

2011

ARIZONA CITIZEN REVIEW PANEL Thirteenth Annual Report



ARIZONA CITIZEN REVIEW PANEL

Thirteenth Annual Report

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Points of view represented in this report are those of the Arizona Citizen Review Panels and do not necessarily represent the official position or policies of the Arizona Department of Economic Security or Division of Children, Youth and Families.

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Executive Summary

The Center for Applied Behavioral Health Policy at Arizona State University (CABHP), through an interagency service agreement with the Arizona Department of Economic Security (ADES), began administering the Arizona Citizen Review Panel (ACRP) Program in December of 2008. The Arizona Department of Economic Security/Division of Children Youth & Families (DCYF) is the state agency responsible for the provision of child protection services. Working in conjunction, DCYF and CABHP are responsible for meeting all federal requirements specified in the Child Abuse Prevention and Treatment Act (CAPTA) regarding Citizen Review Panels. The panels develop recommendations for improvement of Arizona's child welfare system through independent, unbiased system reviews.

Panels are comprised of 13 to 29 volunteers of diverse backgrounds and experience representing citizens; social services providers; child advocates; former victims of abuse and neglect; adoptive and foster care parents; legal, medical, education, and mental health professionals; and faith-based representatives. (See Appendix A) Their duties include review of CPS state policies, current practices, pertinent data, and case record information. As in previous years, guest speakers were invited to present to panel members on topics identified as important to their understanding of the child protection system. The panels make recommendations to CPS for system changes and improvements through the submission of the annual report. The ADES response to the 2010 Citizen Review Panel Report is included in Appendix B.

This 13th Annual Citizen Review Panel Report summarizes the accomplishments, activities, findings, and recommendations of the three ACRPs (Northern, Central, and Southern). Areas for improvements are included in both the case record review section and the panel's recommendations.

Accomplishments

Throughout the past year the panels have continued to observe the many strengths of those who work on behalf of the Arizona child welfare system. Noted positive qualities of CPS Specialists include maintaining good rapport with families, linking families with helpful services, and taking actions early to establish permanency.

Specific examples of exemplary practice identified from case review included:

Examples include:

- The panels found that case record documentation supported the investigative findings in all of the 24 investigations reviewed.
- The CPS case manager utilized the unit psychologist in determining the therapeutic value of continued visitations of the child with his mother following severance (Central Panel)
- An Assistant Program Manager who compiled information for the County Attorney after police were unwilling to consider criminal charges in a fatality case involving neglect (Northern Panel)

- A child was in the same foster home for eleven years and had the same CPS case manager for 4 years. At case transfer, the former worker became the supervisor on the case. The second case manager worked with the child for 2 years, at which time the child was referred for Independent Living Services (Southern Panel)
- Exceptional documentation by CPS Specialists which made two cases easy to review because of the clarity of information they provided.

Panel Activities

Panel members suggested that the 2011 activities focus on an examination of recurring themes identified from cases reviewed over the years. Each meeting the cases reviewed, speakers, and DCYF policy presentations were related to the specific theme for the quarter. The four themes chosen for 2011 were Trauma Informed Care for Children, Sustaining Placements in Foster Care and Adoption, Youth Transitioning from Foster Care, and Chronic Neglect. The cases chosen for each theme were chosen because they represent some of the most severe, chronic and challenging cases and represent only a small fraction of the work done by Child Protective Services. Five (5) of the cases were fatalities, seven (7) were near-fatalities. The findings and recommendations of the Arizona Citizen Review panels result from the reviews of this small number of cases and should be considered in that context.

Panel Findings

The panels identified four common issues that ran through the 24 cases reviewed, regardless of the quarterly theme. These included:

- **INADEQUATE BEHAVIORAL HEALTH ASSESSMENTS AND LIMITED ACCESS TO QUALITY BEHAVIORAL HEALTH SERVICES**

The panels repeatedly observed untreated mental health problems in the parents and children of the families referred to CPS. The lack of access to comprehensive and timely mental health assessments and services exacerbated the problems of the children and families and resulted in repeated reports and investigations involving the same families; multiple disrupted foster and adoptive placements, delays in children obtaining permanency; and CPS involvement in the next generation of children.

This finding is exemplified in the case of a child who came into care at age 10 following multiple prior investigations of reports of abuse and neglect of the child. Both the mother and child had been diagnosed with mental illness, but it was the mother's diagnosed mental health diagnosis that was the focus of the case plan rather than the child's, and as a result services to the child were not provided in a timely or comprehensive manner. The child experienced multiple placement disruptions and was in 14 different placements over the years. At age 11, he assaulted a peer in a group home. At 17, after committing another assault, the child was being prosecuted as an adult and will leave foster care, committed to the Arizona Department of Corrections.

➤ **SYSTEMIC FAILURE TO RECOGNIZE THE IMPACT OF PARENTAL CHILDHOOD TRAUMA ON DEVELOPMENTAL OUTCOMES AND BEHAVIOR**

Parental history of childhood maltreatment was discovered in 21 of the 24 cases reviewed in 2011. Yet, this history was never clearly identified as impacting the parent or as a risk factor for the child, nor were interventions focused on resolving the trauma. This finding was especially evident when the panels looked at the six chronic neglect cases reviewed for the final quarter. In all six chronic neglect cases reviewed, panel members found multi-generation family histories of neglect and abuse. This finding was significant because the cases were identified for review only because there were multiple reports of neglect for the parent and a recent fatality. This strongly suggests the need to find a way to intervene in chronic neglect cases earlier and in a way that sustains successful outcomes.

This finding is highlighted best in one case where all seven of the children had been removed from the mother, each shortly after birth due to the mother's significant substance abuse and resulting inability to provide even minimally for her child. This parent had a significant history of childhood abuse and neglect in Arizona but assessments identified only her substance abuse as a risk factor, when it is likely her substance abuse was trauma symptom of her victimization as a child.

➤ **STABILITY OF CASEWORKERS, PROVIDERS AND PLACEMENTS MAKES A DIFFERENCE IN A CASE**

The stable presence of a case manager was observed to result in better outcomes than in cases where there were frequent changes in case manager assignment. Stability among service providers also had a positive impact as did placement stability. The likelihood of a successful intervention decreased when there was frequent moves and turnover of providers.

This finding is exemplified in the case of one child who came into care at age 9 and has been in the same placement. She had only two case managers prior to being referred for independent living services. At the time of the review she was 18, enrolled in college, and doing well despite her history of significant child abuse and neglect. In another case, a child was free for adoption at age 3, at age 11 she remains without permanency and has been in 13 placements in the last 8 years.

➤ **THE DECISION TO SUBSTANTIATED REPORT FINDINGS, ESPECIALLY IN NEGLECT CASES IMPACTS THE DECISION TO PROVIDE SERVICES**

In the cases reviewed, multiple reports in the same family were observed to have unsubstantiated allegations, even when there was clear evidence of abuse or neglect of the children and the home continued to be chaotic and dysfunctional. The decision to unsubstantiate reports appeared to impact decisions about whether children were safe, or at risk, whether services were provided and whether the prior report history was considered cumulative. The panels were advised that agency policy does not require a substantiated finding to provide services but the panels observed that the decision to unsubstantiate a report did impact whether a case was closed, whether services were offered or provided and when services were provided they were provided for shorter periods of time, often without the problems in the home having been addressed. This was especially true when looking at reports involving neglect allegations.

This finding is exemplified in one case where a family was investigated 22 times over a period of 15 years with very few of the investigations resulting in a substantiated report findings.

Panel Recommendations

Each of the three panels developed recommendations for improvement of the child welfare system based on review of DCYF policy, case record reviews, presentations, and updated materials distributed by representatives from the ADES/DCYF. The recommendations were combined, prioritized, and divided into three categories based on input from the panel members and DCYF.

The first category (*Recommendations for Agency Response*) consists of recommendations that require a formal written response from DCYF as required by the CAPTA. Recognizing the efforts of DCYF to improve practices and services, only areas not currently addressed, or those that panel members identified as benefiting from additional enhancements were included in this category.

The second category (*Recommendations for Alignment with Current Practice and Training*) includes recommendations that are currently being addressed through practice improvement and other activities. DCYF has dedicated Practice Improvement Specialists in all regions who lead case reviews; provide data and performance to both regional and state management. The panel members want to monitor progress in these areas in the upcoming year. Updates on the results of these activities, including new initiatives, are provided annually by DCYF to panel members.

Recognizing that the child welfare system is not solely the responsibility of DCYF, the final category (*Recommendations for Child Welfare System Partners*) includes recommendations directed toward system partners. Panel members and DCYF staff are encouraged to advocate and promote collaborative efforts with systems partners to incorporate these recommendations.

Recommendations for Agency Response

1. DCYF should work more closely with the Department of Health Services to resolve systemic issues so that parents and children with identified behavioral health needs have access to timely, high-quality, comprehensive behavioral health assessment and services.
2. DCYF should take the lead for developing comprehensive collaboration at state, regional and local unit levels with other state agencies including; the Division of Developmental Disabilities, Department of Health Services; Juvenile Probation, Arizona Early Intervention Services; and contracted and community service providers involved with children and families to ensure that when multiple agencies or providers are involved with a family that there is a coordinated service delivery plan in order to avoid assumptions that a family's needs are being met when they are not, and to ensure that there is a clear understanding about what services are being provided and limitations to what can be provided.
3. CPS Specialists and supervisors must receive training on how to identify risk factors, including parental history of childhood abuse and neglect and how to assess when the identified risks represent an immediate safety threat to the child. For example, knowing how to recognize when parental substance abuse, mental illness, domestic violence (or all three) present a safety threat to the child based on a thoughtful assessment of the child's

vulnerability and available support systems, as measured against the capacity of the parent to meet the child's needs.

4. DCYF should ensure case managers thoroughly document identified risk and safety factors in the case plan, as well as service referrals and follow-up to referrals in reports to the court. Cases should not be closed without clear documentation explaining actions taken to resolve identified risk and safety factors.
5. DCYF should build capacity by reorganizing existing resources and by seeking additional funding to provide longer-term support and intervention for families who are unable to demonstrate long lasting change and/or when interventions do not address underlying problems, especially in cases involving chronic neglect.
6. Children with behavioral health issues were observed to experience multiple placements and were often placed in inappropriate situations with foster parents or relatives who did not have the support to meet the child's needs, or in group homes or settings for juvenile delinquents. DCYF should review the process for recruiting foster families for children with behavioral health issues to increase the number and expertise of foster and adoptive homes for these children to reduce placement disruptions.
7. DCYF should increase placement stability for children in out of home care by ensuring that appropriate support is provided to relatives, and foster and adoptive parents who are caring for children with emotional and behavioral health issues to include on-going support when higher levels of intervention are not determined necessary by the RBHA or are not available, and a process for pre and post adoptive parents to receive additional services for the children in their care.
8. DCYF should review substantiation guidelines so that substantiation, particularly in regard to allegations of neglect. The panels suggest the Department start by considering a definition for unreasonable risk of harm specific to neglect situations.

Recommendations for Alignment with Current Practice and Training

1. Child safety assessments must accurately identify safety threats and include a comprehensive assessment of risk.
2. Safety threats and risk factors should be clearly documented in the assessments, particularly when services and interventions to address the threats/risks are prescribed in the case plan, in other words, there needs to be a logical linkage between the assessment and the case plan.
3. It is critical that CPS field staff recognize and understand the impact of trauma symptoms on adult functioning and ability to safely care for and meet a child's needs. Trauma symptoms may result from traumatic events which may be current or historical including a childhood history of abuse and neglect. This understanding is important to case planning in order to identify and implement services that consider the impact of trauma symptoms on child safety as well as in assessing placements with relative caregivers.
4. Key areas that the panel identified, again in 2011, for continuing education of supervisors are medically fragile/complex youth, trauma and grief, identifying and addressing children's safety threats and risk factors.

Recommendations for Child Welfare System Partners

1. It is critical that funding for DCYF and other child welfare partners not be reduced by the legislature to ensure safety and maintain services. This is particularly vital considering that previous reductions to health and human service agencies has negatively impacted the entire child welfare system and complicates the Department's ability to respond to children and families involved with CPS. The majority of cases reviewed involve complex situations including parental history of trauma, substance use, mental illness, domestic violence, and children with health and behavioral health problems. Meeting the needs of these families when CPS Specialists are reportedly working significantly above caseload standards¹ is an enormous challenge.
2. DCYF and community providers should engage in cross training and cross system collaboration when possible, to help reduce duplication and to share in the knowledge and skills of collaborative partners.
3. DCYF, community partners, advocates, and other stakeholders should collectively define when neglect presents an unreasonable risk of harm to children so that risk is more readily identified.
4. The panels recommend that health care providers and other professionals responsible for providing services to families and children consider how to provide information at every opportunity to BOTH parents and other caregivers about Shaken Baby Syndrome (SBS) and the danger of unsafe sleep environments. This information should be delivered during prenatal appointments, prior to discharge from the hospital after giving birth, from pediatricians during well child checks, and from other professionals who are responsible for providing services to the families of infants.

