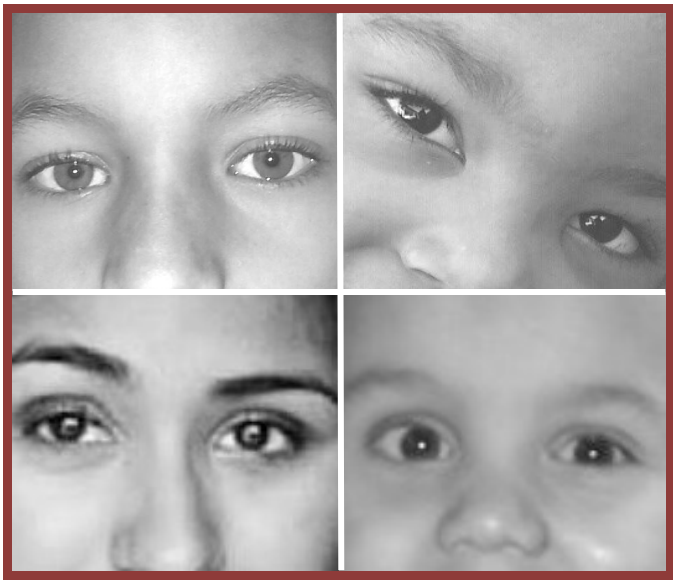

EYES ON CHILDREN

a study conducted by

Governor Janice K. Brewer's Independent Child Advocate Response Examination (CARE) Team

January 31, 2014

Eyes on Children

Governor Janice K. Brewer's
Independent
Child Advocate Response Examination (CARE) Team

Division of Child Safety and Family Services

Janice K. Brewer
Governor

Charles Flanagan
Director

January 31, 2014

Re: Independent CARE Team Report

Dear Governor Brewer:

As you have directed, attached, you will find the report that you required of your independent CARE Team. We are pleased to report that the team you empanelled on December 2, 2013, and the many dedicated staff that are working for the CARE Team, have been focused over the past two months on the two charges you gave us. We feel privileged to have served you and the people of Arizona and to have accomplished the mission with which you entrusted us. We are proud to have worked on this critical task to ensure the safety of all of the many children associated with the thousands of reports that were not investigated, contrary to law and policy.

Our first charge was to oversee the investigations you required on the 6,554 "Not Investigated" (NI) reports. At this time we are proud to provide you with the current update of that work. To date, every report has been assigned, with over 60% of these reports showing a response indicating that these reports are being actively investigated. Most importantly, we have seen over 5,000 children thus far. Over 400 of these children have been removed based on safety concerns, which demonstrates clearly that your actions in response to the disclosure of the NI problem were not only warranted but essential.

When we began this important work, we were heartened by the outpouring of support and assistance from Division of Children, Youth & Families staff, Office of Child Welfare Investigations staff, and Department of Economic Security staff. We had over 200 employees, many of whom already had extremely high case or workloads, volunteer to work the NI reports to ensure the safety of those children. In addition, our efforts were assisted and supported by law enforcement and the social services community, along with many other groups and individuals within and even outside of Arizona. These individuals took a risk to present issues, concerns and recommendations, and agency employees put in countless hours, truly demonstrating the heart that they have for these children and their selfless work in an attempt to keep these vulnerable children safe. We must also mention the support of legislators and constant support of your staff, for which we remain grateful.

The investigative work still required for the remaining NI reports, as well as reporting status and outcomes of this work, will continue until the job is completed. We have put a process in place, within your newly created Division of Child Safety and Family Services, to ensure this work is completed within two to three months, dependent upon various factors.

Both the CARE Team and the many individuals who assisted are grateful for their part in helping to resolve such a critical failure and better protect our vulnerable children. We also remain ever grateful for a Governor who will accept no less than our best efforts to protect children and create lasting positive systemic change.

Our second charge was to assess the policies, processes and personnel of the Division of Child Safety and Family Services and make recommendations for change in order to ensure that something such as this NI problem could never happen again. Although this is a much broader task, there is urgency to this work that didn't afford us the luxury of more time in which to accomplish this work, we have the privilege of reporting to you on our findings and recommendations.

The CARE Team recommendations reflect and support the decisive actions you have taken to date, and express our complete commitment to your pronouncement that Arizona fix our broken child welfare system. Our recommendations, which are strategic as well as tactical, will require continued focus and future action. We believe that the momentum you have created thus far will enable the implementation of these recommendations and allow for the creation of sustainable, permanent, and positive systemic change.

We firmly believe that this systemic change is only possible by virtue of your bold and timely creation of the Executive, Cabinet-Level Division of Child Safety and Family Services and your accompanying call to the Legislature to statutorily establish the division as a separate agency, autonomous from the Department of Economic Security. In addition, your unwavering support of this change is further reflected in your Executive Budget, which provides the Division of Child Safety and Family Services with the resources necessary to do the work of protecting our vulnerable children and effectively assisting families in need.

You will be able to discern from our work that we are excited that Arizona can build a Child Safety and Family Services agency that establishes unequivocally the primacy of child safety and the goal of achieving permanency with safety for children, as well as support for troubled families. In developing our recommendations, the CARE Team was able to observe best practices in action, build new partnerships, begin to create new best practices, consider other systems, and work collaboratively. We also had the benefit of reviewing previous reports that examined and made recommendations regarding our child welfare system, as well as a tremendous outpouring of support from individuals, including many who shared their concerns and solutions. We would like to acknowledge and thank these stakeholders, including the law-enforcement community, service providers, foster parents, employees, community forum participants, the courts, various constituent groups, and many other individuals, who have contributed and whose voices are reflected in this report. Although we recognize that this is not a perfect product, we nevertheless believe that it can form a starting point for creating the positive change that is necessary, and that it points the way toward a legacy of which we can all be proud.

We stand ready to respond to any questions, comments or concerns you may have. We thank you for affording us the privilege to serve.

Sincerely,

Charles Flanagan, Director
Arizona Division of Child Safety and Family Services
CARE Team Chair

Governor Janice Brewer's
Independent Child Advocate Response Evaluation Team

Charles Flanagan
Director, Division of Child Safety
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Kate Brophy McGee
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Deb Gullett
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Leah Landrum Taylor
Arizona State Senator

Greg McKay
Chief, DCSFS, Office of Child
Welfare Investigations

Cindi Nannetti
Maricopa County Attorney's Office

Jan Strauss
Arizona Association of
Chiefs of Police

Special thanks to all who participated in and contributed to the work of the CARE Team. We are extremely grateful to all of the DES, CSFS and OCWI staff, the Government Transformation Office (Robert Woods and Scott Kurish), adoptive/foster parents, law enforcement entities, community providers, child advocates, the courts and concerned citizens committed to the safety and welfare of Arizona's children.

Executive Summary of CARE Team Report

Executive Summary of CARE Team Report

This report highlights the work of the CARE Team to investigate reports of child abuse and neglect that were not investigated as required by law and policy. The CARE Team conducted a thorough examination of the agency, with a focus on identifying contributing factors to failures such as the thousands of cases dispositioned Not Investigated (NI), but also beyond that specific problem. Our work included a comprehensive analysis of the points where a child might be at risk due to agency process or decision making failure, an examination of why and how demand exceeds capacity and how to mitigate the consequences, and finally, a series of recommendations designed to improve child safety and agency effectiveness.

Charge 1: Provide oversight for 6,554 cases Not Investigated (NI).

- One hundred percent of the cases assigned an NI status have been assigned to an investigator.
- More than 60% of the NI cases are actively being worked.
- Experts have put eyes on more than 5,000 children at risk, associated with the NI cases.
- Over 400 children have been removed, to date, due to safety concerns.
- Ongoing structure in place to expeditiously bring the investigations of these cases to closure.

Lessons Learned:

- NI happened due to systemic failure, a lack of accountability and transparency and bad decision making.
- Law enforcement is a critical and underused partner.
- Multi-disciplinary teams (embedded in the community) made up of law enforcement, OCWI, agency specialists and social services offer the best results for ensuring child safety.
- Given the proper staffing levels, statutory and policy compliance and efficient systems, the Agency can accomplish its mission with quality.

Charge 2: Examine the agency to identify areas of concern, including personnel, operations, process and policy, and recommend improvements to the Governor.

The scope of the CARE Team's agency review was primarily focused on the points where a child could be in harm's way, including the call center known as the Hotline, coordination with the Office of Child Welfare Investigations (OCWI) and law enforcement, and the case management of investigations into reports of abuse and neglect. However, a broader perspective was taken, based upon the questions, comments and concerns from those with whom we interacted and from personal team member observations.

- Findings include issues that are varied, complex and inter-related. Solving any one problem will not produce lasting results, because the root cause is that demand exceeds capacity, which leads to policies not being followed.

- Insufficient capacity leads to high employee turnover, caseload backlog, a high reoccurrence rate for families with prior reports, high wait times and abandoned call rate at the hotline, inefficient caseload management and a daily struggle to keep up.

- Insufficient capacity ultimately drives management and process challenges, among them a lack of clear performance standards, inexperienced supervisors, ineffective management of front line staff, no standardized leadership work product, insufficient training, and individual judgment routinely replaces standardized process.

Highlights of the Recommendations:

- Create an agency that is laser-focused on the core mission of child safety with direct accountability to the Governor, as articulated by Governor Brewer in her Executive Order. Once a child's safety has been verified, ensure the child's well-being in a stable home and provide the requisite services to achieve that goal.

- Work with the Attorney General's Office to reevaluate the current interpretation of the Child Abuse Prevention and Treatment Act (CAPTA), including looking at how other states and the federal government operate regarding transparency (reporting data and outcomes, telling the stories of success and being honest about failures) in order to encourage and accept accountability.

- Recommend authorization for an emergency exception to procurement rules, within clearly defined parameters for the CHILDS/database replacement.

- Provide investigator training to the Child Safety Specialists that will conduct field investigations. Determine whether such training may be done in-concert with a community college law-enforcement training program that can provide credits to "students".

- Consider bringing all of the former DCYF/CPS employees under the Governor's Personnel Reform as "uncovered" when the new agency is legislatively created. Such a move would allow for the Department to reward good employees for performance and provide incentive for retaining the best employees.

- Work collaboratively and openly with human services providers, the foster care community, the courts, experts in the related fields and our community partners.

- Create true "quality control" by creating a rigorous inspections bureau and process that reports only to the Director, ensuring that operations are compliant with statute, policy and procedure.

- Create a permanent process improvement team that reports to the Director as part of the Inspections Bureau that is analogous to the Government Transformation Office (GTO) housed at the Arizona Department of Administration (ADOA).

    - We need to identify the resources required to bring in a high quality team conversant in Lean Six Sigma (best practices) which is a wise investment in preventing recurring problems, as well as creating best practices and efficiencies.

- Create an efficient call center/hotline process, and staff it with people trained and skilled in gathering essential facts, assessing the correct referral process (OCWI, law enforcement, Child Safety investigators, etcetera) and, with the correct tools and staffing, being responsive to those calling.

The CARE Team collected voluminous material in support of our work, which is provided in the appendices.

Ultimately, there is broad consensus that the child safety and welfare system is broken and that the creation of a separate Department of Child Safety and Family Services is a critical and necessary first step.

There is broad consensus that the agency needs a clear mission in statute, as well as the resources to do the job of protecting vulnerable children and providing family services that allow, once child safety is assured, family preservation, family reunification and permanency.

There is a palpable hunger for collaboration in our shared communities, so that we create best practices, develop efficient and effective partnerships and leverage our communal resources to impact the entirety of the children protection/child welfare spectrum.

This report can serve as an initial roadmap to fix the problems that virtually everyone has identified, as well as be a cornerstone as Arizona develops a Child Safety and Family Services system that will be a positive legacy of which we can be proud.

EYES ON CHILDREN

~ CARE TEAM REPORT ~

Charge 1: *Provide oversight for the investigation of reports that have been dispositions as "Not Investigation".*

Charge 2: *Examine the Arizona Child Protective Services (CPS) system to identify areas of concern. The review shall include consideration for personnel, operations, processes, and policies. Once areas of improvement are identified, the team shall submit its findings to the Governor.*

Charge 1: *Provide oversight for the investigation of reports that have been dispositions as "Not Investigation".*

Organizational Structure to Implement Charge 1

A total of 6,554 reports originally reported to Child Protective Services (CPS) were assigned a "Not Investigated" (NI) status. As a result, no field investigation was conducted based on these reports. The CARE Team made the commitment to respond to 100% of these reports to verify the safety of the children involved. As a result, the CARE Team created the following functional Teams in order to complete Charge 1 in an efficient, effective manner:

- Case Review, Supervision and Disposition: This Team provides management and oversight of the more than 255 staff (including 68 Field Specialist) resources that have been assigned to help investigate the 6,554 reports originally assigned "Not Investigated" status. This team ensures that investigations are conducted with the highest quality standards to guarantee the safety of the children involved.

- Data Collection: The data collection Team maintains hand verified, real-time information about the status of each investigation and the children involved.

- Coordination with Law Enforcement: Law enforcement agencies play an integral role in helping to locate children and the timely completion of welfare checks for the children involved in the "Not Investigated" reports. This allows for the efficient exchange of information between the CARE Team and law enforcement partners.

- Field Operations: "Boots on the ground" for "eyes on children" effort. Beginning with smaller numbers of non-case carrying staff, training was provided and reports assigned with a separate expedited reporting process. One of the first tasks for the Charge 1 Team was to recruit a qualified pool of temporary resources to conduct these investigations. In order to meet this requirement, the CARE Team identified experienced investigators who had moved on to other roles in the Arizona Department of Economic Security (DES). In addition, recent retirees were recruited to lend their skills to the effort. These resources are committed to the Charge 1 effort until all of the investigations are complete. 100% of the "Not Investigated" reports have now been verified as assigned to a member of this Team.

Summary of Progress to Date

At present, 4,494 cases are verified as responded to. This means that the formal investigation and process of verifying child safety has begun. A related metric is the verification of children seen, which describes the number of children who have been seen either by a member of the CARE Team or by law enforcement. In some instances, law enforcement has conducted an initial assessment and the CARE Team will continue follow up to close the investigation.

Exhibit 1 – Progress to Date:

Current Dispositions	Number of Cases (of 6,554 total)
100% Verified as Assigned*	6,554
69% Verified as Responded to**	4,494
Verified as Children Seen	5,667

* *Three cases of the 6,554 are outside of the State's jurisdiction, on Reservations, and we have referred those cases to the respective authorities.*

** *This does not mean that all of the children related to these cases were seen yet.*

- Subsequent Reports: Identified 1,194 subsequent reports to the original NI's, with 330 of those having 2 or more subsequent reports (and 2 cases having as many as 11 subsequent reports each).

- Removals: To date, a total of 264 NI cases resulted in the removal of 414 children from their homes, as follows:

- We discovered that there were 1,194 subsequent reports, 213 of those cases resulted in 316 children being removed, all of which clearly demonstrated that NI resulted in putting children in harm's way.

- There were 6 cases resulting in the removal of 11 children as an Agency reaction to the discovery of the NI designation.

- After closer scrutiny by the CARE Team, there have been 45 cases resulting in the removal of an additional 87 children, thus far.

- Investigation Closures: To date, 765 NI reports have been closed. Report closure indicates that continued monitoring and or services are required.

- Case Closures: To date, 672 NI cases have been closed. The closure of a case indicates there is no continued monitoring and/or services provided.

Plan to Complete Charge 1

- Keep same structure, using non-case carrying personnel to finish investigations.

- Report out milestones to ensure progress through completion.

- More than 255 staff (including 68 Field Specialists) were utilized to investigate and bring the NI investigations to closure. These staff are trying to balance other assigned duties with DES with the NI investigations. This was a one-time emergency response effort.

