

**3<sup>RD</sup> PARTY**

**POLICY AND PRACTICE REVIEW**

**DENVER DEPARTMENT OF HUMAN SERVICES**

*Submitted by:*

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## Acknowledgments

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Most importantly, we are grateful to the parents, relatives, foster parents and youth who gave of their time to share with us their ideas and concerns regarding services for the children and families of Denver County. We applaud their willingness to partner with us in this process.

## PURPOSE OF THE REVIEW

In October 2007, the Denver Department of Human Services ("DDHS") requested a third party review of its policies, protocols, and practices related to investigating and intervening in possible incidents of child abuse and neglect. The purpose of the third party review is to evaluate whether existing procedures provide sufficient guidance for staff to successfully:

- ❖ Assess risk of child maltreatment for children reported to DDHS;

- ❖ Intervene with families to increase child safety and family functioning; and
- ❖ Make critical decisions regarding the need to place children outside of the home.

This review was prompted by a child fatality in September 2007 in which Denver County had prior involvement with a family whose daughter was an alleged victim of sexual abuse. This fatality was the second in which Denver County played some role, and since the review was requested, there has been one additional fatality. These tragic situations have cumulatively weakened public confidence in the ability of DDHS to protect children and put into question the effectiveness of Denver's child protection practice.

Each child fatality that has occurred in the county has or is being further investigated to understand how DDHS actions and the actions of other stakeholders contributed to the negative outcome. This 3<sup>rd</sup> party review does not examine the decisions that were made in individual cases, but rather seeks to examine the systemic issues that might be compromising child safety. The review focuses on the investigative process, including risk and safety decision-making; services and supports available to families; collaborative relationships with other key stakeholders; internal structures and communications to support the work; and staff capacity to carry out the necessary procedures and protocols.

It should be noted that until the recent 2007 child fatalities, Denver County had made good progress protecting children and preserving families. The County has enabled more families to stay together safely rather than experiencing the trauma and separation of foster care. The community collaboratives have helped to ensure that more families can get services in their own neighborhoods so that they can stay together. The County has also done more to promote speedier reunifications, as well as permanent homes for children who can not return home to live with their own families.

Despite these accomplishments, Denver County, like many other large urban jurisdictions in the country, continues to struggle to balance the primary goals of the agency: to keep children safe and hold families

together. The Review Team commends DDHS for *voluntarily* requesting this 3<sup>rd</sup> party review. By opening its doors to even more intense and public scrutiny than it has already received, and asking the question ‘how can we do better?’ DDHS has taken an important step toward greater transparency and accountability for its work.

Denver County is moving in a direction that is entirely consistent with a national movement – supported by federal policy and accountability measures – to keep children safely in their own homes whenever possible, and to promote permanency for those who are in out-of-home care and can not return home. There is very little argument about the overall philosophical direction in which Denver County is moving: to make more preventive services available in the community, to support families more intensely *before* they need intensive child protection help, and to involve families more closely in decisions about the safety of their children.

The question is not *whether* this is the right direction for families, but rather *how* Denver can actualize this goal without further jeopardizing the safety of its most vulnerable children. We hope the recommendations contained below help the County move in this important direction.

## METHODOLOGY

This review was conducted by two organizations with expertise in child welfare policy and practice, as well as previous history and relationships with DDHS.

The Child Welfare League of America (CWLA) is a national organization that specializes in best child welfare practices. CWLA staff and consultants have a long history of working with public and private child welfare agencies to achieve the best possible outcomes for children and families. CWLA has conducted numerous assessments of county and state child welfare agency operations, and has a solid grounding in national best practice and policy.

The Annie E. Casey Foundation (AECF) is the largest foundation devoted to disadvantaged children and families. AECF staff and consultants have

worked with numerous child welfare jurisdictions, including Denver, to help them improve safety, permanency, and well-being outcomes for children who come into contact with the child welfare system. AECF has worked with DDHS over the past seven years to implement Family to Family, a foster care reform initiative aimed at reducing the length of stay in foster care and achieving more timely permanency for children at risk. The AECF team that conducted the review included eight consultants with expertise in child welfare administration, training and risk assessment, foster family recruitment, development and support, child welfare law, law enforcement and child welfare practice.

The Colorado Department of Human Services (CDHS) reviewed the final report for policy and rule violations. In addition, they observed focus groups conducted by the team members and participated in discussions with Denver Mayor John Hickenlooper and Chief of Staff Kelly Brough, and with the Board of Denver Human Services.

It should be noted that DDHS also requested participation on the review team from staff at the Kempe Center on Child Protection. Unfortunately, Kempe Center staff determined in mid-November that their participation in the review was a conflict of interest given that they are recipients of state and county funding. Although the absence of the Kempe Center initially set the work of the Review Team back by several weeks, County staff was very cooperative in scheduling focus groups and meetings so that the original timeline would not be altered too drastically.

The review took place over the course of 4 months, from November 2007 through February 2008. The Review Team conducted the following steps:

- ❖ Preliminary meetings with DDHS managers to review programs and policies related to investigations, services, and permanency;
- ❖ Twenty five (25) focus groups and interviews with a wide range of DDHS staff and external stakeholders (list attached);
- ❖ Participation in discussion of results of DDHS audit of 160 cases pulled from September, 2007 through mid January, 2008. Twenty six (26) randomly selected cases were reviewed by a CDHS team

- as part of a mock Child and Family Services Review and the results were shared and discussed with the Review Team. The Review Team did its own review of an additional 12 cases;
- ❖ On-going discussions with DDHS management and status report to Mayor Hickenlooper and Chief of Staff Kelly Brough, and also to the Board of Human Services.

The review team is pleased to report that DDHS staff and their partners were cooperative throughout the entire review process. The Review team had easy access to the information they needed to assess agency practice. Furthermore, each focus group was comprised of individuals who had positive things to say about the agency, as well as those who were critical of agency practice. Participants were genuinely interested in recommending concrete solutions to agency challenges and welcomed the opportunity to have their voices heard. There was also good consistency across the board in findings about the challenges the agency is facing and what needs to be addressed to improve child protection practice.

In general, the Review Team found that internal and external stakeholders are taking the Review seriously and have high hopes for its potential to move practice in a more positive direction. The DDHS Manager is already taking steps to make systemic changes and has repeatedly expressed a willingness to make other necessary changes. We are optimistic that Denver County has the dedicated staff, administrators and partners needed to take on the recommended improvements and make them a reality for Denver's families.