¹ Child Protective Services Bi-Annual Financial and Program Accountability Report (CPS Report), August 2011, Arizona Department of Economic Security.

Arizona Citizen Review Panel Overview

The ACRP was established in 1999 in response to the 1996 amendment to the Child Abuse Prevention and Treatment Act (CAPTA) requiring states to develop and establish Citizen Review Panels. The purpose of ACRP is to determine whether state and local agencies are effectively discharging their child protection responsibilities. Panel members develop recommendations for improvement of CPS through independent, unbiased case record and data reviews.

The creation of the ACRP Program is an acknowledgment that protection of our children is the responsibility of the entire community, not a single agency. Although the primary focus of oversight is ADES/DCYF, the ACRP takes into consideration the impact of other entities and assesses whether they support or hinder the state's efforts to protect children from abuse and neglect.

Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (SEC.106 [42 U.S.C. 5106a]) was enacted in 1974 to provide grants to states to support innovations in state child protective services and community-based preventive services, as well as research, training, data collection, and program evaluation. CAPTA was amended in 2003 under The Keeping Children and Families Safe Act of 2003, and again in 2010 with the CAPTA Reauthorization Act.

CAPTA requires states receiving a Basic State Grant to establish no less than three Citizen Review Panels. Panels are comprised of volunteer members who are broadly representative of their community, including members who have expertise in the prevention and treatment of child abuse and neglect and as of 2010, may include those who are adult former victims of abuse and neglect.

Each panel must meet at least once every three months and evaluate the extent to which the state agency is effectively fulfilling its child protection responsibilities in accordance with the CAPTA state plan by examining the policies, procedures, and practices of state and local child protection agencies, and reviewing specific cases, where appropriate. CAPTA also provides panels with permission to examine other criteria important to ensure the protection of children and can include the extent to which the state child protective services system is coordinated with the foster care and adoption programs. Panels are also authorized to review child fatalities and near fatalities in the state.

CAPTA Requirements of Citizen Review Panels

The ACRP Program evaluates the degree that CPS is effectively fulfilling its child protection responsibilities through several means including: the review of the state plan; examining compliance with federal child protection standards; looking at coordination between agencies and child welfare systems of care; conducting outreach to communities; and case record reviews of child fatalities and near-fatalities. All of the findings and panel recommendations are based on one or more of these activities.

Section 106(c)(5)(A) of CAPTA requires states to provide each Citizen Review Panel with access to information on cases that the panel chooses to review if the information is necessary for the panel to carry out its functions under CAPTA.

Section 106(d) of CAPTA requires that Citizen Review Panels develop reports and make them available to the public annually. These reports should contain a summary of the panel's activities, and recommendations to the state and public on improving the child protection system based upon their activities and findings. The appropriate state agency is required to respond in writing no later than six months after the panel recommendations are submitted. The state agency's response must include a description of whether or how the state will incorporate the recommendations of the panel (where appropriate) to make measurable progress in improving the state child protective services system.

Citizen Review Panel members are bound by the confidentiality restrictions in section 106(c)(4)(B)(i) of CAPTA. Specifically, members of a panel may not disclose identifying information about any specific child protection case to any person or government official and may not make public other information unless authorized by state statute.

Compliance with Federal Child Protection Standards

Compliance with federal child protection standards is examined through a review of the DCYF semi-annual reports and information provided through DCYF updates or presentations. Additionally, the ACRP Program case record review instrument and process examine compliance with federal child protection standards. The DCYF Practice Improvement Case Review Instruments (PICR) and the ACRP case record review instrument were both modeled after the *Child and Family Services Review: Onsite Review Instrument and Instructions (2007)*.

Public Outreach and Soliciting Public Comments

The CABHP website hosts a link to the ACRP Program website to inform the community about the ACRP Program and solicit public comments. Questions regarding specific cases are directed to the appropriate state agency for assistance. Over the past two years, only a few comments have been received from the public.

The ACRP Program brochure continues to be distributed at events to inform the public, stimulate interest in the ACRP program, and solicit volunteers. The brochure and ACRP Program information have also been distributed throughout Arizona by multiple community and advocacy email listservs (e.g., Arizona Association for Foster and Adoptive Parents, Arizona Council for Human Services Providers, RBHAs, Governor's Office of Children, Youth & Families, and contacts in the faith-based community).

Arizona Citizen Review Panel Program

At the state level, the CABHP administers and supports the three regional panels located in Phoenix (Central), Tucson (Southern), and Flagstaff (Northern). Each of the panels represents specific DCYF regions and counties, and CABHP staff are responsible for the coordination and sharing of information across the three panels.

2011 Panel Activities

The three ACRPs met quarterly in 2011 as required by CAPTA. Each meeting was scheduled for three (3) hours. Panel members were sent agendas with case record summaries and other meeting materials prior to each regional meeting. All meetings were digitally recorded and formal meeting minutes were prepared and emailed to respective panel members for review and comment.

Coordination meetings occurred regularly between DCYF and CABHP staff. DCYF representatives provided quarterly meeting program reports to ensure that the panels received information on the status of ACRP recommendations, process improvement initiatives, new policies and procedures, budget updates, and other relevant information. A focus on continuous formal feedback mechanisms serves to improve communication, facilitate collaboration, increase panel member satisfaction, and identify opportunities for innovation. CABHP and DCYF each maintain internal tracking systems for monitoring the implementation of ACRP recommendations. DCYF will continue to provide updates to the panels on a routine basis as many of the proposed changes span across multiple years.

During 2011, optional pre-meeting workshops were added to the quarterly meeting agendas. In the first quarter, the workshop included a tour of the Childhelp Children's Center for the Central Panel and a tour of the Southern Arizona Advocacy Center for the Southern Panel. At the 2nd and 4th quarter meetings, orientation sessions for new and continuing panel members were held and at the 3rd quarter meeting a presentation on Trauma Informed Care for Parents was provided. Panel members were also provided the opportunity to attend a webinar on Trauma Recovery with Families in the CPS System on April 7, and were invited to attend a seminar on Secondary Trauma in Central and Southern Arizona. Additionally, CABHP routinely sent panel members informative news items from the National Citizen Review Panel, and links to teleconferences and publications.

In May, CABHP provided travel, hotel, and registration reimbursement for three panel members, one from each region, to attend the 10th Annual National Citizen Review Panel Conference in Charleston, South Carolina.

Panel members suggested thematic areas of focus for 2011 based on recurring issues identified in the cases reviewed in 2010. These themes were Trauma Informed Care for Children, Sustaining Placements in Foster Care and Adoption, Youth Transitioning from Foster Care, and Chronic Neglect. Based on these suggestions, the 2011 annual schedule of meetings was developed and distributed to each ACRP member (Appendix C). Each quarter the cases reviewed, speakers, information and DCYF policy presentations were related to the specific theme.

Below are highlighted topics from each of the quarterly meetings:

- **Quarter 1**- Pre-meeting Workshop Tour of the regional Child Advocacy Center for the Southern and Central Panels. Guest speaker presentations on *Never Shake a Baby*; DCYF *policy presentations*: Concurrent Case planning; and The Reunification Prognosis Assessment Guide
- **Quarter 2** - Pre-meeting Workshop: Orientation Sessions. Guest Speaker Presentations: Sustaining Placements in Foster Care and Adoption; DCYF Program Report: Collaboration with Schools resulting from a recent 9th Circuit appellate decision.
- **Quarter 3** - Pre-meeting Workshop: Trauma Informed Care for Parents; Guest Speaker Presentation: *The Experience of a Former Foster Youth*; DCYF Program Report: Youth Transitioning from Foster Care and the Young Adult Program.
- **Quarter 4** - Pre-meeting Workshop: Orientation Sessions. DES Program Report: *Chronic Neglect Update*.

Case Record Reviews

Panel members reviewed 24 cases in 2011. Figure 1 below provides an example of a case reviewed for each theme and panel recommendations based on the review.

Figure 1	2011 ACRP Case Review Themes/Special Topics
Quarter 1 Trauma Informed Care for Children	Cases were selected for review based on identified issues related to trauma informed care for children. Example: In one case, an 11 year-old boy committed suicide after being sent to his bedroom. This child had a history of untreated emotional problems. CPS had 8 prior reports involving this family and was unable to assist the mother in receiving needed services. Related Panel Recommendations and Comments: Timely, comprehensive behavioral health assessment and treatment must be easily accessible to parents of children with behavioral health needs.
Quarter 2 Sustaining Placements in Foster Care	Cases were selected for review that represented situations where the stability of the placement impacted the outcome for the case. Example: A child whose parents' rights to her were terminated when she was a toddler remains without a permanent placement at age 11 with on-going behavioral problems and services provided with frequent disruptions and changes. Related Panel Recommendations and Comments: DCYF should resolve systemic issues with Regional Behavioral Health Authorities to ensure that parents and children with identified behavioral health needs have access to timely, quality, and comprehensive behavioral health assessment and treatment.
Quarter 3 Youth Transitioning from Foster Care	Cases that involved youth transitioning from foster care to adulthood were examined during the fourth quarter. Example: A child, who came into care at age 9, remained in the same placement for 11 years. During this time she had the same case manager for 4 years, this case manager then became the supervisor for the case and until the case transferred to Independent Living Services she had only one other case manager. At the time of the case review, the child was still in the same foster home, enrolled in college, and doing well despite experiencing significant abuse and neglect in early childhood. Related Panel Recommendations and Comments: After care support and services need to be available to foster parents who have children with special needs post adoption. DCYF needs to focus efforts on retention of CPS Specialists.
Quarter 4 Chronic Neglect	Cases with multiple prior reports for neglect were identified for review. In these cases the criteria for review was that there had been a fatality or near fatality in the family and prior CPS investigations of neglect in that family. Example: In one case CPS had a 15 year history of involvement with the family, investigating numerous reports, filing dependency petitions on several occasions, and providing many services but never addressing the mother's depression and lack of attachment to her children. Depression was identified by a provider early in the case as a risk factor for recurrence. Over the years the mother never engaged in mental health services and the case was repeatedly closed quickly, even when the court was involved, once the home was cleaned. The condition of the home had been the focus of intervention rather than identified as a symptom of the mother's depression. Recent reports on this family involved the next generation of children from this family. Three of the adult children's children were involved with CPS. One of these children died after his mother fell asleep on top of him after drinking heavily. Related Panel Recommendations and Comments: DCYF should review policy for substantiating reports, especially those reports involving neglect.

Case Record Review Process

Throughout the past three years, CABHP staff have continued to refine the case record review process with the assistance and input of DCYF staff and panel members. Feedback from panel members continues to be an important part of the design and quality of the case review tool. The standards for case reviews established in 2009 (i.e., criteria for case selection, tool standardization, and adherence to established instructions) have resulted in a comprehensive and consistent method for case review preparation, presentation, and a procedure to obtain and organize feedback from panel members during the interactive case review process at quarterly meetings.

Twenty-four cases were selected for review in 2011. Two cases were presented at each panel region (Northern, Southern, and Central) quarterly. Reviews included cases that demonstrated a specified theme. CABHP met with DCYF staff who agreed to identify cases depicting the theme. Selected cases included both in-home and out-of-home placements of children and included both, fatality and near fatality incidents. A CABHP staff member with a background in child welfare serves as the primary case reviewer. The case reviewer is responsible for writing case reviews and presenting cases to the panels.

The CABHP reviewer is authorized to access the CPS electronic records (CHILDS) system. CPS staff also provides a “hard” copy file to CABHP that contains additional information that is not accessible through CHILDS and may include autopsy reports, medical records, law enforcement records, and service provider progress reports. Upon receipt, the case reviewer organizes the case record information and documents the information in the review tool. If information relevant to the case review is not in the case record, the case reviewer contacts a designated key contact person at DCYF to request further assistance in obtaining the information.

The reviewer also works with CPS Practice Improvement Specialists and other key persons in each region to obtain additional information, including clarification regarding specific cases or policies, as necessary. A preliminary review of the case summary is conducted by the case reviewer and Program Manager to ensure the information is comprehensive and thorough. The CABHP staff are available one hour prior to each meeting, affording panel members access to hard copies of the CPS case files.

