Introduction

Every year, the Office of Colorado's Child Protection Ombudsman (CPO) reviews more than 1,000 cases, each of which are brought to the agency by citizens with a concern, frustration or question regarding the state's child welfare system. By design, the CPO is charged with independently assessing these concerns and helping citizens gain clarity regarding these systems.[1] Unlike any other agency in Colorado, the CPO is uniquely positioned in state government to impartially study the child welfare system, through the perspective of the people it impacts.

Since its inception as an independent agency, the CPO has received thousands of cases from parents, youth, siblings, extended family and professionals connected to child welfare systems. Those cases have revealed systemic issues impacting the safety and well-being of children and families in Colorado. They have also highlighted a pervasive erosion of the public trust in child welfare systems in the state.

While the CPO is charged with looking at all entities that serve children and families in Colorado, this committee has specifically requested information regarding issues with how child welfare services are administered in the state.[2] During the past seven years, the CPO has identified, studied and reported on many of these issues. As such, the CPO is providing four issues currently impacting the child welfare system in Colorado. The CPO has provided a summary of each issue and possible legislative solutions for the committee's consideration.

ISSUE #1: Colorado must find more effective and creative methods to support county departments to ensure that parents involved in child welfare cases receive required monthly face-to-face contacts with caseworkers.

Every month, less than half of all parents involved in child welfare cases in Colorado receive the required monthly face-to-face contacts with child welfare services. Since its inception, one of the most consistent concerns the CPO hears from parents with open cases – including parents whose children have been removed from their care – is that they are not receiving regular contact with child welfare services. Current state data shows that difficulty maintaining such contact is a pervasive issue.

Why It's Important

Inconsistent or insufficient communications with parents or other caregivers can delay the administration of services for children and families, delay needed safety assessments for children and, in some cases, delay the proper return of a child to their parent's care.

After a child welfare case is opened, state regulations require child welfare services to make and document monthly efforts to meet with all parents face-to-face.[3] Current data from the Colorado

[1] See C.R.S. §19-3.3-101 to 111
[2] See C.R.S. §10-3.3-102(1)(a)(III). The CPO does not have authority to review the actions of attorneys or judges. In pertinent part, the CPO's enabling statute states the CPO shall "refer any complaints relating to the judicial department and judicial proceedings, including but not limited to complaints concerning the conduct of judicial officers or attorneys of record, judicial determination, and court processes and procedures to the appropriate entity or agency within the judicial department."
[3] See 12 CCR 2509-3, 7.204 – Case Contact Requirements

Department of Human Services (CDHS) shows that compliance with this rule has not exceeded 47% during the past five years.[4] This means that that during the past five years, less than half of Colorado parents involved in child welfare cases have been contacted face-to-face the required amount.[5] A closer review of that data shows that, during the past year, some child welfare departments have dropped as low as 10% compliance with this rule. Some child welfare departments are as high as 84%. The standard set by the U.S. Department of Health & Human Services' Administration for Children and Families is that 41% of all parents involved in child welfare cases will receive a monthly face-to-face contact effort by county departments.[6]

The CPO is acutely aware that the child welfare system – both in Colorado and nationally – is struggling to retain and recruit a qualified workforce. Such difficulties inevitably have significant impacts on the delivery of services to children and families. In reviewing these cases, the CPO has found that many county child welfare departments share the CPO's concern that contacts are not occurring as frequently as needed or required. They have routinely cited a consistent lack of support and resources as one reason this issue persists.

Without regular contact with child welfare services, parents are not able discuss key elements of ongoing cases, such as parenting time decisions and issues related to treatment plans. Conversely, without making monthly contact with parents, there is no ability to observe the home to determine whether it is safe for children. The cumulative effects of these missed contacts, in many cases, impedes a parent's ability to comply with case requirements. It also delays the return of children to their parents and homes. But failing to attempt to make monthly face-to-face contacts with families also poses a significant risk to the physical safety and well-being of children who remain in their homes.

