Colorado Five-Year Family First Prevention Services Plan

SUBMITTED SEPTEMBER 30, 2021

COLORADO
Department of Human Services

Contents

Background, Vision and Approach

Colorado's child welfare system is in the midst of a significant transformation. Over the last several years, there has been an intentional shift to focus on proactively strengthening families through prevention and early intervention strategies, on keeping families together safely, and when necessary, placing children and youth in family-like settings. This redirection has helped reduce deep child welfare system penetration and produced positive change for the state's most vulnerable children, youth and families. Colorado is committed to continuing this trajectory and ensuring that all children, youth and families have timely access to community services and supports that meet their needs and promote safety and well-being.

Colorado's population has grown rapidly in recent years, with a 14.8% increase since 2010. As shown in the graph below, over the last five years (2014-2019), there has been an almost 27% increase in the number of child welfare reports across Colorado, which appears to be driven both by the overall increase in population and by implementation of a statewide Child Abuse and Neglect Hotline. Despite increases in the number of reports, the absolute number of out-of-home placements has remained relatively stable. Additionally, Colorado has decreased the length of stay in out-of-home care, decreased the number of children/youth in congregate care, and increased the percentage of children/ youth in family-like or kinship care.

In February 2018, the U.S. Congress passed the landmark bipartisan Family First Prevention Services Act (Family First). Family First offers an exciting opportunity to accelerate Colorado's progress toward greater investment in prevention services and increased capacity to ensure that, when necessary, children are placed in the least restrictive, most family-like setting possible.

At the same time, Colorado views Family First as an important piece of a broader strategy to further evolve the child welfare system into one that truly improves the safety, permanency and well-being of all children, youth and families through a continuum of community-based prevention services and supports. Colorado's five-year prevention plan reflects this broader vision and is deeply rooted in a strong foundation of practices and principles that have been honed and tailored in Colorado over the last decade.

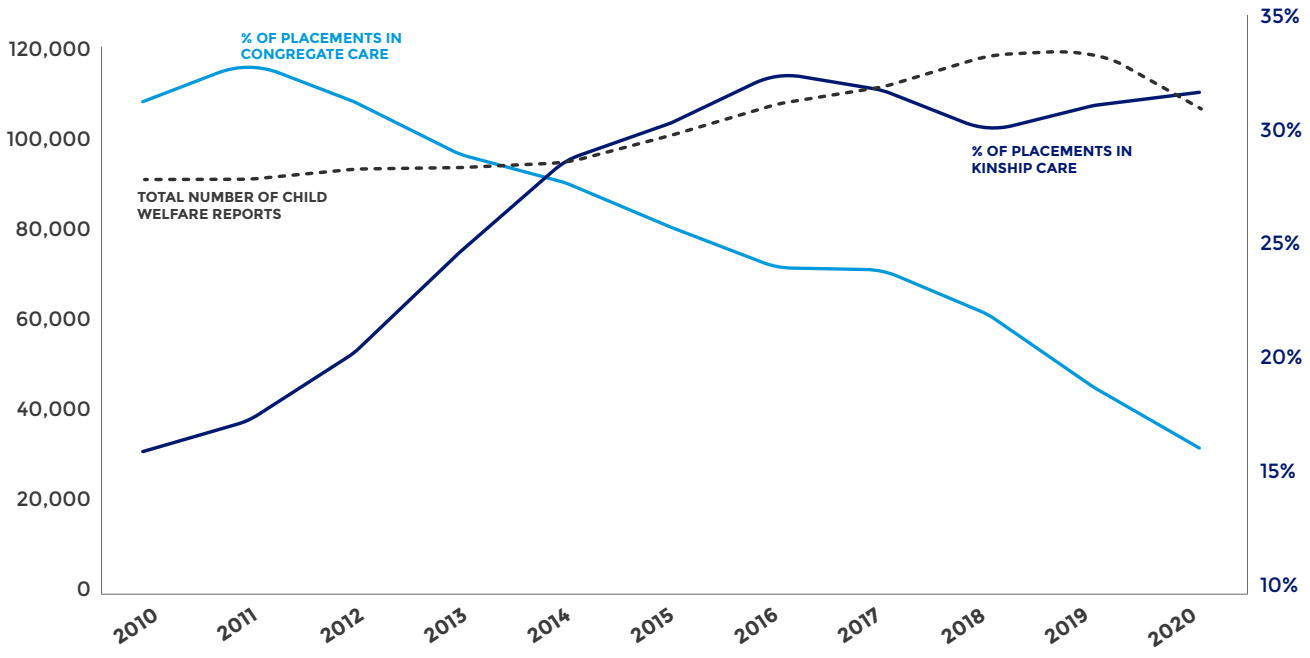

FIGURE 1: TRENDS IN REFERRALS, CONGREGATE CARE, AND KINSHIP

The Vision

Colorado has created a bold vision for a 21st century child welfare system that positively and proactively supports children and youth through strong and healthy family formation with a continuum of community-based, prevention-focused services. While Family First centers on evidence-based secondary and tertiary prevention services,[1] Colorado sees this as one component of a more comprehensive approach to preventing child/youth maltreatment. Thus, while Colorado is fully committed to and engaged in implementing Family First, it must simultaneously focus on activating all points along the prevention services continuum. Critical elements of this strategy include continuing to invest in robust primary prevention efforts, building multi-sector partnerships under a common vision, maximizing Medicaid and Title IV-E reimbursements for effective practices, and utilizing state and local resources to build capacity in evidence-based services. This multi-layered strategy requires leveraging diverse funding streams alongside Family First.

Additionally, Colorado acknowledges this vision cannot be realized through child welfare programs alone. Colorado has approached Family First implementation as a broad systems transformation effort that cuts across multiple offices within the Colorado Department of Human Services (CDHS), including the Division of Child Welfare (DCW), Office of Behavioral Health (OBH), Office of Early Childhood (OEC), and Office of Economic Security (OES). Other state agencies, including the Colorado Department of Health Care Policy and Financing (HCPF) and the Colorado Department of Public Health and Environment (CDPHE) have been essential in ensuring a holistic approach to implementation. And as a state-supervised, county-administered human services system, our 64 county departments of human services have been critical partners in

1 In this context, primary (universal) prevention includes services aimed broadly at the general population (e.g., public awareness campaigns about the scope and effects of child maltreatment, parenting classes, efforts to educate children about safety). Secondary prevention includes services such as home-visiting programs, parenting classes or respite care that are targeted to populations at higher risk for maltreatment. Tertiary prevention includes services for families already affected by maltreatment (e.g., family preservation services, parent mentoring and support groups, and mental health services).

co-designing the future of child welfare, along with private providers and community-based organizations.

Over the next five years, Colorado will continue to carefully assess where Family First interventions are most appropriate along the prevention services continuum, while also progressively expanding their reach—both in terms of at-risk populations served and the variety of evidence-based practices tailored to the unique needs of Colorado communities and Tribes. Colorado has intentionally designed a broad definition of candidacy for placement prevention services that pushes to serve children, youth and families as early as possible and, ideally, before a report is made to the child welfare system.

Colorado has been building the groundwork for a 21st century child welfare system over the past decade, and the opportunities and challenges of Family First must be viewed within the context of Colorado's ongoing work with children, youth and families. The following are four key components of this foundation, each serving to strengthen and amplify the impact of Family First implementation.

Core Services Program

The Core Services Program was established within CDHS in 1994 to provide strength-based resources and support to families. The program's goals are to safely maintain children and youth in the home, return children and youth home, promote the least restrictive setting for children and youth, and provide services for families at risk of involvement or further involvement in the child welfare system. Each of the state's 64 counties develops a plan annually to address program goals through locally tailored strategies and services. Colorado's two federally recognized Tribes can opt to submit a plan to access Core funding as well, and funds are set aside for them. The Core Services Program is a $55-million distinct funding stream, essential to the current continuum of care in Colorado.

In calendar year (CY) 2020, a total of 24,829 distinct clients were served by the Core Services Program. Annual evaluations have shown the Core Services Program is an effective approach to strengthening families and keeping children and youth at home. Without it, Colorado counties would have spent an additional estimated $50 million in CY 2020 on out-of-home placements for children and youth.[2]

CORE SERVICES AND FAMILY FIRST

The Core Services Program has helped build a prevention infrastructure across the state, by enhancing collaboration with community partners and providers, and expanding intensive in-home therapeutic services, substance abuse treatment and mental health services, and innovative county-designed services. The implementation of Family First in Colorado will benefit from and build upon this existing network.

In 2020, county-designed services represented the most common type of service provided through Core funding, accounting for 35% of all service episodes statewide. County-designed services are innovative and/or otherwise unavailable services proposed by a county to meet the unique needs of their children, youth and families. Examples of county-designed services include family group decision-making, domestic violence interventions, and family support services. Many of these services will likely not meet the Family First evidence standards and qualify for federal reimbursement in the near future. At the same time, not all families will benefit from the limited set of evidence-based interventions approved by the Family First Title IV-E Prevention Services Clearinghouse. Thus, Colorado has prioritized continuing to maintain, evaluate and adapt county-designed prevention services to meet the needs of local communities, while clarifying how these services will complement and align with Family First. Additionally, Colorado will increase engagement with both Tribes, as one of the two Tribes did not submit a Core plan this year. CDHS is committed to collaborating with both the Southern Ute Indian and Ute Mountain Ute Tribes individually to evaluate and adapt prevention services to meet the needs of their communities.

