COLORADO OFFICE OF THE STATE AUDITOR

We Set the Standard for Good Government

DEPARTMENT OF HUMAN SERVICES

CHILD WELFARE

OCTOBER 2014

PERFORMANCE AUDIT

THE MISSION OF THE OFFICE OF THE STATE AUDITOR
IS TO IMPROVE GOVERNMENT
FOR THE PEOPLE OF COLORADO

LEGISLATIVE AUDIT COMMITTEE

Senator Lucia Guzman - Chair

Senator David Balmer
Senator Kevin Grantham
Representative Dan Nordberg
Representative Dianne Primavera
Representative Su Ryden
Representative Jerry Sonnenberg
Senator Lois Tochtrop

OFFICE OF THE STATE AUDITOR

Dianne E. Ray	State Auditor
Monica Bowers	Deputy State Auditor
Nina Frant	Audit Manager
Jenny Atchley	Team Leader
Dana Berry	Staff Auditors
Lindsey Ragatz	
Cindi Stetson	
Kara Trim	
Meghan Westmoreland	

AN ELECTRONIC VERSION OF THIS REPORT IS AVAILABLE AT
WWW.STATE.CO.US/AUDITOR

A BOUND REPORT MAY BE OBTAINED BY CALLING THE
OFFICE OF THE STATE AUDITOR
303.869.2800

PLEASE REFER TO REPORT NUMBER 1303P WHEN REQUESTING THIS REPORT

OFFICE
OF THE STATE AUDITOR

DIANNE E. RAY, CPA
STATE AUDITOR

October 21, 2014

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of child welfare activities in Colorado. The child welfare system is supervised by the Department of Human Services and administered by county departments of human/social services. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Human Services.

OFFICE OF THE STATE AUDITOR
1525 SHERMAN STREET
7TH FLOOR
DENVER, 80203
COLORADO

303 869 2800

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

CONTENTS

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

REPORT HIGHLIGHTS

CHILD WELFARE

PERFORMANCE AUDIT, OCTOBER 2014

DEPARTMENT OF HUMAN SERVICES

CONCERN

Our audit found deficiencies in the Department of Human Services' (Department) oversight of and guidance for county departments of human/social services, particularly with respect to screening and assessing child abuse and neglect allegations. The audit findings collectively suggest a need for the Department to improve its supervision of the child welfare system to promote strong and consistent practices by the counties to help protect children.

KEY FACTS AND FINDINGS

- **Referral Screening.** In our review of 20 screened out referrals and 10 referrals of incidents reviewed by the Child Fatality Review Team, it was unclear that counties had followed statutes and rules to make appropriate screen-out decisions for six referrals. If referrals are inappropriately screened out, the county takes no further action, and children and families may not get the services they need.
- **Timeliness of Initial Contact.** For 4 of 40 sampled assessments, Trails documentation showed that caseworkers did not interview or observe children involved with child welfare referrals within county-assigned response times.
- **Assessments.** The Trails records for all 40 assessments of child safety and risk in our sample did not demonstrate adequate or timely completion of all required elements. For example, 21 risk assessments had incorrect information about families and their histories, and 5 assessments did not identify child safety issues.
- **Child Fatality Review Team (CFRT).** The CFRT reviews child fatalities, near fatalities, and egregious incidents of child abuse or neglect. Our review of 18 CFRT reports summarizing reviews of Fiscal Year 2013 incidents found that the CFRT did not always identify violations and did not recommend improvements for about 34 percent of the deficiencies it found related to referral screening and assessments. Further, 75 percent of the CFRT's recommendations for incidents that occurred from Fiscal Years 2011 through 2013 had not been fully implemented as of April 2014.
- **Interpretation of Department Authority.** In several instances, the Department established processes to direct or approve counties' not following certain State Board of Human Services rules.
- **Collaborative Management Program.** The Department allocated $1.3 million in incentive fund monies to county programs for Fiscal Year 2013, but lacks processes to ensure that the programs are accomplishing the intent of the Program.
- **Differential Response Pilot Program.** Of 10 sampled referrals that were assessed using an alternative method called differential response, three assessments may have been more appropriate to assign as investigative assessments. The audit found problems with the completeness of Trails documentation for the sampled differential response assessments.

BACKGROUND

- Colorado's child welfare system was established to protect the interests of abused and neglected children, preserve and strengthen family ties, and remove a child from parental custody when the child's welfare and safety are endangered.
- The system is supervised by the State and administered by Colorado's 64 counties.
- In Fiscal Year 2013, counties statewide received about 70,400 referrals of child abuse or neglect and screened in about 28,700 (41 percent) for investigation.
- For Fiscal Year 2015, the Department was appropriated $448.3 million for child welfare activities. This represents 24 percent of the Department's total Fiscal Year 2015 appropriation of $1.9 billion.

KEY RECOMMENDATIONS

The audit made 16 recommendations (47 sub-parts) to the Department of Human Services to improve various aspects of the child welfare system. The Department agreed with 31 recommendation sub-parts, partially agreed with 6 recommendation sub-parts, and disagreed with 10 recommendation sub-parts.

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

RECOMMENDATION LOCATOR

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
1	53	Ensure that counties make appropriate child welfare referral screening decisions based on requirements by working with the State Board of Human Services as needed to (a) implement guidance and training that clarifies how counties should interpret statutes and rules and use referral information to determine if an allegation could indicate known or suspected child abuse or neglect, and meets the legal definition of abuse or neglect and (b) establish requirements for counties to include in Trails a brief narrative of the rationale behind their referral screening decisions.	A PARTIALLY AGREE B DISAGREE	A JANUARY 2015 B —

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
2	64	Strengthen performance measures and monitoring related to counties making actual contact with children within assigned response times by (a) expanding C-Stat performance measures to include a separate measure on actual initial contacts with children and (b) developing and publicly reporting a separate performance measure that reflects actual initial contacts with children on the Community Performance Center website.	A DISAGREE B AGREE	A — B MARCH 2015
3	84	Improve safety and risk assessments by (a) establishing clearer written guidance on how caseworkers should identify child safety concerns in situations that may be difficult to assess, such as those involving substance use, and determine when overrides of risk assessment scores are appropriate; (b) establishing written expectations that counties implement controls to prevent the same person from both requesting and approving the extension or closing of an assessment; (c) modifying Trails so that supervisors can clearly document their review and approval of the safety and risk assessment tools before approving closure of the overall assessment; (d) enforcing requirements for caseworkers to request and supervisors to approve assessment extensions, and documenting the approval in Trails; and (e) ensuring that all Department staff who interact with county departments of human/social services for the purposes of child welfare activities understand the requirements regarding documenting sufficient assessment details in Trails and consistently communicate the requirements to counties.	A AGREE B DISAGREE C AGREE D AGREE E AGREE	A MARCH 2015 B — C JULY 2015 D JANUARY 2015 E JANUARY 2015

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
4	105	Improve the Child Fatality Review Team process by (a) implementing a process to (i) provide Team members written information on county violations identified by Department staff so members can more easily participate in the process of identifying violations of statutes and rules and (ii) allow Team members to review and provide feedback on all reports before they are finalized; (b) working with the State Board of Human Services to promulgate rules to provide additional guidance on the Child Fatality Review Team process, including (i) what factors should be covered in reviews to comply with statute, (ii) what information should be included in annual reports to policy makers, and (iii) requiring the Team to request responses and include them in the final review reports; and (c) implementing written guidance to use performance data and other information in a consistent manner when determining whether a recommendation should be made.	A PARTIALLY AGREE B PARTIALLY AGREE C AGREE	A JANUARY 2015 B JANUARY 2015 C JANUARY 2015
5	113	Improve county reporting of egregious incidents of abuse and neglect by (a) working with the State Board of Human Services to further define in rules, or implementing through other formal mechanisms, egregious incidents of child abuse and neglect that require review and (b) providing training and guidance to county departments of human/social services on the identification and reporting of egregious incidents.	A AGREE B AGREE	A JANUARY 2015 B JULY 2015

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
6	126	Ensure compliance with the requirements for providing certain mandatory reporters with information about cases they have reported to the county by (a) working with the State Board of Human Services to promulgate in rule, or implementing through other formal mechanisms, guidance for counties regarding (i) what it means for a county to have "actual knowledge" that mandatory reporters continue to be officially and professionally involved with the child for whom they made a report of suspected abuse or neglect and (ii) the type of information a county may provide mandatory reporters; (b) working with the State Board of Human Services to modify the rule that requires counties to inform all reporting parties when their referrals are screened out so that rules are consistent with statute; (c) expanding the reviews conducted by the Administrative Review Division to include whether the county complied with requirements to notify mandatory reporters when required; (d) pursuing a modification of Trails to capture data needed to monitor counties' compliance with notifying mandatory reporters of case information and enforcing requirements for counties to document their compliance in Trails; and (e) implementing a process to regularly analyze Trails data and the results of reviews conducted by the Administrative Review Division to monitor counties' compliance with notification requirements and provide technical assistance to counties based on the analysis.	A AGREE B AGREE C AGREE D AGREE E AGREE	A JANUARY 2015 B JANUARY 2015 C APRIL 2016 D JANUARY 2016 E JULY 2016

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
7	142	Work with child welfare and county stakeholders to assess whether Child Protection Teams are still needed and work with the General Assembly on statutory changes to either make Child Protection Teams effective as an oversight mechanism for the child welfare system or to eliminate the requirement for Child Protection Teams.	AGREE	JUNE 2015
8	143	As long as Child Protection Teams continue in their current form, improve their use as an oversight mechanism by (a) seeking legal guidance from the Office of the Attorney General on whether statute allows counties to employ a risk-based approach to determine which cases should be reviewed by a Child Protection Team. Based on that guidance either (i) work with the State Board of Human Services to promulgate rules on how to employ such a risk-based approach or, (ii) work with General Assembly to seek statutory change to allow for a risk-based approach; (b) working with the State Board of Human Services to promulgate rules providing parameters for counties to determine (i) which cases should be reviewed by Child Protection Teams, (ii) when in the case such reviews should occur, (iii) how the results of the reviews should be used by counties, and (iv) how to publicly report the results; and (c) implementing a process for monitoring Trails data to ensure counties are complying with requirements for using Child Protection Teams and following up with counties that are not complying.	A AGREE B AGREE C DISAGREE	A OCTOBER 2015 B OCTOBER 2015 C —

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
9	151	Ensure the appropriate exercise of authority when advising and overseeing counties regarding requirements for the child welfare system by (a) requesting a legal opinion from the Office of the Attorney General on whether the Department has authority to waive rules that govern the child welfare system or to otherwise provide direction to counties to operate in a manner that is inconsistent with requirements in rules; (b) if the Attorney General finds that the Department does not have authority to waive or contravene rules, discontinuing the practice of directing or allowing counties to operate in a manner that is not consistent with State Board rules; and (c) based on the opinion of the Attorney General obtained in response to PART A, as well as the Attorney General's recent guidance to the Department regarding its authority to establish and enforce policies, taking steps to communicate any changes in practice or expectations. This should include informing Department staff who provide technical assistance to counties of any new Department policies or practices and revising quality assurance review tools used by the Administrative Review Division as needed.	A DISAGREE B DISAGREE C PARTIALLY AGREE	A — B — C JANUARY 2015
10	157	Improve the SMART Government Act performance measure for child welfare by revising the "Timeliness of Assessment Closure" measure, or adding an additional measure, to align with the regulatory requirement for investigative assessments to be closed in 30 days unless an extension is approved by a supervisor. The revised measure should be used as the basis for awarding incentives to counties.	DISAGREE	—

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
11	172	Promote compliance with the statutory requirement that county departments of human/social services establish cooperative agreements with the law enforcement agencies in their jurisdictions by (a) working with the State Board of Human Services to promulgate in rule, or otherwise providing, formal written guidance on (i) establishing effective cooperative agreements and (ii) reviewing and updating the agreements on a specified frequency; (b) implementing processes to obtain county agreements, including any time the agreements are revised; review the agreements for compliance with requirements; and provide technical assistance to counties that do not have adequate agreements; and (c) providing a statewide agreement with Colorado State Patrol that counties can use or ensure counties create a separate agreement.	A AGREE B AGREE C AGREE	A MARCH 2015 B MARCH 2015 C JANUARY 2015

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
12	192	Improve oversight of the Collaborative Management Program (CMP) by (a) establishing procedures and deadlines to comply with State Board of Human Services rules for MOUs or working with the State Board to revise the deadlines and discontinue allocating incentive funds to county-level programs that do not submit MOUs on time; (b) establishing processes to determine whether county-level programs have "successfully implemented the elements of collaborative management," working with the State Board as needed and the Judicial Department to revise the MOU template to adequately capture statutory and regulatory requirements; promulgating and communicating guidance; and establishing MOU review criteria and checklists; (c) developing standardized performance measures that (i) specify the results that all county-level programs must achieve to be eligible for incentive funding, (ii) are based on outcome measures already used by the Department; and (iii) include process measures to incentivize compliance with requirements; (d) establishing a monitoring program to (i) determine whether county-level programs have implemented collaborative management in accordance with statute, rule, and MOUs and (ii) verify the accuracy and reliability of county-level program data used to award incentive funding; and (e) revising the allocation methodology to incentivize performance in an equitable manner within the funds available, and use actual data on participants served to allocate incentive payments.	A AGREE B AGREE C DISAGREE D AGREE E AGREE	A JUNE 2015 B JUNE 2015 C — D JULY 2015 E JULY 2015

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
13	203	Improve management of general fund savings from the Collaborative Management Program by (a) working with the State Board of Human Services to promulgate a rule to determine general fund savings resulting from the Collaborative Management Program as set forth in statute; (b) discontinuing the practice of requiring county-level programs to elect either a savings or surplus distribution in their MOUs; and (c) seeking further legal guidance on the use of surplus funds for distributing general fund savings and proposing legislative change to establish a mechanism for distributing general fund savings if needed.	A PARTIALLY AGREE B DISAGREE C AGREE	A JULY 2015 B — C JULY 2015
14	213	Improve accountability for the Collaborative Management Program (CMP) by (a) requesting an opinion from the Office of the Attorney General whether the Department is exercising its full authority under current statute. Depending on the results of the opinion, ensure practices are consistent with the opinion and work with the General Assembly to request clarification of authority related to CMP funding if needed; (b) developing improved data collection and reporting protocols for programmatic and expenditure data and requiring all county departments that participate in county-level programs to comply with them; and (c) assessing options for implementing a single data system to maintain CMP data.	A DISAGREE B PARTIALLY AGREE C AGREE	A — B JULY 2015 C JULY 2015

AGENCY ADDRESSED: DEPARTMENT OF HUMAN SERVICES

REC. NO.	PAGE NO.	RECOMMENDATION SUMMARY	AGENCY RESPONSE	IMPLEMENTATION DATE
15	230	If the General Assembly enacts legislation to continue the use of differential response, ensure successful expansion of differential response by (a) establishing guidance that clearly defines risk levels that influence whether a differential response assessment is appropriate and clarifies how different factors can influence a child's risk of maltreatment, working with the State Board of Human Services as appropriate; (b) enforcing Department policies and guidance or working with the State Board of Human Services to codify in rules all requirements that counties must follow when handling assessments and cases through differential response; and (c) implementing a more robust process to monitor differential response activities that includes modifying Trails so the Department can easily monitor the risk level of referrals undergoing differential response assessments.	A AGREE B AGREE C AGREE	A AUGUST 2015 B AUGUST 2015 C JANUARY 2016
16	238	Ensure that counties statewide implement the RED Team process consistently and effectively by (a) establishing guidance that (i) clarifies when counties must use RED Teams and when they have discretion to use a different screening method, and (ii) clarifies how counties should document RED Team discussions and supervisory approval of decisions, working with the State Board of Human Services as appropriate; (b) adding a component to the Administrative Review Division's quality assurance reviews to review Trails documentation that supports RED Team decisions for referrals that are assigned for assessment; and (c) modifying Trails so the database fields more closely align with the factors RED Teams consider.	A AGREE B AGREE C AGREE	A MARCH 2015 B OCTOBER 2015 C MARCH 2015

CHAPTER 1

OVERVIEW OF THE CHILD WELFARE SYSTEM

Colorado's child welfare system was established based on the concept of "parens patriae," which asserts government's role in protecting the interests of children and intervening when parents fail to provide proper care. The Colorado Children's Code (Title 19 of the Colorado Revised Statutes) established guiding principles for the child welfare system to provide care for abused and neglected children, preserve and strengthen family ties whenever possible, and remove a child from the custody of his or her parents when the child's welfare and safety or the protection of the public would otherwise be endangered.

Statute (Section 19-1-103, C.R.S.) defines three general categories of child abuse or neglect based on who perpetrates the maltreatment and where it occurs.

- **INTRAFAMILIAL** abuse or neglect means any case of child abuse or neglect that occurs within a family context by a child's parent, stepparent, guardian, legal custodian, relative, or spousal equivalent; or by any other person who resides at, or is regularly in, the child's home for the purpose of exercising authority over or care for the child. Intrafamilial abuse does not include abuse by a person who is paid for rendering care and is not related to the child [Section 19-1-103(67), C.R.S.].

- **THIRD-PARTY ABUSE** means a case in which a child is subjected to abuse by any person who is not included in the definition of intrafamilial abuse [Section 19-1-103(108), C.R.S.].

- **INSTITUTIONAL ABUSE** means any case of abuse that occurs in any public or private facility in the state that provides child care out of the home [Section 19-1-103(66), C.R.S.].

The focus of this audit was on the processes of county departments of human/social services related to allegations of intrafamilial abuse or neglect. Throughout this report, we use the term "parent" to refer to any of the individuals listed in statute as possible perpetrators of intrafamilial child abuse or neglect.

Child abuse or neglect, as defined in Section 19-1-103(1)(a), C.R.S., means an act or omission that threatens the health or welfare of a child, including:

- **PHYSICAL INJURIES** (e.g., skin bruising, bleeding, bone fractures, malnutrition) or death of a child that are not justifiably explained or may not be an accidental occurrence based on the circumstances of the injury or death.

- **UNLAWFUL SEXUAL BEHAVIOR** to which the child is subjected.

- **INADEQUATE PROVISION OF BASIC NEEDS**, such as food, clothing, shelter, medical care, or supervision that a prudent parent would provide.

- **EMOTIONAL ABUSE**, which means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development, or a substantial risk of such impairment.

- **EXPOSURE TO CONTROLLED SUBSTANCES** that are manufactured on the premises where a child is found or resides, or cases in which a child tests positive at birth for a schedule I or schedule II controlled substance.

- **OTHER NEGLECT OR ABUSE**, such as abandonment of a child or a parent or guardian allowing others to abuse or mistreat a child without taking lawful means to stop such mistreatment.

PROGRAM ADMINISTRATION

Colorado is one of nine states that operate a state-supervised, county-administered child welfare system. This type of system can create unique challenges because counties function with a great deal of autonomy and are governed by local oversight bodies. However, counties also serve as agents of the state in administering public assistance and welfare and related activities [Section 26-1-118(1), C.R.S.] under the supervision of the Department.

Both federal and state laws, including the Colorado Children's Code and the Human Services Code (Title 26 of the Colorado Revised Statutes), govern the child welfare system, along with federal regulations and state rules. All levels of government are involved with some aspect of overseeing or administering the child welfare system as follows.

FEDERAL GOVERNMENT. The Children's Bureau, within the U.S. Department of Health and Human Services, oversees federal activities related to child welfare. These activities include providing guidance on

federal laws, allocating financial resources, providing competitive grants for research and program development, offering training and technical assistance, monitoring child welfare services, and sharing research to help child welfare professionals improve their services. The federal government requires states to submit plans outlining how they will use federal funding and comply with federal laws, such as the Child Abuse Prevention and Treatment Act (CAPTA).

STATE GOVERNMENT. The Colorado Department of Human Services (Department) is responsible for administering or supervising all public assistance and welfare activities in Colorado, including child welfare [Section 26-1-111(1), C.R.S.]. According to rules, within its supervisory role the Department has the authority to address county performance issues through a "continuum of actions," including informal consultation with counties, routine monitoring, quality assurance reviews, program intervention, corrective action, and financial sanctions (Sections 1.110 and 1.152, 9 C.C.R., 2501-1).

Two divisions within the Department provide oversight of the child welfare system.

- The Division of Child Welfare, within the Office of Children, Youth, and Families, provides supervision of, and technical assistance to, counties; oversees implementation of new initiatives and child welfare program requirements; oversees county staff training through the Child Welfare Training Academy; allocates state and federal funding to counties; approves county plans to administer child welfare services; and responds to complaints from various stakeholders.

- The Administrative Review Division, within the Office of Performance and Strategic Outcomes, is Colorado's mechanism for providing a federally required case review system and a portion of the quality assurance system for the Division of Child Welfare. This division also administers a statutorily created process for reviewing certain child fatalities, near fatalities, and egregious incidents.

The State Board of Human Services (State Board) is a nine-member oversight body responsible for rulemaking, holding hearings related to formulating and revising Department policies, and advising the Executive Director of the Department on matters he or she brings forth [Sections 26-1-107(1) and (6), C.R.S.]. According to statute, State Board rules are binding upon county departments of human/social services [Section 26-1-107(10), C.R.S.]. Statute [Sections 24-1-120(3) and 24-1-105(1), CR.S.] establishes the State Board as a Type I Board, which means it has the power to exercise its authority, such as rulemaking, independently from the Department's Executive Director.

COUNTY GOVERNMENT. The State's 64 county departments of human/social services are responsible for administering the child welfare system in accordance with the Department's rules [Section 26-1-118(1), C.R.S.]. County responsibilities include accepting reports of known or suspected child abuse or neglect, assessing allegations of child maltreatment, and authorizing and providing services.

There are several programs established to strengthen the child welfare system through collaboration of various levels of state and county government and other community representatives. First, the Administrative Review Division supports the Department's Child Fatality Review Team (Team). The Team includes representatives of state and county governments as well as individuals in fields such as physical medicine, mental health, education, and law enforcement. The Team conducts in-depth case reviews of substantiated child fatalities, near fatalities, and egregious incidents due to abuse or neglect to understand the causes of the incidents and mitigate such incidents in the future. Second, Child Protection Teams are local, multidisciplinary advisory teams that review reports of child abuse or neglect to make recommendations to the county department for action or improvement. Child Protection Teams are also intended to allow for public discussion and reporting of how counties handle reports of abuse and neglect. Third, the Collaborative Management Program is an optional program through which participating counties work with other local agencies, such as judicial districts and school districts, to

share resources or manage and integrate the services provided to children and families. The goals of the Collaborative Management Program are to improve services for better outcomes while reducing costs.

CHILD WELFARE PROCESS

Anyone can report known or suspected child abuse or neglect. When counties receive these reports, called "referrals," they must decide whether to "screen in" the referrals for further investigation of the allegations based on requirements in rules.

Once a county screens in a referral, it initiates an assessment (also known as an investigation). The assessment process involves determining whether a child is safe; concluding on whether child abuse or neglect occurred; identifying risks for future maltreatment; determining what, if any, services the family needs; and planning for such services. As of July 2014, the Department reported that eight counties in Colorado were fully participating in a program to pilot a new approach to assessments called **DIFFERENTIAL RESPONSE**. As part of the Differential Response Pilot Program, the Department implemented RED (Review, Evaluate, and Direct) Teams, a group decision-making process used to determine the county's response to child welfare referrals (Section 7.202.3, 12 C.C.R. 2509-3).

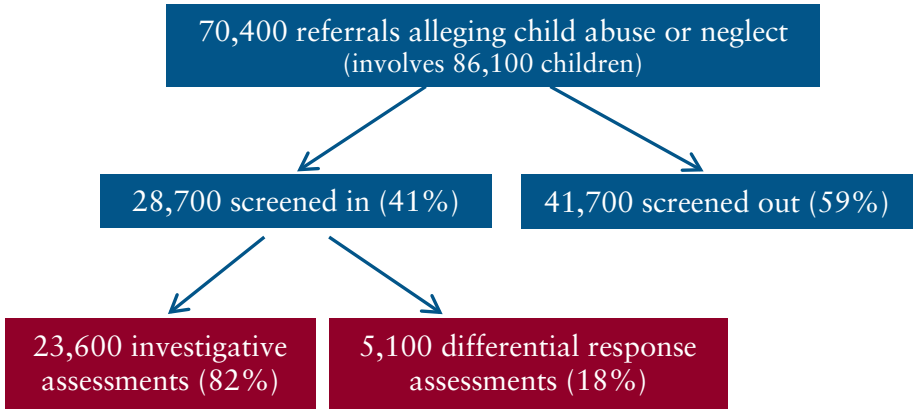
Counties also have the option to "screen out" referrals that do not meet criteria for a child welfare assessment. In those cases, the child welfare system does not get involved with the families to assess the allegations of child abuse or neglect or provide services.

Our audit work focused on 70,400 child welfare referrals that counties received in Fiscal Year 2013 related to children in need of protection. These referrals included allegations of intrafamilial abuse or neglect and allegations that counties did not categorize in Trails, the State's official electronic case record for all child welfare documentation. Department staff reported that uncategorized allegations likely represent referrals that were screened out, because the Department does not require counties to categorize allegations

until after referrals have been assigned for assessment. Our audit did not include referrals related to youth in conflict, institutional abuse or neglect, or third-party abuse.

Exhibit 1.1 shows the breakout of Fiscal Year 2013 referrals we focused on, by type of assessment.

EXHIBIT 1.1. CHILD WELFARE REFERRALS AND ASSESSMENTS
FISCAL YEAR 2013



SOURCE: Office of the State Auditor's analysis of Fiscal Year 2013 Trails data provided by the Department of Human Services.

CHILD WELFARE FUNDING

Statute [Section 26-1-121(2), C.R.S.], authorizes the General Assembly to appropriate monies from the General Fund to pay for the Department's administrative costs associated with administering public assistance and welfare functions, including child welfare programs. In addition, the General Assembly has authority to appropriate general funds to pay for the State's share of county costs to administer these programs at the county level. County departments of human/social services are responsible for paying 20 percent of the cost to administer child welfare programs [Section 26-1-122(1)(a), C.R.S.]. The remaining 80 percent of costs are paid for with state and federal funds [Section 26-1-122(5), C.R.S.]. Statute [Section 26-1-109(1), C.R.S.] establishes the Department as the sole state agency responsible for administering federal grants related to child welfare

services. The U.S. Department of Health and Human Services is the federal agency responsible for grant programs related to child welfare.

The Department works with a Child Welfare Allocations Committee established under Section 26-5-103.5(1), C.R.S., to determine what portion of federal, state, and county block grants will be allocated to each county. Those funds are distributed to counties on a reimbursement basis according to actual county expenditures for child welfare services and administrative costs.

For Fiscal Year 2015, the Division of Child Welfare was appropriated $446 million, and the Administrative Review Division was appropriated $2.3 million. Combined, this represents 24 percent of the Department's total Fiscal Year 2015 appropriation of $1.9 billion. Exhibit 1.2 shows the annual appropriations for the Division of Child Welfare and Administrative Review Division for Fiscal Years 2013 through 2015.

EXHIBIT 1.2. ANNUAL APPROPRIATIONS
DIVISION OF CHILD WELFARE AND ADMINISTRATIVE REVIEW DIVISION
DEPARTMENT OF HUMAN SERVICES
FISCAL YEARS 2013 THROUGH 2015
(DOLLARS IN MILLIONS)

	2013	2014	2015	PERCENTAGE CHANGE
DIVISION OF CHILD WELFARE				
FUNDING	$401.5	$418.5	$446.0	11%
FTE	57	63.4	89.4	57%
ADMINISTRATIVE REVIEW DIVISION				
FUNDING	$2.1	$2.2	$2.3	10%
FTE	24.2	25.1	26.2	8%

SOURCE: Office of the State Auditor's analysis of Long Bills for Fiscal Years 2013 through 2015.

In Fiscal Year 2015, the Division of Child Welfare's total budget appropriation included various funding sources, as shown in Exhibit 1.3.

EXHIBIT 1.3. FUNDING SOURCES
DIVISION OF CHILD WELFARE
FISCAL YEAR 2015
(DOLLARS IN MILLIONS)

FUNDING SOURCE	AMOUNT	PERCENTAGE OF TOTAL
STATE FUNDS		
State General Funds	$249.1	56%
Cash Funds	82.2	19%
Reappropriated Funds	15.1	3%
Total State Funds	346.4	78%
FEDERAL FUNDS		
Title IV-E (Social Security Act)	$71.3	
Title XX Social Services Block Grant	23.9	
Title IV-B (Social Security Act)	4.0	
Child Abuse Prevention and Treatment Act	0.4	
Total Federal Funds	$99.6	22%
TOTAL	$446.0	100%

SOURCE: Office of the State Auditor's analysis of Fiscal Year 2015 Long Bill (House Bill 14-1336).

RECENT LEGISLATION AND POLICY INITIATIVES

In February 2012, Governor Hickenlooper unveiled his administration's child welfare plan, "Keeping Kids Safe and Families Healthy." The plan included five key strategies:

- **IMPLEMENTING A COMMON PRACTICE APPROACH TO CHILD WELFARE ACTIVITIES,** which included implementing a child welfare practice philosophy for the entire state and expanding the Differential Response Pilot Program.

- **PERFORMANCE MANAGEMENT,** which included a performance measurement and management system called C-Stat, designed to analyze performance on a monthly basis using the most currently available data. Through root cause analysis, C-Stat is intended to identify what processes work and support informed decisions and strategies for processes that need improvement. In 2014, the Department also launched the Community Performance Center website to provide public access to state and county performance

data, and inform child welfare improvements at the policy, state, and county levels.

- **WORKFORCE MANAGEMENT**, which included updating and expanding the Child Welfare Training Academy.

- **FUNDING ALIGNMENT**, which included using available resources more efficiently to ensure the right services are delivered to the right people, and aligning funding sources with outcomes.

- **INCREASING TRANSPARENCY AND PUBLIC ENGAGEMENT**, which included pursuing legislation allowing the Department to publicly share information about child welfare investigations, and establishing a new governance council to oversee and recommend policy and practice efforts across the state.

In February 2013, the Governor introduced the second phase of his child welfare plan, called "Keeping Kids Safe and Families Healthy 2.0." The updated plan calls for new initiatives in the strategic areas identified in the original child welfare plan.

Since 2010, the General Assembly has enacted various laws to implement changes to Colorado's child welfare system. Exhibit 1.4 highlights key legislation related to our audit objectives.

EXHIBIT 1.4. CHILD WELFARE LEGISLATION 2010 THROUGH 2013[1]

BILL	TOPIC	SUMMARY
Senate Bill 10-152	Mandatory Reporter Follow Up	Required counties to provide certain follow-up information to mandatory reporters who report child abuse or neglect.
House Bill 10-1226	Differential Response Pilot Program Creation	Authorized the Department to establish and evaluate in five selected counties a pilot program to use an alternative approach to addressing reports of alleged child abuse or neglect when the safety of the child is of low to moderate risk.
House Bill 11-1181	Child Fatality Review Team	Codified and made modifications to the Child Fatality Review Team to review child fatalities that involve abuse or neglect where the family had previous involvement with the child welfare system within the 2 years prior to the fatality. The purpose of these reviews is to improve understanding of why fatalities occur, identify systemic deficiencies, and recommend changes to help mitigate future child deaths.
Senate Bill 12-011	Differential Response Pilot Program Expansion	Expanded the Differential Response Pilot Program by removing the limit on the number of counties that may participate, and required the State Board to promulgate rules to define and implement the Pilot Program.
Senate Bill 12-033	Expanded Child Fatality Reviews	Expanded the Child Fatality Review Team's responsibilities to include reviewing incidents of egregious and near-fatal child abuse. The bill also required the Department to publicly disclose information related to these incidents.
Senate Bill 13-255	Incidents Subject to Child Fatality Review Team Reviews	Required the Child Fatality Review Team to review incidents where the family had previous involvement with the child welfare system within 3 years prior to the incidents, instead of 2 years.
Senate Bill 13-278	Definition of Drug-Endangered Child	Required a task force to develop a definition of "drug-endangered child" in the context of child abuse or neglect by January 1, 2014.
House Bill 13-1271	Statewide Child Abuse Reporting Hotline	Requires a 24-hour statewide child abuse reporting hotline to be implemented and publicized by January 1, 2015. Authorizes the State Board to adopt rules related to the hotline.

SOURCE: Office of the State Auditor's analysis of 2010 through 2014 Session Laws.
[1] Legislation enacted during the 2014 Legislative Session was not significant to our audit objectives.

AUDIT PURPOSE, SCOPE, AND METHODOLOGY

We conducted this audit pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions and agencies of state government. The audit was prompted

by a legislative audit request. Audit work was performed from July 2013 through October 2014.

Our audit focused on the initial stages of a family's involvement in the child welfare system—referrals and assessments—as well as on programs that involve collaboration between county departments of human/social services and other providers. The key objectives of the audit were to evaluate:

- County processes related to screening reports of possible child abuse or neglect and assessing allegations of child maltreatment.
- Processes related to reviewing child fatalities, near fatalities, and egregious incidents.
- County notification of mandatory reporters about the outcome of child welfare referrals.
- The Department's performance measures and compliance with the SMART Government Act.
- Cooperative agreements between county departments of human/social services and law enforcement agencies.
- Implementation and Department oversight of the Collaborative Management Program.
- Controls over implementation of the Differential Response Pilot Program.
- The Department's supervision of county departments of human/social services, including the quality assurance review process.

We assessed the effectiveness of those internal controls that are significant to the audit objectives described above. Our conclusions on the effectiveness of those controls are described in the audit findings and recommendations.

The scope of this audit did NOT include evaluating the appropriateness of authorized services, funding sources for child welfare services, payments to entities that provide child welfare services, eligibility of service recipients, judicial processes that affect the child welfare system, foster care, adoption, processes for handling allegations of

third-party and institutional child abuse or neglect, or grievance processes for individuals involved with the child welfare system.

To accomplish our audit objectives, we:

- Reviewed relevant state and federal laws; federal regulations; rules promulgated by the State Board; and Department policies, procedures, and practices.

- Interviewed Department staff to understand processes related to referral screening, assessments, differential response, oversight mechanisms, and the Collaborative Management Program.

- Conducted site visits at a sample of 10 county departments of human/social services around the state. We considered a variety of criteria when selecting these counties, including county referral volume during Fiscal Year 2012, geographic location, population of children under age 18, number of individuals receiving core services, participation in the Differential Response Pilot Program, participation in the Collaborative Management Program, and performance data for individual counties. We visited large and small counties (in terms of Fiscal Year 2012 referral volume) and counties located in urban and rural settings. These counties included Denver, El Paso, Fremont, Jefferson, Kit Carson, Larimer, Mesa, Montrose, Prowers, and Weld. During our site visits, we interviewed county staff about referral screening, assessments, differential response, and oversight mechanisms. We also observed county processes related to these activities. Collectively, our site visits included interviews with a total of 131 county representatives, including 50 caseworkers, 31 supervisors, 36 senior managers, and 14 other county staff.

- Analyzed aggregate Trails data for referrals that counties received during Fiscal Years 2012 and 2013. In our aggregate analyses, we included referrals categorized as intrafamilial abuse or neglect, and referrals that counties did not categorize at all (i.e., were not marked in Trails as intrafamilial, third-party, or institutional). In Fiscal Year 2013, referrals involving allegations of intrafamilial abuse or neglect

represented 81 percent of all referrals in Trails, and referrals involving uncategorized allegations represented 18 percent. Thus, our aggregate analyses included 99 percent of all child protection referrals in Trails. We included uncategorized referrals in our analyses to address the risk that some referrals might actually be intrafamilial abuse or neglect but were not marked as such in Trails.

- Reviewed and analyzed all reports issued by the Child Fatality Review Team for child fatalities, near fatalities, and egregious incidents that the team reviewed during Fiscal Year 2013, as well as the implementation status of recommendations included in Child Fatality Review Team reports issued for incidents that occurred from Fiscal Years 2011 through 2013.

- Interviewed relevant stakeholders, including law enforcement officials, members of the Child Fatality Review Team, the Collaborative Management Program steering committee, and organizations that represent social workers and families involved with the child welfare system.

- Reviewed Department training materials provided by staff between October 2013 and October 2014.

- Reviewed and analyzed other Department and county information related to child welfare processes, county performance, and quality assurance reviews.

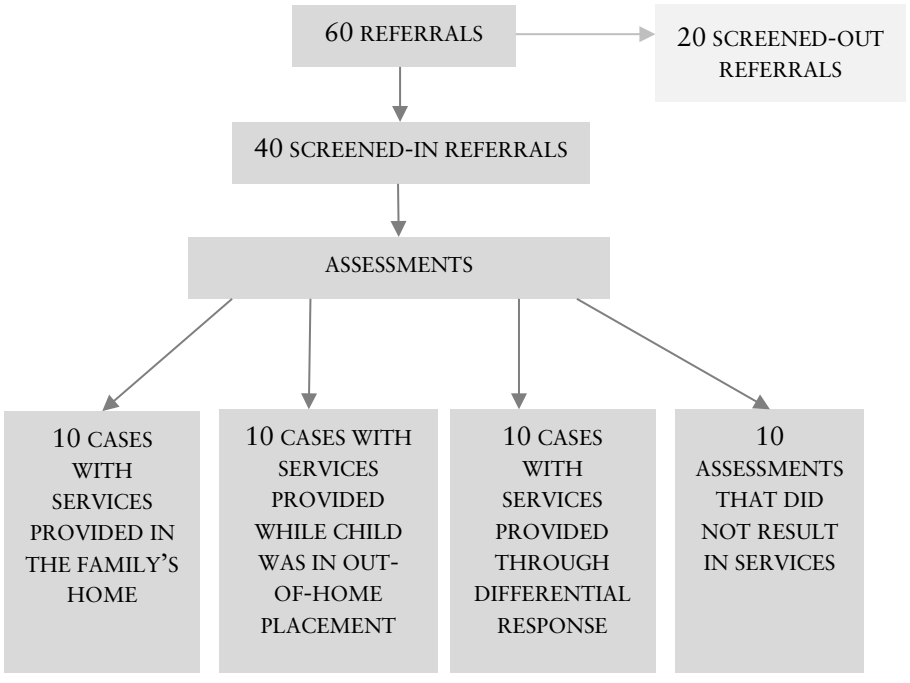
- Reviewed the Trails records for a sample of 60 referrals (i.e., allegations of child abuse or neglect) that counties statewide received during Fiscal Year 2013. We also reviewed a total of 10 referrals associated with one near fatality and one egregious incident that occurred in Fiscal Year 2013. To conduct our review, we obtained read-only access to all child welfare records in Trails, including records that are restricted from other Trails users at county departments of human/social services. According to the Department, restricted records include those related to child fatalities, near fatalities, or egregious incidents, and other high-profile incidents.

Trails contains protected data and is not accessible to the general public.

FILE REVIEW SAMPLE. We selected our sample from the 70,400 referrals that counties received during Fiscal Year 2013. We separated the population based on the outcome of the referrals (i.e., whether the referrals were screened in or out, and what types of services resulted from assessments that were conducted). From those sub-populations, we used data analysis software to randomly select our sample. We reviewed our sample methodology with Department staff. Our sample included referrals received by the following 19 counties: Adams, Alamosa, Arapahoe, Boulder, Denver, El Paso, Fremont, Garfield, Huerfano, Jefferson, La Plata, Larimer, Logan, Mesa, Montrose, Morgan, Park, Routt, and Weld.

Our sample included the following types of referrals:

EXHIBIT 1.5. FILE REVIEW SAMPLE
FISCAL YEAR 2013



Source: Office of the State Auditor and Fiscal Year 2013 Trails data provided by the Department of Human Services.

We focused our review of the sample on Trails for two reasons. First, Trails is the official case record for all child welfare documentation; it fulfills the federal CAPTA [42 USC Sec. 5106a(b)(2)(B)(xxiii)] requirement that the Department have a technological system that supports the child protective system and tracks reports of child abuse and neglect from intake through final disposition. Federal law requires states to have such systems as a foundation for their quality assurance functions which, according to federal regulations [45 C.F.R., pt. 1355.53(g)], must include a "review of case files for accuracy, completeness and compliance with Federal requirements [and] State standards." In its June 2013 "Annual Progress and Services" report to the federal government, the Department affirmed that Trails fulfills these federal requirements, stating: "Trails is the official case record for all child welfare documentation. …ARD [Administrative Review Division] reviews to the Trails record." Second, rules require counties to document all child welfare referrals in Trails, regardless of whether they are screened in or screened out (Section 7.200.61, 12 C.C.R. 2509-3), and the reasons why further assessment was not needed for screened-out referrals (Section 7.202.4.J, 12 C.C.R. 2509-3).

As described throughout this report, we applied statute, rules, and Department guidance to evaluate the Trails documentation in our sample. The results of our review cannot be extrapolated to the entire population of Fiscal Year 2013 child welfare referrals. Rather, we designed our sample based on our audit objectives to test the Department's controls over county compliance with requirements for screening referrals and conducting assessments, including documentation in Trails to support county decisions in these areas.