- Ongoing coordination and collaboration with law enforcement is part of the continuation plan.

- The CARE Team website will remain active until all NI investigations are brought to closure: https://azcareteam.az.gov.

Lessons Learned from Charge 1

As a result of the CARE Team investigations of the NI cases the following is clear:

- Multi-Disciplinary Teams (MDT) made up of law enforcement, agency investigators, the Office of Child Welfare Investigations (OCWI), medical and social services working in co-located areas offer the best results for ensuring the safety of a child. This is a best practice that is evidence based and should be adopted as Agency policy.
    - We learned from the Southern Arizona, Yuma and Maricopa County Child Advocacy Centers that this model is a best practice to form collaborative relationships, co-locate resources and efficiently leverage partners' resources. This is a model that the Division of Child Safety and Family Services, formally known as Division of Children, Youth & Families (Agency) or (CSFS) can and must act as a catalyst to create.
- The Agency has a crushing capacity problem. An emergency response such as the CARE Team investigation of the NI's is an ill-advised way to conduct the business of child safety long-term. It does, however, illustrate that a dedicated effort - properly staffed, diligently supervised and adequately funded - can mitigate capacity issues in the short term.
    - Charge 1 was worked in crisis mode, but this methodology cannot be sustained over the long haul. The Governor's proposed budget and the bi-partisan supplemental request are essential steps to solving the caseload management crisis.
- No statute, administrative rule, agency policy, or agency procedure allowed for an NI report designation. Assignment of the designation occurred nonetheless due to a systemic failure and pervasive lack of transparency, lack of accountability and inadequate checks and balances. OCWI must have total access to all call center work product and there must be an independent inspections bureau.
- Law Enforcement is a critical partner. Law enforcement agencies from across the state made direct offers to help and many remain engaged; Scottsdale alone investigated 110 cases and has changed its processes permanently to better collaborate with the Agency and investigate charges of child abuse. Together, law enforcement and Agency employees have established a best practice model then can be replicated by the Agency in partnership with law enforcement throughout Arizona.

Examples of our Outreach Outcomes

Scottsdale Police Department Changed its Process Permanently

- Through this emergency effort Scottsdale Police Department has adopted a new method of collaboration that promises to improve our efficiency and create a best practice.
- Leveraging resources of the Agency and police department staff.
- They bring strong investigation skills and enhance the safety of Agency Field Specialist.

Tucson and Yuma Community Forum

- An open and honest conversation between the CARE Team and service providers, law-enforcement, county attorneys, court personnel and others has led to a new commitment to work together that is already producing positive outcomes.

- The Agency agreed to give access to call information much earlier, and cross report immediately.

- Yuma has established a best practices model for training of mandatory reporters, as well as engagement between schools, law enforcement and County Attorney, that could be replicated.

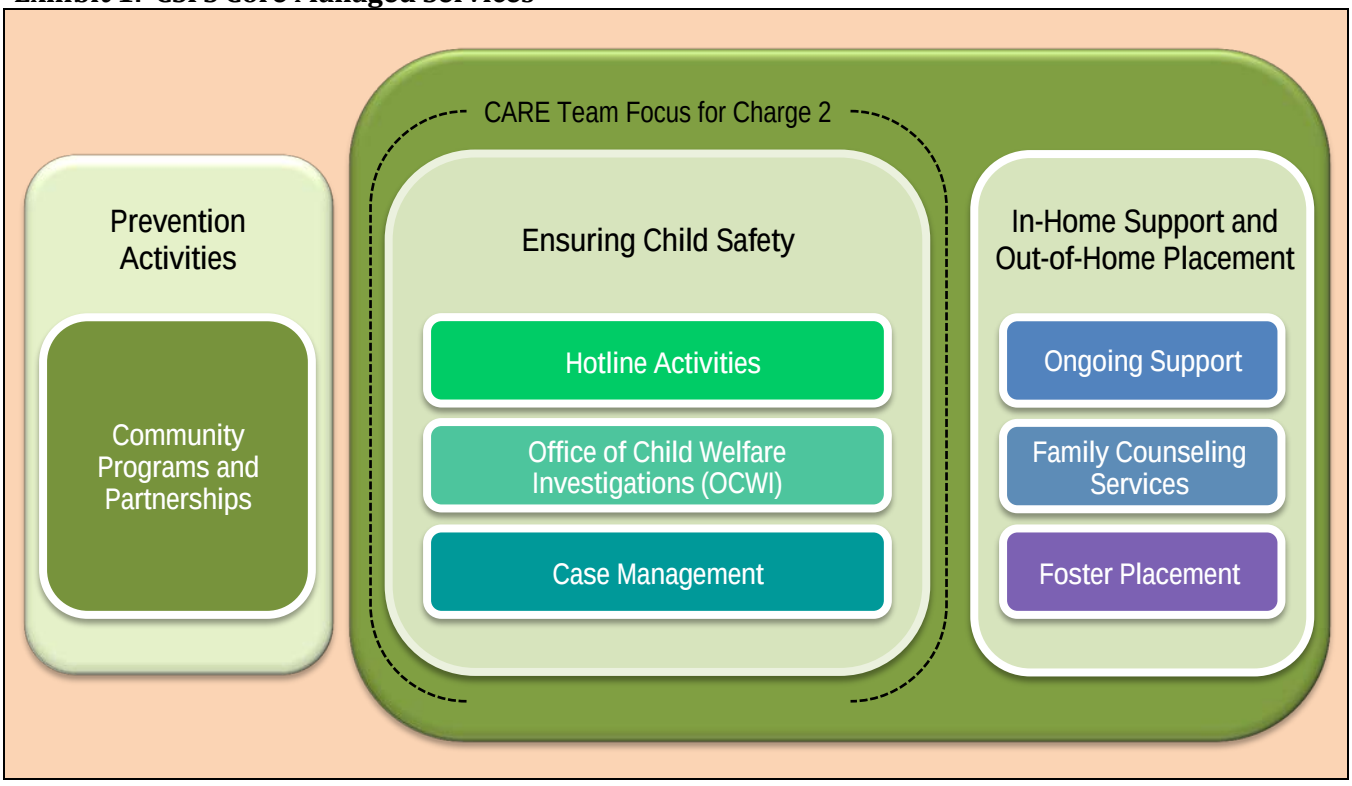
Charge 2: *Examine the Arizona Child Protective Services (CPS) system to identify areas of concern. The review shall include consideration for personnel, operations, processes, and policies. Once areas of improvement are identified, the team shall submit its findings to the Governor.*

Charge 2 – Scope of Work

The actions that led to the "Not Investigated" reports are unacceptable and exposed Arizona children to unnecessary risk. With direction from the Governor, the CARE Team focused its efforts to examine personnel, processes and policies, and identify areas of concern related to child safety. The Team examined the Agency process from the arrival of a call to the Hotline, through the completion of an investigation, in order to identify areas where the current process does not adequately respond to safety concerns for children at risk. It is clear that a failure at the front-end of the process presents the greatest risk to the safety of children.

The CARE Team conducted a review of the need for effective prevention programs or ongoing processes for managing children and families in the Agency system, significant feedback in these areas was collected [see appendixes] and will inform future efforts. While these areas are vitally important to child welfare in Arizona, they are not directly related to the conditions that led to the "Not Investigated" cases.

Exhibit 1: CSFS Core Managed Services



Demand Exceeds Capacity

One of the primary challenges facing the Hotline and the investigations process is the capacity of staff to keep up with the incoming volume of child abuse communications and reports.

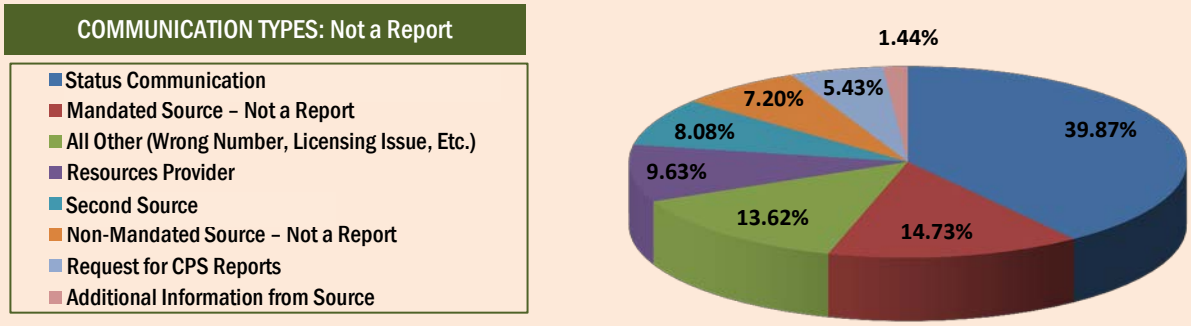
Hotline

Exhibit 2 summarizes weekly demand at the Hotline. In 2013, the Agency Hotline received over 3,200 calls per week. The Hotline currently has a 26% abandoned call rate, which translates to nearly 848 calls not answered by the Hotline. It is reasonable to assume some of these callers make additional attempts to contact the Hotline and do so successfully, but the high abandoned call rate adds delay to the process. Data does not exist to determine how many child abuse reports were missed.

Exhibit 2: Hotline

These numbers and percentages are averages based upon the average of 848 reports per week as reported for fiscal year 2013.

Of the approximately 1500 calls per week classified as communications, not reports, this pie chart reflects the percentages of how these are classified as communications, as identified in this key.



Calls answered by the Hotline are all considered "communications," but only a portion of these communications rise to the level of a report. Reports are cited statutorily as defined in terms of the risk to a child through a priority system (Priority One [P1] through Priority Four [P4]). The Agency has a statutory obligation to investigate 100% of the reports.

Investigation Process

In 2013, prior to the arrival of the CARE Team, the Agency completed what has been described as a time study, resulting in the current investigation process, as well as having changed the call center process in an effort to create efficiencies. Although subsequent analysis initiated by the CARE Team has identified significant points of actual and potential operational failure in the current investigation process, the time

study is the only process measurement currently available. Therefore, the CARE Team is compelled to rely upon the study to examine demand vs. capacity.

The time study examined the amount of process time or "touch time" that would describe the number of hours to conduct investigations. While there can be significant variation in the complexity of a case (including the size of the family, number of children, etc., the skill level of the investigator, and driving time required), the study identified, as shown in Exhibit 3, an overall investigation average process time of 11.8 hours.

Exhibit 3: Investigation Process

Investigation Summary	Required Capacity (Avg)
Preparation	0.5 hours
Contact & Reporting	7.7 hours
Planning	2.6 hours
Non-CHILDS Documentation	0.5 hours
Consultation	0.5 hours
Total Time per Investigation	**11.8 hours**

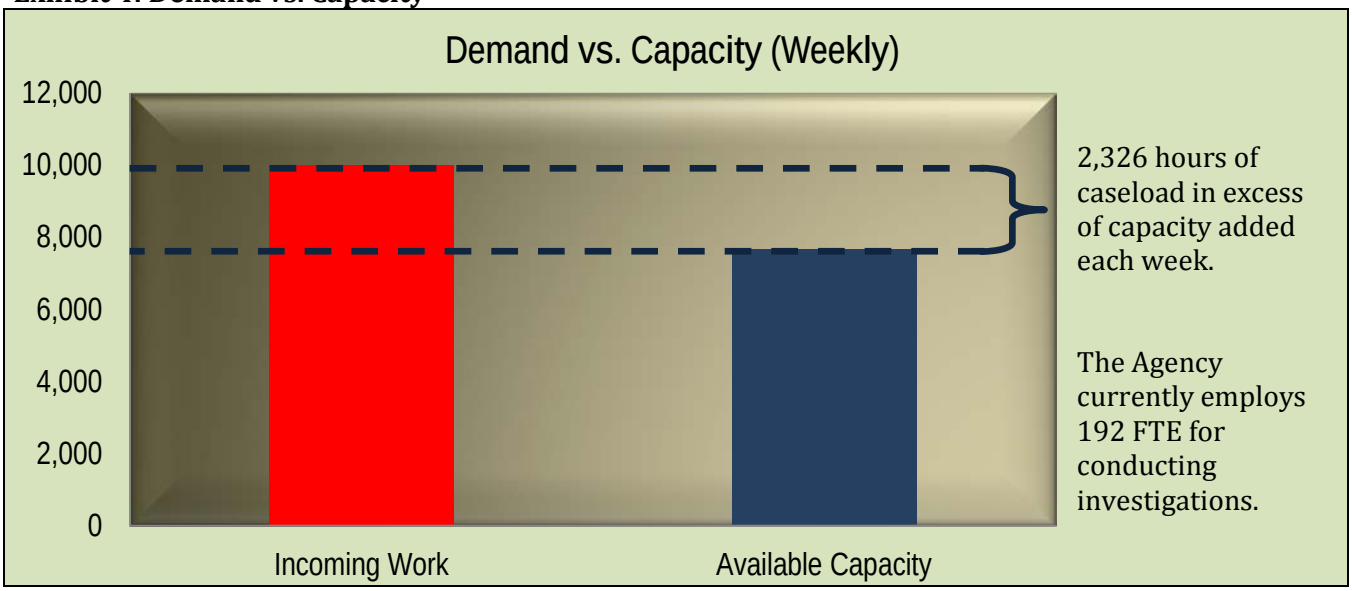
11.8 hours per investigation
x
848 incoming investigations per week
= 10,006 hours of new case work arrives each week

**** Children's Information Library and Data Source (CHILDS)***

This time study indicates that investigations consume 11.8 hours of time for the assigned investigator. This figure forms the basis of the required capacity for the Agency. The Hotline volumes indicate that at least 848 investigations arrive each week, which translates to over 10,000 hours of new case work.

Virtually every case manager who provided feedback to the CARE Team spoke to the overwhelming volume of incoming cases. Unlike other organizations responsible for public safety, the Agency has a legal obligation to respond to 100% of the calls to the Hotline that rise to the level of "reports." – 192 Full Time Equivalent (Employee/FTE) working cases are able to complete 7,680 hours of investigative work each week. With the arrival of 848 reports weekly requiring over 10,000 hours of investigation, that leaves 2,326 hours of incoming work that is beyond the capacity of the Agency.

Exhibit 4: Demand vs. Capacity



While there are challenges beyond capacity that must be addressed by Agency leadership, virtually none of those solutions to these issues are likely to have a significant impact on performance without increasing the Agency's capacity to conduct investigations. In order to balance capacity with demand, the Agency will need to add additional investigators.

