2007-2008 Colorado CAPTA: Citizen Review Panels

1. Colorado's Children's Justice Task Force
2. Institutional Abuse and Neglect Review Team
3. Pueblo County Children Protection Team

The Colorado Department of Human Services has designated the above three teams as the State's three Citizen Review Panels in order to meet the CAPTA requirement of June 20, 1999. Federal Statute authorizes the Children's Justice Task Force. The CDHS Institutional Abuse Team is authorized by CDHS–Child Welfare Code of Colorado Regulations and the Pueblo County Child Protection Team as a child protection team is authorized by Colorado Revise Statutes and the Code of Colorado Regulations.

REPORT AND RESPONSE TO CITIZEN REVIEW PANELS

Annual report responses are verbally transmitted back to the teams. Updates are provided quarterly unless there is a particular area of concern or request that requires immediate action. Members of the panels are often involved in any training offered and/or participate on the workgroups initiated in part to address the panels' areas of concern. The panels are provided quarterly progress reports on the PIP and the plans for the next Child & Family Services Review.

2007-2008 CHILDREN'S JUSTICE ACT TASK FORCE
Citizen Review Panel

The **Colorado's Children's Justice Task Force** (CJTF) is a designated citizen review panel that is comprised of volunteers who represent agencies and professionals involved in children's issues. The Task Force is a requirement of the Children's Justice Act which provides grants to States to improve the investigations, prosecutions and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, in a manner that limits additional trauma to the child victim. This also includes child fatality cases in which child abuse or neglect is suspected and specific cases of children with disabilities and serious health problems who are victims of abuse and neglect.

At the quarterly meetings, the CJTF panel provides ongoing input and oversight to Colorado's progress on the Child and Family Services Review, Performance Improvement Plan, interagency collaboration, child fatalities, abuse and neglect, domestic violence, substance abuse and coordination and collaboration with agencies and professionals with CPS investigations. This past year members have received the CDHS-CW Child and Family Services Review Newsletters with regular updates and progress toward reaching the goals. County directors, judges and state court administrators wrote many informative articles.

This task force has continued to actively review the current practices and statutes regarding the judicial and administrative handling of the investigation of child abuse, child fatalities as well as proposed legislative changes and model programs. The CJA

Grant funded the following activities in the past year to address the recommendations of the Task Force.

Task Force Recommendations:
(Department response to recommendations are indicated by ●)

1. Ensure that all available resources are utilized for cases that need more specialized interviews and evaluations. This would include using consultants to assist with the investigation.
    - The Kempe Children's Center START (State and Regional Team) has provided expert consultations on 171 difficult cases for multidisciplinary staff in local communities.
    - The Department has developed a list of 12 consultants whose child protective services expertise as listed above assisted county departments. Access to the consultants is a streamlined process.
2. Provide support in order to improve staff performance, and prevent staff turnover by offering training and debriefing for staff members involved in child abuse and child fatality investigations.
    - This year we saw an increased number of staff accessing the Secondary Trauma Training Prevention Project. This is partly due to the unfortunate fact that in Colorado, in 2007 there were 12 child fatalities in families previously known to the county departments of human services. The Project provided the following for county child protection staff, and other multidisciplinary professionals involved in the investigation of child fatalities and serious child abuse: 1) 74 Individual Consultations; 2) 21 Secondary Trauma Training Seminars with a total of over 142 attending; 3) 15 Group Stress Debriefings; and 4) 74 Traumatic Stress Educational Support Group sessions throughout the state. Another presentation this year was given to the Directors of Human Services for Colorado Counties at their annual meeting. The focus was on how to assist their staff following a child death. This project and its benefits have been published by the National Resource Center on Organizational Management.
3. Continued utilization of the pediatrician on contract with the CDHS to provide assistance and training to physicians and caseworkers, to assist with evaluating and determining abuse and neglect and to provide testimony, when necessary, to the court on difficult cases when expert medical testimony is necessary.
    - Pediatric consultations were provided for child protection staff, law enforcement and prosecutors on over 30 child abuse/neglect cases from across the State.
4. Improvement of Investigative, Judicial and Administrative Handling of Cases of Child Abuse and Neglect, including children with disabilities and serious health problems.
    - Yearly training is provided to Institutional Abuse Investigators. This year the training encompassed how to evaluate the use of restraints on children in 24 hr. out of home care. CDHS-CW staff trained on the goals of crisis intervention, the definition of restraint, when to restrain, quality standards and restraint expectations, and therapeutic holds. There was also a live demonstration of

