains three Panels, which are located in Maricopa, Pima, and Yavapai counties. Each Panel meets at least once a quarter and is responsible for review of Child Protective Services' statewide policies, local procedures, pertinent data sources and individual case records to determine compliance with CAPTA requirements and the State Plan. The State Citizen Review Panel, located in Maricopa County, serves a dual purpose of assessment of Child Protective Services and oversight of the local Citizen Review Panels.

Progress On Implementation Of Prior Year Recommendations

The following recommendations for improvement in the Child Protective Services system were identified in the 2000 Citizen Review Panel Report:

- Recommendation: Expand the child abuse hotline cue questions to identify language barriers in all household members.

  Progress: Cue questions used by the child abuse hotline now include identification of language barriers in all household members.

- Recommendation: Increase efforts to recruit and retain bilingual case management staff.

  Progress: Efforts to increase recruitment of bilingual staff include advertisement in urban and rural newspapers, and minority publications, such as The Arizona Informant and Saludos Hispanos. Job announcements are included on various Internet web sites including the New Social Worker, the National Association of Social Workers, and university sites.

- Recommendation: Develop policies on medical neglect investigations, to include medical consultation in all reports of medical neglect with moderate or high risk.

  Progress: Policy now directs case managers to obtain consultation with a physician, preferably with expertise in child maltreatment, in cases of medical neglect with moderate or high risk. The agency is researching availability of medical consultants throughout all areas of the state and is pursuing expansion of such resources.

- Recommendation: Obtain autopsy results prior to entering a determination of the investigation findings involving a child fatality.

  Progress: Child death reports now require autopsy results and review by the Program Administrator prior to final closure.

- Recommendation: Increase funding for prevention programs and alternative response programs such as Family Builders, Family Preservation and Healthy Families.

  Progress: Family Builders was expanded statewide during this past year.

Panel Activities

In order to evaluate the extent to which ADES/DCYF is effectively discharging their child protection responsibilities, the Panels held regular meetings, reviewed the State Plan, completed case record reviews, examined agency policies and procedures, and reviewed the Child Protective Services appeal process. Quarterly meetings were held with DCYF administrators to advise the agency of Panel findings and to discuss plans or actions taken by the agency to implement the Panel's recommendations.

The development stage of Arizona's Citizen Review Panel Program is complete and the three Panels are fully operational. As a result, the Panels were able to focus more fully on review of Child Protective Services in Arizona. Recruitment of additional members continued during this reporting period to assure multidisciplinary representation and to address vacancies.

Each Panel met on a more frequent basis than the quarterly requirement. The Pima County Panel met on five occasions; the Yavapai County Panel met on seven occasions; and the State Panel met on six occasions.

During this reporting period, training was provided to Panel members on the Child Protective Services appeal process and on Arizona's Comprehensive Medical and Dental Program, which is the health care program for children in foster care.

Arizona's Citizen Review Panels reviewed 18 cases during this reporting period. Case record reviews primarily focused on investigations by Child Protective Services of fatalities, near fatalities, other high-risk maltreatment, and investigations resulting in appeals of proposed substantiated findings. Of these 18 cases, the State Panel completed six record reviews, the Pima County Panel completed five record reviews and the Yavapai County Panel completed seven record reviews.

Case Record Review Findings

Panels identified family risk factors in each review. Cases reviewed revealed the most frequent categories of risk factors included lack of parenting skills, lack of adequate resources (financial, childcare, housing), and parental substance abuse. The following is a comprehensive list of identified risk factors:

- Lack of parenting skills - 17 cases
- Lack of resources - 11 cases
- Prior Child Protective Services reports - 11 cases
- Substance abuse - 10 cases
- Lack of anger control - 9 cases
- Mental health issues - 7 cases
- Lack of motivation to provide a safe environment- 7 cases

- Parental violence outside home - 6 cases
- Domestic violence - 5 cases
- Disability of parent - 4 cases
- Prior severance/dependency of children - 3 cases
- Teen parent - 2 cases

Case record reviews consisted of the assessment of specific activities by Child Protective Services during the initial stages of involvement with the families. These stages included Intake/Screening, Investigation, Crisis Intervention, and Case Determination. In addition to the agency activities, the Panels explored community involvement with each case. An established form is completed in each record review and the results are maintained in a database.