We also reviewed Trails records associated with one near fatality and one egregious incident that occurred in Fiscal Year 2013. We relied on random sampling techniques to select these cases from among the 18 child fatalities, near fatalities, and egregious incidents that occurred in Fiscal Year 2013 and were reviewed by the Child Fatality Review Team. We reviewed a total of 10 referrals related to these two incidents, including referrals that counties received about the families in the 1 year prior to the incidents occurring. The results of our review

cannot be extrapolated to the entire population of child fatalities, near fatalities, and egregious incidents that occurred in Fiscal Year 2013.

GOVERNMENT AUDITING STANDARDS. We conducted this performance audit in accordance with generally accepted government auditing standards (standards). Standards (1.02) state that "legislators, oversight bodies, those charged with governance, and the public need to know whether management and officials manage government resources and use their authority properly and in compliance with laws and regulations," and whether "government services are provided effectively, efficiently, economically, ethically, and equitably." Further, standards (1.03) indicate that government audits provide this information through independent assessment of the stewardship, performance, or cost of government policies, programs, or operations.

Standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. This includes planning the audit to reduce audit risk (6.07). Audit risk is the possibility that the audit's findings, conclusions, or recommendations may be improper or incomplete as a result of factors such as evidence that is not valid or reliable (6.05).

To comply with standards, we collected documentary evidence, including information in Trails, Administrative Review Division reports, Child Fatality Review Team reports, C-Stat results, and memoranda of understanding related to the Collaborative Management Program. We also collected physical evidence through observation of certain Department and county processes, including the Administrative Review Division's annual Screen-Out Review, an assessment review, county group decision making through RED Team meetings, live referral phone calls answered by county staff, and a live interview with a family member during a child welfare assessment. We also gathered testimonial evidence through discussions with directors, supervisors, and caseworkers at 10 counties and with numerous Department staff at various levels, including senior management. Documentary and physical evidence are generally considered the

strongest forms of evidence. They allow auditors to draw conclusions based on documentation that exists for purposes of managing the program and direct observations of standard practices. Evaluating the reliability and validity of evidence relies on auditor judgment. Standards note that the reliability and validity of testimonial evidence may be reduced based on factors such as whether the evidence was obtained under conditions in which persons may not be able to speak freely or was obtained from individuals who are biased or have indirect or partial knowledge about the area (6.61). Standards also require that the audit report describe limitations or uncertainties with the reliability or validity of evidence if the evidence is significant to the findings and conclusions. Such disclosure is intended to avoid misleading the report users and provide a clear understanding regarding how much responsibility the auditors are taking for the information (7.15).

Overall, we believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. However, in accordance with standards, we are reporting that, in our judgment, the testimonial evidence we received from the Department in the two areas described below was not valid or reliable.

- We notified the Department of the specific exceptions from the review of our sample of 60 referrals, which included 20 screened-out referrals and 40 assessments. Exceptions occurred when we found a lack of clear evidence that statutes and/or rules were adhered to during the referral screening and assessment processes. We asked the Department to respond to the exceptions by indicating whether it agreed with our conclusions and by providing additional information and documentation, if available, to demonstrate adherence. We received a first set of written responses to the exceptions in May 2014. The Department then provided a second set of written responses in August 2014. For many of the problems we found, the Department changed its response in the second set of responses. We also notified the Department of the specific exceptions from the review of our sample of 10 referrals related to families involved with one egregious incident and one near fatality that occurred during Fiscal Year 2013. The

Department provided written responses to these exceptions in April 2014 and did not submit revised responses.

Further, in discussing our overall conclusions and recommendations near the end of the audit work, the Department provided some new information related to the exceptions that was different from earlier information. It is common in the audit process to discuss exceptions with different levels of agency staff at different points during the audit to gain a complete understanding of the issue. The Department indicated that the purpose of providing multiple, different responses and information related to the exceptions was to correct inaccurate information that had been provided earlier in the audit.

However, the multiple and varying responses provided during this audit raised concerns about our ability to rely on the information for two main reasons. First, as additional written responses and anecdotal information were provided, they were not accompanied by documentary evidence that would allow us to verify that they were more accurate than what we had received previously. Second, the anecdotal information provided near the end of the audit consisted, in many cases, of theoretical information about why a county may have made a screening or assessment decision. In other words, this later information was not based on review of the specific Trails documentation or our exceptions. For example, one of the exceptions involved a caseworker not contacting an alleged victim of child abuse within the county-assigned time frame, as required by rules. In its first set of written responses, the Department agreed with the exception. However, Department staff later told us they disagreed because it was acceptable for the caseworker not to interview or observe the alleged victim within the required time frame since the child was under a physician's care at a hospital at the time. This anecdotal response directly contradicted both the Department's original response and written instructions in the Department's quality assurance review tool, which states that "a medical or police check will not be accepted" when evaluating whether a county sees or observes a child within the assigned response time. Due to our concerns regarding the multiple, inconsistent responses to our exceptions, we reduced our reliance on

the Department's testimonial evidence related to our sample review and modified some of our conclusions to rely only on evidence we evaluated as valid and reliable.

- At various times during the audit, different levels of Department management provided us with varying interpretations of whether counties must adhere to Department guidance, such as directives communicated in "agency letters" to counties and written guides. Early in the audit, some members of management told us that counties are expected to follow this type of guidance. When discussing our audit conclusions and recommendations later in the audit, however, the Department reported that it cannot hold counties accountable for complying with Department guides or letters, only with State Board rules and statutes. Finally, as we were completing the audit, the Department reported that it had received legal guidance that it CAN develop Department policies to guide county practice and hold counties accountable for following such policies. Because the Department indicated throughout most of the audit that it could not enforce its own guidance, many of the audit recommendations suggest strengthening or expanding rules.

  In addition, the Department reported at the end of the audit that it can enforce its own guidance, we made one recommendation that the Department communicate any changes in practice or expectations, such as by informing Department staff who provide technical assistance to counties of any new Department policies or practices. Finally, due to the conflicting and changing interpretations of the Department's authority, we reduced our use of Department guidance and directives as criteria for our audit work. We also describe in the audit report those areas in which the Department initially told us it could not enforce counties' compliance with its guidance or directives but later indicated that it can enforce compliance.

  We used testimonial evidence provided by the Department in areas other than those described above to help interpret or corroborate documentary or physical evidence. We also used testimonial evidence

from our county site visits to help interpret or corroborate documentary or physical information.

INFORMATION PROHIBITED FROM PUBLIC DISCLOSURE. The Department provided us correspondence from the Office of the Attorney General addressing two issues relevant to our audit objectives: the Department's authority to not enforce rules and determining general fund savings distributions as part of the Collaborative Management Program. The Department reported that the legal advice it received about its authority to not enforce rules is subject to attorney-client privilege, and the Department did not agree to waive this privilege. Section 7.39 of Government Auditing Standards states that "if certain pertinent information is prohibited from public disclosure or is excluded from a report due to the confidential or sensitive nature of the information, auditors should disclose in the report that certain information has been omitted and the reason or other circumstances that make the omission necessary." As a result, although pertinent to this audit, information contained in one correspondence from the Office of the Attorney General to the Department has been omitted from this report.

COUNTY WORKLOAD STUDY. In August 2014, the Office of the State Auditor issued a study of county child welfare workload in Colorado. The study was conducted by ICF International, in collaboration with Walter R. McDonald & Associates. The workload study found that the estimated time needed to complete required activities and meet program goals exceeds the time available from the current number of county caseworkers. Using an accepted modeling methodology, the study estimated that an additional 574 full-time caseworker positions and 122 related supervisory positions may be needed to handle caseloads, based on the amount of time workers spend on child welfare-related job tasks, if no changes are made to current processes and requirements. The study was requested by members of the General Assembly subsequent to the Department requesting that a workload study be conducted.

Workload demands may be a contributing factor to certain problems we found during this audit. For example, the Workload Study found that a 57 percent increase in staffing may be needed to permit caseworkers to complete all assessment tasks in accordance with requirements and ensure the assessments are high quality. Our audit work was not designed to identify a causal relationship between county workload issues and specific deficiencies we found in the child welfare system. However, the Workload Study may provide insights to the Department in addressing the recommendations in this audit.

CHAPTER 2

INITIAL CONTACT WITH THE CHILD WELFARE SYSTEM

The potential for a family to get involved with the child welfare system begins when someone reports known or suspected child abuse or neglect to a county department of human/social services. Anyone can report child abuse or neglect, although individuals in certain professions are required to do so. Upon receiving a referral, county staff begin a process that can involve various decisions, including whether an allegation warrants

further investigation, whether child abuse or neglect occurred, what child safety concerns exist, what a child's risk is for future maltreatment, and what services may be needed to help the family. In some cases, the court system becomes involved to adjudicate dependency and neglect cases and/or require families to engage in services.

This chapter outlines our recommendations related to the processes that occur when families first get involved with the child welfare system, including referral screening, assessments, and other related aspects of these processes. Overall, our audit found areas in which the Department of Human Services (Department) should strengthen the guidance it provides to counties and its oversight and measurement of county performance related to screening and assessments.

SCREENING REPORTS OF CHILD ABUSE AND NEGLECT

The most common type of child welfare allegations in Colorado involve intrafamilial abuse or neglect. Section 19-1-103(67), C.R.S., defines intrafamilial abuse as "any case of abuse…that occurs within a family context by a child's parent, stepparent, guardian, legal custodian, relative, spousal equivalent…or by any other person who resides or is regularly in the child's home for the purpose of exercising authority over or care for the child." In Fiscal Year 2013, counties received more than 70,000 referrals involving allegations that were categorized as intrafamilial abuse or neglect, or not categorized in Trails. Our audit work focused on county processes related to screening referrals of intrafamilial child abuse or neglect. We did not review allegations of third-party abuse, which are investigated by law enforcement, or institutional abuse, which are investigated through county processes that were outside the scope of this audit.

Counties are required to "respond immediately upon receipt of any report of a known or suspected incident of intrafamilial abuse or neglect to assess the abuse involved and the appropriate response to the report" [Section 19-3-308(1)(a), C.R.S.]. The Colorado Children's Code (Sections 19-1-103 and 19-3-102, C.R.S.) defines various types of physical, sexual, and emotional abuse, as well as neglect. Counties have two options for handling referrals, as described below.

- **SCREENED-IN REFERRALS.** Counties can "screen in" a referral to assess child safety and the risk of future child maltreatment [Section 19-3-308(1)(a), C.R.S.]. Rules (Section 7.202.4.G, 12 C.C.R. 2509-3) require counties to screen in (i.e., investigate) referrals that contain "specific allegations of known or suspected abuse or neglect as defined in statutes and regulations." A **KNOWN INCIDENT** of abuse or neglect is defined as a situation in which a child has been observed being subjected to circumstances or conditions that would reasonably result in abuse or neglect. **SUSPECTED ABUSE OR NEGLECT** involves referrals that are made based on patterns of behavior, conditions, statements, or injuries that would lead to a reasonable belief that abuse or neglect has occurred or that there is a serious threat of harm to the child.

  Counties statewide screened in about 28,700 of the 70,400 total referrals of child abuse or neglect (41 percent) received during Fiscal Year 2013.

- **SCREENED-OUT REFERRALS.** Counties can decide that no further action is warranted and "screen out" referrals [Section 19-3-308(1)(a), C.R.S.]. Rules (Section 7.202.4.H, 12 C.C.R. 2509-3) allow counties to screen out referrals for various reasons, including when the:

  - Referral does not meet criteria of abuse or neglect as defined in statutes and rules.
  - Current allegations have previously been assessed and determined to be unfounded.
  - Referral is duplicative of a previous referral.

- Referral information contains allegations of past incident of abuse/neglect (i.e., there is no current allegation of abuse or neglect).

Counties statewide screened out about 41,700 of the 70,400 total referrals of child abuse or neglect (59 percent) received during Fiscal Year 2013.

Statute [Section 26-5.5-102(1)(a), C.R.S.] indicates that "maintaining a family structure to the greatest degree possible is one of the fundamental goals that all state agencies must observe, and the state's intervention in family dynamics should not exceed that which is necessary to rectify the cause for intervention."

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to assess whether Trails documentation supported counties' referral screening decisions based on statute, rules, and other guidance promulgated by the Department. To accomplish this objective, we (1) reviewed relevant statutes, rules, and Department guidance; (2) interviewed Department staff about referral screening processes and observed the Department's annual review of a sample of screened-out referrals; (3) interviewed and observed county staff during site visits at 10 counties around the state; (4) analyzed aggregate Trails data for referrals that counties received during Fiscal Year 2013; (5) reviewed other information provided by the Department, including training materials provided from October 2013 through October 2014; (6) analyzed reports resulting from the Administrative Review Division's 2013 Screen-Out Review as well as quality assurance reviews conducted in 50 counties from January 2013 through November 2013; (7) compiled and analyzed information contained in 18 confidential, case-specific reports issued by the Child Fatality Review Team related to child fatalities, near fatalities, and egregious incidents that occurred during Fiscal Year 2013; and (8) reviewed Trails records for 60 referrals that counties received during Fiscal Year 2013, consisting of 20 referrals from our sample that counties screened out and 40 referrals that counties screened in; and

(9) reviewed 10 referrals associated with a sample of two incidents reviewed by the Child Fatality Review Team—one near fatality and one egregious incident—that occurred during Fiscal Year 2013. Our sample included 19 counties around the state.

Our review of the referral screening process relied on information in Trails. Although some counties reported during site visits that they maintain separate electronic and hard copy files outside of Trails, we used Trails as the primary source of evidence for our testing because it is the official case record for all child welfare documentation and rules require counties to document all referrals in Trails, as discussed in CHAPTER 1. We also relied primarily on Trails documentation to draw conclusions because documentation in Trails is the key mechanism through which counties demonstrate accountability for decisions that affect the lives of children and families.

WHAT PROBLEMS DID THE AUDIT WORK FIND AND HOW WERE THE RESULTS MEASURED?

In evaluating 20 screened-out referrals from our sample, and 10 referrals associated with incidents reviewed by the Child Fatality Review Team, we found that Trails documentation did not clearly demonstrate that county screening decisions aligned with rules or statutes for six referrals. For all six referrals, we first concluded that the Trails record did not clearly support that the screen-out decisions were consistent with the following rule (Section 7.202.4.G, 12 C.C.R. 2509-3) that states which referrals must be screened in.

> The county department **SHALL** assign a referral for assessment if it…contains specific allegations of known or suspected abuse or neglect as defined in statutes and regulations. A "known" incident of abuse or neglect would involve those referrals in which a child has been observed being subjected to circumstances or conditions that would reasonably result in abuse or neglect. "Suspected" abuse or

> neglect would involve those referrals that are made based on patterns of behavior, conditions, statements or injuries that would lead to a reasonable belief that abuse or neglect has occurred or that there is a serious threat of harm to the child [emphasis added.]

The responsible county and the Department agreed that the decisions to screen out two of these referrals were not clearly compliant with applicable statutes and rules. These two referrals consisted of:

- An allegation of a parent who had previously had the child removed from the home due to using drugs in the presence of the 1-year-old child.

- A report of a 7-year-old child who had not been in school for 2 months and had a court case for truancy.

The responsible county and the Department disagreed that the decisions to screen out the other four referrals were not clearly compliant with applicable statutes and rules. These four referrals consisted of:

- An allegation that parents who had children previously removed from their home did not appear to be feeding their newborn often enough and left the newborn unattended for hours.

- A report of a 4-year-old child who showed visible evidence of physical abuse (e.g., bruising) and possible sexual abuse.

- An allegation that one parent struck another parent in the presence of their 3 year old, leading to a call to law enforcement who smelled marijuana in one parent's home, and the request for a restraining order by one parent against the other.

- A report of a child being born to high-risk parents who had already had other children removed from the home. The county department had previously asked the hospital to provide notification when this newborn arrived.

In these four referrals, the counties and Department cited various reasons why the screen-out decisions were appropriate. For some referrals, the counties and Department cited multiple reasons. The reasons provided are summarized in Exhibit 2.1, along with the reasons why we concluded that the Trails record did not clearly demonstrate that statutes and rules had been followed:

EXHIBIT 2.1. DETAILS ABOUT FOUR SCREENED-OUT REFERRALS

County/Department Reason(s) Why Screen Out Was Appropriate	Reasons Trails Does Not Demonstrate Adherence to Statutes or Rules
The referrals contained no specific allegations of abuse or neglect or no indications that the children were unsafe (4 referrals).	According to Trails, these four referrals **did** contain specific allegations of known or suspected abuse or neglect. **Allegations of neglect.** Sections 19-3-102 and 19-1-103(1)(a)(III), C.R.S., define a child as being neglected if any of the following circumstances exist: ▪ The child's parent fails to take actions to provide adequate food or supervision that a prudent parent would take. ▪ The child's parent has subjected another child to a pattern of habitual abuse, has been adjudicated as having neglected another child, and the pattern and type of past abuse pose a current threat to a child. ▪ The child's environment is injurious to his or her welfare. **Allegations of physical abuse.** Section 19-1-103(1)(a)(I), C.R.S., defines abuse or neglect as including when "a child exhibits evidence of skin bruising… [that is] not justifiably explained."
The children were added to child welfare cases that already existed for their families and/or other steps had been taken, such as services had begun or would be provided through the existing case; therefore, a new assessment is not necessary (3 referrals).	By screening out these referrals, no assessments were done to identify the specific safety risks for the children, so new concerns may not be addressed in a timely or thorough manner. Rules (Section 7.202.62.F, 12 C.C.R. 2509-3) only require caseworkers to contact children involved with open cases once a month and do not require new safety or risk assessments. By contrast, rules require caseworkers to contact children who are newly screened in within no more than 5 working days and complete safety and risk assessments within 30 days. In addition, rules (Section 7.202.62.B, 12 C.C.R. 2509-3) state that "ongoing child protection services shall be based on the safety and risk issues identified in the safety assessment instrument and plan, risk assessment instrument, and in the family social history and assessment summary in the Family Services Plan." Without an assessment, the county may not have sufficient information to justify new services.
The child had not himself or herself disclosed abuse or neglect (1 referral).	There is no guidance in statute, rules, training, or other Department communications indicating how a child not disclosing abuse or neglect himself or herself could or should influence the screening decision.
A parent had taken action that demonstrated his or her ability to protect the child (1 referral).	There is no guidance in statute, rules, training, or other Department communications indicating that a referral can or should be screened out based on a belief, formed before conducting an assessment, that a parent may be able to provide protection to a child.

SOURCE: Office of the State Auditor's analysis of Trails, information provided by the Department of Human Services and specific county departments of human/social services, Colorado Revised Statutes, and Code of Colorado Regulations.

Our audit work also included reviewing a sample of 40 screened-in referrals to determine if the Trails documentation clearly supported

the counties' screening decisions in accordance with rules or statutes. We found that the Trails documentation for five referrals did not clearly indicate that these referrals met the criteria to be screened in, primarily due to a lack of specific allegations or information that abuse or neglect, as defined in law, were being alleged. In some cases, the referrals also seemed to describe very similar circumstances to referrals that the counties had screened out. We recognize that every referral is different and the outcome of these referrals illustrates the difficulty in deciding how to make referral screening decisions. Specifically, for these five referrals, after the assessment, three families did not receive any services and two families did. Nonetheless, these five cases indicate that counties and caseworkers may be inconsistent in their interpretation and application of the screening criteria. Screening in referrals that do not meet criteria for assignment could result in both intrusion into a family's life by the child welfare system and costly assessments that are not warranted. The Department agreed with one of our exceptions but disagreed that four of these referrals should have been screened out for reasons including a child's inability to self-protect and risk factors such as a child's vulnerability.

The Department has various mechanisms in place to monitor county compliance with applicable statutes and rules, including those related to screening referrals. As described below, some, though not all, of these mechanisms also identified the need for improvements in county referral screening.

Quality Assurance Reviews for Screened-In Referrals. During the audit, the Department provided 50 quality assurance reviews conducted by the Administrative Review Division from January 2013 through November 2013. Those reviews found that all 50 counties appropriately screened in referrals at least 71 percent of the time. The Administrative Review Division considers any aspect of a county's child welfare process that scores at or below 70 percent during a quality assurance review to be an area of improvement. Any area scoring 95 percent or higher is considered an area of strength.

CHILD FATALITY REVIEW TEAM. A total of three of the 18 Child Fatality Review Team reports issued for incidents that occurred in Fiscal Year 2013 cited a policy violation for a county inappropriately screening out a referral involving a family who was the subject of an egregious, near fatal, or fatal incident. One report cited a county that inappropriately screened in a referral. Child Fatality Review Team reports do not identify policy violations as causal links to the fatal, near fatal, or egregious incident under review.

QUALITY ASSURANCE SCREEN-OUT REVIEW. During its 2013 annual Screen-Out Review (the most recent such review completed at the time of our audit), the Administrative Review Division identified Trails errors related to referral screening that needed to be corrected in more than 140 of the 1,600 screened-out referrals reviewed (9 percent). In addition, the review identified 10 screened-out referrals that required further follow up or additional information due to potential risk and/or safety concerns. According to Administrative Review Division staff, if reviewers determine that child safety concerns appear to exist and a referral should not have been screened out, they will notify the county right away. Depending on how recently the referral was submitted, the Administrative Review Division may ask the county to initiate an assessment of the allegations.

WHY DID THE PROBLEM OCCUR?

NEED FOR ADDITIONAL GUIDANCE AND TRAINING. Determining whether a referral of child abuse or neglect should be screened in or out is not an exact process; it requires consideration of many factors and the application of judgment and expertise on the part of the decision maker. To support the decision-making process, the Department provides extensive training to new caseworkers and training on new requirements and initiatives to all counties on a periodic basis. However, the training primarily focuses on gathering information from reporters about allegations of child abuse or neglect; organizing reported information for a group decision-making process; and county processes that occur after referral screening, such as assessments. We reviewed rules and training materials and interviewed 131 county staff

during site visits at 10 counties around the state, and identified two main areas in which rules, written guidance, and training are lacking or unclear on how counties should interpret statutes and rules to make screening decisions.

The first area relates to how counties should determine if an allegation meets the definition of "known" or "suspected" child abuse or neglect and how to distinguish between "known" and "suspected" as described in Exhibit 2.2.

EXHIBIT 2.2. KNOWN OR SUSPECTED CHILD ABUSE OR NEGLECT

KNOWN (Section 7.202.4.G, 12 C.C.R. 2509-3)—situations in which a child has been observed being subjected to CIRCUMSTANCES OR CONDITIONS that would reasonably result in abuse or neglect.

Examples of Key Questions That Need Clarification[1]
Element of Requirement: Patterns of Behavior
▪ How extensive does a family's prior child welfare involvement have to be to establish a "pattern" of behavior?
▪ Could other factors besides prior child welfare involvement (e.g., criminal history) establish a "pattern" of behavior?
Element of Requirement: Circumstances or Conditions
▪ At what point does a parent's use of alcohol or drugs become a child welfare issue?
▪ Does the type of reporter affect the credibility of allegations reported firsthand or secondhand?
▪ Do children themselves have to make an outcry of abuse or neglect for a referral to be screened in?
▪ Are child vulnerabilities considered "conditions" that could result in child abuse or neglect?
Element of Requirement: Serious Threat of Harm
▪ What constitutes a "serious threat" of harm?
▪ How does a child's ability to protect himself or herself from abuse or neglect influence the risk of serious threat of harm?
▪ Is educational neglect an indicator of a serious threat of harm?

SOURCE: Office of the State Auditor's analysis of Colorado Revised Statutes (Sections 19-1-101, et seq., and 19-3-101, et seq., C.R.S.) and rules.

SUSPECTED (Section 7.202.4.G, 12 C.C.R. 2509-3)—referrals made based on PATTERNS OF BEHAVIOR, CONDITIONS, statements, or injuries that would lead to a reasonable belief that abuse or neglect has occurred or that there is A SERIOUS THREAT OF HARM to the child.
EXISTING GUIDANCE
▪ Section 19-3-102(2), C.R.S., references the concept of an identifiable pattern of habitual abuse. Rules (Section 7.202.4.E, 12 C.C.R. 2509-3) require counties to review a family's prior involvement in the child welfare system. However, there is no written guidance that explains what factors, such as a certain number of prior involvements or a history of children being removed from the home, counties should consider when determining that a "pattern" of abuse or neglect exists.
▪ When counties receive allegations of sexual abuse, they must conduct sex offender checks of the alleged perpetrator (Section 7.202.52.I.1, 12 C.C.R. 2509-3). Criminal history checks are not required for other allegations. There is no written guidance on how counties should use the results of any checks to determine if there is a pattern that should influence the screening decision.
▪ Newborns who test positive for certain controlled substances and children found or residing where controlled substances are manufactured are considered abused or neglected [Section 19-1-103(1)(a)(VI) and (VII), C.R.S.]. However, existing guidance does not address other instances when a parent's substance use could be considered child abuse or neglect.
▪ Counties are required to gather and document, as available, information about a reporter's credibility (Section 7.202.4.F, 12 C.C.R. 2509-3). However, existing guidance does not address if or how the type of reporter affects the referral screening decision.
▪ Existing guidance does not address if or how a child's outcry affects the referral screening decision.
▪ Rules require counties to consider child vulnerabilities when deciding how quickly to initiate an assessment (after screening in referrals), but not as part of the referral screening decision (Section 7.202.41, 12 C.C.R. 2509-3).
▪ Although rules define "threat of moderate to severe harm" (Section 7.202.3, 12 C.C.R. 2509-3), existing guidance does not define "serious threat of harm." It is not clear if or how these concepts relate to each other in the context of referral screening. "Moderate to severe harm" applies when counties decide how quickly to respond after screening in a referral and during the assessment when caseworkers are concluding on the severity of abuse or neglect that may have occurred.
▪ Existing guidance does not address if or how a child's ability to protect himself or herself influences whether a serious threat of harm exists.
▪ Existing guidance does not address whether educational neglect could indicate a serious threat of harm.

[1] These questions are based on comments from county staff during site visit interviews, issues we identified during our file review, and counties' written responses to our file review.

The second main area where rules, written guidance, and Department training could be improved relates to how counties should determine if an allegation meets the legal definition of abuse or neglect. During site visits county staff told us that certain types of child abuse or neglect, such as physical abuse, are clearly defined in statute and rules. However, information from county staff and observations during our file review indicate that some forms of child abuse or neglect listed in the Colorado Children's Code (Sections 19-1-103 and 19-3-102, C.R.S.) are not clearly defined, such as the following, which presents a challenge to caseworkers in making screening decisions:

- **Emotional Abuse**—"An identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment" thereof [Section 19-1-103(1)(a)(IV), C.R.S.].
- **Environmental Neglect**—"The child's environment is injurious to his or her welfare" [Section 19-3-102(1)(c), C.R.S.].
- **Failure to Protect**—A parent or caregiver has "allowed another to mistreat or abuse the child without taking lawful means to stop such mistreatment or abuse and prevent it from recurring" [Section 19-3-102(1)(a), C.R.S.].
- **Lack of Supervision**—A parent or caregiver "fails to take the same actions to provide…supervision that a prudent parent would take" [Section 19-1-103(1)(a)(III), C.R.S.], or "the child lacks proper parental care through the actions or omissions of the parent" [Section 19-3-102(1)(b), C.R.S.].
- **Neglect**—A parent or caregiver "fails to take the same actions to provide adequate food, clothing, shelter, medical care…that a prudent parent would take" [Section 19-1-103(1)(a)(III), C.R.S.].

The training materials we reviewed did not include complete guidance on **how** counties should interpret these statutory concepts and determine whether information provided by reporters indicated these or other types of child abuse or neglect. During site visits, county staff expressed a desire for written "real-life" vignettes that illustrate specific situations and types of behavior that could indicate the occurrence of child abuse or neglect for use during referral screening.

The Department's tools and training materials for assessments include concrete examples of situations that could indicate child abuse or neglect, such as leaving young children alone overnight or repeated failure to provide children clothing that is appropriate for current weather conditions. Providing written examples that caseworkers can reference when evaluating a referral could help them more easily identify situations that might warrant county involvement, as well as those situations that do not.

The Department's training materials do provide some direction for screening using a group decision-making approach, directing caseworkers to follow rules and a written guide, and advising them that "Trails history, legal history, child vulnerability and culture/family view/ethnicity should always be used to inform decision making." However, the materials do not provide any further guidance on how such information may or should influence the screening decision. Guidance on interpreting referral information is also missing from the Department's Enhanced Screening Guide, which reflects a new approach that involves gathering more detailed information from reporters to help counties make more informed referral screening decisions. The Enhanced Screening Guide lists questions counties should ask, but it does not advise them on how to interpret the additional information they obtain to make the appropriate screening decision.

DEPARTMENT AND COUNTY STAFF SOMETIMES APPLY SCREENING CRITERIA THAT ARE NOT IN STATUTE, RULES, WRITTEN GUIDANCE, OR TRAINING MATERIALS. In some responses to our file review, both Department and county staff explained screening decisions based on criteria that are not in any guidance. For example:

- In response to one case in which the Trails record did not clearly support the county's decision to screen out a referral, county staff responded to our file review by saying that whether a child makes an "outcry" of abuse or neglect can influence how counties screen referrals. Department staff also referenced this concept in their response to our review of screened-out referrals associated with an

egregious incident. However, there are no requirements or guidance indicating how a child NOT making an outcry of abuse should influence the screening decision.

- In response to another case in which the Trails record did not clearly support the county's decision to screen out a referral, the Department indicated that the county's decision was appropriate because the parent making the referral had sought a restraining order against the other parent. The Department indicated that by seeking a restraining order, the parent who made the referral demonstrated an ability to keep the child safe. However, there are no requirements or guidance indicating that a referral should be screened out solely on the basis that one parent indicates some ability to keep a child safe.

While we acknowledge that a child's outcry or a parent's ability to protect a child could be reasonable factors for counties to consider when deciding if a family requires involvement from the child welfare system, without clear guidance there is a risk that counties will apply these factors inappropriately or inconsistently during the referral screening process.

REFERRAL DOCUMENTATION IS NOT CONDUCIVE TO EFFECTIVE MONITORING. Although counties are required to gather and document certain referral information and select a reason for screening out a referral from a menu of at least 18 options in Trails, counties are not required to document any detail about HOW they applied referral screening criteria to arrive at their screening decisions. Our review of aggregate Trails data for referrals received during Fiscal Year 2013 found that of the 41,700 referrals that were screened out, the most common reason was "no information from the reporter of abuse and neglect as defined in law," representing 65 percent of those screened out. This was also the reason counties screened out four of the six referrals that we concluded may have been appropriate to be screened in. However, since counties are not required to explain in their Trails documentation WHY they felt a referral did not meet criteria for an assessment, it is difficult to determine how effectively counties apply statute and rules during referral screening.

In addition, counties are not required to document in Trails their reason for screening in referrals (i.e., there are no menu options for screened-in referrals as there are for screened-out referrals), or WHY they felt a referral met the criteria to be screened in. Statute and rules do not indicate that a referral should be screened in as a default; rather, there needs to be certain conditions present for a county to screen in a referral. Although referral information in Trails contains details about a reporter's allegations, that documentation does not necessarily reflect how a county interpreted the reporter's information to decide that a referral met criteria for assessment. It is therefore important for counties to clearly indicate their rationale for screening in a referral. The lack of documented insight about how counties determined whether a referral met the requirements to be screened in, combined with a lack of clear guidance discussed above, can create challenges for the Department in monitoring counties to ensure that they make appropriate screening decisions.

WHY DOES THIS FINDING MATTER?

Incomplete Trails records inhibit efficient administration and monitoring. Rules (Section 1.110, 9 C.C.R., 2501-1) note the Department's statutory responsibility to supervise county departments of human/social services and grant authority for the Department to pursue a "continuum of actions" to address any identified performance issues. These actions can include informal consultation with counties, routine monitoring, quality assurance reviews, program intervention, corrective action, and financial sanctions. In the fall of 2013, the Department exercised this authority by placing a county on a corrective action plan after identifying "numerous compliance issues." According to Department documentation, staff became aware of problems in the county in part because the county's Trails "data was compared to data of three counties of similar population size," and the county "showed significantly lower numbers of referrals and assessments than other counties." The documentation noted that county "staff interviews and observation of Trails indicates that both after-hours and daytime referrals are not being entered into the

system," which led the Department to cite the county for violating requirements to document referral information in Trails. This example illustrates the importance of having complete documentation in Trails, which serves as the primary source of information for the Department's monitoring efforts. When documentation in Trails is not complete or does not provide sufficient insight about county activities, that lack of information can hinder the Department's ability to fulfill its role as supervisor of the State's child welfare system.

In addition, counties could miss opportunities to intervene in children's lives. Any time a county screens out referrals that should be screened in, it creates a risk that the county does not take steps to keep a child safe. In addition, the lack of guidance we discussed creates a risk that counties do not screen referrals using appropriate criteria in a consistent manner.

Developing a more robust training curriculum related to referral screening and providing guidance on how to interpret enhanced screening information would align with the legislation that requires establishment of the statewide child abuse reporting hotline by January 1, 2015. The Department has reported that the volume of referral calls could increase by up to 20 percent once the hotline is implemented. House Bill 13-1271, which establishes the hotline, requires the Department to establish a "consistent decision-making process with criteria and steps for the county department to follow when deciding how to act on a report or inquiry, or when to take no action on a report or inquiry." The bill also includes specific provisions authorizing the State Board of Human Services (State Board) to establish rules related to ensuring "standards for the consistent screening, assessment, and decision-making in response to reports of known or suspected child abuse and neglect," as well as "standardized training and certification standards for all staff prior to taking reports and inquiries." The results of our work related to referral screening identify areas in which improved guidance to counties could help the Department and State Board fulfill these statutory requirements.

RECOMMENDATION 1

The Department of Human Services should ensure that counties make appropriate child welfare referral screening decisions based on established requirements by working with the State Board of Human Services as needed to:

A Implement guidance and training that clarifies how counties should interpret statutes and rules and use referral information, including additional insight obtained through enhanced screening, to determine if an allegation could indicate known or suspected child abuse or neglect, and meets the legal definition of abuse or neglect. The guidance and training should also be clear regarding (i) how a child not making an outcry of abuse should influence the screening decision and (ii) whether a referral can be screened out solely on the basis that one parent indicates some ability to keep a child safe. The Department should consider providing vignettes based on real-life scenarios so that counties have concrete examples from which to draw when deciding how to screen a referral.

B Establish requirements for counties to include in Trails a brief narrative of the rationale behind their referral screening decisions.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A PARTIALLY AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to provide county departments with clear guidance and training regarding factors that should be considered in making the screening decision to ensure that counties make appropriate child welfare referral screening decisions based on established requirements. This finding is consistent with the

Governor's plan, "Keeping Kids Safe and Families Healthy 2.0," which led to House Bill 13-1271 requiring the creation of a statewide child abuse and neglect reporting hotline system, effective on January 1, 2015. In anticipation of this new law, the Department initiated rulemaking relative to training, certifications, and enhanced screening requirements, which will apply to all workers who are responsible for hotline and screening decisions. This requirement includes an annual recertification for hotline workers and supervisors. The proposed rules will mandate enhanced screening and RED team requirements in all counties by January 2015. All counties were trained in 2014 on these protocols. Following training, CDHS staff observed each county's RED team process and provided technical assistance regarding the fidelity of their model. The Department disagrees with the recommendation to provide vignettes based on real-life scenarios. The Department already uses vignettes in Modules 2 and 3 of the training. In addition, the new hotline will record all phone reports of child abuse and neglect to be used in trainings to be developed.

AUDITOR'S ADDENDUM

The audit found that Trails documentation did not clearly demonstrate that county referral screening decisions always aligned with rules or statutes. This problem occurred, in part, because there is a need for additional guidance and training that focuses on making referral screening decisions. The training and vignettes referenced in the Department's response do not focus on the referral screening issues identified in this finding. For example, the referenced trainings focus on how to gather detailed information from reporters about allegations of child abuse or neglect, and how to organize referral information, but do not on how counties should interpret statutes, rules, and reported information to decide whether a referral meets criteria for assessment. The vignettes referenced in the Department's response also address aspects of the child welfare process other than referral screening, such as whether someone should report suspected child abuse or neglect and how to identify child abuse or neglect during assessment, a process that occurs after the referral screening decision has been made.

B DISAGREE.

The Department disagrees with this recommendation because it is unnecessary, duplicative, and establishes a new mandate for county departments. The requirements for county department workers to explain the rationale behind their referral screening decisions in Trails already exists. With reference to screened-in referrals there is already a screen in Trails where the worker documents and supervisor approves their rationale behind the screening decision. This is located in the Framework within the referral, Referral Acceptance Tab. When a referral is recommended for screen-out, workers are required to select the justification for their screening decision from a pick list of options. Whenever a worker selects the category of "other," an additional mandatory field is then enabled where the worker must provide a brief narrative in Trails explaining their rationale behind the selection of "other." In either event, Trails contains all relevant information required by rule as part of the screening process. In addition, with the new child welfare hotline there will be recordings of the reporter's allegations collected in Trails that can be reviewed for additional monitoring and training.

AUDITOR'S ADDENDUM

The section in Trails that captures a county's decision to screen in or out a referral consists of a check box, but the Trails system does not require users to populate this field. When counties select the field indicating that a referral is screened out, Trails requires staff to select an option from a drop-down menu that explains a general reason why they screened out the referral. A similar field does not exist for screened-in referrals. Recordings of referral calls may provide a useful format for capturing information provided by individuals who report child abuse or neglect. However, such recordings will not contain information to support the county's rationale for the screening decision.

TIMELINESS OF INITIAL CONTACT

After county staff screen in a referral, they must decide how quickly to begin assessing a child's safety and risk of future maltreatment. Rules (Section 7.202.41.A, 12 C.C.R. 2509-3) specify that counties must assign a response time of either immediate, within 3 calendar days, or within 5 working days of receiving the referral. In March 2013, a rule was added (Section 7.202.41.A, 12 C.C.R. 2509-3) stating, "If the caseworker is unable to locate the child within the assigned response time, reasonable efforts shall continue to locate the child according to the original assigned response time."

In Fiscal Year 2013, counties assigned an immediate response time to 11 percent of the 28,700 referrals that were screened in, a 3-day response time to 19 percent, and a 5-day response time to 70 percent.

According to rules (Section 7.202.5, 12 C.C.R. 2509-3), the county must begin the assessment phase with face-to-face contact with the family and/or alleged victim and gather information to assess safety and take action to secure safety.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to assess whether counties interviewed or observed children within assigned response times. To accomplish this objective, we (1) reviewed statutes and rules; (2) reviewed Trails records associated with a sample of 40 screened-in referrals that counties received during Fiscal Year 2013; (3) conducted site visits at 10 counties around the state, which included interviewing county caseworkers and other staff; (4) interviewed Department staff to understand the assessment process and the State's monitoring of counties; (5) reviewed Department data related to a performance

measure that tracks the timeliness of response to abuse or neglect referrals; (6) analyzed reports resulting from the Administrative Review Division's quality assurance reviews conducted in 50 counties from January 2013 through November 2013; and (7) compiled and analyzed information contained in 18 confidential, case-specific reports issued by the Child Fatality Review Team related to child fatalities, near fatalities, and egregious incidents that occurred during Fiscal Year 2013.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY AND HOW WERE RESULTS MEASURED?

Our audit work focused on whether caseworkers made **ACTUAL** contact with children, not whether the caseworker unsuccessfully attempted contact with the child. This distinction is important, as discussed later in this finding, because of the way the Department typically monitors county compliance with the requirements.

We found that for four of the 40 assessments in our sample, the Trails documentation showed that caseworkers did not actually make initial contact with children within the assigned response time. Statutes and rules [Section 19-3-308(3)(a), C.R.S., and Section 7.202.52, 12 C.C.R. 2509-3] require caseworkers to conduct an initial face-to-face interview with or observation of the child who is the subject of the referral of abuse or neglect within the response time assigned by the county. An interview is required if the child has verbal capacity to relate information relevant to safety decisions. Otherwise, an observation of the child is sufficient. Exhibit 2.3 summarizes the results of our analysis and the Department's responses.

EXHIBIT 2.3. TIMELINESS OF INITIAL CONTACT WITH CHILDREN FISCAL YEAR 2013 SAMPLED ASSESSMENTS

SAMPLE CASE #	ASSIGNED RESPONSE TIME	DID CASEWORKER INTERVIEW/OBSERVE CHILD WITHIN RESPONSE TIME?	DEPARTMENT RESPONSE
1	3 days	No *Child contacted in 4 calendar days*	Agreed that child was not contacted within response time.
2	5 days	No *Child contacted in 9 working days*	Agreed that child was not contacted within response time.
3	5 days	No *Child contacted in 12 working days*	Disagreed because the referral involved a family with two children, and county staff did not believe the second child was a victim who needed to be contacted. However, the referral narrative suggests that the second child was a victim of lack of supervision and, therefore, should have been contacted within the response time.
4	Immediate	No *Referral received mid-morning and child was not contacted until at least midnight the next day. Trails does not specify the actual interview time.*	Agreed that child was not contacted within response time.

SOURCE: Office of the State Auditor's analysis of a sample of 40 screened-in referrals received during Fiscal Year 2013 and information provided by the Department of Human Services.

