

# **ARIZONA'S CITIZEN REVIEW PANEL FOURTH ANNUAL REPORT**

**December 2002**

## **Program Background and Purpose**

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

## **Program Structure**

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

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

## **Update On Recommendations From 2001 Report**

The following are recommendations for improvement in the Child Protective Services system identified in last year's Third Annual Citizen Review Panel Report and the responses from DCYF:

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

Response from DCYF: DCYF recommended that the Citizen Review Panel Report from 2001 be sent to the director of the Office of Administrative Hearings. DCYF agreed to encourage the Administrative Law Judges to participate in case manager CORE training.

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

Response from DCYF: DCYF responded that this could be accomplished through their planned implementation of a peer review process, which includes a review of the investigative findings.

The Peer Record Review has been implemented and is conducted quarterly. The review evaluates compliance with the federal element of Safety and focuses on the Child and Family Services Review topic related to repeated maltreatment. Quarterly Summary Reports that identify low substantiation rates in relation to low rates of maltreatment will begin providing data that should assist in assessing the impact of the appeal process.

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

Response from DCYF: Administration for Children, Youth and Families' (ACYF) policy requires staff to make reasonable efforts to locate a family that has moved prior to case closure. In practice, the investigation proceeds with efforts to locate the family and gather information from persons who have knowledge of the alleged abuse or neglect. The investigation of a report that is closed as unable to locate may result in a substantiated finding if there is sufficient evidence to support the finding. Policy guidelines were developed in August 2002, to assist in strategies to attempt to locate families prior to closure of a CPS investigation.

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

Response from DCYF: In 2001, ACYF policy on “Determining Whether to Open the Case for Ongoing Services” added questions to assist the case manager when determining additional actions needed, such as an in-home dependency petition. In October 2002, ACYF expanded policy to identify types of situations that would warrant an in-home dependency petition. DCYF noted in their response that an increase in dependency cases will impact the court system and will increase the workload of CPS staff, Attorney General staff and court appointed attorneys.

- Recommendation: The panel recommends that allegations involving a child living with a convicted sexual offender, if the offense was against a child, should be classified as a moderate risk.

Response from DCYF: The ACYF Response System examples used by the Child Abuse Hotline have been modified to add a new description under the Sexual Abuse, Moderate Risk category to include the above descriptor. This change is also being added to the online Children’s Services Manual Response System Exhibit 9.

- Recommendation: The panel recommends that policy directing staff to review all prior reports involving the family during the course of an investigation be fully implemented, through internal reviews and training.

Response from DCYF: DCYF is receiving Technical Assistance from the National Resource Center on Child Maltreatment on decision making, assessing child safety, identification of patterns and risk factors, evaluation of cumulative risk to a child, and assessment of a family’s service needs. The review of all prior reports has been incorporated in the Child Welfare Training Institute Investigation curriculum. In addition, the peer review process, case review tool and policy for clinical supervision currently being developed, will assist in identifying additional training needs or policy revisions.

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

Response from DCYF: The Request for Proposal was finalized and a Request for Quote submitted for a board-certified pediatrician. It is anticipated that interviews will be held in the near future and that a board-certified pediatrician will be in the position of Medical Director by early 2003.

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

In 2002, an Unexplained Infant Death Scene Investigation Checklist was developed by the Unexplained Infant Death Advisory Council (formerly SIDS Advisory Council) and distributed to Arizona's Medical Examiners' Offices. Training for law enforcement through Arizona POST has been implemented on use of this checklist and scene investigations involving unexplained infant deaths.

## **Panel Activities For Reporting Period December 2001 Through November 2002**

Arizona's Citizen Review Panel Program continued to develop strategies for improvement to child protection efforts in Arizona. As in the prior year, all panels met on a regular basis to review case records, agency policies, pertinent legislation, and new agency projects. Quarterly meetings were held with DCYF administrators to advise the agency of panel findings and to discuss plans or actions taken by the agency to implement the panel's recommendations.