2 Core Services Program Annual Evaluation Report: Calendar Year 2020. Social Work Research Center, Colorado State University, October 2021.

Title IV-E Waiver Demonstration Project

In October 2012, the Children's Bureau, an office of the Administration for Children & Families, awarded the CDHS Division of Child Welfare (DCW) a Title IV-E Waiver Demonstration Project (Waiver). The Colorado Waiver focused on five interventions to build on existing child welfare practice: Family Engagement, Permanency Roundtables, Trauma-Informed Assessment, Trauma-Informed Treatment and Kinship Supports. Collectively, the interventions were designed to support children, youth and families throughout the various levels of child welfare involvement.

Colorado's Waiver interventions were far-reaching, with 53 of 64 counties across the state receiving funds to implement one or more of the five interventions during the initial five-year Waiver period and almost 30,000 children and youth receiving one or more interventions. Overall, the independent third party evaluation findings indicate that the percentage of all out-of-home removal days in kinship care increased, while the percentage of foster and congregate care days, as well as the total expenditures for out-of-home care, decreased. At the same time, children and youth who received the interventions generally had better permanency and safety outcomes than matched children and youth who did not receive the interventions.[3]

IV-E WAIVER AND FAMILY FIRST

Colorado's IV-E Waiver design was not merely a collection of individual interventions, but rather the beginnings of a uniquely Colorado child welfare model. Family engagement and kinship supports in particular have become engrained in statewide practice. During the 2019 legislative session, $9.7 million was appropriated specifically to extend Title IV-E Waiver interventions, with the requirement that CDHS develop a detailed plan for long-term sustainability. Thus, similar to Core Services, the question is not how Family First will replace the Waiver, but rather how Family First will align with and continue to strengthen Colorado's current approach to promoting child and family well-being.

Colorado's Waiver experience offers lessons learned that can be applied to Family First implementation. Overall, the approach was to have consistent parameters around a common set of interventions statewide and to allow flexibility in county implementation. For example, with facilitated family engagement, counties determined which established model fit county-specific philosophy and goals, with all models having the same basic components. (The most commonly implemented model was Family Team Meetings, followed by Team Decision Making.) Similarly, Colorado's Family First statewide planning efforts have resulted in a common set of key values, definitions and policies, while embracing the fact that local implementation will look different county to county.

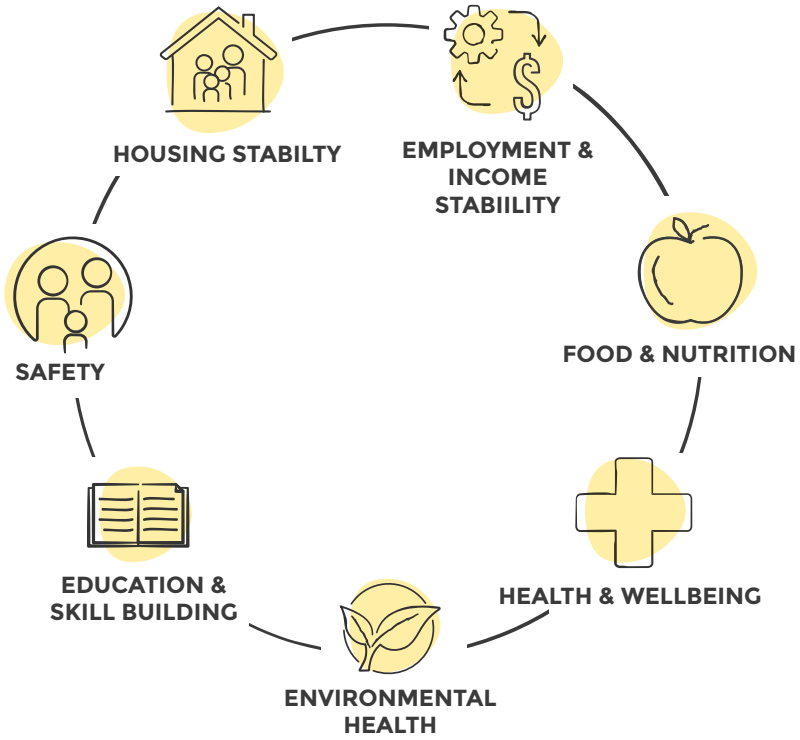

FIGURE 2: THE SOCIAL DETERMINANTS OF HEALTH AND KINSHIP

3 Colorado Title IV-E Waiver Final Evaluation Report. Human Services Research Institute, December 2018.

Human Services Approach

Colorado is a state-supervised, county-administered human services system consisting of 64 counties and 22 judicial districts. Under this system, county departments are the main provider of direct services to Colorado's families. County human services departments are not only responsible for overseeing traditional child welfare services, but also a broad range of other programs from food assistance and low-income child care to health coverage, Temporary Assistance for Needy Families (TANF), child support services and employment development programs. Human services are viewed through a Social Determinants of Health lens that informs both the variety of services that county departments provide directly and the coordination across sectors and agencies. Thus "child welfare" means something much broader in this state; with a wide array of supports, Colorado aims to address the root causes of crisis and instability through integrated prevention and service delivery focused on supporting whole families and individuals across generations.

HUMAN SERVICES APPROACH AND FAMILY FIRST

In 2019, the Colorado Human Services Directors Association (CHSDA), which represents 64 counties from all regions across the state, identified Child Maltreatment Prevention through Early Childhood Investments as a critical focus area. The priority is to provide services to those in need as early as possible to strengthen families, boost health and well-being, and avoid more difficult and costly crises later. It is clear that Colorado human services is on a path that is fully aligned with the vision of the Children's Bureau and Family First to keep families healthy, together and strong.

Collaborative Management Program

The Collaborative Management Program (CMP), administered by CDHS, was created in 2004 and establishes a collaborative approach at the county level to improve outcomes for children, youth and families involved with multiple systems, including child welfare, juvenile justice, education and health/behavioral health. Through incentive funds and grants, local CMPs improve service delivery by facilitating cross-agency coordination and creating a tailored collective community approach to serving children and youth with complex needs.

CMP has 10 mandated system partners, including human services, courts, probation, school districts, public health, mental health centers, domestic violence provider, managed service organizations for the treatment of drugs and alcohol, and behavioral health organizations. Forty-six Colorado counties are currently implementing CMP.

COLLABORATIVE MANAGEMENT PROGRAM AND FAMILY FIRST

Findings from the 2018 independent evaluation of CMP indicate multiple benefits to structured collaboration, including efficacy in coordination of resources and serving multi-system-involved families, staying informed on community-specific practices, and learning from other partner agencies regarding shared successes and challenges. As such, CMP will be a critically valuable asset to implementing approved Family First practices in coordinated and meaningful ways, with a shared commitment to keeping families together.

In addition to these four foundational components of Colorado's child welfare system, the state has promising initiatives underway that focus specifically on strengthening and integrating primary prevention strategies. Two of these initiatives are highlighted below.

Colorado Child Maltreatment Prevention Framework for Action

Colorado uses the Child Maltreatment Prevention Framework for Action (Framework) as a road map for child abuse prevention strategies at the state and local level. This includes the development of county child abuse prevention plans. The Framework and accompanying community planning toolkit were jointly developed by CDHS's Office of Early Childhood, the Chapin Hall Center for Children at the University of Chicago, the Children's Trust of South Carolina, the Children's Bureau, and numerous Colorado agencies and partners. The Framework has helped guide investments,

programs and policy under the purview of CDHS. CDPHE has also adopted the Framework to inform its child maltreatment prevention efforts.

In 2021, the Office of Early Childhood will undertake a process to develop a revised version of the Framework to center the road map from an equity lens and develop new tools for local communities to engage cultural brokers in their planning. Furthermore, in response to Family First requirements, Colorado's Child and Family Services Plan (CFSP) calls for revisions to the Framework to include additional strategies needed to serve as the state's Child Maltreatment Fatality Prevention Plan.

Colorado's CFSP also requires support for all counties to develop and implement local child abuse prevention plans using the Framework. Federal Community Based Child Abuse Prevention (CBCAP) funds are being used to support local planning in counties and implementation of identified strategies. Tribes will be consulted to explore prevention practices within their communities should CDHS consider funding toward this end.

OFFICE OF EARLY CHILDHOOD

CDHS's Office of Early Childhood (OEC) utilizes the Framework to guide its work. The Office's Division of Community and Family Support houses a good portion of the state's secondary prevention programs, including several of the programs listed on the Title IV-E Clearinghouse (Parents as Teachers, SafeCare, Nurse Family Partnership, Child First and Motivational Interviewing). It administers the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) funding, Promoting Safe and Stable Families (PSSF) funding, Fatherhood FIRE funding, as well as CBCAP funding. In addition, there are six state funding streams supporting home visiting, family resource centers, parenting education, and other child abuse and neglect prevention programs. Starting in 2022, the Colorado Child Abuse Prevention Trust Fund will be utilized to pool funds that can increase capacity across the state to implement services listed on the Title IV-E Clearinghouse.