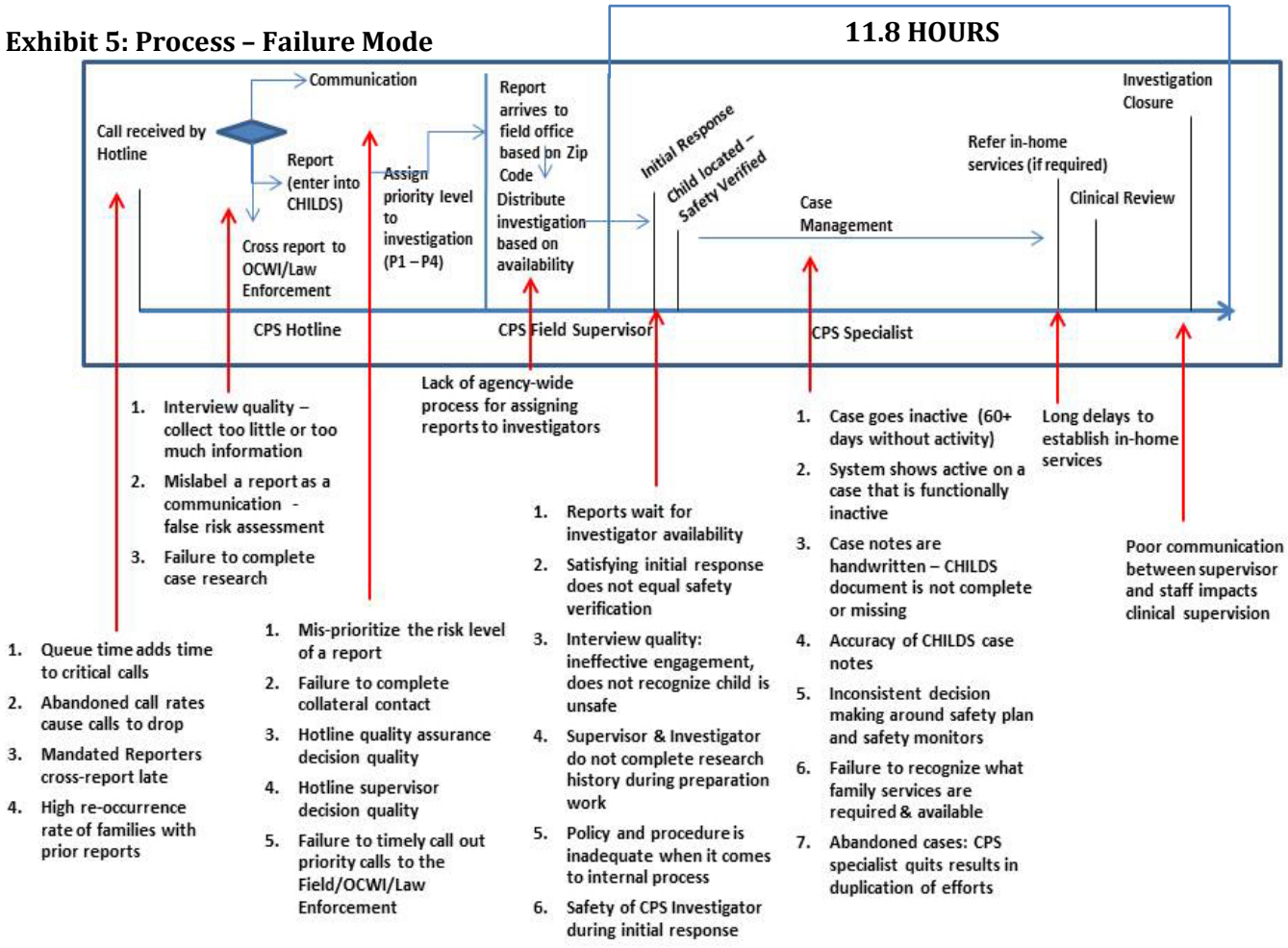
Current Backlog

The calculations above do not include any discussion related to the current 11,000 case backlog, or the 6,554 NI cases. What this means is that, at least initially, our "incoming" or existing work demands are far greater, and the employee hours available to conduct that work results in an even greater amount of workload in excess of capacity.

Risk Analysis Approach

In addition to the capacity analysis, the Charge 2 Team examined the Hotline and investigations process to identify potential points of operational failure. At each step of the process, our Team asked the question, "Where could process or decision failures put children at risk?" In order to give the reader of this report a very small sense of the intensive process review conducted by the CARE Team and GTO, the diagram below represents a very small percentage of the failure modes identified through focus groups and online surveys. This exhibit is intended for demonstration purposes only.

Exhibit 5: Process – Failure Mode



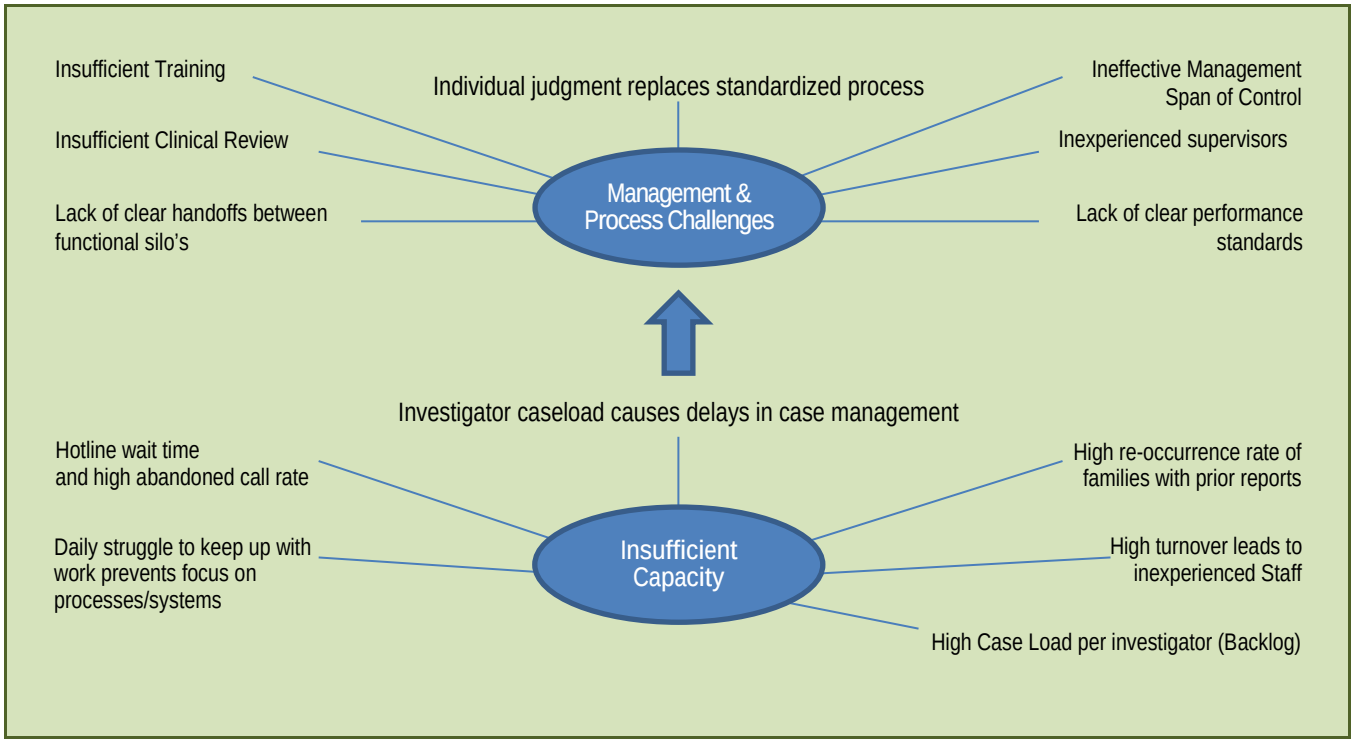
Our Team used a method called Failure Mode Effects Analysis (FMEA) to systematically identify process risk. FMEA has been used in manufacturing and service industries to reduce the occurrence of process failures. We assembled a cross functional team made up of supervisors and front-line employees from the Hotline, Quality Assurance, and Investigations. The Team examined the process step-by-step to define the highest risk failures.

The cost of a failure in this process is significant. A process failure puts a child in harm's way; a single failure can result in the death of a child. The CARE Team was launched because individuals intentionally stopped cases from moving through the process. Our FMEA Team examined the process to determine where future cases could intentionally or unintentionally fail to move through the process effectively.

Our FMEA Team identified 142 total failure points between a call arriving at the Hotline and closing an investigation. This highlights a few systematic problems. Firstly, there is a lack of checks and balances (including the lack of an inspection process that is independent of the chain of command being inspected). Secondly, there is too much individual discretion in decision making and review. Thirdly, there is too little reliance in and availability of policy in operational practice. The FMEA process allows the Team to prioritize risk based on the frequency of occurrence, the severity of the failure when it occurs, and the detectability of the failure. These failures occur most often, and present the greatest risk to child safety.

The value of the FMEA exercise is to develop solutions that reduce risk in the future. In order to accomplish this, our Team identified the root causes for the failures. The root causes of the failure points are informed not only by the FMEA focus group, but also by the interviews and survey data collected for the CARE Team. A majority of the failure points in the process are explained by the system challenges presented below in Exhibit 6.

Exhibit 6: Root Causes



*Most of the tactical issues identified through the FMEA exercise can be reduced to **management challenges** or **capacity issues;** however, it is critical to understand the impact that capacity challenges have on the overall system. The daily struggle to keep up with incoming volume prevents many of the management activities from taking place.*

Capacity challenges exist both at the Hotline and in investigations. CSFS staff described the operational impact as well as the human cost of capacity challenges. Operationally, insufficient capacity leads to long wait times at the Hotline which correlates to a high abandoned call rate. In addition, reports that arrive to investigations without available investigators will sit uninvestigated until resources are available. In addition to these process measures, CSFS staff described the negative impact to morale that insufficient capacity causes. It essentially creates an "unwinnable game" that creates high stress levels and contributes to high turnover. The capacity challenges affect both front-line employees and the management levels of the organization.

The daily struggle to keep up with work becomes an all-consuming tactical focus that prevents more strategic activities such as continuous improvement and employee development from taking place. In order to improve the processes at CSFS, managers will have to balance their focus on getting the work done with implementing standard processes and improved management tools. They will also have to bring a much stronger focus on employee development.

Individual judgment replaces standard decision making in many areas of agency operations. To improve management practices in CSFS, the Agency will need a strong commitment to the implementation of standard processes. Standard processes identify the best current model of performing a task and promotes that method throughout the organization. Since much of the work of CSFS is knowledge work and critical decision-making, management will need to develop tools that breed a common understanding and interpretation of policies such that all staff will make consistent decisions about child safety when presented with the same facts. Agency leadership has the responsibility to implement standard processes, which requires appropriate span of control and a commitment to staff training.

Incoming Volume Exceeds Capacity

Independent of the process challenges that exist within the Agency, in any environment where capacity exceeds demand, the process will hit numerous "breaking points." The capacity challenges cause the following conditions which are the "root cause" of many process failures:

- CPS Hotline Queue Time: Capacity challenges at the Hotline result in long hold times, which in turn causes high abandoned call rates. While we know that many of these callers do call again, it is reasonable to assume that some do not. Even one missed report of abuse is significant.

- Daily Struggle to keep up with Work Prevents Continuous Improvement: The focus to keep up with incoming work impacts the capacity of front-line employees and management to conduct continuous improvement activities. Continuous improvement requires the support of leadership and requires that those who do the work are allowed to participate in developing better processes. The all-consuming focus on simply keeping up with the work has prevented these types of activities from happening.

- High Reoccurrence Rate: A large amount of families enter the system more than once. This is both a cause of high volume and an expression of the challenges in the current system.

- The Net Result: The Agency is slow to confirm child safety, endures a significant employee turnover and inexperienced staff, and experiences high case load volume per investigator. Ultimately, the net result is that children remain in unsafe settings and become victims of crime.

    - The attrition of new employees is approximately 25 to 30%, and there is a significant representation of employees whose tenure reflects months not years.

Management Challenges

Simply giving the Agency enough capacity to meet demand will not address all of the risks identified in the process.

- Lack of Clear Handoffs Between Functional Silos: The transitions between each of the departments (Hotline, OCWI, Investigations) present opportunities for process failures.

- Inexperienced Supervisors: Supervisor positions have also suffered from high turnover. Supervisor positions have also been difficult to fill due to the perceived gap in pay differential relative to the added job stress. Many supervisors have promoted into these positions because they were more senior than their peers, but still relatively junior in conducting child safety investigations. (Although seniority has not been the only factor in promotions.)

- Ineffective Management Span of Control: The current ratio of supervisors to investigators can be as high as 10:1. Supervisors are unable to spend adequate time with case managers. This is exacerbated by the fact that most supervisors have a near constant supply of new case managers due to high annual turnover in these roles. Additionally, supervisors do not have the time to effectively manage and mentor, nor have them been trained to effectively manage.

- Insufficient Clinical Review: Insufficient clinical review is the result of ineffective span of control along with inexperienced supervisors. Supervisors don't have the time to effectively manage, nor have they been trained to effectively manage.

- Insufficient Training: Critical training such as supervisor training, forensic interview training, encompassing both children and adults, and up to date training is conducted late, if at all. The results are skill gaps from the most experienced to the newest employees.

- Individual Judgment Replaces Standard Process: Our focus groups continually identified that critical decisions made at the Hotline and during field investigations are subject to the individual judgment of staff. With complex knowledge work, it is impossible to eliminate individual variation entirely; however, it is the responsibility of management to identify best practices that should be standard and implement those best practices through development of standard work and continual training across the organization.

- Lack of Clear Performance Standards: Critical areas of agency operations lack clear performance standards; for example, the abandoned call rate and maximum queue time at the Hotline are unacceptably long, yet there are not clear performance standards that point to the performance goals of the system. In addition, the P1-P4 system has performance standards that are not aligned with child safety. The defined timelines pertain to the initial attempt to locate children versus the actually locating children.

Strategic Recommendations

It is noteworthy that several efforts have taken place over the prior ten years to examine the Child Protective Services model as it exists in Arizona. Two of the commonly referenced reports are Arizona Voice for Crime Victims: *In Harm's Way (2003)* and the Child Safety Task Force report (2011). The significant overlap between the reports indicates that the Agency continues to suffer from the same challenges. In order for the recommendations of the CARE Team to drive meaningful change, the Agency must have accountability and transparency in documenting progress towards implementation of these solutions.

Exhibit 7: Prior Reports

Major Categories of Recommendations	In Harm's Way (2003)	Child Safety Task Force (2011)	CARE Team (2014)
Multi-Disciplinary Teams	X	X	X
Safety has primacy with re-unification	X	X	X
CPS as separate agency	X		X
Clearly Define Criminal Conduct	X	X	X
Improve Transparency	X	X	X
Enhance Investigation Practices and Training	X	X	X
Increase Agency Capacity	X	X	X
Independent Review by Outside Expert*	X		
Improve Performance at the Hotline		X	X
Improve functionality of CHILDS		X	X
CPS Worker Safety			X
Address Ongoing Process*	X	X	
Courts*	X	X	

** NOTE: It is the intent of the CARE Team that these things be done at some future point by CSFS leadership.*

Strategic Overview

The current Division of Children Youth and Families is comprised of exceptional professionals, dedicated to the welfare of the children of Arizona. These individuals have endured numerous challenges, but continue to work hard each and every day in the effort to keep children safe.

This report to Governor Janice K. Brewer on the CARE Team charges has evolved in recent weeks to serve a dual purpose, identifying concerns and recommendations, as well as a road map for the new agency she envisions, Child Safety and Family Services. The recommendations that follow -- based on an exhaustive review from the moment a caller tries to contact the Hotline to the moment a child safety investigation concludes -- include the views of a diverse group of Team members and professional staff. Equally important, these recommendations have been informed by the work that resulted in reports that

preceded the CARE Team, and the voices of thousands who have shared their considerable expertise, experience, wisdom and heartfelt beliefs about how to improve child safety in Arizona.

Chief among the CARE Team recommendations is to establish an agency grounded in transparency, with a rigorous commitment to accountability. Despite the adversity of the NI cases, the Agency is now positioned for transformative change: in its mission and culture, in its leadership and organizational design, in statute and rule, in process and procedures, and ultimately, in the management and front-line responsibilities of the hundreds of dedicated people who serve in the Agency on behalf of Arizona's children and families in crisis and at risk.

What follows is a mix of strategic and task level recommendations that are interdependent on one another. The Hotline, for example, must be fixed. Fixing the Hotline will require new rules and procedures, staff training, an infusion of resources, likely statutory change and law enforcement engagement, but fixing the Hotline must happen. It is a priority. Clearly, with the Hotline and the other critical components of the Agency, much more detail is required than can be provided in this strategic overview, acknowledging that some issues can be addressed administratively, while others will require a legislative solution.