### **Case Record Reviews:**

During this period, the record reviews expanded from a review of the initial investigative stages of Child Protective Services cases, to include all stages of involvement with the families. This provided the panels with a more comprehensive understanding of Child Protective Services' activities. The focus of the case record reviews continued to be fatalities and near fatalities due to maltreatment, and other high-risk reports of maltreatment.

The number of records reviewed increased from 18 cases in the prior reporting period to 23 cases. Of these 23 cases, the State (Maricopa) Panel completed six record reviews, the Pima County Panel completed eight record reviews, and the Yavapai County Panel completed nine record reviews. Geographic coverage was expanded this period to include all of Arizona.

The State Panel made revisions to the Case Record Review Form. It is anticipated that these revisions will increase the effectiveness of reviews through a focus on pertinent issues and increase the number of records reviewed.

### **Meetings:**

Each panel met on a more frequent basis than the quarterly requirement. The Pima County Panel met on eight occasions. The Yavapai County Panel met on nine occasions. The State Panel met on seven occasions.

## **Case Record Review Findings**

Panels identified family risk factors in each review. Cases reviewed revealed the most frequent categories of risk factors included lack of parenting skills, substance abuse by parent, and prior reports to CPS.

The following is a list of identified risk factors and the number of cases in each category:

- Lack of parenting skills - 21
- Substance abuse – 18
- Prior Child Protective Services reports - 16
- Lack of motivation to provide a safe environment- 11
- Domestic violence – 10
- Lack of resources - 9
- Lack of anger control - 8
- Mental health issues - 5
- Physical/mental disability of parent - 5
- Teen parent - 4
- Parental violence outside home - 2
- Undocumented alien, language barrier – 2
- Prior deaths of children – 1
- Prior severance/dependency of children – 1
- Prior conviction of child abuse – 1

Case record reviews consisted of the assessment of specific activities by Child Protective Services during their involvement with the families. These stages included Intake/Screening, Investigation, Crisis Intervention, Investigative Finding/ Determination, Case Plan Implementation, and Case Closure. In addition to the agency activities, the panels explored community involvement with each case. An established form was completed in each record review and the results were maintained in a database.

**The Intake/Screening Stage** involves activities performed by the Child Protective Services Child Abuse Hotline. Activities include gathering enough information to determine if a report of suspected child maltreatment requires investigation or assessment by Child Protective Services or Family Builders, the severity of the allegation, and how quickly an initial response must be made to ensure the safety of the child victim.

Record reviews identified this stage as a strength in the child protection system. The panels felt that risk levels, response time, and maltreatment categories were appropriately assigned in all of the 23 cases reviewed. In 22 of the 23 cases, reports were assigned for investigation within required time frames.

**The Investigation Stage** involves gathering enough information to assess the child's immediate safety needs and to determine whether a reported or disclosed incident of maltreatment occurred.

Activities reviewed in this stage were determined to comply with agency policy in the majority of cases reviewed. Investigations were initiated and completed within established time frames in 20 of the cases reviewed. The investigations were determined to be thorough and accurate, confidentiality of the reporting source was protected, and appropriate steps were taken to reduce trauma to the child in the majority of cases. Six cases reviewed did not reflect compliance with agency policy. As found in the past year's report, the areas of concern in these cases primarily involved inadequate documentation of activities by the investigative case manager and the lack of required interviews, particularly interviews of all children in the household.

**The Crisis Intervention Stage** involves assuring the safety of the child, including the decision of whether the child could safely remain in the home or if emergency removal was necessary.

Panels found that in all cases, where indicated, safety assessments were completed; relatives were considered as a placement resource; and judicial oversight was timely and provided for all parties. In 21 cases, panels concluded that the decisions regarding emergency placements were based on adequate criteria. In one case, the panel concluded that the investigation should have resulted in the emergency placement of the child. In 19 of the 23 cases, panels determined that appropriate services were offered. In the remaining four cases, services either were not offered or did not address identified needs such as domestic violence, mental health, and substance abuse.

**The Investigative Finding/Determination Stage** refers to the process of classifying a case as substantiated or unsubstantiated based on information collected and analyzed during investigation.