Colorado Partnership for Thriving Families

The Colorado Partnership for Thriving Families (Partnership) is a multi-sector, multi-community partnership at the state and local level that bridges public health, health care, human services and nonprofit organizations—the first of its kind in Colorado—focused on the primary prevention of child maltreatment. The Partnership works collaboratively across Colorado to create the conditions for strong families and communities where children are healthy, valued and thriving. The goal over the next five years is to strengthen and promote a statewide vision around primary prevention. Together, the Partnership will target efforts to significantly reduce child fatalities and child maltreatment for children ages zero to five with an initial focus on the well-being of families during the prenatal period through the first year of a child's life. The Partnership has identified strategies across three priority areas: community norms change, expansion of an early touchpoints service array, and systems alignment (data sharing, braiding funding, policy development and leadership.)

The Partnership is a systems change initiative that requires attention to the underlying conditions and root causes that maintain and perpetuate inequities and prevent families from receiving the support they deserve and need to thrive. Therefore, the Partnership prioritizes family voices and expertise of all kinds to drive systems change at every level and is committed to centering equity at every step along the way. The Partnership has begun to recruit housing/homeless experts in its work, which provides an opportunity for integration, specifically addressing housing security as a prerequisite to socioeconomic mobility for families.

In Focus: Juvenile Justice in Colorado

The juvenile justice system in Colorado is unique. Youth are served in a trifurcated system between county government, the judicial branch, and multiple state executive branch agencies. This complex, multidisciplinary service network requires ongoing collaboration to effectively serve the state's youth who are involved in the juvenile justice system. Often, the same agencies surface at multiple intervention points while working with this population, causing a youth and his/her family to be simultaneously served by multiple systems/agencies.

The Division of Youth Services (DYS) within CDHS is responsible for juvenile detention, state delinquency institutions and juvenile parole. A youth who commits a delinquent act is first served by the pre-trial and detention services overseen and provided by DYS. However, if a youth in the juvenile justice system needs out-of-home placement, placement is coordinated by the local county department of human services; these youth are considered in "foster care."

Colorado sees Family First as an important opportunity to ensure youth who are at risk of or involved with the juvenile justice system and their families have access to prevention services and quality placements if they cannot remain safely at home. Due to Colorado's unique system, a Juvenile Justice workgroup is explicitly included in Family First implementation planning. This group is providing recommendations on specific evidence-based placement prevention services that are well suited for this population, as well as possible services that Colorado would like to explore as being evidence-based. The workgroup is also ensuring that other stakeholders are well informed on Family First through a juvenile justice lens, including delinquency judicial officers, probation officers, client manager/parole officers, defense attorneys and prosecutors.

Alignment and coordination with Colorado's Juvenile Justice Reform Act Task Force has been essential. The Juvenile Justice Reform Act (Senate Bill 108) was signed into law in May 2019 to help improve outcomes for youth, strengthen public safety and use resources more efficiently. Among other things, the legislation expands opportunities to divert youth from the juvenile justice system, and requires implementation of a validated risk and needs assessment tool to inform court decision-making and case planning.

CDHS is also working with partners to connect information across the child welfare and court systems to help inform policies and practices aimed at serving crossover youth. This data will help measure and ensure youth are not pushed into the juvenile justice system as a result of a lack of other available placements, per the Family First Act.

Target Population and Eligibility

Historically, Colorado's child welfare system has provided services and support to children, youth and families in three different categories (called Program Areas):

- **Program Area 4 (PA4):** Youth in conflict services are provided to reduce or eliminate conflicts between a child/youth and their family members, which may include the community, when those conflicts affect the child/youth's well-being, the normal functioning of the family, or the well-being of the community. This is the program area that most juvenile justice youth fall into.
- **Program Area 5 (PA5):** Child protection services are provided to protect children/youth whose physical, mental, or emotional well-being is threatened by the actions or omissions of parents, legal guardians or custodians, or persons responsible for providing out-of-home care.
- **Program Area 6 (PA6):** Services to children, youth and families in need of adoption assistance, relative guardianship assistance, or Medicaid-only services, or to children/youth for whom the goal is no longer reunification.

As previously described, Colorado has a strong foundation and history of providing prevention and early intervention services through the use of Core Services, IV-E Waiver interventions, CMPs and integrated human services delivery. In addition, during Colorado's 2011 legislative session, House Bill 11-1196: Flexible Funding for Families, was signed into law. The bill redefined family preservation services to serve "appropriate families who are involved in, or who are at risk of being involved in the child welfare, mental health, and juvenile justice systems." This created a new program area (Program Area 3) that allows county departments to provide prevention and early intervention services with existing state funding sources, such as the State Child Welfare Block and Core Services Program allocations.

Program Area 3 (PA3) services can be provided after a referral has been screened out, when an assessment does not require child protection services, or when a child welfare case is closed but additional supports are needed to improve a family's protective factors, reduce the possibility of recurrence of abuse or neglect, and prevent the family's deeper involvement in the child welfare system. PA3 services are optional, offered as 100% voluntary to a family, and based on county-by-county available funding and ability to provide preventive services. While the legislation was similar to Family First in its approach, no additional funds were allocated by the state legislature so the impact of PA3 has been somewhat limited and inconsistent across the state. Colorado sees Family First as a means to considerably expand this prevention work.

In state fiscal year (SYF) 2018, 6,518 children, youth and families received PA3 services in Colorado. Within this context of successfully serving PA3 children, youth and families, and a history of providing prevention and early intervention services, Colorado sees Family First as an opportunity to extend services even further upstream through a bold definition of candidacy.

In Colorado, the intent of placement prevention services is to proactively strengthen and support families as early as possible, before they are in crisis, regardless of whether they are formally involved with the child welfare system or not. In order to achieve true change and improve outcomes, the existing system cannot just be modified; rather, a fundamental shift in service delivery and support to families must occur. The definition below describes the circumstances and characteristics that put children and youth at serious risk of entering or re-entering foster care as identified by research and experience. The definition intentionally does not designate specific pathways to becoming a candidate for Title IV-E prevention services. Colorado is committed to working closely with partner agencies and community providers to ensure robust monitoring processes and reporting, as child/youth safety is of utmost importance.

Colorado's Proposed Definition of Candidacy

A child/youth is a candidate to receive Title IV-E prevention services when they are at serious risk of entering or re-entering foster care and who is able to remain safely at home or with kin, with the support and provision of mental health, substance use treatment, or in-home parenting services for the child/youth, parent or kin caregiver. Youth in foster care who are pregnant or parenting are also candidates.

A child/youth may be at serious risk of entering foster care based on circumstances and characteristics of the family as a whole and/or circumstances and characteristics of individual parents or children/youth that may affect the parents' ability to safely care for and nurture their children/youth.

Colorado's proposed definition of candidacy includes the following circumstances and characteristics of the child/youth, parent or kin caregiver that could put a child/youth at risk of entering or re-entering foster care:

- Substance use disorder or addiction
- Mental illness
- Lack of parenting skills
- Limited capacity or willingness to function in parenting roles
- Parents' inability, or need for additional support, to address serious needs of a child/youth or related to the child/youth's behavior or physical or intellectual disability
- Developmental delays
- Reunification, adoption or guardianship arrangements that are at risk of disruption

"Kin" may be a relative of the child/youth, a person ascribed by the family as having a family-like relationship with the child/youth, or a person that has a prior significant relationship with the child/youth. These relationships take into account cultural values and continuity of significant relationships with the child/youth.

ICWA Kin Caregiver as defined in 25 U.S.C. Sec. 1903 includes an "extended family member" as defined by the law or custom of the Indian child's tribe or, in the absence of such law or custom, is a person who has reached the age of 18 and who is the Indian child's grandparent, aunt or uncle, brother or sister, brother-in law or sister-in-law, niece or nephew, first or second cousin, or stepparent.

Notes on Colorado's Proposed Definition of Candidacy

Colorado's vision is that all children, youth, parents or kin caregivers with these risk factors will be eligible for Title IV-E prevention services—both those who are involved in the child welfare system and those who have not been the subject of a child maltreatment report but share characteristics that deem them at serious risk of out-of-home placement. This approach requires the development of coordinated systems, data sharing related to the identification of candidates and determining eligibility, and robust processes to monitor safety of candidates while on a prevention plan. Colorado and partner agencies will continue exploring the systems and processes currently in place that can contribute to this development, while simultaneously working with youth, families, counties, Tribes and other stakeholders to identify resources needed in order to fully realize Colorado's bold vision.

CDHS is keenly aware that, with such a bold definition of candidacy, there is a risk of further stigmatizing and unintentionally increasing child welfare involvement based on systemic inequalities such as race and poverty factors. CDHS is committed to monitoring data statewide for increased impact on disproportionality as a result of identifying at-risk children, youth and families further upstream.

The table on the following pages includes some of the key characteristics from Colorado's candidacy definition, along with state-level data describing the targeted population.