## Overview of Findings

Despite the recent fatalities in Denver's child welfare system, we find that there are many innovative things Denver has done to improve its system in recent years. For the most part, these positive directions are well supported by key child welfare stakeholders. They include:

- ❖ Restructuring agency practice and protocols so that all children entering foster care who are under the age of 12 can be placed with a family rather than having to go to a temporary shelter placement, and working to keep young children and older youth in general out of congregate care;
- ❖ Reinvesting money saved from high end residential and shelter placements into community based collaboratives that can focus more on providing services to families in the community to prevent abuse and neglect;
- ❖ Embracing Family to Family practice and becoming one of 15 anchor sites in the country who are implementing and evaluating this national model;
- ❖ Supporting a dedicated data analyst who is improving the capacity of the county to collect, analyze, and share data and providing resources to support a Quality Improvement Team that regularly collects and analyzes performance data;
- ❖ Making available a physician trained in child abuse who is willing to examine all children who come into the system, thereby providing critical support to the investigations process;
- ❖ Implementing team decision making, a decision making process that ensures that a skilled, experienced agency facilitator leads meetings to determine whether an at-risk child can safely remain home or must be placed in foster care;
- ❖ Collaborating more effectively with schools, including investigating all school reports and funding three full time Denver Public School (DPS) social workers to act as liaisons with the DDHS and the Denver Public Schools and who will accompany DDHS Intake staff as they investigate school reports of abuse and/or neglect
- ❖ Keeping children safely at home, as evidenced by a repeat maltreatment rate of 2.7%, which is considerably lower than the Federal Standard of 6.1%.

Yet we also find that there are key areas that need attention if Denver wants to continue on the road to improved outcomes, and most importantly, to prevent future tragedies from occurring for families involved with DDHS. These include:

- ❖ Inappropriate interpretation of risk assessment tool that has caused workers to minimize risk factors that jeopardize safety of children still living in the home;
- ❖ Lack of clarity about voluntary cases that leaves families with little oversight, few services, and inability to re-assess risk that requires court intervention;
- ❖ Inadequate services and support for kinship caregivers so that children in kinship placements lack the oversight, monitoring and support they need to ensure safety;
- ❖ Inappropriate application of the TDM model so that TDMs are being used for purposes that go beyond the scope of the model;
- ❖ Tension between the courts and DDHS that prevents the two entities from working together in the best interests of children;
- ❖ Uneven access to services and support through community collaboratives, so that the intent of the collaboratives – to help families in a more preventive and community-based approach – is not being fully realized;
- ❖ Organizational challenges that have left workers feeling they are working in a punitive and unsupportive environment, and in turn, has fueled turnover. Low morale has also been caused by poor communication between management and the frontlines, as well as an organizational structure that is not working as effectively as it can to ensure child safety, and;
- ❖ Lack of responsiveness of the system to its constituents so that parents and youth do not feel respected, involved, or engaged with DDHS. In general, constituents feel disenfranchised by the system and do not feel they have meaningful opportunities for involvement.

## FINDINGS

The review team has reached strong consensus that the eight (8) challenges described below must be addressed by DDHS in order to ensure it can fulfill its primary mission: to protect children. While many issues surfaced during the course of our review, it is these issues that we believe create the biggest challenges for DDHS.

We provide some background on each of these challenges, with a summary of the findings that relate directly to Denver's system. We conclude with concrete recommendations for improvements.

### 1. Risk and Safety Assessment

At the heart of every child protection investigation is the assessment of risk for future abuse and neglect. Risk and safety assessment tools provide workers with a structured way of assessing the risk factors present in the environment, and whether or not the child can safely remain in the home. When risk factors are present, workers are trained on how to rate the risk in categories of low, medium and high, and to make recommendations based upon their findings.

The Colorado Department of Human Services (CDHS) has taken several actions in recent years to strengthen its risk and safety assessment process. In 2002, CDHS issued an Agency Letter detailing findings from a state child fatality review team which examined state fatalities from 1994-2001. The 2002 state review team recommended that the state look at a number of practice improvements to improve staff ability to assess and ensure child safety. In 2005, CDHS formed a Safety Advisory Group to respond to concerns that grew out of the 10-year retrospective review on child fatalities. In March 2007, the CDHS issued an Agency Letter which again reported on the work of the advisory group to address safety assessment and planning issues statewide.

One of the advisory group concerns related to Colorado's performance on the Child and Family Services Review. Its report read that "Colorado failed some of the initial federal CFSR requirements in safety and we are challenged to be ready for the next federal review." The group indicated

that Colorado, in preparation for future federal audits and to address concerns that there was not a consistent and continual assessment of risk and safety, took steps to ensure that findings of assessments could drive delivery of services to families at the local level. Based upon the recommendations of the Safety Advisory Group, the state promulgated a new rule in March 2007 further guiding the use of safety assessments.

CDHS adopted a revised assessment tool from ACTION for Child Protection, a nationally recognized child welfare organization based in New Mexico. The original safety assessment tool was implemented in Colorado in 2000. Statewide training on the revised assessment tool was conducted to develop more consistency in how risk and safety assessments are being conducted.

Unfortunately, our Review Team finds that current risk and safety assessment practices continue to fall short. Long standing problems with the quality of child protective services investigations may have been exacerbated by the recent introduction of the new safety assessment process that is not fully understood or properly utilized. Leaders at the county level are concerned that the current tool does not afford the highest level of protection possible, and that major improvements in practice are needed to fulfill the basic child welfare mission: safety.

### **Findings Related to Risk and Safety Assessment**

Our 3<sup>rd</sup> party review finds widespread problems with the application of the new safety tool. Three of the child fatalities experienced by the county in 2007 have surfaced serious problems with risk and safety assessment. At the time of this report, CDHS had completed one of the Child Fatality Reviews. We have also been able to learn some of the details of the other three fatalities from the DDHS internal Child Fatality Review Team investigation. It is clear that risk and safety assessment continues to be an on-going problem, both within Denver County and in the state.

The findings of the 3<sup>rd</sup> party review are also confirmed in a recent Denver Post article that addresses the application of the new tool. The article quotes another County Director of Human Services: “The new rule....has

been interpreted by some county child-welfare supervisors as restricting when investigators can remove a child from a potentially abusive family....after the rule went into effect, they saw the number of children remaining with parents alleged to have committed abuse increase dramatically, more than 30 percent in one year in some areas of the state.”

Major problems regarding the new risk and safety assessment in Denver that surfaced during our review are as follows:

- ❖ De-emphasis on risk factors – There appears to be major confusion about the training guiding the application of the new safety tool, which is causing workers to put over-emphasis on “present and impending” danger as a deciding factor about whether or not children can safely remain at home. The training also teaches the worker to look at all sources of danger to children, however this still conveys a sense of urgency only and could be causing workers to ignore risk factors that are predictive of future harm. An emphasis on risk, not just safety, is consistent with the practice of most state child welfare agencies;
- ❖ Failure to examine the issues that caused the case to be brought to the attention of child protection – A great concern is that the “present and impending danger” interpretation is causing staff to look only at what is in front of them, not necessarily what brought the case to the attention of the department, or what has been reported about the family in the past. For instance, staff may be assessing for a physical environment that is putting children at risk rather than a chronic neglect issue caused by substance abuse in the home;
- ❖ Lack of a thorough assessment -- Workers are not interviewing all household members, potentially missing important information that could be obtained by or about other family and friends. For example, several of the child fatalities in the County have involved boyfriends, who are not routinely interviewed in existing risk and safety assessment practice. It is also not common practice for workers to interview all collateral contacts, such as schools, neighbors and other service providers to inform their assessment;

- ❖ Poor link between assessment and case planning – There is confusion about how workers can use the results of risk and safety assessments as the basis for planning with families about the services that will help them keep their children safely at home (or have them returned home more quickly). Rather, workers are looking more narrowly at protective plans that deal with imminent dangers, not the broader issues that might be putting children at risk;
- ❖ Failure to re-assess risk – Best practice in risk and safety assessment stipulates that it is most effective if it is an on-going process, with risk being re-assessed continuously during the life of a case. Denver workers do not appear to be uniformly re-assessing risk as they continue to work with a family. This could be due to caseload pressures, as well as lack of guidance about best practice in this area. Re-assessment of risk is particularly important in voluntary cases where there is no on-going court involvement and monitoring.