restraint techniques and a discussion of what questions intake workers should ask during their intake assessments. This was followed by a presentation of investigating allegations of child abuse involving the use of physical management in the Division of Youth Corrections facilities. This included a discussion and demonstration of Phase 1-4, which are used in DYC facilities: Verbal de-escalation, pressure point control tactics, spontaneous knife defense, and mechanical restraints. 45 investigators attended the training.

- 16-2 day Safety Management trainings were presented to a total of 512 county CPS intake caseworkers.
- 9 –2 day Ongoing Safety Management trainings were presented to a total of 288 county CPS on-going caseworkers
- Six-2 day CPS Intake Consistency trainings for CPS intake caseworkers were provided throughout the state by the Kempe Center for Child Abuse and Neglect.
- Representatives from the child welfare system and representation from the judicial system jointly planned the 2007 Annual Colorado Child Welfare Conference. The Conference was attended by approximately 600 participants from the child welfare system and judicial officers, court staff, county attorneys, Guardians at Litem and parents' counsel, all of whom work with Dependency and Neglect cases. The keynote speakers and workshops for the Child Welfare Conference were selected in collaboration with representation from the Colorado State Court Administrators' Office. The annual Colorado Judicial Conference on Families and the annual Colorado Child Welfare Conference were held "back-to-back" in order to encourage attendance by judicial officers at the child welfare conference, which immediately followed the judicial conference at the same large conference site.
- Training was developed and delivered to approximately 30 judges, other judicial officers and legal staff connected with Dependency and Neglect cases regarding use of the Colorado Assessment Continuum's valid and reliable Safety, Risk and Needs (North Carolina Family Assessment Scale-Reunification) assessment instruments in developing and monitoring child protection case plans from "the bench" at the Colorado Child Welfare Conference held in May 2007.
- A 2-day training for approximately 75 representatives of the child welfare system was provided on May 24 and 25, 2007, to which direct and indirect representatives of the judicial system were invited. Numerous individuals, representing various roles in our judicial system, attended. The training focused on how to reduce child and youth moves in foster care, how to maximize effective use of kinship care, how to increase the positive interaction between foster parents and biological parents, and the importance of caseworker contacts with parents as mechanisms to enhance the likelihood of successful reunification.
- Training in best practice regarding visitation between parents and children that is intended to enhance safe and timely reunification of abused and neglected children was delivered again this year to approximately 75 participants, many of them directly or indirectly representatives from the judicial system, through the Child Welfare Division. This two-day training includes protocols specific to children who have been sexually abused.
- The Child Welfare Division continues to be represented by its Director, a Child Welfare Manager and a Child Protection Administrator on the Denver Model

Court Multidisciplinary Team that commenced work in May 2005 to implement various protocols and procedures recommended by the National Model Courts Project to better serve the best interests of children and families who come before the Court. This was an ongoing commitment to engage in inter-agency collaborative work through at least 2007. The Denver Model Court Project identified and is developing interventions to address the following areas:

a. Overrepresentation of minority children in the juvenile court system
b. The need for timely permanent homes for children and youth with a permanent plan of "other planned living arrangement," rather than a permanent home.
c. The need to reduce the number of moves children and youth make while in foster care.
d. Diligent Search
e. Early Identification of and Placement with Appropriate Relatives
f. Improving Outcomes for Children and Families and Developing Means to Measure progress towards Goals
g. Balancing Early Provision of Services with Meaningful Family Involvement in process
h. Increasing the presence of youth in court to self-advocate for their desired case plans.