TABLE 1: CANDIDACY CHARACTERISTICS AND DATA

Candidacy Element	Colorado Population-Level Data
Substance Use – Parents	In Colorado, a sizable amount of the adult population is engaged in substance use behaviors that could put families at risk of becoming involved in the child welfare system. It is estimated that almost one-fifth of the adult population engages in binge drinking, according to 2018 data ("BRFSS Prevalence & Trends Data," CDC). From the 2016-2017 NSDUH State-Specific Tables (SAMSHA): • An estimated 143,000 adults in Colorado had an illicit drug use disorder in 2016-2017. • An estimated 13,000 adults in Colorado had past-year heroin use in 2016-2017. • An estimated 39,000 adults in Colorado had past-year methamphetamine use in 2016-2017 • An estimated 210,000 adults in Colorado had past-year misuse of pain relievers in 2016-2017.
Substance Use – Infants Exposed	Parental substance use is impacting newborn development in Colorado as well. According to Colorado Pregnancy Risk Assessment Monitoring System (PRAMS) data from 2018, an estimated 7.1% of mothers smoked during the last three months of pregnancy, an estimated 14.4% of mothers drank alcohol during the last three months of pregnancy, and an estimated 4.0% of mothers used marijuana or hashish during the last three months of pregnancy. In Colorado in 2016, there were 290 cases of infants born with neonatal abstinence syndrome (NAS), which is a syndrome that occurs when a newborn was exposed to addictive opiate drugs while in the womb (Heroin in Colorado Report prepared by the Heroin Response Work Group (page 16). In August 2019, CDHS began tracking infant exposure. From August 2019 through December 2019, there were 392 referrals that were flagged with an infant born exposed to one or more substances. The majority of these referrals (272) included a concern that an infant was born exposed to marijuana. The second largest category of referrals (115) included a concern that the infant was born exposed to methamphetamines. The remaining largest categories of concern were heroin (37 referrals), other opiates (37 referrals), and stimulants/amphetamines (29 referrals).

Candidacy Element	Colorado Population-Level Data
Mental Health – Parents	Many Colorado adults report a mental illness, but many of these adults also report that they do not receive mental health services. According to National Survey on Drug Use and Health data from 2016-2017, 838,000 adults in Colorado reported having a mental illness in the past year, but only 659,000 of adults reported receiving mental health services in that same year. 214,000 adults in Colorado reported experiencing a serious mental illness in the past year, and 325,000 reported experiencing a major depressive episode ("2016-2017 NSDUH State-Specific Tables," SAMSHA).
Mental Health – Children/Youth	Children and youth in the state are experiencing mental health issues as well, which may create parenting challenges for parents not yet trained in how to respond to mental health issues. In 2016-2017, an estimated 59,000 youth ages 12-17 experienced a major depressive episode ("2016-2017 NSDUH State-Specific Tables," SAMSHA).
Lack of Parenting Skills	The following indicators provide information about the scope of the population in Colorado that may need parenting skills support ("2017-2018 National Survey of Children's Health", Data Resource Center for Child and Adolescent Health). An estimated 10,640 parents in Colorado think that they handle the day-to-day demand of raising children "not very well" or "not very well at all." An estimated 54,752 parents in Colorado felt aggravation "usually" or "always" in the past month from parenting in 2017-2018.
Limited Capacity to Function in Parenting Roles	In CY 2018, there were 13,353 substantiated allegations of abuse/neglect in Colorado. In CY 2018, there were 24,323 parents or caretakers in an open child welfare case for services or identified as the perpetrator of a founded allegation in a child welfare referral/assessment.
Youth involved in the juvenile justice/ delinquency system	CDHS operates detention and commitment centers for youth involved with the justice system. In FY 2018-2019, there were 3,137 unique youth served in state-operated and contract secure detention. In FY 2018-2019, there were 1,171 unique youth served in commitment
At Risk of Re-Entry	In CY 2018, 2,699 children/youth exited foster care to reunification, guardianship, or adoption. Of those children/youth, there were 580 instances of re-entry into out-of-home placement
Substantiated Maltreatment –In-Home Services	In some cases of substantiated maltreatment, existing safety and risk factors can be mitigated by provision of in-home services. In CY 2018, 14,222 children/youth received in-home services.

By continuing to analyze the demographics and characteristics of children, youth and families in each of these categories, Colorado can understand more about those who may be at risk of entering the child welfare system and how to reach them prior to involvement. Colorado has invested in rigorous evaluation studies of its Core Services Program, Title IV-E Waiver interventions, and specific PA3 services such as SafeCare® and Colorado Community Response (described below). CDHS has access to large amounts of data through these studies, our research partners, and sister agencies such as CDPHE, and will continue to utilize this information to guide implementation of its bold definition of candidacy. At the same time, Colorado is sensitive to the risks of furthering systemic disproportionality by using historical data to predict future need. CDHS is committed to addressing these concerns by ensuring that our communities participate in all levels of candidacy implementation. We strive to be leaders in equitable access to services for communities and families across our state.

Candidacy in Practice

To understand how Colorado's candidacy definition will be operationalized, it is important to recognize that Colorado is a local-control, county-administered, state-supervised system. This means that 64 unique county departments and 22 judicial districts will be implementing Colorado's definition in ways that respond to the array of families, services, providers, partners and funding streams in their communities. Some county human services departments are already implementing prevention and early intervention services in the broadest manner and are closely aligned with Colorado's proposed definition of candidacy. Other counties are providing more traditional placement prevention services by focusing on families who are already involved in the child welfare system.

To honor the range of needs and practices across the state, Colorado's candidacy definition is intentionally broad and flexible enough to capture a variety of approaches. Below are descriptions of three unique communities in Colorado and their current and planned approaches to placement prevention services under Family First.

ARAPAHOE COUNTY

Arapahoe County is the third most populous county in Colorado and part of the Denver metro area. Arapahoe County is already successfully connecting children, youth and families who meet the state's broad definition of candidacy with prevention services. For example:

1. The Family Resource Pavilion (FRP) was designed to offer support as early as possible to families struggling with adolescents who, without proper intervention, are not only at risk of child welfare involvement but juvenile justice as well. The Arapahoe County Department of Human Services (ACDHS) has a liaison co-located at the FRP and, when a family either walks in seeking assistance or is referred by ACDHS, probation, schools, or another entity, the ACDHS liaison assists with determining what services are most appropriate for the family. This may or may not involve a formal referral to ACDHS.
2. ACDHS partners with the Arapahoe County Early Childhood Center (ACECC) for the provision of SafeCare® to families referred both by ACDHS and by the community without DHS involvement. SafeCare® is an evidence-based placement prevention service included in this plan.
3. Currently, about 55% of child abuse/neglect referrals reviewed in Arapahoe County is screened out due to not reaching the threshold defined by law as potential abuse or neglect. About 30% of screened out referrals are sent directly to ACDHS' Community Development and Prevention Team for response.

GARFIELD COUNTY

Garfield County is considered a medium-sized county located in Northwest Colorado. Garfield County utilizes Individual Services and Support Teams (ISST) as a collaborative, cross-systems approach to staffing cases for service provision. There are three ISST groups — preschool, school-aged and delinquency involved — and the Garfield County Department of Human Services is a participant in each group. For the two age-based groups, under Family First, the goal will be for candidates to receive prevention services and not permeate further into child welfare involvement. For delinquency-involved cases, the goal will be for candidates to spend less time in detention, access prevention services in the community, and stay out of congregate care through the child welfare or juvenile justice system. In FY 2020, there were 41 ISST referrals and 65 clients who were served in Garfield County.

For those families with child welfare referrals that are screened out, but who could still benefit from intervention, Garfield County utilizes Colorado Community Response (CCR), an evidence-based service that will be discussed later in this plan.

HUERFANO COUNTY

Huerfano County is located in the Southeast region of Colorado and is one of the state's smaller counties in terms of population. Huerfano County Department of Human Services (HCDHS)

plans to continue close collaboration with its Family Resource Center (FRC) in both identifying candidates and connecting them to prevention services. When a candidate for placement prevention services is identified, they will be referred to HCDHS for PA3 assistance. HCDHS can then set them up for short-term ongoing support through the FRC. When a service is needed, HCDHS follows up with the family and the provider every 60 to 90 days to determine whether the service is still needed and whether the child/youth/family is progressing.

Since May 2019, there have been 50 non-child welfare Applications for Services submitted to the Huerfano County FRC. These referrals have mainly come from a community playgroup, probation and FRC walk-ins. The county plans to grow the FRC's relationship with the school districts, Head Start and child care centers in the community so they can also provide referrals to families in need of services.

Candidacy Determination

For open cases within the child welfare system, caseworkers will use the IV-E Prevention Candidacy Determination page in Colorado's Comprehensive Child Welfare Information System (Trails) to document children and youth who are eligible for IV-E prevention services. Once this determination is made, the caseworker will be prompted to create the required child-specific prevention plan, linking the candidate to appropriate services. Candidacy determinations may be made in the following open case situations in PA4, PA5 and PA6 cases: in-home cases; cases when a child or youth has been reunified with family; or cases when a child or youth has been placed with a relative or kin.

For those who have had a referral to child welfare which was accepted for assessment of child abuse and neglect and did not require an open case, the process will look similar to current PA3 cases. The candidacy determination and child-specific prevention plan will be documented in Trails, and the county department will contract with community-based agencies to provide identified prevention services.