Results from the Department's quality assurance reviews and reviews of fatal, near fatal, or egregious child abuse also indicate that some counties struggle to make initial contact with children in a timely manner. Specifically:

- **QUALITY ASSURANCE REVIEWS.** During the audit, the Department provided 50 quality assurance reviews conducted by the Administrative Review Division from January 2013 through November 2013. Those reviews found that 15 counties made actual contact with children within the assigned response time no more than 70 percent of the time. The other 35 counties made actual contact

within the assigned response time at least 71 percent of the time, including five counties that performed at or above 95 percent. The Department considers performance of 95 percent or higher to be an area of strength and performance at or below 70 percent to be an area needing improvement.

- **CHILD FATALITY REVIEW TEAM.** A total of 11 of 18 Child Fatality Review Team reports issued for incidents that occurred in Fiscal Year 2013 cited one or more policy violations for counties failing to make timely actual contact with an alleged victim whose family was the subject of an egregious, near fatal, or fatal incident. Child Fatality Review Team reports do not identify policy violations as causal links to the fatal, near fatal, or egregious incident under review.

WHY DID THE PROBLEM OCCUR?

According to the Department, making contact with children who are the subject of abuse or neglect allegations is not entirely in the county's control; there are barriers that can prevent timely contact. These include: (1) the caseworker may not have reliable information about where to look for the children, (2) children are not always where the caseworker looks, (3) families do not answer their doors when caseworkers visit their homes, and (4) there may be delays caused by coordinating with law enforcement. Department information indicated it can be particularly difficult to locate and contact children when school is not in session, such as during winter holiday breaks.

Understanding the inherent challenges in contacting children who may be the subject of abuse or neglect, we still noted that some of the Department's approaches to measuring and monitoring performance in this area appear to emphasize the importance of ATTEMPTED contact with the child rather than ACTUAL contact. These issues are described below.

- **C-STAT AND THE COMMUNITY PERFORMANCE CENTER MEASURE ATTEMPTED CONTACT.** The Department has established a "Timeliness

of Initial Response" performance measure as part of its C-Stat process and for reporting on the Community Performance Center website. The measure reflects the percentage of children for whom the caseworker attempted to make initial contact, either successfully or unsuccessfully, with the child within the time requirements set in rule (meaning the immediate, 3-day, or 5-day response times). For example, a caseworker making one unsuccessful attempt during a 5-day response time would be considered the same as the caseworker actually making contact. Although the Department has set a benchmark that counties attempt to contact children within the assigned response time at least 90 percent of the time, the Department has not established a benchmark for making actual contact. The Department reports that it focuses on attempted contacts with children because it believes data show that this focus leads to an increase in actual contacts. The Department provided us with summary information showing a general increase in actual contacts when reasonable efforts to contact children increased, according to quality assurance reviews conducted by the Administrative Review Division.

- **ADMINISTRATIVE REVIEW CONCENTRATES ON ATTEMPTED CONTACT.** As part of its quality assurance reviews, the Administrative Review Division captures data on both actual and attempted contacts with children within assigned response times. However, Administrative Review Division staff reported that they focus their quality improvement efforts on counties' **ATTEMPTS** to interview or observe children within the assigned response time, which is consistent with the Department's approach on C-Stat measures. For example, the Administrative Review Division reports that when it considers making recommendations to counties, it may not recommend practice improvements to a county that appears to be making reasonable efforts to contact children, even if the children are not actually interviewed within the assigned response times. Administrative Review Division data show that between the end of Fiscal Year 2011 and the end of Fiscal Year 2014, statewide counties' reasonable efforts have increased from 82 to 89 percent, and actual contact has increased from 72 to 76 percent. However, neither of these two measures has

achieved the Department's benchmark of 90 percent for attempted contact.

WHY DOES THIS FINDING MATTER?

Protection of a child who may be subjected to abuse or neglect is the immediate concern of the child welfare system [Section 19-3-308(1)(a), C.R.S.]. According to the Department's C-Stat information, the reason the Department uses the "Timeliness of Initial Response" measure is that "timely response to initial abuse/neglect assessments improves child safety and reduces the potential for further abuse." A key part of assessing a child's safety and risk for maltreatment is actually seeing and/or talking to the child to help determine the most appropriate intervention.

When assigning response times, counties are required to weigh various factors, including whether present or impending danger exists that could result in harm to a child, the child's vulnerability, drug and alcohol abuse, violence, isolation, or a family's risk of flight from one county to another county or state (Section 7.202.41.A, 12 C.C.R. 2509-3). Counties dedicate time and resources to considering these factors and, according to the Department's quality assurance process, tend to assign the appropriate response times based on consideration of all these factors. As such, it is important that counties then follow through to begin assessments within those response times to help ensure that children remain safe.

In addition to emphasizing efforts over results, the Department's "Timeliness of Initial Response" measure may not be transparent to the public or other non-Departmental users of C-Stat or Community Performance Center data. Up to July 2014, the C-Stat presentations that the Department reviews in monthly public meetings described this measure as "initial contact with the alleged victim." Similarly, as of October 2014 the Community Performance Center website described this measure as "children interviewed within the time-frames specified in State rule." In other words, the descriptions do not tell readers that the measure also includes unsuccessful attempts at contact. For

Calendar Year 2013, C-Stat reports indicate that counties statewide were performing between about 83 and 92 percent on this measure, and data on the Community Performance Center show counties performing between 79 and 89 percent. Both sources would lead readers to believe that counties are successful in making the actual contact with a child that is critical to assessing whether intervention is needed. However, when Department leadership conducted an internal analysis of Administrative Review Division data showing actual contacts and "reasonable efforts" to make contacts, the results, dated January 2014, showed that some counties struggle to make timely actual contact with children. According to that analysis, 29 counties were making actual contact with children within required timeframes between 0 and about 89 percent of the time. This included three of the State's 10 largest counties, which are categorized by the Department in terms of referral volume. These three counties were only successful in making on-time initial contact with children 54 to 62 percent of the time. The analysis also illustrated that there were significant gaps, for some counties, between reasonable efforts and actual contacts. For example, one large county made reasonable efforts to contact children within the required timeframes for 88 percent of its reviewed cases, but actually contacted children only 54 percent of the time.

Another reason this measure may not be transparent is that the Department calculates it differently for C-Stat purposes than for reporting on the Community Performance Center website. For C-Stat, the measure is based on the number of assessments that were closed during the month; for the Community Performance Center, the measure is based on the number of referrals received during the month. As indicated above, the methodologies result in somewhat different outcomes for any given period of time, and different outcomes may be more pronounced for individual counties in individual months. For example, for November 2013, C-Stat data showed one of the State's 10 largest counties had timely initial response to referrals 100 percent of the time, but the Community Performance Center for the same month reported this measure at 74 percent. The Department reports that these different methods are

useful for providing an opportunity to look at data from different perspectives.

From a public accountability perspective, not distinguishing between actual and attempted contacts with children, and using different calculation methods to report the same measure, reduces the transparency of county compliance with assigned response times and diminishes the usefulness of the Department's C-Stat and Community Performance Center information as a management tool. For example, C-Stat was specifically designed to inform the Department and counties about performance and, according to the Department's February 2013 budget request to the Joint Budget Committee, the Community Performance Center "allows State and county department leadership to review data and make informed decisions and practice changes to respond to the needs of Colorado families."

While the Administrative Review Division reviews on an ongoing basis whether counties actually contact children within the response time, expanding C-Stat could provide stronger oversight of this measure. Administrative Review Division monitoring does not always result in recommendations to counties when deficiencies are found and the Department does not have any written guidance or policies to ensure that technical assistance is directed to counties based on quality assurance reports. By contrast, the Department's C-Stat process is designed to identify root causes for lagging performance and the Division of Child Welfare must develop an action plan to improve outcomes as needed by providing training and technical assistance to counties.

Finally, the Department uses performance measure data as a factor when deciding whether to make recommendations to counties from Child Fatality Review Team reviews. For example, our review of Child Fatality Review Team findings related to Fiscal Year 2013 child fatalities, near fatalities, and egregious incidents identified four counties that met the C-Stat goal for the "Timeliness of Initial Response" performance measure and were not issued a recommendation related to improving response times.

RECOMMENDATION 2

The Department of Human Services should strengthen its performance measures and monitoring related to counties making actual contact with children within assigned response times by:

A Expanding C-Stat performance measures to include a separate measure on actual initial contacts with children.

B Developing and publicly reporting a separate performance measure that reflects actual initial contacts with children on the Community Performance Center. This could be in addition to existing performance measures.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A DISAGREE.

The Department disagrees with this recommendation because it already uses actual contact and attempted contacts in its management of "Timeliness of Initial Response" in its C-Stat practice. The current performance management approaches utilized in C-Stat, which consist of both the number of timely face-to-face contacts and attempted contacts, as set forth in rule, are effective. The focus is on ensuring that county workers are making all reasonable efforts to contact a child within the assigned response times. The Department's experience has demonstrated that focusing on reasonable efforts has resulted in improved actual contacts. This is supported by data from the Administrative Review Division, which shows a 6% improvement in reasonable efforts and a corresponding 5% improvement in actual contacts with children, over a three year time period, as a result of monitoring to the current C-Stat measure. In addition, the Department periodically performs a detailed analysis of actual contacts to verify at both the State and county levels that this approach is effective. Lastly,

the Department believes that the OSA Workload Study demonstrates that inadequate staffing levels (574 FTE) may be a larger factor in the achievement of timeliness of initial response. Pursuing sufficient staffing levels throughout all counties in the State will have a more direct effect on timeliness of initial response performance.

AUDITOR'S ADDENDUM

Expanding C-Stat to include a separate measure on actual contacts with children would routinely provide the Department with information about how quickly caseworkers actually observe or interview a child at the beginning of an assessment, giving additional context for the existing C-Stat measure, and thus strengthening the Department's oversight of this county activity. As noted in the report, the Department sometimes reviews data on actual contacts, but not on a monthly basis for all counties. The Department's 2013 review of actual contacts indicated that there were significant gaps, for some counties, between attempted and actual contacts, with 29 counties, including three of the State's 10 largest counties, struggling to make actual contact with children within the assigned response time. While the Department uses the Administrative Review Division to monitor actual contacts with children, Administrative Review Division's monitoring does not always result in an action plan to improve outcomes or provide training and technical assistance to counties.

B AGREE. IMPLEMENTATION DATE: MARCH 2015.

The Department agrees to develop and publicly report an additional outcome indicator that reflects actual initial contacts with children on the Community Performance Center's website.

ASSESSMENT OF CHILD SAFETY AND RISK OF FUTURE MALTREATMENT

The assessment phase of the child welfare process involves work conducted by a caseworker to engage the family and community to gather information to identify safety, risks, needs, and strengths of a child and family and determine actions needed (Section 7.202.3, 12 C.C.R. 2905-3). The immediate concern of any assessment shall be the protection of the child and, where possible, the preservation of the family unit [Section 19-3-308(1)(a), C.R.S.]. Caseworkers are required to document assessment activities in Trails (Section 7.202.52, 12 C.C.R. 2509-3).

The Department's Fiscal Year 2015 Performance Plan notes that timely completion of assessments indicates that child safety issues are identified and mitigated quickly, the child welfare system is not unnecessarily lingering in a family's life, and information regarding the assessment in Trails is up-to-date.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to evaluate whether counties assessed allegations of child abuse or neglect in accordance with established requirements. To accomplish this objective, we (1) reviewed statutes, rules, and other guidance, including training materials related to assessments provided by Department staff from October 2013 through October 2014; (2) interviewed Department staff; (3) interviewed county staff and observed how they conduct different parts of an assessment during site visits at 10 counties across the state; (4) analyzed Trails data that resulted from referrals received during Fiscal Year 2013; (5) compiled and analyzed information

contained in 18 confidential, case-specific reports issued by the Child Fatality Review Team related to child fatalities, near fatalities, and egregious incidents that occurred during Fiscal Year 2013; (6) analyzed reports resulting from the Administrative Review Division's quality assurance reviews conducted in 50 counties from January 2013 through November 2013; and (7) reviewed a random sample of 40 assessments that resulted from referrals that counties received during Fiscal Year 2013. Of the 40 assessments we reviewed, 30 were investigative assessments and 10 were differential response assessments. We also reviewed the assessment history associated with families involved with one near fatality and one egregious incident that occurred in Fiscal Year 2013.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND HOW WERE RESULTS MEASURED?

In all 40 case files we reviewed in which assessments were conducted, we found that the Trails records did not demonstrate that all required elements of the process were completed adequately or on time. The problems we found are described below.

REQUIRED INTERVIEWS

In 13 of our 40 sampled assessments, the Trails records did not document that caseworkers conducted interviews with children, family members, and alleged perpetrators involved with the assessment. Some assessments lacked more than one required interview. Specifically:

- **HOUSEHOLD MEMBERS.** In five assessments, the Trails record did not document that other children living in the home were interviewed and, in eight assessments, that other family members living in the home, such as adult siblings, cousins, aunts, and grandparents, were interviewed. These interviews are required by rules (Section 7.202.52.E, 12 C.C.R. 2509-3) to help caseworkers determine the extent of child maltreatment, circumstances surrounding the

maltreatment, how the child and adults function on a daily basis, parenting practices, and disciplinary practices. The Department agreed with our findings.

- **ALLEGED PERPETRATORS.** In three assessments, the Trails record did not document efforts to interview the person responsible for the abuse or neglect, advise him or her of the allegations, and give him or her the opportunity to respond. Section 19-3-308(3)(a), C.R.S., states that the alleged perpetrator of child abuse or neglect "shall be advised as to the allegation of abuse and neglect and the circumstances surrounding such allegation and shall be afforded an opportunity to respond." Rules further require county staff to make reasonable efforts to interview any person alleged to be responsible for abuse or neglect (Section 7.202.52, 12 C.C.R. 2509-3). The Department agreed with our findings.

  Results from the Department's quality assurance reviews and reviews of fatal, near fatal or egregious child abuse also indicate that caseworkers do not always conduct required interviews. Specifically:

- **QUALITY ASSURANCE REVIEWS.** During the audit, the Department provided 50 quality assurance reviews conducted by the Administrative Review Division from January 2013 through November 2013. Those reviews found that 11 counties interviewed all required individuals during the assessment no more than 70 percent of the time, while the other 39 counties interviewed all required individuals at least 71 percent of the time.

- **CHILD FATALITY REVIEW TEAM.** A total of five of the 18 Child Fatality Review Team reports issued for incidents that occurred in Fiscal Year 2013 cited one or more policy violations for counties not conducting all required interviews during assessments involving families who were the subject of an egregious, near fatal, or fatal incident. Child Fatality Review Team reports do not identify policy violations as causal links to the fatal, near fatal, or egregious incident under review.

SAFETY ASSESSMENTS

In 15 of the 40 assessments in our sample, we found problems with how counties identified and analyzed child safety concerns and sought to ensure child protection. The problems we found were:

- **LACK OF EVIDENCE TO DEMONSTRATE CONSIDERATION OF FAMILY FUNCTIONING.** In three of our 40 sampled assessments, we found a lack of evidence that caseworkers considered all required factors related to a family's functioning during the safety assessment. Caseworkers are required to summarize the following six factors in the safety assessment tool to assess a family's functioning, which can help identify threats of harm to a child: (1) extent of the child maltreatment, (2) circumstances surrounding the child maltreatment, (3) child functioning on a daily basis, (4) adult and caregiver functioning on a daily basis, (5) parenting practices, and (6) disciplinary practices. The three incomplete safety assessments we found lacked information on one to three of these factors. In all three cases, the Department agreed that caseworkers should have documented this part of the safety assessment in the section of Trails designed to capture information about family functioning, even if related information was documented elsewhere.

- **CHILD SAFETY CONCERNS NOT IDENTIFIED.** In five of the 40 assessments, caseworkers may not have appropriately identified child safety issues in accordance with established criteria. Caseworkers must evaluate the following factors to determine whether a family's behavior, condition, or situation threatens the safety of a child: (1) the threat to child safety is specific and observable; (2) conditions reasonably could result in moderate to severe harm to a child; (3) this harm is likely to occur if not resolved; (4) a child is vulnerable to the threat of harm due to his or her age, developmental level, cognitive impairment, physical disability, illness, ability to communicate, ability to meet basic needs, or similar factors; and (5) the caregiver is unable to control conditions and behavior that threaten child safety (Section 7.202.533, 12 C.C.R. 2509-3).

For two assessments, the Department agreed that the caseworker did not adequately identify child safety concerns. For example, a county assessed a referral involving a 2-year-old whose parent was allegedly giving the child prescription pain medication. In the Trails record, the caseworker noted the mother's "history of substance abuse" and noted that the parent "has been in a [drug] treatment program for several years," but did not identify that behavior as a concern.

For three assessments, the Department disagreed that the assessment revealed a child safety concern. For example, a county assessed a report that a parent was relapsing on drugs and had fled from another state's child welfare system "in fear of having [the] children removed again." However, the caseworker did not mark this behavior as a concern, despite the fact that the Department's safety assessment tool includes the following reasons for citing risk of flight as a safety concern: "Parents/caregivers have previously fled in response to a [child welfare] investigation" and "there is precedence for avoidance and flight."

- **Safety Concerns Not Documented.** Of the 40 assessments in our sample, there were 20 assessments in which caseworkers identified a safety concern. Of those, two safety assessments indicated that a child safety concern existed but the Trails record did not provide case-specific details to support why the caseworker had identified each concern. In both instances, the Department agreed. In one case, the caseworker identified six safety concerns and the child was removed from the home. However, the only information documented in Trails was a notation indicating that the child appeared to be the "target" and had been placed out of the home. In another case, the caseworker did not provide any case-specific details to substantiate two safety concerns identified.

- **Incomplete Safety Intervention Analysis.** Of the 40 assessments in our sample, there were 13 assessments in which caseworkers determined that a child safety concern existed and that a safety plan or out-of-home placement would be required. In two of the 13 cases, we found a lack of evidence that the caseworker sufficiently analyzed the

child's caregiver and home environment to support the determination that further safety intervention was needed. Rules (Section 7.202.531.C, 12 C.C.R. 2509-3) require that after a caseworker identifies a child safety issue, he or she must determine whether an in-home safety plan or out-of-home placement is needed to ensure a child's protection. According to rules (Section 7.202.533.E, 12 C.C.R. 2509-3), to determine whether an in-home safety plan can sufficiently manage the safety concerns, the caseworker's analysis must consider and document that:

- The home environment is stable enough to support an in-home safety plan.
- Caregivers are willing to accept and cooperate with the in-home safety plan.
- Resources are accessible and the level of effort required is available to sufficiently control safety concerns without it being necessary to rely on the person responsible for abuse/neglect to initiate protective actions.

The Department agreed in one case involving a parent who routinely used heroin. The Trails record did not include an analysis of the home, caregivers, and resources, as required. The Department disagreed in the second case, which involved a referral from law enforcement about an intoxicated individual who had taken four small children to buy alcohol. The children showed signs of neglect and disclosed to law enforcement that their parent physically abused them. However, the safety intervention analysis did not document information about the family dynamics and home setting. The Department stated that since law enforcement "had already completed the removal and had given custody to [the county], the county knew that the safety intervention at the time of the safety assessment was that the children had been removed." Although law enforcement's intervention secured the children's immediate safety, rules do not exempt the county from analyzing the family dynamics and home setting to conclude on the stability of the home environment and appropriate placement of the children beyond the time period when they were in temporary protective custody.

- **INCOMPLETE SAFETY PLANS.** In six of the 40 assessments we reviewed, caseworkers determined that a safety plan was necessary to help ensure that the child could safely remain in his or her home. In four of these six cases, the safety plans documented in Trails were missing required components. According to rules (Section 7.202.534, 12 C.C.R. 2509-3) and the safety assessment instructions, safety plans must address each safety concern identified and outline who in the family is responsible for each task in the plan, the duration and frequency of the tasks, and how the caseworker will oversee the plan. Signatures of the parents, caregivers, and all other participants in the safety plan, including the caseworker and supervisor, are required to acknowledge their agreement with the plan. Caseworkers are required to document safety plans in Trails (Section 7.202.534.E, 12 C.C.R. 2509-3).

  Missing components we identified included what tasks would be done by caregivers and other family members; how often the tasks would be completed; how the caseworker would oversee the plan; and whether the family, caseworker, and supervisor agreed with the plan. In all four cases, Department staff agreed that caseworkers did not adequately document required elements of the safety plans in Trails.

  Results from the Department's quality assurance reviews, statewide performance measures, and reviews of fatal, near fatal, or egregious child abuse also indicate that some counties experience problems completing safety assessments. Specifically:

- **QUALITY ASSURANCE REVIEWS.** During the audit, the Department provided 50 quality assurance reviews conducted by the Administrative Review Division from January 2013 through November 2013. Those reviews found that six counties completed safety assessments correctly no more than 70 percent of the time, while the other 44 counties completed the safety assessments correctly at least 71 percent of the time.

- **C-STAT.** The Department's C-Stat performance measures for November 2013 showed that counties statewide completed safety

assessments accurately for 83 percent of investigative assessments, which is below the Department's 95 percent goal for this measure.

- **CHILD FATALITY REVIEW TEAM.** A total of nine of the 18 Child Fatality Review Team reports issued for incidents that occurred in Fiscal Year 2013 cited one or more policy violations for county errors made when completing safety assessments of families who were the subject of an egregious, near fatal, or fatal incident. Child Fatality Review Team reports do not identify policy violations as causal links to the fatal, near fatal, or egregious incident under review.

RISK ASSESSMENTS

In 27 of the 40 assessments in our sample, we found problems related to how caseworkers identified the risks of future child abuse or neglect. Rules (Section 7.202.54.A, 12 C.C.R. 2509-3) require caseworkers to complete the Department's risk assessment tool to evaluate the risk for future child abuse or neglect, whether a case should be opened, and what level of services are needed. The tool includes a series of questions related to the family's current and prior child welfare history, domestic violence in the home, and characteristics of the caregiver (e.g., substance use, history of homelessness and mental health treatment, and involvement in disruptive/volatile relationships). Caseworkers are required to document their answers to the risk assessment and score each factor in Trails (Section 7.202.54, 12 C.C.R. 2509-3). The results are then used to determine whether a family has low, moderate, or high risk for future abuse or neglect.

The problems we found were:

- **INACCURATE RISK ASSESSMENTS.** Across 21 of the 40 sampled risk assessments, we found 32 questions related to families and their histories that appeared to be answered incorrectly based on information in Trails. In 20 cases, the Department agreed. For example, in one instance a caseworker noted the child's mental or behavioral health issues as a risk factor. However, interviews with the child documented in Trails did not indicate any such issues. In a

second example, the caseworker miscounted the number of prior child welfare investigations, resulting in the family being rated as having moderate risk for future abuse or neglect, rather than high.

- **Need for assessments of second households.** Three assessments in our sample raised questions about whether clearer guidance is needed related to conducting separate assessments when children are exposed to more than one household. The Department's risk assessment instructions state, "If two households are involved in the alleged incident(s), separate risk assessment forms should be completed for each household." Department staff told us that the instruction to complete a separate risk assessment form for a separate household only applies when a second household is involved in the specific incident of child abuse or neglect being alleged in the referral; separate assessments are not required simply because a child may spend time in multiple households.

  In the assessments we reviewed that raised questions, the Department agreed with one case in which a 1-year-old child's parent was allegedly abusing substances. In this instance, the other parent lived in a separate household but appeared to be actively involved with the family, including taking care of the child at various times. The caseworker did not conduct a risk assessment of the other parent's household.

  The Department disagreed in two other instances. In one, a parent of two children called in a child welfare referral after learning that the other parent had been drinking while driving the children. In the second case, a parent of three children alleged that the other parent was not allowing visits with the children and was maintaining a neglectful home environment (e.g., leaving rotten food out). In both cases, the children spent time with both parents, who lived in separate households, but the counties did not assess all of the households.

- **Policy Overrides That May Have Been Warranted.** We found examples of two risk assessments that may have warranted a policy override to raise the risk level assigned to the case and ensure that

families receive the appropriate level of services. In certain cases, the Department's risk assessment tool allows caseworkers to override the family's risk level as determined by the risk assessment. Caseworkers can use a policy override to "reflect incident seriousness and child vulnerability concerns." According to the Department's risk assessment tool, an override may be appropriate if an incident involves sexual abuse when the perpetrator is likely to have access to the child, or when non-accidental physical injuries require medical treatment or a hospital stay.

For the two assessments where we identified that an override may have been appropriate, one involved a 4-year-old child who suffered extensive third-degree scalding burns, which required hospitalization out of state. The caseworker concluded that the family's risk for future abuse or neglect was moderate. It may have been appropriate to apply a policy override because of the seriousness of the incident, physical injuries requiring a hospital stay, and the child's age. The Department agreed.

The second case involved a 14-year-old who witnessed her stepparent sexually abusing a 15-year-old sibling. Since this assessment involved allegations of sexual abuse, it would have qualified for a policy override after the risk assessment determined that the children's risk of future abuse or neglect was "low." The Trails record stated that a judge issued a no contact order between the alleged perpetrator and the victim and her family members. The Department disagreed about this case, stating that the person responsible for abuse or neglect "is not to have any contact with the [parent] or children. [Parent] demonstrated protective capacity during the course of the assessment." However, since the laws prohibiting sexual relations with a minor did not prevent the stepparent from sexually abusing the 15-year-old, it would be reasonable for the county to question whether a no contact order would prevent similar abuse of the 14-year-old. For context about the use of protective orders, we obtained the following information from the Colorado Bar Association's website: "Having a protective order does not ensure safety. A protective order is only as good as the abuser's willingness to obey it. A protective order should

not be used to give a victim a false sense of safety; it is not a bullet-proof shield."

Results from the Department's quality assurance reviews and reviews of fatal, near fatal, or egregious child abuse also indicate that, in some cases, counties experience problems completing risk assessments. Specifically:

- **QUALITY ASSURANCE REVIEWS.** During the audit, the Department provided 50 quality assurance reviews conducted by the Administrative Review Division from January 2013 through November 2013. Only two of the reviews reported on whether the county completed risk assessments correctly. Those two reviews found that one county completed risk assessments correctly no more than 70 percent of the time, while the other county completed risk assessments correctly at least 71 percent of the time. The one county that completed risk assessments correctly no more than 70 percent of the time is one of the 10 largest counties in the state.

- **CHILD FATALITY REVIEW TEAM.** A total of 10 of the 18 Child Fatality Review Team reports issued for incidents that occurred in Fiscal Year 2013 cited one or more policy violations for county errors made when completing risk assessments of families who were the subject of an egregious, near fatal, or fatal incident. Child Fatality Review Team reports do not identify policy violations as causal links to the fatal, near fatal, or egregious incident under review.

TIMELINESS OF ASSESSMENT CLOSURE

For investigative assessments, rules (Section 7.202.57, 12 C.C.R. 2509-3) require caseworkers to complete assessments within 30 calendar days of the referral date or seek approval for an extension. We reviewed the 30 investigative assessments in our file review for closure timeframes and evidence of approved extensions. We found that eight of the assessments closed more than 30 days after the referral without an approved extension.

Results from the Department's statewide performance measures and reviews of fatal, near fatal, or egregious child abuse also indicate that caseworkers do not always close assessments within the required time frame. Specifically:

- **C-STAT.** The Department's C-Stat performance measures for November 2013 showed that counties statewide closed 84 percent of investigative assessments within the required time frame. This was below the Department's goal of 90 percent. In CHAPTER 3, we outline our concern with this performance measure not measuring operational performance according to regulatory requirements.

- **CHILD FATALITY REVIEW TEAM.** A total of 15 of the 18 Child Fatality Review Team reports issued for incidents that occurred in Fiscal Year 2013 cited one or more policy violations for counties not completing timely assessments of families who were the subject of an egregious, near fatal, or fatal incident. Child Fatality Review Team reports do not identify policy violations as causal links to the fatal, near fatal, or egregious incident under review.

WHY DID THE PROBLEMS OCCUR?

The following factors contributed to the problems we identified.

LACK OF GUIDANCE BEYOND NEW STAFF TRAINING. According to staff, the Department relies on rules, training, and the basic instructions within the assessment tools to provide guidance to the counties. Our review of rules, Department guidance, and new case worker training related to assessments found that these sources of authoritative guidance have varying degrees of usefulness and understandability. For example, the guidance in rules for conducting safety and risk assessments is more robust than it is for other aspects of the assessment process. New caseworker training the Department provided to us in October 2014 provides comprehensive information about conducting assessments and a foundation for child welfare practices. However, there are limitations to relying on training as a primary source of guidance. For example, although county staff must

meet annual training requirements, the Department's training materials we reviewed that are provided through the Training Academy are targeted primarily at new caseworkers. As such, it may not provide adequate instruction on changes in practice to experienced county staff, particularly if staff do not have availability to attend all trainings. Further, training materials may not provide the detailed on-demand references for caseworkers to use as they actually carry out their jobs.

Our file review raised issues about how counties should assess caregivers who use alcohol and drugs. For example, in one case a caseworker should have identified a parent's substance use as a child safety concern. County staff disagreed and stated, "There is no indication that the [parent's] actions were a result of impairment and/or being under the influence." On the other hand, the Department agreed that the parent's substance use *did* appear to be creating a specific and observable threat to child safety. Overall, staff in seven of the 10 counties we visited stated the assessment tools can be confusing and that additional guidance is needed. Department documentation states that in December 2014, counties statewide will begin receiving training on new safety and risk assessment tools, which do provide more guidance for assessments, including how a parent's substance use can affect child safety and a definition of "household" for the purpose of conducting an assessment. However, the training does not clarify questions such as what constitutes "reasonable efforts" to interview the person responsible for abuse or neglect. Finally, rules do not provide guidance on using policy or discretionary overrides in the risk assessment process.

Lack of Supervisory Oversight. We identified two problems relating to supervisory oversight of caseworker activities. First, Trails is currently programmed to allow the same person to both request approval for assessment extensions and closures, and to approve those requests. Our file review found that the assessment closure approval for four of the 30 investigative assessments were both requested and approved by the same person. All four assessments were conducted in county departments of human/social services designated as the State's

10 largest counties, according to the Department's categorization of counties. In addition, of the nine assessment extensions that were requested in the files we reviewed, two were approved by the same person who requested the extension. One of these assessment extension requests and approvals was by one of the State's 10 largest counties. This illustrates a lack of adequate separation between the caseworkers who conduct assessments and the supervisors who are supposed to provide independent review of the assessment process. The Department pointed out that in some small counties where only one staff person works on child welfare, there is no supervisor to approve assessment closures or extensions. In such cases, it is important for counties to implement compensating controls whenever possible to ensure an adequate level of independent review. For example, one small county we visited told us it has the county's director of human services review assessments in high-risk situations.

Second, Trails does not include a specific field for county supervisors to indicate that they have reviewed each safety and risk assessment tool that is completed as part of the overall assessment process. Trails only has a specific field to document supervisory approval to close the overall assessment. As a result, Trails does not reflect what level of oversight occurs during the assessment process, or how aware supervisors are that assessment problems need to be rectified by the time caseworkers are requesting approval to close assessments.

In September 2012, the Office of Colorado's Child Protection Ombudsman raised similar concerns and recommended that the Department provide training to county child welfare staff on the safety assessment, safety plans, and the risk assessment to ensure compliance with rules. At the beginning of our audit, the Department reported that it was in the process of revising the safety and risk assessment tools and would provide counties training on those tools by the end of 2013 to address the Ombudsman's recommendation. As of September 2014, the Department had not implemented the new safety and risk assessment tools, but had begun piloting training on the tool with several counties. Department documentation indicates that counties

statewide will begin receiving training on the new assessment tools starting in December 2014.

Circumstances That Can Delay Assessment Closure. Current requirements may reflect an impractical time frame for closing assessments. For investigative assessments, rules (Section 7.202.57.A, 12 C.C.R. 2509-3) require caseworkers to complete all the required interviews and information gathering to assess child safety and risk of future maltreatment within 30 calendar days of the referral date, unless the caseworker obtains approval to extend the deadline. We analyzed aggregate Trails data for investigative assessments resulting from referrals received in Fiscal Year 2013 and found that of the 24,000 assessments conducted, about half of them took longer than 30 days to complete. Staff at eight of the 10 counties we visited reported various reasons why meeting the 30-day time frame to complete assessments can be challenging. For example, county staff reported that it can be difficult to manage too many concurrent assessments in progress, priorities change as new assessments are assigned, contacting family members can be challenging or time-consuming because of geographic distance or unwillingness to participate in the assessment process, or delays can occur when caseworkers have to wait for results from law enforcement investigations in order to complete child welfare assessments. According to minutes from the meetings of the Department's Child Protection Task Group, the Task Group recommended in March 2013 to extend the assessment closure deadline in rule to 60 days. The minutes indicate that the Department reported that some counties felt that extending the deadline would result in assessments being open even longer, so the Department did not seek a change to the 30-day deadline in rule.

Trails Documentation. The Department does not enforce some requirements that counties document assessment information in Trails. For example, in one case we cited, a county did not document a risk assessment in Trails and Department staff told us in May 2014 that "the risk assessment can be completed on paper with the family, and therefore may not appear in Trails." However, rules (Section

7.202.62.E, 12 C.C.R. 2509-3) state, "The Colorado Family Risk Assessment instrument shall be documented in the State automated case management system." Later in the audit, the Department changed its response and told us that counties *are* expected to follow requirements in rules. During our site visits, some county staff reported that Department staff sometimes provide conflicting information about requirements for child welfare processes. Specific to assessments, one caseworker noted that the Department "went away from" requiring counties to enter certain safety assessment information in Trails. However, at the time of our audit, rule still required this information to be documented in Trails. It is unclear whether Department staff communicate consistent information to counties about what assessment information must be documented in Trails.

We also noted that an assessment closure summary in Trails did not include elements required by Department guidance, including details about the child's safety and support for the overall conclusions of the assessment. Department staff disagreed with our concern and told us that "there are no specific rules that detail what is to be included in a closure summary [in Trails]."

WHY DOES THIS FINDING MATTER?

We identified the following reasons why problems with assessments can adversely impact the children and families involved with the child welfare system:

COUNTIES MAY NOT APPROPRIATELY ASSESS CHILD SAFETY AND RISK OF FUTURE MALTREATMENT. An assessment determines how to approach the case (i.e., whether or not a child can remain safely at home and if services are needed). If an assessment is not done thoroughly, there is a risk that caseworkers could miss important details, which could lead the county to become unnecessarily involved in a family's life, or not become involved with a family that needs assistance. If an assessment is not thorough or completed in a timely manner, families and the community cannot be confident that the county did all it could to

ensure a child's safety. We found an example from our review of 40 sampled assessments, in which the county did not conduct a thorough assessment and the children involved in the assessment later suffered abuse. Specifically, the county had not conducted interviews with all individuals who might have had information about the family and allegations before deciding that further intervention was not needed and closing the assessment. During the 11 months following the referral in our sample, the county received seven more referrals involving the family, including one in which a child involved in the assessment we reviewed became a victim of sexual assault by a household member.

SERVICES MAY NOT BE APPROPRIATE TO ADDRESS THE NEEDS OF CHILDREN AND FAMILIES. Child welfare services that counties provide to families are determined based on the safety and risk assessment (Section 7.301.231, 12 C.C.R. 2509-4). Ensuring that these aspects of the assessment are completed accurately and thoroughly can directly impact what services counties provide to address the identified needs of children and families. Failure to effectively identify these needs can lead to inappropriate or ineffective services being provided. For example, in one case we reviewed, a county authorized mental health services for a family member even though the assessment and case-related documentation in Trails did not identify mental health as a safety or risk area for the family. At the same time, the county identified domestic violence as a safety concern for that family but did not authorize any services to address this issue.

INCONSISTENT OVERSIGHT BY DEPARTMENT STAFF. According to staff, the Department provides technical assistance when counties request guidance and relies on quality assurance reviews conducted by the Administrative Review Division to teach caseworkers how to conduct assessments. However, the lack of clear guidance can result in counties receiving inconsistent information from the Department. During our site visits, one county supervisor reported that different Administrative Review Division staff provide different advice about how assessments should be conducted and documented. Another county supervisor noted that she has observed inconsistencies between guidance

provided by Administrative Review Division and Division of Child Welfare staff.

INADEQUATE HISTORICAL RECORD OF A FAMILY'S INVOLVEMENT WITH THE CHILD WELFARE SYSTEM. In a video on the Department's website about careers in child welfare, a child welfare worker states, "If it's not documented, basically it didn't happen." A judge in the video says, "If the information is not in the case report, I don't know about it." These statements illustrate the importance of documenting all activities that county staff conduct during their involvement with families, because the quality and completeness of documentation could have implications for both the county department's and the judicial system's involvement with a family.

RECOMMENDATION 3

The Department of Human Services should ensure that children's safety and risk of abuse or neglect are assessed in a thorough and timely manner by:

A Establishing clearer written guidance on how caseworkers should identify child safety concerns in situations that may be difficult to assess, such as those involving substance use, and determine when overrides of risk assessment scores are appropriate. This should include working with the State Board of Human Services as needed.

B Establishing written expectations that counties implement controls to prevent the same person from both requesting and approving (i) an extension to complete an assessment or (ii) the closure of an assessment, or implement other compensating controls.

C Modifying Trails so that supervisors can clearly document their review and approval of the safety and risk assessment tools before approving closure of the overall assessment.

D Enforcing requirements for caseworkers to request, and supervisors to approve, extensions when assessments need to take longer than 30 days, and for supervisors to document their approval in Trails.

E Ensuring that all Department staff who interact with county departments of human/social services for the purposes of child welfare activities understand the requirements regarding documenting sufficient assessment details in Trails and consistently communicate the requirements to counties.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: MARCH 2015.

The Department agrees to establish clearer written guidance on how caseworkers will identify child safety concerns in situations that may be difficult to assess, such as those involving substance use, and determine when overrides of risk assessment scores are appropriate.

B DISAGREE.

While the Department recognizes that having a segregation of duties is an ideal practice, it is not practical in all counties in the State at this time. With a need for 30% more caseworkers in the State, as evidenced by the recent OSA Workload Study, it seems reasonable that county supervisors may assist their staff by going through the administrative process of seeking a case closure in Trails. This relief of documentation would free up caseworkers to be more available to children at risk of abuse and neglect. Further, there are several counties in the State that have only one person who serves as both the caseworker and supervisor in the county. Therefore, the Department disagrees with this recommendation because it will create a burden to county departments that may not have the staff resources sufficient to meet this obligation. Lastly, the Department already utilizes existing review and monitoring efforts in the Administrative Review Division (ARD) to ensure that children's safety and risk of abuse or neglect are assessed in a thorough and timely manner. ARD staff review the 10 large counties every 6 months and the Balance of State (BOS) counties every year. Between the ARD reviews and the OSA audit findings, no evidence has been presented that this practice has caused harm to any children.

AUDITOR'S ADDENDUM

Workload demands may be a contributing factor to certain problems

we found during this audit. However, the recommendation recognizes the limitations that some counties may encounter by suggesting compensating controls when needed. The audit work found that Trails records did not demonstrate that all required elements of the assessment process were completed adequately or on time. The Administrative Review Division reviews are after-the-fact and serve a different purpose than the supervisory approval required by rules.

C AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department agrees to modify Trails so that supervisors can clearly document their review and approval of the safety and risk assessment tools before approving closure of the overall assessment. While this functionality will exist in Trails by January 2015, counties will only have access to it once they have been properly trained. These trainings will occur throughout the first part of 2015.

D AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees with this recommendation. The Department will propose to the State Board of Human Services to remove the 30 day case closure requirement in rule in order to align with statute. If the State Board maintains the current rule then the Department agrees to enforce requirements for caseworkers to request and their supervisor to document approval of extensions when assessments need to take longer than 30 days.

E AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to ensure that all Department staff who interact with county departments for the purposes of child protective services understand the requirements regarding documenting assessment details in Trails and consistently communicate the requirements to counties.

CHAPTER 3

STATUTORY OVERSIGHT MECHANISMS

In the legislative declaration for Article 3 of the Colorado Children's Code, the General Assembly established that "the stability and preservation of the families of this state and the safety and protection of children are matters of statewide concern" [Section 19-3-100.5(1), C.R.S.]. The role of community agencies and oversight entities in helping to achieve child safety and provide accountability within the child welfare system has been well established through different provisions of state law. For example, the statute that created a multi-disciplinary team to

review serious incidents of child abuse or neglect states, "It is of the utmost importance and a community responsibility to mitigate the incidents of egregious abuse or neglect, near fatalities, or fatalities of children in the state due to abuse or neglect. Professionals from disparate disciplines share responsibilities for the safety and well-being of children as well as expertise that can promote that safety and well-being" [Section 26-1-139(1)(a), C.R.S.].

This chapter summarizes our review of several statutory oversight mechanisms for Colorado's child welfare system, as well as for government transparency and accountability in general. Our findings and recommendations focus on issues related to the Child Fatality Review Team, individuals who are required to report known or suspected child abuse or neglect, community oversight groups called Child Protection Teams, the Department of Human Services' (Department) interpretation of its authority, and the way in which the Department reports on its performance through the SMART Government Act.