Mission of Agency

The first responsibility of this Agency is child safety. Once a child's safety has been verified, ensure the child's well-being and permanency in a stable home, in-home, in-kinship, or in-care, and provide the requisite services to achieve that goal.

- Align state statutes and Agency culture, practices and operation to ensure this mission is upheld.

Create Independent Agency

Create an agency, laser-focused on the core mission of child safety with direct accountability to the Governor, as articulated by Governor Brewer in her Executive Order. Removal from DES both operationally and in physical location will foster a new and positive culture within the Agency, as well as to ensure a successful transition.

- Clarify the roles and responsibilities of investigations of allegations of criminal conduct against children and social services professionals committed to the safety of the child and providing necessary support and family services. Separate tracks, but conforming goals and cooperative operations.

- Improve the integration of OCWI throughout the Agency. In particular, in the operation of the Hotline and in the investigative track.

- Establish an Inspections Bureau, reporting to the Director, made up of an independent Team of highly skilled child investigations and child welfare professionals to regularly assess whether the operational practices of the Agency reflect compliance with statute, policy and procedure that reflect practices.

- Establish multi-disciplinary partnerships and collaborations, co-located where possible, to take better advantage of the complementary interests and services of law enforcement, as well as medical and social services providers.

- Create a permanent process improvement team that reports to the Director as part of the Inspections Bureau that is analogous to the Government Transformation Office housed at ADOA.
    - We need to identify the resources required to bring in a high quality team conversant in Lean Six Sigma (best practices) which is a wise investment in preventing recurring problems, as well as creating best practices and efficiencies.
- Ensure a thoughtful and successful transition from DES, including a review of all collaborative arrangements and programs that provide services to children and families associated with the child protective agency.
- Create greater fiscal transparency and accountability that ensures the new Agency's operation and practices consistent with mission.
- Safeguard the rights of both children and their parents by conducting timely, thorough and proper investigations conforming and compliant with statute. These neutral fact findings investigations will ensure the protection of people from false or mistaken allegations or identify a need for offender accountability or other interventions.
- Engage the experts among us -- community based providers, foster parents, the medical community law enforcement, child advocates and the courts -- in collaboration and partnership, to keep children safe and families together.
- Explore best practice models from other state agencies or municipalities, regarding the integration of sworn Peace Officers within OCWI, to work in collaboration with and at the request of law enforcement on child fatality cases only (for example some arson investigators have sworn status limited to arson investigations).

Organization Design

Leadership Span of Control: One of the key roles of leaders is to ensure consistent delivery of service and high quality standards, known as leadership span of control. When a single leader supervises too many people, the ability to provide feedback and coaching is diluted. This results in an environment where standard work is difficult to achieve and accountability difficult to maintain.

- An evaluation of appropriate staff-to-supervisor ratio is necessary to ensure proper leadership ratios. This is especially critical given the high annual turnover and relative lack of experience of the frontline employees.
- Frontline staff must be paid appropriately, assigned a manageable case load, receive support staff assistance, quality supervision and mentoring. This is coupled with an expectation of accountability.

Supervisors: Other than the Director, no single role will have a greater impact on system quality than supervisors and their ability to manage and mentor case specialists.

- The staffing model must ensure proper staffing levels, including effective ratios of supervisors, case managers and support staff, allocated efficiently to manage workload.

- Current supervisory duties do not allow for sufficient mentoring and coaching as often as it is needed.

- Supervisors must be paid appropriately, assigned a manageable supervisory case load and receive support staff assistance. This is coupled with an expectation of accountability.

Caseloads are at approximately 177% of previously accepted caseload standards. This does not allow field staff to ensure thorough child safety through investigations conducted in a timely manner.

- Continually validate appropriate caseload standards, based on realistic workloads and current process capabilities, as an ongoing practice. When actual caseloads exceed the established standards it is a strong indicator that the quality of the process is compromised.

- Review and continually improve the caseload standard, based on well documented time-studies of current known best practices. People and resources can be allocated more efficiently (i.e. in co-located units), and caseloads may vary depending on complexity and variables such as travel time (i.e., rural areas) and resource availability.

- Identify opportunities for case aides and support staff to complete tasks that allow higher skilled professionals to focus on their core tasks. This was the single highest issue on the survey of current agency employees.

- Develop opportunities for volunteers and interns to augment existing agency staff.

- The SWAT team and other specialty investigative units need to be reintegrated into agency field operations.

Technology as a Performance Enabler

The State Automated Child Welfare Information System (SACWIS) must promote efficient and effective management of information, available on a real-time basis to OCWI, case managers and agency supervisors.

- Recommend authorization for an emergency exception to procurement rules, within clearly defined parameters, for the CHILDS/database replacement.

- The current lack of mobile device interface and remote access needs to be addressed in order to support the investigation process, which is largely driven by field work. The inability to do this wastes time and contributes to the backlog of cases. Improved technology was the second highest response to the agency survey.

- The integrity of the data must be protected to ensure that entries cannot be modified or deleted, and in order to have a trusted historical record of all information and related employee actions.

- Expanded database and call center work product access to OCWI investigators, especially in criminal conduct allegations, particularly where family/child cannot be located via agency databases. The Agency needs to ensure that all Team members responsible for child safety have appropriate access to information in Children's Information Library and Data Source (CHILDS).

- Statute must ensure that Agency professionals have appropriate access to DES data systems, for the purposes of locating children and families, including food stamps, TANF, etc.

Hotline

The Agency needs to examine and implement best practices for call center management as they apply to the work of child protection. The Hotline raises complex issues:

- High abandoned call rates, long wait times and the current interview design do not facilitate the efficient collection of information from the public. Clear performance standards need to be established and maintained.

- Examine other states' reporting requirements to extract the best practices around what requires a report.

- The information requirements of all Hotline information system recipients need to be assessed to ensure that the most efficient and effective process is in place.

- Provide OCWI unrestricted access and ongoing audit authority over Hotline calls and screening decisions to ensure timely response to criminal conduct cases, particularly where time is of the essence and there is potential to preserve forensic evidence.

- Develop an improved partnership with law enforcement to provide appropriate and timely access to Hotline information consistent with existing statute. The Agency will ensure all employees comply with statutory mandates for cross-reporting.

- The call-center should make the initial call to law enforcement as a mandatory cross report to law enforcement on cases involving criminal conduct. This would fulfill the statutory requirement to cross report to law enforcement in a timely manner.

- Evaluate existing policies around 'unable to locate' to ensure all reasonable attempts to locate children are followed, including through communications information sharing across all disciplines including law enforcement, AHCCCS, schools and medical providers.

Title 8 vs. Title 13

Examine both Titles to ensure they are consistent – maximize and strengthen each discipline's ability to ensure child safety as the primary goal.

- Clarification in the statutes and policy to unequivocally emphasize the role of Agency employees as mandated cross reporters to law enforcement.

- Clarification of role of CPS Investigators when investigating alleged criminal conduct, and realignment of statute 8-803 regarding "Duty to Inform" in the case of a criminal conduct allegation.

- Change statute and rules to admit "other acts evidence" in physical and sexual abuse.

- Promote the prompt release of CPS records, when a criminal defendant or child is the subject of such information in accordance with statute.

Integration with Community Services

Current programs to prevent child abuse must be supported both in terms of funding and in application. Current contracts with community based providers can be expanded to serve short term needs, while long term solutions are designed. In addition to adequate response to existing safety concerns with at risk children, resources must be available to families to allow them to protect their own children. This is both to prevent entrance into the CPS system in the first place, and to reduce reoccurrence of abuse.

- Ensure adequate resources are available to provide family services in order to promote family preservation or reunification, as long as child safety is not compromised.

- Work with community partners to identify and establish Arizona best practices and programs. Yuma, for example, boasts an exemplary training for mandatory reporters that could be replicated throughout the state.

- Partner with the Administrative Offices of the Courts (AOC) and juvenile justice to streamline and improve the process.

- Work with the Arizona Supreme Court to ensure rules are aligned with statutory changes and Agency mission.

- Review successful family support programs that have been cut due to budget constraints, such as childcare subsidies, substance abuse, behavioral health treatment and domestic violence interventions.

It is critical that the Agency maintain a collaborative relationship with the courts. Improved communication and coordination to streamline processes will be beneficial for both entities and the families we serve. Suggestions include:

- Cross-training with court and Agency staff to improve and streamline court-related activities, processes and communications.

- Seek opportunities to collaborate with the courts. For example, the Maricopa County Juvenile Courts' has extended an invitation to the Agency to participate in their process improvement team, which hopes to decrease court-time requirements for all parties, including case managers, by improving the predictability of court hearings.

- Actively pursue opportunities to enhance timely communication regarding notifications for court hearings, case planning and placement decisions, requests for releasable information, and other interrelated processes.

- As one of our most vital partners, it is critical that we share the information necessary to ensure the needs of the child, as well as the family, are met. To that end, we must pursue opportunities to further support and collaborate with foster and adoptive parents, including:

- Strengthen information-sharing, such as family and medical histories of the children in their care.

- Improve sensitivity to foster and adoptive parents' needs, particularly as it relates to notification of hearings and other time-sensitive matters.

- Increase the level of involvement of caregivers in terms of decision-making related to the welfare of the children in their care.

- Review processes to streamline the transition from foster to adoptive care.

Implement Co-Located, Multi-Disciplinary Teams (MDT)

In order to conduct the mission effectively, the Agency must actively partner with other disciplines and community partners. Due to the complex nature of child maltreatment, advocacy centers have proven that multi-disciplinary approaches to child abuse investigations and treatment provide the best possible outcomes for children. There is significant evidence to support the use of MDT's to enhance outcomes and ultimately protect children.

- The Agency should work to expand the Arizona best practice MDT model, including the location of investigation and social work units in advocacy centers and specialized hospitals where it is feasible. In areas where advocacy centers are not feasible, the Agency should work with community partners to establish a multi-disciplinary approach.

- MDT's should adhere to their individual updated, most current county multi-disciplinary protocols.

- Ensure continued collaboration with university and community college partners to develop a workforce accustomed to the MDT protocol.

Achieve Transparency without Jeopardy

The Agency must strive to establish maximum transparency in its actions to recapture the trust of the public and create agency accountability. The key to this recommendation is removing the cloak of secrecy the Agency has operated under in the past, while holding sacrosanct the privacy and safety of children and families involved.

- Develop opportunities to share agency success stories by working with families who have enjoyed the best outcomes thanks to the work of the Agency; for example, the Cradles to Crayons program in Maricopa County Juvenile Court has demonstrated successful outcomes worth sharing.

- Work with the Attorney General's Office to reevaluate the current interpretation of the Child Abuse Prevention and Treatment Act (CAPTA), including looking at how other states and the federal government operate regarding transparency (reporting data and outcomes, telling the stories of success and being honest about failures) in order to encourage and accept accountability.

- It is imperative that the Agency share its outcomes and communicate both positive and negative, information in order to be held accountable by the public it serves, through a robust public information and community liaison operation.

- The Agency should conduct trainings internally to manage public records requests.

Priority System

The current P1 - P4 system does not drive the appropriate Agency response to potential child risk or criminal conduct. Satisfying the initial response for the priority system does not equal verification of child safety.

- Amend the priority system rules to drive the appropriate response levels to assure child safety.

- The criminal conduct component must be clarified in any future call response system, rigorously enforced, and response times configured accordingly. Real-time criminal conduct must be differentiated from alleged previous criminal conduct where a child is not currently endangered.

Case Management

- In high risk cases where child safety remains a concern, establish a mechanism that allows the Agency to verify ongoing safety of the child.

- Inclusion of an additional investigative finding of "undetermined".

Case Work Safety Standards

The Agency lacks robust safety training to contribute to caseworker situational awareness regarding field safety. This type of training could be developed and delivered in partnership with law enforcement.

- Develop operational guidelines that pertain to safety in the field. Caseworkers are often exposed to potentially dangerous conditions without any formal training or decision process to know when to place personal safety above the priority of completing investigations.

- The Agency must improve partnerships with law enforcement to ensure coordinated response to calls identified as requiring law enforcement. The Agency must identify where this joint response is appropriate.

- Identify necessary resources for investigators and caseworks, in order for them to fulfill the specific duties of their job. (e.g., communication devices, adequate supplies of child car seats needed to transport children safely and expeditiously).

- The Agency has invested significant resources in improving its fleet of state vehicles and must evaluate the pool of government vehicles available to employees. Consider the personal and agency risk surrounding the use of personal vehicles.

Training

Training requirements at all levels -- new, annual and in-service -- need to be assessed and an implementation plan developed, to ensure that all field staff receives consistent and current instruction.

- Annual in-service training must include case study analysis and best practices. This training will ensure that all field staff receives consistent and current instruction.

- All training needs to be reviewed relative to the needs and skills gaps of the Agency.

- Pre-service and in-service training need to address the skills gap in the Agency. In addition, this training must incorporate current best practices while incorporating the latest research on evaluating child safety.

- The Agency needs to create clear accountability for training curriculum development and training adherence. Staff that is not current with required training should not be eligible to work in the field.

As the Agency develops a specific investigative track based on immediacy and the need to conduct a neutral fact finding investigation in a timely manner, training must emphasize the specific skills required. Future training for investigators must address investigation skills consistent with county law enforcement protocol requirements.

- Criminal conduct training must be ongoing, and all staff that handle cases or manage investigators, must be conversant in identifying and assessing criminal conduct.

- Require ongoing retraining annually to qualify for field readiness. Investigators and caseworkers are exposed to similar levels of risk and physical harm as law enforcement, yet are not required to retrain annually.

- Implement investigator training, similar to law-enforcement training, and explore a partnership with higher education for educational credits to be awarded.

- Cooperation between the Agency and law enforcement to ensure all county protocols are followed. We also would like to work collaboratively to help inform pre-service and in-service training, particularly for first responders.

Human Resources

The Agency needs to work within state personnel rules to reward strong performance to ensure improved retention of high performance and the recruitment of high potential employees.

- Consider bringing all of the current division of Child Safety and Family Services employees under the Governor's Personnel Reform as "uncovered" when the new agency is legislatively created. Such a move would allow for the Department to reward good employees for performance and provide incentive for retaining the best employees.

- Tuition reimbursement programs and curricula in higher education institutions, particularly in schools of Social Work and Criminal Justice, need to be continually reviewed to ensure high quality employees are attracted and retained by the Agency.

Conclusion

Conclusion:

Ultimately, there is broad consensus that the child safety and welfare system is broken and that the creation of a separate Department of Child Safety and Family Services is a critical and necessary first step.

There is broad consensus that the agency needs a clear mission in statute, as well as the resources to do the job of protecting vulnerable children and providing family services that allow, once child safety is assured, family preservation, family reunification and permanency.

There is a palpable hunger for collaboration in our shared communities, so that we create best practices, develop efficient and effective partnerships and leverage our communal resources to impact the entirety of the children protection/child welfare spectrum.

This report can serve as an initial roadmap to fix the problems that virtually everyone has identified, as well as be a cornerstone as Arizona develops a Child Safety and Family Services system that will be a positive legacy of which we can be proud.

DIVISION OF
CHILD SAFETYAND FAMILY SERVICES

EMPLOYEE SURVEY RESULTS

Presented to:

CHILD ADVOCATE RESPONSE EVALUATION TEAM

and

Charles Flanagan
Director

Prepared by:
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Arizona Department of Juvenile Corrections
January 28, 2014

EXECUTIVE SUMMARY

In December of 2013, the Child Advocate Response Evaluation (CARE) Team conducted a survey of Division of Child Safety and Family Services (DCSFS) staff. The purpose of the survey was to elicit employee suggestions on how the Division could be improved. This report presents the findings from that survey. All comments provided by DCSFS survey respondents are available upon request.