- The Child Welfare Division continues dialogue about the State's Court Improvement Plan and Family Services Plan at the State Court Administrators Office at regularly scheduled meetings to discuss, strategize and coordinate program issues relevant to Child Welfare and Judicial.
- Child Welfare and the State Court Administrators Office continue to work collaboratively on a regular and ongoing basis on Colorado's House Bill 1451 initiative that is developing meaningful collaborative strategies between agencies that serve abused and neglected children and youth.
- Training was provided to 7 county Child Protection Teams. This included safety issues.

5. Improvement in the system response to child fatalities through review and evaluation of fatalities in order to identify and correct system gaps that may have contributed to the failure to protect the child.
   - In January 2008, Colorado Department of Human Services director ordered 21 staff members to conduct an emergency investigation after a year in which a dozen children died in families previously known to the county departments of human services.
   - CDHS Child Welfare Staff conduct on-site reviews, along with county internal reviews.
   - Statewide training was provided for confirming allegations of child abuse/neglect.
   - The Colorado Child Fatality Review Committee is a managed and coordinated by the Colorado Department of Public Health and Environment. It is a multidisciplinary team consisting of professionals representing public health, medicine, law and law enforcement, child welfare, forensics, mental health, and other special interests related to the health and safety of children that reviews all child deaths that occur in Colorado. The goals of the committee include

describing patterns of child death in Colorado, identifying the prevalence of risk factors for child death, characterizing high risk groups in terms compatible with the development of public policy, evaluating system responses to children and families who are at high risk and offering recommendations for improvement in those responses, and improving the quality of data necessary for child death investigation and review. A fundamental purpose of the review process is the development and implementation of prevention strategies that are suggested by the in-depth review of the circumstances of each child fatality. Specific benefits have resulted from the child fatality review process. These include, but are not limited to, a better understanding of how children are dying in Colorado, greater accountability among professionals, participation in the development of prevention strategies, statewide child death investigation training, stimulation of policy assessment, and improvement in dialogue with the media. CAPTA/CJC funding remains a shared funding that supports this endeavor.

6. Conduct training for county Child Protection Team members to improve their knowledge and skills in reviewing cases for safety issues and safety planning
   - The child protection team conference was delayed, as specific county issues related to their child protections team became a priority. As such, county specific consultation/training has been offered. To date the consultant has met with eleven mid size to small (rural) counties. He has done team building and strategic planning. Three more counties have requested this county specific technical assistance; consultation and training that will be scheduled over next 6 months.

2007-2008 INSTITUTIONAL ABUSE REVIEW TEAM ANNUAL REPORT
Citizen Review Panel

The **Institutional Abuse Review Team** meets monthly to review reports of investigations of abuse and neglect in 24 hour out of home childcare settings. These referral/assessments are completed by the counties and submitted for review. The team reviews cases of alleged incidents of abuse and neglect, including child fatalities and near fatalities. Investigations are completed on children in Department licensed and certified out-of-home care settings such as foster care and kinship homes, Residential Child Care Facilities, Child Placement Agency Foster or Group Homes, as well as the Division of Youth Corrections' Juvenile Facilities and Colorado Division of Mental Health Institutions. The Team is made up of volunteers who are representative of the community at large as well as those who possess expertise in the prevention and treatment of child abuse and neglect and it reviews an average of 50-55 cases per month. The Team reviewed 642 reports from January to December 2007.

This Team was specifically designated to focus on the extent to which the child protective service system is coordinated with the foster care and the adoption programs. Institutional Abuse Review Team members review each referral/assessment and make recommendations regarding follow-up. These recommendations are sent to all involved

state and county agencies. The State has provided assistance to the panel with training and administrative support.