## 2. Voluntary Cases

Historically, Denver County has experienced a large number of dependency filings that have created strains on already overwhelmed court systems and subjected families to unnecessarily intrusive actions by both courts and agencies. As a result, during the process of an assessment of a child welfare referral, Denver has relied in recent years on “voluntary cases” or “voluntary agreements,” in which families with lower levels of risk can voluntarily work with the agency to resolve the issues that brought them to the attention of the child welfare agency. In theory, voluntary agreements help families avoid adversarial child protective services investigations, as well as time consuming court processes. Because they are voluntary, it is believed that families generally feel more supported and are more likely to engage in the services needed to help stabilize their family situations. Voluntary cases work if families can indeed access the services and supports needed to keep their children safely at home or with extended family members.

The perception is that voluntary cases are generally closed earlier than court involved cases, which can take up to a year to close. Workers and supervisors generally have discretion about whether or not to close a case based upon a family's compliance with the service plan. Some children in voluntary cases are still living in the home, although increasingly, parents are placing children with relatives to avoid state custody, which is referred to as a voluntary placement.

The move to voluntaries in Denver is consistent with a national movement to develop an alternative or differential response to traditional child protection practice. According to the American Humane Association and the Child Welfare League of America, 15 states and several counties are in different stages of differential response initiatives. In California, differential response is a key component of statewide Child Welfare Redesign. In Minnesota, Family Assessment Response was first initiated as a pilot in 2000, and implemented statewide by 2005. Evaluations have found that families who receive a family assessment response have fewer subsequent child maltreatment reports, receive more services, and were more satisfied with the intervention. The evaluation also documented cost savings. Costs per family were \$1,300 less than for those in the traditional investigative approach.

### **Findings Related to Voluntary Cases**

There is a general perception among court personnel and law enforcement that the process for oversight and monitoring of voluntary agreements is not going well. The use of voluntaries is one of the most contentious issues in the relationship between the courts and DDHS, and will continue to stand in the way of a more effective partnership.

The biggest issues that surfaced during this review are as follows:

- ❖ Lack of clear guidelines – There does not appear to be a clear understanding of the conditions under which a case becomes voluntary. The guidelines reviewed were relatively non-descriptive and vague.<sup>1</sup> Confusion also exists about how voluntaries are handed off from intake to on-going, and how that coordination should occur;
- ❖ Confusion about the difference between voluntary cases and voluntary placements – There is a perception that many of the cases that are voluntary are actually placements with relatives who receive very little support or monitoring, and involve children whose parents are unlikely to receive reunification services. There are many questions about whether or not voluntary cases are actually being “dumped” on relatives with no way to assess child safety;
- ❖ Skepticism about motivation behind voluntary agreements – In general, courts do not believe that parents with voluntary agreements are receiving the services they need, and that they’re being used to avoid court involvement rather than a true belief that families do better under voluntary agreements;
- ❖ Confusion about how the risk and safety tool relates to voluntaries – The decision about whether or not a case is voluntary does not negate the need for on-going risk assessment. Even though it may appear that danger to a child is no longer an impending factor, risk assessment can be the basis for decisions about whether or not a case becomes or remains voluntary. DDHS workers should continue to assess risk once a case enters voluntary status;

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<sup>1</sup>The review team has reviewed new policy regarding voluntary cases, but does not believe the new policy provides sufficient guidance to the field about how to assign or monitor these cases, nor is it clear how a case moves from voluntary to court monitored based upon on-going assessment of risk and safety

- ❖ Lack of data to assess effectiveness – The lack of clear data to guide decision making about the use of voluntary cases was disconcerting to the Review Team. The data do not indicate the types of cases that become voluntary, if children in voluntary cases are coming back into the system, whether families in voluntary cases are stabilized and have access to services, if voluntary cases are being reevaluated for court intervention, and the like. As a result, courts only see or hear about the failures of the voluntary system, not the successes.

### 3. Kinship Care

Federal, state and county policy all reinforce the importance of finding extended family members for children who are in need of placement out of the home. Research confirms that kinship placements are more stable than those with unrelated caregivers, are more likely to enable siblings to stay together, and allow children to minimize the disruption and trauma they experience when placed outside their own homes.

Kinship placements can also be problematic, however, when caregivers are not provided with a level of support that is adequate to meet the needs of a child. Many kinship caregivers are older grandparents who are retired and living on fixed incomes. Others are raising children of their own and did not anticipate taking another family member into their home. For this reason, kinship supports and services are critical to ensure that children are able to live in a safe and nurturing environment.

In Denver County, kinship placements have risen dramatically over the last three years, following a state and national trend to find extended family members who can care for children when their parents cannot. The County has been particularly aggressive at finding family members who can care for children living in shelters, residential placements or group homes. Many families in Denver are also encouraged to voluntarily place their children with kinship caregivers to avoid extended child protection investigations and court involvement. This practice has become more common with the use of voluntaries. DDHS has also recently begun to provide some kinship caregivers with a kinship incentive, making it easier for them to meet the needs of the children in their care.

## Findings related to kinship care

The 3<sup>rd</sup> party review reveals problems with kinship placements that are reflective of kinship challenges in other counties in the state, as well as in other states. These problems fall into two categories: (1) lack of support for children who are placed with kin who do not become licensed foster parents, and (2) lack of information for all kinship caregivers to guide their effective care of the child.

- ❖ Lack of support for non licensed kinship caregivers – Kinship caregivers who do not become licensed, or who are caring for children whose families are in voluntary cases, are in a limbo status and do not feel well supported by DDHS. These caregivers are not provided with foster care subsidies, but rather have access to a kinship subsidy that is equal to the TANF rate, which is \$99 a month for one child, with incremental increases for each additional child, as well as an incentive payment. Although the kinship incentive is a valuable benefit, many of the caregivers are receiving no financial support at all because they are unaware of the benefit. Placing children with unlicensed relatives, while not providing those relatives with adequate financial support is unacceptable practice. It is also unacceptable that in many cases, the County is and failing either to supervise those placements or to ensure judicial review if risk to the child begins to elevate.
- ❖ Lack of access to information for informal caregivers – Caregivers report that while financial resources are important, equally important is access to information about their role and legal relationship to the child, support in terms of nurturing the child's relationship with his or her parents, and services available in the community for the child. It is also unclear whether the parents of children living with kin are getting any reunification services and the extent to which the children are going back home, staying with kin in an unknown legal status, or re-entering the system at a later date. Furthermore, the Review Team believes that because county policy does not actively promote that kin become licensed, many are not aware that this is an option which would enable them to access greater financial

- support and more services. In general, this is a group that needs much better support from the Department to fulfill their care-giving role and to ensure safety of the children in their care.
- ❖ Lack of information for licensed kinship caregivers – In general, the review found that licensed kinship caregivers feel better supported financially while the children are in care because they are receiving the same subsidy as non-related foster parents. They also, however, feel they are not given enough information about the status of the family's case, their role as a foster parent, and the child welfare process in general. This is particularly true when it came to adoption. Adoptive kinship caregivers feel they were not given enough information about the true implications of adoption and that once they finalized the adoption, they were isolated and left without assistance to care for the child.