CHILD FATALITY REVIEW TEAM

In 2011, the General Assembly codified the Department's Child Fatality Review Team (also referred to as "Team" in this chapter) in statute (Section 26-1-139, C.R.S.). The Team was established within the Department to conduct in-depth case reviews of substantiated child maltreatment fatalities, near fatalities, and egregious incidents when the child or family was previously involved with the child welfare system within 3 years prior to the incident. Designed by the General Assembly as a multidisciplinary team, the Child Fatality Review Team consists of up to 20 members including representatives of the Department, county departments of human/social services, the Department of Public Health and Environment, and others with backgrounds in various fields of practice, including child protection, physical medicine, mental health, public health, law, education, child

advocacy, and law enforcement. The Team meets on a monthly basis to review incidents.

Department staff play a key role in the Team's review process. Specifically, the Department identifies and notifies the Team of any policy violations made by the counties that handled the cases being reviewed; prepares a confidential, case-specific report containing details about the incident reviewed and any recommendations for practice improvements; provides the confidential report to the responsible counties and requests responses before finalizing the report; prepares a non-confidential version of the report and posts it on its website; and prepares an annual report summarizing the case-specific reviews.

Exhibit 3.1 shows the number of reviews conducted by the Child Fatality Review Team in Fiscal Years 2011 through 2013. The Team did not begin reviewing near fatalities and egregious incidents of abuse and neglect until Fiscal Year 2013, when statute changed to include reviews of these types of incidents.

EXHIBIT 3.1. CHILD FATALITIES, NEAR FATALITIES, AND EGREGIOUS INCIDENTS REVIEWED BY THE CHILD FATALITY REVIEW TEAM [1] FISCAL YEARS 2011 THROUGH 2013

INCIDENT TYPE [2]	2011	2012	2013	TOTAL
Child Fatalities	12	17	5	34
Child Near Fatalities [3]	0	0	6	6
Egregious Incidents of Child Abuse or Neglect [3]	0	0	7	7
TOTAL INCIDENTS	12	17	18	47

SOURCE: Office of the State Auditor's analysis of Child Fatality Review Team reports prepared for incidents occurring from Fiscal Years 2011 through FY 2013.

[1] House Bill 11-1181, which went into effect April 2011, codified and made modifications to the Department of Human Services' existing child fatality review process. The figures in this table represent incidents reviewed with case-specific reports prepared. These 47 reports represented 52 child victims.

[2] The incidents included in this table include substantiated child maltreatment fatalities, near fatalities, and egregious incidents for children and families who were previously involved with the child welfare system within 2 years of incidents occurring prior to May 2013, and within 3 years of incidents occurring in May 2013 and later.

[3] Senate Bill 12-033 added to the Child Fatality Review Team's purview the review of near fatal and egregious child abuse and neglect, effective April 2012.

Prior to January 2013, the Division of Child Welfare managed duties related to the Child Fatality Review Team. As of January 2013, the

Department transferred that responsibility to the Administrative Review Division, a move that staff reported would better align the oversight role of the Team with the Administrative Review Division's role as the Department's quality assurance reviewer. The Division of Child Welfare is still responsible for ensuring that the Team's recommendations made to the Division of Child Welfare and county departments are implemented. In 2013, Senate Bill 13-255 modified requirements for the Child Fatality Review Team and provided an additional full-time-equivalent (FTE) to the Department to support the Team.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to determine whether the Department has established processes for maximizing the value of reviews conducted by the Child Fatality Review Team. To accomplish this purpose, we (1) reviewed state statutes and rules related to the Child Fatality Review Team; (2) reviewed the Department's internal procedures and guidance related to the Team's activities; (3) interviewed Department staff involved with the administration of the Team, staff at 10 sampled counties, and six members of the Child Fatality Review Team; (4) reviewed and analyzed the 47 confidential case-specific reports issued by the Child Fatality Review Team for child fatalities, near fatalities, and egregious incidents that occurred from Fiscal Years 2011 through 2013; (5) reviewed the annual Child Maltreatment Fatality Review Report for Calendar Year 2013 published by the Department pursuant to Section 26-1-139(4)(i)(I), C.R.S.; (6) reviewed Trails records associated with two sampled incidents that occurred in Fiscal Year 2013, and compared the Trails records for those cases to information presented in the Child Fatality Review Team reports; (7) analyzed the creation of recommendations to address policy violations identified by the Team related to referrals and assessments in Fiscal Year 2013, including reviewing C-stat performance measure results and the results of quality assurance reviews conducted by the Administrative Review Division for counties

that had policy violations; and (8) reviewed reports and recommendations issued by the Office of Colorado's Child Protection Ombudsman.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED AND WHAT PROBLEMS DID THE AUDIT WORK FIND?

In general, we reviewed the Child Fatality Review Team process in light of its two primary statutory goals: (1) to understand the causes of child fatalities, near fatalities, and egregious incidents due to abuse or neglect and (2) to mitigate such incidents in the future. These goals are indicated in the legislative declaration for the statute that establishes the Child Fatality Review Team in law (Section 26-1-139, C.R.S.), which states:

> It is of the utmost importance…to mitigate the incidents of egregious abuse or neglect, near fatalities, or fatalities of children in the state due to abuse or neglect…. Reviews of [such] incidents can lead to a better understanding of the causes of such tragedies and, more importantly, methods of mitigating future incidents…. There is a need…for in-depth case reviews after an incident…to improve understanding of why the incidents…occur, to identify and understand where improvements can be made in the delivery of child welfare services, and to develop recommendations for mitigation of future incidents…. It is the intent of the general assembly to…promote an understanding of the causes of each incident…, identify systemic deficiencies in the delivery of services and supports to children and families, and recommend changes to help mitigate future incidents....

As discussed in the following sections, the problems we identified relate to functions carried out by Department staff in supporting the Child Fatality Review Team.

REVIEWING FOR ALL FACTORS CITED IN STATUTE

Sections 26-1-139(3) and (4), C.R.S., indicate that Child Fatality Review Team reviews should include: (1) assessing the records of each incident and interviewing individuals as deemed necessary; (2) gaining an understanding of the causes of, and identifying factors that may have contributed to, conditions leading to the incidents; (3) identifying gaps and deficiencies that may exist in the delivery of services to children or families; (4) identifying strengths and best practices in service delivery; and (5) reviewing the county department's compliance with statutes, rules, policies, and procedures that are directly related to the incident.

We found that the Child Fatality Review Team reports we reviewed reflected that most of these factors were addressed in the reviews. However, from our comparison of the Trails record with the Child Fatality Review Team's reports for two of the 18 incidents that occurred in Fiscal Year 2013, we found no evidence that the Department identified and communicated to the Team what appear to be violations of rules, or that the Team considered whether the violations may have contributed to the incidents in both reviews:

- **CASE FILE #1 (EGREGIOUS INCIDENT):** The case involved a 2-month-old child who suffered multiple fractures, bruising, and some bleeding due to abuse by a parent. Prior to the child's birth, other children had been removed from the home. Our review of the referral of the egregious incident, as well as seven other referrals the county received in the 1 year prior to the egregious incident, indicated that the Team may have missed instances in which the county did not follow rules. First, the county screened out three referrals on the family that appeared to meet statutory criteria to be screened in. Second, the county did not prepare a new safety assessment related to the newborn, although rules require a new assessment "whenever there is a significant change in family circumstances or situations that might pose a new or renewed threat to child safety." The Child Fatality Review Team

report does not indicate that the Department notified the Team that Trails documentation did not clearly demonstrate that screen-out decisions were consistent with rules, or that the county had failed to prepare a new assessment. Further, the report did not clearly indicate that Department staff brought these violations to the Team's attention, or that the Team assessed whether any of these violations represented deficiencies in the county's operations or could have been a contributing factor in the incident.

- **CASE FILE #2 (NEAR FATALITY):** The case involved a 2-year-old child who suffered a traumatic brain injury resulting from abuse perpetrated by a caregiver about 2 months after the county had determined the child was safe and closed a prior assessment. Based on our review, it is unclear that the caseworker took into account an interview with one of the child's caregivers, who later perpetrated near fatal abuse on the child, in assessing the child's safety. According to the Trails record, the caseworker had assessed the child's safety and requested approval to close the assessment a day before interviewing this caregiver. This request appears to violate rules [Section 7.202.52.E, 12 C.C.R. 2509.3] which state: "To assess for safety, interviews shall be conducted with all … caregivers …" The Child Fatality Review Team report does not note this possible lack of compliance with rules.

MAKING CASE-SPECIFIC RECOMMENDATIONS TO MITIGATE FUTURE INCIDENTS

The legislative declaration for the Child Fatality Review Team (Section 26-1-139, C.R.S.) indicates that part of the Team's responsibilities is to identify and understand where improvements can be made in the delivery of child welfare services and develop recommendations for mitigation of future incidents. We reviewed the 18 Team reports for Fiscal Year 2013 incidents, which were issued after the Child Fatality Review Team transitioned from the Division of Child Welfare to the Administrative Review Division, and found the Department did not consistently draft recommendations for all identified deficiencies. We

focused on deficiencies identified that related to two areas we looked at during our audit—referral screening and assessments. Our review found that 24 of the 70 deficiencies identified in the reports (34 percent) that related to screening and assessments were not developed into recommendations. Exhibit 3.2 provides more detail on the types of deficiencies, which appeared in 17 of the 18 reports we reviewed.

EXHIBIT 3.2. DEFICIENCIES IDENTIFIED IN CHILD FATALITY REVIEW TEAM REPORTS FOR INCIDENTS OCCURRING IN FISCAL YEAR 2013[1]

Type of Deficiency Identified in the Report	Number of Deficiencies Identified[2]	Number of Recommendations Made to Address the Deficiencies	Percent of Deficiencies Resulting in a Recommendation
Referral Screening			
Inappropriately screening in referral	1	0	0%
Inappropriately screening out referral	3	1	33%
Assessments			
Insufficient information to assess child safety	2	0	0%
Not completing a risk assessment	2	0	0%
Not seeing the child within the response time	14	6	43%
Not conducting all required interviews	5	2	40%
Errors in completing the safety assessment	11	8	73%
Not completing the assessment timely	17	14	82%
Errors in completing the risk assessment	15	15	100%
Total	70	46	66%

SOURCE: Office of the State Auditor's analysis of the 18 confidential Child Fatality Review Team reports issued for egregious, near fatal, and fatal incidents of abuse/neglect occurring in Fiscal Year 2013.

[1] Table includes only those deficiencies cited by the Child Fatality Review Team that were related to referrals and assessments.

[2] Count of deficiencies includes one count per county per report. Some reports include multiple citations for the same county for the same issue. For example, one report included five separate citations for one county completing five different risk assessments for the family inaccurately. Since these policy violations were cited for the same county, we counted these only once. Other reports include the same citation for different counties that handled different referrals/assessments for the family at different times. For example, five reports each cite two different counties for completing risk assessments inaccurately. Since these policy violations were cited for different counties, we counted each cited county separately.

There is no requirement in statute or rule that the Child Fatality Review Team reports include recommendations related to every deficiency identified, and there may be valid reasons for not making recommendations in some cases. However, as discussed later in this finding, we identified problems with the reasons the Department

provided for not making recommendations to address all of the deficiencies cited in Exhibit 3.2.

IMPLEMENTING CHILD FATALITY REVIEW TEAM RECOMMENDATIONS

Section 26-1-111(2)(b), C.R.S., requires the Department to "administer or supervise the establishment, extension, and strengthening of child welfare services." Further, the two primary goals of the Child Fatality Review Team process are: (1) to understand the causes of child fatalities, near fatalities, and egregious incidents due to abuse or neglect and (2) to mitigate such incidents in the future. A key step in strengthening the child welfare system and mitigating child fatalities, near fatalities, and egregious incidents due to abuse or neglect would be to implement recommendations from Team reviews in an expeditious manner. According to information provided by the Department, as of April 2014, three-quarters of the recommendations made by the Child Fatality Review Team for incidents occurring from Fiscal Years 2011 through 2013 had not been fully implemented, including 23 recommendations that had been made 2 or more years earlier, as shown in Exhibit 3.3.

EXHIBIT 3.3. IMPLEMENTATION STATUS
OF CHILD FATALITY REVIEW TEAM RECOMMENDATIONS
FISCAL YEARS 2011 THROUGH 2013[1] AS OF APRIL 2014

Agency	FY 2011		FY 2012		FY 2013		Total	
	Total Recs	# (%) Fully Implemented	Total Recs	# (%) Fully Implemented	Total Recs	# (%) Fully Implemented	Total Recs	# (%) Fully Implemented
Department of Human Services	1	0 (0%)	15	5 (33%)	42	5 (12%)	58	10 (17%)
County	13	13 (100%)	12	7 (58%)	30	0 (0%)	55	20 (36%)
No Agency Identified	1	0 (0%)	8	2 (25%)	6	0 (0%)	15	2 (13%)
Totals	15	13 (87%)	35	14 (40%)	78	5 (6%)	128	32 (25%)

SOURCE: Office of the State Auditor's analysis of confidential Child Fatality Review Team reports issued for child fatalities, near fatalities, and egregious incidents of abuse and neglect that occurred from Fiscal Years 2011 through 2013, and analysis of the Department of Human Services' tracker for recommendations included in Child Fatality Review Team reports.

[1] Includes recommendations provided in 37 of 44 reports issued before February 2014. The other seven reports issued during this time period included no recommendations. Analysis does not include 43 recommendations made in three reports for incidents occurring in Fiscal Year 2013, which were issued in February, March, and June 2014.

The Department provided us with an updated implementation status as of August 2014. In the 4 months between April and August 2014, the Department and counties fully implemented an additional 37 recommendations, leaving 59 recommendations still in process. The

Department reports that 18 of these remaining recommendations are not yet fully implemented because it is taking a thoughtful and deliberate approach to developing the new safety and risk assessments that were recommended.

MAKING ANNUAL POLICY RECOMMENDATIONS

Statute [Section 26-1-139(4)(i)(I), C.R.S.] requires the Child Fatality Review Team to issue an annual report that summarizes the reviews it conducted during the previous year and include "policy recommendations based on the collection of reviews" the Team conducted. These policy recommendations "must…follow up on specific system recommendations from prior reports that address the strengths and weaknesses of child protection systems in Colorado." Our review of the 2013 Child Maltreatment Fatality Review Report, the Department's annual report of child fatality, near fatality, and egregious incident reviews that was issued July 1, 2014, found that the Department could strengthen the development of policy recommendations from Child Fatality Review Team reviews in two ways. First, the Department could use the "collection of reviews" more comprehensively to identify gaps and deficiencies that occur across counties as a basis for policy recommendations. For example, Child Fatality Review Team reports summarized in the Calendar Year 2013 annual report cited 15 different counties for closing assessments later than the required time frame and five systemic gaps and deficiencies related to this issue, but the annual report does not distill these problems into any broad policy recommendations. Second, the Department could track when the same recommendations have been directed at a single county multiple times as a basis for policy recommendations.

WHY DID THE PROBLEMS OCCUR?

CHILD FATALITY REVIEW TEAM MEMBERS ARE NOT INVOLVED WITH IDENTIFYING VIOLATIONS. According to Department staff and Child

Fatality Review Team members we spoke to, the Child Fatality Review Team does not use its reviews to identify county violations of statute and rules. Instead, staff within the Administrative Review Division review the Trails record and other documentation for each incident to be reviewed by the Child Fatality Review Team, identify any violations, and draft recommendations for inclusion in the final Child Fatality Review Team reports. There is no requirement that Child Fatality Review Team members receive written information about the policy violations that Administrative Review Division staff have identified in their review of the Trails records, and these staff only provide their recommendations to Child Fatality Review Team members if the recommendations address gaps in the child welfare system. Excluding Child Fatality Review Team members from the process of identifying compliance problems and developing related recommendations would appear to inhibit the Team's ability to fulfill its fundamental responsibility to understand the reasons and contributing factors for the incidents it reviews, and make recommendations for improvement based on that understanding.

CHILD FATALITY REVIEW TEAM MEMBERS DO NOT ROUTINELY REVIEW DRAFT REPORTS. According to the Department and Child Fatality Review Team members we spoke to, several stakeholders review draft Child Fatality Review Team reports before they are issued publicly, including Department staff, county staff involved with the incidents, and representatives from the Office of the Attorney General. However, the Child Fatality Review Team members themselves do not routinely have the opportunity to review draft reports before their issuance. Although Senate Bill 13-255 increased from 30 to 55 calendar days the amount of time the Department has to complete the review and provide a draft report to the counties involved with the reviewed incident, the Department believes that the statutory time frames [Section 26-1-139(5)(c), C.R.S.], does not allow time for Team members to review reports before they are issued. Not providing ample opportunity for Team members to review and provide input on draft reports does not allow Team members to ensure that the reports completely and accurately reflect their reviews prior to the reports' being finalized.

RULES REGARDING THE CHILD FATALITY REVIEW PROCESS ARE LACKING. Statute [Section 26-1-139(7), C.R.S.] grants general authority for rules to promulgated related to implementing the Child Fatality Review Team process. Further, Section 26-1-139(4)(i), C.R.S., requires that the content of the annual child fatality and near fatality review report be determined in rules. The only existing rules related to the Child Fatality Review Team essentially restate the statutory purpose and do not include any further expectations or guidance about the Child Fatality Review Team's process, results, or reporting. One question the rules could address to strengthen the process is: What should be communicated in the annual report to policy makers? As discussed above, we found that the annual reports do not clearly use the results of case-specific reviews to identify broader, system-wide issues that may be important for policy makers to be aware of.

LACK OF GUIDANCE ON ISSUING RECOMMENDATIONS. According to information documented in Child Fatality Review Team reports, the primary reason the Team does not make a recommendation based on an identified deficiency is that performance data from other sources, such as Administrative Review Division reviews and C-Stat measures, indicate that a county has overall good performance in the area. Using a variety of data sources to evaluate the need for improvements makes sense, but we found problems with the reasons the Team chose not to make recommendations for all the reports we reviewed. Currently, there is no guidance for the Department to apply when using performance data and considering other information to decide whether recommendations are warranted. Specifically, we found inconsistencies in how performance data are used:

- **LIMITED DATA.** For 12 deficiencies in the reports we reviewed that did not lead to recommendations, the Department used either a narrow timeframe or a measure based on limited data to evaluate a county's performance and decide whether to issue a recommendation on a deficiency. For example, two reports issued due to near fatalities in 2013 cited the counties for failing to interview or observe the children within the assigned response times. In both reviews, the report noted that the deficiencies were "not reflective of an area needing

improvement," citing the counties' performance on the "Timeliness of Initial Response" C-Stat performance measure above the 90 percent benchmark. However, one report reflected a county's performance results for only two months (July 2012 and July 2013) in which the county met the benchmark. We looked at a longer time horizon, using the "Timeliness of Initial Response" measure on the Community Performance Center website. Although the Community Performance Center was not in place at the time these reports were issued in 2013, the data used for reporting "Timeliness of Initial Response" on that website are pulled from Trails and go back as far as January 2006; therefore, the information is reflective of the county's actual performance at the time the report was issued. Based on the Community Performance Center data, we found the county performed below the Department's 90 percent benchmark for seven of the eight quarters in the 2 years preceding the release of the Team's report. Therefore, the two months of C-Stat data cited in the Child Fatality Review Team report do not appear representative of the county's longer-term performance.

In another example, a December 2013 report issued in response to the near death of a child cited the county for failing to complete an assessment in a timely manner but concluded that the violation "does not reflect current systemic practice in [the county]," citing one month (August 2013) of C-Stat performance measure data showing the county closed assessments 93 percent of the time. The next month after the report was issued, in January 2014, Division of Child Welfare staff started discussions with the county about its poor performance in the timely closing of assessments. As of April 2014, the county was on a performance improvement plan because technical assistance and training provided to the county had "not yielded the needed improvement," and the county's performance over the preceding 6 months "ranged from 61.3 percent to 76 percent." These actions seem incongruent with the December 2013 conclusion that there were no "systemic" problems with the county's practice in the timely closing of assessments, suggesting the Department may have relied too heavily on one month's data in drawing its conclusion for the Child Fatality Review Team report.

- **SIMILAR BUT DIFFERENT DATA POINTS USED.** In five instances, the county's performance on a similar—but not exactly the same—issue was cited as a reason why a recommendation was not needed. For example, a January 2014 report issued in response to the death of a child cited the county for failing to interview or observe the child within the assigned response time. The Department did not make a recommendation, citing the county's performance in making "reasonable efforts" to make initial contact with children 92.5 percent of the time, based on results of a quality assurance review conducted by the Administrative Review Division. However, this same quality assurance review found that the county's performance in actually making timely contact with children (rather than just making an effort at contact) was 74 percent and 83 percent, respectively, in the two review periods preceding the release of the Team's report. The Department considers performance of 95 percent or higher as an area of strength and below 71 percent as an area needing improvement. These results were in the grey area between these two thresholds. In addition, the county performed below the 90 percent benchmark for the "Timeliness of Initial Response" Community Performance Center measure for five of the eight quarters in the 2 years preceding the release of the Team's report.

- **INCONSISTENT INTERPRETATION OF DATA.** In eight instances, performance data appear to have been applied inconsistently either in the same report for two different counties (four instances) or in two different reports for the same county (four instances). For example, one report issued in December 2013 in response to egregious abuse identified a policy violation for one county inaccurately completing a safety assessment. The report cited quality assurance review results from 2013 in which the county completed safety assessments accurately 85 percent of the time. These results were in the grey area of neither being an area of strength nor an area needing improvement, according to the Department's benchmarks for quality assurance reviews. The report recommended that the Division of Child Welfare provide training and technical assistance to the county in this area.

In January 2014, one month after the report was issued, the Team issued a report for a different incident of egregious abuse that again identified a policy violation for the same county inaccurately completing a safety assessment. This second report again used the 2013 quality assurance review performance results of 85 percent, but this time issued no recommendation. It is possible that the Team did not issue a recommendation in the second case because it had issued a recommendation on the issue to the county the month before. However, this was not provided as a rationale for why no recommendation was issued. In addition, we note that as of August 2014, according to the Department's recommendation tracking spreadsheet, the recommendation issued in December 2013 to provide the county with training and technical assistance was still "in progress."

- **USE OF PERFORMANCE DATA TO DISCOUNT PROBLEMS WITH KEY DECISIONS.** For four deficiencies identified, the Child Fatality Review Team report did not include recommendations for improving practice, even though the deficiency related to a key decision point in the child welfare process. In two instances, counties did not complete a risk assessment—one before a fatality occurred, and one for a sibling after an egregious incident. A main purpose of conducting risk assessments is to "determine risk for future abuse or neglect" (Section 7.202.54, 12 C.C.R. 2509-3). The Child Fatality Review Team report stated that since the Department's quality assurance reviews had not identified "a systemic practice issue" in the county, the report did not include a recommendation for improvement. For another two deficiencies, the Child Fatality Review Team reports did not include recommendations, even though the county had inappropriately screened out referrals. The decision not to make a recommendation in one of those reports was based on Department quality assurance performance data indicating the counties typically performed well in these areas. Failing to make recommendations after identifying policy violations undermines the statutory intent for the Child Fatality Review Team to "develop recommendations for mitigation of future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect" [Section 26-1-139(1)(c), C.R.S.].

We also found no guidance for deciding how efforts that are planned or already underway might address an area of deficiency. For example, an August 2013 report issued in response to the death of a child cited the county for, among other things, inaccuracies in completing safety assessments. The report made no recommendation to address inaccurate safety assessments because "planned changes in the safety and risk assessment will occur in 2014 that may impact accuracy of completion performance." According to documentation the Department provided us in September 2014, the Department plans to implement and train counties on the new assessment tools starting in December 2014.

REPORTS DO NOT TYPICALLY INCLUDE RESPONSES FOR IMPLEMENTING RECOMMENDATIONS. Of the 40 reports we reviewed containing recommendations, 37 reports (93 percent) lacked written responses from those responsible for implementing the recommendations. Department staff reported that it offers counties the opportunity to provide written responses in the final report, but counties often do not provide any written responses. The Department could emphasize the importance of counties' taking corrective steps to address deficiencies found by the Child Fatality Review Team process by urging counties to provide written responses that include their plans to address each recommendation and incorporating the responses and plans, or a statement from the county that it has no response, in the final reports. Section 26-1-139(5)(c), C.R.S., establishes a response process for the counties, requiring the Team to submit a draft of confidential, case-specific reports to county departments that have previously been involved with the child or family and allowing the county 30 calendar days to provide a written response "to be included in the final confidential, case-specific review report." According to statute, counties may also submit a statement in writing that they have no response to the recommendations.

Neither statute nor rules address the concept of the Child Fatality Review Team obtaining written responses from the Division of Child Welfare on state-level recommendations. According to the Department, one reason a response process is not needed for

recommendations directed to the Department is that a staff person from the Division of Child Welfare is a member of the Child Fatality Review Team. While we recognize that this provides the Division of Child Welfare an opportunity to have input into Child Fatality Review Team results, this does not serve the same purpose as requesting and reporting a written response and plan, which would permit Division management to address the recommended actions within the final report itself, including any disagreements with the recommendation.

For example, in December 2013, a Child Fatality Review Team report related to an egregious incident recommended that the Department address what the report said was a "systemic gap" related to counties obtaining information from parole officers about parolees involved in referrals. Department staff told us that the Division of Child Welfare, which was responsible for implementing the recommendation, disagreed with the recommendation because it was a single, isolated incident rather than a systemic problem. However, the Child Fatality Review Team report contained no response from the Division of Child Welfare and no indication that its viewpoint on the issue was considered in preparing the recommendation. Since statute [Section 26-1-139(4)(i), C.R.S.] requires that the content of Child Fatality Review Team reports be determined by rule, the Department could seek rule changes that include specifying that the Child Fatality Review Team reports include the responses of those responsible for implementing the recommendations.

WHY DOES THIS FINDING MATTER?

Ensuring that the Child Fatality Review Team reviews all factors related to an incident is critical to identifying when improvements in the system may be needed to better protect children. The effectiveness of Child Fatality Review Team reviews may not be maximized without processes and guidance to (1) consistently use performance and other data to translate deficiencies identified during Child Fatality Review Team reviews into recommendations for action, (2) identify and report systemic deficiencies that surface from the reviews, and (3) obtain and

report responses and action plans related to Child Fatality Review Team recommendations.

If recommendations of the Child Fatality Review Team are not implemented in a timely manner, the extensive effort that goes into reviewing fatalities, near fatalities, and egregious incidents is not maximized to deliver results the General Assembly intended for improving the child welfare system. Not implementing Child Fatality Review Team recommendations in a comprehensive or timely manner undermines the ability to resolve gaps or deficiencies in the delivery of services and help mitigate future incidents.

RECOMMENDATION 4

The Department of Human Services (Department) should improve its Child Fatality Review Team process by:

A Implementing a process to (i) provide Child Fatality Review Team members written information on the county violations identified by Department staff so that members can more easily participate in the process of identifying violations of statutes and rules and (ii) allow members to review and provide feedback on all reports before they are finalized.

B Working with the State Board of Human Services to promulgate rules in accordance with Sections 26-1-139(4)(i) and (7), C.R.S., to provide additional guidance on the Child Fatality Review Team process, including (i) what factors should be covered in reviews to comply with statute, (ii) what information should be included in annual reports to policy makers, and (iii) requiring the Child Fatality Review Team to request responses for implementing recommendations and include the responses in the final review reports.

C Implementing written guidance to use performance data and other information in a consistent manner when determining whether a recommendation should be made. This should include (i) using performance data that reflect a consistent and appropriately broad time horizon, are comprehensive, and are applied consistently across reports; (ii) establishing a standard that the performance data must show performance at or above the Department's benchmarks for a pre-determined period; and (iii) establishing when it is appropriate to rely on current or planned efforts to address a deficiency.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A PARTIALLY AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department supports virtually any process that would enable the volunteer Child Fatality Review Team (CFRT) members to more easily participate. However, the Department can only partially agree with this recommendation because it would require additional resources and statutory changes to either ease the timeframes, create more than one CFRT team and secure additional staff to support those teams, or have fewer cases to review based upon changing the criteria of who or what is reviewed. Part (ii) would require statutory changes either allowing more time after the county has reviewed the report and responded and before it is released to the public, or additional CFRT teams. Additional teams would allow the volunteer CFRT members more time between meetings to read and provide feedback on draft reports. Without this additional time, it is unlikely that CFRT members would have the time necessary to both review files for new incidents while also reviewing draft reports.

AUDITOR'S ADDENDUM

As noted in the audit, the Department received a longer time frame for Child Fatality Review Team reviews in 2013. Senate Bill 13-255 increased the number of days from 30 to 55 to complete the review of cases and provide a case-specific draft summary to the counties involved in the incident.

B PARTIALLY AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to work with the State Board of Human Services to promulgate rules in accordance with Sections 26-1-139(4)(i) and (7), C.R.S., to provide additional guidance on the Child Fatality Review Team (CFRT) process, including what factors will be covered in reviews to comply with statute, what information will be

included in annual reports to policy makers, and requesting and including responses in the final review reports. However, the Department believes that the implementation of the recommendations should be monitored at the local level by the Division of Child Welfare, not the CFRT.

AUDITOR'S ADDENDUM

The recommendation does not ask the Department to monitor implementation of Child Fatality Review Team recommendations, only to request responses and include them in the final review reports to improve transparency regarding whether counties intend to make improvements as recommended by the Child Fatality Review Team.

C AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to implement written guidance to use performance data and other information in a consistent manner when determining whether a recommendation should be made. This will include using performance data that reflect a consistent and appropriately broad time horizon, are comprehensive, and are applied consistently across reports; establishing a standard that the performance data must show performance at or above the Department's benchmarks for a pre-determined period; and establishing when it is appropriate to rely on current or planned efforts to address a deficiency. The Department will take the written guidance to the Child Fatality Review Team (CFRT) members and seek approval of the methodology as all findings and recommendations are the exclusive responsibility of the CFRT.

REPORTING OF EGREGIOUS INCIDENTS

The Department's Child Fatality Review Team has historically reviewed only child fatalities caused by abuse or neglect. In 2012, the General Assembly passed Senate Bill 12-033, which required the Team to begin also reviewing child near fatalities and egregious incidents of child abuse and neglect, defined by Section 26-1-139(2), C.R.S., as the following:

- **INCIDENT OF EGREGIOUS ABUSE OR NEGLECT** is an incident of suspected abuse or neglect involving significant violence, torture, use of cruel restraints, or other similar, aggravated circumstances that may be further defined in rules.

- **NEAR FATALITY** is a case in which a physician determines that a child is in serious, critical, or life-threatening condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment.

The change in statute to require the review and public disclosure of findings related to near fatalities brought Colorado into compliance with CAPTA, which requires any state receiving CAPTA funds to adopt "provisions which allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality" [42 USC 5106(a)(b)(2)(B)(x)]. CAPTA does not require states to review or publicly disclose the findings of "egregious" incidents.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to determine whether incidents reviewed by the Child Fatality Review Team were reported properly by county departments of human/social services. To accomplish this

objective we (1) reviewed requirements under CAPTA as well as state statutes and rules; (2) interviewed Department staff involved with the administration of the Child Fatality Review Team, six current members of the Team, and staff from a sample of 10 county departments related to their reporting of fatalities, near fatalities, and egregious incidents and their involvement with the Child Fatality Review Team process; and (3) reviewed and analyzed the 18 confidential case-specific reports issued by the Child Fatality Review Team for child fatalities, near fatalities, and egregious incidents that occurred in Fiscal Year 2013.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Section 26-1-139(5)(a), C.R.S., requires counties to report suspicious incidents of fatal, near fatal, and egregious abuse to the Department within 24 hours of becoming aware of the incident. We evaluated timeliness of county reporting by comparing the referral date with the date the county notified the Department of the incident, because the Child Fatality Review Team reports we reviewed identified violations using this method. After making the report to the Department, the county continues conducting its investigation to determine whether the suspicious incident was caused by founded abuse or neglect. If the county determines that abuse or neglect was founded, and if the Department determines that the family was involved with the child welfare system in the prior 3 years, the Child Fatality Review Team reviews the incident.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

We reviewed the timeliness of counties' reports to the Department for the 18 Fiscal Year 2013 incidents of egregious, near fatal, and fatal abuse or neglect that were reviewed by the Child Fatality Review Team. Although we did not identify significant problems with counties

reporting near fatal or fatal incidents, we found that counties were often not timely or sometimes failed in reporting egregious incidents to the Department. Similarly, of the seven egregious incidents occurring in Fiscal Year 2013 that were reviewed by the Child Fatality Review Team, only one incident (14 percent) was reported to the Department in a timely manner. In the other six cases, the Child Fatality Review Team reports cited counties for untimely reporting of the incidents. One incident was not identified by the county at all, but rather was identified by Department staff. Specifically:

- In one case (14 percent), the county department did not determine the incident to be egregious. About 4 months after the county received the referral, an Administrative Review Division staff member conducting a quality assurance review for the family's ongoing out-of-home placement case identified the case as egregious.

- In five cases (71 percent), counties reported the incidents to the Department more than 24 hours after receiving the referrals. The amount of time counties took to report the incidents ranged from 2 days to nearly 1 month after receiving the referrals.

WHY DID THE PROBLEM OCCUR?

There may be several reasons why counties do not always report an egregious incident within 24 hours, as required by statute. According to the Department, one reason is that such incidents occur rarely so county staff may not remember the reporting requirement. In addition, based on our review of information cited in the case-specific reports for these incidents, and interviews with county staff, it can be difficult to determine if an incident is egregious within 24 hours of accepting the referral, since investigation of the referral is often needed to determine if torture or cruel restraints were used or other aggravated circumstances existed. Understanding these challenges, counties also indicated that additional guidance in identifying which incidents meet the definition of egregious could help them identify and report such incidents in a timely and consistent manner. For example, staff from two of the county departments we visited indicated the need for

further definition, pointing out that what is egregious to one person may not be egregious to another, making the identification of such incidents challenging. Department staff also stated that they have received feedback from counties that further definition is needed and began working on options for further defining "egregious" in 2014.

Although statute [Section 26-1-139(2), C.R.S.] allows "egregious incident" to be further defined in rules, current rules (Section 7.202.75, 12 C.C.R. 2509-3) do not expand on the definition in statute, which is "an incident of suspected abuse or neglect involving significant violence, torture, use of cruel restraints, or other similar, aggravated circumstances." One option would be for the Department to assess the egregious incidents reviewed to date and determine if there are common characteristics that could be (1) incorporated into a clearer definition that could also help counties make a determination more quickly and (2) developed into vignettes for counties to reference when assessing whether a situation fits similar fact patterns to incidents the Child Fatality Review Team has reviewed. For example, in the case of the egregious incident identified and reported by the Administrative Review Division staff person rather than the county, the referral stated that the child had swelling and a skull fracture on the side of the head. Guidance could be provided to counties via rules or vignettes to help counties determine whether "significant violence" or "aggravated circumstances" are present that could make an incident of physical abuse rise to the level of being "egregious." Further, the Department has not provided general training to the counties on how to determine whether an incident meets the definition of "egregious."

WHY DOES THIS FINDING MATTER?

One of the primary goals of the Child Fatality Review Team is to "identify and understand where improvements can be made in the delivery of child welfare services and to develop recommendations for mitigation of future incidents." The proper reporting of egregious incidents and near fatalities ensures that the Child Fatality Review Team is given the opportunity to review these incidents and to identify

and recommend ways that the child welfare system can be improved to minimize and prevent future incidents of egregious abuse and neglect and near fatalities. Timely reporting of incidents requiring review by the Child Fatality Review Team is important for identifying needed improvements to the child welfare system as expeditiously as possible.

RECOMMENDATION 5

The Department of Human Services should improve county reporting of egregious incidents of abuse and neglect by:

A Working with the State Board of Human Services to further define in rules, or implementing through other formal mechanisms, egregious incidents of child abuse and neglect that require review.

B Providing training and guidance to county departments of human/social services on the identification and reporting of egregious incidents.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to further define egregious incidents of child abuse and neglect that require review. Egregious incidents were created in statute in 2012, based upon a recommendation by this administration. Colorado joins Wisconsin as the only two states in the country that require review and reporting of egregious incidents. Given the lack of national precedence, Colorado moved forward with implementation with this law while gathering experience that will now go into policy guidance. This has been our intended approach since statute was enacted. The Department is conducting a policy and research analysis to examine the components of the existing statutory definition within the context of child welfare. This effort will result in written policy guidance that can be updated and refined through use with the Child Fatality Review Team and counties.

B AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department agrees to provide training and guidance to county departments on the identification and reporting of egregious incidents. The guidance will be accomplished as described in part "a" above, and, was part of the intended approach since statute was enacted. Training related to the reporting of egregious incidents of abuse and neglect is already provided in Modules 2 and 3 of the Child Welfare Training Academy. This training will be enhanced based on this analysis and included in the new training contract with the Kempe Center by July 2015. It is important to note that while training and guidance will help with recognition of egregious incidents, we are not convinced that it is sufficient to resolve the problems of timeliness of egregious incidents as identified in the audit.

SHARING INFORMATION WITH MANDATORY REPORTERS

Receiving reports of suspected child abuse or neglect is the first step in the county intake process. While statute [Section 19-3-304(3), C.R.S.] states that any person can report known or suspected child abuse or neglect, statute [Section 19-3-304(2), C.R.S.,] also **REQUIRES** individuals in certain professions to report known or suspected abuse or neglect to the county department of human/social services, the local law enforcement agency, or the statewide child abuse reporting hotline that will be implemented in January 2015. Individuals who are required to report based on their profession are referred to as "mandatory reporters." Colorado has 37 categories of mandatory reporters, including teachers, law enforcement, physicians, social workers, youth sports workers, and emergency medical service providers.

During Fiscal Year 2013, counties received about 45,200 out of about 70,000 total referrals (64 percent) from mandatory reporters. Exhibit 3.4 shows the most common types of mandatory reporters who reported known or suspected child abuse or neglect during Fiscal Year 2013.

EXHIBIT 3.4. REFERRALS FROM MANDATORY REPORTERS[1] FISCAL YEAR 2013

Reporter Category [2]	Types of Reporters	Number of Referrals	Percent of Total Referrals
School Staff	Teachers, Principals, Guidance Counselors, Other School Staff	14,100	20%
Law Enforcement	Law Enforcement Officials	11,500	16%
Counselors	Counselors, Therapists, Mental Health Providers	7,400	10%
Social Workers	School, County, or Hospital	6,300	9%
Medical Personnel	Nurses, Physicians, Hospital Staff	4,600	7%
Other	Daycare Providers, Residential/Institutional Facility Staff, Clergy, Coroners	1,300	2%
Total	All Mandatory Reporter Types	45,200	100%

Source: Office of the State Auditor's analysis of Department of Human Services Trails data for Fiscal Year 2013.

[1]Total includes referrals related to children in need of protection. Total does not include referrals related to youth in conflict. In addition, total includes referrals of intrafamilial abuse or neglect and referrals of abuse or neglect that were not categorized by the county. Referrals of third-party or institutional abuse or neglect are not included.

[2] Section 19-3-304(2), C.R.S., designates employees within 37 different professions as mandatory reporters. The categories listed in this table reflect the mandatory reporters who reported child abuse or neglect during Fiscal Year 2013. Some mandatory reporter categories were not documented in Trails as having reported child abuse or neglect during Fiscal Year 2013.

Mandatory reporters are required by law to make timely reports of known or suspected abuse or neglect, and they are afforded some legal protections related to their reports. Below are some of the main requirements and protections afforded to mandatory reporters.

- Mandatory reporters shall immediately, upon receiving information about known or suspected child abuse or neglect, make a report [Section 19-3-304(1)(a) C.R.S.]. A mandatory reporter who willfully fails to make a report commits a class three misdemeanor and is liable for damages [Section 19-3-304(4) C.R.S.].

- Privileged information relationships are waived for the purposes of reporting known or suspected abuse or neglect (Section 19-3-311 C.R.S.). For example, if a client were to share knowledge of abuse or neglect of a child with his or her therapist, the therapist would not be

able to keep that information confidential since therapists are mandatory reporters under statute.