For those who have either been the subject of a child maltreatment referral which was not accepted for assessment or those who have not been the subject of a child maltreatment referral and are therefore not known to the child welfare system, and have risk factors present, CDHS is working with state program intermediary organizations and community providers to create processes for the state to approve and document candidacy status. Partner agencies are responsible for gathering the documentation necessary for the state to make the final determination of candidacy eligibility. In Appendix A, the target populations and eligibility criteria for each proposed service in this plan is provided in more detail. Colorado is building the technological solutions necessary to ensure sufficient safeguards around client data while allowing CDHS, as the IV-E agency, to track, verify and report on IV-E prevention candidates outside of the child welfare system.

Title IV-E Prevention Services Array

One of the key workgroups of the Colorado Family First Implementation Team was the Services Continuum workgroup, made up of diverse members representing CDHS, counties, service providers and community partners. The primary purpose of the workgroup was focused on understanding and identifying opportunities for Colorado to access IV-E reimbursement for current and future placement prevention services.

The workgroup strongly recommended that the state prioritize the evidence-based services that are currently in place and being implemented successfully in Colorado. This strategy will allow the state to build upon existing capacity, continue to assess program efficacy, make efforts to scale where appropriate, and minimize start-up costs for initial implementation. All of Colorado's proposed prevention services, therefore, are currently being implemented in the state, although to varying degrees.

Colorado is formally proposing nine services in this initial five-year plan. Six are Clearinghouse-rated well-supported, one is rated well-supported by an independent systematic review with documentation included in this plan, one is Clearinghouse-rated supported with a rigorous evaluation plan, and one is rated supported by an independent systematic review with documentation and a rigorous evaluation plan included.

In terms of future services expansion, CDHS contracted with the Colorado Evaluation and Action Lab (Colorado Lab) to develop a short- and long-term strategy for implementing and scaling evidence-based practices that both meet the unique needs of Colorado communities and maximize Title IV-E reimbursement. Utilizing a data-driven, community-informed approach, the final report recommends a phased strategy to implementation and capacity-building in order to move Colorado closer to a comprehensive prevention services continuum. The report also highlights geographic priorities for expansion, as Colorado's goal is to ensure that all children, youth and families have access to the services they need regardless of where they happen to live in the state. The final report is linked here: https://coloradolab.org/wp-content/uploads/2021/07/Strategy-for-the-Evidence-based-Aspects-of-the-Family-First-Service-Continuum.pdf

The following section summarizes the services being proposed in this five-year plan, with more detailed information on each service in Appendix A.

The Most Vulnerable: Children Ages Zero to Five

Collectively, Colorado understands a great deal regarding the specific risk factors that increase children and youth's vulnerability to maltreatment and subsequent removal, including age (younger than four), parental challenges (substance abuse, mental health issues, intimate partner violence), parental characteristics (young age, low income, low education) and social isolation. Nationally, children in their first year of life have the highest rate of victimization at 24.8 per 1,000 children. In comparison, the national rate of child maltreatment victimization across all ages is 9 per 1,000 children.[1] Children who die from abuse and neglect are overwhelmingly young. For SFY 2019-2020 in Colorado, 42.3% of maltreatment fatalities were under the age of one and 65.4% were under the age of five; 42.3% of near fatalities were under the age of one and 84.6% under the age of five.[2]

Thus, it is vital to proactively identify and support families with infants and young children who are at risk of maltreatment and/or out-of-home placement. Meeting the prevention needs of

1 U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). Child maltreatment 2016. Available from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment

2 Extracted from the CDHS Child Fatality Review Team data, September 2021.

families with young children requires that a suite of in-home parent programs be available in each county and tribal community across Colorado. Colorado is proposing five services in this area:

Nurse-Family Partnership (NFP) is a home visiting program that serves young, first-time, low-income mothers/birthing parents. NFP is currently available in all 64 Colorado counties as well as both recognized tribal communities and is supported by Invest in Kids as the state intermediary. NFP is a Clearinghouse-rated well-supported practice that aims to improve the health, relationships and economic well-being of the parent and child.

SafeCare® is an in-home behavioral parenting program that targets risk factors for maltreatment by teaching parents/caregivers skills in three topic areas: home safety, child health and parent-child/parent-infant interaction. SafeCare® is a Clearinghouse-rated supported practice, and Colorado has therefore included its well-designed and rigorous evaluation plan in Appendix A. It is being implemented in Colorado through a partnership between the Office of Early Childhood and county departments of human services, with support from the Kempe Center as the state intermediary. Thirty-eight counties and one Tribe in Colorado currently provide SafeCare® as a resource for families. In Colorado, SafeCare® was specifically designed to serve the PA3 population (screened out referrals and closed child welfare cases). While the program currently serves a broader population, about 50% of SafeCare® clients are child welfare referrals with data already in Trails.

Parents as Teachers (PAT) is a home visiting parent education program that teaches new and expectant families skills to promote positive child development and prevent child maltreatment. PAT is currently available in 38 counties in Colorado as well as both recognized tribal communities and is supported by Parent Possible as the state intermediary. PAT is a Clearinghouse-rated well-supported practice that has demonstrated positive effects on child safety, child social functioning, and child cognitive functions and abilities.

Child First is a two-generation mental health intervention offered in the home to serve young children and families who are most impacted by systemic and structural inequities. Child First is currently being launched across seven communities in Colorado with support from Invest in Kids as the state intermediary. The practice aims to promote child and parent emotional health, improve child development and learning, enhance parent and child executive capacity, and prevent child maltreatment. Child First targets children from the prenatal stage through 5 years of age who have experienced disruption in secure attachment with their parent. Child First is a Clearinghouse-rated supported practice, and a rigorous evaluation plan is being developed for submission in the near future (therefore Child First is not being officially proposed in this initial submission).

Healthy Families America is a home visiting program for new and expectant families designed to build and strengthen nurturing parent-child relationships, promote healthy child development, and enhance family functioning. Healthy Families America is a Clearinghouse-rated well-supported practice that targets families with children who are at risk for child maltreatment or other adverse childhood experiences, and hits multiple target outcomes to holistically address child and family needs early in the life course. Currently, only one Colorado county is implementing this program, but plans for expansion are underway with support by Illuminate Colorado as the state intermediary and endorsement by Colorado's Home Visiting Investment Task Force.

Promoting Mental Health Well-Being

There is growing evidence that children and youth across Colorado are reporting higher levels of emotional distress. Among children ages 3 to 17 years, 22.6 percent have a mental, emotional, developmental or behavioral problem in Colorado. At the same time, Colorado ranked 33rd in the US for youth mental health access to care, suggesting

Colorado has a higher prevalence of mental illness and lower rates of access to care.[3]

Among subgroups of children with complex needs, it is estimated that nearly 80 percent of foster children in the US have a significant mental health issue, which is four to five times the incidence found within the general population.[4] In Colorado, during CYs 2014-2018, there were 15,874 removals related to substance use, and this represents a specific area Colorado intends to target through prevention services. Colorado has further identified runaway youth as a subcategory of youth at high risk of entry into the child welfare or juvenile justice system. Through an analysis of a statistically significant random sample of runaway youth between the ages of 10 and 17, Colorado found that approximately 55% of youth who run away are not system involved at the time of the run. However, of those "non-system"-involved youth, half go on to formally enter the child welfare or juvenile justice system within 18 months.

In looking at building out Colorado's mental health services array, two service tracks have been identified:

1. Services designed to meet the mental health needs of the child or youth.
2. Services designed to improve family functioning, which may include addressing youth delinquent behavior.

TRACK 1: MENTAL HEALTH NEEDS OF THE CHILD OR YOUTH

Colorado is proposing four services in this track. Note that Child First (discussed above) is an eligible practice under both the mental health and the in-home parent skill-based domains.

Parent-Child Interaction Therapy (PCIT) is a parent coaching program that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the parent-child relationship. Currently, there are 13 agencies across Colorado offering PCIT International with 21 providers. There are also six within-agency trainers and one regional trainer available to scale the service. Because this model uses an individual therapy approach, there is no state intermediary. PCIT is a Clearinghouse-rated well-supported practice that has been researched with culturally diverse families. In PCIT, parents are coached by a trained therapist in behavior management and relationship skills, using "bug-in-the-ear" technology to provide live coaching and allow parents/caregivers to master specific competencies across the treatment duration. PCIT targets families with children who are 2 to 7 years of age and experiencing frequent, intense emotional and behavioral problems.

Fostering Healthy Futures for Preteens (FHF-P) is a mentoring and skills group program for preadolescent children (ages 9-11) who have current or previous child welfare involvement due to one or more adverse childhood experiences (ACEs). These ACEs may include the experience of maltreatment, out-of-home placement, housing, caregiver or school instability, violence exposure and/or parental substance use, mental illness, or incarceration. FHF-P uses a combination of structured individual mentoring and group-based skills training to promote prosocial development and to ameliorate the consequences of ACEs. FHF-P is currently available in several metro area counties and is supported by the Kempe Center as the state intermediary for training and implementation support. FHF-P has not yet been rated by the Clearinghouse. Colorado conducted an independent systematic review, with a determination of FHF Preteen as a well-supported practice (see the Attachment for full documentation of this review).