#### **4. Team Decision Making**

Team decision making is one of the four core strategies being implemented by Denver County as part of the Annie E. Casey Foundation's Family to Family Initiative. The goal of team decision meetings is to provide families with an opportunity to take leadership in planning for their children's safety and to ensure that everyone involved in the family's life has an opportunity to support the family to keep children safe. Team decision making is one among many models that is embraced nationally as a way to provide parents, youth and their support systems with a greater role in decision making about children's safety.

Ideally, team meetings occur at every critical decision making point, including prior to placement, when placement changes occur, and prior to reunification or another permanency goal. Team meetings are held at times that are convenient for families, and families are encouraged to invite anyone who can support them to achieve the goals of their safety plans, including relatives, neighbors, friends, and clergy. Representative from other systems serving the family may also attend.

Denver County has embraced team meetings as a way to improve decision making for families and provide a more coordinated and

collaborative intervention on behalf of children. The County has a core group of 6 team decision making facilitators who are well trained, highly skilled, and consistent in their approach to team meetings. These facilitators oversee an average of 210 TDMs a month. Denver County is to be commended for taking this innovative approach to engaging families and making it a routine part of decision making, not the exception.

### **Findings related to team decision making**

Despite the positive momentum with team decision making, the 3<sup>rd</sup> party review reveals some problems with implementation of the model that will need to be addressed for TDMs to continue to be an effective decision making vehicle for families:

- ❖ Overuse of TDMs – Attorneys and workers alike feel that TDMs are being held for non safety and placement related decisions, and are becoming overly time consuming and not achieving their goals. Examples given include meetings that are held to iron out visitation issues and custody disputes. This overuse of TDMs is causing “meeting fatigue” and confusion about the original intent of the meetings.
- ❖ Decisions not actually being made at TDMs – There is a widespread belief that in many TDMs, decisions about placement have already been made by administration or supervisors and not at the TDM table. Clearly, if the original intent of the TDM is to have the entire team develop a safety plan for the child, the perception that decisions have already been made is of great concern.
- ❖ Role of the Placement Evaluation Team (PET) in TDMs – There is also a perception among attorneys and court staff that the PET often denies services or placement decisions that are planned for in TDMs. Although the only authority the PET has is to review residential and congregate care referrals, if this is done after the TDM, then the original intent of the TDM recommendation is often lost.

- ❖ Role of lead child welfare management – A number of interviewees expressed concern that there is no regular process for the facilitators or the workers to discuss practice and/or policy issues that consistently arise during the course of the hundreds of TDMs. A valuable opportunity to assess consistency and quality of practice is missed when the TDM facilitators do not have a regular opportunity to discuss concerns with management.

## 5. Court Collaboration

Over the last decade, there has been increasing attention to the relationships between courts and child welfare agencies and how they can work more effectively together to improve child welfare outcomes. Recognizing that the courts have ultimate decision making about the fate of abused and neglected children, and provide an important oversight role on their behalf, the child welfare field has put the relationship between the two entities in a greater spotlight. The federal government has recognized this critical relationship by supporting Court Improvement Plans, which provide funding to every state to assess judicial processes for abused and neglected children and make needed improvements. Private funders such as the Pew Charitable Trusts have also invested in stronger state leadership to strengthen the role of courts and the relationship between courts and agencies.

In Denver, there is a strong recognition of the historical tension between the Denver Juvenile Court and DDHS. In recent years, both organizations have taken steps to improve this relationship. With funding from Denver Human Services and after a request to increase collaboration, the Presiding Judge of Denver's Juvenile Court, on behalf of the court, their two judges and three magistrates, hired a court liaison position to facilitate stronger collaboration. In addition, the Presiding Judge and the DDHS child welfare director have been meeting monthly, trying to identify key challenges between their organizations and make needed improvements. Denver County is also implementing one of three Model Court Programs in the state to improve its court processes. Denver County is focusing its Model Court project on providing a stronger voice for youth in court

hearings and on the needs of older youth, particularly those who leave the system with no permanent home.

### **Findings related to court collaboration**

Despite the efforts above, the Review Team finds that the relationship between the Denver Juvenile Court and DDHS can only be described as tense. There is a strong perception on both sides that court-agency relationships are at an all time low. Unfortunately, these tensions override any positive steps each of the institutions has taken to better serve children and families.

From the Review Team's perspective, the whole system leaves the impression of well-intentioned people on both sides, reacting to gut-level feelings about what families need. Unfortunately, individuals on both sides are either under-informed or inarticulate about the standards and tools which should be applied to decisions about how to intervene with families. Hence, legal personnel don't seem to struggle with the balance of reasonable efforts requirements and ensuring safety but simply react to the fact and duration of voluntary cases. By contrast, DHS personnel do not justify their practice with data showing successes or with protocols that provide assurances of a logical framework for making case distinctions.

From the court's perspective, there are major trust issues that stem primarily from DDHS' belief that the courts do not share their philosophy. Court personnel feel that DDHS thinks the court is overly intrusive in the lives of families and too quick to place children out of the home. As a result, the perception is that workers do everything they can to avoid court involvement and have little respect for the court's authority. In the meantime, the court enters into the practice of social work from the bench.

From the DDHS perspective, courts and the agency are completely out of alignment. Workers and supervisors feel that courts do not trust worker judgment and are too quick to overturn decisions that have been made by workers and their supervisors, as well as TDM decisions. Staff at Denver Human Services believes that recent critical comments from retired court staff in the media and media being present in the courtrooms are also

illustrative of an overall distrust from the courts toward the workers. Court treatment of workers was described as “demeaning.” Workers are also critical of the range of things magistrates order them to do and feel that magistrate orders have become unreasonable. Examples provided include orders to obtain DMV records and proof of insurance for parents who transport children. Finally, workers do not feel they have internal support to manage their relationship with the courts. They noted in particular the feeling that the Department’s legal department, whose primary client is the agency, does not adequately represent their point of view in court.