As stated last year, as of October 2006 enhancements of the State automated system (TRAILS) improved the states ability to identify and provide a team review of the county referral/assessments of abuse/neglect in 24hr care. The purpose of this change was to ensure more statewide consistency in institutional referral /assessments.

System changes a) specifically identified the referral as an institutional abuse/neglect referral b) connected the care provider identification number with county referral/assessment c) added specific assessment questions that the county investigator had to complete as a part of the investigation/assessment e) electronically sent to the state the completed assessment/investigation upon the county supervisor's approval of the closure of investigation/assessment d) captures the state's team review of the county's investigation/assessment.

The Institutional Abuse Review Team completes a Findings and Recommendations report on each referral/assessment, which is sent electronically via TRAILS to the county intake supervisor who approved the closure. As expected, in 2007 there were an increased number of cases submitted to the state for review. The Team met twice in August because 100 cases were submitted for review that month.

The team supported and participated in the yearly training provided to Institutional Abuse Investigators. This year the training encompassed how to evaluate the use of restraints on children in 24 hr. out of home care. CDHS-CW staff trained on the goals of crisis intervention, the definition of restraint, when to restrain, quality standards and restraint expectations, and therapeutic holds. There was also a live demonstration of restraint techniques and a discussion of what questions intake workers should ask during their intake assessments. This was followed by a presentation of investigating allegations of child abuse involving the use of physical management in the Division of Youth Corrections facilities. This included a discussion and demonstration of Phase 1-4, which are used in DYC facilities: Verbal de-escalation, pressure point control tactics, spontaneous knife defense, and mechanical restraints. 45 investigators attended the training.

Last year's recommendations and progress:
(*Department response to recommendations are indicated •*)

1. Expectations of accurate and timely entry of information in TRAILS should be reinforced, so that caseworkers have access to previous history of the child and placements.
   - This has been a focus of ongoing training between CDHS-CW staff and county intake workers and supervisors. The issue of timely entry of data into TRAILS is being examined as a need to review and strengthen policy requirements with the added enforcement of state sanctions.

2. Ongoing training for abuse investigators and intake supervisors regarding the importance of entering their referral/assessment data correctly in the TRAILS system.
   - CDHS-CW staff has worked closely with county intake supervisors and workers to accomplish this. Due to the high turnover in county intake workers and supervisors, this training will be ongoing.
   - As noted, major enhancements were made to TRAILS in 2006. A number of fixes to the system are still outstanding. Instructions have been sent to the counties outlining the TRAILS changes and operational recommendations.
3. Institutional Abuse investigators must have access to prior reports of child abuse/neglect on the placement facility in order to be more thorough in their investigation.
   - CDHS-CW staff as well as county intake workers and county intake supervisors have been providing training on how to access this information in TRAILS.
4. Institutional Abuse Investigators need to be more diligent about reviewing the placement agency's records for such things as training requirements of staff, and policies and procedures regarding such things as medication storage and administration and the use of both mechanical and physical restraints.
   - These recommendations were a focus of the 2007 Institutional Abuse/ Neglect Training for the IA (institutional abuse) investigators.
5. Out-of-Home Placements:
   a. Placement facilities need to report alleged abuse immediately.
   b. Staff in some residential facilities should interact with clients more and observe clients through video cameras less often.
   c. The temperature setting of water heaters in foster homes should be checked to ensure that they are not on the highest setting.
   - The above recommendations have been forwarded to the State and County licensing entities as well as the States monitoring units.