In an effort to prepare and assist panel members for each case review, they are provided with ACRP Case Summary and Presentation Forms (Appendix D), a timeline of key events, and a genogram (pictorial display of family relationships and key information including ages and medical history) in advance of each meeting. Panel members also receive redacted copies of Child Safety Assessments (CSA), Family Safety and Risk Assessments (SRA), case plans, and aftercare plans (when applicable) completed by DCYF staff for each case. Key areas in which information is examined and discussed by the panels include:

1. Timeliness of Initiating Investigation of Reports of Child Maltreatment-Information on whether responses to every child maltreatment report received was initiated within timeframes established by policy including: identification of risk level; allegation of maltreatment; mitigated timeframes; accuracy of Hotline reporting procedures; whether

law enforcement or other emergency personnel was notified; CPS confirmation of child's safety; and CPS Specialist's attempts at face-to-face contact with alleged victim(s).

2. Initial Child Safety Assessment-Information on whether the CPS Specialist made concerted efforts to gather and analyze sufficient and relevant information to accurately assess child safety including: the decision whether any child in the home was unsafe due to present danger was consistent with observations at initial contact with child and family; if concerted efforts were made to interview or observe all relevant persons and gather sufficient and relevant information to identify potential safety threats; and did the CPS Specialist subsequently make correct safety decisions based on analysis of information gathered in the CSA.
3. Safety Planning to Protect Children in Home and Prevent Removal-Information on whether the CPS Specialist took sufficient and least intrusive actions to: control present or impending danger (through protective action and safety plan), ensure child(ren)'s safety in-home, and prevent child(ren)'s entry into foster care or re-entry after reunification. The panel determines if the actions taken by CPS to manage and control safety threats were appropriate.
4. Family Strengths and Risk Assessment and Provision of Services to Reduce Risks-Information on whether CPS Specialist made concerted efforts to assess the risks that were of sufficient severity to necessitate CPS services including: gathering sufficient and relevant information about each domain in the Family Strengths and Risks Assessment (SRA); identify consistency of risk indicators and protective behaviors; identify necessity of intervention; and case opening and closure includes information gathered during the assessment and is documented in the case record. The SRA provides the panel with an overview of the number and type of risk factors identified in the family/caregiver constellation. Identified risk factors include: parental substance abuse; physical/mental/emotional limitations of caregivers; parental history of abuse, family violence, and inter-partner violence; parental history of trauma and mental illness; observed parental nurturing, bonding and empathy; recognition of the problem and willingness to change; child vulnerability and special needs.
5. Determine Whether Maltreatment Occurred-An analytical and evidentiary process carried out by the CPS Specialist which involves synthesizing pertinent case information and applying the legal definitions of abuse and neglect to determine if maltreatment has occurred. Panels utilize the evidence presented in the CPS case file, police investigation, and medical and autopsy records to determine if the statement of maltreatment reflects the severity and type of child maltreatment documented.
6. Aftercare Planning-Panels review information to determine if aftercare planning was developed with input from family, and if parents/caregivers were provided adequate information on services and supports to address whether the safety and risk factors necessitating department involvement have been adequately addressed or if there are needs that may improve family functioning. When applicable, the panel determines if the CPS Specialist met with parents/caregivers and the child; assessed their needs and preferences with regard to aftercare services; and if parents/caregivers and children were provided with sufficient information on community or other supports.

The ACRP case review instrument, adapted from the In-Home/Out-of-Home section of the DCYF Practice Improvement Case Review Instrument, is completed on each case presented to the panel. In 2011, the applicable information examined and criteria discussed by the panel included:

- ongoing safety and risk assessment and management
- permanency goal for child
- concurrent permanency planning
- independent living services
- visiting with parents and siblings in foster care
- relative placement
- needs and services of child, parents and foster parents
- case plan development
- worker visits with child
- worker visits with parents
- educational needs of child
- physical health of the child
- mental/behavioral health of child
- foster homes

The panel recommendations and comments section focuses on the following information:

- precipitating events or triggers
- family risk factors
- factors that may have contributed to death
- joint investigation protocol
- potential policy issues or issues not addressed
- exemplary CPS practices that should be noted
- CPS supervision and communication

Case Record Review Findings

During this reporting period, 24 cases of child maltreatment were reviewed. Because panels chose to address specific themes for case reviews, CPS Practice Improvement Specialists assisted the Project Coordinator in identifying a sample of cases from each of the three regions. Cases were also selected from the Child Fatality/Near Fatality database compiled by CPS. Each of the three ACRPs completed reviews of two cases each quarter. Five (5) of these cases were fatalities, seven (7) were near-fatalities.

Case record review findings summarized below are consistent with the state's process by which reports of child abuse and neglect are received and addressed. Examination of the operations of the CPS system at each of these stages as outlined below are also recommended in the *Citizen Review Panels for Child Protective System: Guidelines and Protocols* (October 2001.)

Prior Child Protective Service History

Of the cases selected in 2011, 3 (13%) had no prior CPS reports. CPS received a total of 96 reports in the twenty-one (21) cases with prior report histories. Of the twenty-one cases with prior reports, the number of reports in these cases ranged from one (1) to seventeen (17) with an average of 4.6 reports per case. These numbers were impacted by the decision of the panels to review chronic neglect cases which were selected because of the multiple prior report history.

Crisis Intervention and Initial Child Safety Assessment

The panels concluded that CPS adequately fulfilled its role of assessing child safety in 15 (63%) of the 24 investigations reviewed. This finding is a little higher than the 59% finding in 2010. In nine (9) cases, the panels found that various critical safety factors were not identified or thoroughly addressed in the Child Safety Assessments. Many of the cases had multiple safety factors, as noted in the next section. Identification of safety threats and risk factors in the Child Safety Assessment assists the worker in developing a timely and appropriate safety plan for the child and case plan for the family, and should reflect all identified safety factors. This assessment process drives the intervention for the removal of safety threats.

Of the nine (9) cases in which the panel identified lack of action in response to an inadequate safety assessment:

- Substance abuse history of the parents was not sufficiently addressed in 3 cases
- Prior substantiated reports that were not factored into the Child Safety Assessment tool's safety threats analysis in 3 cases
- Mental health issues, and/or domestic violence were not factored into the safety assessment in 3 cases

Family Risk Factors Related to the Case Record Review

The most prevalent family risk factors identified during the reviews were lack of parenting skills (100%), parental mental health (100%), mother with traumatic event history (88%), prior reports (88%), and parental substance abuse (83%). Alcohol (67%), marijuana (50%), and methamphetamines (42%) were the most prevalent types of drugs identified in case record reviews. The predominant risk factors identified are consistent with the findings from the prior two years of case record reviews.

It is important to note that looking at individual risk factors does not take into consideration cumulative risk. The number of risk factors per case ranged from 3 to 12 with an average of approximately eight (8) risk factors identified per case.

Figure 2 shows the risk factors identified in the 24 cases reviewed (more than one factor may be identified in a single case).

Figure 2	Frequency of cases
Risk Factors	(n=24)
Lack of parenting skills	24 (100%)
Parental mental health	24 (100%)
Prior reports (unsubstantiated/substantiated)	21 (88%)
Mother with traumatic event history	21 (88%)
Parental substance abuse*	20 (83%)
Lack of physical/mental ability to provide adequate care	19 (79%)
Lack of willingness/motivation to provide adequate care	19 (79%)
Domestic violence	18 (75%)
Lack of resources for adequate food/shelter/medical/childcare	17 (71%)
Lack of anger control	13 (54%)
Chaotic household	13 (54%)
Cases with prior substantiated reports	12 (50%)
Developmentally delayed child	6 (25%)
Teen/ young parents	4 (16%)
Father with trauma history	4 (16%)
Prior removals by CPS/severance of parental rights	4 (16%)
Incarcerated parent	4 (16%)
Co-Sleeping with infant	3 (13%)
Lack of engagement in voluntary services	3 (13%)
Medically complex/medically fragile child**	2 (8%)
Abandoned by parent(s)	2 (8%)

*Alcohol 16, (67%)/Drugs 14, (58%)/Both 10 (42%): Drugs Identified: Methamphetamine 10, (42%) Marijuana, 12 (50%); Cocaine 5, (21%); Heroin/Methadone 3, (13%); Pain Medications 2, (8%)

**Children with health issues including premature birth, physical and developmental disabilities, and substance exposed newborns.

In addition to the risk factors listed in the table, the CABHP staff started tracking the following risk factors in 2011 as requested by the panels:

- Lack of parental engagement in voluntary services
- Abandoned by parent(s)
- Chaotic household

These additional risk factors will be compiled and incorporated into the 2012 annual report.

Investigation Stage

When examining each case investigation process, the panel identifies the strengths of the investigation and exemplary practice of CPS case staff. Noted positive qualities of CPS Specialists include maintaining good rapport with families, linking families with helpful services, and taking actions early to establish permanency. Some examples of exemplary practice included:

- CPS filed for dependency after a parent withdrew from a prior voluntary agreement for relative placement (Southern Panel)
- The CPS case manager utilized the unit psychologist in determining the therapeutic value of continued visitations of the child with his mother following severance (Central Panel)
- A CPS Assistant Program Manager was commended for compiling information and presenting it to the County Attorney (Northern Panel)
- A “Red File” for adoption of a child was started prior to the termination of parental rights (Central Panel)
- An Independent Living Services worker and the CPS independent living program worker were diligent in their efforts to support and provide helpful services to the identified youth (Northern Panel)
- A child was in the same foster home for eleven years and had the same CPS case manager for 4 years. At case transfer, the former worker became the supervisor on the case. The second case manager worked with the child for 2 years, at which time the child was referred for Independent Living Services (Southern Panel)

Panels also identify aspects of the investigation process where barriers hindered investigation, determination of findings, and/or case closure. Panels concluded that thorough investigations were completed in 15 of the 24 cases reviewed (63%). The following investigation concerns were identified:

- Child’s history of fire setting and the parents’ histories of substance abuse were not addressed in CPS assessments with the family;
- A family had multiple complex problems which were not adequately addressed;
- Inaccurate assessment of substance abuse and mental health concerns for some parents and children.
- Parents’ mental health needs were not adequately addressed in assessment or case planning;

Investigative Finding/Determination

The panels found that case record documentation supported the investigative findings in all of the 24 investigations reviewed. Of the 24 cases reviewed by the panels, 5 cases (21%) involved joint investigation. A properly conducted joint investigation includes the following elements: CPS case record documentation; police, forensic, and/or autopsy reports; CPS observations; interviews conducted by law enforcement; utilization of forensic services, inclusion of audio/video recordings of child interviews; child interviews conducted by a trained forensic interviewer in a child-friendly, safe environment; all evidence gathered by a multidisciplinary team; and CPS and law enforcement working cooperatively with county attorneys and the juvenile court.

The panels cited the following issues concerning the lack of joint investigation in 3 cases:

- Witnesses called police after seeing a caregiver hit a child and pull her out of the store by her hair. Law enforcement responded, but allowed the perpetrator to take the child home immediately following the incident of abuse; no charges were pressed.
- In an incident involving an infant fatality, no joint investigation took place because law enforcement did not communicate the information to the Hotline as a report of possible neglect or abuse.
- In the case of a child fatality, law enforcement ruled the death as an accident and did not take into account the objective evidence of neglect and lack of supervision by parents. There were several young children living in the home. The case was closed by police the day after the incident occurred.

Case Planning and Implementation

Seven (7) cases did not receive ongoing services because these cases were closed following investigation. The panels determined that in 15 of the 24 cases reviewed in 2011, case planning and ongoing case management activities were appropriate and timely. Panels noted instances when parents or guardians refused to participate in services voluntarily. In such instances, CPS is unable to enforce recommended case plans when safety concerns do not rise to the level that requires court intervention. Some specific concerns about ongoing assessment and provision of timely and appropriate services included:

- The panel was concerned about several young children placed in the care of their father living out of state. Concerns centered on what services the father was able to access, especially for the youngest child who suffered a brain trauma and needed appropriate and timely medical follow-up. The panel requested CPS request case plans and case notes from the out-of-state CPS (ICPC) to determine if adequate services were provided to assure the safety and well-being of the children. CPS acted on the concerns voiced by the Panel and requested the ICPC case plan and case notes, which indicated appropriate services were in place for the family.
- The panel was concerned that a mother's underlying depression was the primary problem but over many years of CPS involvement, the only problem addressed was the cleanliness of the home. In this case the mother never engaged in mental health treatment services.
- The panel was concerned about a lack of leadership in coordination of services and dissemination of information in complex cases, particularly cases where children are medically fragile.
- The panel was concerned about CPS worker access to purged case information in light of the multi-generational histories of neglect found in the chronic neglect cases reviewed.
- The panel noted there was often very little birth family involvement in transition planning for youth.
- The panel was advised that contracted Independent Living Specialists are not allowed to provide direct client service to youth in detention. The panel was concerned that this could be a barrier to discharge planning and timely implementation of services.
- The panel was concerned that imminent danger in neglect cases is difficult to identify.