Issues causing conflict that surfaced repeatedly include:

- ❖ Voluntary agreements – Courts believe these are being inappropriately overused by DDHS as a way to avoid court involvement. They are also frustrated by the lack of data to support the idea that voluntary cases are safe and stable. This issue is described more fully above.
- ❖ Placement Evaluation Team (PET) – The PET consistently meets to make decisions about youth placement after the court has already made an order. Court personnel are concerned about the lack of alignment between PET decisions and court orders and in general, about the extent to which the process keeps changing. They are also concerned that the PET is doing work that could be accomplished at the TDM.
- ❖ Worker issues – In general, court personnel and attorneys felt strongly that workers are not prepared for court and are not receiving adequate supervision. They often have trouble articulating agency practices and protocols, particularly in relation to new practices such as TDMs and the PET, and in general are poorly prepared to articulate their point of view to the courts.
- ❖ Attorney issues – County attorneys are equally frustrated over the fact that workers are unprepared in court and do not seem to be able to manage court processes.

## 6. Community Collaboratives

In 2004, Denver created seven community collaboratives in neighborhoods in which there are high concentrations of families with whom the County works. The purpose of the collaboratives is to serve as a focal point for coordination of service delivery and advocacy on behalf of families in the neighborhood, and to promote greater community responsibility for child protection. Community child protection is a growing national trend that grows out of the recognition that community-based solutions are critical to ensure child protection, and that public child welfare agencies cannot work in isolation of the communities in which families live.

Community collaboratives in Denver are funded primarily through reinvestment of funds that were previously spent on high end residential placements, including shelter placements. A combination of funding streams supports the development of the collaboratives, including Human Service funding streams. . The collaboratives have a contractual agreement with the DDHS to provide needed services. Contracts are awarded to each community collaboration based on their response to a county request for proposals and performance outcomes are regularly monitored by DDHS.

The collaboratives differ in their organizational structure and scope, but in general consist of a network of private provider agencies, churches, neighborhood groups, and other indigenous organizations. The networks serve families in whose children are still living at home. They also support children in state custody with the provision of mental health and visitation services. Many of the Team Decision Making meetings are held at community collaborative sites.

### Findings Related to Community Collaboratives

In general, workers and supervisors feel that the community collaboratives are a positive addition and that they are beginning to enhance community

involvement in child protection. There is widespread agreement, however, that the quality of the community collaboratives is uneven. Some are not as responsive as they should be and have trouble accessing the services and supports families need. In some, there is not adequate staff to supervise visitations. Turnover in some of the collaboratives is cited as a particular concern. Overall, the general sense is that community collaboratives have high potential for contributing to better communication and coordination, but they have not yet realized that potential in most sites.

From the community collaborative perspective, a significant problem is the lack of worker presence and involvement in the networks. Community collaborative staff worry that DDHS is “dumping” families at their door without a clear sense of the issues that need to be addressed to ensure child safety and sometimes with little follow-through from DDHS. In essence, community collaboratives are seeking a tighter connection with DDHS workers and supervisors to ensure they are working together toward common goals for families.

## **7. Organizational Challenges**

When children with whom a child welfare agency has had contact die, it is not uncommon for the morale of an entire organization to suffer tremendously. Workers, supervisors, administrators and court personnel often second guess themselves, and the media scrutiny can be overwhelming and unnecessarily intrusive. For instance, some DDHS agency staff have reported being accosted by a reporter as they stepped out of their cars, at their homes, or left public buildings. Individual workers’ names have also been in the headlines and included in recent stories. For an organization whose mission is to protect children, a child fatality can be a devastating event, causing each and every individual in the system to question what they could have done to prevent the tragedy from occurring.

No organization bounces back immediately after such an event, but child welfare organizations can do many things to build the strength of their organization back to a well functioning level as quickly as possible. These

include having a strong child fatality review process to learn from the experience, creating a sense of teamwork to support each other and make changes needed to prevent future tragedies, and having strong communications mechanisms so that management and workers can communicate effectively with each other and with the public about what has happened and how to deal with it.

## **Findings Related to Organizational Challenges**

In Denver County, which has suffered from these tragedies in the past 9 months, the Review Team finds that morale over the loss of children is at an all time low. Prior to these events, many frontline workers were excited about the practice changes taking place and energized by the spirit of innovation that they believed was making a difference for families. A recent satisfaction survey conducted by the City showed high satisfaction rates among DDHS staff. Since the fatalities, however, the organizational culture has, in the words of several interviewees, “gone downhill”.

In general, frontline workers that work with children and families do not feel they have received the internal support needed to deal with the tragedies of the past year. At every turn, workers feel their judgment is being questioned and that they are powerless to help the children and families they serve. Workers feel that their decisions are questioned by administration, by the courts, or by the Placement Evaluation Team. They further feel they are not supported by their own attorneys in court.

Compounding this feeling of powerlessness is the sheer number of cases with which they have to work and the sense that they are not doing enough to help fragile families. Workers who have been trained as social workers feel that when their caseloads get too high they are being encouraged to be case managers, not social workers. High caseloads are not just a function of too many families to work with, but the requirements that are added on as a result of each tragedy (i.e. responding to all school reports) and the constant promulgation of new policies that are not well communicated to the frontlines. Workers also perceive that management is looking over their shoulders and are concerned that no matter how much work they do, it is not enough to protect themselves from a future

tragedy. These morale issues, ultimately, contribute to already high turnover levels that leave the agency short staffed, unresponsive to key constituents, and in a constant cycle of training and caseload caps.<sup>2</sup>

Low morale has also been exacerbated by the child fatality review process itself and a perception that the review process is slow and not well communicated across the agency. Since the first fatality, some changes have been made to the child fatality review process and they are an improvement over previous practices. The responsibility for child fatality review is now with the Quality Improvement unit rather than where it had been, within the child protection units. As each fatality review completes its investigation and new understanding is gained about what went wrong, results can contribute to building the organization's strength and resilience back to previous levels.

The Review Team also finds that the DDHS management team is not structured as effectively as it could be to absorb the on-going challenges of a crisis driven organization, and to communicate effectively with the frontlines. Problems with the existing structure include:

- ❖ Division director overload – DDHS has seven units that report directly to one manager. The Review Team believes that it is difficult to manage and communicate effectively without a more robust management structure
- ❖ Lack of cohesiveness in the management team – The Review Team finds that the management team (heads of each of the units) is not functioning effectively as a team. Much more needs to be done to create a cohesive management philosophy and direction, which in turn can filter to the frontlines. The team also

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New workers, those who have been fully trained, have a caseload cap of 10 for the first six months. This leaves other workers carrying additional cases because new workers can not, and also minimizes the time that workers and supervisors have to mentor new workers. The Review Team heard consistent complaints about the lack of on-the-job training, and little opportunity to shadow more seasoned workers

- heard many complaints about lack of mentoring and coaching skills within the line supervisory staff.
- ❖ Problems with handoffs from one unit to another – Workers consistently mentioned the lack of effective handoff from intake to CPS to on-going workers. A more streamlined handoff system in which workers do face to face handoff of cases is needed. This is particularly important given the fact that new assessments requiring intake investigations have risen close to 60% over the past two years. The importance of careful transfer of case information during this time of increasing caseloads cannot be overstated.
  - ❖ Structure of the Youth Services Division – The artificial designation of 12 and over cases does not function well in a child welfare organization and is at odds with fundamental goals of DDHS to work with families and keep siblings together. This structure results in families with multiple children being split between divisions, and these workers also expressed concern about accessing adequate services for youth.
  - ❖ Turnover due to transfers to non case carrying jobs – While we have not yet been able to quantify the extent to which this is occurring, many workers and supervisors indicate that workers jump to non case carrying positions as soon as possible, which may result in higher pay if the position is promotional and which are generally viewed as less stressful. The result of this is that there are temporary spikes in existing caseloads as the remaining unit staff cover the cases that are left.