The panel found that in 20 out of 23 cases, sufficient information was gathered to make a final determination. In the remaining three cases, panels identified that interviews of the children or parents were either missing or inadequate. The panels supported the findings in 18 cases, however the panels concluded that in five cases reviewed, the allegation should be substantiated rather than unsubstantiated.

**The Case Planning/Implementation Stage** refers to activities by Child Protective Services to ensure families receive timely, appropriate services designed to address the reasons children entered the child protective service system. The plan should reduce the risk to the children and enhance the family's functioning. The plan should be based on an accurate family assessment, individualized to the family's circumstances, and modified as the family's circumstances change.

The panel found that in all cases reviewed, where indicated, case plans were developed and reviewed within policy guidelines. In all but one case, the family and other team members were involved with case planning, and the plan adequately addressed the reasons for involvement by Child Protective Services. In two cases, the use of Family Group Decision Making enhanced the case planning stage. Difficulties noted with this stage primarily involved lack of face-to-face contacts with family members and insufficient documentation of contacts.

**The Case Closure Stage** should occur when the issues that led to the family's involvement with the child protective service system, or subsequent issues identified by the agency during its involvement with the family, are resolved or significantly improved, or permanency has been achieved.

This was the most problematic stage in cases reviewed by the panels. Panels disagreed with the decision to close the case in six of the twelve cases closed, due to continued risks that the panels felt warranted further involvement by CPS.

## Recommendations

Panel members identified five areas as the focus of this year's recommendations. These recommendations to enhance Arizona's efforts to protect children are made with the understanding that adequate funding, staffing, and community resources are essential for success:

- **Investigative findings**

The panel is concerned with the high rate of unsubstantiated findings in Arizona. According to the National Child Abuse and Neglect Data System, in 1999 Arizona's substantiation rate (17.3%) was lower than the national average (26.4%). The unsubstantiation rate of Arizona was 63.1% compared to the national average of 54.7%. The following are specific concerns and recommendations regarding unsubstantiated findings:

- The two classifications of investigative findings, substantiated or unsubstantiated, are inadequate. **The panel recommends adding a third option of "unable to investigate" or "unable to locate" to be used when an investigation cannot be completed due to the inability to locate the family.** This recommendation was included in last year's report. The panel continued to identify this as a continuing problem in the system.
- The inability to identify a specific perpetrator currently results in an unsubstantiated finding, regardless of evidence that the child was abused. For example, an infant has life threatening injuries due to shaken/impact syndrome. The investigation revealed that either of the parents may have abused their child, but could not determine which one. This would result in the unsubstantiation of physical abuse allegations. **The panel recommends adding a finding on all investigations, specific to the abuse or neglect of the child. This finding should not be dependent upon the identification of the specific perpetrator.**
- Record reviews revealed that the standards for substantiation were inconsistently applied. **The panel recommends that DCYF implement a process to systematically review unsubstantiated findings.**

The immediate supervisor should complete a review of all unsubstantiated findings. This review should be documented within the case record.

In addition to this first level review, a CPS representative outside of the CPS unit should periodically review a sample of unsubstantiated findings. This may be accomplished through a quality assurance unit, program specialist, or peer review. The result of these reviews should be utilized to develop strategies to increase the consistent application statewide ultimately increase the safety of Arizona's children.

- **Documentation**

Documentation in several cases reviewed was poor. Critical documents such as medical reports, police reports, investigative interviews, services offered, and provided, and contacts with family members were missing. Case management decisions, including reasons for removal of a child, return of the child to parents, dismissal of dependencies, were missing in some cases.

**The panel recommends the following strategies for improvement in critical documentation:**

- Increase communication to case managers and supervisors on fiscal and case specific impact of inadequate documentation;
- Monitor documentation, through supervisory reviews and quality assurance team reviews, with feedback to case manager of the results;
- Prioritize documentation, reduce redundant documentation, eliminate nonessential documentation, and provide training to staff on preparation of succinct, relevant case notes; and
- Establish positions to assist case managers with obtaining records from outside agencies.