Counties are required to provide certain mandatory reporters who are involved in the ongoing care of the child with information the reporter has a need to know in order to fulfill his or her professional and official role in maintaining the child's safety [Section 19-1-307(2)(e.5), C.R.S.]. This requirement was added to statute after the Child Welfare Action Committee, which had been formed by Governor Ritter, provided recommendations on how to improve the child welfare system. The Child Welfare Action Committee reported that allowing mandatory reporters to receive feedback would increase child safety by (1) strengthening the partnership between the county departments of human/social services and the mandatory reporters and (2) enhancing the transparency and accountability of the child welfare system.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to ensure that the State and counties have adequate processes for following up with mandatory reporters who are entitled to have information about the cases of known or suspected abuse or neglect that they have reported to the county. To accomplish this objective, we (1) reviewed requirements under CAPTA as well as state statutes, rules, and other Department-issued guidance; (2) conducted interviews with Department staff, staff at 10 sampled counties, and stakeholders in the law enforcement community; (3) reviewed recommendations made by the Child Welfare Action Committee and the Office of Colorado's Child Protection Ombudsman; (4) reviewed whether notification to mandatory reporters occurred for a sample of 60 referrals received in Fiscal Year 2013; (5) analyzed Trails data for all referrals received in Fiscal Years 2012 and 2013; (6) reviewed the Department's log of technical assistance provided to counties from February 2014 through April 2014; (7) reviewed training materials related to mandatory

reporters provided by Department staff from October 2013 through October 2014; and (8) reviewed the tools used by the Administrative Review Division and the Child Fatality Review Team in assessing compliance with statutes and rules.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Requirements under CAPTA, as well as state statute, generally require child abuse and neglect records to be confidential to protect the rights of children and their parents [42 USC Sec. 5106a(b)(2)(B)(viii) and Section 19-1-307, C.R.S.]. However, Section 19-1-307(2)(e.5)(I), C.R.S., requires counties to provide certain information, such as whether a referral was screened in, to specified mandatory reporters who are involved in the ongoing care of a child. Statute specifies 15 types of mandatory reporters who shall be given access to child abuse or neglect records and reports, if those records and reports contain information the reporter needs to know to fulfill his or her professional and official role in maintaining the child's safety. Examples of reporters eligible to access such records and reports include mental health professionals, physicians, and school officials [Section 19-1-307(2)(e.5)(I), C.R.S.]. To ensure that mandatory reporters entitled to access child abuse and neglect records and reports get the information they need, Section 19-1-307(2)(e.5), C.R.S., requires counties to:

- Request written affirmation from a mandatory reporter, if that reporter is one of the 15 types outlined in statute, stating that the reporter "continues to be officially and professionally involved in the ongoing care of the child who was the subject of the report" and describing the nature of the involvement, "unless the county department has actual knowledge that the mandatory reporter continues to be officially and professionally involved in the ongoing care of the child who was the subject of the report."

- Within 30 days of a referral, provide the following information to the mandatory reporter: (1) whether the referral was accepted for

assessment, (2) whether the referral resulted in services related to the safety of the child, (3) contact information for the caseworker responsible for investigating the referral, and (4) notice that the reporter may request updated information and the procedure for obtaining updated information.

The Department issued an agency letter in May 2011 [CW 11-16-P] directing counties to document their notification of mandatory reporters in Trails. Specifically, Trails has a check box for counties to indicate whether the mandatory reporter was notified and a text box for descriptive information, such as whether the notification was provided by phone or letter, and the date and time.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

Overall, we found that counties are not complying with requirements to provide certain mandatory reporters with information about cases they reported to the county.

First, our review of Trails data for all referrals received by counties in Fiscal Years 2012 and 2013 indicates that few mandatory reporters are notified of case-specific information after the county makes a referral screening decision. Exhibit 3.5 summarizes county notification of mandatory reporters in Fiscal Years 2012 and 2013.

EXHIBIT 3.5. MANDATORY REPORTER NOTIFICATIONS FISCAL YEARS 2012 AND 2013

	Fiscal Year 2012		Fiscal Year 2013	
	Number of Reporters	Percentage of Total	Number of Reporters	Percentage of Total
Notification Documented in Trails	1,100	3%	2,000	6%
Notification **NOT** Documented in Trails	30,500	97%	31,600	94%
Totals[1]	31,600	100%	33,600	100%

SOURCE: Office of the State Auditor's analysis of Fiscal Years 2012 and 2013 Trails data provided by the Department of Human Services.

[1] Includes referrals made by the 15 types of mandatory reporters outlined in statute as being eligible to receive follow up information from counties [Section 19-1-307(2)(e.5)(I), C.R.S.]. Therefore, the totals reflected in this table do not equal the total number of referrals that appear elsewhere in this report.

The 2,000 notifications documented for Fiscal Year 2013 represent notifications made by 19 counties; the remaining 45 counties documented no notification for any referrals they received from mandatory reporters in Fiscal Year 2013.

Our review of 60 case files from Fiscal Year 2013 also showed higher compliance with the requirement to notify certain mandatory reporters of case-specific information, but still illustrates weaknesses in the process. Our sample included 31 referrals from the 15 mandatory reporter types that may be eligible to be given access to child abuse or neglect records and reports. Based on our review of Trails, nine of the 31 mandatory reporters were notified of case-specific information. In one referral, the notification was documented in the designated field in Trails, and in eight referrals the notification was documented elsewhere in Trails, such as a narrative field.

For 11 referrals, the county reported that it notified the reporter of the results of the referral but had not documented the notification in Trails. For six referrals, the county reported that there was no indication that the mandatory reporter had an ongoing and professional relationship with the child, although it was unclear whether these counties had requested any kind of written affirmation from the reporter to confirm their understanding. For the remaining

five referrals, the county and the Department agreed that no reporter notification occurred and it may have been required.

The Office of Colorado's Child Protection Ombudsman's 2013 annual report also indicates that mandatory reporters are not always receiving information from the counties about their referrals. The report noted that the Ombudsman received "numerous" complaints from mandatory reporters who did not know how or if their reports were ever acted upon, and sometimes assumed that their reports were not investigated.

WHY DID THE PROBLEM OCCUR?

INSUFFICIENT STATE BOARD RULES. Two sections of statute direct the State Board to promulgate rules relevant to the requirement for providing certain mandatory reporters with information about cases they have reported to the county. First, Section 19-1-307(2)(e.5)(V), C.R.S., requires the State Board to promulgate "any rules necessary for the implementation" of this specific requirement. Second, Section 19-3-313.5(4), C.R.S., more generally requires the State Board to establish guidelines for the release of information related to child welfare records to ensure compliance with state and federal confidentiality requirements, including what information is to be made available. We identified the following areas where State Board rules could be enhanced and modified to better implement mandatory reporter notification requirements:

- **NO GUIDANCE ADDRESSING HOW TO ASSESS WHETHER A MANDATORY REPORTER IS ENTITLED TO RECEIVE INFORMATION.** Statute requires counties to request written affirmation, or have actual knowledge, that a mandatory reporter continues to be officially and professionally involved in the ongoing care of the child [Section 19-1-307(2)(e.5), C.R.S.]. However, rules do not define what constitutes a county's "actual knowledge" of a mandatory reporter's continued involvement with a child and how to document that knowledge. In addition, language in the Department's agency letter [CW 11-16-P] seems to conflict with statutory requirements. Specifically, the letter indicates

counties "may" ask for an affirmation, but not that they must do so if they do not have actual knowledge of the reporter's continued involvement with the child, as required by statute.

- **INCOMPLETE GUIDANCE RELATING TO WHAT INFORMATION COUNTIES CAN PROVIDE.** Currently, rules indicate that counties "shall notify" mandatory reporters of the specific items listed in statute, including whether the referral was accepted, whether services were provided, and how the reporter can request updated information (Section 7.202.4.D, 12 C.C.R. 2509-3). However, rules do not provide any guidance on whether additional information may be needed by a mandatory reporter to fulfill his or her professional and official role in maintaining the child's safety. For example, one county reported that it has stopped providing any information to mandatory reporters because of confusion about the type and amount of information to provide. Several other counties cited confusion about whether they could disclose the reason a referral was screened out. We reviewed the Department's log of technical assistance provided to counties from February through April 2014 and training materials related to mandatory reporters and found no evidence that Department staff have addressed this issue with counties.

- **CONFLICTING GUIDANCE.** Rules require counties to notify any reporting party when that party's referral was screened out, and the reason it was screened out (Section 7.202.4.C, 12 C.C.R. 2509-3). This requirement appears to contradict statutory requirements for only providing certain mandatory reporters under certain circumstances information they need to know to fulfill their professional responsibilities for maintaining a child's safety. The Department's training provided to caseworkers is consistent with this rule, as is the Trails User Guide. Both indicate that reporters, not limited to certain mandatory reporters, can ask for information about the disposition of their report. According to the Department, rules being proposed to the State Board in October 2014 will address this conflict.

LACK OF OVERSIGHT OF COUNTIES' COMPLIANCE. The Department does not monitor counties' compliance with requirements for providing certain mandatory reporters with information about the cases they have reported. First, the Department does not review Trails to assess whether counties are documenting notification of mandatory reporters, which would be a simple review since there is currently a check box to document notification. To do a thorough review using Trails, the Department may need to modify Trails to capture (1) the county's assessment of whether the mandatory reporter has ongoing involvement with the child and (2) the specific type of involvement reported. Currently, Trails has a text box used for descriptive information but does not have a field that is designated to document the county's evaluation of whether a mandatory reporter should receive notification.

In addition, Trails currently includes 47 general categories of reporters which do not match up with the 37 types of reporters identified in statute. Some reporter types can be classified under multiple reporter categories, which makes it difficult to track the frequency of referrals from certain reporter types. For example, a doctor could potentially be categorized under any of the following reporter categories in Trails, based on information provided by the Department: "Alcohol and Drug Agency," "Hospital Staff," "Institutional Staff," "Medical Personnel," "Physician," "Private Agency," "Public Social Agency," or "Residential Facility Staff." The array of options makes it difficult to track the frequency of referrals from specific categories of mandatory reporters specified in statute.

To make a review of Trails an effective monitoring tool, the Department would also need to enforce rules (Section 5.700, 11 C.C.R. 2508-1) that require counties to use Trails to record their activities and the Department's agency letter that specifically directs counties to document their notification of mandatory reporters in Trails. For 11 referrals from our file review, counties reported that they provided information to the mandatory reporters but did not populate the appropriate fields in Trails, and instead said they maintained relevant documentation outside of Trails. The Department

told us this practice was acceptable and reported it cannot hold counties accountable for complying with Department guides or letters, only State Board rules and statutes. As we were completing the audit, the Department reported that it had received legal guidance that it can develop Department policies to guide county practice and hold counties accountable for following such policies. Administrative Review Division staff do not look at compliance with these requirements in any of their reviews.

WHY DOES THIS FINDING MATTER?

Mandatory reporters play an important role in keeping children safe and in helping to ensure that the child welfare system is functioning well; they are uniquely positioned, by virtue of their professional role in working with children, to be an extra set of eyes and ears on at-risk children. They are able to best carry out this role if they are kept informed by counties of how their reports of abuse and neglect are being handled by the child welfare system. According to the Child Welfare Action Committee's report issued in September 2009, mandatory reporters believe that having information from the county about how the case is being handled can help them provide "useful service to the child and the family" and "contribute to the child's protection." In addition, follow ups to reporters act as a secondary layer of oversight for the county to help ensure that actual cases of abuse and neglect are investigated. The Child Welfare Action Committee anticipated that an expected outcome of the mandatory reporter notification legislation would be that mandatory reporters would have the opportunity to "further elaborate on the information provided" in the event that their initial report of suspected abuse or neglect was screened out by the county.

Without clear guidance regarding the type of information counties can share with the mandatory reporters specified in statute, there is also a risk that counties will provide information they should not to individuals who do not have authority to access the information. For example, one county told us their staff give every reporter a referral

reference number and let the reporter decide if they want to follow up on information about the disposition of their referral.

RECOMMENDATION 6

The Department of Human Services should ensure compliance with the requirements for providing certain mandatory reporters with information about cases they have reported to the county by:

A Working with the State Board of Human Services to promulgate in rule, or implementing through other formal mechanisms, guidance for counties regarding (i) what it means for a county to have "actual knowledge" that mandatory reporters continue to be officially and professionally involved with the child for whom they made a report of suspected abuse or neglect and (ii) the type of information a county may provide mandatory reporters to allow them to fulfill their professional and official roles in maintaining a child's safety.

B Working with the State Board of Human Services to modify the rule that requires counties to inform all reporting parties when their referrals are screened out (Section 7.202.4.C, 12 C.C.R. 2509-3) so that rules are consistent with Section 19-1-307(2)(e.5), C.R.S.

C Expanding the reviews conducted by the Administrative Review Division to include assessments of whether the county complied with requirements to notify mandatory reporters of case information when required.

D Pursuing a modification of Trails to capture data needed to facilitate monitoring of counties' compliance with notifying mandatory reporters of case information when required and enforcing requirements for counties to document their compliance in Trails.

E Implementing a process to regularly analyze Trails data and the results of reviews conducted by the Administrative Review Division to monitor counties' compliance with notification requirements and provide technical assistance to counties based on the analysis.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to work with the State Board of Human Services to promulgate in rule, or implement through other formal mechanisms, guidance for counties regarding what it means for a county to have "actual knowledge" that mandatory reporters continue to be officially and professionally involved with the child for whom they made a report of suspected abuse or neglect, and the type of information a county may provide mandatory reporters to allow them to fulfill their professional and official roles in maintaining a child's safety.

B AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to work with the State Board of Human Services to modify the rule that requires counties to inform all reporting parties when their referrals are screened out (Section 7.202.4.C, 12 C.C.R. 2509-3) so that rules are consistent with Section 19-1-307(2)(e.5), C.R.S.

C AGREE. IMPLEMENTATION DATE: APRIL 2016.

The Department agrees to expand the reviews conducted by the Administrative Review Division (ARD) to include assessments of whether the county complied with requirements to notify mandatory reporters of case information when required. The Department agrees to monitor the limited information (checkbox) currently available in Trails. The Department would like to enhance the reviews to be more meaningful and will work with its county partners to do so. This would require resources for the modification of Trails as the system does not currently provide the ability for workers to document all of the mandated reporter notification requirements. If Trails is modified,

ARD will convene a workgroup to align the review tool to the changes in Trails for notification to mandatory reporters

D AGREE. IMPLEMENTATION DATE: JANUARY 2016.

The Department recognizes the importance of notifying mandatory reporters with information about cases they have reported to the county department. While the Department agrees to pursue this modification, it is contingent upon additional resources to build out Trails, as well as to collaborate with our county partners to pursue the appropriate changes.

E AGREE. IMPLEMENTATION DATE: JULY 2016.

The Department recognizes the importance of implementing a process to regularly analyze Trails data and the results of reviews conducted by the Administrative Review Division to monitor counties' compliance with notification requirements and provide technical assistance to counties based on the analysis. The Department agrees to monitor the limited information (checkbox) currently available in Trails.

CHILD PROTECTION TEAMS

As part of the Child Protection Act of 1975, the General Assembly put into place a community oversight mechanism for the child welfare system called Child Protection Teams. A Child Protection Team is a local, multidisciplinary advisory team consisting, where possible, of representatives of local law enforcement, juvenile court, the county department of human/social services, a mental health clinic, a public health agency, a public school district, an attorney, a physician, and members of the lay community, at least one of whom serves as a foster parent. Any county with 50 or more referrals of suspected or known child abuse annually is required to convene a Child Protection Team [Section 19-3-308(6)(a), C.R.S.]. In Fiscal Year 2013, a total of 52 of the State's 64 counties received 50 or more referrals of suspected or known child abuse or neglect and, therefore, were required by statute to have a Child Protection Team.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to assess whether the Department has adequate processes for ensuring that counties comply with statutory requirements for using Child Protection Teams. To accomplish this objective, we (1) reviewed statutes and rules; (2) conducted interviews with Department staff, and staff at 10 sampled counties; (3) reviewed the websites of 10 sampled counties and the Department's website; (4) reviewed recommendations made by the Office of Colorado's Child Protection Ombudsman; (5) reviewed a sample of 40 screened-in referrals received in Fiscal Year 2013; and (6) analyzed Trails data for all referrals received in Fiscal Year 2013.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

Statute establishes Child Protection Teams to review cases of child abuse and neglect and to provide public feedback for improvements to the system.

- **Child Protection Teams review each child abuse and neglect case and make recommendations for further action.** A child Protection Team reviews the county's "investigatory reports" of child abuse or neglect cases, including "diagnostic, prognostic, and treatment services being offered to the family in connection with the reported abuse" [Section 19-3-308(6)(b), C.R.S.], and "make[s] a report of its recommendations to the county department with suggestions for further action or stating that the team has no recommendations or suggestions" [Section 19-3-308(6)(i), C.R.S.]. The Department has interpreted Child Protection Team requirements to apply to screened-in referrals that are assigned for assessment.

- **Child Protection Teams provide public feedback on the child welfare system.** In the declaration for the Child Protection Act (Section 19-3-302, C.R.S.), the General Assembly declared its intent for public discussion of counties' responses to reports of abuse and neglect so that the public and the General Assembly may be better informed concerning the operation and administration of the child welfare system. Specifically, the Child Protection Team publicly states whether the county's response to each report was (1) timely, (2) adequate, and (3) in compliance with the Children's Code. The Child Protection Team also reports nonidentifying information relating to any "inadequate response" [Section 19-3-308(6)(f), C.R.S.] and makes recommendations to the county for further actions or states that the team has no recommendations or suggestions [Section 19-3-308(6)(i), C.R.S.]. In addition, the Child Protection Team is required to "publicly report whether there were any lapses and inadequacies in the child protection system and if they have been corrected" [Section 19-3-308(6)(h), C.R.S.].

CAPTA [42 USC Sec. 5106a(b)(2)(B)(xxiii)] requires the Department to have a technological system that supports the child protective system and tracks reports of child abuse and neglect from intake through final disposition. Trails is that system. Therefore, we would expect the Department to require counties to populate information about Child Protection Team reviews in Trails. Trails includes several fields for counties to document Child Protection Team reviews, including (1) the date on which the Child Protection Team reviewed the case, (2) whether the team supported the county's findings for the case, (3) whether the team found the county's investigation to be timely, (4) whether the team found the county's investigation to be adequate, and (5) any comments from the team's review. These fields document compliance with Section 19-3-308(6), C.R.S., which requires the use of Child Protection Teams in certain circumstances as part of the process that occurs between intake and final disposition.

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY?

Overall, it is unclear that Child Protection Teams, as currently operating, are adding value to the child welfare system as the General Assembly intended. Counties do not document review by Child Protection Teams for a significant number of cases and report that conducting Child Protection Team reviews for all cases is not feasible. Additionally, the findings of Child Protection Teams are not publicly accessible or used to identify system-wide deficiencies. We discuss these problems below.

FEW CASES RECEIVE REVIEW BY A CHILD PROTECTION TEAM, ACCORDING TO TRAILS DOCUMENTATION. From our review of Fiscal Year 2013 referrals, we found that just over one-third of the screened-in referrals requiring a review by a Child Protection Team received such review. Of nearly 29,000 Fiscal Year 2013 referrals assigned for assessment in counties that receive greater than 50 referrals per year, approximately 11,000 (38 percent) had a Child Protection Team review documented in Trails. In addition, there is a wide range in

counties' compliance with Child Protection Team requirements. Only one of 52 counties required to use Child Protection Teams documented a Child Protection Team review for all of its Fiscal Year 2013 screened-in referrals. A total of 20 counties documented a Child Protection Team review for fewer than 25 percent of their screened-in referrals.

EXHIBIT 3.6. COUNTY DOCUMENTATION OF CHILD PROTECTION TEAM REVIEWS FISCAL YEAR 2013

Percentage of County Screened-In Referrals that had a Child Protection Team Review Documented in Trails	Number of Counties	Percentage
<25%	20[1]	38%
26-50%	6	12
51-75%	7	13
>75%	19[2]	37
TOTAL	52	100%

SOURCE: Office of the State Auditor's analysis of Trails data reflecting referrals received in Fiscal Year 2013 by the counties required by statute to use Child Protection Teams [Section 19-3-308(6)(a), C.R.S.]. In Fiscal Year 2013, a total of 52 counties were required to use Child Protection Teams.

[1] One county documented no Child Protection Team review for any of its Fiscal Year 2013 screened-in referrals.

[2] One county documented a Child Protection Team review for each of its Fiscal Year 2013 screened-in referrals.

VALUE RECEIVED FROM CHILD PROTECTION TEAM REVIEW MAY BE LIMITED. A total of 19 of the 40 sampled cases we reviewed showed evidence of a Child Protection Team review. Of those 19 cases, we identified eight in which the value provided by the review is unclear because the Child Protection Team did not identify deficiencies that we found, the reviews resulted in no suggested improvements in spite of identifying deficiencies, and/or the reviews included recommendations that were not implemented. Specifically:

- In six cases we found exceptions with the timeliness of the county's response, but the Trails record indicated that the Child Protection Team found the county's response to be timely. Specifically, we found one case in which the county failed to make contact with the child within the assigned response time (Section 7.202.41.A, 12 C.C.R. 2509-3), four cases in which the county failed to complete the assessment within the required timeframe (Section 7.202.57, 12 C.C.R. 2509-3), and one case in which the county neither made

contact with the child within the assigned response time nor completed the assessment within the required timeframe. For example, we found one differential response case in which the county did not complete the assessment for 149 days, or almost 90 days longer than the 60 days allowed by rules.

- In one case we found an exception with the adequacy of the county's assessment, yet the Child Protection Team found the county's overall response to the referral to be adequate. Specifically, according to the Trails record, the county failed to interview all family members in the home (Section 7.202.52.E, 12 C.C.R. 2509-3), failed to identify and determine the condition of additional children living in the household [Section 19-3-308(2)(d), C.R.S.], and failed to interview collaterals as part of the assessment (Section 7.202.52.F, 12 C.C.R. 2509-3).

- In the same case in which we had an exception about the adequacy of the county's assessment, the Child Protection Team had a recommendation on how the county should proceed with the case, but no documented follow up by the county. In this case, the Child Protection Team recommended that the county provide a certain service for the family. The county agreed with our concern that that there was no evidence that the caseworker followed up on the Child Protection Team's recommendation. Although the role of the Child Protection Team is advisory only [Section 19-1-103(22), C.R.S.], and therefore counties are not obligated to follow the Child Protection Team's recommendations, we would expect counties to consider its recommendations. None of the other 18 cases included any recommendations from the Child Protection Team, according to information in Trails.

- In one case, the Child Protection Team found that the county had not responded in a timely manner, which we agreed with, but the Trails record included no corresponding recommendation from the Child Protection Team.

The question of the value of Child Protection Teams, as they currently operate, was also raised by the Office of Colorado's Child Protection

Ombudsman, which identified Child Protection Teams as one of 12 areas of concern in 2012. In its Fiscal Year 2012 annual report, the Ombudsman states that it is "concerned about the time caseworkers spend preparing for and participating in Child Protection Team meetings and questions the value gained for the time, resources, and effort spent." For example, the Ombudsman reported caseworkers spend a lot of time preparing for very short presentations on cases with minimal yield for results.

Counties reported mixed opinions about the value of the Child Protection Teams. Staff at six of the 10 counties we contacted stated that they did not think the Child Protection Teams are beneficial, citing, among other issues, that the reviews were not effective, took a lot of staff time, and were not a collaborative process. In addition, staff at three of the counties stated that often the Child Protection Teams would agree with the service plan the caseworker has already implemented and the review was more of a "rubber stamp" than a collaborative process. By contrast, staff at four counties said Child Protection Teams serve to engage the community in child welfare, and several county staff members cited the benefits of getting an outside perspective on the case, including collaborating with individuals in the community to identify more services available to the family and children.

FINDINGS OF CHILD PROTECTION TEAMS ARE NOT PUBLICLY ACCESSIBLE. We reviewed the Department's website and the websites of 10 sampled counties and found little information available about Child Protection Teams or their findings. Of the 10 sampled county websites, only two provided any information about Child Protection Teams; these websites provided information such as a description of Child Protection Teams and the names of the members. None of the websites included any reports or findings of the Child Protection Teams for improvement of the child welfare system or information about how a member of the public can attend a Child Protection Team meeting. In addition, no information about Child Protection Teams or their findings was available on the Department's website. While there is no requirement that the information be published online

by counties or by the Department, it is reasonable that information that is required to be publicly reported be made available online. The Department does not otherwise maintain or make publicly available the findings of Child Protection Teams statewide.

CHILD PROTECTION TEAM REVIEWS DO NOT IDENTIFY SYSTEM-WIDE PROBLEMS. Statute indicates that one purpose of the Child Protection Teams is to identify lapses or inadequacies in the child protection system [Section 19-3-308(6)(h), C.R.S.]. We found no evidence that the results of Child Protection Team reviews are used for this purpose.

WHY DID THE PROBLEM OCCUR AND WHY DOES IT MATTER?

NO GUIDANCE FOR COUNTIES ON USING CHILD PROTECTION TEAMS

The Department has not provided guidance to counties on how to use Child Protection Teams. The only mention of Child Protection Teams in rules directs counties to comply with statute (Section 7.202.61, 12 C.C.R. 2509-3). However, we found indications that there is a need for written guidance in the following areas:

- **WHICH CASES SHOULD BE REVIEWED.** The Department told us that Child Protection Team Reviews are not required for differential response cases, although we found the Department issued a Differential Response Implementation Guide that requires that Child Protection Team reviews be documented in a case note. Our file review results show that some counties do use Child Protection Teams for differential response cases; out of 10 differential response cases we reviewed, four included documentation in Trails that the case had been reviewed by a Child Protection Team.

  Implementing a more risk-based approach for selecting cases to be reviewed by Child Protection Teams could be an effective use of limited resources. Staff at two counties we visited reported that they do not use Child Protection Teams for all their cases because it is not

feasible to do so. For example, one large county told us that the case volume is so high they cannot have a Child Protection Team review every case. In eight of 40 assessments we reviewed (20 percent), the county acknowledged that a Child Protection Team review should have been done and was not. Citing concerns about the amount of time caseworkers spend on preparing for and participating in Child Protection Team reviews, the Ombudsman recommended in its Fiscal Year 2013 annual report that the Department assist counties in identifying effective practices for using Child Protection Teams and maximizing time and effort staff spend preparing for and participating in reviews. As of June 2014, the Department had not provided guidance to counties about how they should utilize these teams. The Department has also not sought legal guidance on whether statute, as currently written, would allow for a risk-based method to select cases for review by a Child Protection Team.

- **When in the process a case should be reviewed.** The Department has not provided any written guidance to counties regarding when a Child Protection Team review should occur to maximize its value. As a result, counties have developed different practices. Three of the 10 counties we visited reported they have Child Protection Teams review screened-in cases that are open for assessment. In these cases, the Child Protection Team may conduct its review early in the case and is not able to assess the timeliness and adequacy of the county's assessment, but may be able to recommend services or approaches that can help influence the case. On the other hand, five counties we visited reported they use the Child Protection Team to review the case as the last step before they close a case or once the case is closed. These Child Protection Teams may be well positioned to assess the timeliness and adequacy of the county's assessment, but, as staff at two counties told us, waiting until a case is almost closed, or already closed, limits the collaboration and input that the Child Protection Team can provide.

In three of the eight cases where we found problems that were not identified by the Child Protection Team, the reason is most likely that the Child Protection Team met too early in the process to identify the problems. For example, in one case cited previously in which we found inadequacies with the assessment, the Child Protection Team conducted its review 8 days into the case, which was nearly 2 weeks before the county completed its assessment. Therefore, the Child Protection Team may not have been positioned to evaluate the adequacy of the assessment. In the other two cases, the Child Protection Team met within the first week of the county's receiving the referral and, therefore, would not have been able to assess the timeliness of the assessments, which were not yet required to be completed.

- **How Child Protection Teams' recommendations should impact a specific case.** Statute states that input from a Child Protection Team is "advisory only" [Section 19-1-103(22), C.R.S.], but seven staff at five counties reported confusion over how the Child Protection Teams' advisory input should affect the services provided to the family, and whether the purpose of the Child Protection Team was to review larger trends in the county or to review the individual actions on every case. Without guidance on how caseworkers should use the advisory input of a Child Protection Team, there is a risk that the input is not actually being considered and implemented as appropriate and that the resources applied to the Child Protection Team process are wasted.

- **How Child Protection Teams should publicize their findings.** Child Protection Teams are required to "publicly report" their findings [Section 19-3-308(6)(h), C.R.S.]. However, the Department has provided no guidance to counties on how to effectively do this. Other more recent review mechanisms that have been put into statute include provisions requiring findings to be publicly reported by posting on the Internet and notifying key stakeholders. For example, both the Child Fatality Review Team [Section 26-1-139(4)(i), C.R.S.] and the Office of Colorado's Child Protection Ombudsman (Section 19-3.3-108, C.R.S.) are required to develop and distribute an annual

report to be posted on the Department's website and distributed to key stakeholders. Without public notification of the Child Protection Team's findings, the reviews are not effectively serving as a way for the public and the General Assembly to be better informed about the operation and administration of the child welfare system (Section 19-3-302, C.R.S.).

No processes for using Child Protection Team results for system improvements

The Department currently has no process to analyze the results of Child Protection Team reviews to identify inadequacies in the system as a whole and thereby help improve the system. Such a process could allow the Department to (1) identify whether there are trends across the counties in terms of cases not being handled expeditiously, adequately, or in compliance with statute and (2) develop solutions to help address any such trends. Since Child Protection Team findings are not reviewed, aggregated, or analyzed, the Department is missing an opportunity to compile and use information about needed system improvements.

Lack of monitoring of compliance with Child Protection Team requirements

The Department does not monitor counties' compliance with requirements to use Child Protection Teams. For example, the Department has not reviewed its Trails data to identify counties that are documenting Child Protection Team reviews for few cases. In addition, the Department does not include in its Administrative Review Division or Child Fatality Review Team reviews whether the county used a Child Protection Team. As a result, the Department does not ensure that counties are implementing this statutory requirement.

LACK OF ENFORCEMENT FOR DOCUMENTING COMPLIANCE

For four of the 40 assessments we reviewed, counties indicated that they conducted a Child Protection Team review, but did not document the review in Trails. Trails is the official record of child welfare cases, so all relevant information about a case should be documented in Trails. The Department initially told us that documenting Child Protection Team reviews in Trails is not required. As we were completing the audit, the Department acknowledged that it does not monitor county documentation of Child Protection Team reviews in Trails. By not enforcing the collection of Child Protection Team feedback in the established Trails data fields, Trails does not fully track reports of child abuse and neglect from intake through final disposition, as required by CAPTA, and the Department does not have complete and reliable information upon which to analyze Child Protection Team feedback and counties' compliance with Child Protection Team requirements.

POLICY CONSIDERATIONS FOR THE FUTURE OF CHILD PROTECTION TEAMS

The Department reports that when Child Protection Teams were established in 1975, there was little quality assurance and oversight of child welfare work, and Child Protection Teams filled that gap. However, since that time, Colorado has instituted a number of State- and county-level quality assurance systems and increased the transparency of the child welfare system. Exhibit 3.7 outlines some of the major reform initiatives to create oversight and transparency in the child welfare system since 1975.

EXHIBIT 3.7. CHILD WELFARE REFORMS INVOLVING REVIEW AND OVERSIGHT FOR THE CHILD WELFARE SYSTEM

REVIEW MECHANISM	DESCRIPTION	DATE
Child Protection Teams	Local, multidisciplinary advisory teams intended to allow for public discussion of counties' response to reports of abuse and neglect. Required for counties receiving 50 or more reports of abuse or neglect annually (Section 19-3-308, C.R.S.).	1975
Administrative Review Division	Independent third-party review system established by the Department. Responsible for the federally required Case Review System and a portion of the Quality Assurance System for both the Division of Child Welfare and the Division of Youth Corrections. For child welfare cases, each out-of-home placement case is reviewed every 6 months and a sample of in-home cases is reviewed every 6 months for the State's 10 largest counties and every year for the rest of the state (approximately 1,200 to 1,400 sampled in-home cases are reviewed each year). Aggregate results of reviews are publicly accessible.	1991
Citizen Review Panels	Created by the local government to review grievances brought forward by citizens related to the child welfare system and make recommendations to the county department of human/social services (Section 19-3-211, C.R.S.).	1996
Screen-Out Review	Process established by the Department in 2007 to assess, on a sample basis, whether counties are appropriately screening out referrals of abuse and neglect. The review is conducted annually in September for a sample of statewide screened-out referrals received in the previous 6 months. Results of the review are made public.	2007
Office of Colorado's Child Protection Ombudsman	Created through Senate Bill 10-171 to facilitate a process for independent, impartial review of family and community concerns. If appropriate, conducts case reviews to help resolve child protection issues (Section 19-3.3-101, et seq., C.R.S.).	2010
Child Fatality Review Team	Although the State had been reviewing child fatalities since the late 1980s, House Bill 11-1181 codified the process for families with previous involvement in the child welfare system and established the Child Fatality Review Team within the Department (Section 26-1-139, C.R.S.). In 2012, the scope of the Child Fatality Review Team expanded to include review of near fatalities and egregious incidents (Senate Bill 12-033). The Child Fatality Review Team's findings are publicly accessible.	2011
C-Stat	Management strategy implemented by the Department that analyzes counties' performance in meeting specified performance benchmarks using aggregate data from Trails and other sources and uses performance data to identify what processes need improvement.	2012
Community Performance Center	Publicly accessible website established by the Department to provide real-time, county-specific data to increase transparency and accountability in child welfare in Colorado.	2014

SOURCE: Office of the State Auditor's review of statutes governing the child welfare system, information available on the Department of Human Services' website, and documentation provided by Department staff.

The issue of whether Child Protection Teams are needed to provide transparency and accountability for the child protection system is a

matter of public policy. However, given the reforms described above, along with the issues in the current operation of Child Protection Teams we found during the audit, it may be appropriate to consider what role Child Protection Teams should have, and how they can most effectively fulfill that role, nearly 40 years after they were first put into place. The Department indicated to us that it wishes to "create or designate an existing county-state group to explore the current practice of [Child Protection Teams] and analyze current quality assurance and transparency initiatives at both the county and state levels" to determine whether there is still a need for Child Protection Teams.

RECOMMENDATION 7

The Department of Human Services should work with child welfare and county stakeholders to assess whether Child Protection Teams are still needed and work with the General Assembly on statutory changes to either make Child Protection Teams effective as an oversight mechanism for the child welfare system or to eliminate the requirement for Child Protection Teams.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

AGREE. IMPLEMENTATION DATE: JUNE 2015.

The Department agrees to work with child welfare and county stakeholders to assess whether Child Protection Teams are still needed, and work with the Legislative Audit Committee and General Assembly on statutory changes to either make Child Protection Teams effective as an oversight mechanism for the child welfare system or to eliminate the requirement for Child Protection Teams.

RECOMMENDATION 8

As long as Child Protection Teams continue in their current form, the Department of Human Services should improve their use as an oversight mechanism by:

A Seeking legal guidance from the Office of the Attorney General on whether statute as currently written allows for counties to employ a risk-based approach for determining which cases should be reviewed by a Child Protection Team. Based on that guidance either (i) work with the State Board of Human Services to promulgate rules on how to employ a risk-based approach for selecting which cases are reviewed by the Child Protection Team, or (ii) work with the General Assembly to seek statutory change to allow for a risk-based approach.

B Working with the State Board of Human Services to promulgate rules providing parameters for counties to determine (i) which cases should be reviewed by Child Protection Teams, (ii) when in the case the Child Protection Teams should review the case, (iii) how the results of the Child Protection Team review should be used by the counties to improve their cases and processes, and (iv) how to publicly report the results.

C Implementing a process for monitoring Trails data to ensure counties are complying with requirements for using Child Protection Teams and following up with counties that are not complying. This should include requiring counties to populate Child Protection Team review information into Trails.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: OCTOBER 2015.

The Department agrees to seek legal guidance from the Office of the Attorney General on whether statute as currently written allows for counties to employ a risk-based approach for determining which assessments should be reviewed by a Child Protection Team (CPT). The Department believes that CPTs best serve children and their communities when led at the local level; and, that counties should have sufficient flexibility to meet their unique community needs. Based on the guidance from the Office of the Attorney General, the Department will engage its county partners to either work with the State Board of Human Services to promulgate rules on how to employ a risk-based approach for selecting which assessments are reviewed by the CPT or work with the General Assembly to seek statutory change to allow for a risk-based approach.

B AGREE. IMPLEMENTATION DATE: OCTOBER 2015.

If there is no statutory change to eliminate CPTs, the Department agrees to engage its county partners, and will work with the State Board of Human Services to promulgate rules providing parameters for counties to determine which assessments will be reviewed by CPTs, when in the assessment the CPTs will review the assessment, how the results of the CPT reviews will be used by the counties to improve their assessments and processes, and how to publicly report the results. The Department believes that CPTs best serve children and their communities when led at the local level; and, that counties should have sufficient flexibility to meet their unique community needs.

C DISAGREE.

The Department disagrees with this recommendation because it believes that throughout the statute (Section 19-3-308(6)(a)-(11), C.R.S.), the charge is to the county to act upon the statute. Specifically, the direction in the statute is to a county, or contiguous group of counties, which indicates the intent of Child Protection Teams (CPT) to be locally administered and controlled. Additionally, the statute (Section 19-3-308(8), C.R.S.) states that the county director or his/her designee shall be deemed to be the local coordinator of the CPT. Local CPTs should have flexibility in what they review, as long as it is statutorily allowed. The Department has not previously monitored Trails data for county compliance related to CPTs for this reason. Additional staffing resources would be necessary in order to implement this recommendation.

AUDITOR'S ADDENDUM

Section 26-1-118(1), C.R.S., requires county departments of human/social services to administer child welfare activities in accordance with the rules and regulations of the state department. Rules require that counties comply with the statute requiring the use of Child Protection Teams (Section 7.202.61, 12 C.C.R. 2509-3). Since statute [Section 26-1-111(1), C.R.S.] requires the Department to administer or supervise all public assistance and welfare activities in Colorado, including child welfare, we would expect the Department to ensure that counties comply with Child Protection Team requirements.

INTERPRETATION OF DEPARTMENT AUTHORITY

The Department is responsible for administering or supervising all public assistance and welfare activities in Colorado, including child welfare (Section 26-1-111, C.R.S.). Since Colorado operates a state-supervised, county-administered child welfare system, the Department is responsible for overseeing the county departments of human/social services that serve as agents of the State [Section 26-1-118(1), C.R.S.]. Rules indicate that the Department's supervisory responsibility includes "ensuring that the county departments comply with requirements provided by federal laws and regulations, state statutes, Executive Director and State Board of Human Services rules, and contract and grant terms" (Section 1.110, 9 C.C.R. 2501-1).

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to evaluate whether the Department exercises clear authority when enforcing requirements of the child welfare system. To accomplish this objective, we (1) reviewed relevant statutes and rules; (2) conducted interviews with Department staff, and staff at 10 sampled counties; (3) reviewed a sample of 40 screened-in referrals received in Fiscal Year 2013, and responses provided by county and Department staff; and (4) reviewed other documentation provided by the Department.

WHAT PROBLEM DID THE AUDIT WORK FIND AND HOW WERE RESULTS MEASURED?

The Human Services Code and Children's Code establish the statutory framework for the child welfare system, while the State Board has legal authority to establish rules that govern child welfare (Section 26-1-107, C.R.S.). These rules are binding upon county departments of human/social services (Section 26-1-107, C.R.S.). Statute [Sections 24-1-120(3) and 24-1-105(1), C.R.S.] further establishes the State Board as a Type I Board, which means it has the power to exercise its authority, such as rulemaking, independently from the Department's Executive Director.

Statute [Section 26-1-118(1), C.R.S.] specifies that county departments of human/social services "shall serve as agents of the state department and shall be charged with the administration of public assistance and welfare and related activities in the respective counties in accordance with the rules and regulations of the state department." Practically speaking, this means that counties must comply with the statutory and regulatory provisions that govern the child welfare system.

Our audit identified several instances in which the Department has established processes to direct or approve counties' not following certain rules, as follows:

SPECIAL ECONOMIC ASSISTANCE. Our file review found that the Department waives rules limiting how much assistance counties can provide to families for certain emergency services. Under rule (Section 7.303.1.F, 12 C.C.R. 2509-4), counties can provide up to $400 per family per year for "special economic assistance," which includes certain emergency services such as housing expenses, food, clothing, and transportation. In August 2012, the Department sent an agency letter to counties stating that counties could request a waiver of the $400 limit on special economic assistance to double the limit to $800 per family per year. The letter included information indicating that the

option to request a waiver had been in place since at least Fiscal Year 2011. Rules do not provide for such waivers.

NEEDS ASSESSMENTS. Our file review found that the Department formally advised counties that they were not required to follow rules requiring needs assessments as part of case planning. Rules specify that a needs assessment shall be completed for each child welfare case accepted by the county and shall be the basis for case planning (Section 7.301.1.B, 12 C.C.R. 2509-3). This requirement applies to both investigative and differential response assessments. In February 2013, the Department issued what it calls a "dear director" letter to county directors informing them that, as of January 2013, caseworkers no longer had to comply with the rule requiring a needs assessment. Specifically, the letter stated that the needs assessment "will no longer be required in Trails," but that the tool would "still be available in Trails if a caseworker wishes to complete it to assist in case planning and assessment." The letter also noted that the needs assessment "is a very useful tool in a therapeutic environment, but is not as effective for caseworkers." In the fall of 2014, the Department reported that it was formally seeking a rule change regarding needs assessments.

In addition to providing some direction to counties that is inconsistent with statutes or rules, we found that the Department does not typically enforce county compliance with any guidance or directives it provides, such as through written guides or letters. We note this lack of enforcement in various areas throughout the report.

WHY DID THE PROBLEM OCCUR?

