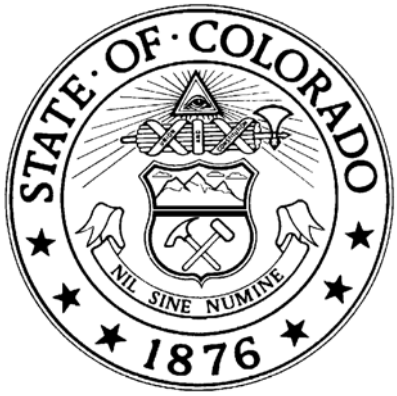

REPORT OF

THE

STATE AUDITOR

Foster Care Services
Department of Human Services

Performance Audit
May 2007

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May 25, 2007

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of foster care services administered by the Department of Human 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.

Sally Symanski

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SALLY SYMANSKI, CPA
State Auditor

Foster Care Services
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Performance Audit
May 2007

Authority, Purpose, and Scope

This performance audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit work, performed from April to December 2006, was conducted in accordance with generally accepted government auditing standards.

Our audit focused on how the Colorado Department of Human Services (Department) supervises the foster care services provided by county departments of human/social services and child placement agencies (CPAs) in the State. We evaluated the Department's methods for ensuring that children remain safe while in foster care and that the quality of foster care provided by counties and CPAs is adequate to ensure the State meets federally established foster care standards. We also examined the processes the Department uses to license CPAs and monitor counties and CPAs. Finally, we evaluated the effectiveness of Core Services, which are designed to prevent or shorten foster care placements or allow children to move to less restrictive placement settings.

We gratefully acknowledge the assistance and cooperation extended by management and staff at the Colorado Department of Human Services, county departments of human/social services, and child placement agencies.

Overview

Under statute [Sections 26-1-111 and 118, C.R.S.], the State's foster care system is supervised by the Department but directly administered by counties, which provide foster care services through county-certified homes or by contracting with CPAs. CPAs are private entities that arrange for the placement of children for the purpose of foster care or adoption. The Department's oversight responsibilities include supervising the foster care system, compiling data and other necessary information about system activities, obtaining federal foster care reimbursement moneys available through Title IV-E of the Social Security Act, licensing CPAs, and monitoring county foster parent certification programs and subrecipients of federal foster care funding. As supervisor of the system, the Department must ensure that services provided by counties and CPAs meet national foster care standards established by the U.S. Department of Health and Human Services (DHHS).

About 23,000 children, or about 2 percent of all children in Colorado, experienced an out-of-home placement and/or received Core Services in Fiscal Year 2006. The Department spent about $366 million on child welfare services in Fiscal Year 2006, including about $74 million on out-of-home placements and about $46 million on Core Services. The Department is generally responsible for funding 80 percent of child welfare expenditures, using a combination of state and federal sources. The counties fund the remaining 20 percent. The Department uses federal funds from several sources as part of its contribution. In Fiscal Year 2006, federal moneys funded about 35 percent of the State's child welfare expenditures.

Key Findings

Safety of Foster Children

The U.S. Department of Health and Human Services (DHHS) established national standards for assessing the safety and stability of children in foster care. As of December 2006, the Department was not meeting key benchmarks related to abuse in foster care, the stability of foster care placements, and monthly face-to-face visits with foster children. We reviewed the Department's processes for ensuring the safety of foster children and found significant problems, some of which we also identified in our 2002 foster care audit:

- **Foster parent certification, recruitment, and retention.** Out of 128 foster parent files we reviewed, 103 files (80 percent) were missing documentation to show that foster parents had fulfilled all training requirements, passed criminal history checks, and been involved in family case planning. Missing documentation included evidence that foster parents had completed (1) 12 core training hours required before a child can be placed in the home, (2) 20 hours of ongoing training required annually, and (3) CPR/First Aid training. The Department also lacks accurate data on county foster parent recruitment and retention rates. These data are needed to identify counties with foster home recruitment and retention problems and to provide technical assistance.

- **Institutional abuse or neglect investigations.** Out of the 1,520 abuse or neglect investigations (known as Stage I investigations) conducted by counties during Fiscal Years 2002 through 2006, the Department's Institutional Abuse Review Team (Team) disagreed with the county's conclusion in 389 investigations. For 133 of the 389 cases, the Team concluded that abuse likely occurred. When the Team disagrees with the county's conclusion, the Department does not routinely take action to resolve those disagreements. Additionally, the Department identified deficiencies in the county's investigative practices in about 35 percent of Stage I reports it reviewed. Counties did not implement more than half of Department recommendations to reevaluate the suitability of a home for foster care, provide extra training, and increase monitoring of the home. Overall, weaknesses in the Department's oversight of abuse or neglect investigations may result in counties' and CPAs' continuing to place foster children in abusive foster homes.

- **Timeliness of Stage I abuse or neglect investigations and reports.** During Fiscal Years 2003 through 2006, counties were late initiating Stage I abuse or neglect investigations for 25 percent of allegations. Additionally, during the same period, counties submitted 48 percent of their investigation reports late. Timely investigations and reports are important to ensure that foster children remain safe and that counties are conducting competent investigations. These results are similar to the findings in our 2002 audit report on foster care.

- **Stage II investigations.** The Department does not provide the results of its Stage II investigations of CPAs to the counties for use in making placement decisions. A Stage II investigation follows a Stage I investigation at a CPA and determines if the CPA's licensing practices or the foster home's operating practices contributed to the alleged abuse or neglect incident. In addition, the Department is not applying sanctions authorized by law, such as suspension, probation, fines, or license revocation when CPAs repeatedly violate regulations. For example, the Department recommended that one CPA be fined at the beginning of Fiscal Year 2004 but then cited the CPA for 19 more violations between Fiscal Years 2004 and 2006 without recommending or imposing additional sanctions. Finally, the Department does not investigate counties to determine whether their practices have contributed to instances of abuse or neglect. Almost half of all foster children were placed in county-certified foster homes in Fiscal Year 2006.

- **Critical incident reporting.** During Fiscal Years 2003 through 2006 CPAs reported 28 percent of critical incidents late and we found evidence suggesting that CPAs are not reporting all critical incidents to the Department. Department regulations require CPAs to report critical incidents involving foster children to the Department within 24 hours of occurrence, excluding weekends and holidays. A critical incident is any event that poses a threat to a foster child's safety and well-being. We identified similar problems in our 2002 audit.

Quality of Care

DHHS conducts federal Child and Family Service Reviews to ensure states are meeting national standards related to child welfare, including foster care. In 2002 a DHHS review identified significant compliance issues at the Department, which resulted in the Department's being issued a Performance Improvement Plan (Plan). The Plan contains 19 compliance goals that the Department was required to meet by March 2007 to avoid federal penalties. As of December 2006, the Department was not in compliance with 6 of the 19 goals. To address these compliance issues and ensure the safety, stability, and well-being of foster children, the Department has a number of processes for overseeing county and CPA foster care services. We identified several weaknesses, as described below.

- **Oversight of counties.** The Department has two primary mechanisms to ensure that counties fulfill their foster care responsibilities: individual corrective action plans for 21 of the largest counties that are related to the Plan negotiated between the Department and DHHS and periodic on-site reviews of all county foster care programs. We found that these mechanisms are not effective because (1) the Performance Improvement Plan and corrective action plans do not include strategies to clearly and directly address the problems in the system; (2) the Department does not use ongoing corrective actions or fiscal sanctions to compel counties to correct problems and improve their achievement of the national standards; and (3) the Department does not ensure that counties correct problems found in the county foster care reviews in a timely manner (e.g., it took an average of 2.7 years for the Department to confirm that counties had implemented corrective action plans). State statutes and regulations do not provide specific and practical authority for the Department to direct county activities, require compliance with Department directives, or penalize counties for noncompliance through fines or other corrective action. More specific authority may be needed to ensure the State can comply with federal standards. The Department reported in November 2006 that it could be subject to $2.2 million in penalties for lack of compliance with the national standards.

- **Licensing and monitoring CPAs.** We reviewed reports and documentation from 8 license renewal and 11 monitoring visits of CPAs and found that the Department visited all eight CPAs on or after the date their license expired and that staff identified 15 licensing violations related to child safety during seven of the eight reviews. We also found the Department does not appear to focus on monitoring high-risk CPAs. During Fiscal Years 2002 through 2006, five CPAs with at least 20 Stage I investigations each did not receive monitoring visits for at least four years. Conversely, seven CPAs with fewer than five investigations each received multiple visits.

Core Services

Core Services are child welfare services designed to prevent or shorten out-of-home placements or allow foster children to move to a less restrictive placement setting. We evaluated the effectiveness of Core Services and found that the Department has not substantiated that these services are meeting intended goals. Specifically:

- **Eligibility.** Out of 79 family case files reviewed at eight counties, 33 of the files (42 percent) contained no documentation showing that the families were at "imminent risk" before they received Core Services. Department policy requires that families must be at "imminent risk of out-of-home placement" to be eligible for Core Services. Statute defines imminent risk as "without intercession, a child will be placed out of the home immediately." For the 46 files with documentation, we found that 34 did not sufficiently explain why Core Services were the best choice for the family, 25 did not provide adequate information about alternative services, and 11 did not demonstrate that the family was at imminent risk.

- **Effectiveness and cost-efficiency.** The Department does not have valid and accurate methods for meeting the statutory requirement to evaluate and report the effectiveness and cost-efficiency of Core Services annually. As a result, the Department is misrepresenting the effectiveness and costs of Core Services.

- **Statutory clarification.** The Department should review the statutes and work with the General Assembly to clarify the intent of Core Services. Three different statutes and Department regulations provide authorization for Core Services, but the statutes and regulations are not always consistent in terms of the services to be provided, the populations to be served, and the time limits on services.

Our recommendations and responses from the Department of Human Services can be found in the Recommendation Locator and in the body of the report.

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RECOMMENDATION LOCATOR
Agency Addressed: Department of Human Services

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	29	Improve oversight of the foster parent certification process by (a) requiring county departments of human/social services and child placement agencies (CPAs) to conduct desk audits of their certified foster parent files; (b) developing and applying sanctions when the Department finds discrepancies between county and CPA attestations and actual foster parent qualifications; (c) requiring counties to provide Family Service Plan information to CPAs; and (d) working with counties to develop a solution for providing foster child information to foster parents without violating confidentiality requirements.	a. Agree b. Agree c. Agree d. Agree	a. July 2008 b. July 2008 c. July 2008 d. October 2008
2	32	Work with county departments of human/social services to evaluate and improve foster parent recruitment and retention by (a) identifying data needs and improving data collection methods to ensure accurate data for tracking and analyzing foster care certifications and closures; (b) developing measures to assess the effectiveness of county recruitment and retention efforts; (c) annually analyzing county recruitment and retention rates; and (d) compiling and sharing best practices about foster home recruitment and retention and providing technical assistance to counties with less effective practices.	a. Agree b. Agree c. Agree d. Agree	a. September 2007 b. January 2008 c. January 2008 d. January 2008
3	38	Improve oversight of institutional abuse or neglect investigations (i.e., Stage I) of children in foster care by (a) implementing a formalized process for following up with county departments of human/social services on disagreements between conclusions by the Department's Institutional Abuse Review Team (Review Team) and the county departments regarding Stage I investigations; (b) ensuring that the Review Team provides detailed recommendations to counties for corrective action related to Stage I investigations and following up on these recommendations; and (c) requiring the Review Team to provide specific recommendations in its annual federal report on improving county Stage I investigations.	a. Agree b. Agree c. Agree	a. July 2008 b. July 2007 c. September 2009

RECOMMENDATION LOCATOR
Agency Addressed: Department of Human Services

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
4	42	Expand efforts to ensure that county departments of human/social services meet established timelines for investigating and reporting on institutional abuse or neglect allegations in the foster care program by (a) considering revising Department regulations to allow counties to prioritize response times for institutional abuse or neglect allegations; (b) modifying Trails to allow reporting on a county-by-county basis of investigations that are initiated and/or reported late and the reasons that counties did not meet the deadlines; (c) working with counties to address problems that prevent them from conducting and reporting on investigations timely; and (d) implementing a progressive discipline system for counties that repeatedly fail to meet compliance standards for investigations.	a. Agree b. Agree c. Agree d. Agree	a. December 2008 b. October 2007 c. December 2008 d. July 2008
5	45	Strengthen oversight of the safety of foster homes by (a) requiring county departments of human/social services and child placement agencies (CPAs) to report when they have closed foster homes with substantiated cases of abuse or neglect and (b) requiring counties and CPAs to provide a written report explaining why the home should remain open in those cases in which foster homes with substantiated cases are not closed.	a. Agree b. Partially Agree	a. July 2008 b. March 2008
6	48	Improve the Stage II investigation process by (a) identifying and implementing methods for informing county departments of human/social services of the results of Stage II investigations so that the information can be used to determine foster care placements; (b) establishing a process to conduct Stage II investigations on county departments; and (c) establishing and formalizing a process for using progressive adverse licensing actions against CPAs that repeatedly violate Department regulations.	a. Agree b. Agree c. Agree	a. July 2008 b. December 2009 c. July 2008

RECOMMENDATION LOCATOR
Agency Addressed: Department of Human Services

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
7	50	Improve oversight of critical incident reporting by (a) identifying annually the child placement agencies (CPAs) and county departments of human/social services that are not reporting all critical incidents within regulatory time limits; (b) setting standards for the percentage of critical incidents that counties and CPAs must report on time to avoid sanctions and establishing a process for using corrective action when counties and CPAs do not meet these standards; (c) working with counties and CPAs to determine the reasons for noncompliance on an ongoing basis and applying remedies to correct these problems; and (d) expanding the CPA licensing and monitoring process and the county foster care program reviews to include an examination that determines if counties and CPAs report all critical incidents.	a. Agree b. Agree c. Agree d. Agree	a. October 2007 b. October 2007 c. July 2008 d. January 2008
8	57	Strengthen oversight of county foster care programs by (a) including specific strategies in its corrective action plans for addressing county noncompliance with federal foster care standards and federal and state requirements; (b) developing a system of ongoing or recurring corrective action to use when county departments of human/social services are out of compliance; (c) improving the monitoring of counties' corrective action plans; and (d) modifying procedures to focus more resources on case file reviews rather than on interviews and policy reviews.	a. Agree b. Agree c. Agree d. Agree	a. December 2008 b. July 2008 c. Ongoing d. October 2007
9	60	Improve oversight of child welfare programs at county departments of human/social services by (a) reviewing statutes that relate to the Department's responsibilities for ensuring that counties meet applicable state and federal requirements; (b) assessing whether the statutes are sufficiently clear about the Department's authority to compel counties to change practices when they are noncompliant; and (c) revising its regulations and working with the General Assembly, if necessary, to clarify its supervisory responsibilities over counties.	a. Agree b. Agree c. Agree	a. October 2007 b. October 2007 c. November 2008

RECOMMENDATION LOCATOR
Agency Addressed: Department of Human Services

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
10	65	Improve oversight of child placement agencies (CPAs) by (a) establishing risk-based schedules for licensing and monitoring CPAs; (b) revising procedures for renewing CPA licenses to ensure that CPAs receive materials more than 90 days before their licenses expire; (c) establishing and implementing policies to fully document all key areas reviewed during licensing and monitoring visits and retaining the supporting documentation; and (d) evaluating current licensing and monitoring procedures to identify and eliminate duplication.	a. Agree b. Agree c. Agree d. Agree	a. October 2007 b. Implemented c. January 2008 d. January 2008
11	69	Track the timeliness of all federally mandated foster care reviews by monitoring how long reviews are delayed once they have gone beyond the federal deadline, establishing a process to prioritize reviews that have not been completed within a predetermined period, such as a year, and reallocating resources to immediately complete those reviews.	Agree	July 2008
12	72	Strengthen oversight of the county grievance process authorized under the Children's Code by (a) providing for Department review of grievance policies and procedures at county departments of human/social services and the composition of citizen review panels to determine county compliance and providing for imposing corrective action when counties are not compliant; (b) requiring counties to provide complainants with clear and specific information about their rights under the statutory grievance process; (c) requiring county citizen review panels, rather than county department personnel, to determine and inform complainants when their grievances do not meet statutory guidelines for referral to the panels; and (d) eliminating the requirement that counties attempt to resolve grievances informally before using the statutory grievance process, or clarifying the meaning of this rule in a way that is consistent with the rights provided in statute.	Agree	July 2008

RECOMMENDATION LOCATOR
Agency Addressed: Department of Human Services

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
13	79	Increase oversight of Core Services programs by (a) implementing procedures to review samples of files to verify counties are only providing Core Services to eligible families; (b) developing written policies to impose fiscal sanctions and/or require repayment of funds from county departments of human/social services for cases in which Core Services eligibility has not been adequately documented; and (c) providing training and technical assistance to the counties to ensure that counties understand eligibility documentation requirements and that counties are aware of available sanctions if documentation is not sufficient.	a. Agree b. Agree c. Agree	a. November 2007 b. July 2008 c. July 2008
14	84	Ensure that it has accurate and valid methods for evaluating the effectiveness of Core Services programs by (a) excluding children already in out-of-home placement from the calculation of prevention rates and expanding the period over which program success is measured after services conclude; (b) analyzing prevention rates by levels of family risk and by type of placement; and (c) considering using standardized tools for assessing changes in family functioning to evaluate the effectiveness of Core Services.	a. Agree b. Agree c. Agree	a. October 2007 b. October 2008 c. January 2008
15	86	Ensure that it has accurate and valid methods for evaluating the cost-effectiveness of Core Services programs by (a) basing the county Core Services averages on the actual number of service-months that children receive the services; (b) weighting the averages of county Core Services costs appropriately when calculating the State's average cost; (c) considering other methods for calculating cost savings; and (d) developing valid methods for assessing the cost savings attributable to Core Services for children who enter or remain in out-of home placement after receiving Core Services.	a. Agree b. Agree c. Agree d. Agree	a. October 2007 b. October 2008 c. October 2008 d. October 2008

RECOMMENDATION LOCATOR
Agency Addressed: Department of Human Services

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
16	89	Review statutes related to Core Services to identify areas in which the statutes could be made clearer and more consistent with respect to the services to be provided, populations that are eligible for services, and any time limits on services and work with the General Assembly, as necessary, to clarify the statutory authority for Core Services.	Agree	November 2008

Overview of Colorado's Foster Care System

Colorado's child welfare system typically provides services for children under the age of 18 who need protection, are in conflict with their families or communities, or require other specialized services. Some services may be provided up to age 21 for individuals who were in the system before age 18. Under statute [Sections 26-1-111 and 118, C.R.S.], the system is supervised by the State through the Colorado Department of Human Services (Department) but directly administered by county departments of human/social services. County involvement with a family usually begins when the county receives a referral about possible abuse or neglect of a child. If the county determines the referral is credible, it assesses the safety of the child and opens a case if the assessment determines that the child is in danger. Once the county opens a case, it conducts further assessments to determine which services it should provide to the family. Child welfare services include:

- Case plan development and management to prevent future abuse or neglect and to ensure permanent living arrangements for children.
- Foster care placement for those children who cannot remain home safely.
- Therapy, skills training, or other types of services, known as Core Services, to prevent or shorten foster care placements, achieve permanency, or allow for a less restrictive placement.
- Subsidized adoption, which reduces financial barriers to adoption of special-needs children in the custody of the counties by providing monthly subsidies to adoptive families and Medicaid coverage for the adopted child.
- Independent living skills training for children who will emancipate from the foster care system without being adopted.