Fostering Healthy Futures for Teens (FHF-T) is a mentoring and skills training program for 8th and 9th graders with current or previous child welfare involvement due to one or more adverse childhood experiences (ACEs).These ACEs may include the experience of maltreatment, out-of-home

3 2020 Statewide Behavioral Health Needs Assessment: Children and Youth with Complex Behavioral Needs. https://drive.google.com/file/d/1-RPGkZCoIxJsmzZjc9tniSlYcnGxUYrg/view

4 Howard, A. Mental Health Among Children in Foster Care. SAFY. https://www.safy.org/mental-health-among-children-in-foster-care/

placement, housing, caregiver or school instability, violence exposure and/or parental substance use, mental illness, or incarceration. FHF-T has not yet been rated by the Clearinghouse. Colorado conducted an independent systematic review, with a determination of FHF-T as a supported practice (see the Attachment for full documentation of this review). FHF-T's outcomes are being examined in an ongoing randomized controlled trial, but effects on permanency have already been demonstrated in a published paper.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a clinical intervention designed for children and adolescents who have symptoms associated with single, multiple and complex trauma experiences. TF-CBT is currently available in 42 Colorado counties. Because this model uses an individual therapy approach, there is no state intermediary in Colorado for the service. TF-CBT is a Clearinghouse-rated promising practice and a rigorous evaluation plan is being developed for submission in the near future (therefore TF-CBT is not being officially proposed in this initial submission). TF-CBT aims to treat children/youth with post-traumatic stress disorder symptoms, dysfunctional feelings or thoughts, or behavioral problems. The intervention also supports parents/caregivers in addressing personal distress, effective parenting skills, and positive interactions with their child or youth. As such, TF-CBT may offer families of children who are too old for the in-home parent programs the support and skills they need to thrive. TF-CBT targets children and adolescents with symptoms associated with trauma exposure and can be tailored for any age group, with 3 to 18 being the most common target ages served.

TRACK 2: IMPROVING FAMILY FUNCTIONING

Colorado is proposing two services in the mental health domain that are designed to improve family functioning:

Multisystemic Therapy (MST) is an intensive community-based, family-driven treatment for addressing antisocial/delinquent behavior in youth. MST is currently available in 27 counties in Colorado. Implementation is supported by the Rocky Mountain MST Network located at the Kempe Center. MST is a Clearinghouse-rated well-supported practice that has been researched with culturally diverse families. MST focuses on the "ecology" of the youth during service delivery to address the core causes of delinquent and antisocial behaviors, with a focus on substance use, gang affiliation, truancy, excessive tardiness, verbal and physical aggression, and legal issues. The target age range is 12 to 17, and the service can be delivered in multiple settings by therapists with 24/7 crisis management. Colorado will be able to leverage an MST pilot that was launched in 2019 to expand the availability of the intervention to underserved regions of Colorado.

Functional Family Therapy (FFT) is a short-term program designed to address risk and protective factors to promote healthy development for youth experiencing behavioral or emotional problems. FFT is a Clearinghouse-rated well-supported practice that uses a strengths-based model and focuses on the adolescent and the family system during service delivery. The model uses assessment and intervention to improve parenting skills and communication while reducing conflict. FFT has a strong focus on engagement and motivation within each family member. As such, the program can be particularly helpful when a caregiver is initially reluctant to participate in any kind of service, and the first phase addresses low motivation for change as well as reduces blame for delinquent behavior. FFT targets youth ages 11

to 18 who have been referred by juvenile justice, school, child welfare or mental health systems for behavioral or emotional issues. This service is currently implemented in five Colorado counties.

Focus on Engagement

To truly realize the sustained impact of Title IV-E prevention services, effective family engagement strategies will be critically important. Colorado is currently utilizing Motivational Interviewing (MI) in various ways throughout the child welfare system, and some EBPs included in this plan incorporate MI training for providers. Colorado is actively assessing how to integrate this well-supported practice more intentionally and consistently as a key component of casework practice in the state. Once these plans are solidified, Colorado will submit an amendment to this five-year plan. While Colorado is starting from a strong foundation of existing evidence-based prevention services, MI would help ensure that families have the support and motivation needed to sustain engagement in these service interventions and achieve lasting behavior change.

Colorado Community Response (CCR) is an example of a prevention service used throughout the state that embeds Motivational Interviewing in all aspects of service delivery. CCR is an innovative, voluntary program to prevent child maltreatment and strengthen families by targeting the protective factors of concrete supports and social connections. CCR is currently provided as a prevention service for screened-out referrals and is being delivered at 24 sites encompassing 34 counties in rural and suburban areas across the state. CCR has not yet been rated by the Clearinghouse, and Colorado has determined that it does not yet meet Clearinghouse evidence standards. However, initial research does suggest that this service is beneficial to Colorado families and a new randomized controlled trial is currently underway with the potential to meet Clearinghouse standards for design and execution. In the interim, MI is a core component of CCR, and claiming for MI as part of CCR delivery is being explored. Again, once Colorado solidifies its plans around CCR and MI, an amendment to this five-year plan will be submitted for consideration.

Comprehensive Continuum of Care

In selecting services to propose for Colorado's initial five-year plan, it was important to look at these services collectively as part of a broader continuum of care. While Colorado's proposed service array focuses on the early critical years, Colorado also acknowledges that evidence-based prevention services are needed at every life stage for families. The chart that begins on page 37 provides an overview of Colorado's proposed service array, including the target population for each service, level of effectiveness assigned by the Clearinghouse, and intended outcomes. Also included are those services that Colorado hopes to include in a revised version of this plan in the near future.

As Colorado is limited to the services currently rated by the Clearinghouse and those that meet the standards of evidence for transitional payment, the collection of services presented here does not adequately address all the nuances in a full continuum of care. However, implementation is an ongoing process. Colorado is certain that the current landscape will continue to change as services are added to the Clearinghouse, Family First is implemented across the state, and the makeup and needs of children, youth and families evolve. Moving forward, Colorado has created a Prevention Services Task Group that will continue to meet to evaluate and build upon the current service array, and CDHS will submit amendments to this initial plan to add services as they are approved by the Clearinghouse.

One data source that the Task Group will draw on is the annual report that counties and Tribes submit as part of Colorado's Core Services Program. Each year, counties and Tribes are asked about the availability, capacity, and accessibility of services in their communities. This data is helpful for identifying gaps in services, inequities in access, and opportunities for expansion. For example, based on preliminary data from CY 2018, over 20% of participating counties and Tribes reported that they had inadequate capacity for substance abuse treatment, 17% had inadequate capacity for mental health services, and 28% reported a lack of day treatment facilities/services.

Colorado Research Agenda

Following initial Family First implementation with the prevention services array listed above, Colorado will continue to approach the design process as an ongoing, continuous effort. Colorado is committed to building the evidence base for strategically selected programs that do not currently meet Clearinghouse standards and expanding the service array to meet the needs of Colorado's diverse communities throughout all regions of the state. The Colorado Lab report referenced above contains recommendations of Colorado's short and long-term priorities for evaluation.

Trauma-Informed Approach to Service Delivery

Colorado is fully committed to ensuring that children, youth and their families not only receive the highest quality evidence-based prevention services, but also that these services are delivered in a manner that addresses trauma's consequences and facilitates healing. Colorado's trauma-informed definition comes from the National Child Traumatic Stress Network (NCTSN):

"A trauma-informed service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, adolescents and adults, caregivers and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with their clients, using the best available science, applied in a culturally sensitive manner, to facilitate and support recovery, developmental growth, and resiliency."

Through the Office of Behavioral Health (OBH) within CDHS, Colorado has the infrastructure and expertise to ensure that Title IV-E prevention services are provided under a trauma informed organizational structure and treatment framework:

- **COACT Colorado**, Colorado's Trauma-Informed System of Care, is an initiative of OBH and is federally sponsored by grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). Under the leadership of COACT Colorado, a Statewide Trauma-Responsive Theory of Change was developed by a diverse team of stakeholders from state agencies, individuals with lived experience, and multiple systems, including behavioral health, child welfare, juvenile justice, medicine, education and early childhood. COACT Colorado developed a toolkit that provides an action-oriented guide for all systems in the community that serve children, youth and families to apply the Statewide Trauma-Responsive Theory of Change and meet evidence-based practice standards in creating trauma-responsive systems. The toolkit aims to integrate knowledge about trauma into policies, procedures and practices, as well as to avoid re-traumatization.
- The **Colorado Cross-Systems Training Institute (CSTI)** is a partnership between OBH/COACT and the University of Colorado Denver, in collaboration with the Kempe Center Trauma Informed Practice Team and Partners for Children's Mental Health. CSTI was developed to better address the professional development needs of those who work with families with complex needs across systems, with a particular focus on being trauma-informed. CSTI currently manages the training, coaching and credentialing for the High Fidelity Wraparound workforce in Colorado and has developed approximately 50 hours of training curricula on trauma-informed care. CSTI also maintains a trauma informed care clinical consultation group, which provides coaching and technical assistance to providers across the state.