Department staff provided us with an email containing informal advice from the Office of the Attorney General regarding the Department's authority to not enforce rules. However, the advice is subject to attorney-client privilege, and the Department did not agree to waive the privilege. Section 7.39 of Government Auditing Standards states that, "If certain pertinent information is prohibited from public disclosure or is excluded from a report due to the confidential or

sensitive nature of the information, auditors should disclose in the report that certain information has been omitted and the reason or other circumstances that make the omission necessary." As a result, although pertinent to this audit, information regarding the advice from the Office of the Attorney General has been omitted from this report.

The Department has interpreted its authority to be limited to those requirements specified in rule. In October 2014, the Department reported that it had received guidance from the Office of the Attorney General that the Department has authority to establish and enforce policies beyond those in rules.

WHY DOES THIS PROBLEM MATTER?

The practice of waiving authoritative guidance could result in the intent of rules not being fulfilled. In addition, when the Department directs or permits counties to operate in a manner that is not consistent with rules, it sends a conflicting message to counties. During the audit, we observed this conflict between the Department's practice of waiving certain requirements while enforcing others and the mechanisms it uses to accomplish each objective. On one hand, the Department has used communication methods such as agency letters and dear director letters to advise counties not to follow certain rules. On the other hand, Department staff originally told us that the ONLY requirements it can hold counties accountable to are rules and statute, NOT other sources of Department guidance such as agency letters and dear director letters.

Specific problems we found also matter for the following reasons:

SPECIAL ECONOMIC ASSISTANCE. The State Board set the $400 limit for special economic assistance through the public rulemaking process. By authorizing waivers to this rule, the State Board's intent to limit these funds to a small amount is not being achieved. The Department approved 15 counties' waiver requests in Fiscal Year 2013.

NEEDS ASSESSMENT. The needs assessment required by rules is intended to serve as a basis for case planning (Section 7.301.1.B, 12 C.C.R. 2509-3). Rules also state that the purpose of the needs assessment is to (1) identify the most needed types of services based on the assessed needs; (2) measure where change in child and family functioning has occurred as a result of services delivered; and (3) measure the child welfare outcomes of safety, permanency, and well-being (Section 7.301.1.C, 12 C.C.R. 2509-3). Creating a discrepancy between rules and other sources of guidance may have contributed to inconsistencies in county practice. According to information provided by the Department, as late as the first quarter of Calendar Year 2014, at least 20 counties (almost one-third of the state) continued to complete needs assessments.

Throughout our audit report, we note circumstances in which the Department's interpretation that it lacks authority to direct counties through policies appears to contribute to counties' operating inconsistently and, in some cases, in apparent violation of rules. These violations affect a range of child welfare activities, including referral screening, assessments, and communicating with mandatory reporters. Since the Department has now been provided guidance by the Office of the Attorney General that it can direct counties through policies, this may change in the future.

RECOMMENDATION 9

The Department of Human Services (Department) should ensure that it exercises appropriate authority when advising and overseeing counties regarding requirements for the child welfare system by:

A Requesting a legal opinion from the Office of the Attorney General on whether the Department has authority to waive rules that govern the child welfare system or to otherwise provide direction to counties to operate in a manner that is inconsistent with requirements in rules.

B If the Attorney General finds that the Department does not have authority to waive or contravene rules, discontinuing the practice of directing or allowing counties to operate in a manner that is not consistent with rules.

C Based on the opinion of the Attorney General obtained in response to PART A, as well as the Attorney General's recent guidance to the Department regarding its authority to establish and enforce policies, taking steps to communicate any changes in practice or expectations. This should include informing Department staff who provide technical assistance to counties of any new Department policies or practices and revising quality assurance review tools used by the Administrative Review Division as needed.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A DISAGREE.

The Department disagrees to request a legal opinion from the Office of the Attorney General on whether the Department has authority to waive rules that govern the child welfare system, or to otherwise provide direction to counties to operate in a manner that is

inconsistent with requirements in rules. In the very rare instances in which the Department has granted relief from rule, it is the Department's practice to consult with the Deputy Attorney General before approving relief from any administrative rule. The Department will propose a rule change to Volume 7 which allows workers an exception to Volume 7 requirements in very limited circumstances, which will be well documented, approved by their supervisor, and will not impact the safety and wellbeing of children. The Department will also implement a formal policy development and application protocol to improve its management and clarity of expectations for counties. Both of these actions will occur by March 2015.

B DISAGREE.

The Department disagrees with this recommendation. In the very rare instances in which the Department has granted relief from rule, it is the Department's practice to consult with the Deputy Attorney General (AG) before approving relief from any administrative rule. In instances where the AG's Office has determined we do not have the authority to provide relief from rules, the Department does not take action. The Department will propose a rule change to Volume 7 which allows workers an exception to Volume 7 requirements in very limited circumstances, which will be well documented, approved by their supervisor, and will not impact the safety and wellbeing of children. The Department will also implement a formal policy development and application protocol to improve its management and clarity of expectations for counties. Both of these actions will occur by March 2015.

C PARTIALLY AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department partially agrees with this recommendation. The Department disagrees and will not seek an opinion of the Attorney General as requested in part "a." The Department agrees to communicate changes in practice or expectations. This will include informing Department staff who provide technical assistance to counties of any new Department policies or practices and revising the review process used by the Administrative Review Division as needed.

AUDITOR'S ADDENDUM

The audit notes examples of the Department directing or approving counties' not following certain rules of the State Board of Human Services. These rules are established through a comprehensive process that allows for public and stakeholder input into the guidance and directives promulgated as formal rules. By allowing counties to sometimes operate in a manner inconsistent with rules, the Department is not supporting the intent of those rules and is sending a conflicting message to counties. The Department provided us with an email containing informal advice from the Office of the Attorney General regarding this issue, but did not agree to waive its attorney-client privilege with respect to that communication. As a result, we are unable to discuss the content or extent of the advice. These recommendations ask the Department to ensure that its actions are consistent with its authority with respect to adherence to State Board rules.

PERFORMANCE MEASURES

The SMART Government Act (Section 2-7-201 et al, C.R.S.) provides guidance for how departments should measure performance to ensure accountability and transparency showing value received for tax dollars spent. The SMART Government Act generally requires that departments develop performance measures covering their "major functions" and report performance annually through their Performance Plans distributed to the General Assembly and made available to the public [Section 2-7-204(3) and (4), C.R.S.]. In its Fiscal Year 2015 Performance Plan, the Department identified 20 performance measures to be measured for the SMART Government Act. One of these performance measures—"Timeliness of Assessment Closure"—relates to child welfare.

In addition, the Department has voluntarily launched two other performance management initiatives—C-Stat and the Community Performance Center—as described in Chapter 1. Overall, the Department tracks 27 performance measures related to the Division of Child Welfare.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

We assessed the Department's SMART Government Act performance measure for child welfare in terms of its integrity, accuracy, and validity. To accomplish this objective, we (1) reviewed relevant statutes, rules, and other guidance promulgated by the Department; (2) interviewed and obtained information from Department staff about performance measures and how performance is tracked; and (3) reviewed the Department's Fiscal Year 2015 Performance Plan prepared under the SMART Government Act.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

The SMART Government Act requires the State Auditor to review the "integrity" of performance measures and the "accuracy and validity" of reported results as part of one or more performance audits annually [Section 2-7-204(5), C.R.S.]. We assessed the integrity, validity and accuracy of the Department's child welfare performance measure identified in its SMART Government Act Performance Plan, using the law's definition of a "performance measure" as a quantitative indicator that is used to assess operational performance that should be reasonably understandable to the public [Section 2-7-202(18), C.R.S.].

WHAT PROBLEM DID THE AUDIT WORK IDENTIFY AND WHY DID IT OCCUR?

THE DEPARTMENT'S SMART GOVERNMENT ACT PERFORMANCE MEASURE FOR CHILD WELFARE DOES NOT MEASURE OPERATIONAL PERFORMANCE ACCORDING TO REGULATORY REQUIREMENTS. The Department's "Timeliness of Assessment Closure" performance measure determines the percentage of child welfare assessments closed within 60 days of the referral, which is not consistent with rules that require counties to complete investigative assessments within 30 days unless a supervisor approves a 30-day extension (Section 7.202.57, 12 C.C.R. 2509-3). Thus, the SMART Government measure assumes that any assessments that were closed between 30 and 60 days were approved for extensions or were completed as part of the Differential Response Pilot Program (see CHAPTER 5), which requires assessments to be completed within 60 days of the referral. However, our review of a sample of 30 investigative assessments identified seven assessments that closed more than 30 days after the referral without an approved extension. The Department's timeliness of assessment closure performance measure would consider six of these assessments to have been closed on time.

The Department reported that it considers assessments closed within 60 days to be timely for this measure because statute allows counties to have 60 days to "submit a report of confirmed child abuse or neglect within sixty days of the [referral] to the state department" [Section 19-3-307(1), C.R.S.]. This statutory requirement is generally understood to refer to the process by which counties complete assessments in Trails. However, the Department's approach to consider any assessment closed within 60 days to be timely does not take into account that the rules require assessments to be completed within 30 days unless an extension is granted.

WHY DOES THE PROBLEM MATTER?

Using a "Timeliness of Assessment Closure" measure that is not consistent with regulatory requirements sends a conflicting message to counties about what performance is actually expected. For example, supervisors in two of the 10 counties we visited reported that their goal is to have caseworkers close assessments in 60 days, rather than 30 days, since the State measures performance based on 60 days.

In addition, the Department provides funding to counties through an allocation model that includes incentives awarded for meeting certain C-Stat performance measures, including the "Timeliness of Assessment Closure" measure. In the first quarter of Fiscal Year 2014, the Department provided more than $500,000 to 32 counties that met the performance measure standard of closing 90 percent of assessments within 60 days. Therefore, the Department is incentivizing counties for performance even when the performance may not comply with rules and State Board policy that established a narrower timeframe of 30 days. The Department reports that the Child Welfare Allocations Committee recommended allocating incentive funds based on the 60 day time period. According to Statute [Section 26-5-104(3), C.R.S.], the Allocations Committee provides "input" to the Department on county allocations. In addition, by reporting a measure that does not reflect regulatory requirements, the meaning of the measure may not be transparent to the public, policy makers, and other users of the performance measure data.

RECOMMENDATION 10

The Department of Human Services should improve its SMART Government Act performance measure for child welfare by revising the "Timeliness of Assessment Closure" measure, or adding an additional measure, to align with the regulatory requirement for investigative assessments to be closed in 30 days unless an extension is approved by a supervisor. The revised measure should be used as the basis for awarding incentives to counties.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

DISAGREE.

The Department disagrees with this recommendation. The Department will retitle the "Timeliness of Assessment Closure" measure to read "Compliance with the Statutory Requirement Related to Timeliness of Assessment Closure" within the SMART Government Act performance measures for child welfare. The Department believes that its current measure has integrity, accuracy, and validity as required by the SMART Government Act. The Department also disagrees with the recommendation to revise the measure to be used as the basis for awarding incentives to counties as it is inconsistent with existing statute. Pursuant to 26-5-104(3)(b), C.R.S., the Child Welfare Allocation Committee (CWAC) has authority to recommend the methodology for the Child Welfare allocation formula. If the Department disagrees with the CWAC's recommendation, the decision then is made by the Joint Budget Committee. The Department does not have the authority to unilaterally use this measure as the basis for awarding incentives to counties.

AUDITOR'S ADDENDUM

To have integrity, accuracy and validity the Department's SMART Government Act performance measure must be a quantitative indicator that is used to assess operational performance and is reasonably understandable to the public [Section 2-7-202(18), C.R.S.]. The Department's SMART Government Act performance measure, "Timeliness of Assessment Closure" does not meet that standard because rules require counties to complete investigative assessments within 30 days unless a supervisor approves a 30-day extension (Section 7.202.3, 12 CCR 2509-3) and the measure considers all assessments timely that are completed within 60 days. Using a "Timeliness of Assessment Closure" measure that is not consistent with regulatory requirements, and using that measure to provide incentives to counties, disregards the rule and sends a conflicting message to counties about what performance is actually expected. We note that this recommendation does not prohibit the Department from working with the Child Welfare Allocation Committee, which according to Statute [Section 26-5-104(3), C.R.S.], provides "input" to the Department regarding the allocation formula, to ensure it incentivizes performance based on the requirements in State Board Rule.

CHAPTER 4

COORDINATION OF SERVICES

Ensuring the safety and protection of Colorado's vulnerable children requires cooperation and collaboration among state and local social service agencies, law enforcement, courts, health/mental health systems, and school districts, among others. When these agencies work together, the social service system is better able to focus services on the child and his or her family, and optimize services and treatment to improve outcomes. This chapter focuses on two areas where federal and/or state law requires county departments of human/social services to work

together with other state and local agencies through cooperative agreements or memoranda of understanding to better coordinate services and protect at-risk children.

COOPERATIVE AGREEMENTS BETWEEN COUNTY DEPARTMENTS AND LAW ENFORCEMENT AGENCIES

Child abuse reporting laws allow referrals of child abuse and neglect to be made to either law enforcement agencies or county departments of human/social services. Law enforcement and county departments may each have a role in investigating a report of alleged abuse or neglect. As a result, cooperation and coordination between law enforcement agencies and county departments of human/social services are essential for ensuring that prompt actions are taken to protect children and that each agency has the information it needs to take action. One of the mechanisms used in Colorado to encourage this coordination is written cooperative agreements between law enforcement agencies and county departments of human/social services. These agreements are intended to define the types of cases that will be jointly investigated by law enforcement agencies and county departments and those cases that will be independently investigated by one of the agencies, as well as detail protocols for notifying the respective agencies of child abuse and neglect incidents and conducting the investigations.

County departments use various approaches to establish agreements with law enforcement agencies. Some county departments of human/social services develop individual agreements with each law enforcement agency within the county, while others establish one agreement that includes all law enforcement agencies in their jurisdictions.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of the audit work was to (1) determine whether county departments of human/social services have established cooperative agreements with all law enforcement agencies in their jurisdictions, (2) assess whether the agreements contain the required provisions and fulfill their statutory purpose, and (3) identify the types of provisions in agreements that promote effective coordination and cooperation between county departments of human/social services and law enforcement agencies.

To accomplish these objectives, we (1) reviewed federal requirements under the Child Abuse Prevention and Treatment Act (CAPTA), as well as state statute and rules; (2) interviewed Department of Human Services (Department) staff and staff at 10 sampled counties; (3) compiled a list of 324 law enforcement agencies operating in Colorado, which includes county sheriff departments, local police departments and marshal offices, military police, college campus police departments, and the Colorado State Patrol; (4) reviewed the 83 cooperative agreements provided by the Department and county departments of human/social services to determine whether agreements were established with all law enforcement agencies; (5) conducted an in-depth review of a random, non-statistical sample of 29 cooperative agreements; (6) reviewed a sample of 60 referrals that counties received in Fiscal Year 2013; (7) reviewed the Trails records associated with two incidents reviewed by the Child Fatality Review Team that occurred in Fiscal Year 2013; and (8) reviewed recommendations made by the Child Fatality Review Team, the Office of Colorado's Child Protection Ombudsman, and Governor Ritter's Child Welfare Action Committee.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

In accordance with CAPTA, Colorado's State Plan includes an assurance that the State has in effect and is enforcing a state law requiring the cooperation of state law enforcement officials, courts of competent jurisdiction, and state agencies providing human services in the investigation, assessment, prosecution, and treatment of child abuse and neglect [42 USC Sec. 5106a(b)(2)(B)(xi)]. Section 19-3-308(5.5), C.R.S., is the state law that requires law enforcement agencies and their respective county departments of human/social services to implement cooperative agreements to coordinate the duties of both agencies in connection with the investigation of child abuse and neglect cases. The focus of these agreements is "to ensure the best protection of the child." The agreements must provide for special requests by one agency for assistance from the other agency and for joint investigations by both agencies.

Rules (Section 7.202.51.A, 12 C.C.R. 2509-3) require county departments of human/social services to develop cooperative agreements with law enforcement agencies that include five specific provisions, as described later in this section. These provisions are generally designed to provide clarity for how key requirements of investigating abuse and neglect will be met when both the county and law enforcement are involved.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

While the State does have a law in place to require the cooperation of law enforcement and county departments of human/social services, we found several problems with implementation of the law as outlined below.

Lack of Cooperative Agreements. We found that 12 of the 64 county departments of human/social services (19 percent) have not

established cooperative agreements with any of the law enforcement agencies within their jurisdictions. Another 47 county departments of human/social services (73 percent) have established agreements with some, but not all, of the law enforcement agencies within their jurisdictions. When we looked at how many of the State's law enforcement agencies have a cooperative agreement with a county department of human/social services, we found that 186 of the 324 law enforcement agencies in the state (57 percent) have an agreement, 117 agencies (36 percent) do not have an agreement, and 21 agencies (7 percent) have an unsigned agreement. See Appendix B for a breakdown, by county, of the law enforcement agencies in the state and which ones participate in a cooperative agreement.

Additionally, at the time of our audit, only eight county departments of human/social services had established cooperative agreements with the Colorado State Patrol related to investigations of child abuse and neglect. The State Patrol operates in all 64 counties and can be the lead law enforcement agency investigating incidents involving child abuse and neglect that require notification and coordination with county departments (e.g., a car accident involving charges of child abuse or neglect).

SOME COOPERATIVE AGREEMENTS LACK REQUIRED ELEMENTS. We found that 19 of the 29 cooperative agreements in our sample (66 percent) were missing at least one of the five provisions required by rule, as shown in Exhibit 4.1.

EXHIBIT 4.1. REQUIRED PROVISIONS IN 29 COOPERATIVE AGREEMENTS ESTABLISHED BETWEEN COUNTY DEPARTMENTS OF HUMAN/SOCIAL SERVICES AND LAW ENFORCEMENT AGENCIES

REQUIRED PROVISION	DID THE AGREEMENT CONTAIN THE PROVISION? YES	NO
1—Protocol for distributing the Notice of Rights and Remedies[1] when required by Section 19-3-212, C.R.S., and Section 7.200.3.G of rules.	10 (34%)	19 (66%)
2—Procedures for law enforcement investigations of abuse or neglect in out-of-home care settings.	22 (76%)	7 (24%)
3—Procedures for independent law enforcement investigations and child welfare assessments by either party.	27 (93%)	2 (7%)
4—Procedures for joint law enforcement investigation and child welfare assessments.	27 (93%)	2 (7%)
5—Protocol for cooperation and notification between parties on child abuse and neglect referrals and child maltreatment deaths.	28 (97%)	1 (3%)

SOURCE: Office of the State Auditor's analysis of a random sample of 29 cooperative agreements established between county departments of human/social services and law enforcement agencies based on requirements in Section 7.202.51.A, 12 C.C.R. 2509-3

[1] Section 19-3-212, C.R.S., requires social service and law enforcement agencies in the state to deliver a standardized written form that includes the notice of rights and remedies to all parents and families from whom children are removed under court order or by law enforcement personnel. This notice must contain a statement as to the cause of the removal of the child or children and a disclosure of the availability of the conflict resolution process to persons who are the subject of any child abuse or neglect report.

Further, we found that seven of the 27 agreements that contained procedures for independent law enforcement investigations and child welfare assessments (Provision 3 in Exhibit 4.1) were limited in scope. Specifically, these agreements described the types of child fatality cases, but not the other types of abuse and neglect allegations, such as third-party child abuse, that will be independently investigated by law enforcement.

Content and Depth of Agreements Varied Greatly. In general, we found wide variation in the information included in the agreements. Some of the agreements contained general high-level procedures and protocols, while others included detailed procedures for both law enforcement agencies and county departments of human/social services. For example, one of the agreements contained one sentence to address the coordination and cooperation between the county department of human/social services and law enforcement

agency, stating that the two agencies "shall cooperate to ensure that the child at risk" is safe. In comparison, another agreement in our sample lists specific procedures, such as protocols for how interviews will be coordinated and how cases involving drug-endangered children will be managed.

SOME AGREEMENTS ARE OUTDATED. We found that three of the 29 cooperative agreements in our sample (10 percent) were 16 or more years old. Exhibit 4.2 shows that only about one-third of the 29 agreements in our sample were established within the past 2 years.

EXHIBIT 4.2. AGE OF RANDOM SAMPLE OF COOPERATIVE AGREEMENTS BETWEEN COUNTY DEPARTMENTS OF HUMAN/SOCIAL SERVICES AND LAW ENFORCEMENT AGENCIES

AGE OF AGREEMENTS AS OF DECEMBER 31, 2013	NUMBER IN SAMPLE	PERCENT OF TOTAL IN SAMPLE
< 2 years	11	38%
2 to 5 years	13	45%
6 to 15 years	1	3%
16 to 20 years	3	11%
Unknown[1]	1	3%
TOTALS	29	100%

SOURCE: Office of the State Auditor's analysis of a sample of 29 cooperative agreements established between county departments of human/social services and law enforcement agencies related to investigations of child abuse and neglect.

[1] One of the cooperative agreements in our sample did not contain any dates or signatures. As a result, we do not know if the agreement was implemented or, if implemented, the date it became effective.

WHY DID THE PROBLEMS OCCUR?

INSUFFICIENT WRITTEN GUIDANCE. The Department has not developed written guidance, such as a manual, to provide direction to county departments of human/social services on how to develop and maintain effective cooperative agreements with law enforcement agencies. For example, the Department has no rules, policies, procedures, or other materials that:

- Establish a required or recommended frequency for reviewing and updating agreements to ensure that the provisions are still relevant. For example, guidance provided by Wisconsin's Department of Children and Families requires that counties "revisit" cooperative

agreements with law enforcement at least every 2 years and modify them as needed.

- Specify which law enforcement agencies should be included in agreements. Although statute does not specifically require counties to establish cooperative agreements with the Colorado State Patrol, the State Patrol has a local presence in communities throughout the state and may be involved in child abuse and neglect cases. We found that 56 counties (88 percent) did not have agreements with the State Patrol at the time of our audit. The Department reports that it developed a statewide cooperative agreement with the State Patrol in the spring of 2014.

  A working group of Governor Ritter's Child Welfare Action Committee recommended in October 2010 that the Department create "clearly written protocols to be implemented by counties for smooth interaction between child welfare and law enforcement." Wisconsin's Department of Children and Families developed a manual for counties on establishing agreements and working with law enforcement. Further, the U.S. Department of Health and Human Services, Administration for Children and Families, offers several best practices for developing agreements with law enforcement agencies that the Department could use to develop a manual and template for county departments of human/social services.

  LACK OF TRAINING. The Department has not provided training to county departments of human/social services or law enforcement agencies on how to develop effective cooperative agreements. Staff from one county we visited said that they conduct joint trainings with caseworkers and law enforcement officers with the intent to improve coordination and collaboration between the agencies. The staff reported that they believe this approach has been effective in building relationships with law enforcement agencies and that it would be helpful for the Department to offer regular trainings for county staff and law enforcement agencies statewide.

LACK OF MONITORING. The Department does not routinely request that county departments of human/social services submit their current law enforcement agreements to the Department. Additionally, the Department does not have a process for reviewing the agreements it receives to ensure that they contain all required provisions and that they are consistent with current child welfare laws, policies, and initiatives as well as best practices. At the beginning of the audit, the Department had 50 cooperative agreements from counties around the state on file at the Department. Of these, six agreements (12 percent) were not the current agreements in place within counties; the counties provided current agreements when requested during the audit. Further, in response to our audit request, counties provided an additional 20 agreements that the Department had never received.

Although we identified areas in which guidance, training, and oversight of the cooperative agreement process should be improved, we recognize that establishing effective cooperative agreements requires efforts not just by the Department and county departments of human/social services, but also by law enforcement agencies. Three county departments of human/social services reported to us that some or all of the law enforcement agencies in their jurisdictions refused to sign cooperative agreements for coordinating child abuse and neglect referrals and investigations. Three additional county departments of human/social services reported that even though they have established cooperative agreements, they have had problems with coordinating child abuse and neglect referrals and investigations, including problems with full and timely reporting of child maltreatment allegations by law enforcement to the county departments and coordinating efforts for removing children from the home.

WHY DOES THIS FINDING MATTER?

National research has shown the importance to the child welfare system of having cooperative agreements with law enforcement agencies. A research study conducted by the Children and Family Research Center at the University of Illinois at Urbana-Champaign in June 2012, using national data collected by the U.S. Department of

Health and Human Services, found that the odds of a criminal investigation occurring in cases of child abuse and neglect were 92 percent higher when the agencies responsible for conducting child welfare investigations and law enforcement agencies have written agreements governing their interactions. According to the study, a written agreement clarifies procedures in a way that makes it easier for law enforcement to become involved and indicates a greater commitment by the child welfare agency and law enforcement to work together, which can help increase law enforcement involvement. A collaborative approach also helps to avoid conflict when both agencies are conducting investigations and improves investigative outcomes.

From our audit work we identified ways in which a lack of sufficient coordination can negatively impact the child welfare system, as listed below. The purpose of requiring comprehensive cooperative agreements is to help prevent these problems.

- **Lack of reporting by law enforcement agencies to county departments of human/social services.** Through the course of law enforcement's interactions with families, such as in responding to a welfare check or domestic violence dispute, law enforcement is made aware of situations that indicate a child may be abused or neglected. However, two counties we visited reported their concern that law enforcement agencies may not be reporting all suspected cases of child abuse or neglect to them. In addition, the Child Fatality Review Team identified systemic gaps and deficiencies related to coordination efforts between county departments of human/social services and law enforcement agencies in three child maltreatment fatalities and egregious incidents that occurred from Fiscal Years 2011 through 2013. In these cases, law enforcement agencies either did not report at all, or did not report to the county departments of human/social services in a timely manner, incidents of child abuse and neglect and incidents of domestic violence that occurred when children were present.

- **Lack of response by county departments of human/social services to law enforcement requests.** When law enforcement is

called to a home, there is often a need to have personnel from the county department of human/social services on site to help facilitate the care or custody of a child who is suspected of being a victim of abuse or neglect, or whose parents are being arrested. The Office of Colorado's Child Protection Ombudsman (Ombudsman) received complaints from three separate law enforcement jurisdictions in Fiscal Year 2013 regarding lack of or inadequate response from county departments of human/social services after hours and/or during weekends, leaving law enforcement personnel to find care for children whose parents were being arrested. In its Fiscal Year 2013 annual report, issued in September 2013, the Ombudsman recommended that the Department monitor counties' coordination with law enforcement in situations involving arrests and decisions about child care and custody. The Department responded that it would develop a policy for tracking counties' cooperative agreements with law enforcement and ensure that these agreements were updated regularly by October 2014.

- **Lack of timely assessment closure.** There are instances when both law enforcement and the county department of human/social services need to be involved in investigating suspected abuse or neglect, such as in cases of alleged sexual abuse or domestic violence. We heard from six counties we visited that caseworkers sometimes have difficulty closing their assessments in a timely manner because of a lack of coordination with law enforcement. For example, law enforcement in some counties do not want the caseworker to interview the alleged perpetrator until law enforcement does, or the caseworker cannot close the assessment until law enforcement's investigation is complete. We found examples of this problem in our audit work, including:

  - One referral in which the caseworker had to follow up with the law enforcement agency three times over 11 days before the agency assigned an investigating officer. During this time, the caseworker did not take any action to interview the family and complete the assessment.

  - An incident reviewed by the Child Fatality Review Team in which a county, at the request of law enforcement, did not notify parents

suspected of sexual abuse of a child. Counties are required by statute [Section 19-3-308(3)(a), C.R.S.] to advise alleged perpetrators of allegations and to afford them an opportunity to respond. The Department told us it is common for counties to comply with law enforcement requests during the investigation in order to preserve the ability of law enforcement to complete a criminal investigation. One of the purposes of the cooperative agreement is to help agencies plan in advance for these sorts of conflicts.

- An incident reviewed by the Child Fatality Review Team in which law enforcement officers did not allow anyone, including the county department of human/social services' treatment team, to provide support to siblings of a child victim.

It is also important that when county departments of human/social services establish cooperative agreements, those agreements are updated periodically to reflect current child welfare laws, policies, and initiatives, as well as changes in leadership at either the county department of human/social services or the law enforcement agency. For example, law enforcement stakeholders we spoke to pointed out that there may be nearly 30 new sheriffs in Colorado following the November 2014 elections, which may require revisiting existing cooperative agreements. Doing so would help ensure that the new leadership is aware of the agreement and that they agree with the terms of the agreement or make revisions, if necessary.

Finally, without agreements between counties and the State Patrol, county departments of human/social services may not be aware of incidents that require their involvement. For example, in 2011 there was a car accident that resulted in the death of a child and injuries to the other children in the vehicle. None of the children were wearing seatbelts or any type of restraints at the time of the accident. The Colorado State Patrol investigated the accident and charged the parents with child abuse resulting in death and in serious bodily injury. The county where this accident occurred did not have a cooperative agreement established with the State Patrol, and the State Patrol did not make a referral to any county departments of

human/social services related to the incident. The hospital treating the victims called in a referral to the county.

RECOMMENDATION 11

The Department of Human Services should promote compliance with the statutory requirement that county departments of human/social services establish cooperative agreements with the law enforcement agencies in their jurisdictions by:

A Working with the State Board of Human Services to promulgate in rule, or otherwise provide, formal written guidance on (i) establishing effective cooperative agreements and (ii) reviewing and updating the agreements on a specified frequency.

B Implementing processes to obtain county agreements, including any time the agreements are revised; review the agreements for compliance with requirements in statute, rule, and applicable guidance; and provide technical assistance to counties that do not have adequate agreements.

C Providing a statewide agreement with Colorado State Patrol that counties can use, or ensuring that counties create a separate agreement.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: MARCH 2015.

The Department agrees to work with the State Board of Human Services to promulgate in rule, or otherwise provide formal written guidance, on establishing effective cooperative agreements by March 2015 and reviewing and updating the agreements on a specified frequency by January 2015.

B AGREE. IMPLEMENTATION DATE: MARCH 2015.

The Department agrees to implement processes to obtain county agreements, including any time the agreements are revised; review the agreements for compliance with requirements in statute, rule, and applicable guidance; and provide technical assistance to counties that do not have adequate agreements. This action alone may not be sufficient as neither CDHS nor any other single State agency has the authority to enforce this requirement upon local law enforcement agencies and there are no consequences should a local law enforcement agency refuse to enter into an agreement as was identified in the audit.

C AGREE. IMPLEMENTATION DATE: JANUARY 2015.

The Department agrees to keep its statewide agreement with the Colorado State Patrol up to date and to make it available so all county departments have the choice to sign on to the statewide agreement or create a separate agreement of their own that complies with statutes and rules.

COLLABORATIVE MANAGEMENT PROGRAM

The General Assembly created the Collaborative Management Program (CMP) in 2004 to encourage and reward collaboration among the local and state social service systems—such as child welfare, mental health, and local school districts—that serve children and families who are involved with these multiple systems. Statute establishes a framework for the CMP that is intended to create a "more uniform system of collaborative management" and accomplish the following four statutory goals [Section 24-1.9-101(3)(a), C.R.S.]:

- Reduce service duplication and eliminate fragmentation.
- Increase service quality, appropriateness, and effectiveness.
- Encourage cost sharing among providers.
- Lead to better outcomes and reduced costs for the services provided to participants.

Statute allows one or more county departments of human/social services to execute Memoranda of Understanding (MOUs) with other state and local social service agencies and involve the child and his or her family in managing services and developing an integrated treatment plan. For the purposes of this report, "CMP" refers to the combination of state and local social service agencies, including the Department, that together are involved in implementing collaborative management across the state.

COLLABORATIVE MANAGEMENT PROGRAM OVERSIGHT

By statute, oversight of, and accountability for, the CMP are shared between county-level programs and the Department.

COUNTY-LEVEL PROGRAMS. "County-level program"—the term used in this report to refer to the local-level programs created by county departments of human/social services and their partners as executed through MOUs—are responsible for day-to-day operation of the CMP and the provision of services to participating children and families. CMP participation by county departments of human/social services is voluntary, but to participate, each county or group of counties must agree to (1) enter into an MOU with representatives of state and county systems that serve children, and (2) create an Interagency Oversight Group (Oversight Group), which oversees the CMP at the local level. Statutes also authorize Oversight Groups to create individual service and support teams (Service Teams), which are multidisciplinary assessment and service teams that focus on developing an integrated service plan for a child and family [Section 24-1.9-102(1)(a), C.R.S.]. County participation in the CMP has increased from six counties in Fiscal Year 2006, to 35 counties, representing 32 county-level programs, in Fiscal Year 2013.

DEPARTMENT AND STATE BOARD OF HUMAN SERVICES (STATE BOARD). Statute (Section 24-1.9-101, et seq., C.R.S.) authorizes the Department and State Board to oversee specific aspects of the CMP. First, the Department, in conjunction with the Judicial Department, was required to develop a model MOU based on elements outlined in statute. Further, the Department is responsible for (1) specifying the performance measures that county-level programs must meet to be eligible for incentive funds, (2) determining the methodology for allocating incentive funds, (3) providing training and technical assistance, and (4) overseeing an external evaluation of the CMP. The State Board is responsible for approving the Department's proposal for allocating incentive funds and for promulgating rules specifying

the "elements of collaborative management" and the method for determining "general fund savings."

House Bill 08-1005 authorized the Department to contract for ongoing external evaluations of counties participating, as well as not participating, in the CMP. The Department and CMP stakeholders use the external evaluation to evaluate the CMP's progress in meeting legislative intent and the goals outlined in statute. The Department's evaluation contractor (contractor) was selected in 2009 to conduct a 5-year phased evaluation of the CMP, producing a report each year. The contractor maintains a database to support the evaluation, and began collecting county-submitted data on program participants in Fiscal Year 2012. The contractor also collects annual report data from county-level programs; these data are self-reported and unverified.

PARTICIPANTS, SERVICES, AND FUNDING

Statute requires CMP services to be targeted toward "children and families who would benefit from integrated multi-agency services" [Section 24-1.9-102(2)(c), C.R.S.]. Typically, these are children involved in the most complex social services cases and, thus, are the most costly to serve. Children and families who need services from multiple agencies may have more than one assessment, receive case management services from more than one caseworker, and have more than one case plan, increasing the cost and complexity of service delivery. The CMP intends to organize and integrate services around the child.

CMP services are unique to each county-level program but can include prevention, intervention, or treatment services; family stabilization services; out-of-home placement services; probation services; public assistance; medical assistance; and any other services that the parties to the MOU deem necessary. According to information reported by county-level programs to the Department, approximately 21,000

individuals (a duplicated figure that includes both children and family members) received services through the CMP in Fiscal Year 2013.

Statutes identify two funding sources for the CMP. First, Section 24-1.9-104, C.R.S., created the Performance-based Collaborative Management Incentive Cash Fund (Incentive Fund), funded by fees from divorce proceedings, as a source of funds to incentivize county participation in the CMP. The Department allocates incentive funds to county-level programs each fiscal year. Second, Section 24-1.9-102(2)(h)(I), C.R.S., requires county-level programs to determine general fund savings and allows them to retain the savings to reinvest in providing appropriate support to children and families who would benefit from collaborative management of treatment and services.

MEMORANDA OF UNDERSTANDING AND INCENTIVE FUNDING

In accordance with statute (Section 24-1.9-102, C.R.S.), the Department has jointly developed with the Judicial Department an MOU template and has created a checklist to assist county-level programs with developing their MOUs. In addition, the Department allocates incentive funds according to a formula described below, which was developed with input from county-level programs and was first implemented for the Fiscal Year 2006 performance period.

BASE ALLOCATION. The first incentive fund allocation is the base allocation or "meaningful minimum." The Department pays the meaningful minimum to county-level programs that execute an MOU and report meeting at least one of four of their performance measures. The meaningful minimum is $33,500 if the county-level program operates in one of the 10 large counties (Adams, Arapahoe, Boulder, Denver, El Paso, Jefferson, Larimer, Mesa, Pueblo, or Weld). These counties represent about 85 percent of the child welfare workload. The meaningful minimum is $25,500 if the county-level program operates in one of the remaining counties, or "balance-of-state" counties. Nine large counties (all but Arapahoe) and 26 balance-of-

state counties participate in the CMP. All county-level programs met at least one performance measure and received the meaningful minimum allocation for Fiscal Year 2013.

REMAINING ALLOCATION. Once the Department has paid out the meaningful minimum allocations, it allocates remaining incentive funds on a per-share basis to county-level programs that have reported achieving additional performance measures. The following three factors drive the number of shares county-level programs earn:

- **NUMBER OF PERFORMANCE MEASURES THE COUNTY-LEVEL PROGRAM REPORTED MEETING.** County-level programs must develop a total of four performance measures, one for each of four Department-specified domains: child welfare, juvenile justice, education, and health/mental health. Once county-level programs receive their meaningful minimum, they earn one additional share for meeting each additional performance measure.

- **PROPORTION OF THE CHILD WELFARE POPULATION SERVED BY THE COUNTY-LEVEL PROGRAM.** County-level programs receive one share if they estimate they will serve less than one-third of their child welfare population; two shares if they estimate they will serve between one-third and two-thirds of their child welfare population; and three shares if they estimate they will serve more than two-thirds of their child welfare population.

- **SIZE OF THE COUNTY.** The 10 large counties receive three shares, and the balance-of-state counties receive one share.

Exhibit 4.3 shows the number of shares county-level programs may earn based on the number of performance measures they report achieving, the proportion of child welfare population they estimate serving, and the size of the county.

EXHIBIT 4.3 PERFORMANCE-BASED COLLABORATIVE MANAGEMENT INCENTIVE CASH FUND
ALLOCATION FACTORS AND SHARES EARNED
REMAINDER OF INCENTIVE FUND ALLOCATION[1]

	Performance Measures Achieved[2]			Proportion of Child Welfare Population Estimated Served by the County-Level Program			Size of County	
	One	Two	Three	1/3 or Less	Between 1/3 and 2/3	More than 2/3	Balance-of-State	10 Large
Number of shares earned per factor	1	2	3	1	2	3	1	3

SOURCE: Office of the State Auditor's analysis of documentation provided by the Department of Human Services.
[1]Remainder of incentive fund allocation is paid out after county-level programs have received their base allocations or "meaningful minimums."
[2]Indicates the additional performance measures, in addition to the first performance measure, that each county-level program reported achieving.

The Department tallies the number of shares each county-level program has earned and calculates the total shares earned by all county-level programs. The Department then divides the remaining incentive funds by the total number of shares earned by all county-level programs to determine the allocation amount per share. Finally, the Department multiplies the allocation per share by the number of shares each county-level program earned to allocate remaining incentive funds.

Revenue and expenditures for the incentive fund have remained largely stable from Fiscal Years 2009 through 2013. On average, each year the incentive fund received approximately $2.8 million in revenue from court fees and interest and had expenditures of approximately $3.3 million, which were mainly for incentive payments to counties and payments to the evaluator. The expenditure amounts above the annual revenue are funded from a fund balance, which has decreased from approximately $3.1 million at the start of Fiscal Year 2009 to approximately $380,000 at the close of Fiscal Year 2013.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

We reviewed CMP statutes and rules and MOUs for all 32 county-level programs during Fiscal Year 2013 to determine whether required processes were included, county-submitted performance measures met statutory requirements, and MOUs met required deadlines. We conducted a detailed review of a sample of eight MOUs to determine whether they adequately addressed the "elements of collaborative management" outlined in statute and in rule. We interviewed Department staff and the contractor that conducts an annual evaluation of the CMP, conducted site visits at a sample of eight counties participating in the CMP, and talked to members of the CMP steering committee established by the Department. We reviewed the following materials to understand CMP operations and outcomes: the contractor's annual evaluation reports for Fiscal Years 2012 and 2013, county-level program annual reports submitted for Fiscal Year 2013, the CMP handbook prepared by the steering committee, and other resources maintained on the CMP website. Finally, we reviewed the Department's methodology for allocating incentive funds and the allocations made to county-level programs for the Fiscal Year 2013 performance cycle.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

The General Assembly outlined specific processes that county-level programs must include when executing an MOU to participate in the CMP. These processes include:

- **ESTABLISHING COLLABORATIVE MANAGEMENT PROCESSES.** Statute [Section 24-1.9-102(2)(e), C.R.S.] requires county-level programs to establish "collaborative management processes" that address the following five elements: risk-sharing, resource-pooling, performance expectations, outcome-monitoring, and staff training. To assist with complying with this statutory requirement, the MOU template and

checklist require county-level programs to specify their collaborative management processes in their MOUs.

- **DEFINING THE TARGET POPULATION.** Statute broadly defines the target population as "children and families who would benefit from integrated multi-agency services." However, statute also requires county-level programs to develop and include a functional definition of the targeted service population in their MOUs [Section 24-1.9-102(2)(c), C.R.S.]. The MOU template provides the following example of a functional definition for the target population: "children and families of children with complex needs…[which] include, but are not limited to, the need for substantial services and supports to address the areas of developmental, physical, and mental health; substance abuse; risk and/or criminal behaviors; homelessness; domestic violence; and abuse/neglect." Rules (Section 7.303.36, 12 C.C.R. 2509-4) require the Department to approve the functional definition submitted by county-level programs.