Upon completion of each review, the panel asks key questions regarding whether state and federal policies were followed and then makes any recommended changes for policies and procedures.

Panels also comment on actions they believe could have been taken to prevent or avoid the abuse or neglect and their overall recommendations on the case. The results of each review are entered into a database that is maintained by the CABHP.

The case record reviews encompass all aspects of the child welfare system, and throughout the year resulted in a variety of recommendations or actions taken by individual panel members, DCYF staff, and system partners. Figure 3 below highlights some of the recommendations or actions that resulted from case reviews.

Figure 3	
Case Examples	Action
The child safety and risk factor assessment information documented in the CPS case record was not comprehensive and did not identify the severity of the substance abuse and mental health issues indicated during the investigation	The panel recommended that CPS conduct an administrative review of this case and several others. DCYF representatives on the panels took responsibility for this follow up and reported back to the panels about the outcome of this action.
The panel was concerned about several young children placed in the care of their father living out of state. Concerns were about the services the father was able to access, especially for the youngest child who suffered a brain trauma and needed services.	The panel requested CPS obtain case plans and case notes from the other state to determine if adequate services were provided to assure the safety and well-being of the children DCYF reported to the panels that this was accomplished and it was learned that the father was receiving appropriate services.
Law enforcement determined that an incident, resulting in a child's death was an accident. The CPS investigator believed the family had been grossly negligent due to substance abuse and failing to supervise their young children. The Assistant Program Manager provided the case information for review by the County Attorney. The panels formally recognized and sent letters of acknowledgement to CPS staff who exceeded expectations.	The panels formally recognized and sent letters of acknowledgement to CPS staff who exceeded expectations.
The case review of former youth identified incorrect information had been given to the youth about services and supports available to him after leaving care.	The DCYF representative on the panels was able to contact the youth, provided him with correct information, and offered to meet with him to explain the information further if he desired.

System Issues

At the conclusion of case reviews, panel members determine if state and federal policies were followed. In addition, panels evaluate the impact of policies/actions of community service and healthcare providers as related to the identification, prevention, and treatment of child maltreatment. Figure 4 provides a list of the issues identified in each of the 24 cases reviewed by the ACRP's in 2011.

Figure 4 System Issues Identified by the Panel Members
In many of the cases reviewed the underlying risk factors of mental illness were not identified as risk factors in the strength and risk assessments. Likewise, while substance abuse was often a concern, interventions were not identified often as being an area for intervention, even when the substance abuse was significant.
Service providers should understand trauma symptoms and the special needs of children who have been abused and neglected.
Safety threats and risk factors should be clearly documented in the assessments, particularly when treatments and services to address the threats/risks are prescribed in the case plan.
In several cases, multiple agencies and organizations were involved with the family but in each of the cases reviewed, there was no leadership for communicating or coordinating services and supports to the family. In these cases, this led to assumptions about who was responsible for providing intervention.
Children with severe behavioral and mental health problems need to have access to intensive long term residential or day program services.
Family preservation services are not appropriate when the family members have multiple needs for example when both the parent and child have serious mental illness diagnosis, the child is found to be harmed in physical altercations and both the parent and child have long histories of non-compliance with behavior health services and treatment.
There appears to be some confusion about Home Care Training for Home care Clients (HCTC) foster homes. The panels believe it is detrimental to the child to have to move from these placements once the child is stable due to the child being viewed as requiring a lower level of care and the foster parent being unable to take another child in as an HCTC placement with another child in the home.
Behavioral health should provide an array of services targeted toward children involved with CPS who also have behavioral health needs. Services should be provided to adoptive families specific to the children's long term needs. DCYF should advocate for the Department of Health Services Division of Behavioral Health to view children in foster and adoptive homes as a special population with additional service needs.
DCYF should consider a portable continuous educational record that accompanies children in CPS care as they move from placement to placement to reduce inappropriate educational placement

and duplicated testing and evaluations.

The stability of case managers impacted the outcomes for children, both good and bad. When case manager turnover was low better outcomes for the children were indicated.

In all six cases reviewed for the chronic neglect theme, the history of neglect was found to be multigenerational, even though cases with a multigenerational history were not identified in the criteria for case selection. Multigenerational abuse and neglect was rarely identified as a risk factor in the strength and risk assessments and these reports rarely resulted in a substantiated finding. In all six cases, when services were provided they were provided to respond to a symptom of the problem, for example, a dirty house, rather than underlying mental illness, most often depression and or substance abuse in the parent (e.g., in all six cases the home and children were identified as filthy, so when an intervention was provided, most often this was parent aide services, even though parental depression and/or substance abuse were indicated. Once the home was cleaned the case was closed without intervention provided to resolve the mental health or substance abuse concerns.) In these cases long term change was not sustained and a new report was made at a later time. In all six of the cases reviewed, ultimately there was a fatality or near fatality in the family due to an undetermined cause or neglect.

DCYF should explore options to increase the number of foster homes willing and able to take children with challenging behaviors and mental health needs. These children were observed to experience multiple placements and were often placed in inappropriate situations with foster parents or relatives who did not have the support to meet the child's needs, or in group homes or settings for juvenile delinquents.

Multiple reports in the same family were observed in many of the cases reviewed to have unsubstantiated allegations, even when there were many indicators that the children in the home had an on-going history of multiple needs not being met and the parent was unwilling to accept services but no single incident represented a threat to the child's immediate safety. DCYF should review policy for substantiating reports, especially those reports involving the accumulation of neglect.

The needs of the child as well as the needs of the parent should be included in assessments when services are offered or provided.

The youth advisory board may be an appropriate resource to assist in training educators and school staff in the needs of youth and the services and supports available for independent living.

Guidelines for independent living services need to be clarified for CPS supervisors and case managers.

The creation of a placement review process is recommended to allow an independent review of placement denials for families who are interested in caring for older children who have fewer vulnerability concerns. The process could review the benefit of placement vs. the placement concerns and determine if the concerns are addressed.

Relatives and kin willing to take older children should be provided with support and resources needed to stabilize housing if they are unable to meet licensing requirements due to their housing.

The legislature should consider new laws to require accountability for parents and caregivers who choose to home school and the regulations related to home schooling should be strengthened.

CPS Specialists need clarification for assessing safety in homes involving repeated reports of neglect.

Older children in care could benefit from mentors to help teens plan for the future in terms of vocation, education, budgeting, selecting friends, self care and parenting, set realistic goals about their future and help them gain access to resources and supports.

There continues to be a need for a National CPS registry to expedite identification of CPS involvement with individuals/families in other states.

A definition of chronic neglect to guide removing a child from their home or substantiating an allegation of neglect is needed.

Clear documentation results in better information being understood, repeated and addressed as CPS is sometimes involved with families over time. When prior case information was not well documented the family history was not identified in later investigations.

CPS should focus on assessing needs of foster families and providing supportive services to foster families and supportive services to families who adopt, especially families who adopt children with behavioral health needs.

Cases with multiple reports should be visibly flagged for CPS supervisory review and tracked to assure the review was completed.

There should be a public awareness campaign on the dangers of co-sleeping and better coordination of information for providers who are responsible for the care of infants.

Those responsible for identifying placements for children whose mother is in jail or prison when a child is born should identify a procedure or authority for checking on the safety of the child when an alternative caretaker is identified, at a minimum through a CPS or criminal history check.

Stability of placement and stability of the case manager resulted in a positive outcome for a youth aging out of the foster care system. Child lived in foster home for 11 years; foster parent was not interested in providing legal permanency due to concerns about losing supportive services.

DCYF should build capacity to provide longer-term supports and intervention for families who are unable to demonstrate long lasting change and/or when interventions do not address underlying problems.

Mental health and substance abuse concerns must be identified early in the case and resolved before cases are closed.

2011 Citizen Review Panel Program

Membership

Panels are comprised of 9 to 23 volunteers of diverse backgrounds and experience. (See Appendix A) Below is a chart of the panel membership from each region, showing member's agency or discipline representation.

The panel members have a wealth of knowledge and experience in child and family serving systems. Each panel has increased its diversity with members representing a variety of schools, hospitals, faith-based organizations, non-profit organizations, law enforcement, courts, government agencies, as well as private citizens and adoptive/foster care parents (see Figure 5).

Figure 5 Panel Member Representation			
*Representational Area	Central n=29	Southern n=19	Northern n=13
Private Citizens	3	1	1
Educators	4	4	
Mental Health	1	2	
Legal	2	3	
Law Enforcement	2		
Health Care	4	2	1
Social Services	8	8	8
Child & Family Advocates	3	1	2
Adoptive Parents		1	1
Adoptees			
Foster Parents	3		1
Foster Care Alumni			
Faith Based			
Tribal	2		
Former victims of abuse or neglect	1		
<i>*n= as of December 2011. Members may belong to more than one representational area.</i>			

Panel Member Survey

The annual survey of the panel members was conducted between October 10 and December 5, 2011, as a means to provide information on the level of satisfaction and suggestions for improvement of the program as well as to provide information to inform strategic planning activities. All panel members were encouraged to complete the survey including panel members who don't come often to meetings. Thirty-one (31) panel members completed the survey; 17

responses were from Central (55%), 9 from Southern (29%) and 5 from Northern (16%). Overall, the majority of the respondents reported satisfaction as indicated by noting they “agreed” or “somewhat agreed” as indicated below:

- 74% indicated that their regional panel broadly represents the community in which the panel is established and another 10% were neutral.
- 75% reported satisfaction with the size and membership of their regional panel and another 19% were neutral.
- 87% indicated the current meeting schedule was effective and 10% indicated it was neither effective nor ineffective.
- 83% were satisfied with the content of information provided at panel meeting and another 7% were neutral.

The survey also provided panel members with an opportunity to provide their suggestions for utilizing the panels’ time and expertise. A few examples of members’ suggestions included:

- Hear more from panel members in terms of how their given profession’s impact the panels’ effectiveness in facilitating support and direction for CPS;
- Allow more panel members the opportunity to participate in the discussion;
- Learn more about the overlapping systems involved in the work of child protection;
- Explain acronyms;
- Present ideas for solutions and improvements to issues identified within the child welfare system;
- Utilize research to improve the lives of children and families in collaboration with academia and government agencies;
- Utilize technology to assist with improving efficiency and expanding the quarterly meeting times.

Panel members were also asked an open ended question: I would like to see the panels... Those responses included:

- Share and discuss experience and impact on families and communities in their given fields;
- Understand law and policy more fully;
- Have more time to spend discussing each case, it seems rushed all the time

The complete survey results with all of the comments are included in Appendix E.

The survey results and responses will be utilized to guide strategic planning efforts to be held in January 2012.

2011 Areas of Focus

CABHP continues to be committed to providing panel members with the information they need to fulfill the program requirements as outlined in the CAPTA and to make certain the program is functioning in an efficient manner. To ensure that practices are employed consistently with a process for continuous quality improvement, several areas for enhancing the ACRP Program had been identified in the 2010 report. Due to time and resource limitations, not all of the activities proposed were able to be implemented. Below is an update on the suggestions identified by DCYF representatives, CABHP staff and panel members in 2010:

- ***Request technical assistance from the National Resource Center*** for DCYF to sponsor a facilitator to conduct strategic planning with panel members to facilitate the development of actions steps and strategies to meet program requirements

Status: A technical assistance application was submitted and approved. Strategic planning with all three panels is scheduled to take place in January 2012.

- ***Presentations on*** trauma informed care, the *Never Shake a Baby* program, multiple placements, and disruptions in foster care

Status: Completed. In addition to the above presentations, panel members were also provided with opportunities to attend a webinar on trauma informed care and a community presentation on secondary trauma.

- ***Case record review of cases that include*** youth aging out of the CPS system; teen parents including those in foster care; adopted youth returned to CPS

Status: Completed. Panel members were concerned about youth transition to independence, so the panel reviewed cases where youth were aging out of the foster care system. In addition, although not the specific theme for cases reviewed in 2011, several cases were identified for review that involved teen parents in foster care and adopted youth returned to CPS.

- ***Training for panel members on*** the child welfare system, assessing strengths and risks; impact of blended families on child welfare and domestic violence, additional trauma training for foster parents and CPS supervisors and staff, shadowing CPS staff in the field, observe the Hotline, foster care services and ethics, criteria for child abuse prosecution, child abuse prevention strategies/resources (Healthy Families Arizona, etc.);

Status: Not complete due to time limitations and the meetings being focused on specific themes.

