Arizona Department of Child Safety

MEMORANDUM

TO: Governor Douglas A. Ducey
President Andy Biggs
Speaker David M. Gowan

FROM: Gregory McKay, Director

DATE: October 2, 2015

SUBJECT: Auditor General Report on Child Safety, Removal and Risk Assessment Process

The Department of Child Safety (DCS) made a commitment to transparency and has exemplified this quality by its conduct since February, 2015. One such example was the latest audit regarding DCS "Child Safety, Removal and Risk Assessment Processes" conducted by the Arizona Office of the Auditor General. Once again, DCS leadership embraced this process and provided the audit team with the fruits of what was reported widely as a scathing review of DCS practice. Contrary to sentiments expressed in the news and by various stakeholders, the current DCS administration was not surprised by the findings, we furnished them. Additionally, quite like the Chapin Hall report revealed, these issues were created over time by a variety of factors and decisions of past administrations.

By way of institutional experience and exploration of past administrations' processes, current leadership provided the auditors a pre-drawn road map of deficiencies in the Department's Comprehensive Safety and Risk Assessment tools and reporting mechanism. Because current leadership already knew of the inherent problems, deliverables were documented in the new DCS Strategic Plan and work has already begun to implement change and safeguard against subjective decision making. Additionally, data has been captured to detect regional trends suggestive of variations in interpreting present and impending danger. Specifically, data was acquired regarding children whom were returned home shortly after being removed. This research identified specific field offices and oversight was immediately put into place. Higher level management approval was required in every removal sought in these geographic areas. Coaching and development was put in place to educate staff on threshold criteria requiring temporary custody. Immediately, data showed a decrease in removals in this area. This knowledge and remediation efforts were well underway prior to discovery by the audit staff. The current DCS leadership team either provided the needed information for a successful audit, or, directed the audit team to the most appropriate areas to learn more about deficiencies. Although the current DCS administration values oversight and welcomes insightful recommendations, the public assertions made regarding this report are an unfair characterization of this new team. The

audit was conducted fairly and informed the public and stakeholders; however, it was the current DCS leadership team that most profoundly informed this audit and its subsequent report.

When the audit commenced, the auditors astutely recognized the need for widespread uniformity in the application of a standardized decision making tool. In fact, the audit staff initially believed the department had no such formal tool and acted solely on caseworker decisions. Current DCS leadership provided the "Action for Child Protection" decision making tool and explained the lack of compliance was created by an automation change made by a former administration in 2012. This "Action for Child Protection" tool was adopted in 2004. It was automated in the CHILDS database and caseworkers were required to fill it out for every child's safety and risk assessment. It was used in an objective manner for every safety and risk assessment of a child. Employee training and development was supported through extensive and ongoing consultation services from Action for Child Protection, provided at no cost to the Department through the federally funded National Child Welfare Resource Center. But in 2012, past department leadership was suffering from an intense increase in report volume, decided the process was time intensive and eliminated it from automation. This prior leadership also discontinued all consultant services from Action for Child Protection. From 2012 until present day, caseworkers have not had this model in automation to support their decision making and became more subjective in their assessments. The current DCS administration had begun the process of re-implementing this automated tool prior to this audit. This standardization of decision-making during investigations is one of the most pressing needs addressed in the Department's strategic plan, which was published in July 2015. This audit, and the Independent Evaluation published by Chapin Hall on June 30, 2015, found that the Department's safety and risk assessment framework is a model used by several states and that no evidence exists that a different model will provide more consistent results. Both audits also found that changes made to the safety and risk assessment automated form in 2012 were devastating. These changes removed all structure to guide the collection of thorough information and consistent decision-making. Last week, the Department released a new Documentation & Field Guide that puts this information back in front of our Child Safety Specialists conducting investigations. This new tool helps Specialists collect relevant information during interviews with children and families, and provides structure to decisions about child safety and removal.

Another finding of the audit indicated there may be a predetermination among some DCS staff prior to engaging in the team decision making (TDM) process. Again, prior to these audit findings, the Department's strategic plan noted several initiatives to expand and standardize the process of family team meetings. These meetings are considered best practice as a highly effective method to engage family members to make the best possible decisions for the safety and well-being of children. Current DCS leadership committed to the expansion of TDM's to prevent avoidable removals. Again, this was in process prior to this audit and was on the front burner of important modifications to safeguard against unnecessary, traumatizing removals.

Regarding the increase in child removals from 2010 to 2014, clearly the increase in report volume has brought an increase in child removals. In fact, there has not been an increase in the percentage of children being removed by DCS under this administration. The ability of the Department's staff to make sound and consistent decisions is being addressed through a multi-pronged approach that impacts training, supervision, workload, tools for standardized process, and service availability. These changes are being implemented through the activities described in the Department's strategic plan, with the assistance of our partners from Arizona State University, Northern Arizona University, Casey Family Programs, and many community-based agencies. We are also aggressively seeking successful practices in other states to better Arizona's process for considered emergency temporary custody. Our agency is one piece of a broad solution. The current administration is keenly aware of the problems and DCS is well on its way to needed reforms. We understand the public and our stakeholders have become weary of crisis and want results now. We must manage our desires for quick fixes and commit to long term sustainable changes. We need every Arizonan's help and support to be successful. The cost of failure is immeasurable and therefore will not be considered an option. The wellness of our state requires the wellness of our children and families.

Sincerely,

Gregory McKay
Director