  In addition, the Department is responsible for allocating incentive fund monies to county-level programs that meet the following three conditions [Section 24-1.9-104(3)(a), C.R.S.]:

- Submit signed MOUs regarding collaborative management. Rules require county-level programs to submit, and the Department to accept, signed MOUs by July 1 of each fiscal year (Section 7.303.35, 12 C.C.R. 2509-4).

- Successfully implement the elements of collaborative management specified in rule.

- Meet or exceed the performance measures specified by the Department.

  The statute does not provide specific guidance on what should be considered when allocating incentive funds.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

MEMORANDA OF UNDERSTANDING

Although all 32 county-level programs have executed MOUs, we found that some of the required processes set forth in statute were not implemented by all county-level programs. Specifically:

SOME MOUS DID NOT ADDRESS THE FIVE COLLABORATIVE MANAGEMENT PROCESSES REQUIRED BY STATUTE. Five of the eight MOUs we reviewed in detail (63 percent) did not provide any information on how the county-level program planned to establish the collaborative management processes.

SOME COUNTY-LEVEL PROGRAMS DID NOT ALIGN THEIR TARGET SERVICE POPULATION WITH THE STATUTORY DEFINITION. Although all 32 county-level programs provided a functional definition for "children and families who would benefit from integrated multi-agency services," definitions varied widely, raising questions as to whether the definitions are consistent with statute. For example, out of our sample of eight counties, two counties' target populations included every child with an open child welfare case. However, not every child with an open child welfare case would necessarily benefit from integrated multi-agency services, the focus of the target population defined in statute. Despite the wide variation, the Department approved all of the functional definitions.

The Department's Fiscal Year 2013 external evaluation report points out variations across county-level programs in terms of both the defined target population and alignment with the statutory definition. According to the report, county-level programs reported that of the 3,153 newly-enrolled participants who were served by Service Teams and provided information on level of involvement with multiple agencies at enrollment, only 1,738 (55 percent) were receiving services from more than one agency at the time of enrollment. The evaluation results raise questions as to whether the other 45 percent of

participants, who were reportedly receiving services from only one agency, fit the statutory definition of benefitting from integrated multi-agency services.

INCENTIVE FUNDING

We found fundamental problems with the Department's allocation of $1.3 million in incentive fund monies for the Fiscal Year 2013 performance cycle, as outlined below.

INCENTIVE FUNDS AWARDED WITHOUT ENSURING CONDITIONS REQUIRED IN STATUTE AND RULE WERE MET. For the Fiscal Year 2013 performance cycle, the Department did not verify that county-level programs met all applicable conditions before awarding incentive funds.

- **LATE MOUS.** The Department allocated incentive monies to 10 of 32 county-level programs (31 percent) that did not have MOUs submitted and accepted by the July 1, 2012, deadline. For these 10 county-level programs, the number of days late ranged from 9 to 72 days.

- **LACK OF EVIDENCE THAT THE ELEMENTS OF COLLABORATIVE MANAGEMENT SPECIFIED IN RULE WERE "SUCCESSFULLY IMPLEMENTED."** Seven of the eight MOUs reviewed in detail during our audit (88 percent) did not provide information on how the county-level program had or planned to address any of the six CMP components required by rule.

- **LACK OF DEPARTMENT-SPECIFIED PERFORMANCE MEASURES AND METHODS TO VERIFY PERFORMANCE RESULTS.** Once the Department "accepts" the MOUs and performance measures, the Department considers the measures to be "Department-specified." In total, county-level programs selected 128 different performance measures for Fiscal Year 2013. County-level programs indicated that developing their own performance measures allows them to focus their programs on the specific needs of their communities.

ALLOCATION METHODOLOGY DOES NOT APPEAR TO EQUITABLY INCENTIVIZE PERFORMANCE. Specifically:

- **A GREATER PROPORTION OF INCENTIVE FUNDS GOES TO LARGE COUNTIES THAN TO BALANCE-OF-STATE COUNTIES.** For Fiscal Year 2013, large and balance-of-state county-level programs received base allocations of $33,500 and $25,500, respectively, for implementing CMP and meeting one performance measure. However, large counties received proportionally more incentive funds—about double—for achieving additional performance measures than balance-of-state counties. For example, El Paso County, a large county that estimated it would serve two-thirds or more of its child welfare population, received an additional $33,607, or just over 100 percent of its base allocation, for meeting all three additional performance measures in Fiscal Year 2013. By contrast Lincoln County, a balance-of-state county that also estimated it would serve two-thirds or more of its child welfare population, received an additional $11,202, or 44 percent of its base allocation, for meeting all three additional performance measures in Fiscal Year 2013. In other words, although both counties estimated they would serve the same percentage of their child welfare population, and both counties achieved all four performance measures, the large county received an incentive that was proportionally more than double the incentive provided to the balance-of-state county.

- **BASE ALLOCATION DOES NOT REFLECT THE NUMBER OF PARTICIPANTS COUNTY-LEVEL PROGRAMS SERVE IN THE CMP.** Each of the nine large county-level programs received base allocations of $33,500 in Fiscal Year 2013, but reported serving widely varying numbers of participants—as few as 84 in Pueblo County and as many as 3,634 in Larimer County. Similarly, each of the 23 balance-of-state county-level programs received base allocations of $25,500 during Fiscal Year 2013, but reported serving as few as eight participants in Park County and as many as 2,058 participants in Fremont County. Further, two balance-of-state counties (Fremont and Chaffee) reported serving more participants than four large counties (Adams, El Paso, Jefferson, and Pueblo). However, Fremont and Chaffee Counties received base

allocations of $25,500, while Adams, El Paso, Jefferson, and Pueblo Counties received base allocations of $33,500. The self-reported number of participants is not verified by the Department and may include duplicates.

- **Allocation of remaining incentive funds not based on actual proportion of child welfare population served in the CMP.** We found that 14 of the 32 county-level programs (44 percent) served fewer participants than they estimated they would serve and that five county-level programs (16 percent) served more participants than they estimated they would serve. Exhibit 4.4 compares the estimated and actual participants served as reported by these 19 county-level programs for Fiscal Year 2013. The five county-level programs that reported serving more participants than estimated are shaded in blue.

EXHIBIT 4.4. COMPARISON OF ESTIMATED AND ACTUAL PARTICIPANTS SERVED AS REPORTED BY COUNTY-LEVEL PROGRAMS FISCAL YEAR 2013

County	Percent of Open Child Welfare Cases County-Level Programs Estimated Serving[1]	Percent of Open Child Welfare Cases County-Level Programs Actually Served[2]
LARGE COUNTIES		
Denver	2/3 or more	1/3 to 2/3
El Paso	2/3 or more	1/3 or less
Jefferson	2/3 or more	1/3 to 2/3
Mesa	1/3 to 2/3	1/3 or less
Pueblo	1/3 to 2/3	1/3 or less
BALANCE-OF-STATE		
Alamosa	2/3 or more	1/3 or less
Douglas	1/3 or less	1/3 to 2/3
Eagle	1/3 to 2/3	1/3 or less
Elbert	2/3 or more	1/3 to 2/3
Fremont	1/3 to 2/3	2/3 or more
Garfield	1/3 to 2/3	2/3 or more
Lincoln	2/3 or more	1/3 or less
Logan	1/3 or less	2/3 or more
Montezuma/Dolores	2/3 or more	1/3 to 2/3
Montrose	1/3 to 2/3	1/3 or less
Morgan	2/3 or more	1/3 to 2/3
Park	1/3 to 2/3	1/3 or less
Rio Grande	1/3 to 2/3	1/3 or less
Teller	1/3 to 2/3	2/3 or more

SOURCE: Office of the State Auditor's analysis of documentation provided by the Department of Human Services and the Department's contractor.
[1]Calculated by the Department from estimates provided by county-level programs in their memoranda of understanding.
[2]Reported by county-level programs to the Department's contractor through the annual report template. Figures are not verified and may include duplicates.

WHY DID THE PROBLEMS OCCUR?

County-level programs clearly have responsibility for operating their programs; however, the Department and State Board also have statutory responsibility for establishing expectations for the CMP, such as through the promulgation of rules to define the elements of collaborative management, the development of an MOU template that incorporates statutory requirements, and the specification of performance measures.

THE DEPARTMENT HAS NOT DEVELOPED AN ADEQUATE MOU REVIEW PROCESS OR MOU TEMPLATE. First, the Department's MOU review process does not always identify or reject MOUs that are inconsistent with statutory requirements, including MOUs that:

- Fail to address the collaborative management processes required by statute.

- Contain functional definitions for the targeted population that are not closely aligned with the statutory definition. Rules authorize the Department to review and "approve" target populations defined by county-level programs.

Second, the MOU template does not clearly state requirements and expectations, or provide sufficient detail, to enable county-level programs to explain their programs or the Department to identify insufficiencies. The MOU template and instructions do not:

- Specify the detail county-level programs should provide when explaining their collaborative management processes. For example, the MOU template and instructions do not define the five collaborative processes or indicate the amount of detail programs are expected to provide when specifying their processes or explaining how their processes will achieve statutory goals.

- Explain that county-level programs must submit functional definitions for their targeted population that align with the guidance provided in

the instructions or state that MOUs will be rejected if functional definitions are not consistent with the guidance.

- Require county-level programs to explain how they plan to implement the six required CMP components outlined in rule or provide clear guidance to communicate what county-level programs must do to demonstrate "successful implementation" of the elements of collaborative management.

Third, the Department stopped enforcing the July 1 deadline for the MOUs. Department staff report that some county-level programs have had difficulty acquiring timely signatures from their mandated partners and, therefore, in July 2011 the Department stopped enforcing the July 1 deadline and instead agreed to accept MOUs up to 90 days late. However, the Department did not request a revision to change the July 1 deadline in rule.

THE DEPARTMENT HAS NOT SPECIFIED PERFORMANCE MEASURES. The Department interprets CMP statutes as allowing county-level programs to develop their own performance measures within four Department-specified domains. County-level programs have selected 128 different measures. Our review of the statute indicates the Department's interpretation may be inconsistent with the plain meaning and intent of the statute. First, according to Merriam-Webster Dictionary, "specify" means "to name or state explicitly or in detail." Establishing four broad domains within which counties may select performance measures does not appear to constitute stating measures explicitly or in detail. Second, the General Assembly indicated in the legislative declaration for the CMP that "a uniform system of collaborative management is necessary…to effectively and efficiently collaborate to share resources or to manage and integrate the treatment and services provided to children and families who benefit from multi-agency services" [Section 24-1.9-101(2), C.R.S.]. Although county-level programs may benefit from evaluating their performance on measures that are specific to their programs, using up to 128 performance measures that vary across counties as a basis for providing incentive funding does not appear consistent with statute. In

addition, although county-level programs reported meeting 116 of the performance measures they selected (91 percent), the Department has no procedures to verify the data and performance results.

THE DEPARTMENT DOES NOT MONITOR PROGRAM IMPLEMENTATION to verify whether county-level programs have successfully implemented their programs in accordance with statute, rule, and plans set forth in MOUs or to verify performance results. The Department indicates that it has a one-half full-time-equivalent (FTE) position overseeing the CMP and lacks both statutory authority and appropriated resources for monitoring county-level programs or verifying reported data. We address the Department's authority in more detail at the end of this chapter. The Department has authority and resources available through the incentive fund for conducting the external evaluation.

THE DEPARTMENT'S INCENTIVE FORMULA HAS NOT BEEN SIGNIFICANTLY MODIFIED since it was first implemented for the Fiscal Year 2006 performance period. The problems identified in this audit, along with decreases in incentive funding and increases in the number of county-level programs participating, indicate a need for the Department to reevaluate the allocation methodology on an ongoing basis to ensure allocations are equitable and adequately incentivize performance within the funds available. Over the past 8 years, the number of county-level programs participating in the CMP has increased from six to 32, and the incentive funds available for distribution to county-level programs have decreased by 50 percent from $2.6 million in Fiscal Year 2006 to $1.3 million in Fiscal Year 2013. Consequently, incentive funds are allocated across more county-level programs and less funding is available per county-level program. The Department convened a subcommittee in August 2011 to study the incentive fund performance measurement and allocation process and make recommendations for improvement, but as of the completion of our audit, no changes have been implemented.

In June 2013, the Department's evaluation contractor recommended the Department consider standardizing several key areas of the CMP including (1) Department-specified performance measures to establish

what the CMP should achieve, (2) a defined target population that would benefit from collaborative management efforts and achieve the outcomes intended by the legislation, and (3) core data elements and clear data collection expectations (discussed at the end of this chapter). The contractor also recommended the Department consider adopting standardized outcome measures already in use by the Department, which would allow outcomes for CMP participants to be compared with outcomes for non-CMP participants as suggested by statute [Section 24-1.9-102.5, C.R.S.]. Additionally, the contractor suggested the Department consider developing process measures to incentivize standardized practices.

WHY DOES THIS FINDING MATTER?

By not implementing the requirements outlined in statute, the CMP is not operating as intended by the General Assembly, accomplishing statutory goals, or maximizing the benefits the CMP was intended to achieve. In addition, the Department cannot ensure that the roughly $15.3 million in incentive funds allocated from Fiscal Years 2009 through 2013 were used to equitably incentivize and reward performance, as intended by statute.

First, when MOUs do not address the five collaborative management processes, it is unclear whether the processes are actually in place and operate effectively to reduce duplication and fragmentation, improve the quality of services, achieve better outcomes for participants, or encourage cost-sharing, as directed by statute.

Second, when county-level programs do not align their service population with the statutory definition, programs may be serving participants the General Assembly did not intend to serve, which may in turn reduce funds available for serving the intended target population. Ensuring that services are directed toward complex cases involving multiple systems and providers provides maximum opportunities for the CMP to achieve the efficiencies and cost savings intended by statute.

Third, by not ensuring that MOU submission and acceptance deadlines comply with rules, the Department has not placed all county-level programs on equal footing for the purpose of evaluating their eligibility for incentive funding, since some programs will be assessed on a full fiscal year of performance data, while other programs will be assessed on as few as 9 months of performance data before becoming eligible to receive incentive funds.

Fourth, without methods to gather evidence that county-level programs have successfully implemented the elements of collaborative management, or to verify the accuracy and reliability of performance data, the Department cannot be sure that county-level programs have actually implemented programs consistent with the statutory and regulatory requirements and goals, or that the programs have achieved their reported results. The Department also cannot reasonably rely on the results for allocating incentive funds.

Fifth, by not developing a set of Department-specified performance measures, the Department has not identified the results the CMP should achieve in accordance with statute or communicated the results county-level programs should strive to accomplish to receive incentive funding. The Department also cannot compare performance results across county-level programs or identify strong and weak-performing programs. One of the eight counties we visited expressed concerns about the latitude counties had with respect to selecting performance measures. This county was concerned that goals associated with the measures were not set high enough to motivate continuous improvement.

Finally, by using estimated rather than actual data to calculate incentive distributions, the Department is overpaying some programs and underpaying others. We recalculated the incentive fund distributions based on the number of participants that county-level programs reported actually serving, rather than the number of participants they estimated serving. According to our calculations, the Department overpaid 14 county-level programs by amounts ranging

from about $1,400 to $20,000, and underpaid five county-level programs by amounts ranging from about $3,600 to $9,900.

RECOMMENDATION 12

The Department of Human Services (Department) should improve its oversight of the Collaborative Management Program (CMP) by:

A Establishing procedures and deadlines to comply with State Board of Human Services (State Board) rules for submitting and accepting memoranda of understanding (MOUs) or working with the State Board to revise the deadlines. The Department should then communicate the due dates to county-level programs and discontinue allocating incentive funds to county-level programs that do not submit MOUs in accordance with rules.

B Establishing processes to determine whether county-level programs have "successfully implemented the elements of collaborative management," working with the State Board as needed. This should include working with the Judicial Department to revise the MOU template to adequately capture statutory and regulatory requirements, including defining the target population and detailing expectations and requirements for collaborative management processes; promulgating and communicating guidance; and establishing MOU review criteria and checklists.

C Developing a set of standardized performance measures that (i) specify the results that all county-level programs must achieve to be eligible for incentive funding; (ii) are based on outcome measures already used by the Department to allow comparisons between CMP participants and non-CMP participants; and (iii) include process measures to incentivize compliance with Department requirements, statutes, and rules.

D Establishing a monitoring program to (i) determine whether county-level programs have implemented collaborative management in accordance with statute, rule, and MOUs and (ii) verify the accuracy and reliability of county-level program performance data used to award incentive funding.

E Revising the allocation methodology to ensure that it incentivizes and rewards performance in an equitable manner within the funds available, and uses actual data on participants served to allocate incentive payments.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: JUNE 2015.

The Department agrees to establish procedures and deadlines to comply with State Board of Human Services rules for submitting and accepting MOUs or working with the State Board to revise the deadlines. The Department will then communicate the due dates to county-level programs and discontinue allocating incentive funds to county-level programs that do not submit MOUs in accordance with rules.

B AGREE. IMPLEMENTATION DATE: JUNE 2015.

The Department agrees to establish processes to determine whether county-level programs have "successfully implemented the elements of collaborative management," and work with the State Board to promulgate rules as needed. This will include working with the Judicial Department to revise the MOU template to adequately capture statutory and regulatory requirements, including defining the target population and detailing expectations and requirements for collaborative management processes; promulgating and communicating guidance; and establishing MOU review criteria and checklists.

C DISAGREE.

The Department disagrees with this recommendation because it

believes that local officials know their communities and citizens best (including children in need within their communities). The practice that CDHS has been using to establish performance measures is consistent with State law, which requires the Department to "specify measures." The Department allows participating counties to identify their proposed performance measures consistent with program requirements and locally identified needs. The Department reaches the specified measure objective through this process.

AUDITOR'S ADDENDUM

Statute [Section 24-1.9-104(3)(a), C.R.S.] authorizes the Department to allocate incentive funds if counties "met or exceeded the performance measures specified by the [Department]…." A plain reading of the statute indicates that the General Assembly expected the Department to specify measures that it would use as the basis for allocating incentive funds to the county-level programs.

D AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department agrees to establish a monitoring program to determine whether county-level programs have implemented collaborative management in accordance with statute, rule, and MOUs; and to verify the accuracy and reliability of county-level program performance data used to award incentive funding. However, without additional resources, the Department will only be able to monitor one collaborative per quarter. While the Department believes that such limited monitoring is insufficient, no administrative funds are allocated to the Department for this program with the exception of funds for the statutorily required external evaluation. The Department has repurposed a 0.5 FTE from existing staff. To increase the number of Collaborative Management Programs monitored per quarter, additional staffing resources would be required.

E AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department agrees to work with the county departments to revise the allocation methodology to ensure that it incentivizes and rewards

performance in an equitable manner within the funds available, and use actual data on participants served to allocate incentive payments.

GENERAL FUND SAVINGS

The legislative declaration for the Collaborative Management Program indicates that one purpose of creating the CMP was to reduce costs in the child welfare system. Specifically, the declaration (Section 24-1.9-101, C.R.S.) states that "the general fund moneys saved through utilizing a collaborative approach…will allow for reinvestment of these moneys…to provide appropriate support to children and families who would benefit from collaborative management of treatment and services."

The Department considers "general fund moneys saved through utilizing a collaborative approach" to be incurred when a county-level program underspends its Child Welfare Services allocation. Statute [Section 26-5-104(7), C.R.S.] provides that when counties collectively underspend their Child Welfare Services allocations, the Department may redistribute unexpended funds , based upon the recommendation of the Child Welfare Allocations Committee, to counties that overexpended their total allocation (referred to as "surplus distribution" in this report). The Allocations Committee's role according to statute [Section 26-5-103.5(1), C.R.S.] is to advise the Department regarding allocations to counties. The Department also uses the surplus distribution to distribute general fund savings to counties operating the CMP. To be eligible for the savings distribution, county-level programs must meet the following two conditions, as outlined in the CMP handbook:

- Elect in their MOUs that they will not participate in the surplus distribution and, instead, will participate in the savings distribution for the CMP.

- Underspend their Child Welfare Services allocation.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our work was to evaluate the adequacy of mechanisms used by county-level programs and the Department to measure and distribute general fund savings for CMP services. To accomplish this objective we (1) reviewed statutes and rules; (2) interviewed Department staff, conducted site visits at a sample of eight counties participating in the CMP, and spoke to members of the CMP steering committee established by the Department; (3) reviewed the Department's allocation formula and the total allocation amounts awarded to counties for Fiscal Years 2009 through 2013; (4) reviewed the Child Welfare Services allocation, expenditures, and surplus distribution for counties for Fiscal Year 2013; and (5) performed an in-depth review of the Fiscal Year 2013 MOUs for the six counties participating in the savings distribution. Three of the county-level programs involved two counties combining to create one entity. For purposes of our analysis, we report on the combined entities—the county-level programs.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

MEASURING GENERAL FUND SAVINGS. Statute [Section 24-1.9-102(2)(h)(I), C.R.S.] requires county-level programs to determine general fund savings in accordance with rules established by the State Board. Such a rule would provide a mechanism for counties to determine general fund savings in a valid and consistent manner. Statute [Section 24-1.9-103(1)(b), C.R.S.] further requires county-level programs to annually report "any estimated…cost savings that may have occurred by collaboratively managing the multi-agency services provided through [Service Teams]" to the Executive Director of each MOU partner agency.

DISTRIBUTING GENERAL FUND SAVINGS. Statute does not explicitly provide a mechanism for distributing general fund savings incurred as

a result of implementing the CMP. The surplus distribution statute [Section 26-5-104(7), C.R.S.] authorizes redistribution of unexpended Child Welfare Services allocations to counties "whose spending has exceeded [the] allocation" and does not explicitly authorize redistribution to the CMP.

WHAT PROBLEMS DID THE AUDIT WORK FIND AND WHY DID THE PROBLEMS OCCUR?

General fund savings from implementing the CMP is not measured consistently across county-level programs. Specifically:

- **COUNTY-LEVEL PROGRAMS AND THE DEPARTMENT DO NOT AGREE ON GENERAL FUND SAVINGS.** According to the Fiscal Year 2013 annual reports submitted by county-level programs, only four county-level programs (13 percent) reported earning general fund savings, which totaled, in combination, about $432,000. By contrast, the Department identified four different counties that earned almost $1.3 million in general fund savings through the Fiscal Year 2013 savings distribution. Exhibit 4.5 compares the general fund savings identified by the four counties through their annual reports with the savings identified through the Department's savings distributions for Fiscal Year 2013.

EXHIBIT 4.5. COMPARISON OF SAVINGS AS REPORTED BY COUNTY-LEVEL PROGRAMS AND AS DETERMINED BY THE DEPARTMENT IN FISCAL YEAR 2013

County-level Program	Reported Savings in Annual Report	Savings Distributed by Department
Adams	$0	$0
Alamosa	0	0
Boulder	0	0
Chaffee	0	0
Conejos	0	0
Crowley-Otero	0	43,306
Denver	0	1,145,871
Douglas	0	0
Eagle	0	0
El Paso	168,761	0
Elbert	0	0
Fremont	115,595	0
Garfield	0	0
Grand	0	43,785
Gunnison-Hinsdale	69,604	0
Huerfano	0	0
Jefferson	0	0
Lake	0	0
Larimer	77,746	0
Lincoln	0	0
Logan	0	0
Mesa	0	0
Moffat	0	0
Montezuma-Dolores	0	0
Montrose	0	0
Morgan	0	0
Park	0	0
Pueblo	0	59,599
Rio Grande	0	0
Routt	0	0
Teller	0	0
Weld	0	0
TOTAL	$431,706	$1,292,561

SOURCE: Office of the State Auditor's analysis of Fiscal Year 2013 county-level programs' annual reports and data provided by the Department.

As Exhibit 4.5 shows, the four county-level programs that received a savings distribution from the Department (Crowley-Otero, Denver, Grand, and Pueblo) for Fiscal Year 2013 reported no cost savings,

while the four county-level programs that reported cost savings in their annual reports (El Paso, Fremont, Gunnison-Hinsdale, and Larimer) received no savings distributions. In addition, the Department distributed roughly three times more in savings distributions than county-level programs reported saving.

- **General fund savings is not measured consistently across county-level programs.** Although 13 county-level programs underspent their Child Welfare Services allocation in Fiscal Year 2013, the Department distributed savings to only four of them, as shown in Exhibit 4.5. The remaining nine county-level programs did not receive a savings distribution because they elected to participate in the surplus distribution when they executed their MOUs at the beginning of the fiscal year. County-level programs that elect to participate in the surplus distribution and then underspend their Child Welfare Services allocation are not eligible for either a savings distribution or a surplus distribution. Had these nine county-level programs received a savings distribution in accordance with the Department's distribution formula, we estimate these counties would have received general fund savings distributions totaling about $660,000.

  The primary reason that county-level programs and the Department do not measure general fund savings consistently is that the State Board has not promulgated rules for how county-level programs should determine general fund savings, as required by statute. In the absence of adequate guidance, county-level programs and the Department have devised their own methods for measuring general fund savings. However, statute provides explicit authority for determining a method for measuring general fund savings only to the State Board; statute does not provide this authority to county-level programs or the Department.

- **Unclear statutory authority for the Department's general fund savings allocation.** The surplus distribution statute [Section 26-5-104(7), C.R.S.] does not explicitly authorize the Department to distribute general fund savings from unexpended Child Welfare Services allocations to county-level programs; rather, the statute [Section 26-5-104(7), C.R.S.] authorizes redistribution to counties

"whose spending has exceeded [the] allocation." Additionally, it is unclear that the Department has authority to require county-level programs to elect in their MOUs whether they will participate in either the savings distribution or the surplus distribution. Statute appears to allow all county departments of human/social services that overspend their child welfare allocations to participate in the surplus distribution, regardless of whether the county participates in the CMP.

The Department references Section 24-1.9-102(h)(II), C.R.S., as its authority for the general fund savings distribution. This provision states that "a county that has implemented a collaborative management process...**WHICH SERVICES ARE NOT INCLUDED...IN THE MEMORANDUM OF UNDERSTANDING**...and that underspends the general fund portion [of its Child Welfare Services allocation] may use the portion of general fund savings realized...for the provision of existing services for...children and families in the county" [emphasis added]. However, this provision appears to refer to collaborative services that counties may provide outside of the MOUs required by the CMP. Therefore, it is unclear that this provision provides the Department with authority to use the surplus distribution to distribute general fund savings under the CMP. In 2005, the Department sought informal legal advice from the Office of the Attorney General on the source of funds for determining general fund savings. The response from the Office of the Attorney General indicated that the statute is unclear and did not definitively resolve the general fund savings distribution issue.

WHY DOES THIS FINDING MATTER?

Fundamentally, no reliable cost savings data exist to indicate the extent to which one of the underlying purposes of the CMP—to achieve general fund savings to be reinvested to serve other children and families—is being accomplished. In addition, the problems we identified mean that some counties are unable to reinvest to provide services to additional children and families as intended by statute. Nine county-level programs that underspent their Child Welfare

Services allocations and may have incurred general fund savings of approximately $660,000 in Fiscal Year 2013 did not receive any savings distributions. Similarly, four counties reporting general fund savings in their annual reports totaling $432,000 did not receive any savings distribution. Therefore, general fund savings earned from collaborative management are not available to reinvest into serving more families.

Further, by using a portion of unspent child welfare funding to provide savings distributions, the Department reduces the amount available for surplus distributions to those counties that exceeded their allocations. Thus, both counties participating and not participating in the CMP that overspend their child welfare allocations potentially have smaller surplus distributions because there are fewer funds available to distribute.

RECOMMENDATION 13

The Department of Human Services should improve its management of general fund savings from the Collaborative Management Program (CMP) by:

A Working with the State Board of Human Services to promulgate a rule to determine general fund savings resulting from the CMP as set forth in Section 24-1.9-102(2)(h)(I), C.R.S.

B Discontinuing the practice of requiring county-level programs to elect either a savings or surplus distribution in their memoranda of understanding.

C Seeking further legal guidance on the use of surplus funds for distributing general fund savings, and proposing legislative change to establish a mechanism for distributing general fund savings, if needed.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A PARTIALLY AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department will work with the Child Welfare Allocation Committee and the State Board of Human Services to promulgate a rule to determine general fund savings resulting from the Collaborative Management Program (CMP) as set forth in Section 24-1.9-102(2)(h)(I), C.R.S. The Department sees a conflict between Title 24 and Title 26. The conflict arises as Title 24 directs the State Board to promulgate rules regarding general fund savings from the CMP, while Title 26 empowers the Child Welfare Allocation Committee to recommend the allocation of any unexpended capped funds at close out.

AUDITOR'S ADDENDUM

As noted in the report, statute [Section 24-1.9-102(2)(h)(I), C.R.S.] requires county-level programs to determine general fund savings in accordance with rules established by the State Board of Human Services. The State Board has not established any rules for determining general fund savings. As a result, counties and the Department use different methods to calculate the savings. Although statutes do charge the Child Welfare Allocations Committee with recommending the allocation of unspent child welfare funds to counties that have overspent their allocation [Section 26-5-104(7), C.R.S.], the Committee's role is to advise the Department [Section 26-5-103.5(1), C.R.S.]. As such, there does not appear to be a conflict between the State Board's rule making authority and the Child Welfare Allocations Committee's advisory role.

B DISAGREE.

The Department disagrees with this recommendation because the decision to discontinue the practice of requiring county-level programs to elect either a savings or surplus distribution in their MOUs is recommended by the Child Welfare Allocation Committee. The result of this action would impact the close out of the Child Welfare Block Grant in which the Child Welfare Allocation Committee has a statutory role.

AUDITOR'S ADDENDUM

According to statute [Section 26-5-104(7), C.R.S.], the Child Welfare Allocations Committee's role with regard to the surplus distribution is to make a recommendation to the Department regarding the surplus distribution to counties that have overspent their allocations. Although the Department may have instituted the process of requiring county-level programs to elect in their MOUs either the savings distribution or surplus distribution based on the recommendation of the Child Welfare Allocations Committee, statute appears to allow all county departments of human/social services that overspend their

child welfare allocations to participate in the surplus distribution regardless of whether the county participates in the CMP.

C AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department agrees to seek further legal guidance on the use of surplus funds for distributing general fund savings and proposing legislative change to establish a mechanism for distributing general fund savings, if needed.

DATA MANAGEMENT AND PROGRAM ACCOUNTABILITY

Through the collaborative management statute, the General Assembly has emphasized the importance of accountability for programmatic and expenditure data. Specifically, statute (Section 24-1.9-103, C.R.S) requires county-level programs to report programmatic and expenditure data through annual reports submitted to the Executive Directors of each county-level program's partner agency. The Department's contractor maintains a CMP database to collect county-submitted data on program participants. Accountability for programmatic and expenditure data, of necessity, depends on maintaining accurate, complete, and reliable data that are reviewed and verified before they are reported. Reliable data are the starting point for evaluating whether the CMP is achieving intended results and whether funding levels are adequate.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to determine whether the CMP has adequate, reliable data to demonstrate accountability and support decision making. We reviewed statutes and rules to determine data reporting requirements for the annual report and the evaluation prepared by the Department's contractor, and to identify required accountability mechanisms and statutory goals. We interviewed Department and contractor staff to find out how the CMP data are collected, maintained, and evaluated. We conducted site visits at a sample of eight counties participating in the CMP and spoke to members of the CMP steering committee established by the Department. We reviewed annual reports prepared by county-level programs and participant data submitted to the contractor's CMP

database as part of the Fiscal Year 2013 annual evaluation and performance cycle. We also reviewed CMP-related expenditure data recorded in the Department's County Financial Management System (CFMS) for Fiscal Years 2009 through 2013. Finally, we reviewed the CMP handbook to identify any guidance provided to county-level programs on accountability and reporting.

HOW WERE THE RESULTS OF THE AUDIT WORK MEASURED?

PROGRAMMATIC DATA. Statute [Section 24-1.9-103(1)(a), C.R.S.] requires county-level programs to annually report the number of children and families served through Service Teams and the outcomes of services provided. For county-level programs to be able to report meaningful programmatic information in response to this requirement, county-level programs must, out of necessity, maintain basic demographic, service, and outcome data for each participant.

EXPENDITURE AND COST DATA. Statute [Section 24-1.9-103(1)(b) and (c), C.R.S.] requires county-level programs to annually report any estimated cost-shifting or cost savings that may have occurred through managing multi-agency services through Service Teams, and an accounting of cost savings reinvested into additional services. Additionally, all county-level programs receive incentive funds and some receive allocations of general fund savings; these funds must be expended to provide services to children and families who would benefit from integrated multi-agency services [Sections 24-1.9-102(2)(h)(I) and 104(3), C.R.S.]. To identify cost-shifting or cost savings, and to demonstrate that incentive funds and general fund savings are spent to provide appropriate services to the participants outlined in statute, county-level programs must have systems in place to track expenditures by service type and funding source.

For programmatic and expenditure information to be useful for demonstrating accountability and supporting decision making, the data must be reliable. The U.S. Government Accountability Office

defines "reliability" as data that are complete and accurate. Completeness refers to the extent that all necessary records are present. Accuracy refers to the extent that recorded data reflect actual underlying information.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY?

PROGRAMMATIC DATA ARE NOT COMPLETE. The Department does not have complete data regarding the CMP or assurance that the data available are accurate. All participant data provided by county-level programs through annual reports or to the CMP database are self-reported and not verified for accuracy. Although the data issues described below apply to the Fiscal Year 2013 performance cycle, the same data issues have existed since the CMP began operating in Fiscal Year 2006.

- **PARTICIPANT DEMOGRAPHICS AND OUTCOME DATA.** Basic demographic information—such as name, age, gender, and address—and data on outcomes—such as whether participants had a repeat involvement with the child welfare system following provision of collaborative management services—are available at the statewide level for 6,577 CMP participants. This includes 3,318 participants who were newly enrolled in Fiscal Year 2012 and 3,259 participants who were newly enrolled in Fiscal Year 2013 and were reported by county-level programs to the contractor's CMP database. However, since county-level programs reported serving an estimated 21,000 total participants in their annual reports during Fiscal Year 2013, it is unclear how many individual children were served and are captured in the CMP database. As noted previously, the 21,000 total participants is a duplicated number, which may include both children and family members, and may be reported by more than one service agency.

- **SERVICE DATA.** The volume and types of services provided to participants, including child welfare services provided by county departments of human/social services or other services provided by MOU partner agencies, such as Medicaid and Temporary Assistance

for Needy Families (TANF), are lacking at the statewide level for all CMP participants.

- **EXPENDITURE AND COST DATA ARE NOT COMPLETE.** The county-level programs do not track or report complete expenditures and costs. Similar to the participant data discussed previously, issues with expenditures and costs have existed since the CMP began operating in Fiscal Year 2006. During Fiscal Year 2013, none of the 32 county-level programs reported having a process to measure cost-shifting or cost savings from their collaborative management efforts. Additionally, county-level programs do not report consistent data on incentive fund expenditures. According to data from CFMS, county-level programs recorded incentive fund expenditures totaling $1.7 million during Fiscal Year 2013. By contrast, annual report data submitted to the Department indicate that county-level programs spent a total of $3.3 million in incentive funds during Fiscal Year 2013. Since the cost data reported by the county-level programs is incomplete, the CMP does not have sufficient information to identify the cost-shifting or cost savings that may have occurred through managing multi-agency services through Service Teams, implementing collaborative management, and reinvesting in additional services.

WHY DID THE PROBLEM OCCUR?

Overall, the CMP lacks adequate data systems and data reporting protocols to ensure that complete and accurate programmatic and expenditure information is available to demonstrate accountability and support decision making.

THE CMP LACKS A SINGLE DATA SYSTEM. No single data system currently captures complete programmatic and expenditure data for all participants. Instead, three data systems track data related to the CMP—the Department's Trails and CFMS databases and the contractor's CMP database. None of these databases contains complete records on all CMP participants. Specifically, the Department's Trails database is used to track and monitor children who are either involved, or are receiving services to prevent their

involvement, with the child welfare system. County-level programs are not required to specify in Trails whether children receiving services through the child welfare system are also CMP participants; consequently, the CMP cannot easily identify its participants in the Trails database or determine which child welfare services its participants received. The CMP database, as noted previously, only maintains data on a subset of participants voluntarily reported by county-level programs, and this database does not contain service or expenditure data. To complicate matters further, some CMP participants receive services through other state or local partner agencies, and the services are funded by other funding sources, such as Medicaid or TANF; these participants are not recorded in Trails and not all are recorded in the CMP database. Due to lack of interoperability between Trails and the various automated systems operated by state and local partner agencies to the MOUs, the CMP cannot identify services provided or purchased through other state programs outside of the child welfare system and link these services to CMP participants.

DATA REPORTING STANDARDS AND PROTOCOLS ARE NOT IN PLACE. Statute (Section 24-1.9-102.5, C.R.S.) requires the Department, with input from the entities participating in the CMP, as well as others, to determine the criteria and components of the external evaluation. Statute also requires county-level programs to participate fully in the evaluation. The Department could use this authority to develop protocols for standardized reporting of programmatic and expenditure information by county-level programs.

THE DEPARTMENT QUESTIONS ITS AUTHORITY. The Department believes that the General Assembly specifically intended that accountability for the CMP rest primarily at the local level and that it lacks authority in statute to mandate data reporting and hold counties accountable for implementing requirements, which are key parts of the Department's responsibility to oversee incentive funds. Specifically, the Department points out that:

- The collaborative management statute does not charge one entity with supervising implementation or outcomes.

- The collaborative management statute does not specifically house the CMP within Title 26, the Human Services Code, or Title 19, the Children's Code, where the Department's authority for overseeing the child welfare system is clearly laid out.

- The State Board's rulemaking authority in the collaborative management statute is limited to specific areas, and statute [Section 24-1.9-102(1)(a), C.R.S.] directs the county-level program partner agencies to enter into MOUs designed to promote "a collaborative system of local-level interagency oversight groups and individualized service and support teams to coordinate and manage the provision of services…."

  As noted previously, the Department requested legal advice from the Office of the Attorney General in August 2005 to assist with interpreting a section of the collaborative management statute and the attorney identified difficulties with interpreting some of the statute's provisions. However, the Department did not seek further guidance from the Office of the Attorney General on its authority to oversee the CMP. The Department also has not requested statutory revisions from the General Assembly to further clarify its authority.

WHY DOES THE PROBLEM MATTER?

Due to the lack of basic data and accountability mechanisms, the Department has invested a total of $21.1 million ($15.3 million in incentive funds and $5.8 million in general fund savings) between Fiscal Years 2009 and 2013 without knowing whether the CMP is operating as intended. The absence of reliable programmatic and expenditure data has impaired the Department's ability to evaluate the success of the CMP in achieving the four goals outlined in statute and take steps to maximize the CMP benefits for participants. Basic accountability mechanisms recommended throughout this chapter, including data management protocols, promulgation of rules and

guidance, standardization of processes and performance measures, and monitoring, are needed to prevent the continued allocation of resources without evidence of results. Although county-level programs report qualitative information showing examples of the benefits achieved through collaborative management, quantitative evidence is lacking that the CMP has succeeded in (1) reducing duplication and fragmentation of services; (2) increasing the quality, appropriateness, and effectiveness of services provided; (3) promoting cost sharing among service providers; and (4) providing better outcomes and cost reduction for the services provided to children and families who would benefit from integrated multi-agency services.

Further, from Fiscal Years 2009 through 2013, the Department has paid its contractor approximately $1 million to conduct a statewide evaluation for 32 individual county-level programs that operate so differently that overall statewide performance cannot be assessed. To improve information on the impact of CMP services at the statewide level, the contractor recommended that the Department consider providing more direction and clearer standards related to outcomes, target population, implementation practices, and data.

RECOMMENDATION 14

The Department of Human Services (Department) should improve accountability for the Collaborative Management Program (CMP) by:

A Requesting an opinion from the Office of the Attorney General on whether the Department is exercising its full authority as permitted in current statute. Depending on the results of the opinion, the Department should ensure its practices are consistent with the opinion and work with the General Assembly to request clarification of its authority related to CMP funding, if needed.

B Developing improved data collection and reporting protocols for programmatic and expenditure data and requiring all county departments of human/social services that participate in county-level programs to comply with them. This could include requiring county departments to identify CMP participants in the child welfare system in Trails so that participant demographics, services, outcomes, and expenditures can be tracked and monitored.

C Assessing options for implementing a single data system to maintain CMP data. This should include determining whether to acquire capacity to bring data collection and management, currently performed by the contractor, in-house or evaluating the feasibility of improving the interoperability of existing state information systems to better track CMP data.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A DISAGREE.

The Department disagrees to request an opinion from the Office of the Attorney General (AG) on whether the Department is exercising its

full authority as permitted in statute. The Department believes that the Collaborative Management Program was written into Title 24 intentionally as a shared program with other State departments. The Department understands that it has accountability for, but only partial authority over, the program. The Department believes that children are best served by this program when decisions are made at the local level. If the Office of the State Auditor believes that the Department is to have more direct authority over the direction of this program, this policy decision should be resolved by the General Assembly, rather than interpreted by the AG's Office.

AUDITOR'S ADDENDUM

The report identifies several instances in which CMP does not appear to operate according to statutory requirements and the General Assembly's intent. Basic accountability mechanisms recommended in the report appear to be within the Department's existing statutory authority and are needed to prevent the continued allocation of resources without evidence of results. The recommendation does not suggest that the Department should have more direct authority over the CMP.