Key findings include:

- Streamlining the process for requesting services for such things as parent aides or counseling was viewed as the best way to improve efficiency. Another popular recommendation to improve efficiency was to provide employees with access to tablet or laptop computers thus enhancing their ability to conduct work from remote locations;

- Many felt that their productivity could be enhanced if the Division improved data entry, transcription of notes and the process for updating Children's Information Library and Data Source (CHILDS) data;

- Many employees also stated that Division restructuring efforts should concentrate on staff recruitment and retention;

- Many employees suggested that the content of policy training be revised to improve compliance;

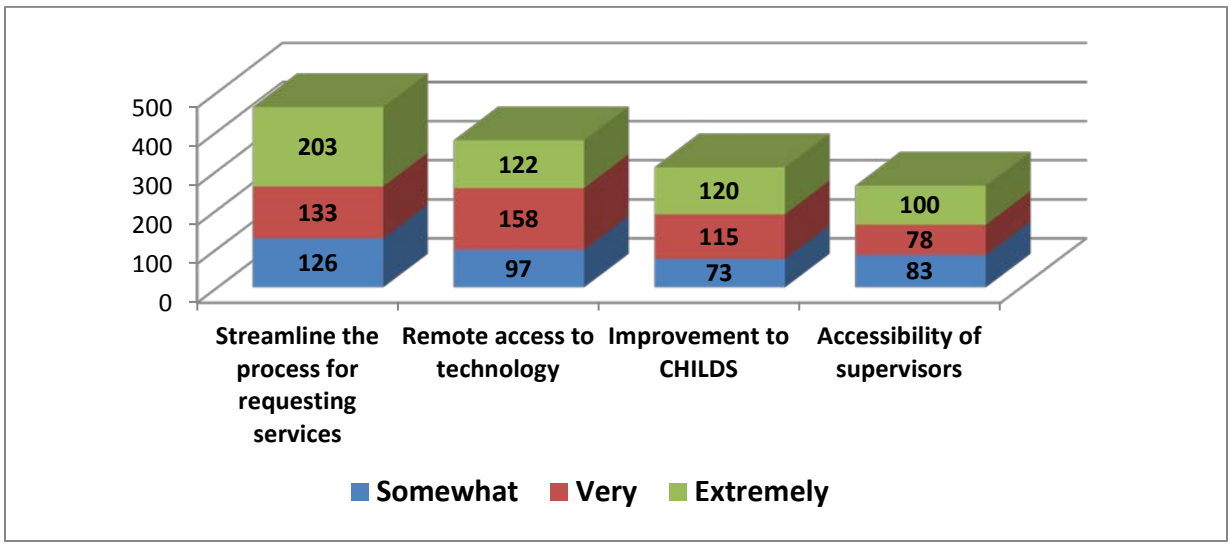
- DCSFS employees choose to work in this field because of their commitment to protecting children; and

- When given the opportunity to provide additional recommendations to the CARE Team, many employees suggested that work should be done to improve the Division's Human Resources system.

Given that this survey was conducted over the holidays, the compressed timeframe busy employees had to respond within and the challenge associated with contacting employees working throughout the state, this online survey received a better than anticipated response. We received completed surveys from 768 (45%) of the 1,704 Division employees. It is encouraging to note that the characteristics of survey respondents matched well with overall Division staff, in terms of both their current jobs and experience.

SURVEY FINDINGS

Figure 1: **What would make your job more efficient?**



Streamlining the process for requesting services for such things as a parent aide, counseling or psychological evaluations was the top recommendation for improving efficiency. Two-thirds chose this option and among those that chose it, almost three-quarters (73%) said it was extremely or very important. Two-thirds (66%) of the case management respondents selected this option.

Remote access to technology such as tablet/laptop computers and voice recorders was the second most common recommendation to improve efficiency. Approximately half (51%) selected this option and three-quarters (74%) said it was extremely or very important.

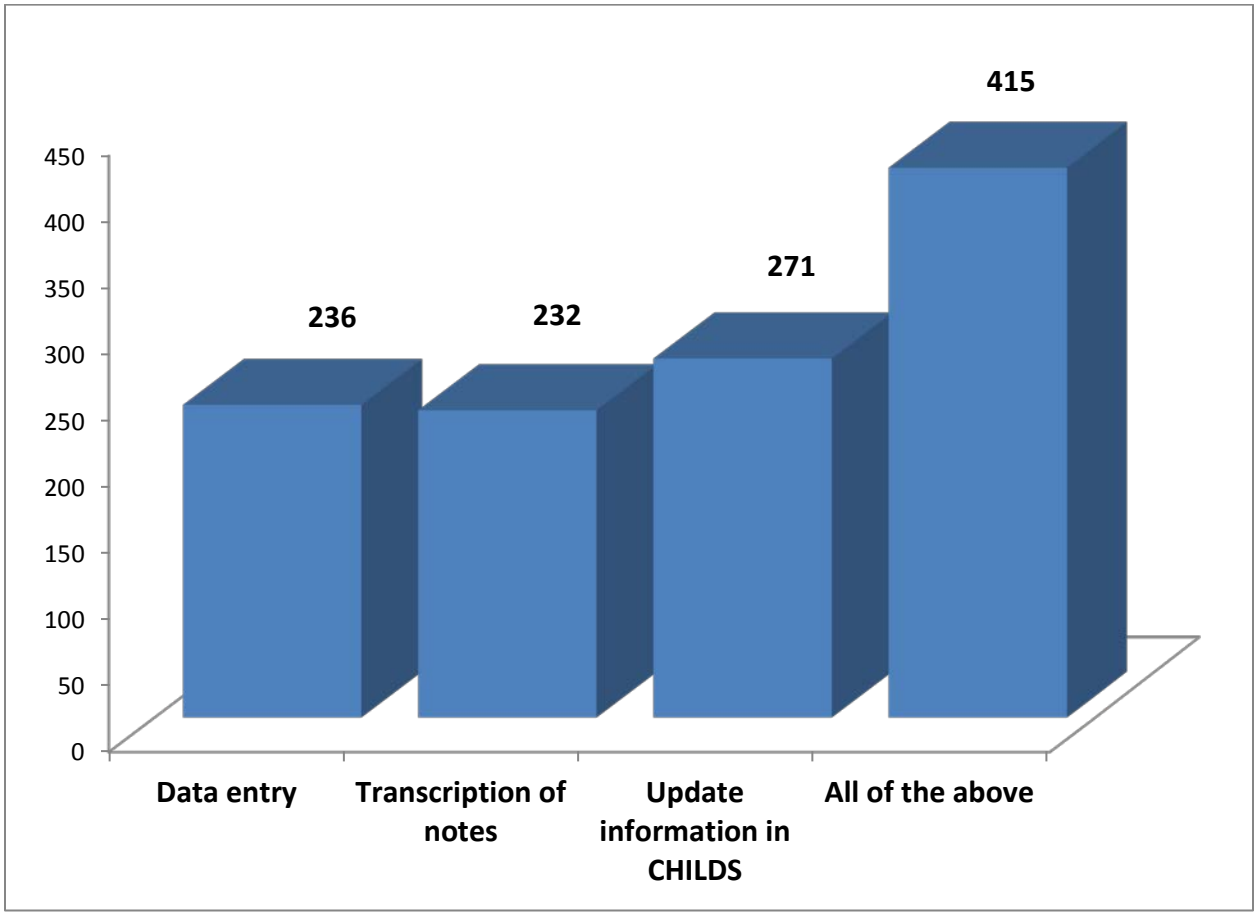
Improvements to the Children's Information Library and Data Sources (CHILDS) was favored by 42% of respondents. Among the supervisors who selected this option, 82% thought this recommendation would be extremely or very important.

Accessibility of supervisors was another top recommendation, and it was favored by 35% of the survey respondents. Interestingly, less than half (40%) of case management respondents selected this option and only 25% of the supervisors selected it.

Among the remaining options presented, only 22% favored the availability of mentors, 19% additional training as related to case management and 18% additional training on policies and 10% additional training regarding use of available technology.

Respondents wrote-in 187 additional suggestions to improve efficiency and the most common suggestions involved technology or other improvements to reduce case workload and policy and procedure e.g., as it relates to the Hotline.

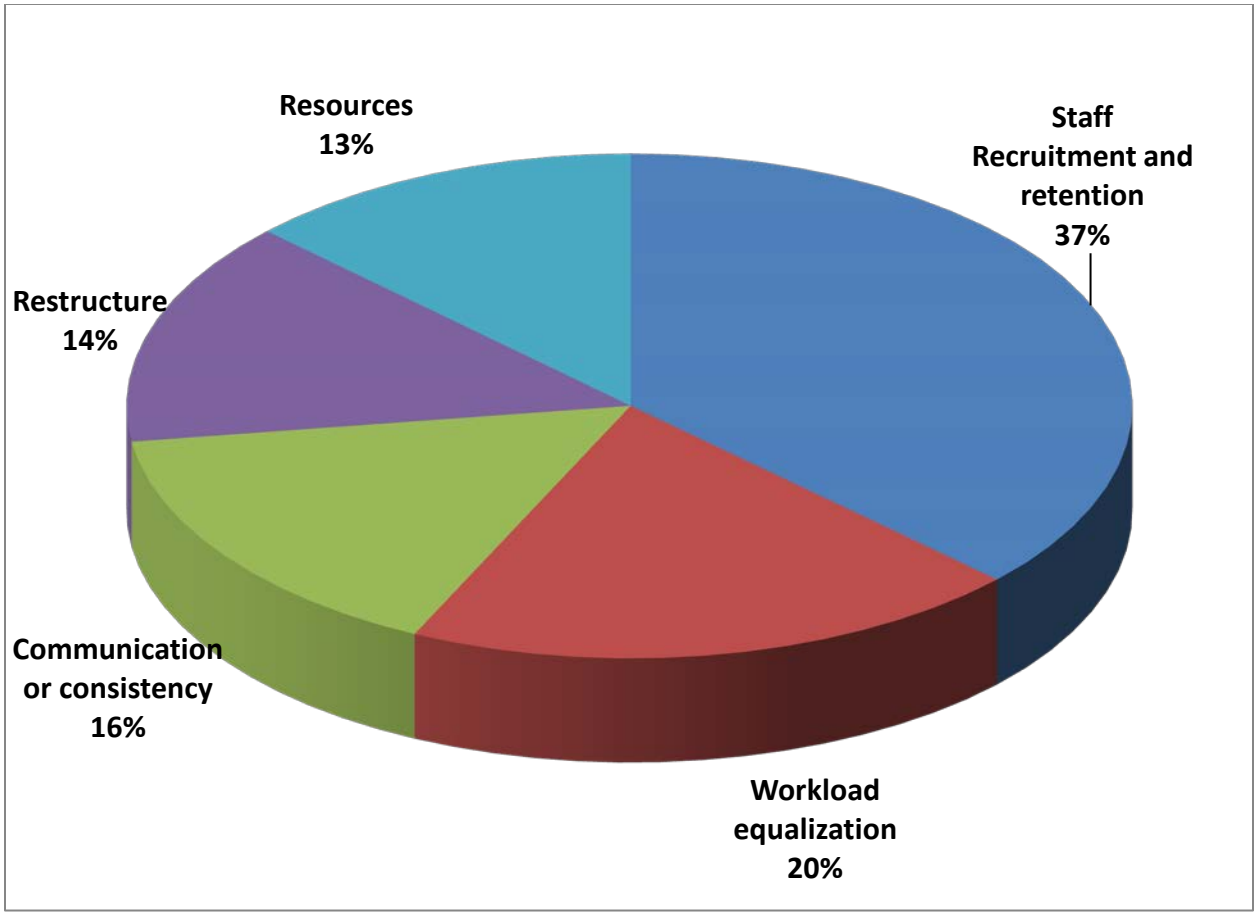
Figure 2: **What functions should be expanded to increase productivity?**



Over half (415 or 56%) of the respondents said that data entry, transcription of notes and updating information in CHILDS together should be expanded to increase their productivity (see Figure 2). Among those that said all three should be enhanced, 88% thought this was extremely important.

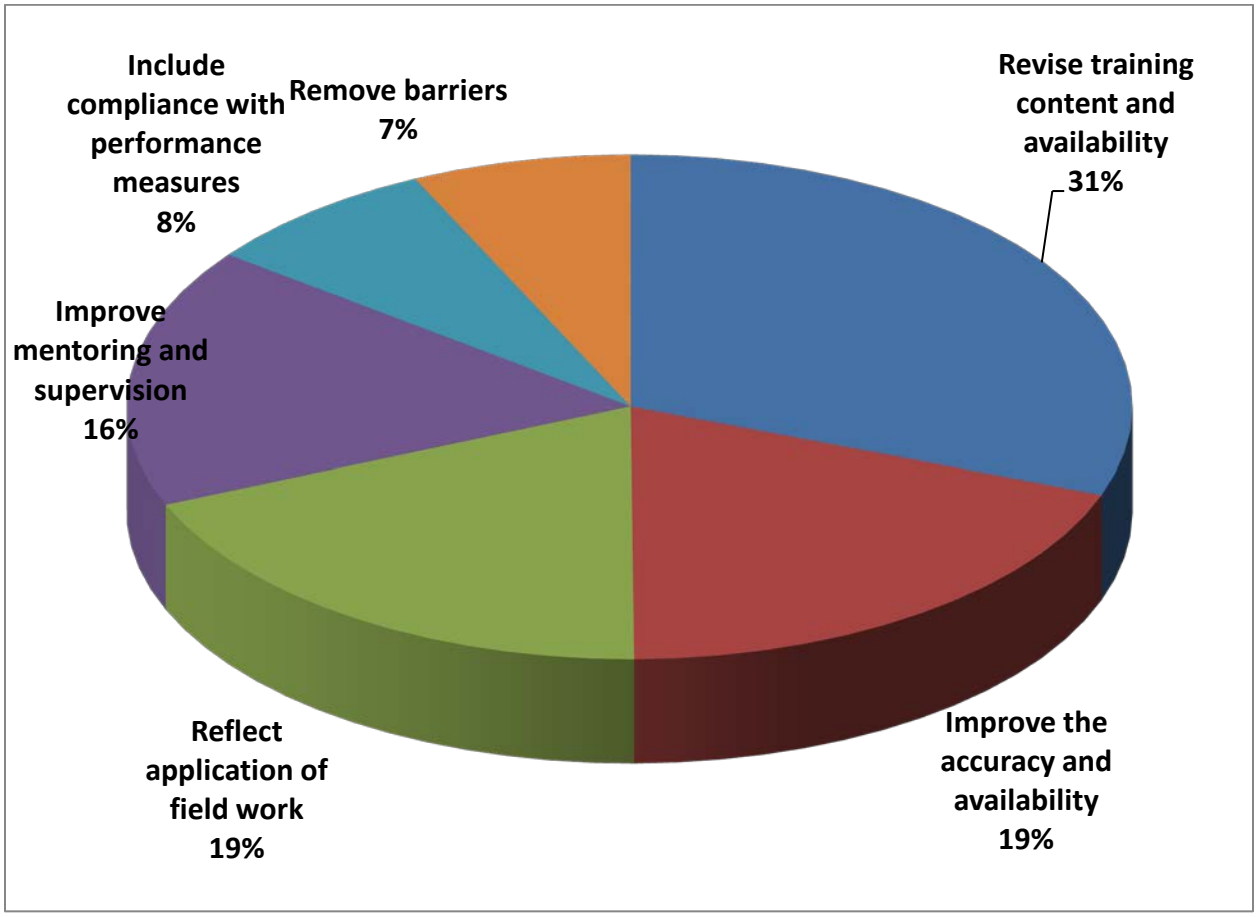
Respondents wrote-in 85 additional suggestions to increase productivity and the most common suggestions involved case assistance involving such tasks as faxing, filing, referrals or visits.