## 8. Parent and Youth Involvement

Caseworkers serve as all important lifelines for parent and youth consumers of the DDHS. The parents and youth the Review Team met expressed deep concern about the uncaring, judgmental, and hostile caseworkers with whom they have had interactions. In general, they did not report having caseworkers who had helped and supported them. All reported difficulty accessing services and most seemed unaware that

there is a process for them to participate in regarding decisions being made about them, especially the youth.

Court involvement is also a negative experience for parents and youth. Court involvement is not perceived as ensuring better services or more access to caseworkers. When asked where they might go to make suggestions or complaints about the Department, none knew where to go. Neither parents nor youth participants believed that they had a meaningful voice in what happened to them. This is of particular concern with the older youth who will soon emancipate from the DDHS system.

## RECOMMENDATIONS

### 1. Risk and safety assessment

Our third party review finds widespread problems with the existing risk and safety assessment tool, which de-emphasizes risk and replaces it with an assessment of “imminent danger” to the child that might be missing important markers for future abuse or neglect. We recommend that Denver County immediately re-evaluate how risk and safety assessments are conducted and take the following steps:

- ❖ At the top management levels, clarify that Denver County will use a risk and safety assessment process that:
  - Examines both risk and safety factors in the home;
  - Assesses “present and impending danger” to a child for decision making purposes, but not to the exclusion of examining risk factors that are predictive of abuse and neglect;
  - Ensures that workers interview all members of the household (especially significant others) and collateral contacts, including other agencies, family members and neighbors;
  - Promotes a connection between the findings of the assessment and case planning with the family;
  - Re-assesses risk throughout the department’s involvement with the family, including on voluntary cases;
- ❖ Coordinate findings of this 3<sup>rd</sup> party review with state review of risk assessment protocols. The state is currently reviewing its risk assessment process and Denver County should ensure that state actions to improve the assessment process are coordinated with the needs identified above;

- ❖ Work with the State to train all workers, supervisors, and other constituents (courts and attorneys) on a risk and safety process;
- ❖ Ensure that a new case review system (see below) closely monitors the effectiveness of risk and safety assessment in planning for child safety and is able to identify when improvements in the process are needed.

## 2. Voluntary cases

DDHS' practices regarding families who enter into voluntary agreements are causing significant strains between the public child welfare agency, the courts, and attorneys. The philosophy behind voluntaries is sound: to enable families at lower levels of risk to engage in voluntary services that can meet the needs of families in the community without overly intrusive agency and court involvement. Unfortunately, the policies and protocols that support this practice are not well articulated. Given the tension that this practice is creating in the system, we recommend that the County promulgate policy on use of voluntary agreements to:

- ❖ Clarify when voluntary agreements are appropriate;
- ❖ Articulate how risk and safety assessments can guide decision making about which families become voluntary cases and how risk and safety can/will be re-assessed throughout the department's involvement with the family;
- ❖ Clarify the difference between voluntary agreements and voluntary placements;
- ❖ Articulate how voluntary cases in which children are living with kin will be supported financially and with an appropriate level of oversight;
- ❖ Clarify circumstances under which a voluntary case turns into a court monitored case; and

- ❖ Ensure that appropriate oversight and monitoring of voluntary cases is in place.

It should be noted that as Denver develops new protocols for voluntaries, they can learn from the differential or alternative response initiatives referenced earlier. Materials developed in support of these initiatives, including protocols for assigning cases and protocols for changing the status of the case might prove informative.

We further recommend that the County does the following:

- ❖ Develop a plan for using existing and new data on voluntary agreements to more systemically track outcomes. This includes an effort to show how successful voluntaries are working to keep children safely at home and to look for common elements of successful approaches. The County can also track re-entry rates for voluntaries and examine the factors that led to re-entry. DDHS currently has a low rate of repeat maltreatment rate of 2.7%, which is considerably lower than the Federal Standard of 6.1%. Regularly reporting this kind of successful outcome to key stakeholders (i.e. court personnel) will show success in this area. Finally, the county can track when voluntaries move to court involved cases and reasons for change in status; an
- ❖ Develop a case review system that allows DDHS to review practices related to all cases, including voluntaries. As DDHS develops a new plan for regularly reviewing cases, it should develop a clear set of standards for assessing voluntaries, including the adequacy of the assessment process, services needed and whether or not they were received, and the extent to which the case “fits” the voluntary framework. DDHS has reviewed the ChildStat process in New York City that allows for continual case reviews. A system similar to ChildStat will help ensure that the system has built in quality assurance mechanisms across the system and can identify when practice is not consistent with agency philosophy, both on an individual case and systemic level.

- ❖ Build in mechanisms for staff to be more involved in community collaboratives. Community collaboratives have the potential to more systematically meet the needs of voluntary families, but agency staff must be involved in building relationships with community collaboratives so they can better understand the needs of their families. A closer alignment between the issues presented by voluntary cases, the services being coordinated by the community collaboratives, and the oversight, safety and risk assessment of agency staff will help build a stronger network of support for these families than currently exists (see recommendations for strengthening this connection below). The County can also provide forums for community collaboratives and the agency to jointly determine what is and is not working with regard to successful outcomes for volunteers.

### 3. Kinship Care

The active use of kinship placements in Denver has been critical to the County's success in keeping children out of foster care, providing support for parents in voluntary cases as they work out the issues that brought them to the attention of the system, and allowing children to stay connected to their family and culture. The kinship incentive for kinship families accessing TANF payments is also a positive development. For kinship care to work most effectively to achieve better child welfare outcomes, however, children living with relatives need support, oversight and monitoring to ensure their safety and well-being. The following steps will help Denver County make the most of their kinship system:

- ❖ Develop a Kinship Support Unit or Kinship Contract to Meet the Needs of Kinship Caregivers – The use of kinship care has increased significantly in Denver County, but with the exception of the kinship incentive payment, the County has not in turn responded adequately to meet the unique needs of caregivers. We recommend the development of a kinship support unit – either internal to DDHS, with a private provider or within a community collaborative – that can assess the capacity of kinship families to care for children; educate kinship caregivers on their role and the

- legal implications of their decisions; help caregivers access financial support and services for the children; and provide an appropriate level of oversight to kinship families. Many agencies have created this internal capacity – or contracted with private providers – to ensure that caregivers get the help they need to ensure child safety and prevent re-entry.
- ❖ Develop a kinship care working group to (1) streamline the process for kinship caregivers to become licensed foster parents for children in state custody; (2) articulate the supports and services needed by kinship caregivers who are caring for children under voluntary agreements; (3) for all kinship caregivers, develop processes to ensure timely provision of financial and other supports; (4) develop written materials to educate caregivers about their roles and responsibilities, as well as the financial and legal implications of their involvement with DDHS.
  - ❖ Reinvigorate the Connections Initiative with paid agency staff and/or agreements with community collaboratives to ensure that relatives are found as early in the child welfare process as possible, can participate in Team Decision Making meetings, have an opportunity to play a meaningful role to support the family, and are considered as placement resources when children need out of home care.