- ***DCYF staff to provide updates on*** activities related to panel recommendations (e.g., national registry, chronic child neglect) and impact of economic downturn (e.g., budgets, referrals for services)

Status: Partially completed, information was provided about chronic neglect, but other areas were not discussed due to time limitations.

- ***Areas for further inquiry include:*** an examination of the child welfare system to identify areas where child abuse victims are “falling through the cracks;” examine initiatives in other states that intended to strengthen and support their child welfare system, child maltreatment attributed to the economic downturn, educational services/supports for children in foster care, intergenerational child abuse and neglect, and opportunities to collaborate with the Medical Examiner’s Offices;

Status: Partially completed, cases explored in 2011 were cases in which victims were “falling through the cracks,” and intergenerational child abuse and neglect was identified and discussed in the chronic neglect cases, but other areas were not discussed due to time limitations.

- ***Continue recruitment efforts targeting*** juvenile court/judge, legislators, court-appointed special advocates (CASA), concerned citizens, guardian ad litem, law enforcement, medical providers, faith-based representatives, adoptees, and foster children.

Status: Partially completed, each panel has increased membership but plans for further expansion of the panels was put on hold and will be explored further in the upcoming strategic planning sessions to ensure that panel membership is appropriate to meet the goals of the panels.

Appendix A - Citizen Review Panel Members Central Region

Darryl Bailey

DES/DCYF Central Region

Lisa Barrientos

Mesa Police Department, Homicide Unit

Gary Brennan

Quality Care Network

Bernadette Chambers

Southwest Human Development

Cindy Copp

DES/DCYF Southwestern Region

Janet Cornell

Scottsdale City Court

Patricia Danielson

DES/Child Protective Services

Diana Devine

Native American Connections

Pamela Fitzgerald

Citizen/Former Teacher

Jo Fuhrmann

CHEERS, Inc.

Emilio Gonzales

DES/DCYF Policy Unit

Simon Kottoor

Sunshine Group Home

Kris Jacober

Foster Mother

Arizona Friends of Foster Children

Nancy Logan

Office of Disability Adjudication, SSA

Joanne MacDonnell

AZ Ombudsman -Citizens Aide

Linda Madrid

Arizona State University

Jennifer Mullins-Geiger

Arizona State University

Samantha Nordvoid

Madison School

Princess Lucas-Wilson

Citizen

Pamela Ruzi

Hospice of the Valley

Beth Rosenberg

Children's Action Alliance

Tracy Sloat

Maricopa County Dept. of Public Health

Marcia Stanton

Phoenix Children's Hospital

Natalie Miles Thompson

Crisis Nursery

Roy Teramoto, M.D.

Indian Health Services

Allison Thompson

Maricopa County Adult Probation

Stephanie Zimmerman, M.D.

Phoenix Children's Hospital

Appendix A: Citizen Review Panel Members Southern Region

Comel Belin, Ph.D.

Tucson Unified School District

Gloria Bernal

Tucson Unified School District

Anna Binkiewicz, M.D.

*Retired Professor/Medical Director
Casa de los Ninos Crisis Nursery*

Cheryl Brown

*Pima County Attorney's Office
Juvenile Unit*

Robin Gerard

Casa de los Ninos Crisis Nursery

Sandy Guizzetti

Foster Care Review Board

Karen Harper

*Southern Arizona Children's Advocacy
Center*

Carla Hinton, Ph.D.

Amphitheater Public Schools

Jaymie Jacobs

*Office of Pima County School
Superintendent*

Linda Johnson

*Manager, DCYF Policy and Legislative
Analysis*

Karen Kelsch

Pilot Parents of Southern Arizona

Christie Kroger

DES/Child Protective Services

Monica McDonough

DES/Child Protective Services

Martha McKibben

*Northwest Medical Center, Social
Work Dept.*

Joan Mendelson

Citizen/Attorney

Darlene Moten

Amphitheater Public Schools

Laurie San Angelo

Office of the Arizona Attorney General

Appendix A - Citizen Review Panel Members Northern Region

Judy Gideon

Citizen/Retired Foster & Adoptive Parent

Emilio Gonzales

DES/DCYF Policy Unit

Sandra Lescoe

DES/DCYF Policy Unit

Carli Moncher

Safe Child Center/Flagstaff Medical Center

Dani O'Connell

DES/Child Protective Services

Kathi Raley

Victim/Witness Services for Coconino County

Ruth Ellen Suding

Coconino Coalition for Children and Youth

Beya Thayer

Northland Family Help Center

Cindy Trembley

DES/Child Protective Services

Liana Van Ormer

DES/Child Protective Services

Suzette Vigil

DES/Child Protective Services

Melissa Young

DES/Child Protective Services

Appendix B - Agency Response to the 2010 Arizona Citizen Review Panel Program

12th Annual Report Recommendations

The Division of Children, Youth and Families (DCYF) provides the following response to the Citizen Review Panel Program recommendations.

Recommendation 1: DCYF should seek opportunities with collaborative partners to evaluate outcomes and systems collaboration, and explore expansion of the Arizona

Response: *The Division of Children, Youth and Families (DCYF) agrees with this recommendation. DCYF will seek opportunities to collaborate with the Courts and other child welfare partners to improve the assessment and delivery of services to infants and toddlers. Additionally, DCYF supports efforts to enhance the Court's knowledge of the unique needs of infants and toddlers.*

At this time, 12 of Arizona's 15 counties are in various stages of implementing the Court Teams for Infants and Toddlers Project which includes:

- the Juvenile Court Judge in the 12 counties has completed training and implemented the program in his/her court;*
- the attorneys appointed to represent children participated in the "Best for Babies"*
- attorney training;*
- the CASAs assigned to infants have participated in the "Best for Babies" training.*

DCYF management level representatives are currently engaged in collaborative effort to expand court teams for children in Maricopa County, the largest metropolitan area in the state. The Maricopa County Presiding Juvenile Court Judge plans to establish three specialized courts to hear dependency cases involving children under five years of age.

The Division's diligent review and monitoring of case record data indicates a disconcerting trend that children under one year of age are more likely to enter foster care, remain in foster care longer and more likely to re-enter foster care from reunification than children of other ages. In response to this emerging trend, the DCYF, in collaboration with the Administrative Office of the Courts, is convening a "Babies Summit" on July 7, 2011. This Summit will bring together approximately 35 key child welfare partners including DCYF management and "front-line" staff, Juvenile Court Judges, child advocacy groups, early intervention, community-based prevention agencies, foster/adoptive parent representatives, the Attorney General's Office, substance abuse providers, etc. The purpose of the Summit is to:

- explore the age disparities in the rate of entry, length of stay, reunification and reentry from reunification for children under age one;*

- *heighten awareness of and identify current initiatives to address this issue; and*
- *develop a shared vision and agenda that will lead to systemic change for this population.*

Additionally, DCYF addresses the needs of these young children through extensive policy and procedures that require a prompt individualized assessment of and response to the placement needs for all children who enter out-of-home care. These measure include but are not limited to:

- *a referral, within 24 hours of out-of-home placement, for a behavioral health assessment by a mental health provider;*
- *Child and Family Team assigned to address the unique behavioral needs of the child;*
- *comprehensive medical and dental assessments of children within thirty days of out-of-home placement and care coordination through the Comprehensive Medical and Dental Program (CMDP);*
- *a referral for early intervention screening, assessment and services through the Arizona Early Intervention Program (AzEIP); and*
- *integration of early childhood, child and adolescent development in Case Manager CORE training which focuses on the cognitive, social, emotional and physical development with emphasis on brain function for children.*

Recommendation 2: DCYF should review policies related to medically fragile children and their families/caregivers and ensure that supervisors receive training related to this population (e.g., gathering, assessing and documenting key medical information; identification of high risk medical conditions and identifying needed services; accessing consultation from CMDP; expectations for service coordination with medical providers including Children’s Rehabilitation Services; and providing clinical supervision to staff working with medically fragile children). DCYF should encourage and assist families of children with complex medical needs to invite their health care provider or an identified health care coordinator to interdisciplinary meetings (e.g., case staffing, care plan coordination meetings, and/or Child and Family Team Meetings) so they may assist with case planning, link families with resources, educate families/caregivers on the child’s needs, and coordinate ongoing services. Alternative methods for participating in these meetings that maximize the use of technology should continue to be explored (e.g., teleconferencing and web-based applications).

Response: *The Division of Children, Youth and Families (DCYF) agrees with this recommendation. The DCYF will review current policy to ensure that it provides sufficient direction to staff about how to identify, assess, and intervene in cases involving medically complex children.*

The department’s child safety and risk assessments require the CPS Specialist to obtain (and document) sufficient and relevant information about the child’s functioning including vulnerability, special needs, physical and emotional health, child developmental status, school performance, attachment with parents, etc. This assessment also includes documentation of the outcome of services previously provided to the child and family. The CPS Specialist is expected to make contacts with and request records from collateral sources including medical, dental, school,

behavioral health providers and law enforcement.

The DCYF recognized the need to enhance the skills of caregivers to meet the needs of medically fragile children in out-of-home care. In response to this need, the DCYF collaborated with the Comprehensive Medical and Dental Program (CMDP) Medical Director, Adoption Subsidy Program staff, and licensing agency staff (including a Nurse Practitioner and two Pediatric Nurses) to develop eighteen hours of advanced pre-service curriculum for foster parents. Licensing agency staff will attend train-the-trainer five day workshops prior to receiving a copy of the curriculum and making the curriculum available to their foster parents.

For foster parents, the purpose of the training is to provide them with a basic awareness level of what qualifies a child to be assessed as “medically fragile;” general information about the qualifying diagnoses or conditions; the special needs a medically fragile child may have; basic skills from concrete examples of how to meet those special needs; and, the ability to assess and determine the impact of caring for a medically fragile child on their own family. In addition, the child’s health care providers are required to provide instructions about the medically fragile child’s needs to the child’s caregiver.

The DCYF supports the inclusion of the child’s health care providers in the case management processes (e.g., case plan staffings, Team Decision Making meetings, Child and Family Team meetings, care coordination meetings, etc.) and service delivery meetings. Medical case management and coordination is frequently provided through CMDP and CMDP staff are included in the child’s service team. State law and policy also require participation of the child’s physician in the review of the decision to remove a child from his/her home when the child has a medical need or chronic illness. If the child’s physician is not available, the CPS Specialist must include a physician who is familiar with children’s health care. The DCYF will develop and disseminate a policy clarification for field staff reminding staff of this policy requirement and of the ability to maximize participation of service providers in case management and service delivery processes through the use of teleconferencing and language lines.

The DCYF will identify curriculum development and staff training regarding identifying, assessing, intervening, and treating medically fragile children as a priority for SFY 2012. The DCYF will use its current contract with Arizona State University to advance this initiative.

Recommendation 3: Expand to all regions the remedial training for proper documentation that was initially piloted in one region of the state.

Response: *The Division of Children, Youth and Families (DCYF) agrees with this recommendation. The Child Welfare Training Institute (CWTI) provides opportunities for documentation training as part of its structured Case Manager and Supervisor Core training. The class covers:*

- why documentation is important,*
- how to write what is relevant,*
- paint the picture—who, what, when, where and how, and*

- *proper grammar.*

The CWTI also provides, upon request, a seven-hour advanced documentation training to line staff. This advanced training focuses on the fundamental foundation for documentation (e.g., the importance of documentation, how to record important tasks and events in the life of a case, and who/what/when/where/how).

In addition, DCYF continues to reinforce policy and documentation requirements for completing a thorough investigation including the assessment of child safety in all cases through:

- *instructional tips and model examples:*
 - *of documentation, and*
 - *on who to interview, what documents to review, review of criminal history information, and obtaining and reviewing court orders that restrict or deny custody, visitation or contact;*
- *case record reviews that evaluate whether or not the required interviews occurred, whether required documents were obtained and reviewed, whether sufficient relevant information was gathered to confirm the presence or absence of each of the 17 safety threats, and whether there is documentation of an analysis of the*
- *information in relation to the 17 safety threats and the safety threshold;*
- *real-time feedback to staff about their documentation following each case review to clarify and reinforce the practice standards for staff at all levels in the regions and to improve consistency and accountability; and*
- *employee performance evaluations*

The Practice Improvement Unit has developed a number of tools and guides to educate and assist staff in their documentation for all steps of their investigation. These tools, guides, and tips are distributed to all the staff and reinforced through the case review process. The DCYF will continue to assist staff in strengthening documentation by providing ongoing feedback, training, and creating other “good case examples” for staff to utilize.