Figure 3: **What organizational changes could help CPS be more effective?**



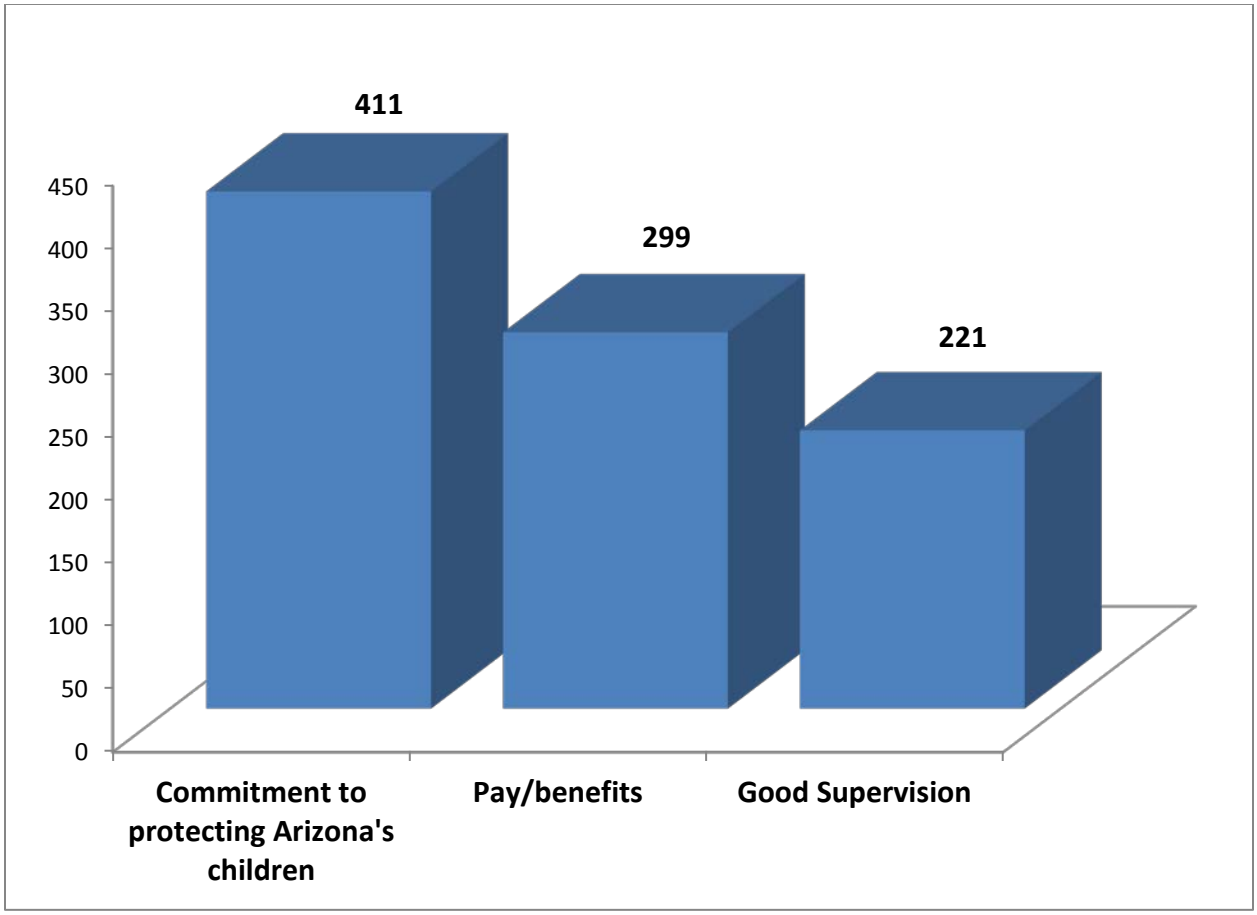
More than a third (37%) of the respondents said that in order to make the Division of Child Safety and Family Services more effective, restructuring efforts should focus upon staff recruitment and retention (see Figure 3). Another popular target of restructuring involved workload equalization (20%).

Figure 4: **How can staff be better trained on policies and procedures?**



Almost a third (31%) said staff could be better educated and trained on policies and procedures by expanding or revising the content of training. Other popular enhancements include improving the accuracy of policies (19%) and ensuring that policies reflect the practical application of field work (19%).

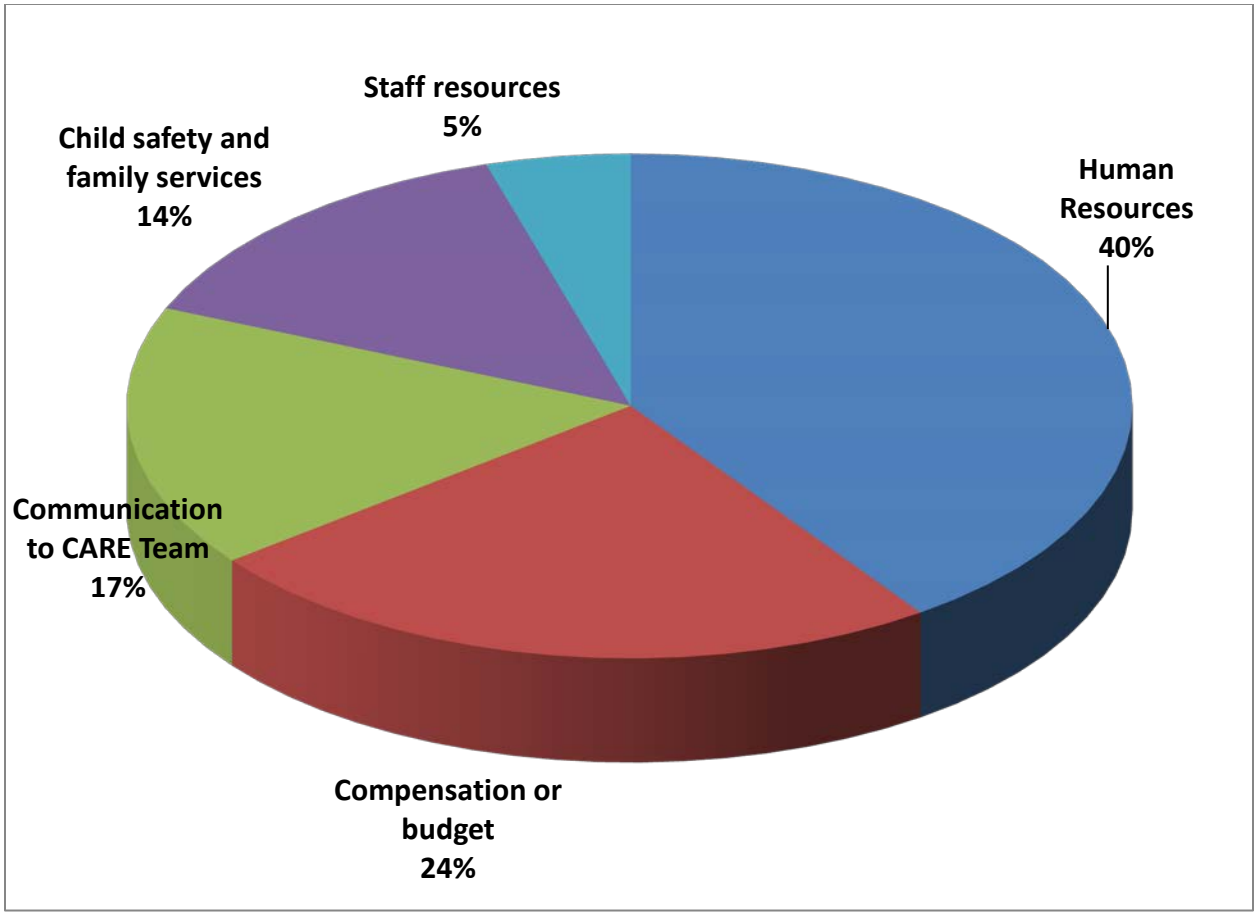
Figure 5: **Why do you continue to work as a Child Protective Services worker?**



When asked why they chose to stay working with CPS, over half (411 or 56%) of the respondents mentioned their commitment to protecting Arizona's children (see Figure 5). Other popular reasons were pay/benefits (299 or 41%) and good supervision (221 or 30%). Among the remaining options presented, tuition reimbursement was selected by 20%, 16% said that they were seeking experience and 33% provided other reasons.

Respondents wrote-in 240 additional comments on why they chose to continue working as Child Protective Services Workers. Salary/compensation was the most commonly mentioned reason that they wrote-in followed by workforce development.

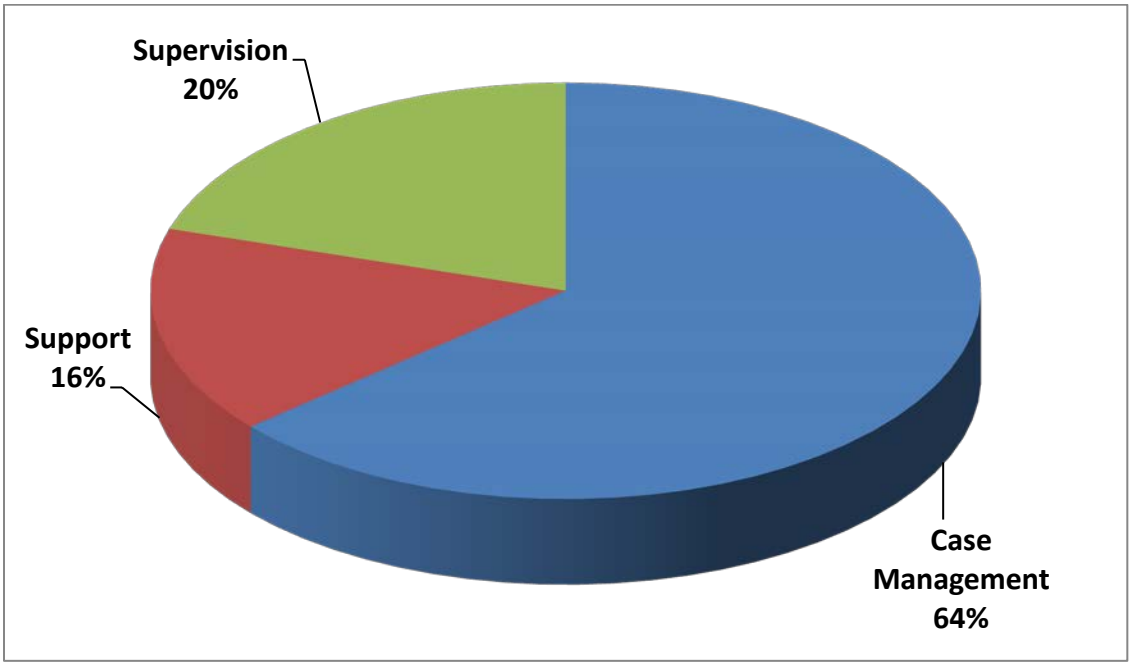
Figure 6: **Additional recommendations for the CARE team.**



Respondents were given an opportunity to make additional recommendations (see Figure 6) to the CARE Team and the most frequent recommendation involved changes to the Human Resource system (40%) e.g., more Case Management staff, followed by compensation or budget changes (24%).

SURVEY RESPONDENTS

Figure 7: **What services do you provide at Child Protective Services?**



A total of 768[1] staff responded to the survey. As shown in Figure 7, most (64%) of the respondents were Case Management staff followed by supervisors (20%) and support (16%).

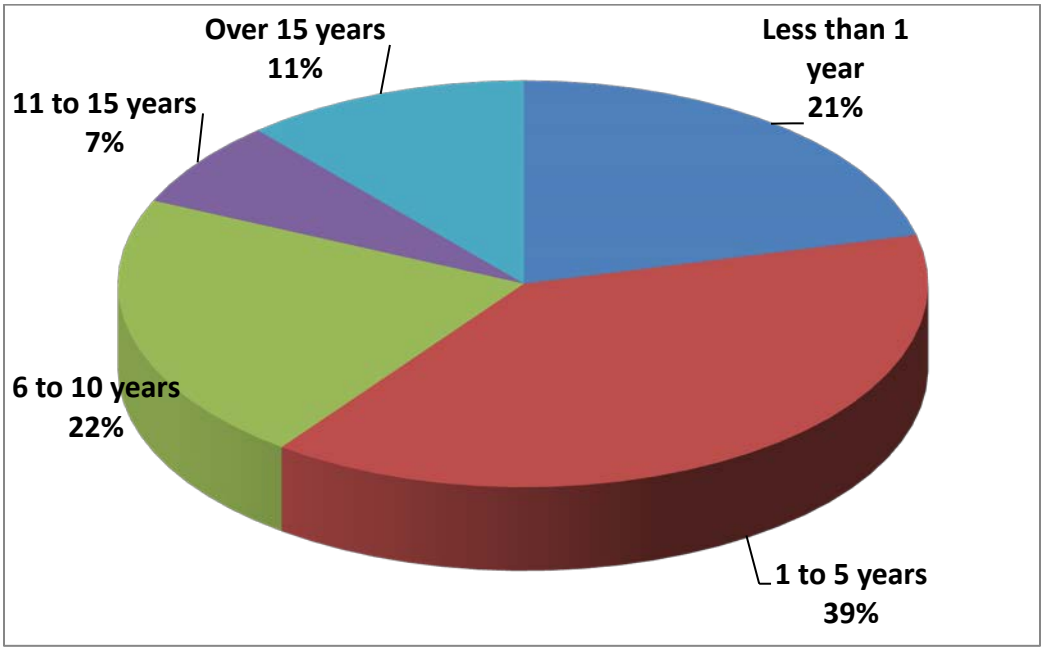
Table 1

Job Category	Total DCSFS Staff	Survey Respondents
Case management	63%	64%
Supervision	12%	20%
Support	25%	16%
	100% (n=1,704)	100% (n=768)

Our respondents matched well with the total Division of Child Safety and Family Services (DCSFS) staff because in both cases 64% were Case Management staff (see Table 1). Survey respondents were slightly over representative of supervisors and under representative of support staff.

[1] This represents a 45% response rate.

Figure 8: **Survey respondents years of experience**



Over one-third (39%) of the survey respondents had between one and five years of Child Protective Services (CPS) experience. The other respondents were split between those with less than a year (21%) and those with six or more years of experience (40%).

Table 2

Years of Service	Total DCSFS Staff[2]	Survey Respondents[3]
Less than one year	28%	21%
1 – 5 years	42%	39%
6-10 years	18%	22%
11-15 years	5%	7%
Over 15 years	7%	11%
	100% (n=1,704)	100% (n=768)

Survey respondents matched well with the total DCSFS workforce. As can be seen in Table 2, the survey respondents had very similar years of service as total DCSFS staff. Moreover, 39% of the case management survey respondents had 1-5 years of CPS experience while 42% of the total DCSFS case management staff had the same length of state experience.

[2] Total state service.
[3] Time with Child Protective Services

DIVISION OF
CHILD SAFETY AND FAMILY SERVICES

FOSTER and/or ADOPTIVE PARENT SURVEY RESULTS

Presented to:

CHILD ADVOCATE RESPONSE EVALUATION TEAM

and

Charles Flanagan
Director

Prepared by:
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January 29, 2014

EXECUTIVE SUMMARY

In January, 2014, Child Advocate Response Evaluation (CARE) Team, in cooperation with the Arizona Association for Foster and Adoptive Parents, conducted a survey to illicit feedback of the experiences of Foster and Adoptive Parents. Between January 13 and January 20, the CARE Team received 258 responses.

Among the major findings are:

- A majority of parents (58%) felt that they had inadequate information on children placed in their home.

- A strong majority (72%) of parents felt they had accurate contact information in the event of an emergency with a child placed in their homes.