B PARTIALLY AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department agrees to develop improved data collection and reporting protocols for programmatic and expenditure data, and require all county departments that participate in county-level programs to comply. The Department believes that Collaborative Management Programs (CMP) best serve children and their communities when led at the local level; and, those counties should have sufficient flexibility to meet their unique community needs. The Department will partner with counties and other participating members of the CMPs to develop these new processes to be realistic and achievable. However, the Department disagrees with requiring county departments to identify CMP participants in the child welfare system in Trails. CMPs serve participants from one or more of the following domains: health/mental health, education, juvenile justice, and child welfare, some of which do not have access to Trails, the

statewide automated case management system for child welfare. Therefore, having some CMP participants in one data system and others in another data system(s) does not represent an improvement in data collection and reporting protocols.

AUDITOR'S ADDENDUM

The recommendation suggests having counties identify CMP participants in Trails as one possible method for improving the programmatic and expenditure information the Department has. The recommendation provides latitude for the Department to implement other mechanisms to accomplish this intent.

C AGREE. IMPLEMENTATION DATE: JULY 2015.

The Department agrees to assess options for implementing a single data system to maintain Collaborative Management Program (CMP) data. This will include determining whether to acquire capacity to bring data collection and management, which is currently performed by the contractor, in-house or evaluating the feasibility of improving the interoperability of existing state information systems to better track CMP data.

ENSURING PROGRAM OUTCOMES

As described throughout this chapter, the CMP currently lacks a variety of controls and accountability mechanisms, including methods to ensure that county-level programs implement statutory and regulatory requirements for the CMP; incentives are allocated equitably to achieve desired results; target populations are defined consistently with statute; methods for measuring and distributing general fund savings are consistent and comply with laws; and complete, reliable programmatic and expenditure data are collected and analyzed. Fundamentally, the CMP has been operating for 8 years without demonstrating that it has achieved any of the results intended by statute.

Given the shortcomings of the CMP, we were unable to draw any conclusions as to whether the CMP is effective in accomplishing its statutory purpose. The decision as to whether the CMP should continue as currently structured in statute is a matter of public policy and outside the scope of our audit. However, deficiencies identified in the implementation of the CMP according to statute raise questions as to the outcomes the CMP has achieved, which may indicate that an evaluation of whether the CMP should be discontinued, thereby making funds available for other purposes in the child welfare system, is appropriate.

CHAPTER 5

NEW INITIATIVES

In 2010, the General Assembly enacted House Bill 10-1226 (Section 19-3-308.3, C.R.S.), creating the Differential Response Pilot Program (Pilot Program) in five counties. The legislative declaration in House Bill 10-1226 noted that protection of children from abuse or neglect is the highest priority of Colorado's public child welfare system, but that existing laws and practices treated all reports of alleged child abuse or neglect in the same manner, often resulting in an adversarial court process when county departments of human/social services found that abuse or neglect did occur. The declaration went on to state that for some cases in which the safety of the child is not at risk,

an adversarial court process may not provide the best intervention to help the family prevent future incidents. Thus, the Pilot Program was established to provide a model for responding to allegations of child abuse or neglect that allows counties to provide services to low- or moderate-risk families without investigating whether abuse or neglect occurred. The General Assembly intended the Pilot Program to encourage willing families to participate in services that address the underlying causative factors resulting in child abuse or neglect; expedite the delivery of such services to families; and provide knowledge and skills to families to responsibly protect their children.

House Bill 10-1226 authorized the Department of Human Services (Department) to select the five counties to participate in the Pilot Program, and the Department selected Arapahoe, Fremont, Garfield, Jefferson, and Larimer Counties. The Colorado Consortium on Differential Response—a group composed of the five counties, the Division of Child Welfare, and Colorado State University (CSU)—received a $1.8 million federal research and development grant to fund implementation and administration of the Pilot Program from February 1, 2010, through September 30, 2014.

In 2012, the General Assembly passed Senate Bill 12-011, removing the limit on the number of counties the Department could select to participate in the Pilot Program. As of July 2014, the Department reported that eight counties had implemented differential response as part of the Pilot Program, and 22 counties were in various stages of preparation to begin using differential response. The enabling legislation for the Pilot Program will be repealed on July 1, 2015.

By January 1, 2015, the Department is required to submit an evaluation to the General Assembly that considers the Pilot Program's effectiveness in achieving (1) child safety and permanency, (2) family and caseworker satisfaction, and (3) cost effectiveness. The report is also required to include any problems encountered in operating the Pilot Program, recommendations the Department may have for legislation to address such problems, and a recommendation as to whether the General Assembly should repeal, continue for a specific

period, or establish the Pilot Program statewide on a permanent basis [Section 19-3-308.3(8)(c), C.R.S.].

This chapter describes our review of differential response as it was operating in Pilot Program counties at the time of our audit. We also reviewed counties' use of Review, Evaluate, and Direct (RED) Teams, a group decision-making process that was first introduced in Pilot Program counties as part of differential response. In its June 2013 "Annual Progress and Services" report to the federal government, the Department stated, "The [RED Team] program will be expanded to roll out in all counties, whether or not they are implementing differential response." According to Department information, implementation of RED Teams will be completed in all counties by December 2014.

OPERATION OF THE DIFFERENTIAL RESPONSE PILOT PROGRAM

Counties participating in the Pilot Program make a determination whether to handle each screened-in referral through either the differential response assessment track or through a traditional assessment track. Assessments conducted through the differential response track are referred to in rules and throughout Colorado's child welfare system as Family Assessment Response (FAR) assessments, while assessments conducted through the traditional track are referred to as "high risk" assessments. However, in this report, we refer to assessments conducted through the differential response track as "differential response" assessments for ease of understanding by all readers. We refer to assessments conducted through the traditional track as "investigative" assessments because an investigation to determine whether abuse or neglect occurred is required.

Investigative assessments are mandatory if a child is deemed at high risk of maltreatment based on the nature of the allegations and for referrals that allege a child fatality, near fatality, egregious incident, or sexual abuse. Differential response assessments can be assigned by a county if the referral has been assessed, pursuant to rule of the State Board, to be of low or moderate risk [Section 19-3-308.3(1)(a), C.R.S.]. According to an April 2011 letter issued by the Department, counties participating in the Pilot Program must generally comply with all the same requirements for differential response assessments as they do for investigative assessments. In addition, the Department, in cooperation with the Colorado Consortium on Differential Response, created a Differential Response Implementation Guide that provides guidance to promote consistent implementation of differential response in the Pilot Program counties. Exhibit 5.1 compares key aspects in which a county's involvement with families varies depending on whether the county is using an investigative assessment or differential response.

EXHIBIT 5.1. DIFFERENCES BETWEEN INVESTIGATIVE AND DIFFERENTIAL RESPONSE ASSESSMENTS

PROCESS STAGE	INVESTIGATIVE	DIFFERENTIAL RESPONSE
Assessment	Child must be interviewed away from the person responsible for the abuse or neglect.	Child can be interviewed in the presence of the person responsible for the abuse or neglect, unless the child's safety could be compromised.
Assessment	Assessment must be completed within 30 days, or within 60 days if an extension is approved.	Assessment must be completed within 60 days.
Finding	Counties are required to conclude on whether child abuse or neglect occurred.	Counties are **NOT** required to conclude on whether child abuse or neglect occurred.

SOURCE: Office of the State Auditor's analysis of statute (Section 19-3-101, et seq., C.R.S.), House Bill 10-1226, rules (12 C.C.R. 2509-3), and documentation provided by the Department of Human Services.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

We assessed whether the Department has sufficient controls over the assessment process for differential response cases handled in Pilot Program counties. To accomplish this objective, we (1) reviewed relevant statutes, rules, and other guidance promulgated by the Department; (2) interviewed and obtained information from Department staff about the differential response model and implementation of the Pilot Program in Colorado; (3) observed and interviewed county staff during site visits at 10 counties around the state, including three Pilot Program counties; and (4) reviewed Trails records for 10 referrals received during Fiscal Year 2013 that resulted in services provided through a differential response case. These 10 referrals were a part of our total random sample of 60 referrals.

Because this is a pilot program, our goal was to evaluate aspects of the program and provide results that can help inform decisions about differential response if the program becomes a permanent component of the child welfare system.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND HOW WERE RESULTS MEASURED?

To evaluate the 10 differential response assessments in our sample, we reviewed how counties handled assessments relative to statute, rules, and the Department's Differential Response Implementation Guide. Overall, we identified problems with how effectively Pilot Program counties handled assessments using the differential response process, as described below.

SOME DIFFERENTIAL RESPONSE ASSESSMENTS MAY HAVE BEEN MORE APPROPRIATELY ASSIGNED AS INVESTIGATIVE ASSESSMENTS. In our review of 10 sampled referrals that were assigned for differential response

assessments, we evaluated whether the Trails record indicated that counties had made the most appropriate decision in assigning referrals for differential response assessments. The decision of whether to assign a referral to the differential response track or the investigative assessment track requires judgment. Based on our review of the 10 referrals assigned for differential response against rules and applicable guidance, we concluded that it may have been more appropriate to assign three of the referrals as investigative assessments.

- **EXAMPLE #1.** The county received a referral alleging that a parent of two children is absent most of the time and leaves supervision of the younger child (age 9) to the older child (age 13). In addition, the reporting party expressed concerns about the parent's possible use of methamphetamine. The Trails record indicated that the family had been involved with two prior differential response cases, one of which had been closed due to the "client's failure to cooperate." Rules (Section 7.202.41.C, 12 C.C.R. 2509-3) grant counties the discretion to assign an investigative assessment based on factors including multiple previous referrals, and the Department's Differential Response Implementation Guide allows Pilot Program counties to assign an investigative assessment based on factors, including that the caregiver declined services in the past. In this example, the family had multiple prior referrals and had failed to cooperate in a prior assessment, both of which indicate that an investigative assessment may have been more appropriate. The Department disagreed but did not provide any written explanation for this specific referral.

- **EXAMPLE #2.** While a family had an open differential response case, the county received a new referral alleging domestic violence and substance abuse involving a newborn in the family. The county assigned the new referral for assessment through differential response, even though one parent was facing a criminal child abuse charge resulting from the incident, and the newborn was immediately removed from the home. The county also would not allow the other parent to care for the child because the parent refused a drug and alcohol test. Seven months after the new

referral, the child had not been returned to the parents. Rules (Section 7.202.41.C, 12 C.C.R. 2509-3) grant counties the discretion to assign an investigative assessment based on factors including present danger, multiple previous referrals, and/or case characteristics such as type of alleged maltreatment paired with high vulnerability of the alleged victim. In this example, the family had five prior child welfare referrals, the child was an infant and therefore of a vulnerable age, and the allegations—domestic violence and substance abuse—were serious enough for the county to identify impending danger to the child and assign a 3-day response time. These factors indicate that an investigative assessment may have been more appropriate.

The Department disagreed and stated that the "county was able to put a safety plan in place based on appropriate family supports. The safety plan creates protection." However, safety plans are developed **AFTER** a county has determined whether to use a differential response assessment. As such, the Department's response did not address whether differential response was the most appropriate type of assessment to assign.

- **EXAMPLE #3.** A parent moved to Colorado after another state's child welfare system removed the children from the home and subsequently returned them. The reporting party contacted the Colorado county to report concerns about the parent's drug use and ongoing risk of flight to avoid further intervention from the child welfare system. Rules (Section 7.202.41.C, 12 C.C.R. 2509-3) grant counties the discretion to assign an investigative assessment based on factors including high level of risk and multiple previous referrals. The Department's Differential Response Implementation Guide allows Pilot Program counties to assign an investigative assessment based on factors that include whether past safety concerns were not addressed and the parent declined services in the past. In this example, the family had a history of prior child welfare involvement in another state, including prior removals of the children from the home. In addition, the parent had allegedly fled from another state's child

welfare system, which might indicate that safety concerns were not addressed, and the parent had declined services in the past.

The Department disagreed and stated, "Whether there is reason to believe the family will flee is a safety concern and is not identified as a risk factor on the risk assessment tool. The risk assessment tool that was completed…rates the family at a moderate level of risk, which is appropriate for a [differential response] track assignment." However, risk assessment tools are completed **AFTER** a county has determined whether to use a differential response assessment. As such, the Department's response does not address whether differential response was the most appropriate type of assessment to assign.

In addition to the issues we noted during our file review, anecdotal information gathered during our site visits suggest that county staff may inappropriately assign referrals for assessment using differential response. For example, staff at two Pilot Program counties we visited expressed concerns about inappropriate differential response assignments, and one county noted that it handles a lot of high-risk cases through differential response assessments. In another differential response county, a caseworker reported that staff sometimes consider the impact on the family of an investigative assessment that could result in a finding of child abuse or neglect, such as one of the caregivers losing his or her job, rather than established requirements, as a basis for deciding to use differential response.

INCOMPLETE DIFFERENTIAL RESPONSE ASSESSMENTS. We found various problems related to the completeness of the 10 differential response assessments we reviewed.

Some files contained more than one problem, as described below.

- **INITIAL ASSESSMENT OF FAMILY NEEDS, STRENGTHS, AND NEXT STEPS.** Five of the 10 sampled files lacked documentation to substantiate that the caseworker identified some or all aspects of

the initial assessment. The Differential Response Implementation Guide requires that documentation be "complete in Trails for initial assessment of family needs and strengths."

- Four files lacked any documentation of needs, strengths, and next steps. In one instance, the Department agreed. In the other three instances the Department initially disagreed and reported that it cannot hold counties accountable for complying with Department guides or letters, only with State Board rules and statutes. As we were completing the audit, the Department reported that it had received legal guidance that it can develop Department policies to guide county practice and hold counties accountable for following such policies.

- One file lacked information about the family's strengths. The Department disagreed, despite the fact that the information the county entered under "strengths" was duplicated verbatim from the information the county entered under "needs."

- **NEW SAFETY ASSESSMENTS.** One of the 10 sampled files lacked new safety assessments in response to two new referrals the county received while the existing differential response case was open. The Department agreed. The Differential Response Implementation Guide states that a "new safety assessment is completed" for any new referrals received regarding the family while the case is open.

- **INCOMPLETE CASE SUMMARIES.** Nine of the 10 sampled files had incomplete case summaries documented in Trails to support closure of the differential response case. The Differential Response Implementation Guide requires the "assessment closure summary [to be] complete in the Case Summary window [in Trails]" before the case closes. Information that should be documented as part of the case summary includes the family's response to agency involvement; services offered/utilized; the Child Protection Team response; and the family's history, worries, and strengths.

Some files had more than one factor missing from the case summary. Information that was not documented included the following:

- Nine files did not have worries and strengths documented.
- Eight files did not have the Child Protection Team's response documented.
- Four files did not have family history documented.
- Two files did not have services offered/utilized documented.

In all nine instances, Department staff initially disagreed and reported that it cannot hold counties accountable for complying with Department guides or letters, only with State Board rules and statutes. The Differential Response Implementation Guide explains that completing the required steps for closing a differential response case, including the case closure summary, is important for ensuring an effective evaluation of the Pilot Program. As we were completing the audit, the Department reported that it had received legal guidance that it can develop Department policies to guide county practice and hold counties accountable for following such policies.

SOME DIFFERENTIAL RESPONSE ASSESSMENTS EXCEEDED 60 DAYS. Three of the 10 sampled assessments remained open in the assessment phase for longer than 60 days. Differential response assessments must be completed within 60 days (Section 7.202.57.B, 12 C.C.R. 2509-3), compared to 30 days for investigative assessments. The length of these differential response assessments ranged from 66 days to 156 days (about 5 months). The Department agreed.

WHY DID THE PROBLEM OCCUR?

Several issues may have contributed to the problems we found and should be addressed if the program is made permanent.

LACK OF REGULATORY GUIDANCE. Statute [Section 19-3-308.3(6), C.R.S.] requires the State Board to "promulgate rules to define and implement differential response and for the administration of the pilot program." This requirement became effective when the Pilot Program was expanded in 2012. We identified several areas where rules could

be strengthened to provide clear direction. First, although rules currently include general provisions to help counties determine when to use differential response, there are no definitions of what constitutes a child who is at "low," "moderate," or "high" risk of abuse. Second, rules are not clear about how different factors, such as multiple previous referrals and other case characteristics, could influence a child's risk level. Third, there are no rules regarding what steps must be taken to complete a differential response assessment and how the assessment should be documented.

LIMITATION ON MONITORING USING AGGREGATE TRAILS DATA. Trails does not have a field that captures whether a referral is low, moderate, or high risk, so the Department cannot easily verify at an aggregate level whether counties appear to be assessing only low- or moderate-risk referrals using differential response. The most comparable field in Trails captures the severity of child abuse or neglect allegations (i.e., "minor," "moderate," "severe," or "fatal"). However, counties are only required to document the severity of child abuse or neglect allegations as part of determining a "finding" of whether abuse or neglect occurred (Section 7.202.601.D, 12 C.C.R., 2509-3), which is not part of the differential response process. Therefore, it is possible that counties would not enter severity information in Trails for differential response assessments.

The Department reported that it has not pursued extensive rules or made Trails modifications to accommodate differential response because it is a pilot program and such actions would be premature until the program is made permanent. However, Senate Bill 12-011 added a statutory requirement for the State Board to promulgate rules for differential response, even though it would continue to be a pilot for at least 3 years after the requirement was put in place.

WHY DOES THIS FINDING MATTER?

In April 2014, the Colorado State University Social Work Research Center issued an evaluation report of the Pilot Program commissioned by the Department. The report found that the use of differential

response involves a mean weighted cost of $1,212 per case, compared to a mean weighted cost of $954 per investigative case. In addition, the study showed no significant difference in the safety of children when differential response was used. These results underscore the importance of ensuring that counties handle differential response assessments and cases in accordance with requirements. Department management agreed that differential response is more costly within the first year but noted that there could be greater cost-benefit over the long term.

The evaluation report also stated that county staff, as well as stakeholders such as law enforcement and courts "continue to have reservations about certain types of assessments being assigned to [differential response], urging ongoing review of the eligibility criteria. These concerns center on cases with domestic violence, certain types of substance abuse, and prior involvement with the child welfare system." The report also states that stakeholders "call for more consistency and transparency in the assignment of assessments."

EXPANSION OF PILOT PROGRAM. In the event that the General Assembly implements differential response statewide, it is important that the Department be prepared for a consistent and manageable implementation of this new approach to child welfare practice. During the Pilot Program, the Department embarked on a proactive rollout plan to implement differential response. In April 2014, the Department provided us documentation showing a plan to implement differential response in all 64 counties by December 2014. As of July 2014, eight counties had fully implemented differential response and another 22 were preparing for implementation. In light of the problems identified in this audit across various aspects of the child welfare system, it is not clear if the Department and counties are well-positioned to effectively administer existing child welfare processes while also accommodating the demands of implementing a new process statewide.

In June 2014, Department staff reported to us that the Department slowed the pace of differential response implementation and began

requiring counties to meet certain C-Stat performance measures before counties could be approved for participation in the Pilot Program. Continued thoughtful planning will be important if the Department recommends, and the General Assembly approves, implementing differential response in Colorado on a permanent basis.

RECOMMENDATION 15

If the General Assembly enacts legislation to continue the use of differential response beyond July 1, 2015, the Department of Human Services (Department) should ensure successful expansion of differential response by:

A Establishing guidance that clearly defines risk levels that influence whether a differential response assessment is appropriate and clarifies how different factors can influence a child's risk of maltreatment. This should include working with the State Board of Human Services as appropriate.

B Enforcing Department policies and guidance or working with the State Board of Human Services to codify in rules all requirements that counties must follow when handling assessments and cases through differential response.

C Implementing a more robust process for monitoring differential response activities that includes modifying Trails so the Department can easily monitor the risk level of referrals undergoing differential response assessments.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: AUGUST 2015.

If the General Assembly enacts legislation to continue the use of differential response beyond July 1, 2015, the Department agrees to establish guidance that clearly defines risk levels that influence whether a differential response assessment is appropriate, and clarifies how different factors can influence a child's risk of maltreatment. This

will include working with the State Board of Human Services to promulgate rules, as appropriate.

B AGREE. IMPLEMENTATION DATE: AUGUST 2015.

If the General Assembly enacts legislation to continue the use of differential response beyond July 1, 2015, the Department agrees to enforce Department policies and guidance or work with the State Board of Human Services to codify in rules all requirements that counties must follow when handling assessments and cases through differential response. Differential response is a pilot program in Colorado, and as with all pilot programs, the Department has been testing all approaches at both the county and state levels. The Department has also contracted for an independent evaluation by the Colorado State University School of Social Work and will use the results of the evaluation to guide its policy and oversight of the program.

C AGREE. IMPLEMENTATION DATE: JANUARY 2016.

If the General Assembly enacts legislation to continue the use of differential response beyond July 1, 2015, the Department agrees to implement a more robust process for monitoring differential response activities that includes modifying Trails so the Department can easily monitor the risk level of referrals undergoing differential response.

RED TEAM GROUP DECISION MAKING

As part of the Pilot Program, the Department implemented RED Teams, a group decision-making process that considers various factors and Department guidance to determine the county's response to child welfare referrals (Section 7.202.3, 12 C.C.R. 2509-3). RED Teams are composed of multiple county staff, including caseworkers and supervisors and, in some cases, representatives from other county-administered public assistance programs.

WHAT AUDIT WORK WAS PERFORMED AND WHAT WAS ITS PURPOSE?

The purpose of our audit work was to evaluate whether counties using RED Teams followed guidance for the RED Team process. To accomplish this objective, we (1) reviewed statutes, rules, and Department policies, including training materials related to RED Teams provided by Department staff from October 2013 through October 2014; (2) reviewed Trails records associated with a sample of 60 referrals that counties received during Fiscal Year 2013; (3) conducted site visits at 10 counties around the state, which included interviewing county staff and observing RED Team discussions at eight of those counties; (4) interviewed Department staff to understand the RED Team process; and (5) reviewed the Administrative Review Division's tools for conducting quality assurance reviews.

WHAT PROBLEMS DID THE AUDIT WORK IDENTIFY AND HOW WERE RESULTS MEASURED?

Of the 22 referrals in our sample that were received by Pilot Program counties, 20 were required to be reviewed by RED Teams because they did not require an immediate response, as explained in the following section. We found the following issues related to these 20 referrals.

PILOT PROGRAM COUNTIES DID NOT ALWAYS DOCUMENT RED TEAM DISCUSSIONS AS PART OF THEIR REFERRAL SCREENING PROCESS. For three referrals, the Trails documentation did not contain evidence that RED Team meetings were held to discuss any of these referrals. Rules (Section 7.202.3, 12 C.C.R. 2509-3) define RED Teams as providing a group decision-making process that uses the "Agency Response Guide" to determine county responses to referrals. The Agency Response Guide was developed by the Department to help counties operate in accordance with rules. The Agency Response Guide for Pilot Program counties asks RED Teams to determine if referrals should be screened in or out. Rules (Section 7.202.41.C, 12 C.C.R. 2509-3) also state that counties participating in the Pilot Program, "SHALL utilize a RED Team process to determine the appropriate track assignment [i.e., investigative or differential response assessment] and response time…except for referrals indicating an immediate response" [emphasis added]. This requirement was codified in state rules in March 2013, but Department staff reported that Pilot Program counties have been expected to use RED Teams as part of differential response since the inception of the Pilot Program.

Department staff disagreed in all three cases, and stated that "there is not a mandated number/percentage of required referrals to be sent to RED Team." However, rules do not indicate that counties have discretion to decide when to use RED Teams. The only exception to a RED Team review specified in rule occurs when a referral requires an immediate response. None of the three referrals required an immediate response.

RED TEAMS IN BOTH PILOT PROGRAM COUNTIES AND OTHER COUNTIES DID NOT ALWAYS DOCUMENT CONSIDERATION OF DECISION-MAKING FACTORS. Our sample included 12 referrals that were screened by RED Teams and were received on or after March 2, 2013, the date when rules were revised to specify factors that RED Teams should consider. Of those, seven referrals were received by Pilot Program counties, and five referrals were received by non-Pilot Program counties.

We reviewed Trails documentation for these 12 referrals and found that for seven referrals, county RED Teams did not document information about all the factors in Trails. Five of these RED Teams were conducted in Pilot Program counties, while two were in non-Pilot Program counties. RED Teams organize and analyze referral information related to various factors, including but not limited to: (1) danger/harm, (2) complicating/risk factors, (3) child vulnerability, (4) gray areas, (5) cultural considerations/race, (6) safety/strengths, (7) history, and (8) next steps (Section 7.202.3, 12 C.C.R. 2509-3). According to Department guidance, counties should document this information in a section of Trails that was designed to help counties "organize all elements of the differential response case around common themes necessary for the safety and solution-focused nature of differential response work."

The lack of documentation made it difficult to know if the RED Teams considered all aspects of the referral information. The Department disagreed in all but one case, stating: (1) factors outlined in rules for RED Teams to consider are "suggested" but not required, (2) counties may not have had information available from the reporting party to address certain factors, and (3) Trails is not set up to clearly capture all eight factors.

WHY DID THE PROBLEM OCCUR?

We identified the following factors that may have contributed to the problems we identified.

GUIDANCE FOR RED TEAMS. We identified a need for more specific and comprehensive guidance related to RED Teams in three key areas.

- **RED TEAMS IN PILOT PROGRAM COUNTIES.** Rules appear to require RED Teams to be used 100 percent of the time in Pilot Program counties, except for those referrals requiring an immediate response. This requirement is restrictive and does not provide counties or the Department discretion in the use of RED Teams, such as to help counties manage their workloads. For example, staff at one Pilot Program county told us that their referral volume only allows them to accommodate time for RED Team discussions for about 70 percent of their referrals. That county manages its workload by allowing supervisors to approve screening out referrals that do not contain allegations of child abuse or neglect without a RED Team review.

- **RED TEAMS IN NON-PILOT PROGRAM COUNTIES.** Current provisions in rules focus on Pilot Program counties and do not contemplate that other counties also use RED Teams. This may create inconsistencies in light of the Department's efforts to expand the use of RED Teams statewide.

- **DOCUMENTATION OF REFERRAL SCREENING FACTORS.** Rules indicate that RED Teams should consider and document eight factors. In some cases, though, Department staff said that certain information might not be known at the time of referral, and counties are not required to write "unknown" so the Trails record reflects this absence of information. As a result, it is not clear what it means when information is missing from the Trails record (i.e., whether RED Teams did not have access to certain information, or had the information but did not document their discussion of it).

SUPERVISORY REVIEWS. Rules (Section 7.202.41.C, 12 C.C.R. 2509-3) require county supervisors to approve all RED Team decisions. We found that none of the RED Team discussions we reviewed had documentation of a supervisor's approval in the section of Trails designated for that purpose, but instead reflected supervisory approval

in a separate section of Trails that captures general approval of the screening decision.

STATE MONITORING. As part of its annual Screen-Out Review, the Administrative Review Division reviews counties' use of RED Teams, including which of the eight factors were addressed in the Trails record and whether documentation of the RED Team discussion supports the county's decision to screen out the referral. This process provides some State oversight of RED Teams. However, the Screen-Out Review focuses only on referrals that have been screened out, not referrals that counties assigned for assessment. While the Administrative Review Division does consider whether a referral was appropriately screened in and assigned the correct response time as part of its assessment reviews, the Administrative Review Division does not specifically look at and comment on RED Team information. Therefore, the State does not have a process for comprehensively reviewing RED Teams as part of its routine quality assurance reviews.

TRAILS DOCUMENTATION. Although rules outline eight factors that counties should organize and analyze, Trails contains only three fields in which to document this information. This mismatch can make it difficult to verify whether RED Teams considered all eight factors during their discussions.

WHY DOES THIS FINDING MATTER?

Rules do not require the use of RED Teams for counties that have not implemented differential response. However, during our audit the Department initiated a plan to implement the RED Team process in all counties across the state by December 2014. According to Department training materials, "one of the main purposes of RED Teams is to help counter the tendency of child welfare organizations to silo their work and their workforce." The group dynamic of RED Teams—which can involve various individuals including child welfare caseworkers, child welfare supervisors, county support staff, other county human services staff, consultants, and visitors—helps to achieve this purpose. Department training materials state that RED Teams provide "an

organizational intervention intentionally meant to slow the decision making process down." Ultimately, RED Teams should result in "more balanced" and "more consistent" agency decisions. When Pilot Program counties do not use RED Teams for all eligible referrals or consider all the required factors, these counties cannot realize the benefits of the RED Team process.

To ensure that RED Teams in all counties operate similarly and document consistent information, it will be important to establish clear, consistent guidance for the RED Team process. The Differential Response Implementation Guide states that "comprehensive family assessment is achieved by learning from the family about their worries, the things which are going well, and to also agree on initial next steps to assist in engagement," all of which are factors that RED Teams should consider and document in Trails. Similar to other documentation problems we noted throughout this report, not documenting RED Team discussions limits the Department's ability to monitor county decision making.

RED Teams are resource intensive for counties because they require multiple staff members to review each referral. According to the Department, from January 2014 through March 2014, RED Teams in the original five Pilot Program counties involved an average of 5.3 county staff members. With the anticipated increase in child welfare referral volume once the statewide child abuse reporting hotline is implemented, county resources could be further strained. The Department has reported that the volume of referral calls could increase by up to 20 percent once the hotline, authorized by House Bill 13-1271, is implemented. Based on Fiscal Year 2013 referral data (70,400 total referrals), the hotline could generate an additional 14,000 referral calls annually. Since the Department is in the process of implementing RED Teams in all counties statewide, regardless of whether differential response continues, it will be important for the Department to establish clear parameters for effective implementation and documentation of the RED Team process.

RECOMMENDATION 16

The Department of Human Services should ensure that counties statewide implement the Review, Evaluate, and Direct (RED) Team process consistently and effectively by:

A Establishing guidance that clarifies (i) instances when counties must use RED Teams and when counties have discretion to use a different referral screening method, and (ii) how counties should document RED Team discussions and supervisory approval of RED Team decisions. This should include working with the State Board of Human Services as appropriate.

B Adding a component to the Administrative Review Division's quality assurance reviews that includes reviewing Trails documentation that supports RED Team decisions for referrals that are assigned for assessment.

C Modifying Trails so the database fields more closely align with the factors that RED Teams consider during their discussions.

RESPONSE

DEPARTMENT OF HUMAN SERVICES

A AGREE. IMPLEMENTATION DATE: MARCH 2015.

The Department agrees to establish guidance that clarifies instances when counties must use RED Teams and when counties have discretion to use a different referral screening method, and clarifies how counties will document RED Team discussions and supervisory approval of RED Team decisions. This will include working with the State Board of Human Services to promulgate rules, as appropriate. The Department is already in the process of moving this practice

model from a pilot to statewide implementation through standard operating procedures.

B AGREE. IMPLEMENTATION DATE: OCTOBER 2015.

The Department agrees to add a component to the Administrative Review Division's (ARD) quality assurance reviews that includes reviewing Trails documentation that supports RED Team decisions for referrals that are assigned for assessment. The ARD initiated instrument review workgroups in October 2014. The work specific to this recommendation will be incorporated into those workgroups. The resultant instruments will be piloted in July 2015 with an anticipated effective date of October 2015.

C AGREE. IMPLEMENTATION DATE: MARCH 2015.

The Department agrees to modify Trails so the database fields more closely align with the factors that RED Teams consider during their discussions.

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

APPENDIX A

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

OFFICE OF THE STATE AUDITOR
SUMMARY OF FINDINGS RELATED TO THE SMART GOVERNMENT ACT
CHILD WELFARE PERFORMANCE AUDIT
DEPARTMENT OF HUMAN SERVICES
OCTOBER 2014

The SMART Government Act [Section 2-7-204(5), C.R.S.] requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments. These audits may include, but are not limited to, the review of:

- The integrity of the department's performance measures audited.
- The accuracy and validity of the department's reported results.
- The overall cost and effectiveness of the audited programs or services in achieving legislative intent and the department's goals.

The child welfare performance audit was selected for focused audit work related to the SMART Government Act. We reviewed the Department of Human Services' (Department's) Fiscal Year 2015 SMART Government Act performance plan and identified one performance measure that was relevant to the scope of the child welfare performance audit. This document outlines our findings related to the integrity and reliability of that performance measure. We have presented our findings as responses to six key questions that can assist legislators and the general public in assessing the value received for the public funds spent on certain child welfare activities by the Department.

What is the purpose of this program/service?

Colorado is one of nine states that operate a state-supervised, county-administered child welfare system. The Department is responsible for administering or supervising all public assistance and welfare activities in Colorado, including child welfare [Section 26-1-111(1), C.R.S.]. The Division of Child Welfare, within the Office of Children, Youth, and Families, provides supervision of and technical assistance to county departments of human/social services, oversees implementation of new

initiatives and child welfare program requirements, and oversees county staff training through the Child Welfare Training Academy. Other Division of Child Welfare responsibilities, which were outside the scope of the child welfare performance audit, involve approving county plans to administer child welfare services and responding to complaints from various stakeholders, as well as permanency and treatment planning, case management, core services, adoption, emergency shelter, out-of-home placement, utilization review, early intervention and prevention, and the youth-in-conflict function [Section 26-5-101(3), C.R.S.].

The Administrative Review Division, within the Office of Performance and Strategic Outcomes, is Colorado's mechanism for providing a federally required case review system and a portion of the quality assurance system for the Division of Child Welfare. This division also administers a statutorily created process for reviewing certain child fatalities, near fatalities, and egregious incidents.

What are the costs to the taxpayer for this program/service?

Child welfare activities are funded through a combination of state general funds and federal funds. For Fiscal Year 2015, the Division of Child Welfare was appropriated $446 million, and the Administrative Review Division was appropriated $2.3 million. Combined, this represents 24 percent of the Department's total Fiscal Year 2015 appropriation of $1.9 billion.

The Division of Child Welfare's Fiscal Year 2015 appropriation included $346.4 million (78 percent) in state funds (including state general funds, cash funds, and reappropriated funds) and $99.6 million (22 percent) in federal funds.

How does the Department measure the performance of this program/service?

The Department's Fiscal Year 2015 SMART Government Act performance plan includes 20 performance measures. One of these performance measures, "Timeliness of Assessment Closure," was relevant to the

objectives of the child welfare performance audit. As discussed in CHAPTER 3, this measure determines the percentage of child welfare assessments that are closed within 60 days of the date a county department of human/social services receives a referral alleging child abuse or neglect.

In addition to its SMART Government Act performance measures, the Department has 26 performance measures related to the Division of Child Welfare that it created as part of two voluntary performance management initiatives it launched—C-Stat and the Community Performance Center. We evaluated a subset of these 26 measures that were relevant to the objectives of the child welfare performance audit. C-Stat is a Department-wide performance measurement and management system that began in January 2012. It is designed to analyze performance on a monthly basis using the most current data available to identify processes that need improvement and make informed decisions. The Community Performance Center began in 2014 and is a website that allows the public to review state and county performance based on Department performance measures related to the child welfare system.

Is the Department's approach to performance measurement for this program/service meaningful?

As discussed in CHAPTER 3 of the report, we found that the Department's SMART Government Act measure, "Timeliness of Assessment Closure," is not meaningful because it counts assessments as timely that would not be timely according to rules. The performance measure determines the percentage of child welfare assessments that were closed within 60 days of the referral. However, rules require county caseworkers to complete investigative assessments within 30 days of the referral unless an extension is approved by a supervisor [Section 7.202.57, 12 CCR 2509-3]. We reviewed a sample of 30 investigative assessments and identified six (20 percent) that closed between 30 and 60 days without an approved extension. Given how the performance measure counts timeliness, these six assessments would have been counted as timely in the performance measure. Assessments completed as part of the Differential Response Pilot Program (see CHAPTER 5) must be completed within 60 days. Thus, the SMART Government Act measure does not take into account the deadline of 30

days set in rules for investigative assessments and assumes that any assessments closed between 30 and 60 days were approved for extensions in accordance with rules. The measure is consistent with statute, which allows counties to have 60 days to "submit a report of confirmed child abuse or neglect within sixty days…to the [Department]" [Section 19-3-307(1), C.R.S.].

Additionally, in CHAPTER 2, we identified concerns with the Department's "Timeliness of Initial Contact" performance measure, which is one of the Department's C-Stat measures. The measure reflects the percentage of children for whom the caseworker attempted to make initial contact, either successfully or unsuccessfully, with the child within the time requirements set in rule. Statutes and rules [Section 19-3-308(3)(a), C.R.S., and Section 7.202.52, 12 C.C.R. 2509-3] require caseworkers to conduct an initial face-to-face interview with or observation of the child within the assigned response time. Although the Department has set a benchmark that counties attempt to contact children within the assigned response time at least 90 percent of the time, the Department has not established a benchmark for making actual contact. For example, a caseworker making one unsuccessful attempt during a 5-day response time would be considered the same for the purposes of this performance measure as the caseworker actually making contact. Also, the Department reports on "Timeliness of Initial Contact" for C-Stat and the Community Performance Center, but, at the time of our audit, the measure was described inaccurately in both places. As late as July 2014, the Department's C-Stat results described the measure as the "number of…investigations where the assigned caseworker made initial contact with the [child] within time requirements set in rule…" As of October 2014, the Community Performance Center's website described this measure as "children interviewed within the time-frames specified in State rule."

Are the data used to measure performance for this program/service reliable?

We did not identify any concerns with the reliability of the data used to calculate either "Timeliness of Assessment Closure" or "Timeliness of Initial Contact." We determined that the data were reasonably complete and accurate.

Is this program/service effective in achieving legislative intent and the Department's goals?

Overall, our audit found areas in which the Department should strengthen the guidance it provides to counties and its oversight and measurement of county performance related to referral screening and assessments. The audit identified needed improvements in the following areas: screening reports of child abuse and neglect, timeliness of initial contact, assessment of child safety and risk of future maltreatment, statutory oversight mechanisms, collaborative programs, and the Differential Response Pilot Program. Additionally, the audit identified concerns with the Department's practice of waiving authoritative guidance, which could result in the intent of rules and statutes not being fulfilled.

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

APPENDIX B

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876

COOPERATIVE AGREEMENTS (MOUs) BETWEEN COUNTY DEPARTMENTS OF HUMAN/SOCIAL SERVICES AND LAW ENFORCEMENT AGENCIES[1]

	Number of Law Enforcement Agencies					Number of Law Enforcement Agencies			
County	Total	With Signed MOUs	With Unsigned MOUs	With No MOU	County	Total	With Signed MOUs	With Unsigned MOUs	With No MOU
Adams	10	9	0	1	La Plata	7	6	0	1
Alamosa	4	0	0	4	Lake	3	2	0	1
Arapahoe	13	12	0	1	Larimer	9	8	0	1
Archuleta	3	2	0	1	Las Animas	4	0	0	4
Baca	4	2	0	2	Lincoln	4	4	0	0
Bent	4	3	0	1	Logan	3	2	0	1
Boulder	9	8	0	1	Mesa	6	6	0	0
Broomfield	3	1	1	1	Mineral	2	1	0	1
Chaffee	4	0	3	1	Moffat	3	2	0	1
Cheyenne	2	1	0	1	Montezuma	4	2	0	2
Clear Creek	5	5	0	0	Montrose	5	1	0	4
Conejos	6	0	0	6	Morgan	6	5	0	1
Costilla	2	1	0	1	Otero	6	5	0	1
Crowley	3	2	0	1	Ouray	4	3	0	1
Custer	2	0	0	2	Park	4	3	0	1
Delta	6	2	0	4	Phillips	4	3	0	1
Denver	7	1	0	6	Pitkin	5	1	0	4
Dolores	2	0	0	2	Prowers	4	3	0	1
Douglas	5	5	0	0	Pueblo	3	2	0	1
Eagle	7	0	6	1	Rio Blanco	4	0	0	4
El Paso	16	12	0	4	Rio Grande	6	4	0	2
Elbert	5	0	4	1	Routt	5	0	0	5
Fremont	4	3	0	1	Saguache	3	0	0	3
Garfield	8	0	7	1	San Juan	2	1	0	1
Gilpin	4	0	0	4	San Miguel	4	3	0	1
Grand	4	0	0	4	Sedgwick	2	1	0	1
Gunnison	5	4	0	1	Summit	6	5	0	1
Hinsdale	2	1	0	1	Teller	4	3	0	1
Huerfano	4	3	0	1	Washington	2	1	0	1
Jackson	2	0	0	2	Weld	22	16	0	6
Jefferson	13	9	0	4	Yuma	4	3	0	1
Kiowa	2	0	0	2	TOTALS	324	186	21	117
Kit Carson	4	4	0	0	Percent of Total		57%	7%	36%

SOURCE: Office of the State Auditor's analysis of cooperative agreements established between county departments of human/social services and law enforcement agencies related to the coordination of referrals and investigations of child abuse and neglect cases and data on the law enforcement agencies operating in Colorado.

[1] Total includes one count for Colorado State Patrol for each county.

STATE · OF · COLORADO
UNION AND CONSTITUTION
NIL SINE NUMINE
1876