Recommendation 4: Clarification should be provided to CPS staff regarding the need to complete a safety assessment when an infant is born to a parent with an open case.

Response: The Division of Children, Youth and Families (DCYF) agrees with this recommendation. *The DCYF will send a policy clarification to all staff reinforcing existing policy requirements to complete a reassessment of child safety when any of the following occur:*

- *prior to the case plan reassessment, minimally every 6 months;*
- *changes in household composition (additions or departures of individuals from the household);*
- *any time there is an indication that a child may be in danger;*
- *prior to beginning unsupervised visits;*

- *prior to reunification; or*
- *prior to case closure.*

This clarification will summarize and reference existing policy regarding who should be included in the assessment, what information needs to be gathered, and how this information is documented in the assessment tool.

Appendix C: 2011 Agenda and Meeting Locations

	<u>Monday (1:00 – 4:00)*</u>	<u>Monday (1:00 – 4:00)*</u>	<u>Friday (9:00 – 12:00)*</u>
1st Quarter	March 21	March 7	March 11
2nd Quarter	June 13	June 20	June 3
3rd Quarter	August 29	September 19	September 23
4th Quarter	October 31	December 5	November 4

* Pre-meeting Workshops held one hour before the regularly scheduled meetings.

1st Quarter Meeting

Pre-meeting Workshop: Tour of Child Advocacy Center for Central and Southern Panels
 Presentation: Never Shake a Baby
 CPS Policy Review Related to Case Record Presentation
 Case Record Review #1: Trauma Informed Care for Children
 DES Program Report: Immigration Policy Issues; Concurrent Case Planning
 Case Record Review #2: Trauma Informed Care for Children
 Recommendations from 1st Quarter Meeting

2nd Quarter Meeting

Pre-meeting Workshops: Orientation Sessions
 Presentation: Sustaining Placements in Foster Care and Adoption
 CPS Policy Review Related to Case Record Presentation
 Case Record Review #1
 DES Program Report: 9th Circuit Court of Appeals Update; Collaboration with Schools
 Case Record Review #2
 Recommendations from 2nd Quarter Meeting

3rd Quarter Meeting

Pre-meeting Workshops: Trauma Informed Care for Parents
 Presentation: Youth Transitioning from Foster Care
 CPS Policy Review Related to Case Record Presentation
 Case Record Review #1
 DES Program Report: Youth Transitioning from Foster Care
 Case Record Review #2
 Recommendations from 3rd Quarter Meeting

4th Quarter Meeting

Pre-meeting Workshops: Orientation Sessions
 Presentation: Annual Report and Survey
 CPS Policy Review Related to Case Record Presentation
 Case Record Review #1
 DES Program Report: Chronic Neglect Update
 Case Record Review #2
 Recommendations from 4th Quarter Meeting

Appendix C

2011 Meeting Locations

Southern Region

La Paloma Family Services
870 West Miracle Mile
Building A
Tucson, AZ 85705
(520) 750-9667
<http://www.lapalomakids.org>

Central Region

School of Social Work
Arizona State University
Downtown Phoenix Campus
University Center (UCENT)
411 North Central Avenue
Suite 822A, 8th Floor
Phoenix, AZ 85004-0698
(602) 496-0800
<http://ssw.asu.edu/portal/>

Northern Region

United Way of Northern Arizona
1515 East Cedar Avenue
Suite D-1
Flagstaff, AZ 86001
(928) 773-9813
<http://www.nazunitedway.org/>

Appendix D: CABHP Case Record Summary and Presentation

Arizona Citizen Review Panel

___ Quarter, ___, 20__

___ Region, Case # ___

Purpose: Highlight key data and findings extracted from CPS CHILDS system and other documentation to provide information to the regional Citizen Review Panels so that recommendations can be developed and areas of exemplary practice identified. Panel members will receive a copy of this document with copies of the Practice Improvement Case Review Instrument and the In Home or Out of Home (if applicable). All personal identifying information will be redacted from the materials before distribution. The period under review will be the last 12 months except for items that are related to history of CPS involvement and /or may be relevant to the current case being reviewed (e.g. substance use, criminal history, etc.)

- A. **Narrative Overview of Case Description** - allegation(s)/what trigger the call, age, gender and race/ethnicity of victim(s), reporter, perpetrator(s), summary of history of CPS reports and findings, relevant factors (e.g. substance use, mental illness, physical health, developmental disability), manner and cause of death (specify per medical report, autopsy and/or death certificate), relevant toxicology testing performed including results and any charges filed, summarize services received and/or needed but not received.

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- B. **DES Practice Improvement Case Review Instrument Summary** - review should use the directions in the tool also refer to the DCYF Quality Improvement System Procedures, Training Manual and any relevant DCYF policies and procedure. **Significant information** - summary of information reviewed in the copy of the DES record and/or collected from CHILDS. **Key Findings**-document findings of safety & risk assessment and investigations, plus any relevant decisions made by DES and the courts. **Comments**- additional information that would be beneficial to share with CRP members, DES Administration and/or CABHP staff.

Item	Significant Information, Key Findings & Comments
Item 1 Timeliness of Initiating Investigation of Reports of Child Maltreatment	<i>Consider also the relevance and sufficiency of the information gathered during current or prior CPS investigations and case planning</i>
Item 2 Initial Child Safety Assessment	-ATTACHED COPY OF CSA FROM CHILDS-
Item 3 Safety Planning to Protect Child(ren) in Home and Prevent Removal	-ATTACHED COPY OF CSA FROM CHILDS

Item 4 Initial Strengths & Risk Assessment and Provision of Services to Reduce Risks	-ATTACHED COPY OF SRA FROM CHILDS- <i>Document whether services offered and/or provided addressed the identified safety threats and risk factors and any outcomes as a result of services received. Also need to consider whether actions were taken in a timely manner to ensure the safety of other children remaining in the home.</i>
Item 5 Determining Whether Maltreatment Occurred	
Item 6 Aftercare Planning	

- C. ***DES Practice Improvement Case Review Instrument-In Home or Out of Home- review*** - should use the directions in the tool and any relevant DCYF policies and procedure. **Key Finding-** should include information that justifies the rating. **Comments-** additional information that would be beneficial to share with CRP members, DES Administration and/or CABHP staff.

Item	Significant Information, Key Findings & Comments
Item 1 Ongoing Safety and Risk Assess. And Safety Management	-ATTACHED UPDATES OF SRA FROM CHILDS-
Item 2 Permanency Goal for Child	
Item 3 Concurrent Permanency Planning	
Item 4 Independent Living Services	
Item 5 Visiting with Parents & Siblings in Foster Care	
Item 6 Relative Placement	
Item 7 Needs & Services of Child, Parents and foster Parents	
Item 8 Case Plan Development	

Item 9 Worker Visits with Child	
Item 10 Worker Visits with Parents	
Item 11 Educational Needs of the Child	
Item 12 Physical Health of the Child	
Item 13 Mental/Behavioral Health of the Child	
Foster Homes <i>Complete only if <u>allegations involve foster family</u> placement. Identify any findings from foster care review board on their barriers.</i>	

D. Panel Recommendations and Comments

Precipitating Events and/or Suspected Triggers: ☐ Commission of Another Crime ☐ Family Violence ☐ Revenge ☐ Crying	☐ Disobedience ☐ Feeding Difficulty ☐ Toilet Training ☐ Other:
Family Risk Factors: ☐ Substance Use ☐ Mental Health Problems ☐ Domestic Violence ☐ Sexual Abuse ☐ Violence Outside the Home ☐ Lack of Physical or Mental Ability to Provide Adequate Care ☐ Lack of Motivation to Provide Adequate Care ☐ Prior Removals by CPS or Severance of Parental Rights ☐ Lack of Resources for Adequate Food/Shelter/Medical/Child Care ☐ Child(ren) with special needs: ☐ Medical ☐ Developmental ☐ Emotional/Behavioral Health	☐ Lack of Parenting Skills ☐ Teen Parent ☐ Prior Child Death ☐ Lack of Anger Control ☐ Co- sleeping with Infant ☐ Prior Substantiated Reports ☐ Other: Were all risk factors identified in the record? ☐ Yes ☐ No If not, specify additional risk factors identified by the panel members:
Were all identified risk factors addressed and/or resolved? ☐ Yes ☐ No If No, describe:	
Joint Investigation: reference the joint investigation protocol for the applicable region and note any areas in which the protocol was not followed.	
Was a thorough investigation completed? ☐ Yes ☐ No If No, describe:	

Supervision: note any instances or documentation that indicates that there was inadequate communication (e.g. reporting facts, clear instructions) between the CPS worker and their supervisor. Also specify any decisions/findings were overturned.
Potential Policy Issues: indicate whether there are any specific policy issues, concerns or recommendations. 1) Areas where policy not followed or quality concerns; 2) Policy followed but still bad outcome or concern identified (may need to re-evaluate or modify the policy); 3) Issue not addressed in the policy.
Exemplary Practices: note any practices that should be shared to encourage the continued practice.
Other: note any known circumstances that you believe may have impacted the outcome (e.g. lack of services, support services, case load size, training). Document any barriers outside the CPS agency that impacted the agency's ability to ensure a continuity of consistent, timely and adequate services.
What actions does the panel believe could have been taken to prevent/avoid this event?
Recommendations:

Demographics

Age of Child: Race: Hispanic/Latino: ☐ Yes ☐ No

Prior CPS involvement: Number of prior complaints: Number of substantiated complaints:

Age of Parents/Gender (e.g. 43F 51M): Marital Status:

Father History of Abuse: ☐ Yes ☐ No Check Type: ☐ Physical ☐ Sexual ☐ Mental/Emotional ☐ Neglect

Mother History of Abuse: ☐ Yes ☐ No Check Type: ☐ Physical ☐ Sexual ☐ Mental/Emotional ☐ Neglect

Does mother work out of the home? ☐ Yes ☐ No

If yes, was perpetrator primarily responsible for caring for Target Child during mother's absence? ☐ Yes ☐ No

Birth Order of Target Child: Number of Children Under Age 5:

Was substance abuse a risk factor for this family: ☐ Yes ☐ No Identify substance(s):

Was Target Child identified as having a behavioral health disorder? ☐ Yes ☐ No If yes, specify:

Time Line

Date	Significant Events for the Target Child	Notes

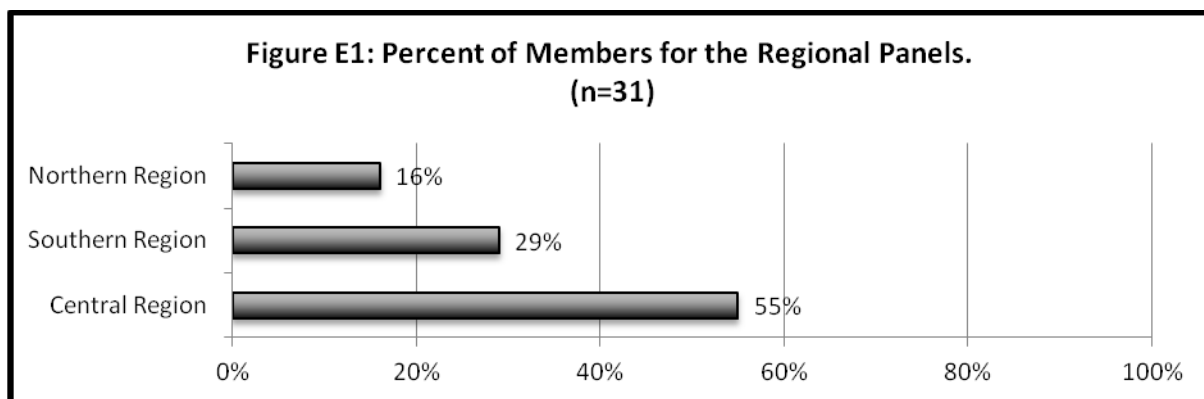
Appendix E: Citizen Review Panel Survey

On October 10, 2011, Panel members received an email request from the Citizen Review Panel Program Coordinator requesting them to complete a 14-question survey by October 21, 2011. This was done as a means to provide information on the level of satisfaction and suggestions for improvement of the program and as a way to provide information to inform strategic planning activities. All panel members were encouraged to complete the survey including the panel members who don't come often to meetings.