For example, the CPO received a call from a relative of a sibling group who remained in the care of their mother during an open child welfare case. The children's relatives worried for the safety of the children, stating that the children's mother was suffering with mental health issues, using illegal substances and that the children were being physically abused by the mother's boyfriend. The CPO's review of the case found that the mother was not contacted face-to-face for 13 of 22 months – almost half of the time the case was opened.

It should be noted that, in many cases reviewed by the CPO, court filings do not reflect this deficit. As a result, judges are making decisions regarding the placement of children and treatment plans for caregivers, without knowledge that required contacts were not made.

Potential Solutions

1. Develop legislation to convene a public-facing working group within the Colorado Supreme Court Improvement Program. This group should assess current compliance rates with monthly face-to-face requirements and the impacts on child welfare cases, judicial decision making and children and families. This group should also consider alternative methods and models to increase face-to-face contact with parents.

[4] This figure is based on available C-Stat data provided by the CDHS' Results Oriented Management System. C-Stat measures key areas of county child welfare department performance, including monthly contacts with parents. The figure above is an average of all county human services departments monthly face-to-face contacts with parents. It should be noted that some county departments exceed 47% compliance each month and others were dramatically below this rate.

[5] This data takes into consideration parents who do not reside in Colorado, are incarcerated for longer than two years, and those whose whereabouts are unknown.

[6] See U.S. Department of Health and Human Services Administration for Children & Families' Colorado Child and Family Services Reviews Final Report 2017

ISSUE #2: Colorado needs to support strong and effective caseworkers by creating standards that ensure caseworkers who act unethically or unlawfully are not able to continue providing child welfare services to children and families.

Colorado currently has no law or regulation regarding adverse action against child welfare employee's certification and no requirements that clients or departments are notified of verified, gross misconduct. Seven years ago, the CPO first raised its concerns about the lack of clarity – and correlating law and regulation – regarding the certification of child welfare employees in Colorado. The current system lacks clarity regarding whether CDHS or county departments are responsible for seeking revocation of child welfare certifications. Colorado currently lacks any process to take adverse action against an employee's certification in instances in which the employee violates state law, regulation or other areas of ethical concern. The impact of this gap is that, unless an employee is criminally charged, there is no way to know whether a child welfare employee has violated regulations or ethical standards. As such, their certification to work with children remains in place and they are able to move from county to county undetected.

Why It's Important

Without a mechanism to take adverse action against a child welfare employee's certification, there is no effective way to ensure Colorado children and families are served by qualified individuals who maintain industry standards.

Since 2015, the CPO has identified four incidents in which child welfare workers have been criminally charged with falsifying records in the state child welfare database.[7] The majority of these false records indicated the employee had seen a child and/or assessed their safety when they had not. In at least one of the cases above, the employee was rehired by another county department prior to criminal action being taken. To be clear, these cases represent a small minority of child welfare employees in Colorado. And yet, the impacts of these cases permeate through the entire system and erode the public's trust in the very individuals charged with keeping them safe.

In Colorado, there is no mechanism in the state to take adverse action against a child welfare employee's certification after it is received through the Colorado Child Welfare Training Academy. This deficit makes it nearly impossible for county departments hiring child welfare employees to determine whether an employee has a history of misconduct or concerning practice.

County human services departments may take direct personnel action when an employee violates county and state regulations or commits a criminal act. But they have no mechanism to take adverse action against the certification of a child welfare employee. There is also no standard statewide policy for investigating such incidents. As such, instances of misconduct are handled dozens of different ways. Equally important, the children and families involved in these cases are not aware of the misconduct and potential impacts to their cases and other county departments are unaware of incidents when hiring employees.