- Almost half (49%) were satisfied with their interactions with CPS specialists. When the question turns to support from CPS specialists and/or CPS Unit Supervisors, satisfaction drops to 42%

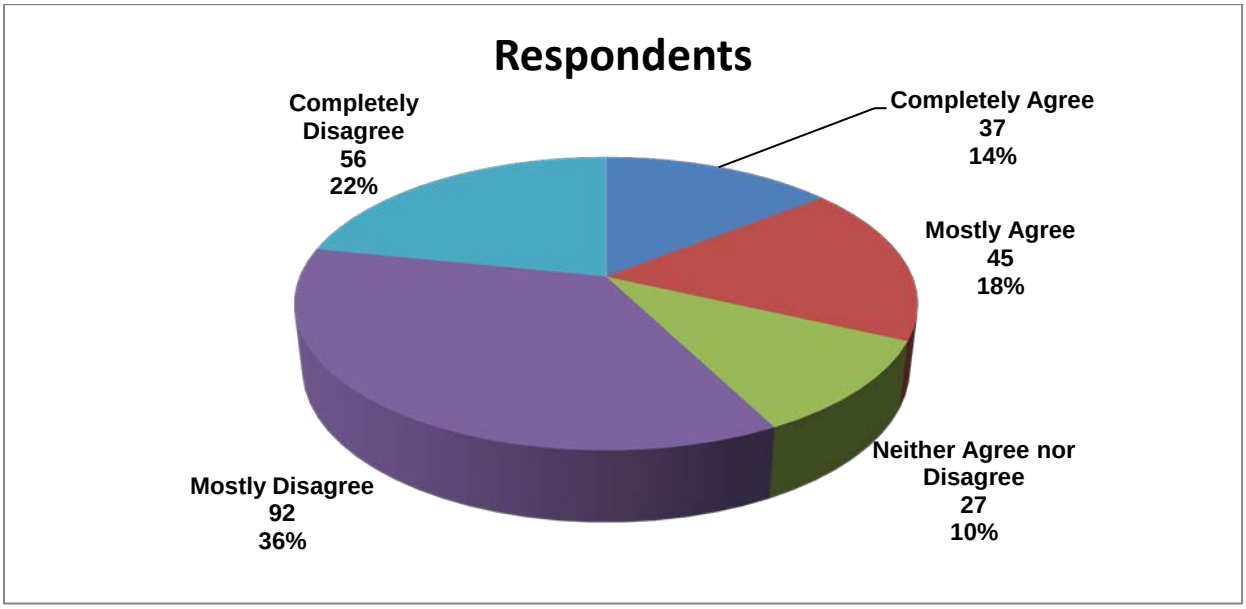
- Half (50%) of the respondents thought CPS considered the parents to be part of the team when it concerned the welfare of the children. Additionally, 60% of parents indicated they felt their work with children was valued by CPS.

- Nearly 40% of parents stated that more involvement in the decisions about the child's welfare was the most important factor in improving their experience as a foster parent. Other important factors included additional funds and additional child care or respite services.

- Factors that were considered least important to improve the experience as a foster parent include better support for sibling visits and better support for kinship foster parents.

SURVEY FINDINGS

Question 1: **I have received adequate background information on the children placed in my home.**

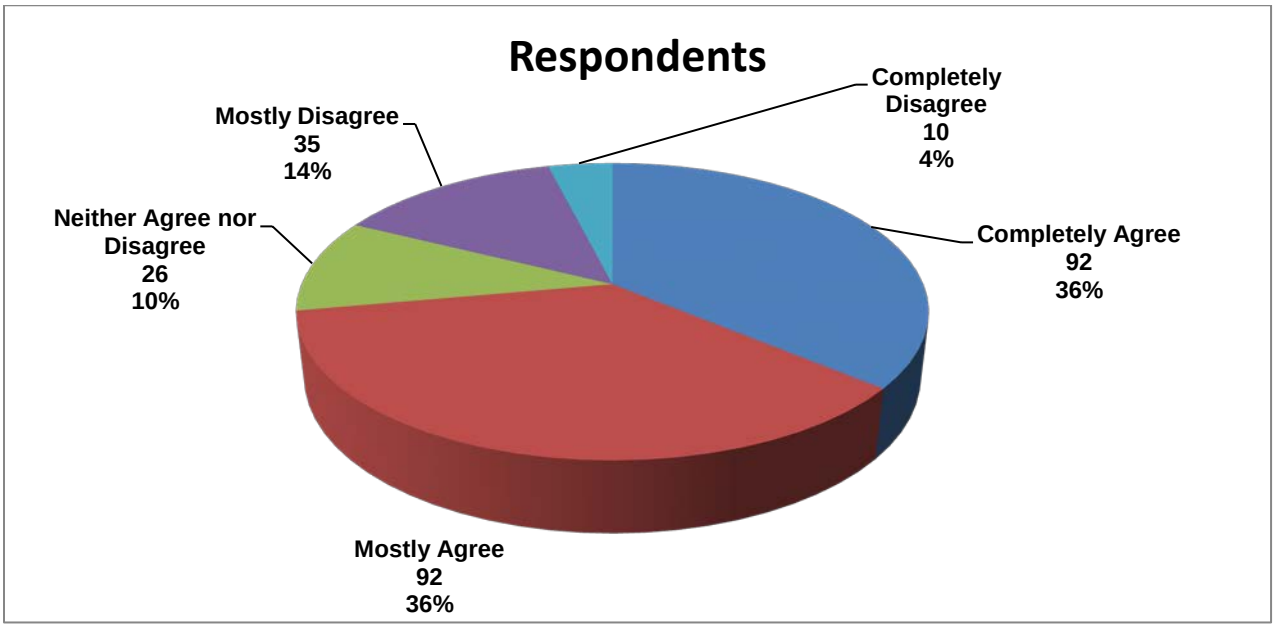


Over half (58%) or 148 of the respondents disagreed that adequate background information had been received with over 1 in 5 strongly disagreeing.

Thirty-two percent or 82 respondents agreed that they had received adequate background information received in their home.

Ten percent or 27 respondents neither agreed nor disagreed.

Question 2: **I know who to contact and have accurate contact information, when there is an emergency with the child(ren) placed in my home.**

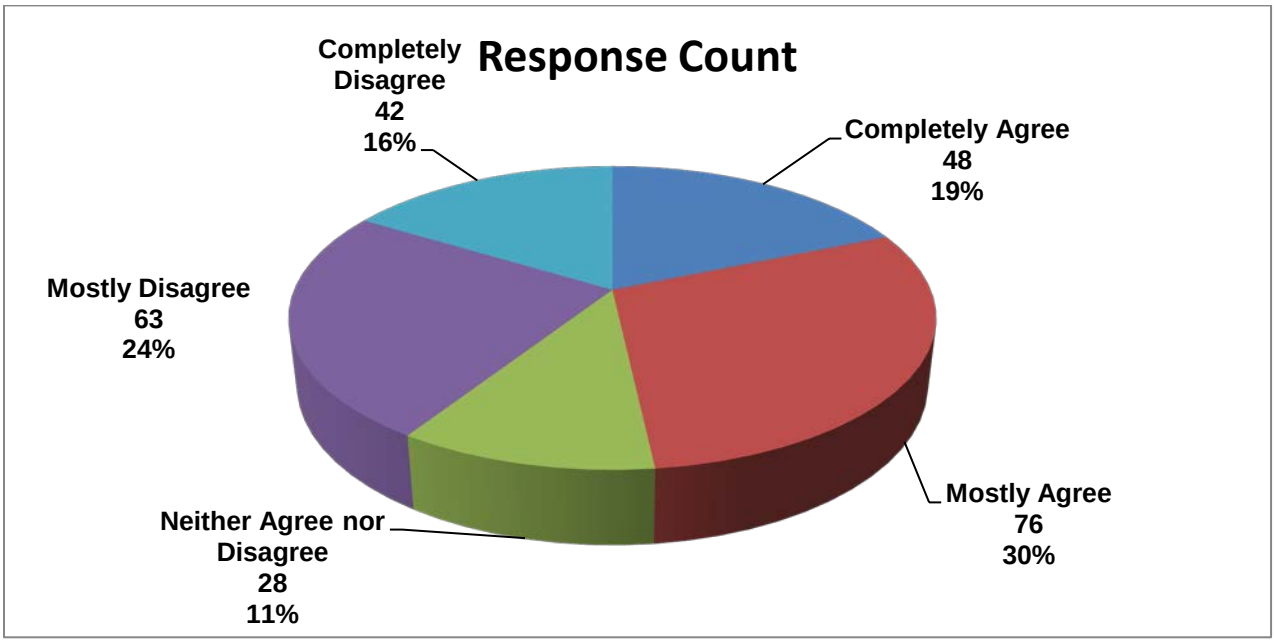


Almost three quarters (72%) or 184 respondents agreed that they knew who to contact and had accurate contact information, when there is an emergency with the child(ren) placed in their home. Over 1 in 3 completely agreed with the statement.

Eighteen percent or 45 of the respondents disagreed that they knew who to contact and had accurate contact information.

Ten percent or 26 respondents neither agreed nor disagreed.

Question 3: **I am satisfied with my interactions with DCYF CPS Specialists. When concerns regarding the children placed in my home are addressed, I feel it is done in a professional and courteous manner and that my input is taken seriously.**

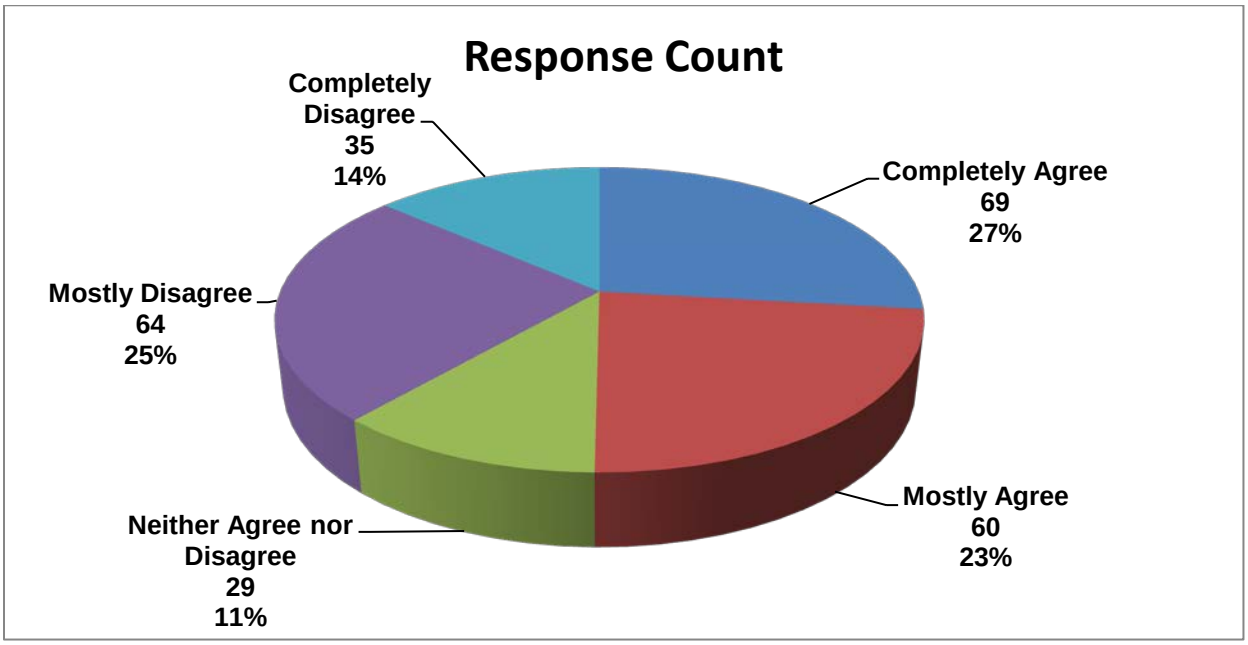


Forty-Nine percent respondents were satisfied with their interactions with DCYF CPS Specialists. Two in 10 or 48 respondents completely agreed.

Forty percent or 105 of the respondents were not satisfied with their interactions with DCYF CPS Specialists**.**

Eleven percent or 28 respondents neither agreed nor disagreed.

Question 4: **I feel DCYF/CPS considers me a part of the team to support and care for the children placed in my home.**

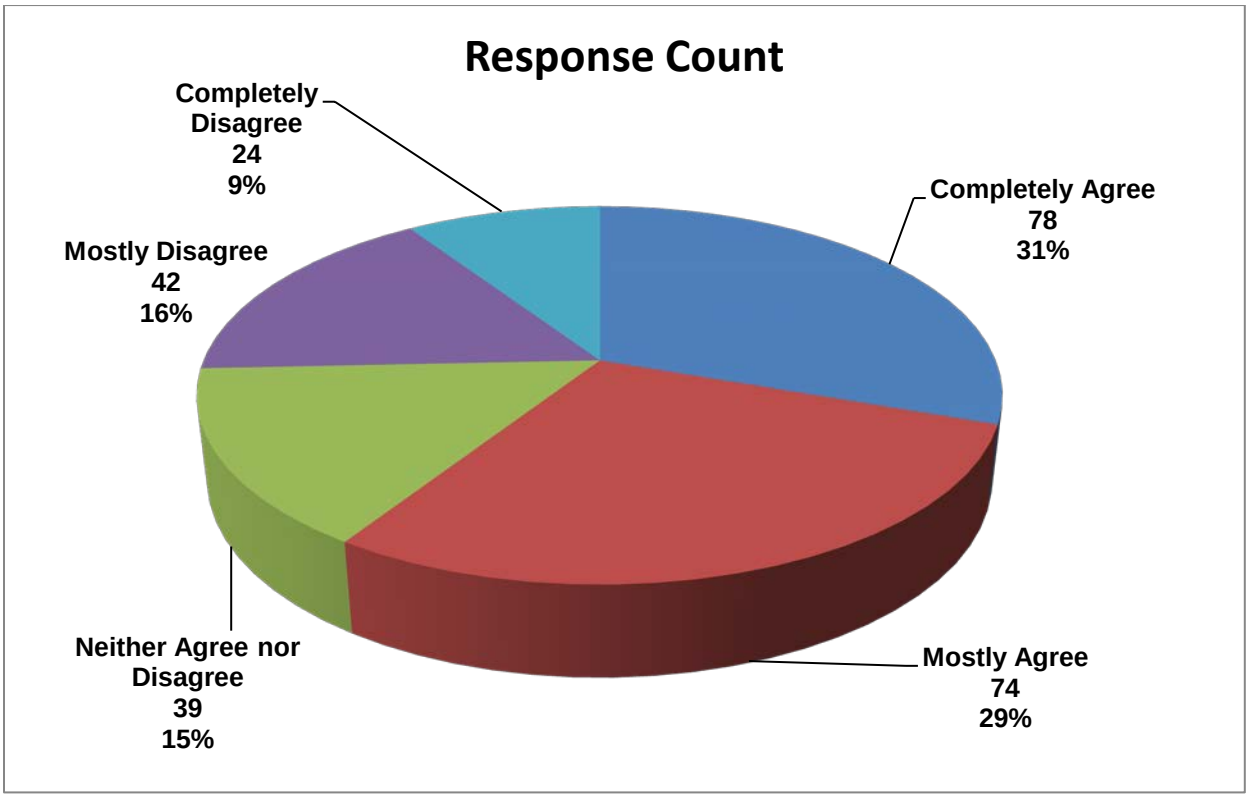


Fifty percent or 129 respondents were satisfied that they did feel that DCYF/CPS considered them as part of the team to support and care for the children placed in their home. More than 1 in 4 respondents completely agreed with the statement.

Thirty-nine percent or 99 of the respondents did not feel that DCYF/CPS considered them as part of the team to support and care for the children placed in their home.