The **Intake/Screening Stage** involves activities performed by the Child Protective Services Child Abuse Hotline. Activities include gathering enough information to determine if a report of suspected child maltreatment requires investigation or assessment by Child Protective Services or Family Builders, the severity of the allegation and how quickly an initial response must be made to ensure the safety of the child victim. Record reviews identified this stage as a strength in the child protection system. The Panels felt that risk levels, response time and maltreatment categories were appropriately assigned in 17 out of the 18 cases reviewed and all reports were assigned for investigation within required time frames.

The **Investigation Stage** involves gathering enough information to assess the child's immediate safety needs and to determine whether a reported or disclosed incident of maltreatment occurred. Activities reviewed in this stage were determined to comply with agency policy in the majority of cases reviewed. Investigations were initiated and completed within established time frames in 16 of the cases reviewed. The investigations were determined to be thorough and accurate, confidentiality of the reporting source was protected and appropriate steps were taken to reduce trauma to the child in the majority of cases. Six cases were considered to not reflect compliance with agency policy. Areas of concern in these cases primarily involved inadequate documentation of activities by the investigative case manager and lack of required interviews.

The **Crisis Intervention Stage** involves assuring the safety of the child, including the decision of whether the child could safely remain in the home or if emergency removal was necessary. Panels found that in all cases, where indicated, safety assessments were completed; relatives were considered as a placement resource; and judicial oversight was timely and provided for all parties. In 14 cases, Panels concluded that the decisions regarding emergency placements were based on adequate criteria. In four cases, the Panels concluded that the investigation should have resulted in the emergency placement of the child, or that the investigation was incomplete. In 14 cases, Panels determined that appropriate services were offered. In two cases, there was no documentation that services were offered. In two cases, services that were

offered did not address identified needs such as domestic violence, mental health and substance abuse.

The **Determination Stage** refers to the process of classifying a case as substantiated or unsubstantiated based on information collected and analyzed during investigation and assessment. The Panel found that in 14 cases sufficient information was gathered to make a final determination. In the remaining four cases, Panels identified that needed medical, substance abuse, or mental health assessments were not completed. The Panels supported the findings in 12 cases and did not agree with unsubstantiated findings in six cases reviewed.

Recommendations

The following recommendations to enhance Arizona's efforts to protect children are made with the understanding that adequate funding, staffing and community resources are essential for success.

- Panels reviewed three cases that resulted in appeal hearings of substantiated findings by Child Protective Services. In addition to the record reviews, training was provided to the Panels on the appeal process. The Citizen Review Panel concluded that Administrative Hearing Officers were not consistently trained on critical issues, such as child maltreatment and child development. DCYF has made available and encouraged participation in such training.

  The number of substantiated reports declined since the appeal process began in 1998. Substantiated reports dropped from 20% for the period of April 2000 through September 2000, to 12% for the period of October 2000 through March 2001 (Note: the number of substantiated reports for the most recent period does not include cases that are pending the appeal process). There are a number of possible factors that may contribute to a decrease in substantiated findings, including the rate in which "proposed substantiated" findings are overturned. During the period of November 2000 through October 2001, 53% of proposed substantiated findings were amended through the internal review program, the Protective Service Review Team. Substantiated findings were amended by the Office of Administrative Hearings in 14% of cases elevated for hearing. The Panel is concerned that, since the appeal process was initiated, case managers may be reluctant to propose substantiation of allegations. Other factors that may contribute to the decline in substantiated findings include: the decision to no longer substantiate allegations of potential abuse or neglect; the lack of supporting documentation in case records; and more consistent, stringent application of the definitions of child abuse and neglect.

  The Panel recognizes that the appeal process provides an essential opportunity for due process, which might otherwise not exist. The reviews completed by the appeal process, provide valuable information on the quality of investigations performed by the agency and assist in identification of training needs.

The Panel recommends that all hearing officers responsible for appeals of Child Protective Services findings receive mandatory training on child maltreatment and child development, as available through DCYF.

The Panel recommends that DCYF explore the impact of appeals on the rate of substantiated findings and that a process for review of unsubstantiated findings be established.

- Reports not investigated, due to the inability to locate the family, are determined to be unsubstantiated. Classification of a report as unsubstantiated should occur after an investigation has been completed and the determination has been made that sufficient grounds do not exist to substantiate findings.

  It is the Panel's recommendation that reports not investigated, due to the inability to locate the family, be classified as "unable to locate".

- According to the Child Welfare Reporting Requirements Semi-Annual Report, during the reporting period of 10/1/00 – 3/31/01, 548 substantiated reports were closed after completion of the investigation. While the risks to the child may be resolved for many of these cases during investigation, cases are closed in which there is continued risk to the child. Typically, in these situations, the level of risk does not warrant removal from the family home.