Colorado is committed to ensuring a trauma-informed and trauma-responsive child welfare system. A cross-disciplinary team has created a multi-year curriculum specifically for Title IV-E prevention service providers targeted at all levels of agency employment, from board members and administrators to direct care staff. In the first year of implementation, Colorado will be focused

on building a robust foundation, with agencies expected to have a trauma-informed vision and meet basic training requirements through our Learning Management System (LMS).

Colorado's assurance of trauma-informed delivery was submitted in conjunction with this plan.

Child-Specific Prevention Plans & Monitoring Child Safety

Colorado will ensure that all required child-specific data elements related to prevention services are captured and reported - both for children/youth with open child welfare cases and those without. At a minimum, this data includes the following:

- Basic demographic information (e.g., age, sex, race/Hispanic Latino ethnicity);
- The specific services provided to the child and/or family;
- The total expenditures for each of the services provided to the child and/or family;
- The duration of the services provided;
- The child's placement status at the beginning, and at the end, of the 12-month period that begins on the date the child was identified as a "child who is a candidate for foster care"; and
- Whether the child entered foster care during the initial 12-month period and during the subsequent 12-month period.

For open in-home child welfare cases, the child-specific prevention plan will be one piece of the broader Family Services Plan (FSP). An FSP is developed in any open case when services are warranted. Under Family First, the FSP will include a prevention plan section that details placement prevention strategies to allow the child/youth to remain safely at home or with kin. Since the child-specific prevention plan will be integrated within the larger FSP, it will also link to other levels of case plans. This will allow caseworkers to ensure that the prevention plan aligns with broader case and service planning efforts.

Continuing reassessment of the child-specific prevention plan and progress toward meeting the child, youth and families' stated goals will be completed every 90 days using information gathered from the family, their supports, collaterals and involved service providers. If there is a significant change in need, a redetermination of eligibility and/or a reassessment of services will occur and the plan will be amended, if applicable.

The prevention plan will be reviewed in conference with the caseworker and the supervisor to address several items, including but not limited to the following:

- The safety needs of the child/youth, including if a new referral was received or a new assessment was completed;

- The appropriateness of the child/youth's current residence and how it meets the child/youth's needs;
- The stated needs/goals of the child, youth and/or family;
- Whether the child/youth and family members are receiving the specific services included in the prevention plan, services are appropriate, time frames are current, and progress is being made toward the specific objectives identified in the plan;
- Identification of the barriers hindering progress and how they are being addressed; and
- Identification of family strengths that move the family forward and away from systems involvement.

For any open cases, required monthly case contacts will also help ensure child/youth safety and well-being and move the case toward achieving stated goals. The county department will have face-to-face contact with the children/youth, parents as often as needed (while meeting the minimum monthly expectation) and contacts with collaterals, as appropriate, to reasonably attempt to ensure safety, permanency, and well-being of the child/youth.

Colorado's Child Protection Ombudsman (CPO)

Irrespective of whether a child welfare case is opened, Coloradans can direct any questions or concerns regarding prevention services or the state's child welfare system to the Office of Colorado's Child Protection Ombudsman (CPO). As an independent state agency, the CPO listens to the public's questions or concerns about the state's child protection system, researches and investigates issues and determines the best resolutions. The CPO also collaborates with lawmakers, professionals and other stakeholders to advance legislation and policies to promote lasting, positive impacts for children, youth and families.

For candidates who do not have an open child welfare case, CDHS is working with state program intermediaries and service providers to ensure required child-specific information is captured and shared. From the perspective of service providers, they will be monitoring progress and addressing barriers according to the established treatment plan. Each individual service proposed in this plan has specific training, assessment tools and/or processes in place to monitor child/family safety (see service-specific details in Appendix A). In addition, all service providers are trained mandatory reporters. If there are concerns for a child or youth's safety, providers will file a report through the Colorado statewide child abuse and neglect Hotline. If a child or youth is in imminent danger, providers will call 911.

Evaluation & CQI Strategy

Below is Colorado's general approach to evaluation and continuous quality improvement (CQI) efforts as required in Family First. Appendix A provides detailed descriptions of fidelity monitoring and CQI processes specific to each prevention service being proposed in this initial plan. For services that have been rated as well-supported in the Title IV-E Prevention Services Clearinghouse, Colorado is seeking an evaluation waiver for these services and, upon approval, will assess program implementation and fidelity through a robust CQI process rather than through formal, independent evaluation.

Evaluation Capacity

Colorado is planning to use the following internal and external resources for completing rigorous evaluations of programs as part of Family First.

CDHS Family First Evaluation Team (Formal Evaluation and Evaluation Waiver): CDHS's internal Family First evaluation team will consist of the following roles and responsibilities:

- Designated leadership within CDHS to prioritize research and evaluation efforts and serve as a liaison with counties, Tribes and providers for participation in ongoing evaluation.
- Designated leadership to serve as the agency point of contact for external partners coordinating the rigorous evaluations and providing CQI support.
- Develop a master data-sharing agreement for Family First evaluation.
- Provide timely access to administrative data for external evaluation teams. Colorado has built a standard child welfare extract that can be routinely generated by internal research and evaluation staff. Internal leadership will need to coordinate with external teams to prioritize data requests for Family First evaluations.
- Manage evaluations that are already underway with contracts established for independent research.

Partnership with the Colorado Evaluation and Action Lab (Formal Evaluation): The Colorado Evaluation and Action Lab (Colorado Lab) is a strategic research partner for Colorado government that works under the Governor's priorities to perform policy and program evaluations. CDHS will partner with the Colorado Lab to function as a coordinating hub for rigorous evaluations of promising and supported practices. The Colorado Lab will do the following:

- Build capacity within the Colorado research community to conduct rigorous evaluation studies to move promising or supported programs along the evidence continuum toward the well-supported criteria outlined in the Prevention Services Clearinghouse Standards Handbook.
- Facilitate the design of rigorous within and across-site evaluations for each promising or supported practice that does not already have a study underway. Evaluation designs will:
  - Build on the existing evidence base for a given intervention;
  - Prioritize opportunities to understand cultural relevance to Colorado communities;
  - Leverage administrative data to minimize the burden on providers and minimize costs;
  - Consider the potential for cross-system benefit; and
  - Be pre-registered to ensure transparency.
- Convene research teams to conduct the program or service specific rigorous process and outcome studies by:
  - Leveraging the expertise of the state first (e.g. the Social Work Research Center, Kempe Center, Colorado Applied Research and Action Network fellows) and national organizations second; and
  - Creating efficiencies across individual program evaluations and research teams.

- Provide secure data infrastructure to research teams.
- Coordinate with designated CDHS leadership to manage the intersection of implementation science, CQI work, and rigorous outcome evaluations.
- Develop and implement communication plans that ensure the findings are well positioned to inform policy and practice.

The Colorado Lab's staff are experts in evaluation design and methodology, and its approach is to serve as a bridge between the decision-making goals of government and the academic and scientific community. It is anticipated that the Colorado Lab will function as the umbrella for rigorous evaluations and facilitate subcontracts for specific projects and scopes of work to organizations throughout Colorado. The volume of rigorous evaluation can be scaled up or down throughout the first five years of the prevention plan.

Program or Service-Specific Rigorous Evaluation Teams (Formal Evaluation): As noted above, the Colorado Lab will convene program- or service-specific evaluation teams. These teams will be developed in response to where the program or service is currently on the evidence continuum, and the unique capacity of individuals or organizations to support movement toward a well-supported practice and/or better understand implementation in the context of unique Colorado communities.

Evaluation Design

Following a building period, the evaluation of each supported and promising program will consist of two studies: a process evaluation and an outcomes evaluation. Descriptions of both are provided below.

Building Period: The building period will begin by setting a broad Colorado research agenda and priorities. Colorado has already begun this work by gathering data on existing evidence for programs in our proposed service array, documenting delivery sites, and hosting a research summit to orient the academic community to opportunities for supporting Family First work in the state.

CDHS, with support from the Colorado Lab, will engage stakeholders in prioritizing process and outcome questions so that evaluation findings are tailored to Colorado's learning and decision-making goals. Close attention will be paid to the contexts and settings in which each program or service is expected to be implemented in Colorado. Furthermore, the research planning process will balance the requirement that each intervention be evaluated individually, while recognizing that these services are delivered within the broader context of the child welfare landscape.

Then, program- or service-specific rigorous evaluation teams will develop and publicly register a well thought out and rigorously designed evaluation plan for each promising or supported practice. CDHS and the Colorado Lab will ensure that there is coordination across the multitude of rigorous evaluations and CQI initiatives so that counties, Tribes and providers are clear about expectations and requirements are reasonable.

The outcomes of the building period will be: (1) evaluation plans for each promising or supported program or service, and (2) a coordinated approach for launching those evaluations in Colorado.

Process Evaluation: For each supported and promising program, a process evaluation will be conducted.

RESEARCH QUESTION 1

Was each program implemented as the model intended? [For all promising and supported programs/ services]

- Each program-specific research team will liaise with model developers to obtain measures, specific methodology, and tools for assessing model fidelity, and propose processes and systems for monitoring fidelity of each program on a periodic basis.
- CDHS-designated leadership and the Colorado Lab will ensure that fidelity monitoring strategies are well coordinated across programs and services, and communication and expectations of counties, Tribes, and providers are clear. The goal is for providers, Tribes, and counties to have clear, consolidated information

about what is required to track and report rather than having multiple messages from several research teams.