2008-2009 Team recommendations:

1. Improve the Institutional Abuse Review Team Findings and Recommendations report in order to improve feedback to county intake workers and supervisors.
2. The Colorado TRAILS User Group should make corrections in the referral/assessment so that the investigating county clearly shows. This is especially important when one county transfers the referral to another county. This affects the Attorney General's office when they contact the investigating county for reports during the appeals process.
3. The CDHS Office of Appeals Division should get copies of the Institutional Abuse Review Team reports on institutional abuse/neglect cases, when the person responsible for the abuse/neglect appeals the confirmation of child abuse/neglect.
4. Foster homes should not accept 8-10 children even if they are sibling groups. The number should be determined based on the foster parents' ability to meet the needs of the children, not on the number that is legally allowed.
5. Due to concerns about foster children being moved too often from one placement to another, the Team recommends that:

a. Placement moves be more closely monitored by the county placement reviews teams.
b. Provide appropriate treatment resources for children in out of home placements
c. Provide supportive services for providers.

- The Department has already initiated action on the above 5 recommendations.

Recommendations 1:
The Department has modified the IART report and initiated TRAILS project requests and/or fixes to alert the counties of action(s) required related to the teams findings. It is anticipated that system enhances will occur by the fall of the 2008 build.

Recommendation 2:
This has been accomplished, as of the April 2008 TRAILS build.

Recommendation 3:
The Office of Appeals will be advised of this recommendation. A presentation to the team by appeals office will be explored to review what thresholds must be met in order to sustain a confirmation. In addition, the appeals office will be asked to consider having a representative from the office be a member of the IART.

Recommendation 4:
This recommendation will be forwarded to the State and County licensing entities as well as the States monitoring units

Recommendation 5:
This recommendation will be forwarded to the child welfare division's manager of the permanency unit.

Pueblo County Child Protection Team 2007-2008 Yearly Report
Citizen Review Panel

The Pueblo County Citizen Review Panel meets weekly to review investigated reports of all cases of child abuse (physical and sexual), fatal child abuse, emotional abuse, neglect, abandonment and institutional abuse incidents made to the Pueblo County Department of Social Services. Recommendations are made addressing the investigation and the proposed treatment plan. The Pueblo County Citizen Review Panel evaluates as per statute the timeliness and appropriate response of the Department plus also functions as both a review and resource panel. Guidance and suggestions are provided to the reporting Intake or Ongoing worker by the members of the team made up of medical, mental health, educational, law enforcement and legal experts. The Pueblo County Child Protection Team reviews approximately 15-20 cases per week.

The membership panel is diverse in its make up of professional and dutiful individuals. Members consist of representatives from

School District #60 and School District #70, CMHIP, Foster parents, a judicial liaison, Pueblo County Health Department, a medical doctor, the El Pueblo Boys and Girls Ranch (RTC), Spanish Peaks Mental Health Center, Pueblo Child Advocacy Center, 1 representative of the minority groups within the community, Deputy District Attorneys, Pueblo Police Department, Pueblo Sheriffs Department, and the Department of Social Services.

The assigned caseworker or their supervisor presents the cases investigated. The team reviews all the information available in regards to the outcome of the assessment. From the synopsis, the team will make recommendations to include but not limited to filing a D&N, seek additional medical or mental health information, whether to confirm an individual as responsible for abuse/neglect on the Trails Automated System, or if the assigned caseworker needs to provide additional information. On occasion the Team will request the ongoing worker and the Supervisor to attend the review so they can be available for questions or recommendations.

Because the Child Protection Team reviews a large number of cases they have become aware of the strengths and deficits in the system.

The Child Protection Team has seen various trends in our community that has had a major impact on the Pueblo County Department of Social Services' Child Welfare Division. The trends consist of the following:

1. Marijuana use is becoming very commonplace.
2. An increase in the number and severity of custody disputes.
3. Mothers choosing boyfriends/significant other over the welfare of their children.
4. An increase in younger children (under 13 years old) being out of their caregiver's control.
5. More children with ADHD symptoms being referred to the local mental health center who are diagnosed with stress related issues rather then ADHD.
6. Generally, poor parenting skills in the families presented to the Child Protection Team.

Referrals reporting abuse and neglect in 2007 continue to reflect substance abuse by parents and teens. Completed investigations resulted in an increase in the number of open cases of abuse and neglect due to the increase of cocaine and methamphetamine drug use by parents.