  The Panel recommends consideration of in-home dependency petitions in cases involving continued risk to the child.

  The Panel recommends further development of community alternatives to ongoing involvement with Child Protective Services.

- One case reviewed involved allegations that a convicted sexual offender resided with a child. At the time this report was accepted for investigation, reports such as this were assigned as a potential risk, if there were no specific allegations that the child had been abused. Subsequent to the date of that report, allegations have been assigned as low risk if a child is living with a parent, guardian, or custodian who has sexual abused a child in the past. Assignments of risk levels, high, moderate, low, or potential determine the time frame for initiation of the investigation.

  The Panel recommends that allegations a child is living with a convicted sexual offender, if the offense was against a child, should be classified as a moderate risk.

- Investigations that involved families with multiple, prior reports of maltreatment did not consistently evaluate the cumulative risk to the child. It is critical to consider prior history known to the agency to identify patterns of risk factors. If there are

multiple reports on a family, agency policy currently directs staff to review all prior reports and requires additional action such as reviews by management and assignment to a different case manager for investigation.

The Panel recommends that policy on families with multiple reports be fully implemented, through internal reviews and training.

- The State Panel received an update on changes to the Comprehensive Medical and Dental Program (CMDP) for Arizona's foster care children. The Panel feels that many of these changes will be very beneficial to the children covered by the program. These children are at very high risk for a multitude of medical problems. In addition, many of them have not received consistent medical care from a primary care physician prior to ADES involvement. Thus, they often have untreated medical problems, immunization delays, undiagnosed developmental delays, hearing and visual deficits. Because these children are at high risk for such medical problems, the committee would like to express their concern over the lack of pediatric oversight of the CMDP program.

  The Panel recommends that a board-certified pediatrician with experience in primary care should provide consultation to the medical component of the CMDP program. This physician could assist ADES in the development of appropriate protocols, chart reviews, and development of tracking mechanisms to assure that these vulnerable children receive the same quality of care available to other children in the community.

- One case reviewed included the fatality of a child in a family with active involvement with Child Protective Services. In this fatality, the Medical Examiner determined the cause of death to be the result of Sudden Infant Death Syndrome (SIDS). The Panel noted that the established SIDS Autopsy Protocols were not followed, and therefore other causes of death were not ruled out. It was felt that thorough compliance with this protocol is critical for an accurate designation of cause of death. Such a determination is essential to Child Protective Services in their assessment of risk to surviving siblings.

  It is recommended that the Sudden Infant Death Syndrome Autopsy Protocol developed by the SIDS Council be utilized in every unexplained infant death.

Objectives for 2002

Arizona's Citizen Review Panels have identified the following objectives for the next reporting period:

- Continue record reviews of fatalities and near fatalities of children due to maltreatment, and other reports of serious maltreatment to identify systemic problems and recommendations for improvement;

- Continue to collect and analyze data on all case record reviews;

- Begin assessment of later stages of Child Protective Services involvement with families, which include Case Plan Implementation and Closure.

- Review health care provided to children in out of home care through Arizona's Comprehensive Medical and Dental Program (CMDP).

- Provide support to DCYF, through consultation on policy, procedural changes and state initiatives to improve the quality of services to children and their families.

Conclusions

Protecting children is the responsibility of the entire community and Child Protective Services cannot be expected to successfully serve this mission in isolation. Volunteers with the Citizen Review Panel are exemplary models of the commitment within our community to the welfare of children and families. Findings and recommendations included in this report are the result of dedication and hard work by the members of each Panel.

It is important to acknowledge the efforts by DCYF to improve their efforts to protect children. DCYF has engaged in several initiatives to enhance the well being of children and families they serve. A few of these initiatives include:

- The development of the Child Welfare Training Academy for Child Protective Services.

- Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together), in partnership with the Department of Health Services provides substance abuse and recovery support services to families involved with Child Protective Services and Temporary Assistance for Needy Families (TANF). This program was implemented statewide in March 2001.

- The Family Builders program was expanded statewide during 2001. This program provides family assessments and services to families in which there was a report of low or potential risk to the child. With the aid of this program, there is now a response to 100% of reports to Child Protective Services.

- Family Group Decision Making expanded statewide in 2001. This program is designed to empower families and their communities to protect and nurture children, through their knowledge, support, and direction.

The Citizen Review Program desires to support DCYF in their continuing efforts to improve services to children and their families. Success in these efforts is dependent upon adequate funding and continued support from the community.

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