#### 4. Team Decision Making

TDM has played a powerful role in Denver’s efforts to prevent the need for foster care, and to conduct a thorough discussion of placement issues if placement is the only viable option to keep a child safe. The TDM also provides an opportunity for families to be active participants in safety planning for the child. Unfortunately, Denver is overusing TDMs for purposes that do not meet the original intent of the TDM model. We further believe that the County has not been diligent enough in efforts to communicate accurate information about this practice to external key stakeholders.

We recommend that DDHS rearticulate TDM policy to:

- ❖ Affirm the intent of TDMs as crucial to the placement decision making process and ensure that the TDM team, and not an administrator outside of the process, is actually making all TDM recommendations;
- ❖ Provide refresher courses for TDM facilitators, workers, supervisors, attorneys and judges on the TDM process;
- ❖ Provide a “gate-keeping” mechanism to ensure that TDMs are not held for non-placement related issues, and create due process for all stakeholders who are concerned about individual or collective misapplication of the TDM concept (including whether or not decisions are truly made at TDM table).

## 5. Court collaboration

Many steps have already been taken to improve the relationship between the Denver Juvenile Court and DDHS, but the recent fatalities and practices around voluntary cases have renewed tensions between the two entities. We believe that by taking joint action to tighten up protocols and policies around the use of voluntary cases, DDHS can help to bridge current gaps and continue on a path of better working relationships. Developing consensus on how to re-assess voluntaries on a continual basis to determine if court oversight is needed will also help.

Other steps that can improve working relationships include:

- ❖ Clarify the roles and responsibilities between DDHS and the courts, the Placement Evaluation Team, and the Team Decision Making teams and develop a joint working agreement for ensuring those roles and responsibilities are respected. Current practice indicates that there is a high level of duplication and high frustration levels when the processes are not working in support of each other’s goals. These processes should be more clearly articulated, with roles and responsibilities more clearly outlined, with an eye toward a more integrated, less redundant process. This will also help to eliminate concerns regarding whether or not DDHS respects the authority of the Court.

- ❖ Conduct training and education by attorneys for workers on court preparation. A major source of tension is that judges, magistrates and attorneys do not believe that workers are well prepared for court. Intensive support to workers should be provided in the form of educational forums, trainings, brown bag lunches and the like so they can feel more competent with court preparation and in turn, feel less threatened by the judges and attorneys when they appear in court. The County should also assess whether current training is adequate, and whether there is sufficient supervisory support for court preparation to ensure that workers adopt best practices conveyed in training.
- ❖ Examine accountability mechanisms around key activities such as completing court reports. The County should consider ways that supervisors can evaluate worker's performance in court and hold them accountable for timely court reports.

## 6. Community collaboratives

The Review Team does not find major problems with community collaboratives, but rather believes they are not yet realizing their full potential at this time. Community collaboratives should be given more time to develop the network of services and supports families need to stay out of foster care; to develop a strong cadre of workers who know the community and can advocate for families for what they need; and to develop stronger working relationships with DDHS staff to ensure that families are not being “dumped” with the collaboratives, but rather DDHS and the collaboratives are working together to resolve risk and safety issues.

Toward this end, we recommend the following:

- ❖ Plan a summit for DDHS workers and community collaboratives to come together and brainstorm about ways to work more closely together. The summit should also involve families and youth to ensure that their voices are part of the solutions;

- ❖ Out of the summit, develop a set of written expectations from DDHS for the roles and responsibilities of DDHS and community collaboratives with regard to joint planning for families; and
- ❖ Showcase the work of community collaboratives, new services and networks developed, and family success stories through an on-line newsletter.

## 7. Organizational Challenges

The Review Team believes that the current morale issues internal to the organization must be addressed proactively in order to move forward in a positive direction. Many of the challenges the organization is currently facing are the result of the stress people are feeling with the high level of scrutiny as a result of the fatalities. Workers are overwhelmed with the perception that they are working in an overly punitive environment, as well as the changing policy directions that they do not feel are well communicated; managers feel the pressure of responding to public and media criticism that they are not doing enough to keep children safe; and communication between the two entities has suffered tremendously. To get back to more trusting relationships that will allow DDHS to move forward, we recommend the following:

- ❖ Restructure and reinforce a unified management team – We recommend hiring a second Division Director so that there are two directors overseeing the seven units that are responsible for child protection. With this change, DDHS has an opportunity to create a management team that can work together from a unified position to affirm and realize the mission and vision to protect children and preserve families. Restructuring can be supported by some concrete efforts to promote leadership development for members of the management team as well as at the line supervisor level, and to create more effective working relationships between units. It should not be left solely to the management team to provide oversight for new reforms. DDHS can learn from the recent experiences of New York City's Children's Services that having line supervisors who understand new practices, can model them

- for staff, and will hold staff accountable for mastering new skills is essential.
- ❖ Structure a more effective response to the needs of youth – The 12 and over structure was established to enable staff to meet the unique needs of youth, but has unintentionally led to a bifurcated system in which youth may be assigned different caseworkers than their siblings and do not always have access to the services needed to meet their needs. We recommend that DDHS develop a more efficient and effective way to meet the unique needs of youth that is driven by an assessment of their needs rather than by age category and enables all on-going workers to have access to youth expertise that has been developed;
  - ❖ Develop a communications plan – Many of the morale issues currently plaguing DDHS are the result of poor communication between management and frontline workers, as well as misunderstandings between DDHS, their community partners, the courts, and the public in general. As a result of these communication gaps, there are many misperceptions about motivations and behaviors that permeate the organization and get played out in the media. We recommend the development of a comprehensive communications plan that can support DDHS efforts to communicate more effectively internally and externally as it makes future changes to improve outcomes for children and families.
  - ❖ Develop a more responsive Child Fatality Review process – In the past, Denver has conducted child fatality reviews from within the units in which the fatality occurred. These review processes were plagued with mistrust, fear, finger pointing and blame. DDHS has since changed this process so that the Quality Improvement (QI) unit is responsible for the reviews. This is a positive development, and presents the QI unit with an opportunity to craft a review process that is less adversarial than in the past. We recommend putting together a working group of workers, supervisors and administrators who can help develop a new review process that

has built in integrity and trust, and can maximize opportunities for the organization to learn and make positive changes for future practice.