If the county believes foster care is the only way a child can be kept safe, it must petition the court for an order to take custody of the child. Counties may take emergency custody of children they believe to be in imminent danger after receiving a verbal or written order from a judge. Counties must follow up emergency removals with a court hearing within 72 hours to confirm that such removal was appropriate. Once the county has custody of the child, Department regulations require the county to find the most appropriate and least restrictive setting for placement. The foster care system includes various types of placement settings, such as family foster homes, group homes, kinship care (in which the foster family is related to the child), receiving homes (which provide short-term emergency care when a child is initially removed from the home), therapeutic residential child care facilities (TRCCFs), and psychiatric residential treatment facilities (PRTFs). Family foster homes and

kinship care are the least restrictive placement settings, and TRCCFs and PRTFs are the most restrictive. Counties place children in certified foster homes and provide for the children to receive case management and appropriate therapeutic services.

Federal Oversight

The federal Adoption and Safe Families Act and Titles IV-B and IV-E of the federal Social Security Act govern child welfare activities, including foster care, at the federal level. The federal government awards funds under Titles IV-B and IV-E to the state agencies designated to oversee child welfare and holds the state agencies accountable for meeting federal regulations. The U.S. Department of Health and Human Services (DHHS) establishes federal regulations for child welfare, including foster care. It also provides oversight of states' child welfare programs through periodic reviews that determine state compliance with national child welfare standards. In addition, states are required to report compliance data to DHHS on a regular basis. For State Fiscal Year 2006, the Department received about $133 million in federal funds for child welfare activities.

State Responsibilities

Several statutes define the Department's supervisory role of the State's child welfare system, including foster care, as follows:

- Section 26-1-111(2)(b), C.R.S., states that the Department shall "administer or supervise the establishment, extension, and strengthening of child welfare services" in cooperation with the federal government and other state agencies.

- Section 26-1-111(2)(d), C.R.S., charges the Department with (1) supervising the county departments of human/social services for the effective administration of child welfare services as set out in Department regulations, (2) compiling statistics and necessary information related to child welfare services, and (3) obtaining federal reimbursement moneys available through Title IV-E of the Social Security Act.

- Section 26-6-107(4), C.R.S., requires the Department to monitor the counties' foster parent certification processes on a quarterly basis within available appropriations.

- Section 26-6-104(1)(c), C.R.S., requires the Department to license child placement agencies (CPAs), which are private entities that certify and oversee some foster homes.

In addition, Section 26-1-107, C.R.S., authorizes the State Board of Human Services to promulgate regulations governing any program administered or supervised by the Department. Finally, the federal Office of Management and Budget *Circular A-133: Audits of States, Local Governments, and Non-Profit Organizations* requires the Department to monitor subrecipients of federal funds, such as those provided by Titles IV-B and IV-E, to ensure compliance with federal laws and regulations.

Three divisions within the Department have primary oversight of the State's child welfare system, including foster care:

- **Division of Child Welfare Services (Child Welfare).** Child Welfare provides oversight and training to counties for all child welfare services. Specifically, Child Welfare monitors and provides feedback on abuse or neglect investigations conducted by counties, provides training to counties on finding permanent placements in foster care cases, and monitors CPAs. CPAs are any private entity that arranges for the placement of children under the age of 18 for the purpose of foster care or adoption. This division also collects and reports on outcome data from Trails, the State's automated case management system. Examples of outcomes reported from Trails include compliance with federal accountability standards such as the number of abuse or neglect incidents in out-of-home care and the frequency at which children reenter the foster care system. We discuss these standards in more detail in Chapters 1 and 2.

- **Division of Child Care (Child Care).** Child Care licenses child care providers in the State, including CPAs that provide foster care services. As of September 2006, there were 61 licensed CPAs that provided foster care.

- **Administrative Review Division (ARD).** ARD conducts federally mandated six-month reviews of foster care cases. The reviews evaluate whether the foster care placement is necessary and appropriate and the child is receiving the services needed to reach his or her permanency goal (e.g., reunification with the family or adoption). The reviews also test county compliance with federal and Department requirements related to child welfare cases. In addition, ARD conducts in-home reviews, which measure the effectiveness of services provided to families whose children remain at home but are at risk of being removed.

County Responsibilities

Under statute [Section 26-1-118, C.R.S.], counties serve as agents of the State and are charged with the administration of child welfare activities in accordance with regulations established by the Department. Colorado is one of 13 states with a state-

supervised, county-administered child welfare system. In accordance with Department regulations, the counties carry out the ongoing responsibilities of the child welfare system, including:

- Accepting and documenting reports of children who are alleged to be experiencing abuse or neglect, are out of the control of their families, are exhibiting behavior that is harmful to themselves or others, or are otherwise in need of services.

- Assessing the safety of children who are the subjects of the reports mentioned above, working with the courts to remove children from their homes if such action is deemed necessary based on the assessment of the child's safety, and placing children in foster homes or other out-of-home placement settings.

- Recruiting and directly certifying foster families. In addition to contracting with CPAs to certify and oversee foster families, the counties directly certify and monitor some foster parents. County supervision of foster homes includes assessing the homes on a periodic basis to certify or recertify them and providing required training to foster parents.

- Contracting with CPAs to provide foster care services. Counties may choose to establish contracts with state-licensed CPAs to carry out some foster care activities. In Fiscal Year 2006, 53 counties used CPAs to provide foster care. Under the contracts, the CPAs are responsible for certifying foster homes, placing children in foster homes, and providing other services to foster children and families such as case management and therapeutic services. The counties are responsible for holding the CPAs accountable for meeting all contractual requirements.

- Investigating allegations of abuse or neglect occurring in out-of-home placement, including in foster homes certified by counties and CPAs. If an investigation determines that abuse or neglect did occur in a county-certified home, the county or CPA may revoke a foster family's certification. For county- and CPA-certified homes, the county may discontinue placing children with the family.

- Reporting to the Department in accordance with regulations.

Populations Served

The State's child welfare system serves children through a range of services intended to protect the child's best interests. About 41,000 children received some type of child welfare service in Fiscal Year 2006. As we discuss later in this chapter, our audit did not review all child welfare services but focused on foster care and Core Services. Over the last four fiscal years, about 22,000 children annually (about 2 percent of the State's child population aged 0-17) either received Core Services or experienced a foster care placement, or both, as shown in the table below.

Department of Human Services
Number of Children in Core Services or Foster Care Placement
Fiscal Years 2003 Through 2006

	Fiscal Year								
	2003		2004		2005		2006		
	Number of Children	Percent of Total	Number of Children	Percent of Total	Number of Children	Percent of Total	Number of Children	Percent of Total	Percent Change FY 03-06
Total Children Statewide (Ages 0-17)	1,147,000	100.0%	1,164,200	100.0%	1,174,300	100.0%	1,180,500	100.0%	+2.9%
Children in Foster Care Placement During Year[1]	13,500	1.2%	13,400	1.2%	13,400	1.1%	13,600	1.2%	+0.7%
Children Receiving Core Services	13,400	1.2%	16,100	1.4%	17,800	1.5%	18,800	1.6%	+40.3%
Children in Placement and/or Receiving Core Services[2]	20,900	1.8%	22,100	1.9%	23,000	2.0%	23,400	2.0%	+12.0%

Source: Core Services and foster care placement numbers calculated by the Office of the State Auditor using data from Trails, the Department of Human Services' database used for child welfare services. Total child population figures from annual estimates prepared by the United States Census Bureau.

[1] Number of children who were in an out-of-home placement for any period of time at some point during the year.

[2] Unduplicated count of children experiencing an out-of-home placement and/or receiving Core Services. Therefore, amounts do not equal the sum of the preceding two rows.

As the table shows, the number of children in placement increased less than 1 percent during the period, while the number receiving Core Services increased about 40 percent. Overall, the number of children receiving Core Services and/or

experiencing placement grew about 12 percent during the period, while the total number of children in the State increased about 3 percent.

Funding

The General Assembly appropriates funding for all child welfare services, including foster care, through the Child Welfare Block Grant. The Child Welfare Allocation Committee (Committee), comprising Department and county representatives, determines how funding should be distributed among the counties. The Committee uses an allocation formula based upon factors, such as the number of referrals, assessments, and foster care placements, that have an impact on caseloads and costs for each county. State statutes give counties flexibility in spending their child welfare funds. For example, counties are allocated a certain amount for foster care placements but can transfer these funds to other child welfare services (and vice versa) as necessary.

The Department funds child welfare services, including foster care, with a mixture of state general funds, local funds, and federal funds. Under statute, the Department reimburses counties for 80 percent of their expenditures, up to their allocated amount, with a combination of state and federal funds. Counties can choose to spend more of their own funds once they have exhausted their allocation of state and federal funds.

The major sources of federal funding for child welfare services come from the Social Security Act, as follows:

- **Title IV-E** (federal payments for adoption and foster care) helps states recoup a portion of foster care maintenance costs for children from families falling below a certain income level as defined by federal law. States must determine if a child is eligible for Title IV-E before claiming these funds. Currently Colorado is reimbursed for 50 percent of its Title IV-E–eligible costs. In Fiscal Year 2006 the State received about $59.3 million in Title IV-E funds for foster care maintenance costs.

- **Title XIX** (Medicaid) pays medical costs for children in foster care. Like Title IV-E, Colorado is reimbursed for 50 percent of its Title XIX-eligible costs. In Fiscal Year 2006 the State received about $31.9 million in Title XIX funds to provide medical care to foster children.

- **Title XX** (social services block grant) funds general child welfare services and is based on a state's overall population. The Department includes a portion of Title XX funds in the child welfare allocations to the counties. In Fiscal Year 2006 the State received about $22.7 million in Title XX funds.

- **Title IV-B** (child and family services) pays for services to preserve and support families and to offset the State's overall general fund spending on child welfare services. States receive a base amount from Title IV-B plus additional funds based on the state's population under the age of 21 and per capita income. In Fiscal Year 2006 the State received about $4 million in Title IV-B funds.

- **Title IV-A** (Temporary Aid to Needy Families or TANF) provides financial assistance to low-income families so that children may be cared for in their own homes. Federal law allows 10 percent of TANF funds received to be transferred to child welfare services. Once transferred, these funds are subject to Title XX requirements. In Fiscal Year 2006 the State transferred about $15.1 million of TANF funds to child welfare services.

In total, federal funding for child welfare services increased about 2.8 percent over the last five years from about $129.4 million in Fiscal Year 2002 to about $133 million in Fiscal Year 2006. The largest increases came from Title IV-E funds and transfers from TANF.

The table on the next page shows total child welfare expenditures, including foster care, for Fiscal Years 2002 through 2006, broken down by type of expenditure.

Department of Human Services
Child Welfare Expenditures [1]
Fiscal Years 2002 Through 2006

	Fiscal Year					Percent Change, FY02-06
	2002	2003	2004	2005	2006	
Administration						
Department Admin	$2,218,000	$2,353,000	$1,661,000	$1,915,000	$2,296,000	3.5%
County 100% Admin [2]	$21,905,000	$24,115,000	$24,683,000	$25,141,000	$25,647,000	17.1%
County 80/20% Admin [2]	$93,151,000	$84,620,000	$89,463,000	$92,840,000	$108,674,000	16.7%
Total Administration	$117,274,000	$111,088,000	$115,807,000	$119,896,000	$136,617,000	16.5%
Out-of-Home Allocation[3]	$78,352,000	$81,122,000	$76,255,000	$73,038,000	$74,427,000	-5.0%
RTC Allocation[3]	$50,646,000	$52,013,000	$54,510,000	$53,489,000	$56,889,000	12.3%
Core Services[4]	$44,416,000	$40,717,000	$37,660,000	$42,429,000	$46,204,000	4.0%
Subsidized Adoption[5]	$31,451,000	$36,957,000	$39,980,000	$40,827,000	$41,848,000	33.1%
CHRP Allocation[6]	$6,988,000	$7,795,000	$7,400,000	$6,781,000	$6,296,000	-9.9%
Child Welfare-Related Child Care[7]	$4,205,000	$3,276,000	$2,885,000	$3,600,000	$2,959,000	-29.6%
Case Services[8]	$3,473,000	$3,171,000	$2,176,000	$871,000	$999,000	-71.2%
Child Welfare - BHO[9]	$0	$6,836,000	$5,987,000	$3,111,000	$210,000	N/A
Total Child Welfare Services	$336,805,000	$342,975,000	$342,660,000	$344,042,000	$366,449,000	8.8%

Source: Department of Human Services' County Financial Management System and the Colorado Financial Reporting System (COFRS).

[1] Child welfare expenditures in this table include expenditures paid through the Child Welfare Block Grant and Core Services. This table does not include other expenditures related to child welfare, such as Title IV-E eligibility determinations, Title XX caseworker training, Promoting Safe and Stable Families (Title IV-B), Title IV-E Independent Living Program, Family-to-Family Grant, Integrated Care Management Program, and Division of Child Care expenses.

[2] County 100% and County 80/20% both refer to county administration costs. The Department reimburses some administrative costs at 100 percent, instead of the normal 80 percent, due to a lawsuit against the Department in the 1990s alleging that child welfare caseloads were too high. As part of the lawsuit settlement, the Department agreed to expand the number of child welfare caseworkers and to fund these additional caseworkers at 100 percent. The County 100% and County 80/20% line items do not include any additional county-only funds spent on child welfare services.

[3] The Out-of-Home allocation covers the cost of foster care placements including those at Residential Treatment Centers (RTCs). The separate RTC allocation line covers additional psychiatric services provided to children in placement.

[4] Core Services are designed to prevent out-of-home placements, facilitate reunification with the family, or allow children to move to less restrictive placement settings.

[5] Subsidized Adoption provides financial assistance to families which adopt children that are difficult to place because of age, membership in a sibling group, or medical needs.

[6] Children's Habilitation Residential Program, which provides residential services to children and youth in foster care who have developmental disabilities and extraordinary needs.

[7] Foster parents automatically qualify for the Child Care Assistance Program. This category captures these expenses.

[8] These are child welfare services that counties are required to provide by statute but are not included in Core Services. These include medical exams for children involved in child welfare cases and arranging subsidized adoptions (but not the subsidy itself).

[9] Reimbursements to Behavioral Health Organizations (BHOs) for providing mental health services to foster children placed by child placement agencies. As of November 2004, the federal Centers for Medicare and Medicaid Services disallowed these reimbursements because these services are already included in the BHOs' capitation payments under the Medicaid program.

As the table shows, overall child welfare expenditures increased about 9 percent between Fiscal Years 2002 and 2006, and expenditures for Department and county administration increased about 4 percent and 17 percent, respectively. Overall, total administrative expenditures represented between 32 and 37 percent of child welfare expenditures during Fiscal Year 2002 through 2006.

In Fiscal Year 2006 the federal government funded about 35 percent of the State's child welfare expenditures, the counties funded about 15 percent, and the remaining 50 percent came from the state general funds. As mentioned earlier, our audit focused on out-of-home placements and Core Services. Expenditures for out-of-home placements declined 5 percent, and expenditures for Core Services increased about 4 percent during the same period.

Previous Child Welfare Audits

Including this audit, the Office of the State Auditor has conducted four performance audits related to the child welfare system since 1990. Although the current audit did not specifically follow up on all previous findings and recommendations from the previous audits, this audit generally includes areas of concern from earlier reports. Throughout this audit report, we identify those issues where we previously made recommendations.

Audit Scope

Our audit focused on foster care provided through family foster homes, group homes, kinship care, and receiving homes. We did not examine more institutionalized forms of out-of-home care such as residential treatment centers (RTCs), therapeutic residential child care facilities (TRCCFs), and psychiatric residential treatment facilities (PRTFs). (TRCCFs and PRTFs replaced RTCs in July 2006.) Overall, our audit evaluated the Department's supervision of foster care services administered by the counties and CPAs. Specifically, we reviewed the Department's oversight of county abuse or neglect investigations, foster parent recruitment and retention rates, and foster parent certification. We also looked at the Department's methods for ensuring that counties and CPAs meet applicable statutory and regulatory requirements. In addition, we analyzed accountability data to determine if the Department is meeting federal standards for foster care. Finally, we evaluated the effectiveness of the Core Services program, which provides services designed to prevent out-of-home placements or facilitate a child's return to home.

During our audit we visited eight counties: Alamosa, Arapahoe, Boulder, Denver, El Paso, Mesa, Pueblo, and Weld. We interviewed staff to determine how their

counties administer foster care services and reviewed data related to Core Services, foster parent certification, and abuse or neglect investigations.

This is the first of two reports related to our evaluation of foster care in Colorado. The second report will focus on financial issues affecting the foster care system.

Safety of Foster Children

Chapter 1

In Colorado, about 13,600 children were in foster care for some period during Fiscal Year 2006 because county departments of human/social services had determined that the children had experienced abuse or neglect in their homes, were beyond the control of their parents, were voluntarily placed, or were court-ordered into foster care through delinquency hearings. While in foster care, children may live in a variety of placement settings ranging from family and group foster homes (the focus of our audit) to institutional environments, such as therapeutic residential child care facilities. Although counties administer foster care services in Colorado, under both state and federal laws and regulations, the Colorado Department of Human Services (Department) is ultimately accountable for ensuring the safety, well-being, and stability of children who have been removed from their homes. For example, federal regulations say that states are accountable for having in place a federally approved state child welfare plan that addresses the safety of foster children.

Ideally, when children are removed from their homes, they are placed in foster homes that keep them safe and stable and help them overcome obstacles that may prevent them from thriving. To promote the well-being of foster children, the United States Department of Health and Human Services (DHHS) developed minimum standards for assessing the safety and stability of children in foster care. We evaluated the Department's success in achieving these key federal benchmarks related to safety and found that, as of December 2006, the Department is not meeting some of these standards. More specifically:

- **Abuse or neglect.** The national standard is that no more than 0.57 percent of foster children will experience abuse or neglect in foster care. During Calendar Year 2006, 94 children in out-of-home placement (0.71 percent of all Colorado children in placement) experienced a substantiated case of abuse or neglect while in foster care.

- **Change in placement.** The Department's negotiated goal with the federal government is that no more than 24 percent of foster care placement changes will be for reasons unrelated to achieving the child's permanency goal. Over the six-month period of July through December 2006, about 45 percent of Colorado's foster care placement changes were unrelated to the child's permanency goal. For these 800 children, placement changes were due to reasons such as abuse by the foster parent, a request by the foster parents to

move the child, a decision by the family to no longer be foster parents, or the child's needing a more restrictive placement.

- **Face-to-face visits.** The Department's negotiated goal with the federal government is that at least 90 percent of foster children will receive monthly face-to-face visits with their caseworkers. The Department reviewed a sample of about 5,800 case files for children who were in foster care during the six-month period of July through December 2006 and found that about 4,900 foster children, or about 84 percent of those who were in placement for this six-month period, did receive monthly face-to-face visits with their caseworkers while another 900 did not receive a visit in at least one month.

Children who are removed from their homes are often leaving a disruptive, chaotic environment, and the foster home placement is key to reestablishing order and stability at a critical time in the child's life. Therefore, high-quality foster homes are crucial to ensuring that children who are removed from their homes are in a safe environment and that no further exposure to abuse or neglect occurs.