By completing this survey, participants documented their time in the Citizen Review Panel, their feelings about it, and their thoughts about the future and direction of the panel. The survey covered questions about the satisfaction of the panel structure and meetings, including scheduling, size and membership, community representation, and the variety/content of information provided at meetings. The survey participants responded positively on all of these measures, either through agreement, satisfaction, or effectiveness scales. The survey also identified interest in future participation within the Citizen Review Panel, either as a chairperson or by participating in a strategic planning session. These questions demonstrated interest in these specific participation areas, while other questions helped identify specific interests and roles of members and chairpersons. These results also show evidence of enthusiasm about the panel and give direction to possible areas of improvement within the Citizen Review Panel. The specific 2011 survey questions and results are provided below.

Question 1: I am a Citizen Review Panel member for the (check one): Central, Southern or Northern Region.

Thirty –one (31) Panel members completed the survey with 17 responses from Central, 9 from Southern and 5 from the Northern Panels.

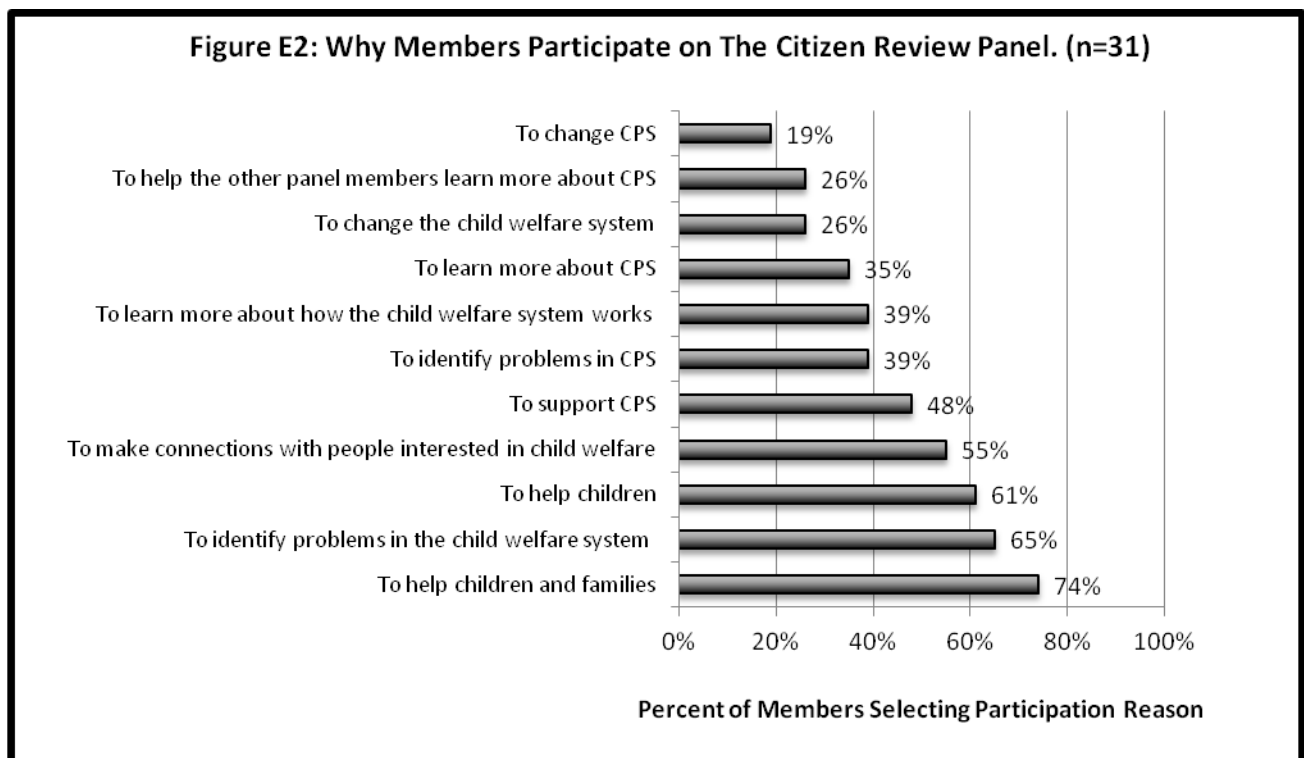


Question 2: I have served on the Citizen Review Panel for: _year(s).

Members who responded indicated that they had served on Panels from less than 1 year to 14 years, with 12 of the respondents serving on the panel for less than 2 years. Eight respondents have served on the Citizen Review Panel for 2 years. Eleven respondents served on the panel for at least 3 years, and as many as 14 years.

Question 3: Which of the following statements reflects why you participate on the Citizen Review Panel (mark all that apply)?

A majority of the respondents selected four distinct reasons for why they participate in the Citizen Review Panel. “To help children and families” was the most heavily cited reason for participation in the survey, with 74% of all respondents selecting this as their reason for involvement. Similarly, 61% of the respondents selected “to help children” as their reason for participation. Twenty respondents selected that a reason for their participation on the Citizen Review Panel stems from an interest in identifying “problems in the child welfare system (CPS and the agencies who work with them).” Participants also showed interest in making connections with others. Indeed, 55% (17 respondents) claimed that a reason for their participation included the motivation “to make connections with other people who have an interest in child welfare.”



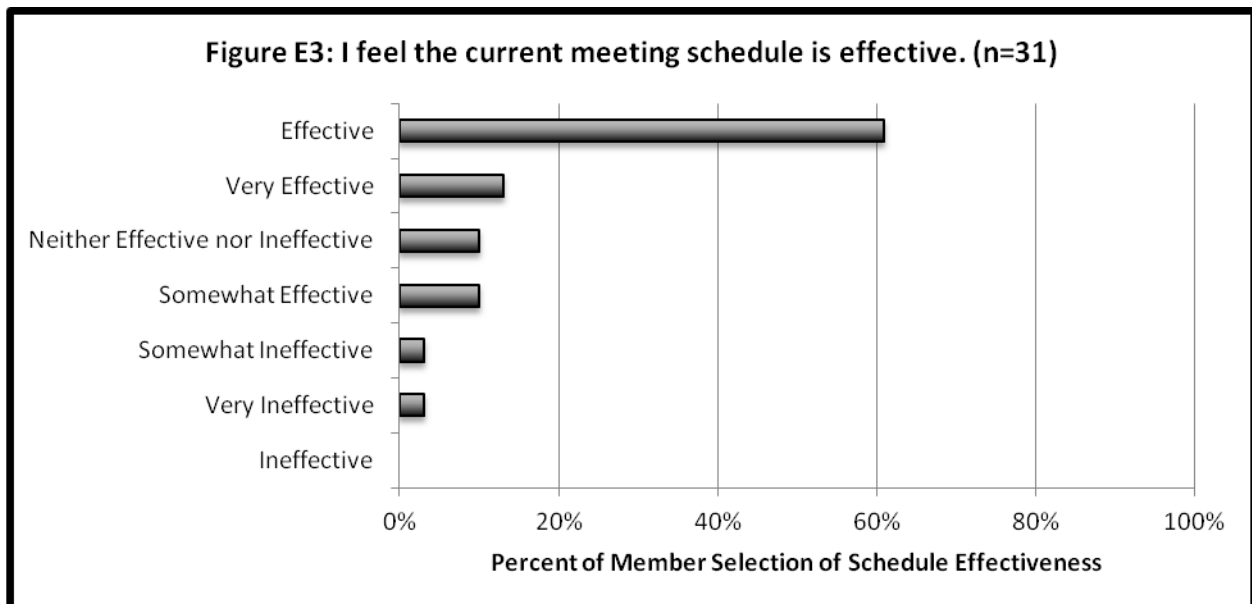
Question 4: Do you have any thoughts or ideas about ways to use the panel's time and expertise better? Provide a brief explanation of your thoughts.

- I am impressed by the field of experience of panel members. I would like to hear more from each panel member in terms of how their given professions impact our effectiveness in facilitating support and direction for CPS. There is also the invaluable contribution of academia by virtue of affiliation with ASU. I would like to see academic connections established between the variety of skill sets and the development of in-services for graduate and undergraduate students who are interested in serving the public sector in areas of education, psychology and related disciplines. We should also research opportunities for research in the above areas to improve lives of children and families in collaboration with academia and government agencies
- I like the discussion format and the preceding presentations. I would greatly appreciate it if the case histories were as complete as possible, but also if someone pre-read them and eliminated the pages and pages of duplication that constitute as much as half of each case history. I go through them all because I don't want to miss relevant info, but feel very frustrated when all I see is the same paragraphs repeated over and over in response to questions that ask for a somewhat different bit of info. A response of " I don't know " or " see my response to question #x " would at least save the reader some time.
- I believe that some of the panel members monopolize the conversations/discussions about their experiences w/ CPS. However, most of this dialogue is no longer relevant as their experience is from 5-15 years ago as a foster parent, or employed w/ agency for 6 months like 10 years ago. Things have changed and CPS no longer conducts business in the same manner. The Citizens Review Panel should consider utilizing or recommending technology to assist with improving efficiency. Maybe the panel should consider inviting a "Tech Savvy" member to the panel?
- In the panel that I sit on, there are so many CPS representatives that it feels like CPS reviewing CPS. I would like to see more true 'citizens' who don't know anything about CPS or the child welfare system looking at these cases to help us identify the obvious, common sense things that do or don't happen to improve children's lives. So many times the panel members are defensive about things that happen to kids, and because they're vocal, theirs are the voices that are heard.
- Have someone from CPS review the case after the ASU person does so that questions/confusion can be cleared up prior to the meeting and the other panel members being exposed to the case information that may be wrong/confusing.
- I wish there was more time to review more cases. Perhaps some of the program information can be shared prior to the meeting or on-line. It has been helpful to new members or those not involved as much in the child welfare system, but then it takes away from case reviews.
- Reviewing cases is very beneficial. I would use some of the experts on the panels to address underclass Social Work classes to give a perspective of what young persons are entering as a career path...more like job-coaching than critics.
- Continue to remind/refresh panel members, who are not directly in the field of child welfare, of the acronyms and protocols in use in CPS matters. Thank you for instructive information to date.
- I feel that the panel's time and expertise is very well used. Comparing it to other organizations I have belonged to this is the best I have worked with.
- Go around and ask each member their thoughts about a case. Some members do all the talking. This will allow everyone a chance to participate.

- I feel as though we don't have enough time to review cases and not everyone has a chance to speak at meetings. Checklist doesn't always capture the extent of the cases.
- To focus on identification of issues within the child welfare system and present ideas for solutions and improvements that could help CPS.
- I think we need to learn more about systems as I would contend that child protection involves many over-lapping systems. The goal of learning about systems would be to learn how best to coordinate efforts between systems for improved outcomes for children.

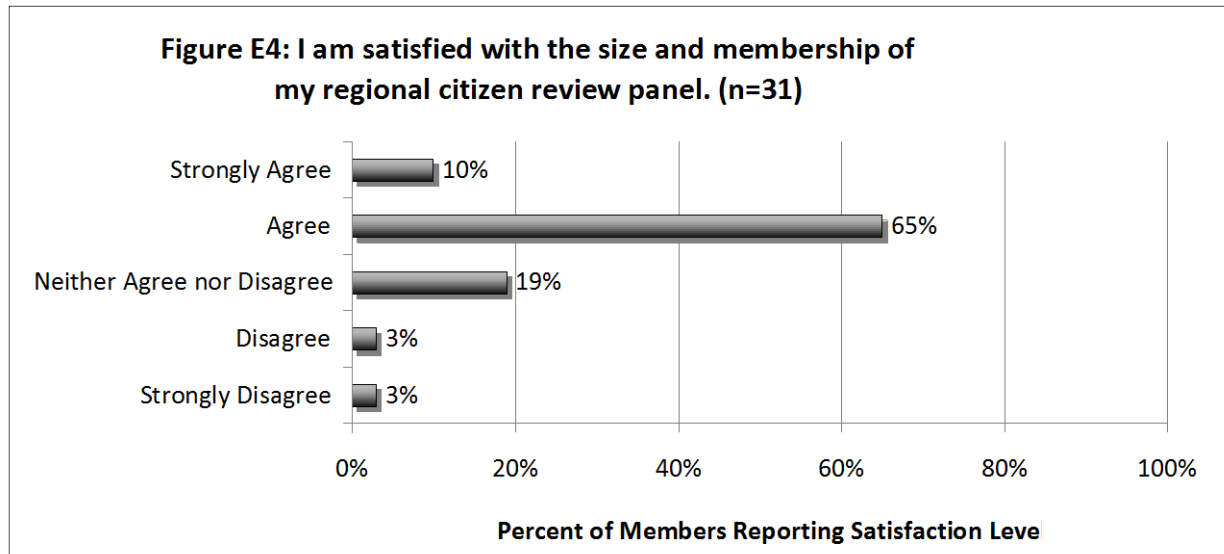
Question 5: I feel the current meeting schedule is effective.