Eleven percent or 29 respondents neither agreed nor disagreed.

Question 5: **DCYF/CPS has valued my work with the children placed in my home.**

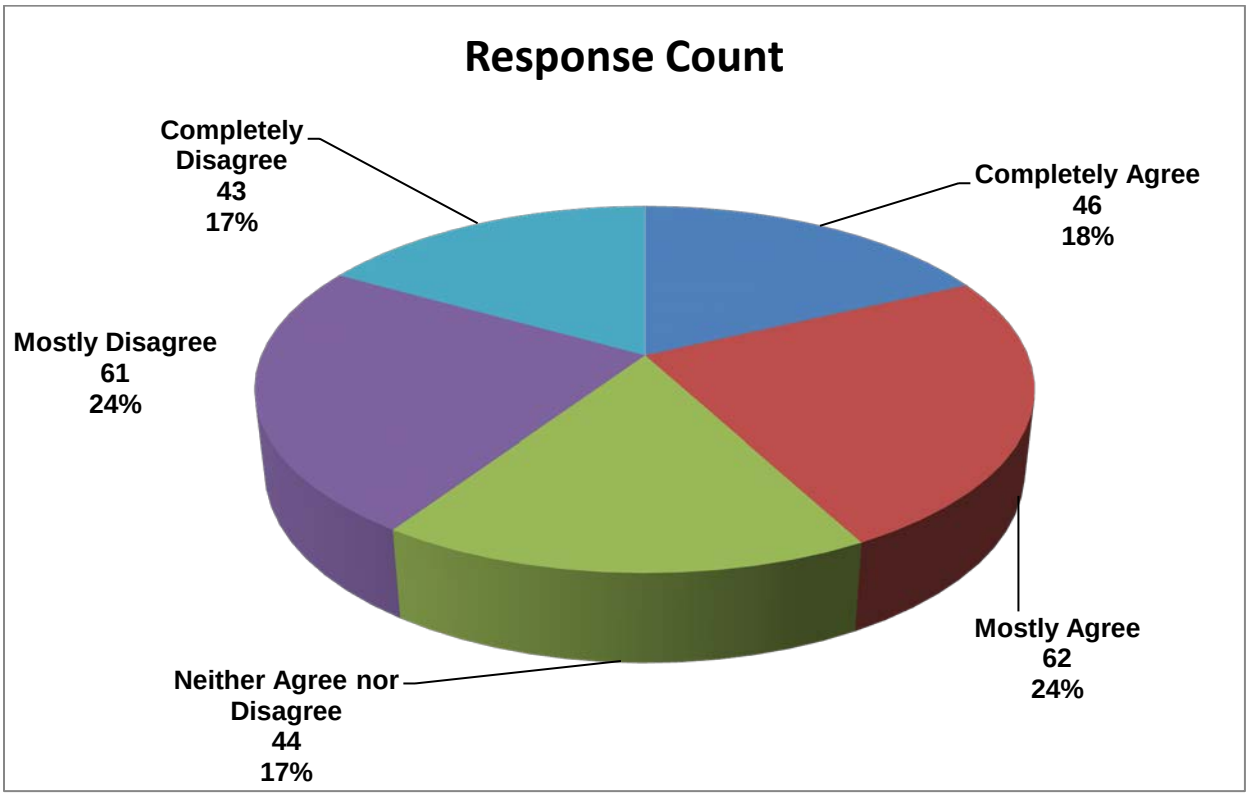


Over half (60%) or 152 respondents were satisfied that DCYF/CPS valued their work with the children placed in their home**.** More than 3 in 10 or 78 respondents completely agreed.

Twenty-five percent or 66 of the respondents were not satisfied that DCYF/CPS valued their work with the children placed in their home.

Fifteen percent or 39 respondents neither agreed nor disagreed.

Question 6: **Overall I would say that I am satisfied with the support that I receive between DCYF/CPS Specialists and/or CPS Unit Supervisors.**

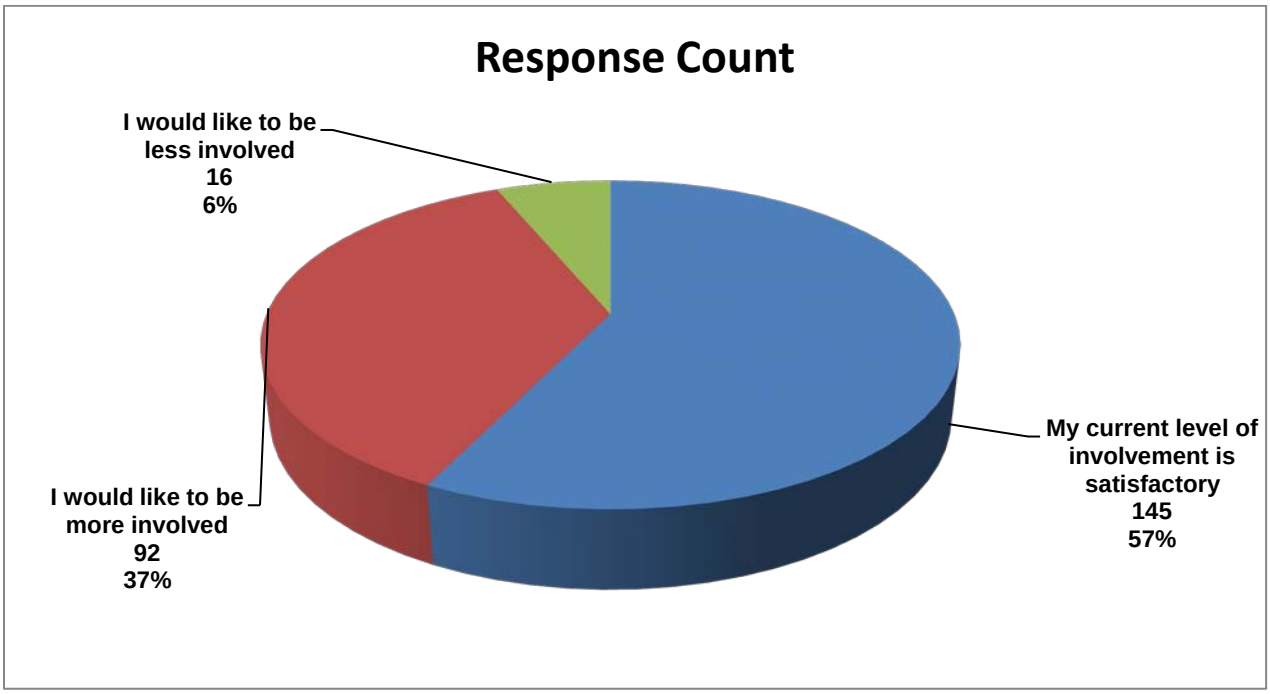


Almost half (42%) or 108 respondents were satisfied with the support they receive between DCYF/CPS Specialists and/or CPS Unit Supervisors**.** Nearly 1 in 5 or 46 respondents completely agreed.

Forty-one percent or 104 of the respondents were not satisfied with the support they receive between DCYF/CPS Specialists and/or CPS Unit Supervisors

Seventeen percent or 44 respondents neither agreed nor disagreed.

Question 7: **Based on my level of involvement, I consider myself a part of the team to support and care for the children placed in my home.**



Over half (57%) or 145 respondents were satisfied with their current level of involvement in the care and support of the children placed in their home.

Thirty-seven percent or 92 respondents would like to be more involved in the care and support of the children placed in their home.

Six percent or 16 respondents would like to be less involved in the care and support of the children placed in their home.

Question 8: **From the list below, select items that could improve your experience as a foster parent. Please rank in order of importance**.

Rank	Answer Options	Points	1st Priority %	1st through 3rd Priority %
1	More involvement in the decisions about the child's welfare	2,161	39.4%	64.7%
2	Additional funds to support the needs of the children in my care	1,849	12.0%	41.0%
3	Additional child care or respite services	1,606	6.8%	35.7%
4	More appreciation and respect from CPS and/or my licensing agency	1,575	12.0%	35.7%
5	Additional behavioral health services	1,564	6.8%	26.5%
6	Behavioral health services that are closer to my home	1,450	2.4%	20.5%
7	Better connection with other foster parents I can call for help and support	1,430	5.2%	22.1%
8	More training opportunities for foster parents	1,396	4.0%	19.7%
9	Better supports for kinship foster parents	1,188	9.6%	20.5%
10	Better supports for face-to-face sibling visits	1,164	0.8%	8.0%
11	More opportunities for sibling visits besides face-to-face; examples include: Internet Video Chat (e.g. Skype)	1,051	0.8%	5.6%

If a respondent ranked an answer as the highest in importance, that response was coded with 11 points. The second highest priority was given 10 points, third highest 9 points, all the way down to the 11th or least important, which was given 1 point.

The answer than ranked of highest importance was "More Involvement in the Decisions about the Child's Welfare." Nearly 40% of respondents reported that more Involvement in the decisions about the child's welfare is of highest importance and almost 65% of respondents reported it as one of the three most important ways of improving the experience of foster parents.

Additional funds to support the needs of the child/children ranked as the second highest priority with 41% of respondents indicating it is one of the top priorities.

Nearly 36% of respondents ranked additional child care or respite services as a high priority. There was a similarly placed importance more appreciation and respect as an important way to improve their experience as a foster parent.

An additional concern seems to be the availability of behavioral health services. While this need was not often identified as among the most important, both behavioral health services variables had more than 30% support as a 4th, 5th, or 6th priority to improve their experience as foster parents.

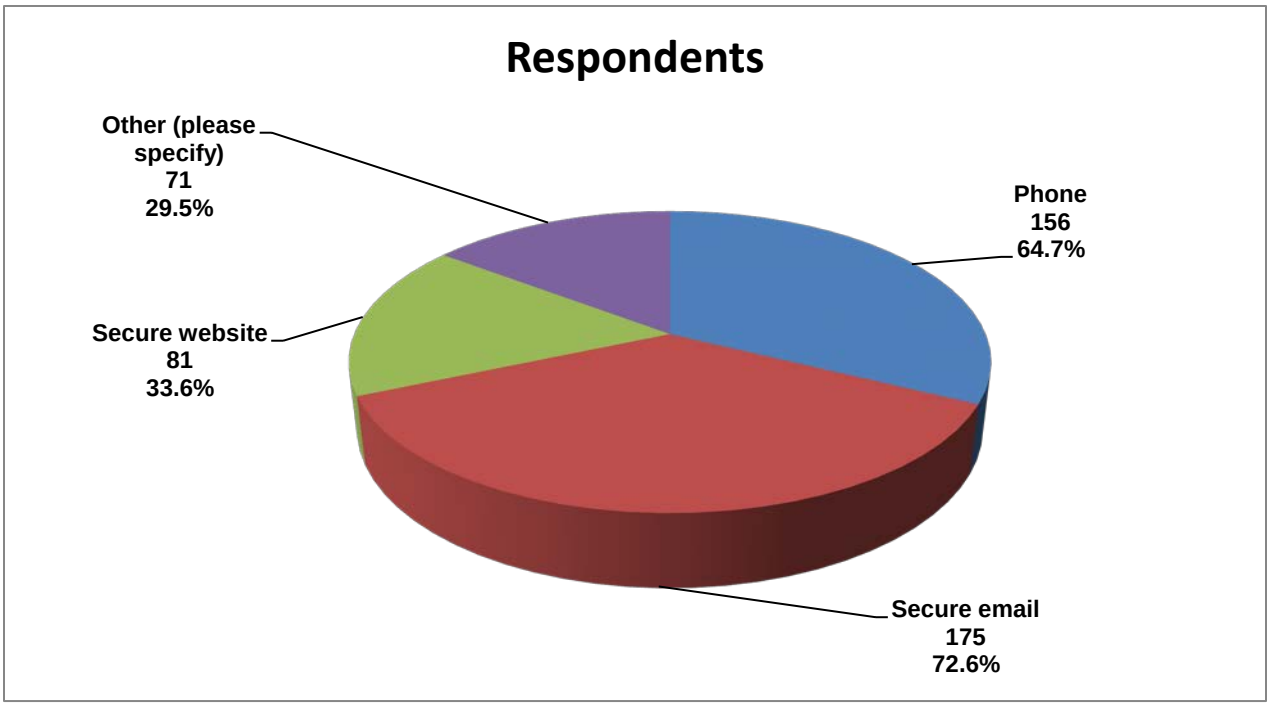
Better connection with other foster parents and more training opportunities were ranked 7th and 8th most important.

Although over 20% listed better supports for kinship foster parents as a high priority, nearly a quarter of respondents (61) listed this as the least important way to improve their experience as a foster parent.

Sibling visits were given the lowest priority, whether the visits were face-to-face or other types of visits such as Skype. This finding, along with the finding on kinship foster parents indicates that the biological family was not the highest priority for the respondents.

Questions 9 and 10 were narrative and asked respondents for comments. Thus, there are no graphs or tables for those questions.

Question 11, **When giving you information about the children in your care, CPS could improve its efficiency if case managers utilized (select all that apply):**



Almost three quarters (72.6%) or 175 responses said that efficiency could be improved if case managers utilized secure email.

Over half (64%) or 156 responses said that efficiency could be improved if case managers utilized phones.

A third (33%) percent or 81 responses said that efficiency could be improved if case managers secured websites

Twenty-nine percent or 71 responses said that efficiency could be improved if case managers utilized other services not specifically identified.

Percentages add up to over 100% because responders were allowed to select more than one answer.

Reference Materials

The below documents will be posted on the CARE Team's website at https://azcareteam.az.gov/

Governor Brewer's Child Advocate Response Examination Team (CARE Team) Overview.
Governor Brewer's Executive Order 2014-01.
Governor Brewer's State of the State Address (2014).
Arizona Council of Human Service Providers. Solutions for CPS-Involved Children and Families.
Arizona Council of Human Service Providers. Family Services Save Lives, Save Money.
National Children's Alliance. Importance of Children's Advocacy Centers. Retrieved from http://www.nationalchildrensalliance.org/ImportanceofCACs
Child Safety Task Force Report (2011).
Arizona Voice for Crime Victims. In Harm's Way - A Report On Policy Conflict That Fails Children And The System Established To Protect Them (2003).
Siegel, Gene C. The Impact of the Mesa Center Against Family Violence on Child Abuse Investigations (1999).
Cenpatico. Texas Foster Care.
Children's Action Alliance. CPS Forum Transcript and Recommendations (2013).
Casey Family Programs. Centralized Intake Systems (2011).
Voices for CASA Children. Legislative Roundtable – Call to Action Summary (2013)
List of CARE Team Community Meetings
Gartner. AZ DES State Automated Child Welfare System (SACWIS) Assessment and Modernization Roadmap – Initiatives Workshop (2013).
Hughes, Ronald C. & Rycus, Judith S. Discussion of Issues in Differential Response (2013).
The Recurrence of Child Maltreatment: Predictive Validity of Risk Assessment Instruments (2007).
Law Enforcement Outreach Executive Summary
Arizona CARE Team Comment Summary
American Academy of Pediatrics' Statement on Arizona's Child Protective Services System.
Maricopa County Juvenile Court Recommendations
Maricopa County Chief of Juvenile Probation Recommendations
Maricopa County Office of the Public Defender Recommendations
Cochise County Presiding Juvenile Court Judge Recommendations
Arizona Association for Foster & Adoptive Parents. The Case for Restoring "Special Allowances" for Children in Foster Care in Arizona.
Youth Advocate Programs, Inc. (YAP) Reference Materials
Supporting Documentation from the Governor's Transformation Office (GTO)
Failure Mode Effects Analysis (FMEA) Report (Scale & Summary)
Call Abandon Rates
Incoming Reports Forecast
Monthly Caseload Report
Arizona Random Moment Sample
Work Hours Calculation