Counties and child placement agencies (CPAs) have a direct role in ensuring children placed in foster homes have an opportunity to thrive. High-quality foster care begins with safe homes and well-trained foster parents. Counties and CPAs are responsible for recruiting foster parents and ensuring they are certified in accordance with state law and Department regulations. County caseworkers are expected to meet face-to-face with their assigned foster children at least once per month to assess the child's progress and monitor the safety of the child's home environment. Also, the counties and CPAs may assign a staff member, separate from the caseworker, who visits with the foster parent at least once per month to provide training and support, monitor the safety of the home, and help address specific problems or concerns. Additionally, the counties and CPAs conduct home studies and annual updates to assess the ongoing safety and quality of each foster home during the recertification process. Finally, in instances where a child may have been abused or neglected in either a county- or CPA-certified foster home, counties are responsible for conducting an investigation to address the immediate safety of the child, determine whether the abuse or neglect actually occurred, and take action as appropriate.

The Department also has a role in ensuring that children are placed in high-quality foster homes that promote the child's safety and well-being. More specifically, the Department oversees county and CPA practices for certifying foster homes and county practices for recruiting and retaining quality foster homes. The Department also tracks and follows up on critical incident reports from counties and CPAs. A critical incident is an event that poses a threat to a foster child's safety and well-being and can include not only abuse or neglect but also other circumstances such as a fire at the foster home, the death of a caregiver, or an accidental injury to the

foster child. When allegations of child abuse or neglect occur at either a county- or CPA-certified foster home, the Department reviews the quality, thoroughness, and appropriateness of the county's abuse or neglect investigations. Finally, as discussed in more detail in Chapter 2, the Department conducts regular monitoring of county and CPA foster care services to ensure compliance with federal and state laws and regulations and to identify areas for improvement.

We reviewed the Department's practices for overseeing the safety and stability of children in foster care. We found problems with the Department's monitoring of (1) foster care certifications by counties and CPAs and (2) foster care recruitment and retention practices by counties. We also found the Department's oversight of county abuse or neglect investigations and critical incident reporting was insufficient. These problems, which are some of the same issues identified in the Office of the State Auditor's *Foster Care Program Performance Audit* (June 2002), diminish the Department's ability to ensure that children placed in foster care are in safe and stable environments. This chapter suggests ways in which the Department can improve its oversight and better ensure the safety and well-being of foster children.

Quality of Foster Homes

According to the Department, several factors have contributed to the State's failure to meet the federal standard for preventing child abuse or neglect in foster homes, including (1) certification of inappropriate homes, (2) inappropriate placements (i.e., poor match between child and foster parents), (3) placing too many children in a single foster home, and (4) lack of support for foster homes. County and CPA practices for certifying foster homes—which assess the background, skills, training, and finances of the foster parent and the physical safety of the home—are paramount to ensuring that foster homes provide high-quality care and services to address the children's needs. Additionally, recruitment and retention strategies are key to ensuring a sufficient number of quality foster homes are available to provide for the number of children in need of placement.

We evaluated county and CPA practices for certifying foster homes and county practices for recruiting and retaining foster parents. We identified problems in both of these areas, as described in the next two sections.

Foster Parent Certification

Colorado Revised Statutes and Department rules set forth the requirements that both counties and CPAs must follow to certify foster parents and foster homes. Counties and CPAs evaluate a range of factors during certifications, including assessing whether (1) the foster parent has sufficient skills, background, and training; (2) the

foster home meets physical, safety, and accessibility requirements; and (3) the foster parents are financially stable and have sufficient resources to perform their responsibilities. Our audit evaluated county and CPA certification practices that specifically affect child safety in the foster home. We reviewed a total of 128 foster parent files: 88 for parents certified by eight counties and 40 for parents certified by four CPAs. Overall, we found that 103 of the 128 files reviewed (80 percent) were missing key documentation related to foster parent training requirements, criminal history checks, and involvement in family case planning. Our findings suggest that the counties and the CPAs are not adhering to basic procedures for certifying quality foster homes and that the Department is not providing sufficient oversight of these certification programs. The problems we found are described below.

Training. Statute requires that foster parents receive 27 hours of initial training. This includes 12 hours of pre-placement core training that follows Department curriculum guidelines and an additional 15 hours that must be completed within three months of child placement in the home. In addition, statute requires foster parents to complete 20 hours of ongoing training during the first year of certification and each year thereafter. Finally, Department rules require foster parents to complete CPR/First Aid training.

Overall, we found that 55 of the 128 files (43 percent) reviewed did not have evidence that foster parents had met these training requirements (some files contained more than one type of problem). Specifically:

- 5 files were missing documentation that the foster parents completed the 12 core training hours required before a child can be placed in the home.

- 28 did not have evidence that the foster parents completed the additional 15 hours of training required within three months of a child being placed in their home.

- 25 files did not have evidence that foster parents completed all 20 hours of ongoing training annually.

- 14 were missing a current Training Development Plan that documents the foster parent's annual training needs.

- 18 files did not have adequate documentation of CPR/First Aid training.

Training of foster parents plays an important role in preventing abuse or neglect of children, providing quality care for children in foster care, and helping to prevent both burn-out for the foster parents and placement disruption for the child. During our site visits, we found that counties vary on how much training they offer and

whether they prioritize training for their foster homes. Some counties emphasized that quality training was a key factor in retaining foster homes, while others viewed the training requirements as onerous barriers to retention.

Background Checks. Statute requires all foster parents to undergo fingerprint-based criminal history checks through the Colorado Bureau of Investigation and checks for previous abuse or neglect allegations through Trails before their initial certification to help ensure they are suitable foster parents. Furthermore, as of May 2001, statute [Section 26-6-107, C.R.S.] requires the Department to instruct counties to conduct a comparison background check in ICON to help determine the disposition of any charges. An ICON search identifies events that would not be flagged by a fingerprint check, such as a restraining order. The Department reports it did not start requiring ICON checks on foster homes until May 2004, three years later than required by statute.

Our audit reviewed county and CPA compliance with the criminal history and ICON checks required by the statutes. We found that for our sample of 128 files, 50 homes were initially certified after May 2004, and 18 of these (36 percent) did not undergo an ICON check. One county told us it did not know it had access to the database. Another claimed it was unaware of this requirement, although it had conducted ICON checks on some of its families. The Department verifies that counties are meeting background check requirements during its reviews of county foster care programs, discussed in Chapter 2. However, we did not find that the Department had identified the problem with the ICON checks during these reviews. The Department should ensure that counties are aware of the ICON requirement and that county certification workers are properly trained in completing the background check.

Case Planning. Department regulations require counties to involve foster parents in each child's Family Services Plan (Plan), including CPA-certified foster parents. The Plan addresses the child's needs for safety, permanency, and well-being, and documents the specific services the foster parent will provide, along with the expected outcomes for the child. Foster parents are required to sign the Plan as evidence of involvement, and the Plan is updated periodically to reflect changes in needs.

We reviewed a sample of 100 Plans at eight counties and four CPAs and found instances where both county- and CPA-certified foster parents were not involved in developing the Plan or were not given specific guidance for caring for their foster children. Specifically:

- 20 Plans did not include the foster parents as participants.
- 26 Plans were not signed by the foster parents.

- 18 Plans were missing the signature page, so we could not determine if the foster parents had signed them.

- 53 Plans did not identify the specific actions the foster parents were expected to take to meet the needs of the children in their care. Rather, the Plans included only broad goals, such as, "the foster home will meet all of the child's physical, medical, and emotional needs."

The CPAs we visited reported that county departments rarely involve CPA foster parents in the Plan development. CPAs also reported that counties do not consistently provide copies of Plans when CPAs request them. During our review we found that CPAs did not have Plans available for 24 (44 percent) of the 54 children in our sample that were placed in CPA-certified homes. If counties do not make Plans available to CPAs and foster parents, the parents will not know what services they are expected to provide to foster children, and CPAs will not have information to make appropriate foster care placements or monitor foster home services.

We were unable to determine why counties do not always provide Plans to CPAs or involve foster parents in their development. However, two of the eight counties we visited report that in some cases county attorneys and judges prohibit sharing the Plans with foster parents because of concerns over confidential birth parent information. Counties can provide important information about a child's needs and behaviors and include foster parents in the Plan without revealing confidential parent information. The Department should require counties to provide Family Services Plan information to CPAs with which they have placed children and to foster parents. The Department should work with the counties, as needed, to find a solution for providing information about the foster child without violating court orders or confidentiality restrictions.

The Department needs to ensure that counties and CPAs comply with regulations related to foster home certification, particularly in areas related to child safety. Currently the Department requires CPAs to attest that their foster parents are qualified in accordance with applicable requirements as part of the annual licensing process. However, some requirements, such as documentation of the annual 20 hours of ongoing foster parent training, are not included in the attestation. In addition, it is not clear that the Department requires CPAs to review foster parent files to verify qualifications as a basis for the attestation. Further, the Department does not have a similar attestation requirement for counties. The Department could require both counties and CPAs to annually desk audit a sample of their foster parent files to ensure that the parents are fully qualified and that their qualifications are documented. The counties and CPAs could use this audit process as a basis for certifying that their foster parents meet all certification requirements. The

Department could then verify a sample of desk audits through its county and CPA monitoring, as discussed in Chapter 2. The Department should also have mechanisms in place to sanction counties and CPAs when it finds discrepancies between the attestations and the actual qualifications of foster parents.

Strong county and CPA certification practices are crucial for ensuring foster parents have the skills, training, and involvement necessary to provide high-quality services to the children in their care. These children are in foster care because they have already experienced abuse or neglect; ensuring that certification reviews focus on promoting high-quality foster care is fundamental for preventing future abuse or neglect of foster children and improving the State's compliance with federal foster care standards.

Recommendation No. 1:

The Department of Human Services should improve its oversight of the foster parent certification process by:

a. Requiring county departments of human/social services and child placement agencies to conduct periodic (e.g., annual) desk audits of their certified foster parents to ensure that the parents meet all applicable requirements and that their qualifications are documented in their files. The Department should require the counties and child placement agencies to attest to the Department each year on the basis of the audits that their foster parents are qualified in accordance with all applicable requirements.

b. Developing and applying sanctions when the Department finds discrepancies between county and child placement agency attestations and actual foster parent qualifications.

c. Requiring that county departments of human/social services provide Family Service Plan information to child placement agencies with which they have placed children and ensuring that county-certified foster parents also receive Family Service Plan information.

d. Working with county departments of human/social services to develop a solution for providing relevant child information to foster parents without violating confidentiality requirements.

Department of Human Services Response:

a. Agree. Implementation date: July 2008.

The Department will require that county departments of human/social services and child placement agencies conduct periodic desk audits, thus allowing them to better self-monitor, verify, and correct any noncompliance issues as a means to ensure that foster home records are in compliance with all applicable requirements. This will include attestation annually from the governing agency that foster homes are qualified in accordance with all applicable requirements.

The Department will work with county departments of human/social services and child placement agencies to develop a rule requiring they complete the desk audit and the annual attestation. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board of Human Services' process by no later than January 2008.

b. Agree. Implementation date: July 2008.

The Department agrees to develop a sanction policy as a part of a progressive discipline policy that will be applied when discrepancies between attestations from counties and child placement agencies' foster home files are found. The Department will work with county departments of human/social services and child placement agencies to develop a rule-based policy. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board process by no later than January 2008.

c. Agree. Implementation date: July 2008.

The Department agrees that county departments of human/social services should comply with providing Family Services Plan (Plan) information to child placement agencies. The Department agrees to review current rules by September 2007 and to modify them if necessary. Additionally, the Department agrees to review the child placement agency contract and will clarify the need to provide the Plan to any placement provider that the county contracts with for placement. If a rule change is needed, it is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board process by no later than January 2008.

d. Agree. Implementation date: October 2008.

The Department agrees to comply with this recommendation and will develop a solution for providing information to foster parents without violating confidentiality. The Department will convene a series of meetings to discuss with county departments of human/social services, child placement agencies, and foster parents how to best solve this matter. If rule changes are necessary to support decisions, then the Department will complete the process necessary to ensure that all parties are involved in the rule-making process, which takes a minimum six months after the conclusion of the meetings.

Foster Parent Recruitment and Retention

When a child who has been abused or neglected is removed from his or her home, the child needs an immediate foster home placement. To ensure sufficient homes are available to meet the needs of foster children, counties and CPAs must continually recruit and retain quality foster homes. According to six of the eight counties we visited, one of the most successful strategies for recruiting foster parents is word-of-mouth from current foster parents. As a result, counties view retaining their current foster parents as key to increasing the pool of high-quality foster homes available for placing vulnerable children.

During Fiscal Year 2007 the Department had one FTE and about $329,000 in funding dedicated to overseeing and enhancing county activities related to foster parent recruitment and retention. We reviewed the Department's efforts to support and assist counties with foster parent recruitment and found that the Department has not done enough to identify and help counties with foster home recruitment and retention problems.

First, we found that the Department lacks accurate data to identify counties that are having problems recruiting and retaining foster parents or to determine the reasons why foster homes close. Currently the Department maintains data on the foster homes that are certified and that close in Trails, its automated case management system. We evaluated Trails data on about 9,700 foster home closures during Fiscal Years 2003 through 2006 and found that the data could not be used to accurately calculate foster home closure rates. More specifically, we could not confirm that about 2,900 (30 percent) of the 9,700 closure records represented actual foster home closures because the Trails data indicated that (1) the home's certificate had expired or that the home had moved but did not confirm whether (2) the foster home permanently closed or was issued a renewal certificate. For about 800 (8 percent) of the 9,700 records, Trails data indicated that the foster home was certified and then closed within five days or less, raising questions of whether the certification and closure dates were accurate and whether the closures had actually occurred.

Second, we found that the Department has not worked with counties or tracked the necessary data to evaluate which of the counties' foster parent recruitment and retention strategies, such as billboard or radio/television advertisements or presentations at community functions, are most effective. Furthermore, the counties we visited do not formally evaluate their recruitment and retention methods either. Department and county staff both reported that foster home turnover rates are increasing because more foster parents are choosing to adopt their foster child. However, due to the inaccurate data in Trails discussed above, the Department cannot determine the extent to which adoptions by foster parents are having an impact on foster home turnover rates.

To help counties recruit foster parents more effectively, the Department needs to improve the accuracy and quality of foster home recruitment and closure data. The Department should determine the types of data it needs to identify counties with foster home recruitment and retention problems and analyze the reasons for those problems. Additionally, the Department should ensure that the codes it uses to identify foster home closures accurately capture only those homes that have actually closed. Finally, the Department should work with counties to evaluate the effectiveness of recruitment and retention strategies, and provide targeted training and best practices to improve county recruitment and retention rates.

Recommendation No. 2:

The Department of Human Services should work with county departments of human/social services to evaluate and improve foster parent recruitment and retention by:

a. Identifying data needs and improving data collection methods to ensure accurate, quality data for tracking and analyzing foster care certifications and closures.

b. Developing measures to assess the effectiveness of county recruitment and retainment efforts.

c. Using the improved data discussed in part "a" and the measures in part "b" to analyze annual foster home recruitment and retention rates for each county and closure reasons statewide and by county. The Department should use these analyses to identify those county departments of human/social services with highly effective practices and those with less effective practices.

d. Compiling and sharing best practices relating to foster home recruitment and retention and targeting technical assistance on successful recruitment and retention activities to county departments that have less effective practices.

Department of Human Services Response:

a. Agree. Implementation date: September 2007.

The Department will comply with this recommendation by submitting the request to make the necessary change to the Trails system. Trails enhancements will be made based on pending priorities, which include federal Statewide Automated Child Welfare Information System (SACWIS) and Adoption and Foster Care Analysis and Reporting System (AFCARS) compliance.

b. Agree. Implementation date: January 2008.

The Department will use federal Child and Family Services Review measures such as placement stability and that homes recruited reflect the diversity of children in care to measure effectiveness of county recruitment and retention efforts. The Department will also measure the rate at which foster parents adopt children in their care.

c. Agree. Implementation date: January 2008.

Annually the Department will analyze county practice to determine highly effective and less effective practices and will communicate the information to county departments and child placement agencies.

d. Agree. Implementation date: January 2008.

The Department will communicate best practices related to foster home recruitment and retention annually through agency letter and at meetings held every other month for county certification workers.

Institutional Abuse or Neglect

Children in foster care are a particularly vulnerable population because they have experienced abuse or neglect prior to removal from their homes. When a foster child experiences abuse or neglect again in the foster home, the consequences may be tragic. Consequently, prompt and effective responses to allegations of abuse or neglect are crucial for keeping foster children safe.

Under federal and state law, the Department is responsible for ensuring that all children receive protection from abuse or neglect. In Colorado, counties are the "first responders" to abuse or neglect allegations. According to statute, counties are

responsible for investigating allegations of intra-familial and institutional abuse or neglect. With respect to children in foster care, counties conduct institutional abuse, or Stage I, investigations when allegations of abuse or neglect occur in a foster home. Department regulations require counties to initiate Stage I investigations within 24 hours of receiving the allegation and to submit a written report of the investigation to the Department within 60 days of the date the incident was first reported. The county's investigation may conclude that (1) the allegation is founded (i.e., substantiated), (2) the allegation is unfounded, or (3) the evidence is inconclusive. The counties conducted 1,520 Stage I investigations during Fiscal Years 2002 through 2006 and determined that abuse or neglect was substantiated in 231 cases (15 percent).

The federal Child Abuse Prevention and Treatment Act requires the Department to evaluate "the extent to which state and local child protection system agencies are effectively discharging their child protection responsibilities" by examining the policies, procedures, and practices of these agencies as well as specific cases. To that end, the Department has established an Institutional Abuse Review Team (Review Team or Team), made up of Department, county, and community representatives to review every county abuse or neglect investigation. In Fiscal Year 2006 there were 18 members and 4 alternates on the Review Team. Counties submit their investigation reports to the Review Team and the Team determines if it agrees with the county's conclusions and assesses whether the county conducted the investigation appropriately. Specifically, individual Team members review five to eight cases each month and discuss their findings at the Team's monthly meeting. The Team then provides the county with a report detailing any deficiencies in the investigation and suggests the county take follow-up action, such as increased monitoring of foster homes, if applicable. In accordance with federal law, the Team also prepares an annual report with recommendations to the Department for improving the state and local child protection systems. There are no state laws or Department regulations defining the Review Team's duties. However, Department staff indicated that the Review Team operates similarly to county child protection teams required by statute [Section 19-3-308, C.R.S.]. Statute requires the counties' child protection teams to review investigations of suspected child abuse, including institutional abuse, and report "any lapses and inadequacies in the child protection system and if they have been corrected."

If in the course of its review, the Team determines that a CPA's or foster home's practices may have contributed to an abuse or neglect incident, the Review Team may also recommend that a Stage II investigation take place. If the Stage II investigation determines that the CPA or foster home is culpable for the abuse or neglect incident, negative sanctions such as fining or suspending the CPA's license or closing the foster home can occur.

We reviewed the Department's methods for overseeing abuse or neglect incidents at county- and CPA-certified foster homes. We found the Department needs to strengthen these processes to better ensure the safety of foster children as described below.