Employers should be provided with more information regarding the individuals trusted to assess the safety and well-being of Colorado children. Additionally, children and families should have meaningful

[7] See "Denver caseworker charged with falsifying records in fatality case" published in The Denver Post on January 22, 2015; "Jefferson County caseworker admits falsifying child abuse records" published in The Denver Post on January 9, 2018; "Moffat County caseworker accused of fabricating child abuse, neglect investigations has been charged with forgery" published in The Colorado Sun on March 30, 2022; and "Former Arapahoe County social worker failed to properly investigate child abuse cases, state audit finds" published on 9New's website on September 26, 2022.

access to information about the standard required of each child welfare employee working with them and proper notification when verified misconduct may have impacted their case. By allowing child welfare employees to maintain a certification regardless of performance, ethical violation or possible criminal activity Colorado is putting children and families at risk.

Potential Solutions

1. Develop laws and applicable regulations regarding the following:
    a. Processes for seeking adverse action against child welfare certifications;
    b. Standard and required notification practices for clients and county departments for when a certification is revoked for cause;
    c. Required development of a statewide, standard policy for investigating cases of alleged misconduct;
    d. Required development of a statewide, standard code of ethics for child welfare employees; and
    e. Development of a public-facing database showing the certification status for all child welfare employees administering services.

ISSUE #3: The current safety tool used by child welfare services to assess the immediate safety of children has never been validated and does not produce consistent results.

The Colorado Family Safety Assessment Tool is the accepted safety tool for child welfare services in Colorado. However, since its inception in 1999, the tool has never been validated. Reviews by national and state professionals have found that the safety tool continues to be utilized inconsistently by child welfare services. The safety tool is a crucial step in assessing the initial needs of a family, the immediate safety of children and, in most cases, whether a child will be removed from their home.

Why It's Important

Unable to yield consistent results, Colorado's unvalidated safety tool creates the potential for bias that may impact decisions made in child welfare cases.

The safety tool includes details of current danger and harm to children, parent functioning and strengths, child vulnerabilities and efforts that have or can be made to mitigate safety concerns. When there is current and impending danger to a child, child welfare services must make the decision to either create a safety plan with the family or remove the child from the caregivers and obtain custody of the child. The safety tool is intended to provide an objective and consistent tool to ensure that decisions affecting child safety are made appropriately. Despite its intended use, the safety tool is used subjectively and inconsistently.

Concerns regarding the use of the safety tool have long been raised by the CPO, as well as others monitoring its use. The first review of the tool took place 15 years after its inception.[8] That review included a study by Colorado State University's Social Research Center (CSU).[9] In that report, CSU was able to validate the state's Colorado Family ***Risk*** Assessment Tool – which is distinct from the safety tool. CSU found that the risk tool could be used consistently by child welfare services. However, CSU could not do the same for the ***safety*** tool. The CPO is unaware of any additional efforts to validate the use of this tool. During 2016 to 2018, CDHS worked to update regulations surrounding the use of the

[8] See Colorado Office of Children Youth & Families Division of Child Welfare Services: 2020 Colorado Program Improvement Plan, In Response to the 2017 Child and Family Services Review, Official Submission May 27, 2019
[9] See Colorado State University College of Health and Human Sciences' School of Social Work: Colorado Family Safety and Risk Assessments: Validation and Revisions, Final Submission January 16, 2014

safety tool and provide additional training to all child welfare employees.[10] However, concerns with the use of the safety tool were again noted by the U.S. Department of Health and Human Services in 2017. In the federal performance improvement plan for Colorado child welfare services, the state's application of the safety assessment included it as an 'area needing improvement' in the state's performance improvement plan.

To date, there has been no additional formal review by the state to ensure that the tool is being consistently utilized as designed.

The CPO routinely reviews cases in which the use of the safety tool is at issue. These cases have revealed systemic impacts, including:

- Safety planning and monitoring were insufficient to manage child safety;
- Safety plans were not created, completed appropriately or communicated to families;
- Safety services that were needed were not provided; and
- Safety plans created were not with the ability of the family to complete.

CPO case reviews have identified that there is a lack of understanding in how to apply basic principles of safety planning and how to create safety plans that were appropriate and met the needs of the family.

The impact is that a child may be removed from their caregivers without cause. Conversely, a child may not be removed from a home when valid safety concerns exist.