Over 60% of the 31 survey respondents felt that the current meeting schedule is effective, with 13% of respondents claiming that the current schedule is very effective. That is, 74% of the participants felt that, at the very least, the schedule was effective. Only 1 respondent said that the current meeting schedule is very ineffective, and only one other respondent said that the schedule is somewhat ineffective.



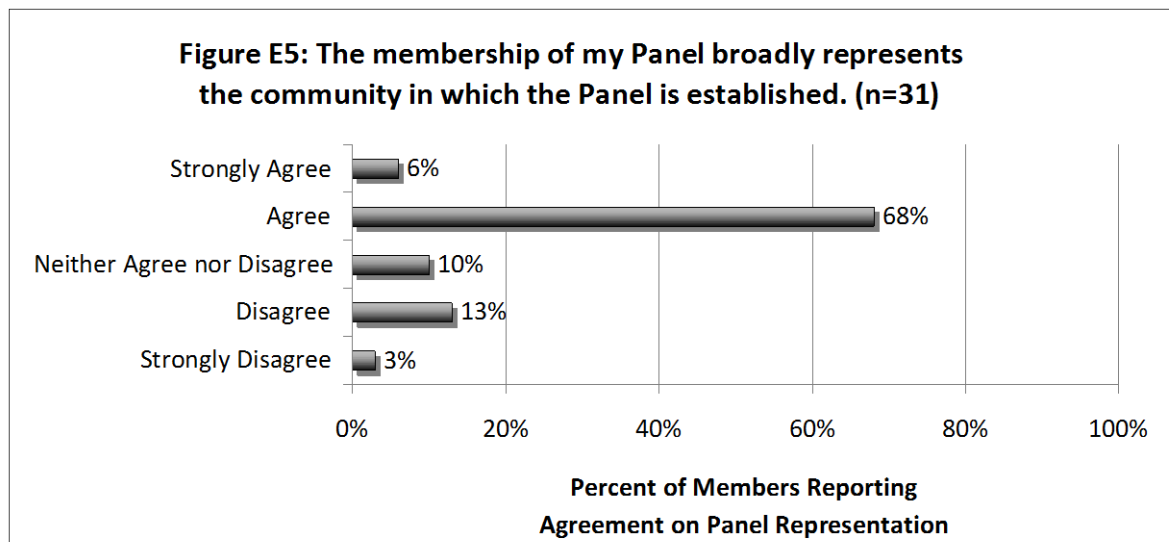
Question 6: I am satisfied with the size and membership of my regional citizen review panel.

In response to the statement, "I am satisfied with the size and membership of my regional citizen review panel," 20 out of the 31 respondents agreed with this statement of satisfaction, while an additional 3 respondents strongly agreed with the statement. Combined, 75% percent of the respondents showed at least some level of agreement with being satisfied with the size and membership of their regional citizen review panel. Only one person strongly disagreed and one person generally disagreed with showing satisfaction towards the size and membership of their regional citizen review panel.



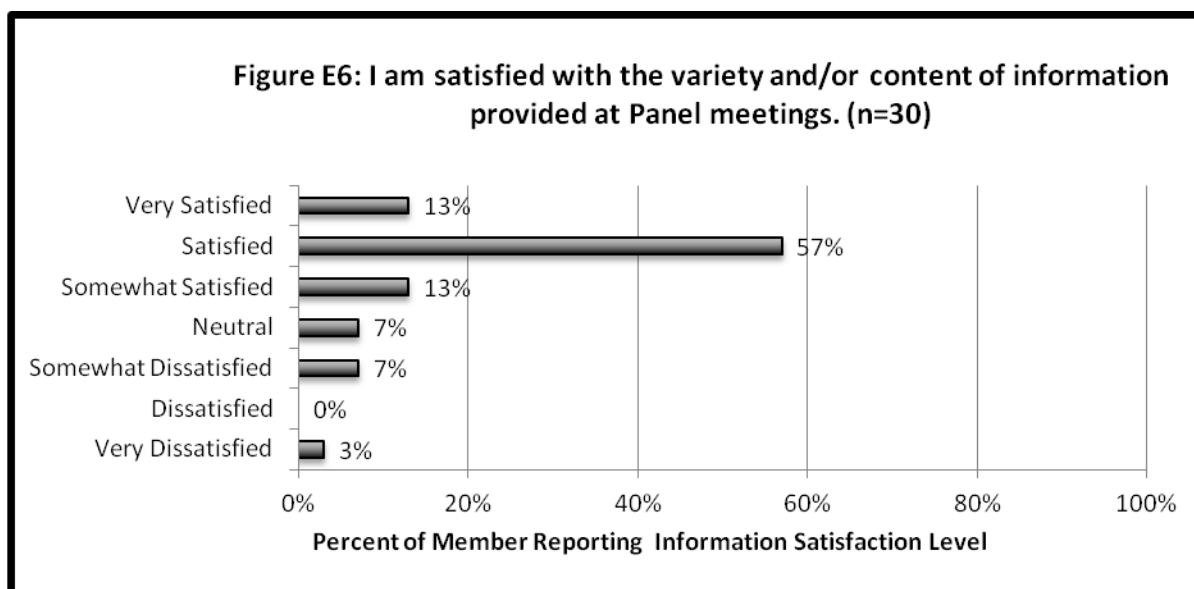
Question 7: The membership of my Panel broadly represents the community in which the Panel is established.

A majority of the 31 respondents (68%) feel that the membership of the Panel broadly represents the community in which the Panel is established. An additional 6% of the survey participants claim that they strongly agree that the membership of the panel is representative of their community. Only five of the respondents claim that they show some level of disagreement with the community representation of the membership of the Panel.

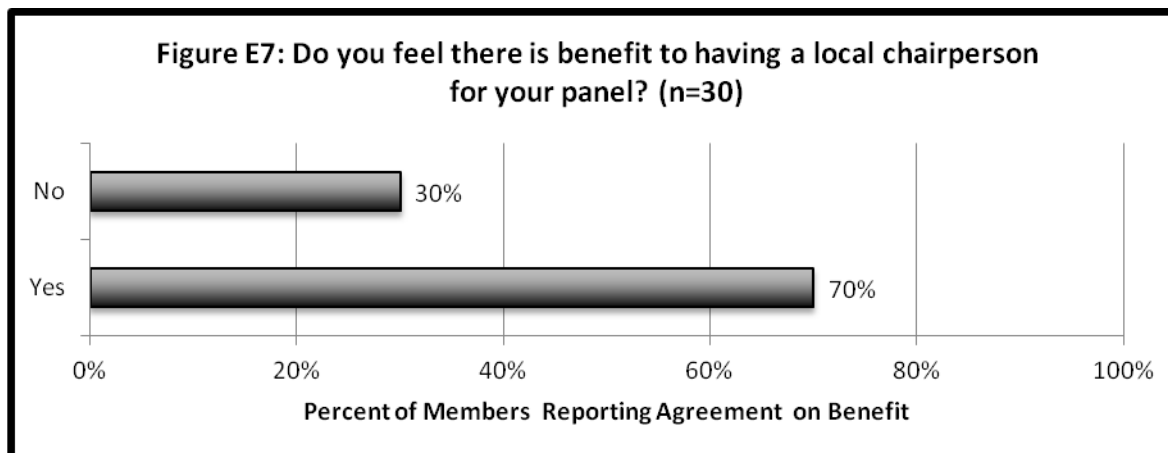


Question 8: I am satisfied with the variety and/or content of information provided at Panel meetings.

Most of the respondents report some level of satisfaction with the variety and/or content of information provided at Panel meetings. Fifty-seven percent of the survey respondents report being satisfied with this information. Thirteen percent of respondents report being somewhat satisfied, and another thirteen percent of respondents report being very satisfied with the variety and/or content of information. Only one person reported being very dissatisfied, no one reported general dissatisfaction, and only two people were somewhat dissatisfied.



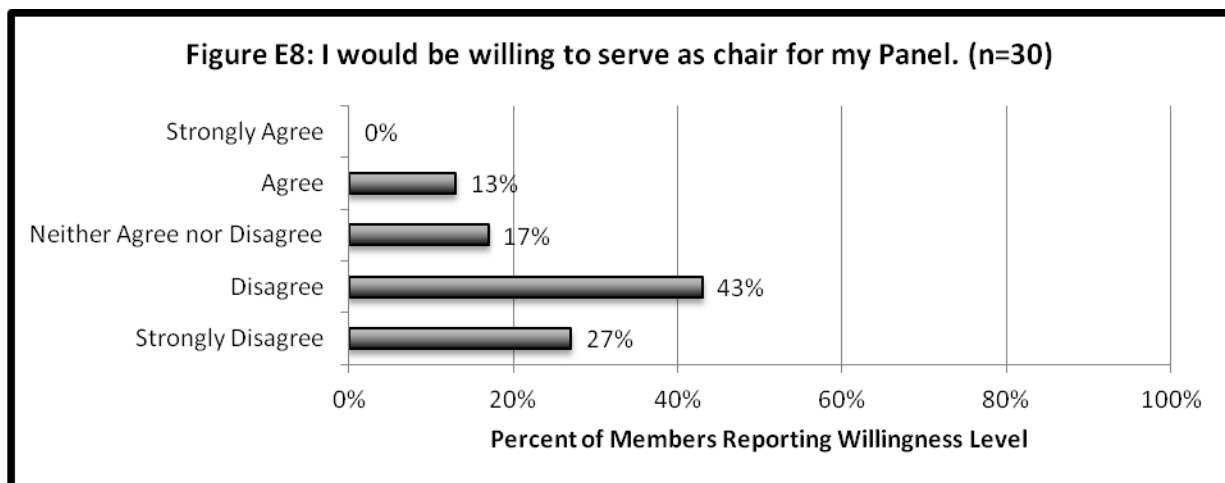
Question 9 and 10 asked about the role and benefit of the local chairperson for their panel. **Question 9 and 10 : Do you feel there is benefit to having a local chairperson for your panel? If yes, what would the chairperson's role be?**



Seventy percent of the 30 survey respondents affirmed that there was a benefit to having a local chairperson for their panel. These 70% percent of survey respondents selected a variety of roles that they felt that the local chairperson should fulfill. Two roles were selected the most, being ranked as the most important out of 7 different provided options. These roles were “to help identify cases to be reviewed” and “to organize and facilitate meetings.” A third role was ranked highly in the 2nd and 3rd position, which articulated that survey participants felt that “to review and present identified cases” was also a critical role of the local chairperson. Identifying opportunities for panel members to become more active in supporting/changing the child welfare system and identifying opportunities to become more active in supporting or changing CPS were two of the lowest ranked roles.

Questions 11: I would be willing to serve as chair for my Panel.

Four survey participants responded with agreement to the statement “I would be willing to serve as chair for my Panel.” Also, at the time of the survey, five additional respondents said they neither agreed nor disagreed to serve as a chair for their panel.



Questions 12 and 13 asked panel members about their interest and willingness to participate in Strategic Planning for future

- **Question 12: I would be interesting in participating in a strategic session in my community in the near future.**
- **Question 13: If I would be able to participate in a strategic planning session, I could commit to: Move your first choice to the top position.**

Forty-three percent (13) of the 30 survey respondents agreed and showed interest in participating in a strategic planning session within their community in the near future, with an additional 17% (5) showing strong agreement. For those able to participate in the such a strategic planning session, 10 of 26 respondents said that their first choice of availability would be to commit one full day to a strategic

planning session, and an additional four respondents said they would commit to whatever was needed. Five respondents had the primary preference of committing a partial day, and six respondents had the preference of one half of a day. Furthermore, the idea of a “weekend planning retreat” was volunteered in the “Other: Please Specify” portion of this question.

This strategic planning session is currently slated to take place in January.

Question 14: I would like to see the panels... (Please write any suggestions that you have for the panel.)

Additional Comments:

- Share and discuss experience and impact on families and communities in their given fields.
- Understand law and policy more fully
- Have more time to spend discussing each case, it seems so rushed all the time.
- Identify more of the support services that are available to CPS and for their transition programs.

To obtain further information, contact:
Arizona Citizen Review Panel Program
Center for Applied Behavioral Health Policy
School of Social Work
College of Public Programs
Arizona State University
500 North 3rd Street
Suite 200
Phoenix, Arizona 85004-2135
Tel: (602) 496-1470
Fax: (602) 496-1494

Information about the Arizona Citizen Review Panel Program can be found on the Internet through the Center for Applied Behavioral Health Policy at:

<http://www.cabhp.asu.edu/>

This publication can be made available in alternative format.
Please contact the Arizona Citizen Review Panel Program at (602) 496-1470.

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