Quality of Stage I Investigations

We analyzed the Institutional Abuse Review Team's reviews of county Stage I investigations involving family foster homes and group homes for Fiscal Years 2002 through 2006. We found the Team is not an effective mechanism for ensuring that counties conduct thorough and accurate investigations and thereby protect the safety of foster children. We found that the Team's review process identifies deficiencies and errors in the counties' Stage I investigations; however, the Department does not follow up sufficiently on these deficiencies and errors to ensure that they are corrected. As a result, the time and effort devoted to the Team by Department and county staff, which staff estimated to be about 6-10 hours per month per person, provides relatively little benefit. We discuss the problems we identified in the next three sections.

County Findings

Our audit compared the results of Review Team reports with findings from county Stage I investigations for Fiscal Years 2002 through 2006. We found that, overall, counties do not appear to accurately identify all instances of abuse or neglect. More specifically, we found that the Review Team disagreed with the conclusion drawn by county investigators for 389 (26 percent) of the 1,520 Stage I cases involving family foster homes and group homes. Although the rate of the Review Team's disagreement trended downward from 28 percent in Fiscal Year 2002 to 18 percent in Fiscal Year 2006, it is still of concern. For 331 of the 389 cases with a disputed conclusion, the Review Team did not agree with the county investigation's conclusion that the abuse or neglect was unfounded or that the evidence was inconclusive. For 133 of the 331 cases, the Review Team concluded that the abuse or neglect likely occurred.

We also found that when the Team disagrees with the county's conclusions about whether abuse or neglect occurred, the Department does not routinely take further action to resolve these disagreements. Therefore, for the 133 cases where the Team concluded that abuse or neglect likely occurred and reported its results to the counties, the State has no assurance that the counties resolved the issues or that the practices leading to the abuse or neglect were addressed. Furthermore, counties may continue to place children in these foster homes, putting children at greater risk of harm.

Our review of the Review Team's records for Fiscal Years 2002 through 2006 illustrates this concern. We identified 205 foster homes during the period that were subject to multiple abuse or neglect allegations. For nine of these homes, we found that confirmed incidents of abuse or neglect against foster children may have been prevented if the Review Team had sufficiently followed up on earlier abuse or neglect allegations against the homes in which the Team disagreed with the county's conclusion that abuse or neglect was either unfounded or that the evidence was inconclusive. In one case, a foster parent severely abused a child after the county concluded that a prior abuse allegation was unfounded. The Review Team disagreed with the county's conclusion that the prior abuse was unfounded, but the Team could not substantiate that the abuse actually occurred because according to the Team's report, the county did not conduct a thorough investigation. The Team noted that the county's investigation report failed to address all pertinent issues, interview all essential parties, and include the results of the child's medical exam. If the county had conducted a complete investigation, it may have concluded that the foster parents had committed abuse in the first incident and were no longer suitable for fostering children, including the one later abused. One of the foster parents was convicted of felony child abuse for the latter incident and sentenced to 15 years in prison.

Department staff reported that they follow up on the most egregious cases in which the Review Team disagrees with the county findings through phone calls and emails to the county requesting further information. However, without consistent follow-up by the Department, issues of abuse or neglect may remain unresolved, children may continue to be harmed, and the Review Team's effectiveness is questionable. Although federal law does not specifically require the Department to resolve differences in conclusions between the Review Team and counties, federal law does hold the Department accountable for curbing foster home abuse or neglect and ensuring the safety of foster children. The Department should implement a formal process for following up on all cases in which the Review Team reaches a different conclusion than the county about whether abuse or neglect occurred. The process should ensure that the Department identifies any deficiencies in the county's investigation, that the county takes steps to address the deficiencies, and that the county provides adequate information to the Department to explain its conclusion. If a county cannot provide information to support its conclusion, the Department should determine if further review or investigation is needed.

County Corrective Actions

As discussed previously, each time the Review Team completes a review of a Stage I investigation, the Department provides the county with a written report of the review results. The reports include recommendations to the county for corrective action when appropriate, such as providing additional training to foster parents, to help reduce the risk of abuse or neglect in the future. During Fiscal Years 2002

through 2006, the Review Team recommended the counties take further action on 345 of 527 Stage I investigations it reviewed involving county-certified homes.

We reviewed the Department's database that tracks the counties' implementation of the Review Team's recommendations and found two problems. First, the Department's database contained no information on the implementation status of about 32 percent of the 345 cases recommended for follow-up. As a result, the Department does not know, and we could not confirm, whether counties complied with the Team's recommendations in these cases. Second, for the 235 cases for which the database did have information on the implementation status of recommendations, data indicated that counties implemented key recommendations for corrective action against the foster homes less than half the time. According to Department data, counties only implemented about 19 percent of recommendations to reevaluate the suitability of a home for foster care, 44 percent of recommendations calling for extra training, and 47 percent of recommendations for additional monitoring of the foster home.

We also found that Department staff do not follow up with the counties to determine why they have not implemented the Review Team's recommendations. The Department reports that it does not have enough staff to track county progress in implementing the recommendations. In its most recent five-year plan for complying with federal Title IV-B, the Department stated that implementation of the Review Team's recommendations was a key measure for ensuring the safety of children in foster care. However, by failing to ensure that counties implement these recommendations, the Department undermines the effectiveness of this mechanism. Counties may be putting foster children at greater risk by failing to follow the Review Team's recommendations to help prevent future abuse or neglect incidents. In addition, State, county, and community resources are wasted because the time devoted by the Team's 18 members does not lead to improvements.

The Department needs to work with the Review Team to ensure the Team provides more detailed recommendations to the counties, ensure information on the recommendations are entered in the Department's database, and then follow up with counties on whether the recommendations were implemented. If the Department's resources are not sufficient to follow up on all of the recommendations made to counties, the Department should identify the most high-risk issues and ensure staff prioritize those recommendations for follow-up.

County Investigative Deficiencies

In addition to identifying cases in which counties need to take corrective action related to a particular foster home, the Review Team often notes problems with a county's investigative practices. During Fiscal Years 2002 through 2006, the Team cited investigative deficiencies in about 35 percent of the Stage I reports it reviewed.

Problems identified included the omission of key information from the report, the failure to consider all essential issues or interview all essential parties, or the submission of a report that was hard to follow or contained unimportant information. The Review Team includes these deficiencies in the written report it provides to the county after each review. In addition, as required by the federal Child Abuse Prevention and Treatment Act, the Team includes a list of recommendations, based on the reviews conducted throughout the year, in an annual report. The recommendations in the annual report may be directed to the counties, the Department, or both.

We found that neither the annual reports nor the individual reports to counties are helping to improve county investigative practices. According to some county staff, one reason counties may not be implementing the Review Team's recommendations regarding investigative practices is that the Team's recommendations do not include sufficient information or explanation for the counties to determine how to address the problems identified in the review. Similarly, we found the Team's recommendations in the annual reports were not specific enough to be effective. For example, the Team's Fiscal Year 2006 annual report recommended that the counties improve their investigation practices and apply rules consistently when conducting their investigations. However, the report did not identify the specific steps counties should take to improve their investigations or explain how the rules were applied inconsistently. Furthermore, the Department does not follow up with counties on the recommendations contained in either the Team's annual or individual county reports to ensure the counties improve the quality of their investigations.

Both the Review Team's individual and annual reports could be valuable tools for informing the counties about deficiencies, providing guidance for correcting them, and ensuring the improvements are made. However, without specific recommendations and follow-up on their implementation, the time and resources devoted to the review process are not being used effectively. The Department should require the Review Team to make specific recommendations for addressing deficiencies in Stage I investigations in its annual reports and then develop steps to ensure that the recommendations are implemented.

Recommendation No. 3:

The Department of Human Services should improve its oversight of institutional abuse or neglect (i.e., Stage I) investigations of children in foster care by:

a. Implementing a formalized and documented process to follow up with counties on disagreements between the conclusions of the Institutional Abuse Review Team and the county departments of human/social services regarding abuse or neglect investigations. The process should ensure that the counties

take steps to address any investigative deficiencies and provide adequate information to the Department to explain their conclusions. If a county cannot provide information to support its conclusion, the Department should determine if further review or investigation is needed.

b. Ensuring that the Institutional Abuse Review Team provides detailed recommendations to county departments of human/social services for corrective actions related to specific Stage I investigations and that Department staff follow up on the Review Team's recommendations to ensure that counties comply with them.

c. Requiring the Institutional Abuse Review Team to provide specific recommendations in its annual Child Abuse Prevention and Treatment Act report for correcting deficiencies identified during its review of county abuse or neglect investigations and ensuring that the recommendations are implemented.

The Department should seek statutory revisions as needed to implement these changes.

Department of Human Services Response:

a. Agree. Implementation date: July 2008.

The Department will develop a system to ensure that a county response is received when the investigation/assessment was deficient. This will include promulgating rules to formalize the process. In the case of a disagreement with the finding, the Department will follow up with the county and request additional clarifying information. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board of Human Services process by no later than January 2008.

b. Agree. Implementation Date: July 2007.

The Department agrees that the Institutional Abuse Review Team will provide detailed recommendations to county departments related to specific Stage I investigations. Staff performing Foster Care Program Reviews will utilize the information from the Review Team when monitoring county compliance. Counties found to be out of compliance with the Review Team's recommendations will be placed on corrective action.

c. Agree. Implementation date: September 2009.

The Institutional Abuse Review Team, in its capacity as a federal Child Abuse Prevention and Treatment Act (CAPTA) State Citizen Review Panel, will annually list specific deficiencies noted in investigations and recommendations for corrections and improvements. The Department will ensure that CAPTA recommendations are implemented during the current five-year state plan.

Timeliness of Stage I Investigations

As noted above, Department regulations require counties to initiate Stage I investigations within 24 hours and submit their investigation reports to the Department within 60 days of receiving the allegation. Initiating Stage I investigations in a timely manner is essential to ensure the safety of the alleged victim and to obtain accurate accounts of the incident from the alleged victim, perpetrator, and witnesses.

We reviewed the timeliness of Stage I investigations over the last four years and found there were delays by the counties in both beginning their investigations and reporting to the Department. First, we found that counties were late initiating investigations for 324 (25 percent) of 1,287 abuse or neglect allegations between July 1, 2002, and June 30, 2006. Late investigations ranged from 1 to 80 days late and, on average, were about 4 days late. Second, counties were late in submitting their investigation reports to the Department for 571 (48 percent) of 1,197 allegations between January 1, 2003, and June 30, 2006. The Department's database did not contain information about the timeliness of reports for July through December 2002. Late reports ranged from 1 day to nearly two years late and, on average, were 28 days late. About 160 reports were submitted more than three months after the abuse or neglect incident occurred.

We also analyzed data for the 10 largest counties and identified 7 that began at least 25 percent of their investigations late. In addition, we found that each of the 10 large counties submitted at least 25 percent of their Stage I reports late. Half of these counties submitted more than 50 percent of their reports late.

Currently the Department does not evaluate data maintained in the Stage I database to identify counties that are consistently late beginning their investigations and submitting their reports. The Department also does not follow up with counties to determine why their reports are late, and the Department's database has no fields to capture this information. Finally, the Department has not established sanctions to be taken against counties that repeatedly miss deadlines for initiating and reporting their Stage I investigations.

During our site visits, county staff indicated that it may not be appropriate to require that abuse or neglect investigations begin within 24 hours in every case. If the incident occurred weeks or months before it was reported and the child is no longer in an unsafe situation, then seeing the child within 24 hours may not be necessary. County staff also reported that it can be difficult to meet the 24-hour standard when counties receive multiple institutional abuse allegations on the same day. For abuse or neglect allegations that do not involve institutional abuse (e.g., intra-familial abuse), Department regulations allow counties to prioritize their response times based on the risk to the child's safety. The Department could consider a similar approach for counties responding to institutional abuse allegations. Finally, Department staff indicated that some counties' reports may be delayed because law enforcement officials are also looking into the allegation and the police investigation takes longer than 60 days to complete.

In our 2002 audit report, we found that counties initiated 29 percent of Stage I investigations late and submitted 57 percent of Stage I reports late. We recommended the Department track the counties' timeliness in starting their Stage I investigations and submitting their reports, provide training and technical assistance about the timeliness requirements, and impose fiscal sanctions on counties that are repeatedly late. The Department agreed to monitor counties' timeliness, develop a process for imposing corrective actions on counties that are repeatedly late, and use fiscal sanctions in "extreme" cases. Although Department staff reported that it runs monthly timeliness reports, we did not find evidence that staff have used these reports to identify counties that are repeatedly late or established criteria to determine when a county's noncompliance in this area requires corrective action or constitutes an "extreme" case. Since county timeliness has not improved significantly in the five years since our last audit, the Department should determine the reasons for county delays and then use this information to establish compliance standards for the timeliness of Stage I investigations and reports. This could include establishing a minimum percentage of cases (e.g., 95 percent) in which counties must initiate investigations and report on them to the Department on time, as well as identifying instances in which the 24-hour initiation requirement may not be appropriate. The Department should also implement a system for progressive discipline, including fiscal sanctions, against counties that do not meet these standards.

Recommendation No. 4:

The Department of Human Services should expand efforts to ensure that county departments of human/social services meet established timelines for investigating and reporting on institutional abuse or neglect allegations in the foster care program on an ongoing basis by:

a. Considering revising Department regulations to allow county departments of human/social services to prioritize response times for institutional abuse allegations based on the risk to the child's safety.

b. Making modifications to Trails to allow reporting on a county-by-county basis of Stage I investigations that are initiated and/or reported late and the reasons the counties did not meet the investigation and reporting deadlines. The Department should annually compile and evaluate this information to identify counties that repeatedly miss deadlines for priority cases.

c. Using the analysis suggested in part "b" to work with county departments of human/social services, as necessary, to help them address the problems that prevent them from conducting and reporting on their Stage I investigations on time.

d. Implementing a formalized process for applying progressive discipline, including fiscal sanctions, against county departments of human/social services that repeatedly fail to meet compliance standards for Stage I investigations.

Department of Human Services Response:

a. Agree. Implementation date: December 2008.

The Department will convene a series of meetings to discuss with county departments of human/social services and child placement agencies the establishment of timelines for investigating and reporting on institutional abuse or neglect allegations. If rule changes are necessary to support decisions, then the Department will complete the process necessary to ensure that all parties are involved in the rule-making process, which takes a minimum of six months.

b. Agree. Implementation date: October 2007.

The Department agrees to comply with this recommendation. A portion of the recommendation is in the process of being implemented.

The Department will initiate a Trails Change Request to have a monthly report that complies on a county-by-county basis Stage I investigations including a justification for report deadlines being missed. A Change Request will be submitted by October 2007.

c. Agree. Implementation date: December 2008.

Upon the implementation of the Trails enhancement in part "b", the Department will work with county departments to analyze the data and address the problems that prevent them from conducting and reporting on their Stage I investigations timely.

The Department is currently involved in completing a large number of Trails enhancements to ensure compliance with state and federal statute. The Department prioritizes these enhancements with input from key stakeholders. Enhancements that have been under production for the past 12 to 15 months are scheduled for a July 2007 and December 2007 build. The Department will convene a series of meetings to discuss with county departments of human/social services, child placement agencies, and foster parents how to best solve this matter. If additional rule changes are necessary to support decisions, then the Department will complete the process necessary to ensure that all parties are involved in the rule-making process, which takes a minimum of six months.

d. Agree. Implementation date: July 2008.

The Department will work with county departments of human/social services to develop a rule-based progressive discipline policy. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board of Human Services process by no later than January 2008.

Multiple Founded Cases of Abuse or Neglect

There are no statutory or regulatory provisions prohibiting counties or CPAs from placing children in foster homes that have one or more instances of substantiated abuse or neglect against a foster child. Instead, counties determine on a case-by-case basis whether to continue using a foster home (either county- or CPA-certified) once the home has a substantiated case of abuse or neglect. During our site visits to eight counties, we found that none of the counties has established a threshold for the

number of founded cases of abuse or neglect above which it will no longer use a foster home.

We analyzed the Institutional Abuse Review Team's (Review Team) database of Stage I investigations occurring between July 2002 and December 2005 and found there were six homes with two founded cases of abuse or neglect each during this period. We found that in two of the six cases, the counties and CPAs should have acted more swiftly to close the foster home permanently. Specifically:

- For one foster home, the first founded case of abuse or neglect occurred in September 2002 and involved alleged sexual assaults by one foster child (a former sex offender) on the other three foster children in the house. The county substantiated the case for lack of supervision because the foster parents did not provide separate sleeping quarters for the alleged perpetrator when the allegations became known. The county's report also noted concerns that the foster parents had not ensured that the alleged perpetrator registered with the local police as a sex offender and often did not know the whereabouts of the alleged perpetrator. The second founded case of abuse or neglect in this home occurred in December 2004 and involved a substantiated allegation that the foster parents' 22-year-old grandson committed sexual abuse against a foster child. The home was closed by the CPA after this instance.

- For another foster home, the first founded case of abuse or neglect occurred in May 2003 and involved an allegation that the foster father hit the child with a toy. The county concluded that the case could be substantiated for lack of supervision (but not for abuse) because there was insufficient evidence to determine how the child was injured while in the care of the foster father. The second founded case of abuse or neglect in this home occurred in November 2003 and involved medical neglect and lack of supervision regarding two foster children with substantial medical needs. The allegations included not taking the children in for medical appointments required by their conditions and continuing to put ties in one child's hair when the foster parents knew the child was prone to putting the ties in her mouth. This child died in December 2003 from a combination of flu-like symptoms and an infection caused by getting a hair tie stuck in her trachea. No criminal charges were pursued against the foster parents. The county founded the case for medical neglect and lack of supervision and the Review Team agreed. The foster parents resigned their license in January 2004.

In the first case, the county or CPA could have prevented further occurrences of abuse or neglect by closing the foster home after the first substantiated incident. In the second case, the death of a child might have been prevented by immediately

closing the foster home after the first substantiated incident in May 2003. It was not clear from the county investigation reports or the Review Team's reviews why these homes remained open.

Currently the Department provides minimal supervision over county decisions to continue using foster parents that have abused or neglected foster children. To curb foster care abuse or neglect and better ensure the safety of foster children, the Department should require the Review Team to follow up with counties and CPAs during the Team's review process and confirm whether foster homes with substantiated cases of abuse or neglect have been closed. If the county or CPA has not closed the home, the Department should require the county or CPA to provide a written report describing why the home should remain open.

Recommendation No. 5:

The Department of Human Services should strengthen its oversight of the safety of foster homes used by county departments of human/social services and child placement agencies by:

a. Requiring county departments of human/social services and child placement agencies to report to the Department when they have closed foster homes with substantiated cases of abuse or neglect.

b. Requiring counties or child placement agencies to provide a written report describing why a foster home should remain open in cases in which the county department or child placement agency does not close a foster home with a substantiated case of abuse or neglect.

Department of Human Services Response:

a. Agree. Implementation date: July 2008.

The Department will promulgate rules requiring county departments and child placement agencies to report to the Department when they have closed foster homes with substantiated cases of abuse or neglect. The Division of Child Care will work closely with the 24-Hour Monitoring Unit to verify that these identified foster homes are closed. The Department will pursue adverse action in cases of licensed care where children are still at risk.

b. Partially agree. Implementation date: March 2008.

The Department partially agrees with the recommendation. The Department will require a written report from the county department or child placement agency when there has been medium to severe abuse or neglect and the home remains open. The Department does not agree to require a report where abuse or neglect is minor.