Potential Solutions

1. Commission a third-party audit of the state's safety tool to include an analysis of the use, efficacy and reliability of the current tool, as well as possible alternative models. The final report shall be provided to the Colorado General Assembly and child welfare stakeholders.

ISSUE #4: Colorado currently has no laws or regulations ensuring consistent and transparent standards regarding the quality of care provided to children and youth residing in residential treatment facilities.

Following the high-profile closure of the El Pueblo Boys & Girls Ranch in 2017, the CPO identified the need for increased and consistent monitoring of residential treatment programs at the state-level. This included recommendations to develop standardized procedures for monitoring licensed facilities and creating more transparency regarding the conditions, services and outcomes in residential treatment programs. However, none of these recommendations have been implemented.

Why It's Important

Families rely on residential treatment programs, however, the state's monitoring system for these facilities is leaving some youth in potentially unsafe conditions.

Colorado's state-licensed residential treatment facilities offer critically important services to some of the state's most high-needs children, including those with severe behavioral health and psychiatric needs. However, Colorado currently lacks a system of quality assurance standards and a collaborative model of quality improvement in which providers and oversight agencies may ensure that such

[10] See Colorado Office of Children Youth & Families Division of Child Welfare Services: 2020 Colorado Program Improvement Plan, In Response to the 2017 Child and Family Services Review, Official Submission May 27, 2019

facilities meet consistent standards. Currently, there is no standard quality assurance system in place for residential child care facilities licensed by CDHS. Additionally, there is no public-facing system that provides caregivers with information about the facilities children and youth are being placed in.

During the past several years, several state-licensed placements have been the focus of the CPO and local media.[11] During 2017, the El Pueblo Boys & Girls Ranch, a center for youth with severe behavioral and psychiatric needs closed. The year preceding its closure, the facility was the subject of dozens of complaints regarding the safety and well-being of the children and youth who were residing there. The CPO reviewed the circumstances surrounding the facilities closure for more than a year, including the complex systems and multiple actors tasked with ensuring the children and youth were receiving quality treatment and care. The CPO published its report and summary of its findings and recommendations for improvement in 2019.[12] Since the publication of its report, the CPO has continuously monitored residential child care facilities, studied the laws and regulations that guide them and engaged families that have been impacted by them. However, many of the recommendations contained in that report have not been implemented, including a recommendation to develop systems that improve the transparency surrounding the conditions and services provided in residential child care facilities.

In 2020, the CPO was notified about the death of 12-year-old Timothy Montoya, which ultimately served as yet another example of why Colorado needs quality assurance and accountability systems for state-licensed facilities. In response to Timothy's death, House Bill 22-1375 established the Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement, which is tasked with addressing and reducing the number of children and youth who run away from care.[13] However, the portion of HB 22-1375 that would have solidified the first steps in implementing a quality assurance and accountability system for state-licensed facilities was severed from the bill.[14] As such, the CPO believes that legislation – specifically the provisions originally drafted in HB 22-1375 – are needed to ensure that a system is not only developed, but that is it developed by a broad range of individuals with personal and professional expertise.

Potential Solutions

1. Introduce legislation to develop quality assurance and accountability systems for state-licensed facilities, including a public-facing database that allows parents, caregivers and county departments to access information about the ongoing performance of such facilities.

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[11] See "Families kept in the dark about children's safety in Colorado's child welfare system" published in The Colorado Sun on May 19, 2021; "With bites, bruises and low pay, caretakers for Colorado's troubled youth say there's not enough staff to keep kids – and each other – safe" published in The Colorado Sun on May 18, 2021; and "Advocates to push for overhaul of Colorado's youth residential centers – and they're looking to Florida for help" published in The Colorado Sun on December 29, 2021

[12] See Office of Colorado's Child Protection Ombudsman: Investigation Report, Case ID 2017-2736, published August 12, 2019

[13] See Timothy Montoya Task Force to Prevent Children from Running Away from Out-of-Home Placement

[14] See introduced version of House Bill 12-1375