- ❖ Appoint a Retention Workgroup – The Review Team is confident that many of the recommendations above will help restore confidence and trust between management and frontline workers so that they can move forward toward a common mission on behalf of children and families. Nevertheless, it is clear that turnover and low morale will continue to challenge the organization without some intentional efforts to deal with retention, and to develop some more effective working relationships together. We recommend the development of a retention workgroup made up of workers, supervisors, administrators and human resources that can examine the policies and practices that fuel turnover, and recommend some changes to more proactively retain workers in those frontline positions. These issues include, but are not limited to: stronger supervision, compensation policies (i.e. creating greater equity for case carrying and non case carrying positions), working relationships across units, etc.

## 8. Parent and Youth Involvement

As DDHS moves to improve its service delivery system it is important to provide regular opportunities to hear from the parent and youth consumers of the system. Recommendations for improving parent and youth voice in the system include:

- ❖ Develop an effective system so that birth parent and youth consumers can advocate for their needs, and ensure that the information about how to access the system is widely publicized and made available to all birth parents and youth who are consumers of DDHS services;

- ❖ Monitor and enforced caseworker responsiveness to youth on their caseloads to ensure regular visits, good relationships with foster families, opportunities for youth to voice questions and concerns, etc; and
- ❖ Establish a youth advocacy group to mentor youth still in the system and to provide advice and coaching regarding practice change.

## CLOSING REMARKS

The Review Team hopes that the recommendations outlined in this report will help DDHS develop the understanding it needs to move forward on behalf of children and families. Few things are as important to the mission of DDHS as re-building public confidence in its ability to protect children.

DDHS will also need additional resources to implement these recommendations. Some things can be done without spending more money, and will simply require investments of time and energy to build better relationships and think even more creatively about how to do better. Yet many things, including better support for kinship caregivers, training for caseworkers and courts on new policies, building management capacity, and building better data systems will require investment of money. The Review Team hopes that these recommendations can help DDHS build the political will among its many partners, including the city, state, county, federal government, foundations, and other private partners to support its efforts. In this way, protecting children can go from being the sole responsibility of one agency to a collective concern about safety, permanency and well-being.

## **3<sup>rd</sup> Party Practice and Policy Review Denver Department of Human Services**

### **FOCUS GROUPS AND INTERVIEWS CONDUCTED BY REVIEW TEAM**

Focus groups and individual interviews were conducted as part of the 3<sup>rd</sup> party review of Denver's policy and practice. A cross-section of Department staff and managers and groups of internal and external stakeholders were interviewed during the months of December, 2007 thru February, 2008.

The focus groups and interviews provided the reviewers with invaluable insights and information regarding internal and external understanding of the work of the Department's numerous Child Welfare units.

The following is a list of the focus groups that were conducted:

- DDHS Director, Family and Children's Division Director, and the Family and Children's Administrative Team
- Child Protection Intake Supervisors
- Child Protection Intake Staff
- Child Protection Ongoing Supervisors
- Child Protection Ongoing Staff
- Youth Services Supervisors
- Youth Services Staff
- Denver Juvenile Court Judges and Magistrates
- Internal Child Fatality Review Team/Manager
- Hotline Staff

- DDHS Staff Attorneys
- Birth Parents/Consumers
- Youth Consumers
- Kinship Families
- Foster Families
- Foster Care Staff
- In-Home Service Provider Staff
- Crisis Center Attending Physician
- Community Members/Collaborative Members
- TDM Facilitators
- Guardians Ad Litem
- Respondent Parent Attorneys
- Follow-up Focus Groups: Approximately three

Interviews:

- Attendance at Intake Supervisors Daily Case Assignment Rotation
- Law Enforcement
- Denver Public Schools Department of Social Work
- DDHS Court Liaison

- Follow-up interviews with individual DDHS Managers
- Selected data review with DDHS Quality Improvement Manager
- Denver Mayor Hickenlooper and Chief of Staff Kelly Brough,
- Board of Denver Human Services
- Individual staff at Colorado Department of Human Services

## Resource List

### **Risk and Safety Assessment**

For an overview of risk and safety assessment and links to other reports and websites, see the federal government's comprehensive child welfare website at:

[http://www.childwelfare.gov/responding/ia/safety\\_risk](http://www.childwelfare.gov/responding/ia/safety_risk)

### **Differential/alternative response**

For an overview of differential response and links to a national survey of differential response programs, as well as numerous evaluations and articles on differential response, see the website of the American Humane Association at:

[http://www.americanhumane.org/site/PageServer?pagename=pc\\_initiatives\\_differential](http://www.americanhumane.org/site/PageServer?pagename=pc_initiatives_differential)

### **Kinship care**

For standards on kinship care practice and other valuable kinship information, see Child Welfare League of America at <http://www.cwla.org/programs/kinship/default.htm>

For state policies related to kinship care see: [www.grandfamilies.org](http://www.grandfamilies.org)

For information on kinship care advocacy, programs and intergenerational approaches, see Generations United at [www.gu.org](http://www.gu.org)

For a guide on searching for relatives at every stage of the child welfare process, see <http://www.childfocuspartners.com/images/RelativeSearchGuide10-15.pdf>

### **Team Decision Making**

For tools to support team decision making practice, see the Annie E. Casey Foundation website at:

<http://www.aecf.org/Home/MajorInitiatives/Family%20to%20Family/Resources.aspx#tools>

### **Court Collaboration**

For a comprehensive set of materials that support court-agency collaborations, see childwelfare.gov at:

<http://www.childwelfare.gov/systemwide/service/collaboration/courts.cfm>

For presentations and handouts from the Children's Bureau's 2007 conference entitled "Fresh Perspectives on Child Welfare Agency Partnerships," see:

[www.agenciesandcourts.com](http://www.agenciesandcourts.com)

### **Community collaboration in child protection**

For examples of community partnerships and an evaluation of a community partnership model, see:

[http://www.cssp.org/center/community\\_partnership2.html](http://www.cssp.org/center/community_partnership2.html)

For tools to support community partnerships as part of the Family to Family Initiative, see:

<http://www.aecf.org/Home/MajorInitiatives/Family%20to%20Family/Resources.aspx#tools>

### **Workforce Development**

For a comprehensive toolkit to support workforce planning, including resources for recruitment and retention, see:

<http://portal.cornerstones4kids.org/>

For presentations and handouts from the Children's Bureau 2006 conference on workforce, see:

[http://www.childwelfare.gov/systemwide/workforce/work\\_dev.cfm](http://www.childwelfare.gov/systemwide/workforce/work_dev.cfm)

### **Parent and youth engagement**

For information on youth engagement, including research on the outcomes for children who age out of foster care, see:

[www.jimcaseyyouth.org](http://www.jimcaseyyouth.org)

For information on how to stimulate peer-to-peer learning for families, see the Powerful Families model developed by Casey Family Programs at:

[www.casey.org/resources/tools/powerfulfamilies.htm](http://www.casey.org/resources/tools/powerfulfamilies.htm)

For resources on youth engagement and peer mentoring from the Child Welfare League of America's Youth Services and Positive Youth Development Department, see:

<http://www.cwla.org/programs/positiveyouth/>

<http://www.cwla.org/voice/0509engaging.htm>