Stage II Investigations

The Department conducts a Stage II investigation on all Stage I investigations involving CPAs, while counties, based on a recommendation from the Institutional Abuse Review Team, may conduct a Stage II investigation on their certified foster homes. A Stage II investigation reviews the licensing practices of a CPA and the operating practices of a foster home to assess the administrative culpability of the CPA or foster home. For example, if a CPA committed a licensing violation in connection with the incident, such as placing too many children in a foster home, the CPA might be culpable in the abuse or neglect incident. The investigation also determines if problems identified during the Stage I investigation can be addressed administratively by the CPA and/or if negative licensing action against the CPA or foster home (e.g., suspending the CPA's license or closing the foster home) should occur.

We reviewed the Department's process for conducting Stage II investigations of CPAs, CPA-certified foster homes, and counties and identified several concerns with the effectiveness of the investigations, as described in the following sections.

The Department does not inform counties of Stage II results of CPA investigations. When the Department completes its Stage II investigation of a CPA, the Department does not provide the results of the investigation to the counties so that counties can consider this information when deciding whether to continue placing children with the CPA. During our audit we found that counties sometimes place children at CPAs with multiple licensing violations. For example, counties placed more than 5,200 children with four CPAs that each committed more than 20 licensing violations during Fiscal Years 2003 through 2006. In June 2006 the Department began including data about Stage II investigations in Trails, but Department staff reported that this information is not organized so that counties can review summary data about all Stage II investigations for a particular CPA. The Department should explore alternate methods for distributing this information. For example, staff indicated that negative licensing actions taken against CPAs are discussed at regular meetings held for county and Department staff. The Department could consider providing Stage II information at these meetings as well.

The Department does not conduct Stage II investigations of counties. The Department does not investigate counties to determine their administrative culpability in abuse or neglect cases. Department staff indicated that the Department does not need to conduct Stage II investigations of counties because the Institutional Abuse Review Team process (discussed earlier in this chapter) and the Department's comprehensive reviews of county foster care programs (discussed in Chapter 2) provide oversight similar to the Stage II investigations. However, the Review Team process and the reviews of county foster care programs are not intended to assess the administrative culpability of counties in abuse or neglect cases. Since a significant number of children are placed in county-certified foster homes (45 percent of all placements in Fiscal Year 2006), it is important for the Department to determine if county administrative practices contribute to abuse or neglect incidents. Therefore, the Department should implement a Stage II-type process for Stage I investigations involving county-certified foster homes.

The Department does not apply sanctions for repeat violations. Under statute [Section 26-6-108(2), C.R.S.], the Department may suspend, revoke, or make probationary the license of a CPA or assess a fine if the CPA consistently fails to maintain Department standards or willfully or deliberately violates any statutory child care licensing standards. Department procedures require a recommendation for adverse licensing action against a CPA (e.g, suspension, probation, fines, or revocation) when the licensee has consistently violated regulations more than two or three times within a five-year period. We analyzed the Stage II database and found that eight CPAs have committed at least 10 violations each over the last four fiscal years. Although Department staff recommended adverse licensing action for each of these CPAs at least once during the period, it does not appear that staff have recommended sanctions as often as they should have. For example, one of these eight CPAs mentioned was fined as a result of a staff recommendation at the beginning of Fiscal Year 2004. From that time until the end of Fiscal Year 2006, the Department cited this CPA for 19 more violations without recommending or imposing additional sanctions. According to staff, the Department pursues further licensing sanctions only when the CPA violates the same rule repeatedly. We found that neither statute nor Department procedures require multiple violations of the same rule for the Department to find that a CPA has "consistently violated regulations."

The Department needs to develop a system of formal progressive discipline for CPAs that repeatedly violate licensing regulations. The Department's current enforcement penalties include license suspension or revocation, probation, and fines, but there is no graduated system for applying these penalties. A progressive system would apply increasingly severe penalties against CPAs that repeatedly violate regulations within a specified time frame and ensure that staff apply these sanctions appropriately.

Stage II investigations perform an essential role in preventing future abuse or neglect incidents in foster homes by determining if the actions of CPAs or counties contribute to these incidents. These investigations are particularly important because Colorado's foster care abuse rate, as discussed earlier in the chapter, exceeded the federal standard as of December 2006. Improving the Stage II process and expanding it to cover county practices will help the Department to ensure the safety of foster children and minimize future abuse or neglect incidents.

Recommendation No. 6:

The Department of Human Services should improve the Stage II investigation process to ensure the safety of foster children and minimize abuse or neglect incidents. Specifically, the Department should:

a. Identify and implement methods to inform county departments of human/social services of the outcomes of Stage II investigations so that the information can be used in determining foster care placements.

b. Establish a process to conduct Stage II investigations of county departments of human/social services to review the administrative culpability of counties in abuse or neglect incidents.

c. Establish and apply a formalized system for using progressive adverse licensing actions, up to and including license revocation, against child placement agencies that repeatedly violate the Department's licensing requirements.

Department of Human Services Response:

a. Agree. Implementation date: July 2008.

   The Department will provide information to the county departments regarding access to the reports so that the information is available for consideration during the decision-making process for placement in certified family foster care homes.

b. Agree. Implementation date: December 2009.

   The Department will comply with conducting Stage II investigations of county departments contingent on additional staffing resources being secured.

c. Agree. Implementation date: July 2008.

The Department will work with county departments and child placement agencies to develop a rule-based progressive discipline policy. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board of Human Services process by no later than January 2008.

Critical Incidents

As noted previously, a critical incident is an event that poses a threat to a foster child's safety and well-being and can include not only abuse or neglect but also other circumstances such as a fire at the foster home, the death of a caregiver, or an accidental injury to the foster child. Regulations require CPAs to report critical incidents involving foster children to the Department within 24 hours of occurrence, excluding weekends and holidays. Timely reporting of critical incidents is important so that the Department can ensure that counties investigate the most serious critical incidents, which involve abuse or neglect allegations, and ensure that foster children remain safe. We reviewed the Department's processes for overseeing critical incidents and identified areas for improvement, as follows.

Critical incident reporting by CPAs. We analyzed the Department's critical incident database for Fiscal Years 2003 through 2006 and found that about 28 percent of the almost 1,800 critical incidents were not reported timely by CPAs. Additionally, for 10 CPAs that submitted 50 or more critical incident reports during the period reviewed, we found that all 10 reported at least 23 percent of their critical incidents late. One of these CPAs reported its critical incidents late about half of the time. The Department did not take any adverse licensing actions against any of these CPAs.

We also found evidence suggesting that CPAs are not reporting all critical incidents to the Department. We compared the number of abuse or neglect (i.e., Stage I) investigations and critical incident reports for each CPA during Fiscal Years 2003 through 2006. The number of critical incident reports for each CPA should be equal to or larger than the number of Stage I investigations because abuse or neglect incidents leading to Stage I investigations are only one type of critical incident. We found that the number of critical incidents reported by 10 of the approximately 60 CPAs licensed over this period were fewer than the number of Stage I investigations conducted at these CPAs. For example, one CPA was involved in 71 Stage I investigations but reported only 67 critical incidents to the Department during the

period. Another CPA was involved in 26 Stage I investigations but only reported three critical incidents.

Our 2002 audit also identified problems with critical incident reporting by CPAs and recommended that the Department identify the CPAs that were not meeting reporting requirements, provide them technical assistance and training, and take adverse licensing actions for repeated failure to report critical incidents timely. The Department reported in May 2003 that it had identified 20 CPAs that were not reporting critical incidents on time and provided them with one-on-one training. However, staff have not reinforced these efforts by continuing to monitor CPA compliance and taking action against CPAs that repeatedly fail to comply.

Critical incident reporting by counties. Prior to November 2006, counties were not required to report critical incidents involving children placed in county-certified foster homes. In November 2006 the Department began requiring counties to follow the same guidelines as CPAs for reporting critical incidents. We were completing our audit work when this requirement went into effect, so we did not conduct an analysis of the counties' reporting under this new requirement. However, we did note that as of January 2007 the Department had not established procedures for monitoring county compliance with these requirements.

Knowledge and timely receipt of critical incidents are essential to ensuring the safety of children in foster care. Therefore, the Department should fully implement the recommendations agreed to five years ago. This should include establishing standards for the percentage of critical incidents CPAs and counties must report on time (e.g., 95 percent) to avoid corrective actions and applying corrective actions when CPAs and counties do not meet the standard. Additionally, the Department should work with repeatedly noncompliant CPAs and counties on an ongoing basis to determine why they are not reporting critical incidents timely and determine appropriate remedies. Remedies may include technical assistance, corrective action, or progressive discipline. Finally, the Department should review the CPAs' and counties' records to identify critical incidents that were not reported to the Department. This should be included as part of the Department's licensing or monitoring reviews of CPAs and the comprehensive reviews of counties discussed in Chapter 2.

Recommendation No. 7:

The Department of Human Services should improve its oversight of critical incident reporting in the foster care system by:

a. Identifying annually the child placement agencies and county departments of human/social services that are not reporting all critical incidents within regulatory time limits.

b. Setting standards for the percentage of critical incidents child placement agencies and counties must report on time to avoid corrective actions and establishing procedures for the use of remedies when CPAs and counties repeatedly fail to meet the timeliness requirements.

c. Working with child placement agencies and county departments of human/social services on an ongoing basis to determine the reasons for noncompliance and designing appropriate remedies, including technical assistance, corrective action, or progressive discipline, to address the problems.

d. Expanding the CPA licensing or monitoring processes and the county foster care program reviews to include an examination of records to determine if the agency or county has failed to report any critical incidents.

Department of Human Services Response:

a. Agree. Implementation date: October 2007.

The Department will comply with this recommendation for county departments by submitting a Trails Change Request by October 2007 that will allow better identification of counties and CPAs that report critical incidents late. In the interim, the Department will utilize a temporary method to comply with this request by reviewing data on a quarterly basis. Trails enhancements will be made based on pending priorities, which include federal Statewide Automated Child Welfare Information System (SACWIS) and Adoption and Foster Care Analysis and Reporting System (AFCARS) compliance.

b. Agree. Implementation date: October 2007.

The Department will establish a baseline and then develop standards for timely reporting. To accomplish this, the Department will submit a Trails Change Request by October 2007 to provide reports that will allow us to establish a baseline. Trails enhancements will be made based on pending priorities, which include federal Statewide Automated Child Welfare Information System (SACWIS) and Adoption and Foster Care Analysis and Reporting System (AFCARS) compliance. Once baselines and reporting standards have been established, the Department will develop

remedies for counties and CPAs that repeatedly fail to report critical incidents timely.

c. Agree. Implementation date: July 2008.

The Department will work with county departments and child placement agencies to develop a rule-based progressive discipline policy. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board of Human Services process by no later than January 2008.

d. Agree. Implementation date: January 2008.

The Department is currently reviews critical incident reports for child placement agencies on a case-by-case basis. The Department agrees to require county departments and child placement agencies to compile a master list of critical incidents by family foster home and group homes on a quarterly basis. The information will be used to review Critical Incident Reports on Trails prior to conducting on-site reviews and during case file reviews. The Department will work with the key stakeholders to draft rules. The rules will be introduced to the State Board process by no later than January 2008.

Quality of Care

Chapter 2

The State's child welfare system, including foster care, is intended to protect abused and neglected children from future harm, strengthen the family's ability to care for its children, and ensure that children have stable, permanent homes. In 2000 the U.S. Department of Health and Human Services (DHHS) established national standards to measure whether states' child welfare programs were in conformity with requirements under Titles IV-B and IV-E of the federal Social Security Act that ensure the safety, permanency, and well-being of foster children. In addition to protecting children, the standards are designed to promote continuous improvement by the states. DHHS also developed on-site Child and Family Service Reviews to monitor whether states are meeting the minimum national standards.

The federal reviews evaluate state performance in terms of providing for the safety, permanency, and well-being of children in the child welfare system and the administrative systems in place to serve these children. The reviews comprise two main components. First, DHHS evaluates the state's achievement of six statewide quantitative standards, such as the percentage of children in the child welfare system that experience abuse or neglect. DHHS has established specific benchmarks for each of these standards. Second, DHHS assesses whether the state is meeting 23 qualitative indicators, such as whether permanency goals were established in a timely manner. DHHS concludes on the qualitative indicators by reviewing a sample of actual case files. If 90 percent of the files reviewed meet the criteria, the state is considered to be compliant. This standard rises to 95 percent when a state undergoes subsequent federal reviews.

DHHS conducted a Child and Family Services Review of the Colorado Department of Human Services (Department) in June 2002. The August 2002 final report showed that the Department was not achieving two of the six quantitative standards– one related to the number of children that are abused in foster care and one related to the number of times children reenter foster care. The Department also failed to meet 15 of the 23 qualitative factors. The results of the 2002 review are shown in Appendix A.

As a result of the 2002 federal review, DHHS and the Department negotiated a Performance Improvement Plan (Plan) to correct the Department's deficiencies. The Plan, finalized in October 2003, contained 19 compliance goals related to the federal quantitative and qualitative indicators. DHHS set a deadline of March 2007 for the Department to meet these goals or face possible fiscal penalties.

We reviewed data from the Department and found that as of December 2006, the Department's performance relative to the federal standards had declined in key areas. First, the State was not meeting three of the six quantitative national standards—the number of children that are abused in foster care, the number of times children reenter foster care, and the stability of foster care placements (measured by the number of children who have been placed in no more than two different foster homes in a 12-month period). Second, the State's performance on three of the six quantitative indicators—repeat maltreatment, length of time to achieve reunification, and the stability of foster care placements—had worsened since the 2002 federal review. Finally, the Department had not met 6 of the 19 goals (32 percent) in its Performance Improvement Plan as of December 2006, just three months before the Plan ended.

The Department has a number of processes in place to oversee both counties and child placement agencies (CPAs) to promote continuous improvement in performance, achieve the federal standards, and thereby ensure that the foster care system provides for the safety, stability, and well-being of foster children. These processes include the development and implementation of improvement plans intended to bring the State into compliance with federal standards in the future, periodic reviews of county foster care programs, licensing and monitoring of CPAs, routine reviews of all foster care cases in accordance with federal requirements, and oversight of county procedures for managing any type of grievance related to a child welfare case. We identified weaknesses in all of these processes that hinder the Department's ability to meet minimum national standards for promoting the safety, permanency, and well-being of foster children, as described in this chapter.

Oversight of Counties

The Department currently has two primary mechanisms to oversee the counties in fulfilling their foster care responsibilities. First, the Department is monitoring the implementation of individual corrective action plans for 21 of the largest counties that manage about 93 percent of the State's foster care cases. The counties developed these plans in August 2005 after the Department evaluated the counties to determine if they were meeting the aforementioned federal standards. The county plans, along with the statewide Performance Improvement Plan, are intended to bring the counties, and therefore the State, into compliance with federal child welfare standards. Second, the Department conducts periodic on-site reviews of all county foster care programs. The reviews include assessments of the counties' foster parent certification processes, institutional abuse investigations, and foster care services provided. The Department details its findings from each review in a written report, and the county provides a corrective action plan for addressing its respective findings.

We reviewed the corrective action plans developed in August 2005 by the 10 largest counties as well as Department reports and corrective action plans submitted by the 22 counties that underwent on-site reviews by the Department between September 2002 and April 2005. We found weaknesses in both types of corrective action planning processes that prevent the counties, and therefore the Department, from achieving the federal standards relating to the safety, permanency, and well-being of children in the child welfare system. The problems we identified are described below.

Specific strategies for correcting problems. Neither the Department nor the counties develop strategies in their improvement and corrective planning processes to clearly and directly address the problems in the system. For example, the statewide Performance Improvement Plan noted that making inappropriate placements (i.e., making a poor match between the foster child and the foster home) and placing too many children in foster homes contributed to the Department's failure to meet the federal data standard for abuse in foster care. These placement problems could be due to a number of deficiencies, such as inadequate training of case workers in the area of making placement decisions. Although the Plan included additional training at the county level, the training did not appear to be focused on ensuring that caseworkers make a good match between foster children and foster homes. In addition, the Plan noted that inaccurate data entry by the counties was partially responsible for the Department's failure to meet the federal standard for foster care reentries. However, the plan did not include any action steps for addressing this problem.

Similarly, counties do not include specific steps to correct deficiencies in their corrective action plans. For example, in a recent county review the Department found that the county did not have evidence that some foster parents met all requirements prior to being certified, but the corrective action plans did not contain steps to ensure this problem would be fixed. This is because the Department did not require the county to conduct case-specific reviews or other analyses to determine whether (1) the parents actually did not meet all requirements, (2) the parents did meet requirements but their qualifications had not been documented, or (3) the parents' qualifications had been documented but the documentation was missing at the time of the review. Making this type of determination is important because the steps needed to address each of these problems would be different. Because neither the Department nor the counties research the elements that lead to deficiencies, the Department's review process is not effective in promoting improvement in county practices.

Use of sanctions and ongoing corrective actions. The Department does not use ongoing corrective actions or fiscal sanctions to compel counties to correct problems and improve their achievement of the national standards. For the 10 counties we

reviewed that implemented corrective action plans in August 2005 to improve their performance related to the federal standards, the compliance rates for nearly 60 percent of the items in the plans had actually declined as of December 2006. Further, 9 of the 10 large counties fell out of compliance with a performance standard that was not specifically covered by their corrective action plans. However, the Department does not impose additional corrective actions to address these declines in county performance. In addition, although Department rules allow the withholding of funds from counties for failing to meet state laws and regulations (the rules state that counties will be reimbursed for child welfare expenditures "when state program and fiscal requirements are met"), the Department has not denied any reimbursements to counties that are repeatedly noncompliant with state requirements. The Department could apply this rule more strictly or seek regulatory or statutory change, as necessary, to establish a comprehensive system of progressive discipline to use when counties are noncompliant with statutes or regulations.

Timely correction of problems found in periodic county reviews. One staff member at the Department monitors the counties' correction of problems identified through the county review process. For reviews conducted between September 2002 and April 2005, it has taken an average of 2.7 years for the Department to confirm that counties completely implemented their corrective action plans. As of April 2007, the Department was still monitoring plans for five counties (23 percent of the counties reviewed during this period), an average of nearly three years after the on-site reviews were completed. This means that nearly three years after the Department completed the reviews, it did not have evidence that all of the problems had been corrected. We could not determine whether these delays were due to the counties' not implementing the plans in a timely manner or the Department's failure to follow up promptly. We did find that the Department has not scheduled subsequent reviews of counties to determine their ongoing compliance with applicable requirements. All of the 10 largest counties were initially reviewed between September 2002 and January 2003 and have not been formally reviewed since.

Examination of files in periodic county reviews. The Department sends a review team of four to six staff to spend several days on each county review. The team conducts interviews, reviews policies and procedures, and examines a sample of case files. The focus of the visits appears to be on conducting staff interviews and reviewing policies and procedures. Extensive interviews and policy reviews may be reasonable the first time the Department visits a county, but we believe subsequent visits would be more effective if the Department de-emphasized the standard interviews and policy reviews in favor of more extensive file reviews to determine if county practices comply with Department rules and to identify the causes of any noncompliance problems found. This approach would also allow the Department to spend less time performing the reviews.

Reviewing county practices and implementing corrective action plans to address deficiencies are important components of the Department's general oversight of counties to ensure they are providing for the safety and well-being of children in the child welfare system. Our review of the foster home certification process and abuse or neglect investigation procedures, discussed in Chapter 1, demonstrates that counties are noncompliant in key areas related to child safety. Therefore, developing mechanisms to motivate improvement by the counties is critical.