- **Contacts with family**

In-home contacts are critical components of safety plans, particularly when the child is residing with the parents or guardians. The panel noted that in some cases reviewed, the frequency of in-home contacts was inadequate for the situation. **The panel recommends that the frequency of personal contacts with the family required by policy be amended to reflect the family's risk factors. Face-to-face contact with family members should be at least monthly and documented. Contacts in the home should be more frequent for in-home placements with increased risk factors.**

- **Substance-exposed newborn reports**

There appeared to be a lack of guidelines for the investigation and decisions regarding emergency placement of substance exposed newborns. The panel has been informed that policy, guidelines and training on this topic has been developed by ACYF. **The panel commends this effort and recommends full implementation of the training and policy.**

- **Interagency investigative protocols**

The panels noted that in cases reviewed in which there was a history of domestic violence, law enforcement response to domestic violence calls did not always result in a report to Child Protective Services. The panel concluded that due to the link between domestic violence and child maltreatment, which has been established in several studies on domestic violence, reports of domestic violence in which a child is present should be routinely reported to Child Protective Services.

Interagency investigative protocols have been developed statewide to provide guidelines for interagency cooperation in the investigation, prosecution, and management of child physical and sexual abuse cases. These protocols have contributed to improved quality of investigations of crimes against children and reduced trauma of the child victim.

**The panel recommends that interagency investigative protocols, statewide, should include instructions to law enforcement to file a report to Child Protective Services when they have responded to a domestic violence incident in which there was a child present in the home.**

The panel commends DCYF on their efforts to increase participation in joint investigations with law enforcement and in DCYF's support of child/family advocacy centers throughout Arizona. **The panel recommends continued expansion of family advocacy centers throughout Arizona.**

## Citizen Review Panel Objectives for 2003

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

- The panel plans to review 100% of fatalities and near fatalities of children due to maltreatment, reported to Child Protective Services in which there was a prior report on the family.
- Additional types of cases will be reviewed, as time allows. These will include high-risk sexual abuse or high-risk neglect, with prior reports.
- The program will continue to collect and analyze data on all case record reviews;
- The program will review the health care provided to children in out of home care through Arizona's Comprehensive Medical and Dental Program (CMDP) and other agency pilot projects.
- The program expects to provide additional support to DCYF, through increased consultation on policy, procedural changes, and state initiatives to improve the quality of services to children and their families.

## Conclusions

It is important to acknowledge DCYF's efforts to improve the quality of services for the children and families involved with their agency. Although there are numerous programs and initiatives within DCYF that merit acknowledgement, the Citizen Review Panel wishes to specifically recognize the following:

- **The use of Family Group Decision Making** was noted to be innovative and beneficial in records reviewed by the panels. This program is designed to empower families and their communities to protect and nurture children, through their knowledge, support, and contribution in the development of the family's case plan. The expansion of Family Group Decision Making by DCYF reflects the agency's commitment to delivering culturally competent and family-centered services.
- **Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together)**, in partnership with the Department of Health Services provides substance abuse and recovery support services to families involved with Child Protective Services and Temporary Assistance for Needy Families (TANF). This program was implemented statewide in March 2001. Recent reviews have demonstrated the

program's engagement rate is higher than the national average for similar programs.

- **DCYF is in the process of accreditation through the Council On Accreditation.** Through this process, several initiatives have been undertaken to bring the agency into compliance with nationally recognized standards of best practice. A comprehensive continuous quality improvement (CQI) system was implemented in September 2001. The intent is to provide a mechanism for evaluating the agency, communicating these findings and developing action plans for improvement. Peer record reviews and a new clinical supervision policy have been implemented as critical components of the CQI system.

Citizen Review Panel members have continued to demonstrate their commitment to the safety and welfare of Arizona's children through their extensive work with this program as community volunteers. While panel members apply high standards to their assessment of DCYF, this is accomplished with the understanding that they cannot be expected successfully meet the goal of protecting children in isolation or without sufficient resources. The Citizen Review Panel desires to support DCYF's efforts to protect Arizona's most vulnerable children.

## Arizona State Citizen Review Panel Members

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