Further, the national standards are intended to ensure that states have adequate procedures in place to protect children from abuse or neglect, promote permanency and stability in their living situations and family connections, and ensure that families can provide for their children's needs. Not meeting these standards can put children at greater risk for abuse, neglect, or otherwise not having their basic needs met. In addition, the Department faces possible sanctions if it has not met all Performance Improvement Plan goals for at least two consecutive quarters between October 2003 and March 2007. In November 2006 the Department estimated to the Joint Budget Committee that the potential penalty would be $2.2 million, which would reduce the amount of funds available for child welfare services. The Department expects another Child and Family Services Review in Federal Fiscal Year 2008. Therefore, it is vital for the Department to put processes in place now to improve the system to protect children and avoid penalties.

Recommendation No. 8:

The Department of Human Services should strengthen its oversight of county foster care programs to ensure a high-quality foster care delivery system by:

a. Including specific strategies in its corrective action plans to address county noncompliance with federal foster care standards and state and federal requirements. The strategies should be based on analyses by the counties of reasons for noncompliance. Such analyses could include conducting case-specific reviews to identify the reasons for noncompliance with federal and state standards and assessing the general strengths and weaknesses of the counties' programs.

b. Developing and implementing a system of ongoing or recurring corrective action and progressive sanctions, up to and including withholding reimbursement of county child welfare expenditures, to use when county departments of human/social services are noncompliant with statutory or regulatory requirements or federal standards. The Department should seek statutory or regulatory change if necessary to implement this system.

c. Improving the monitoring of counties' implementation of corrective action plans to ensure problems are corrected in a timely manner.

d. Modifying the procedures followed in periodic reviews of county foster care programs to focus more resources on case file reviews rather than on interviews and policy reviews.

Department of Human Services Response:

a. Agree. Implementation date: December 2008.

The Department will implement corrective action for noncompliance with federal foster care standards and requirements consistent with federal Program Improvement Plan requirements.

b. Agree. Implementation date: July 2008.

The Department will work with county departments to develop a rule-based progressive discipline policy. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to State Board of Human Services by no later than January 2008.

c. Agree. Implementation date: Ongoing.

The Department will monitor current corrective action plans to completion with the staff person currently assigned. The Department will increase monitoring of corrective actions contingent on securing additional resources.

d. Agree. Implementation date: October 2007.

The Department will conduct initial reviews on approximately 15 counties over the next three years based on existing resources. In counties where re-reviews will be conducted, the Department will focus on case file reviews and practices relevant to the federal Child and Family Services Review.

Department Supervision of Counties

In the previous section, and throughout the audit report, we have identified concerns with the Department's oversight of the counties, including monitoring county activities to achieve federal standards, improving the counties' timeliness in initiating and reporting on institutional abuse investigations (discussed in Chapter 1), and ensuring that counties meet minimum requirements in offering Core Services to prevent and shorten foster care placements (discussed in Chapter 3). These problems indicate that the Department has not been effective in holding counties accountable for ensuring the safety and well-being of children in the child welfare system. In addition, the Department's ineffective oversight could result in the State's incurring millions of dollars in federal penalties.

Currently state statutes and regulations do not provide specific and practical authority for the Department to supervise the counties. The only statutes that specifically cite the scope of the Department's supervisory duties are:

- Section 26-1-111(2)(b), C.R.S., which states that the Department shall "administer or supervise the establishment, extension, and strengthening of child welfare services" in cooperation with the federal government and other state agencies.

- Section 26-1-111(2)(d), C.R.S., which charges the Department with (1) supervising the county departments of human/social services for the effective administration of child welfare services as set out in Department regulations, (2) compiling statistics and necessary information related to child welfare services, and (3) obtaining federal reimbursement moneys available through Title IV-E of the Social Security Act.

- Section 26-6-107(4), C.R.S., which requires the Department to monitor the counties' foster parent certification processes on a quarterly basis within available appropriations.

Although federal laws are very clear that states are responsible for the adequacy of programs funded with federal child welfare moneys (e.g., Title IV-E of the federal Social Security Act requires the Department to monitor and evaluate foster care services paid for with these federal funds), state statutes do not provide the Department with specific authority to direct county activities, require compliance with Department directives, or penalize counties for noncompliance through fines or other corrective action. Similar to programs like Temporary Aid to Needy Families and food stamps, the child welfare program is state-supervised and county-administered.

The Department should work with the counties to identify areas that are key to providing for the safety, permanency, and well-being of foster children and where strengthening the Department's supervisory authority would most likely result in measurable improvements to the foster care system. The Department should then revise its regulations and/or work with the General Assembly, as necessary, to clarify its authority for ensuring that counties meet minimum state and federal requirements in those critical areas. For example, Department staff stated they would like the counties to focus more on outcomes. The Department could work with the counties to determine the outcomes that are most important and the minimum standards for each. Then, the Department could seek expanded oversight authority to make counties adjust their practices when they are not meeting minimum performance standards.

One potential concern is that increased authority for the Department would infringe on local control and the flexibility counties have for spending child welfare funds allocated to them. However, limiting a county's flexibility is a reasonable response when the county is not meeting minimum standards for performance—that is, promoting the safety, permanency, and well-being of children in the child welfare system. At least $74 million was spent in Fiscal Year 2006 to ensure children in foster care are well-cared for and make progress toward a permanent home. The State needs sufficient authority to demonstrate accountability for these taxpayer dollars and fulfill its responsibilities for monitoring foster care services in accordance with federal law.

Recommendation No. 9:

The Department of Human Services should improve its oversight of child welfare programs at county departments of human/social services by:

a. Reviewing the statutes and regulations that relate to the Department's responsibilities for ensuring that counties meet applicable state and federal requirements.

b. Assessing whether these statutes and regulations are sufficiently clear and specific with respect to the Department's authority to oversee counties and compel the counties to revise their practices when they are noncompliant, including the use of fiscal sanctions.

c. Revising its regulations and/or working with the General Assembly, if necessary, to clarify the Department's supervisory responsibilities over the counties.

Department of Human Services Response:

a. Agree. Implementation date: October 2007.

b. Agree. Implementation date: October 2007.

c. Agree. Implementation date: November 2008.

The Department will work within the Executive Branch process to pursue legislation as appropriate.

Oversight of Child Placement Agencies

In addition to supervising county foster care programs, the Department has two primary methods of overseeing Child Placement Agencies (CPAs). First, under statute [Section 26-6-104, C.R.S.] CPAs must be licensed by the Department. The Department's Division of Child Care issues licenses and renews them annually after visiting the CPAs to assess compliance with applicable statutes and regulations. Second, the Department's 24-Hour Monitoring Unit in the Division of Child Welfare conducts periodic on-site monitoring visits to the CPAs to assess compliance with laws and regulations, determine the quality of care provided by the CPA, and evaluate the CPA's financial stability.

Staff of the Division of Child Care and of the 24-Hour Monitoring Unit review information and documentation related to several important CPA activities during their licensing and monitoring site visits. Specifically:

- Both licensing and monitoring staff review CPA records related to abuse or neglect investigations. This type of review is important because a high number of investigations may indicate that the CPA is certifying unqualified foster parent applicants, not ensuring that its foster parents are receiving enough training, or not providing sufficient support to its foster parents.

- Monitoring staff conduct a financial review to evaluate whether the CPA's expenditures are reasonable and whether the CPA is passing along to foster parents the entire child maintenance payment, which covers the cost of providing food, shelter, clothing, and daily supervision of the foster child. These financial reviews are critical; our 2002 audit identified questionable CPA payments to foster care providers, CPA employees and contractors, and family members of a CPA owner. In addition, during our current audit we identified one CPA that loaned a foster parent about $5,700 out of foster care

funds during Fiscal Year 2005, which is not allowed under Department regulations. According to the CPA, one purpose for the loan was to help the foster parent make rental payments on a house, which suggests that this individual did not have the required financial resources to be a suitable foster parent.

- Monitoring staff review CPA placement decisions to determine how effectively CPAs match foster parents with children. If CPAs do not place a foster child in an appropriate setting, it increases the risk that the child will have to be moved. As discussed previously in this chapter, the Department is currently out of compliance with the federal standard for stability of foster care placements.

We reviewed the Department's licensing process and its on-site monitoring of CPAs. Specifically, we reviewed the licensing and monitoring schedules along with reports from a sample of 8 licensing and 11 monitoring visits completed during Fiscal Years 2003 through 2006. We noted concerns, as described below, relating to the adequacy of these processes as oversight mechanisms to ensure that CPAs are placing foster children in safe and stable homes and providing the services children need to maintain their health and well-being.

Delays in renewing CPA licenses by the Division of Child Care. Department regulations require CPAs to submit applications to renew their licenses to the Division of Child Care (Division) at least 90 days before their current license expires. Once a renewal application is received, licensing staff conduct on-site visits to assess the CPA's compliance with Department rules. The Division's goal is to complete the license renewal process before the old license expires. Statute allows the prior license to remain active until the Department approves or denies the renewal application as long as the CPA submits the application on time.

We reviewed the most recent license renewal for a sample of eight CPAs and found the Department visited all of them on or after the date the current license had expired or a new one was issued, with visits to three CPAs occurring more than 30 days after the previous license had expired. This is a concern because the Department identified a combined total of 15 violations related to child safety during seven of the eight late reviews, as follows:

- Five CPAs did not adequately supervise foster homes, including failing to follow up sufficiently on violations found during foster home inspections and not making all required supervisory visits to the foster home.

- Five CPAs did not provide evidence of required foster parent background checks.

- Four CPAs had insufficient foster parent training records, including lack of individual training plans for foster parents and a missing CPR certification.

- One CPA did not provide evidence of required staff background checks.

These violations are consistent with problems we found in our review of the foster care certification process, discussed in Chapter 1. We also found that in Fiscal Year 2006 the Division took an average of 75 days after the expiration date to issue renewal licenses to CPAs that certify foster homes, resulting in an average renewal cycle of about 14.5 months, rather than 12. The Division renewed half of the licenses more than three months after the previous license had expired. Of these, 12 were issued five months or more after the expiration date. These delays mean that some CPAs are operating for long periods while they have outstanding child safety violations because their licensing visits have not occurred.

We identified two main reasons for the delays in the license renewal process. First, Department staff report that the Division does not send out renewal materials to a CPA 90 days before its license expires, so it is not possible for the CPAs to then submit their renewal applications on time. Second, the Department does not use a risk-based licensing system to use resources more efficiently and complete renewals on time. As of January 2004, statute [Section 26-6-104, C.R.S.] authorized the Department to develop risk classifications that could be used for a risk-based approach to CPA licensing. The Department reported it has not developed risk classifications, because it wanted to gather several years of data before developing the schedule. Three years have passed since the statute was enacted; therefore, the Department should have adequate data to develop risk classifications. Risk indicators could include factors such as the number of foster children placed by each CPA, the number of institutional abuse investigations involving foster homes certified by each CPA, and the number of previous licensing violations incurred by each CPA.

Insufficient monitoring of high-risk CPAs by the 24-Hour Monitoring Unit. Currently there are no statutory or regulatory criteria for how often monitoring visits should be conducted. According to staff of the 24-Hour Monitoring Unit (Unit), monitoring visits are scheduled based on factors such as the number of Stage II investigations and critical incidents associated with each CPA and feedback from Department and county staff and parents. We reviewed the Unit's monitoring schedule for Fiscal Years 2002 through 2006 and found several CPAs that appear to be high-risk but that did not receive monitoring visits for long periods. For example, during this period there were 17 CPAs with at least 20 investigations each for alleged abuse or neglect involving foster homes they certified. We found that 5 of the 17 (29 percent), including the two CPAs with the most investigations, have gone at least four years without a monitoring visit, including one that received no visits.

Conversely, seven CPAs with fewer than five investigations over the same period have been monitored multiple times since Fiscal Year 2002. The Unit reported that some high-risk CPAs did not receive frequent monitoring visits because they had undergone multiple on-site visits in connection with Stage II investigations and critical incidents (discussed in Chapter 1). However, unlike monitoring visits, Stage II and critical incident visits do not provide a comprehensive review of the CPA. Furthermore, frequent Stage II investigations and critical incidents may indicate serious systemic deficiencies on the part of the CPA that need to be identified and corrected.

Lack of documentation. We found poor documentation of some elements of both the licensing and monitoring reviews. For example, neither licensing nor monitoring staff could provide documentation of the information they reviewed related to abuse or neglect investigations or the conclusions reached in this area for any of the 8 licensing and 11 monitoring visits we sampled. In addition, the 24-Hour Monitoring Unit generally does not maintain supporting documentation of any of its on-site monitoring reviews. The Unit could not provide checklists for any of the 11 monitoring visits in our sample or the final monitoring report and Report of Inspection for 1 of these visits. Finally, the Unit had no evidence that it had determined whether foster child payments were appropriate or that it had reviewed revenues and expenses for 9 of the 11 visits in our sample. Due to the lack of documentation, we could not determine if staff properly followed procedures during licensing and monitoring visits to adequately assess all areas, resolve concerns, and identify issues requiring corrective action.

Duplication. We found similarities between the licensing and monitoring visits made to CPAs that may indicate some duplication of effort and resources. Specifically, both licensing and monitoring teams are required to review CPA staff, foster parent, and foster children files, as well as records related to abuse or neglect investigations, during their on-site visits. In addition, monitoring and licensing staff use the same checklists to capture information from their visits. Licensing and monitoring staff indicated that the primary difference between their respective visits is that monitoring visits are more in-depth. Specifically, licensing reviews are limited to examining required documents (e.g, evidence of staff qualifications, background checks for staff and foster parents, and sufficient training for foster parents), while monitoring staff review files to determine if the CPA is managing its cases appropriately and following up with training or corrective action when the CPA identifies problems with one of its foster parents. However, we found no evidence in the monitoring reports indicating that monitoring staff are reviewing files in more depth than licensing staff. As a result, it appears that licensing and monitoring staff are duplicating their procedures. The Department stated that the visits are coordinated to occur at the same time to minimize duplication.

Since Fiscal Year 2002, CPAs have received between $34 million and $46 million annually to provide foster care services to about 20,000 children. Therefore, it is important for the Department to implement effective CPA licensing and monitoring procedures. Specifically, the Department should send out license renewal materials to CPAs far enough in advance so that the CPAs can meet the 90-day deadline for submission, implement risk-based schedules for conducting both licensing and monitoring visits, fully document the areas reviewed and the results of the reviews for both licensing and monitoring visits, maintain documentation for a specified period, and evaluate the licensing and monitoring processes to minimize duplication. Improving and streamlining the licensing and monitoring reviews of CPAs will help to ensure the safety of foster children and increase accountability for state expenditures.

Recommendation No. 10:

The Department of Human Services should improve oversight of child placement agencies for the foster care program by:

a. Establishing risk-based schedules for licensing and monitoring child placement agencies. This should include developing criteria for determining risk levels, classifying all child placement agencies by risk level, and revising these classifications, as necessary, on a periodic basis.

b. Revising procedures for renewing child placement agency licenses to ensure that the agencies receive renewal materials in time to submit them at least 90 days before their licenses expire.

c. Establishing and implementing policies to fully document all key areas reviewed during licensing and monitoring visits and retaining the supporting documentation.

d. Evaluating current licensing and monitoring procedures to identify and eliminate duplication.

Department of Human Services Response:

a. Agree. Implementation date: October 2007.

The Department formed a work group in April 2007 to develop a risk-based model for licensing and monitoring child placement agencies. The Department will further comply with this recommendation to improve

oversight of child placement agencies by submitting a Trails Change Request by October 2007 that will allow identification of risk factors. Trails enhancements will be made based on pending priorities, which include federal Statewide Automated Child Welfare Information System (SACWIS) and Adoption and Foster Care Analysis and Reporting System (AFCARS) compliance. The Department will utilize the information made available by reports provided through the Trails enhancement on a regular basis.

b. Agree. Implementation date: Implemented.

The Department has implemented a policy to conduct timely child placement agency visits 120 days prior to the renewal date. This process began January 2007. Staff is also responsible for sending out a 90-, 60-, and 30-day notice to the agency until the renewal application has been received even if the Department has completed its site visit.

c. Agree. Implementation date: January 2008.

The Department is currently identifying reasons for noncompliance and will work to ensure that all key areas are documented and information is maintained with the appropriate forms.

d. Agree. Implementation date: January 2008.

The Department will continue evaluating the monitoring and licensing practices to identify and eliminate duplication in efforts.

Federally Required Foster Care Reviews

In addition to overseeing the quality of the foster care operations of counties and CPAs through the licensing and monitoring functions, the Department conducts reviews of individual foster care cases. The federal Social Security Act requires states to review the cases of all children in out-of-home placement at least once every six months. The general purpose of the reviews is to have an entity that is independent from the service provider (e.g., the county or CPA) assess whether children are being placed in safe settings that are the least restrictive, most appropriate available, and consistent with the best interests of the child. In addition, the reviews provide frequent oversight to help ensure the safety of the children, the continuing necessity for and appropriateness of the placements, the extent of compliance with the case plans, and the progress made toward alleviating the

conditions that led to the placements. The Department's Administrative Review Division in the Office of Performance Improvement is responsible for conducting these reviews.

The federal government's Adoption and Foster Care Analysis and Reporting System (AFCARS) allows a one-month grace period for meeting this six-month requirement. In addition, states have up to 60 days after the review to enter the review date into AFCARS, meaning that a case is flagged as noncompliant if it was not reviewed within seven months and the date of review was not entered within nine months. According to federal regulations, a state that completes and documents less than 90 percent of its six-month reviews within the required time frames may be assessed a penalty based on the amount of funds the state receives under Titles IV-B and IV-E. More importantly, when a state fails to conduct the reviews on time, some foster children's cases do not receive sufficient independent oversight to determine if the child is safe and still needs to be in placement.

We reviewed the Department's progress in completing the federally required reviews of foster care cases and identified two problems. First, according to data submitted by the Department through AFCARS, cases are not always reviewed within required time frames. Between March 2002 and March 2006 an average of 17 percent of foster care cases were not reviewed and recorded within the nine-month period allowed by the federal government. The table below shows that the percentage of foster care cases reviewed late, based on AFCARS' nine-month tracking, has declined over the last five years from 20 percent to 14 percent. The Department has not previously received any penalties for noncompliance in this area but could owe a penalty of about $99,000, based on Fiscal Year 2006 data, for noncompliance in this area.

Department of Human Services
Percentage of Foster Care Cases Not Reviewed On Time[1]
Fiscal Years 2002 Through 2006

	March 2002	March 2003	March 2004	March 2005	March 2006	Percent Change FY02-06
Reviews Required	11,200	10,900	11,600	10,800	11,000	-2%
Reviews Not Completed on Time	2,200	2,000	2,100	1,500	1,500	-32%
Percentage Not Reviewed on Time*	**20%**	**18%**	**18%**	**14%**	**14%**	**-30%**

Source: Office of the State Auditor's analysis of data from the Department of Human Services.
[1] A case is considered to be reviewed on time if it was reviewed within the nine-month time frame allowed by the federal Adoption and Foster Care Analysis and Reporting System.

In Fiscal Year 2006 the Department began tracking the timeliness of case reviews in a separate database. To more precisely monitor its progress in completing the six-month reviews, the Department focuses on whether the case was reviewed within seven months. According to the Department's own data, 39 percent of cases were not reviewed within the seven-month time frame as of March 2006.

The second problem we found with the federally required reviews is that once a case review is delayed beyond the nine-month window allowed by federal requirements, the Department does not prioritize the case to ensure it is reviewed immediately. According to Department data, in September 2006 there were 628 cases, or about 24 percent of all late cases, that had not been reviewed for more than a year, instead of within six months.

The Department indicated that staff reductions as a result of budget cuts is a primary reason for reviews not being conducted on time. The number of FTE appropriated to the Administrative Review Division declined from 31 to 20 between Fiscal Years 2002 and 2006. To counteract the effects of the staff reductions, the Department took steps to increase the timeliness of the six-month reviews. First, in July 2003 the Department reduced the number of questions on the six-month review instrument to increase the number of reviews each staff was able to complete. Between Fiscal Years 2002 (before this change) and 2006, the Department increased the number of reviews completed annually per reviewer by about 50 percent, from about 370 to about 560 each year. Second, the Department curtailed the research activities conducted by the Administrative Review Division that were not specifically related to the federal case reviews.

As of July 1, 2006, the Department was appropriated an additional 2.2 FTE for the Administrative Review Division. It appears that the Department's changes and the additional staff will be adequate to bring delayed reviews current and maintain timely case reviews. Specifically, once new staff are trained, the Department estimates that each FTE can complete 58 reviews per month, which means the 17 FTE currently performing the reviews can do about 11,800 reviews annually, or more than the current demand.

As the Department makes progress toward increasing the timeliness of its foster care reviews, it needs to focus on expediting the review of cases that have exceeded the nine-month deadline. This should include tracking the time elapsed since the last review, establishing a process to prioritize reviews that have not been completed within a pre-determined period of time, such as a year, and reallocating resources to immediately complete those reviews. Completing the reviews on time is important to make sure that children remain in the foster care system only as long as is necessary and that the placement is still safe and appropriate.

Recommendation No. 11:

The Department of Human Services should track the timeliness of all federally mandated foster care case reviews by monitoring how long reviews are delayed once they have gone beyond the federal deadline. The Department should also establish a process to prioritize reviews that have not been completed within a predetermined period, such as a year, and reallocate resources to immediately complete those reviews.

Department of Human Services Response:

Agree. Implementation date: July 2008.

The Department agrees with tracking how late reviews are currently monitored and using this in scheduling reviews.

County Grievance Process

One further mechanism the Department has to oversee the quality of the county-administered foster care system is the monitoring of county grievance procedures. During the period that a child is in foster care, the various parties to the case (e.g., biological parents, foster parents, and case workers) may disagree about the manner in which the county is handling the foster child's case. Statute [Section 19-3-211, C.R.S.] establishes a formal conflict resolution process to "provide a forum for grievances concerning the conduct of county department personnel in performing their duties pursuant to the (Children's Code)." This process requires "transmittal of all grievances to the county (human/social services) director for internal resolution . . . within ten working days after receipt of the grievance." If the director cannot resolve the issue to the complainant's satisfaction, the complainant can then appeal to the county's external citizen review panel. These panels are also established and required by statute. Ultimately, the complainant may appeal to the county's board of commissioners. The county department may also appeal a decision by the citizen review panel to its board of commissioners.

The statute requires the Department to monitor compliance with this grievance process and states that the monitoring should include collecting annual reports from the counties that detail the grievances received and their disposition. The annual reports require each county to provide the composition of its citizen review panel, the number of grievances received by the county director and heard by the citizen review panel or board of county commissioners, the resolution of each grievance,

and the time it took to resolve each grievance. We reviewed the annual reports for all counties for Fiscal Year 2005 and examined the grievance processes in place at the eight counties we visited. We also evaluated the Department's procedures for monitoring the county grievance systems. We found that counties frequently do not comply with requirements for the grievance process, resulting in complainants' being denied their rights to seek resolution from a body outside the county departments, as described below.

Use of citizen review panels and county boards of commissioners. We identified numerous problems relating to the establishment and use of citizen review panels and the use of county boards of commissioners in dealing with citizen complaints related to foster care. Specifically:

- 26 counties have citizen review panels that include members who may not be independent, may not be sufficiently qualified to resolve complaints, or both. Specifically, 13 counties appear to have at least one county department employee on their panels, and 21 lacked panel members with demonstrable professional or personal experience with children and/or at least one member who is the parent of a minor child. Statute [Section 19-3-211(1)(b), C.R.S.] prohibits current employees of county departments of human/social services from serving on the panels to avoid conflicts of interest and requires each panel to include members with professional or personal experience with children, one of which must be the parent of a minor child.

- All eight counties we visited lack mechanisms to specifically inform complainants that they have the right to take a grievance to a citizen review panel or board of county commissioners if they are not satisfied with the county department's resolution. We reviewed county correspondence sent to a sample of complaints from all eight counties, and none of the letters mentioned the citizen review panel or county commission board options. Further, in five of these counties the department staff, not the complainant, determine whether a complaint will be allowed to go to a panel or county board. Statutes specifically give complainants, as well as the county departments, the right to take unresolved complaints outside the county departments. If the complaint does not meet the statutory criteria to be heard by the citizen review panel, the panel should make this determination, not county department personnel.

- Five counties in rural areas of the State indicated that they do not have citizen review panels in place, even though the panels are required by statute. Under statute, without a citizen review panel, complainants have no outside entity to address complaints related to county department actions.

These practices prevent individuals from having their complaints be considered by objective parties outside the county departments. The Fiscal Year 2005 reports from the counties stated that only 3 grievances out of 131 filed with county directors were heard by citizen review panels statewide and none were heard by county commission boards during the year. The reports did not contain information on the number of grievances resolved by staff without being reviewed by county directors, citizen review panels, or county commission boards.

Resolution of grievances by county caseworkers and supervisors. We found counties do not typically follow the statutory requirement for grievances to be transferred to their director for internal resolution. Instead, five of the eight counties we visited allowed caseworkers or their supervisors to directly receive, investigate, and resolve complaints without any involvement by the county director. This approach weakens accountability because the director may not be fully informed of all grievances. Further, this approach indicates the director is not assigning responsibility to ensure that the investigation and resolution of complaints is carried out by staff who are not involved in the case and who have the proper training. The Fiscal Year 2005 annual reports submitted by counties to the Department indicate that having county department staff below the director level independently handle complaints may be a widespread practice. Specifically, of the 10 largest counties which manage about 85 percent of all foster care cases, four reported that they transferred no grievances to the county director and another three reported that they had transferred a single grievance each to the director in Fiscal Year 2005. The Department's rules relating to county grievance processes may be contributing to the counties' practices as the rules state that the counties should "try to resolve grievances informally before using the statutory process." The rules do not clarify whether this is intended to mean that staff below the county director should try to resolve as many complaints as possible or that the county department should try to limit the number of complaints that go to a citizen review panel or beyond. In any case, care should be taken that complaints are afforded independent review.

Time limits on the grievance process. We found that four of the counties we visited had established time limits for their complaint processes which appear to violate statute. Three counties require individuals to file complaints within a specified amount of time (ranging from 30 days to six months) of the incident leading to the complaint; however, statute does not authorize counties to limit the time frame for filing grievances. Another county gives its citizen review panel up to 40 business days to review a grievance, while statute [Section 19-3-211(1)(c)(IV), C.R.S.] requires panels to review referrals within 30 days. The Department should ensure that county grievance policies and procedures comply with statute.

Currently the Department provides limited oversight of counties' grievance processes. Monitoring consists of requesting that counties submit annual reports on the grievances they received. The Department's oversight does not:

- Require counties to submit their written policies and procedures for handling grievances to the Department for verification that they comply with the statutory requirements. The Department was unaware of the problems we found with the county processes.

- Evaluate the information in the annual reports to determine if counties are complying with the grievance process statute. For example, the Department could evaluate if grievances were handled properly by the counties, including within required timelines, and if their citizen review panel membership meets statutory requirements.

- Enforce the requirement for counties to submit annual reports that contain the number of grievances received by the county director and referred to the county's citizen review panel, the time frames for resolving the grievances, and the disposition of the grievances. The Department only received reports from 35 counties in Fiscal Year 2003, 9 counties in Fiscal Year 2004, 58 counties in Fiscal Year 2005, and 50 counties in Fiscal Year 2006.

The Department should revise its rules to establish a stronger monitoring role with respect to county grievance procedures and provide for corrective action if the county procedures do not meet statutory requirements. Specifically, the Department's monitoring should include reviewing counties' grievance policies and procedures to ensure that they include (1) processes for the county director to receive and assign responsibility for investigating and resolving all complaints, (2) mechanisms to inform complainants of their right to take their concerns to a citizen review panel and/or county commission board, (3) deadlines that comply with the statute, and (4) methods to establish citizen review panels with membership as specified in statute. The Department should also enforce the requirement for counties to submit annual reports. Finally, the Department should review the annual reports to determine if counties are handling grievances according to statutory and regulatory guidelines.

Recommendation No. 12:

The Department of Human Services should strengthen its oversight of the county grievance process authorized by the Children's Code (Title 19, C.R.S.) by working with the State Board of Human Services to enact rules that:

a. Provide for Department review of grievance policies and procedures at county departments of human/social services and the composition of citizen review panels to determine if the counties are complying with statutory requirements, and provide for imposing corrective action when counties are not meeting these requirements.

b. Require counties to provide complainants with clear and specific information about their rights under the statutory grievance process. This could be accomplished by revising the Notice of Rights and Remedies given to families whose children are removed or by including information about rights in county correspondence with complainants.

c. Require county citizen review panels, rather than county department personnel, to determine and inform complainants when their grievances do not meet statutory guidelines for referral to the panels.

d. Eliminate the requirement that county departments of human/social services attempt to resolve grievances informally before using the statutory grievance process, or clarify the meaning of this rule in a way that is consistent with the rights provided in statute.

Department of Human Services Response:

Agree. Implementation date: July 2008.

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Core Services

Chapter 3

Sections 26-5.3-101, et seq., C.R.S. and 26-5.5-101, et seq., C.R.S., establish programs intended to preserve families and prevent children from being placed outside their homes. The Colorado Department of Human Services (Department) has implemented these statutes through the Core Services program administered by the counties. The purpose of the program is to limit out-of-home placements and their cost by preventing the removal of children from their homes, facilitating reunification between children and their families, or helping children move to a less restrictive out-of-home placement setting.

The list below describes the types of Core Services provided by the counties and the percentage of county service authorizations represented by each type of assistance in Fiscal Year 2006.

- **Substance abuse treatment.** Diagnosis and/or therapy to assist in developing the case plan; to assess and/or improve family communication, functioning and relationships; and to prevent further abuse of drugs or alcohol (23 percent).

- **County-designed services.** Optional services tailored by each county to meet the needs of families in the community, such as adolescent mentoring, multisystemic therapy, and services to improve family functioning (20 percent).

- **Mental health services.** Diagnosis and/or therapy to assist in developing the case plan, and to assess and/or improve family communication, functioning, and relationships (18 percent).

- **Life skills.** Teaching of household management, effective access of community resources, parenting techniques, and family conflict management (10 percent).

- **Intensive family therapy.** Therapeutic intervention, typically with all family members, to improve family communication, functioning, and relationships (8 percent).

- **Home-based intervention.** Services such as therapeutic and crisis intervention provided primarily in the home (8 percent).

- **Special economic assistance.** Emergency financial assistance of not more than $400 per family per year to pay expenses such as rent, food, or clothing (6 percent).

- **Sexual abuse treatment.** Therapeutic intervention designed to address issues and behaviors related to sexual abuse victimization, sexual dysfunction, sexual abuse perpetration, and prevention of further sexual abuse and victimization (5 percent).

- **Day treatment.** Comprehensive, highly structured services that provide education to children and therapy to children and their families (2 percent).

About 60 percent of Core Services are provided to families with children still in their own homes when services begin, while the other 40 percent of services are provided to families with children in out-of-home placement. For Fiscal Year 2006 the General Assembly appropriated about $43.5 million for Core Services, of which about $36.6 million came from state general funds, about $4.9 million from the counties, and about $2 million from federal Title IV-E funds. The table below shows Core Services expenditures, number of children served, and number of services provided for Fiscal Years 2003 through 2006.

Department of Human Services
Core Services Program
Fiscal Years 2003 Through 2006

	Fiscal Year				Percent Change, FY03-06
	2003	2004	2005	2006	
Expenditures (millions)	$40.7	$37.7	$42.4	$46.2	14%
Children Served	13,400	16,100	17,800	18,800	40%
Expenditure per Child Served[1]	$3,000	$2,300	$2,400	$2,500	-17%
Number of Services Provided	22,200	34,800	39,100	45,000	103%

Source: Office of the State Auditor's analysis of data from the Department of Human Services.
[1] Because children may receive Core Services in more than one fiscal year, this figure does not represent total Core Services expenditures per child for the life of the case.

As the table shows, expenditures for Core Services have increased by about 14 percent since Fiscal Year 2003, while the number of children served has increased by about 40 percent and the number of services has more than doubled. The Department reported that counties are providing more Core Services with their own staff, which increases the number of children served and services provided but does not increase the amount of expenditures charged to their Core Services programs.

We reviewed the Core Services program to determine its effectiveness in meeting the goals of preventing out-of-home placements, helping families reunify, and allowing children to move to less restrictive placements. We identified concerns with the methods used by counties to document the need for Core Services and with the methods used by the Department to measure the cost-effectiveness of these services. As a result, we question whether the Core Services program is serving children and their families effectively and meeting intended goals. This chapter discusses ways in which the Department can better ensure that counties focus these services on those who need them and then determine if the services are successful.

Eligibility

Department policy requires that families must be at "imminent risk of out-of-home placement" to be eligible for Core Services. Statute defines imminent risk as "without intercession, a child will be placed out of the home immediately." In November 2004 the Department mandated that counties document a family's eligibility prior to the start of Core Services and every six months thereafter through the Imminent Risk Checklist, which is part of the Family Services Plan used to document the services needed to address the child's safety, permanency, and well-being. The agency letter issued by the Department announcing this requirement noted that imminent risk "is often not adequately documented in the current version of the Family Services Plan" and that use of the form is "necessary to assure compliance with state and federal funding requirements." The importance of accurately identifying and thoroughly documenting the need for Core Services is also emphasized through Department regulations. Department regulations stipulate that the Department reimburses counties only when their case records contain required program documentation and allow fiscal sanctions to be imposed when a county provides Core Services to an ineligible family.

The Imminent Risk Checklist has three major sections. The first section asks the caseworker to select from a list of conditions present in the family that may put it at risk and to describe how those conditions result in imminent risk. The second section asks the caseworker to explain why alternatives to Core Services-funded programs (e.g., services paid for by the family's private insurance, programs run by

nonprofits, and other government services) are not being used. The third section asks the caseworker to explain why Core Services are the best option for the family.

Department policy also states that "the documentation on the form must explain the reason or circumstances that warrant the determination of imminent risk of out-of-home placement." We reviewed files for 79 families who received Core Services in our eight-county sample and found an overall lack of documentation to show that Core Services were warranted. First, files for 33 of the families (42 percent) did not contain any completed Imminent Risk Checklists, so there was no evidence to show Core Services were needed. All but one county in our sample was missing at least one checklist, with two counties almost never completing the checklist. Of the 46 files that did contain Imminent Risk Checklists, we identified problems in all but 2 of the files, as follows (some files exhibited more than one problem):

- 34 Imminent Risk Checklists either did not explain why Core Services were the best choice for the family, or the explanations provided were insufficient.

- 25 Imminent Risk Checklists did not provide information about the non-Core Services alternatives available to the family, or the information provided was insufficient.

- 11 Imminent Risk Checklists did not sufficiently explain why the family was considered to be at imminent risk, as required by the statute. Of these, seven included descriptions that were too vague (e.g., one stated that a teenager was "out of control" but did not specify how the teenager's behavior was a risk to preserving the family), and two contained no description of the situation that placed the child at imminent risk. Two other checklists identified conditions that did not appear serious enough to create an imminent risk. For example, one checklist stated the child "is not at imminent risk," yet the family received Core Services.

- 12 Imminent Risk Checklists were not completed until after Core Services began, in violation of Department policy.

- In 23 cases where services lasted longer than six months, 14 files did not contain subsequent Imminent Risk Checklists as required by Department regulations.

Finally, 12 of the Imminent Risk Checklists were completed more than a month in advance of services. Although this does not violate Department policy, such gaps are not consistent with the urgency of the imminent risk definition in the statute.

The results of our file review raise concerns about whether counties are providing services to families that are truly at-risk. If some of these families are not at-risk, substantial state general funds are being used inappropriately to provide these families with Core Services. Furthermore, if not all families served are really at-risk, the Department's statistics on the number of out-of-home placements prevented by Core Services are overstated. The Department reported that the Core Services program prevented placements for 88 percent of participants in Fiscal Year 2006.

To better ensure that counties adequately determine and document imminent risk and the need for Core Services, the Department should increase its monitoring and oversight of county Core Services programs. Currently the Department does not review county files to verify that they only provide Core Services to children and families that meet the imminent risk criteria. In addition, the Department was not aware of the two counties in our sample that never complete the Imminent Risk Checklist. According to these two counties, staff were not completing the checklist because they did not know about the requirement. The Department's Administrative Review Division has authority to apply sanctions when counties do not sufficiently document the need for Core Services, but staff indicated that they have not applied these sanctions.

Recommendation No. 13:

The Department of Human Services should increase monitoring and oversight of Core Services programs provided by county departments of human/social services to ensure counties provide these services only to families with children at risk of out-of-home placement. Specifically, the Department should:

a. Implement procedures to review samples of county files during on-site visits to verify that counties are only providing Core Services to children and families that meet the imminent risk criteria.

b. Develop written policies to impose fiscal sanctions and/or require repayment of funds from county departments of human/social services for cases in which Core Services eligibility has not been adequately documented.

c. Provide training and technical assistance to the counties to ensure that counties understand how to document eligibility for Core Services and that counties are aware of available Department sanctions if documentation is not sufficient.

Department of Human Services Response:

a. Agree. Implementation date: November 2007.

The Department will implement a sample-based review of county files to verify that children and families receiving Core Services meet imminent risk criteria.

b. Agree. Implementation date: July 2008.

The Department will work with county departments to develop a rule-based progressive discipline policy. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to State Board of Human Services by no later than January 2008.

c. Agree. Implementation date: July 2008.

The Department agrees to provide technical assistance during reviews of sample cases in county departments, and training will occur with Core Service Program Coordinators. The Department will work with county departments of human/social services to develop a rule-based progressive discipline/sanction policy. It is anticipated that this will take approximately four to six months given other projects the Department is statutorily required to complete. The rules will be introduced to the State Board process by no later than January 2008.

Evaluating the Effectiveness of Core Services

Statute [Section 26-5.5-104(6), C.R.S.] requires the Department to prepare an annual report to the Governor, General Assembly, and the Chief Justice of the Colorado Supreme Court on the effectiveness of Core Services. As discussed previously, these services are intended to prevent out-of-home placements, shorten placements, or allow children to move to less restrictive out-of-home settings. The Department measures program effectiveness by calculating a prevention rate (the percentage of cases in which out-of-home placement does not occur within 90 days of the end of the service) and summarizing "leave reasons" (statements chosen by caseworkers at the conclusion of a service that most accurately reflect the success of the services). We analyzed the Department's methods for determining the effectiveness of Core

Services and found that the Department cannot demonstrate that Core Services are effective at preventing or shortening out-of-home placements or helping children move to less restrictive settings. We found a number of problems with the methods the Department uses to calculate prevention rates and measure the effectiveness of services, as described below.

First, we found that the Department's reported prevention rates for Fiscal Years 2003 through 2006 overstate the number of out-of-home placements actually prevented by Core Services. With respect to Fiscal Year 2006, we found that the Department's methodology for calculating its 88 percent prevention rate included children who were already in an out-of-home placement. More specifically, the Department included all Core Services in its prevention calculation, even though 43 percent of these services in Fiscal Year 2006 were provided to families with children already in out-of-home placement. Similarly, the Department reported prevention rates of 70 percent, 73 percent, and 77 percent for Fiscal Years 2003 through 2005, respectively. Again, for each of those fiscal years, we found that between 39 and 42 percent of Core Services were provided to families with children already in an out-of home placement. Our analysis raises serious concerns about the accuracy of the Department's reported prevention rates for Core Services during the four-year period we reviewed.

Second, we found that the Department does not calculate prevention rates or analyze service effectiveness separately for (1) children who receive Core Services while they are still living with their families and (2) children who receive Core Services while in an out-of-home placement (these services are intended to help them step down to a less restrictive placement or to reunify them with their families). Furthermore, the Department does not calculate prevention rates or analyze service effectiveness by the family functioning or risk level. Research (e.g., *A Retrospective Evaluation of North Carolina's Intensive Family Preservation Services Program* by Raymond Kirk, August 2000) shows that family risk levels have a substantial effect on the success of prevention programs. Disaggregating prevention statistics and program effectiveness data by where the child is living (in-home versus out-of-home) and family risk level (high-risk versus low-risk) provides more meaningful information about service effectiveness and could assist the Department with targeting Core Services toward those families that are most likely to be helped by the interventions.

Third, we found that the Department's time frame for assessing the effectiveness of Core Services is too short. Currently the Department considers Core Services to be successful if a family avoids an out-of-home placement for 90 days after Core Services terminate. A significant number of families that avoid out-of-home placement for 90 days may still experience a placement later. We analyzed Core Services cases for Fiscal Years 2003 through 2006 and found that the out-of-home

placement rate two years after service termination is 25 percent – more than 50 percent higher than the 16 percent rate measured 90 days after service termination. Our analysis only included children who were not in out-of-home placement when they first received Core Services.

Finally, we found that the Department lacks objective, quantifiable measures for assessing the impact of Core Services on family functioning. Currently Department regulations require the Department to assess the success of Core Services by measuring how well clients achieve specific performance indicators in seven areas of family functioning: family conflict management; parental competency; maintaining sobriety; household management; ability to access community resources; the child's academic, behavioral, and emotional competency; and personal and individual competency. County staff measure client achievement related to the seven areas of family functioning by entering "leave reasons" into Trails when Core Services are terminated. We found that during Fiscal Years 2003 through 2006, counties did not provide any specific leave reasons (i.e., the leave reason was left blank or was listed as "other") that tied back to any of the seven levels of functioning for 23 percent of the Core Services provided. Furthermore, when county staff did provide leave reasons, the data were not always specific or quantifiable (e.g., treatment was "successful," "partially successful," or "ineffective") and did not reflect the degree to which clients met specific treatment goals or improved or declined in key areas of family functioning.

We identified several ways in which the Department could implement more robust and accurate data collection and analysis methods to measure the program effectiveness of Core Services. Clearly, the Department needs to ensure that it improves its methodology for calculating prevention rates and evaluates prevention rates and effectiveness data by type of placement (in-home and out-of-home) and family risk level. Furthermore, the Department needs to evaluate prevention rates at multiple points in time—in addition to its current measurement at 90 days after service termination. Additionally, the Department needs to consider options for collecting objective, quantifiable data on the impact of Core Services on family functioning. One option the Department could consider would be to adopt a research-based assessment tool such as the North Carolina Family Assessment Scale (NCFAS). This tool evaluates changes in family functioning in six domains, including family safety, parental capabilities, family environment, family interactions, caregiver/child ambivalence, and child well-being. The NCFAS domains align well with and cover the same areas as the seven performance indicators of family functioning contained in Department rules. The Department should consider requiring that counties use a tool such as the NCFAS to provide pre- and post-testing of families receiving Core Services to collect objective, measurable data to evaluate service effectiveness. Currently the Department requires the counties to complete the NCFAS at least twice for the majority of Core Services

cases. Although we found that the case workers in the counties we visited were completing the NCFAS, neither the Department nor counties use the data to evaluate the impact of services.

During our audit we used NCFAS data to conduct our own analysis of the effectiveness of Core Services. We evaluated data from Fiscal Years 2003 through 2006 for families that received similar NCFAS needs assessment scores and compared the outcomes of those that received Core Services with those that did not. We divided families into low-, medium-, and high-risk levels, based on NCFAS scores, and found that at all levels, families that received Core Services subsequently had children removed from the home at a higher rate than families that did not receive Core Services. For example, for the highest-risk group, 36 percent of families experienced an out-of-home placement after receiving Core Services compared with 25 percent for those that did not receive Core Services. Furthermore, the average length of stay in placement (in those cases in which a child was removed) was longer: 280 days for families receiving Core Services compared with 222 days for families not receiving Core Services.

Our analysis raises questions about whether the current Core Services program is meeting the objective of preventing or limiting out-of-home placements and, therefore, providing cost savings to the State in the form of fewer or shorter placements. The Core Services program has grown dramatically in size, scope, and budget in recent years while a growing body of nationwide research has questioned the effectiveness of similar programs. For example, the number of children reported by the Department as receiving Core Services has more than doubled from Fiscal Years 1995 through 2006 (from about 7,700 to about 19,000), even though the State's child population has increased only about 20 percent during the same period (from about 1 million to about 1.2 million). Despite this increase in the use of Core Services, there has not been a similarly dramatic drop in the out-of-home placement population.

The State has spent an average of about $42 million annually on Core Services during the last five fiscal years, so it is critical that the Department have an effective method to justify these costs. Both our 1990 and 1998 audits of child welfare services also concluded that the Department had not determined the effectiveness of Core Services (referred to as Placement Alternative Programs in 1990 and Family Preservation Services in 1998). The 1998 report also found flaws in the Department's methodology for evaluating Core Services and found that a significant number of children enter and remain in out-of-home placements despite receiving these services. As our current audit shows, the Department has made little progress to correct this deficiency 17 years later. Given that more than $211 million has been invested in these services since Fiscal Year 2002, the Department needs to take the steps outlined above to ensure that these expenditures are cost-effective.

Recommendation No. 14:

The Department of Human Services should conduct a comprehensive evaluation of the effectiveness of Core Services. The evaluation could be accomplished either in-house or through an external contractor. In addition to factors identified by the Department, the evaluation should:

a. Exclude children who are already in out-of-home placement from the calculation of prevention rates and expand the period over which program success is measured after services conclude, taking measurements at multiple points (e.g., 6, 12, and 24 months).

b. Incorporate methods for analyzing prevention rates by risk levels and type of placement (in-home or out-of-home).

c. Consider using standardized tools for assessing changes in family functioning, such as the North Carolina Family Assessment Scale, in lieu of leave reasons, to evaluate the outcomes of Core Services.

Department of Human Services Response:

a. Agree. Implementation date: October 2007.

   The Department will exclude children in out-of-home placement in the calculation of out-of-home prevention rates and will expand the period over which program success is measured after services conclude.

b. Agree. Implementation date: October 2008.

   The Department agrees to determine if an appropriate tool exists to perform this function.

c. Agree. Implementation date: January 2008.

   The Department agrees to evaluate the use of tools for assessing changes in family functioning to evaluate the effectiveness of Core Services.

Calculating Cost Savings From Core Services

Statute [Section 26-5.5-104(6), C.R.S.] also requires the Department's annual Core Services report to the Governor, General Assembly, and Chief Justice of the Supreme Court to assess cost-efficiency. The Department measures cost-efficiency by comparing the average monthly cost of Core Services with the average monthly cost of the out-of-home placements avoided. For Fiscal Year 2006 the Department reported that the average annual monthly cost of Core Services was $118 per case compared with a monthly cost of $1,954 per case for out-of-home placements. The Department calculated that during Fiscal Year 2006, Core Services resulted in potential cost savings of $1,836 per case per month.

We analyzed the Department's cost savings calculations and found that the calculations do not accurately compare the costs of Core Services with the costs of out-of-home placement. First, we found that when the Department calculates the cost per child per month for each type of service, the Department does not factor into its cost calculation the length of time the child receives the service. The period of time that children receive Core Services averages about six months. By not considering the length of service, the Department substantially understates the cost per child for Core Services.

Second, we found that when the Department calculates cost per child per month for Core Services, it does not correctly factor in the number of children served. More specifically, the calculation for children served is not unduplicated and the monthly cost per child data collected from counties and used to calculate the statewide costs per child per month are not weighted to reflect the number of children served in each county. In other words, the Department's methodology gives equal weight to each county's monthly cost per child, regardless of the number of children served in each county.

Third, the Department does not calculate cost savings by comparing the total costs of serving a child in Core Services with the total cost of serving a child in an out-of-home placement. Comparing the total overall costs would provide more useful information about potential cost savings derived from Core Services. For example, as noted earlier for Fiscal Year 2006, the Department reported the average monthly cost of Core Services to be $118 compared with $1,954 for out-of-home placements, which suggests that out-of-home placements are almost 17 times more expensive than Core Services. However, we found that the average amount spent per child on Core Services for the four-year period spanning Fiscal Years 2003 through 2006 was about $4,000 compared with about $10,800 for out-of-home placements. This suggests that using out-of-home placements is about two and one-half times as

expensive as Core Services. Neither our calculations nor the Department's calculations consider that some children received Core Services before, during, or after an out-of-home placement, which increases the total cost of serving the child. As discussed previously, about 40 percent of children are already in placement when Core Services are provided. In those cases, both Core Services and placement costs are being incurred, which would likely further reduce the cost savings attributable to Core Services.

Recommendation No. 15:

The Department of Human Services should ensure that it has valid and accurate methods for evaluating the cost-effectiveness of the Core Services program by:

a. Basing the county Core Services averages on the actual number of service-months that children receive the services.

b. Using correct methods for weighting the averages of county Core Services costs when calculating the State's average cost.

c. Considering other methods for calculating cost savings, such as comparing the average costs for Core Services and out-of-home placements on a per-case or per-child basis, rather than on a monthly, per-service basis.

d. Developing valid methods for assessing the cost savings attributable to Core Services for children who enter or remain in out-of-home placement after receiving Core Services.

Department of Human Services Response:

a. Agree. Implementation date: October 2007.

The Department will base the Core Services averages on the actual amount of service months that children receive the services.

b. Agree. Implementation date: October 2008.

The Department agrees to use correct methods for weighting the averages of county Core Services costs when purchased by the county department.

c. Agree. Implementation date: October 2008

The Department will discuss with the evaluator assigned to this project methods for calculating cost savings.

d. Agree. Implementation date: October 2008.

The Department will identify valid methods for assessing the cost savings attributable to Core Services.

Statutory Clarification

In addition to problems with determining eligibility and evaluating the cost-effectiveness of Core Services, we found that the statutory authorizations for Core Services may need to be streamlined to clarify program intent and improve program effectiveness. According to the Department's budget request documents, there are three separate statutes that provided for the menu of services currently offered through the Core Services program, as listed in the table on the next page:

Department of Human Services
Statutory and Regulatory Authority for Core Services Program

Statute	Services Authorized	Eligible Population	Time Limits on Services
Family Preservation Act (Section 26-5.5-101, C.R.S., et al.)	"Short-term intensive services," such as: • risk and needs assessments • referral to community services • crisis intervention • individual and group counseling • developing parenting and problem-solving skills	"At-risk families." This is defined as a family meeting the Department's out-of-home placement criteria, defined below in Department regulations.	Not to exceed six weeks.
Child Welfare Services Statutes (Sections 26-5-101, et al.)	Includes services authorized in the Family Preservation Act, plus: • case plan development • drug and alcohol treatment • mental health services • out-of-home placement services • home-based crisis counseling • financial services	Families with children who are likely to become neglected or dependent.	None specified.
Emergency Assistance Act (Section 26-5.3-101, C.R.S., et al.)	• counseling • treatment • other family preservation services	Families with children who are at "imminent risk" of out-of-home placement.	Services can be approved only once every 12 months.
Department Regulations (7.303 - Core Services Program)	• home-based intervention • intensive family therapy • life skills • day treatment • sexual abuse treatment • special economic assistance • mental health services • substance abuse treatment • aftercare services • county-designed services	Families that meet the "out-of-home placement criteria": • a child may be at "imminent risk" of an out-of home placement • services from other sources (e.g., community or insurance) are not available, unsuccessful, or exhausted • Core Services are the best option to reduce the risk to the child	Services can be offered up to 18 months with unlimited 6-month extensions.

Source: Office of the State Auditor's analysis of the Colorado Revised Statutes and the Department of Human Services' regulations.

In addition, Section 19-1-125, C.R.S., provides "family stabilization services," which appear similar in scope to Core Services. As the table shows, all of the statutory provisions authorize the Department to provide services to help at-risk families or families at imminent risk of out-of-home placement. However, the services available under each statutory section are not exactly the same, and the time limits on services vary from six weeks to no limits. In addition, the Family Preservation Act requires the Department to conduct a cost-effectiveness and efficiency study of the services provided under the act. The Department has expanded this study to cover all Core Services. Department regulations define Core Services somewhat differently and

allow them to be offered for up to 18 months, with unlimited 6-month extensions. Regulations also limit program eligibility to families with children at imminent risk of out-of-home placement.

Discrepancies among the statutes and between statutes and regulations result in a lack of clarity regarding the intent of Core Services. Specifically, it is not clear if Core Services are intended to be short, intensive services designed to prevent immediate out-of-home placements or long-term services for families exhibiting more general risk factors, or both. We found that the average length of service was 182 days, or about 26 weeks, for Fiscal Years 2003 through 2006. We also found that 66 percent of services lasted longer than six weeks (the time limit in the Family Preservation Act) and 4 percent lasted more than 18 months. It is unclear if these service lengths are consistent with the intent of Core Services. Department staff explained that the six-week limit in the Family Preservation Act is probably related to a particular model of intensive Core Services that was popular at the time the legislation was enacted and does not apply to services as they are practiced today. Staff also said that the Emergency Assistance Act is no longer valid because it was connected to a federal program that was eliminated by federal welfare reform. The Department has not proposed legislation to eliminate obsolete or outdated statutory provisions.

The Department should work with the General Assembly to clarify the statutory authority for Core Services and update its regulations as necessary. These efforts should focus on clarifying the intent/purpose of Core Services and establishing a consistent definition of the services to be included under Core Services, the length of time that services may be offered, and the eligibility requirements. The Department should also ensure that the requirement for evaluating the cost-effectiveness of these services, currently in the Family Preservation Act, remains intact.

Recommendation No. 16:

The Department of Human Services should review the statutes relating to Core Services to identify areas in which the statute could be made clearer and more consistent with respect to the services to be provided, the population that is eligible for services, and any time limits on the services. Using the review, the Department should work with the General Assembly to clarify the statutory authority for Core Services and update its regulations as necessary.

Department of Human Services Response:

Agree. Implementation date: November 2008.

The Department will review Core Services statutes to identify needed changes and contingent on Executive Approval will work with the General Assembly to effect change in the statutes as necessary. The Department will follow the agency protocol for requesting legislation. Upon approval from the Governor's Office, the Department will work with the legislative liaison to seek sponsorship.

Appendix A

U.S. Department of Health and Human Services (DHHS)
August 2002 Child and Family Services Review (CFSR)
Qualitative Onsite File Review Items Related to Outcomes

Item	Description	Score on CFSR[1]
1	Timeliness of initiating investigation of reports of child maltreatment.	69%
2	No repeat incident of abuse or neglect against children within six months of an initial incident.	100%
3	Diligent efforts were made to maintain children safely in their homes and prevent removal.	91%
4	Sufficient efforts were made to reduce the risk of harm to children.	87%
5	No reentries into foster care within 12 months of discharge from a prior foster care episode.	82%
6	Out-of-home placement changes were in the child's best interest.	79%
7	Permanency goals were established for the child in a timely manner.	72%
8	Reunification with relatives occurs within 12 months.	86%
9	Diligent efforts were made to achieve finalized adoptions in a timely manner.	17%
10	Diligent efforts were made to help the child attain the goal of emancipation.	56%
11	The child was placed in a foster home in close proximity to his/her parent, or when the child was placed far away, the placement was necessary to meet the child's special needs.	93%
12	Siblings were placed together or there was a justifiable reason for their separation.	94%
13	Concerted efforts were made to facilitate visitation between parents and the child in foster care.	81%
14	Diligent efforts were made to preserve the child's connections to family, ethnic heritage, church, friends, and/or former foster parents.	72%
15	Diligent efforts were made to locate and assess relatives as potential placement resources for the child.	88%
16	Efforts were made to support the parent-child relationship of children in foster care.	80%
17	The needs and services of children, parents, and/or foster parents had been, or were being, adequately addressed.	64%
18	Parents or the child were appropriately involved in case planning.	72%
19	Caseworker visits with the child were sufficient to ensure adequate monitoring of their safety or otherwise meet their needs.	76%
20	Caseworker visits with parents were sufficiently frequent or of sufficient quality to promote the safety and well-being of the child or enhance attainment of case goals.	67%
21	The child's educational needs were met.	91%
22	The child's health needs were adequately addressed.	77%
23	The child's mental health needs were met.	72%

Source: U.S. Department of Health and Human Services, Colorado Child and Family Services Review Final Report, August 2002.
[1]Scores determined by DHHS's review of 50 case files from Denver, El Paso, and Morgan counties. The 15 items receiving scores below 85 percent were rated as Areas Needing Improvement and were included in the Colorado Department of Human Services' October 2003 Program Improvement Plan with DHHS. The scores represent the percentage of applicable files or cases that were in compliance with the standard.

U.S. Department of Health and Human Services (DHHS) August 2002 Child and Family Services Review (CFSR) Quantitative National Data Standards		
Item	**Description**	**Score on CFSR**
1	**Repeat maltreatment.** National standard is that no more than 6.1% of children suffering an incident of abuse or neglect will experience another incident within six months.	2.7%
2	**Abuse or neglect in foster care.** National standard is that less than 0.57% of foster children will be victims of a substantiated case of child abuse or neglect in foster care.	0.73%
3	**Reentry into foster care within 12 months of a prior episode.** National standard is that no more than 8.6% of children exiting a foster care placement will experience a new placement within 12 months.	19.3%
4	**Length of time to reunification.** National standard is that at least 76.2% of foster children will be reunified with the families in less than 12 months after the latest removal from the home.	85.7%
5	**Length of time to adoption.** National standard is that at least 32.0% of children available for adoption will be adopted in less than 24 months from the latest removal from home.	49.5%
6	**Stability of foster care placements.** National standard is that at least 86.7% of foster children will experience no more than two different placement settings within 12 months.	86.9%
Source: U.S. Department of Health and Human Services, Colorado Child and Family Services Review Final Report, August 2002.		

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