- Program-specific research teams will have responsibility for implementing fidelity monitoring, and making referrals, as needed, to implementation scientists to support shoring up implementation when there is evidence.

Findings from Research Question 1 will be used to inform training and supervision to ensure that the proven benefits of the model are realized through faithful implementation, and to ensure that outcomes can accurately be attributed to the model.

While ongoing fidelity monitoring will be the foundation for our process evaluation, additional questions may be established during the building period or in response to implementation fidelity findings. Sample questions are below:

RESEARCH QUESTION 2

To what extent did each program reach the intended target population? [For select promising and supported programs/services]

This component of the process evaluation will assess the degree to which eligible families within the target population are receiving each service (i.e., reach). Furthermore, it will elucidate barriers to reach and generate strategies to expand it. This information will be viewed in the context of the overall successes and challenges of implementation and the related competency, organization and leadership drivers that may have influenced referrals, service uptake and service completion for each program.

RESEARCH QUESTION 3

What leadership, cultural or capacity building supports are needed to shore up implementation or deliver a given service outside of the Denver metro area or to a historically marginalized population? [For select promising and supported programs/services]

Colorado is a diverse state and residents have uneven access to evidence-based services. Process evaluations may generate insight into delivery methods that are feasible in rural communities or identify minor adaptations that ensure culturally responsive delivery. Colorado and CDHS are committed to culturally responsive practices.

Outcomes Evaluation: The outcomes evaluation will assess the degree to which the supported and promising programs achieve the intended outcomes for children, youth and families associated with each individual program model, as well as distal outcomes related to reduced repeat maltreatment and reduced foster care entry and re-entry. The outcomes measured will be informed by:

- The context in which the service is being implemented in Colorado (i.e., what are the goals of serving a given target audience, with a given promising or supported practice);
- The theory or logic model underpinning the program or service, as articulated by developers in books, manuals, or writings; and
- Prior evidence and what is expected to be realized that is relevant to Family First outcomes and Colorado's overarching vision for healthy families.

The research questions and designs will be fully scoped out during the building period and address the relevant components of the Administration for Children and Families' Evaluation Plan Development Tip Sheet.

RESEARCH QUESTION 4

To what extent did each of the evidence-based practices and other programs meet anticipated outcomes?

The evaluation design will be tailored to the evidence base for a given intervention and an assessment of what information would be needed to move along the evidence continuum. All evaluation designs will be informed by the Prevention Services Clearinghouse Standards Handbook. For example:

- Is a focus on sustained effects important to determine if a program could become a well-supported practice? Or is a rapid-cycle model more conducive to advancing Colorado's learning goals for a given program or service?

- Are the samples in prior evaluations similar to Colorado's target population or are there specific—perhaps historically marginalized—populations that are important to include in the evaluation?
- Are there internal validity limitations in prior research that can be mitigated in future studies?
- Are there delivery settings that may be particularly important to assess outcomes?

The evaluations will use a rigorous approach that is practical, ethical and actionable. It is anticipated that some designs will be quasi-experimental designs and randomized controlled trials aligned fully to the Prevention Services Clearinghouse Standards. It is also anticipated that some evaluations, particularly as Colorado begins to learn what is promising when delivered in unique cultural contexts, may not have a control group or may have an alternative practice as the comparison condition. All causal studies will be pre-registered on the Open Science Framework to ensure transparency. All descriptive or inferential research designs will be made publicly available on a Colorado website or clearinghouse.

CQI Approach

Robust CQI processes ensure that Colorado children, youth and families are, in fact, receiving the services that have been shown to drive positive outcomes. CQI involves using data to determine if the program is delivered as it was designed; if yes, providing support to ensure adherence to the model is sustained; and if not, providing data-informed support to providers in meeting the goal of delivering services with fidelity to the model.

As detailed in Appendix A, for each service proposed in this initial five-year prevention plan, Colorado will implement robust service-specific processes to ensure fidelity to the practice model and use information learned to refine and improve practices. As described in the Appendix, this service-specific CQI work mostly falls to a national technical assistance organization, a state intermediary, and/or clinical supervisors.

In addition, CDHS, as the IV-E agency, will take a high-level approach to monitoring adherence across all services included in this plan and across geographic areas. The goal of state-level CQI is to generate actionable data to inform state-level investments that promote high-quality delivery of services and performance-based contracting decisions. CDHS will also leverage its existing performance management system to monitor outcomes of children, youth and families at the county and state levels.

State-Level CQI Platform

Colorado is developing a state-level CQI Platform that will serve as the central mechanism for meeting federal Family First CQI requirements. The state-level CQI Platform design has been informed by a series of design sessions with providers, counties and state-level partners. High fidelity mock-ups of the platform have been created and development is underway.

To ensure meaningful and comparable data, service-specific CQI measures (as described in Appendix A) will be translated to a standardized scale for state-level adherence monitoring, allowing CDHS to quickly identify trends. For each service, Colorado will work with developers and lead providers to establish business rules for translating program-specific measures to a simple, standardized scale of "not met, approaching, met" fidelity for the service. Service-specific business rules will also be created for how frequently adherence will be reported up to the state platform, timing of adherence tracking relative to service delivery start dates, and sampling strategies.

In addition, the statewide platform can be used for those services that do not have existing state infrastructure and capacity around fidelity monitoring or CQI. This will be the case for some services that do not have a state intermediary in place (for example, TF-CBT). The state CQI Platform will allow these services to systematize processes for collecting fidelity data, ensure sites can access clinical supervision through telehealth platforms, and develop reports that can help the sites, counties and state take a data informed approach to continuous quality improvement and shoring up fidelity to the evidence-based models.

Evaluation Waiver Requests & Ongoing Rigorous Evaluation Plans

Please see the Attachment for Colorado's Request for Waiver of Evaluation Requirements for each well-supported practice in this plan. Appendix A has service-specific justifications for each waiver request. For SafeCare® and Fostering Healthy Futures for Teens, Colorado's ongoing rigorous evaluation plans are also included in Attachment.

Child Welfare Workforce Training & Support

The CDHS Division of Child Welfare (DCW)'s Training Unit was recently renamed the Learning and Development (L&D) team. This holds significance beyond a simple name change; it represents DCW's philosophy and approach to developing a competent, skilled and professional child welfare workforce with a priority focus on equity and inclusion. The L&D team's goal is not just information sharing, but rather creating true learning opportunities that lead to long-term behavior change. Colorado has a robust workforce development infrastructure, and the L&D team is working with multiple stakeholders to integrate additional learning and development opportunities that will translate the values and vision of Colorado's Family First approach into day-to-day child welfare practice.

Colorado's Workforce Development Infrastructure

DCW's L&D team serves as the conduit of collaboration to ensure that needs throughout Colorado are consistently assessed and met. In addition to informal activities, such as meeting regularly with stakeholders and partners, the L&D team formally ensures consistency and collaboration by chairing the Training Steering Committee (TSC). This committee is composed of representatives from CDHS, county departments, county commissioners, foster parents, kin, the judicial system and other partners. The TSC is working to expand to include parents and youth representation as well. The TSC reviews and approves any major changes to rules and activities related to training.

The L&D team oversees training and certification of caseworkers, casework supervisors and hotline workers. Each type of certification has requirements for minimum education, initial training, and annual continuing education. The L&D team also provides training opportunities to both the Southern Ute Indian and Ute Mountain Ute Tribes. Finally, the L&D Team provides oversight and monitoring of the Child Welfare Training System (described below) and IV-E reimbursable training activities.

Colorado Child Welfare Stipend Program: Beginning in 1995, the DCW Training Unit (now the L&D team) contracted with established social work programs at Metropolitan State University of Denver and the University of Denver to offer child welfare stipends to students interested in the child welfare field. This effort focused on recruiting well educated and trained child welfare workers who are working toward a degree in social work to then be employed in one of the 64 Colorado county departments of human services. In July 2016, two additional universities—Colorado State University at Ft. Collins and Colorado State University at Pueblo—joined the program. Currently, 60 to 70 stipends are awarded each state fiscal year amongst all four universities.

Beginning in 2019, DCW and Metropolitan State University of Denver are piloting a process of drawing down additional Title IV-E training dollars in an effort to maximize the number of stipends awarded to qualifying students. Colorado is also conducting research related to the effectiveness of this model in child welfare recruitment and retention.

The Child Welfare Training System (CWTS): The CWTS was created by DCW in partnership with county departments to ensure consistent and comprehensive initial and ongoing training and professional development for child welfare workers in Colorado. It is currently managed by the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe) at the University of Colorado Denver. While the majority of CWTS activities are completed by Kempe, they also subcontract with partner agencies, such as Illuminate Colorado and the University of Denver. Kempe also maintains an extensive learning and development pool of training facilitators, mentors and coaches who currently work in the child welfare field in Colorado.

CWTS provides training to over 8,000 child welfare professionals, service providers, and foster and kin families each year. Standardized training provided by CWTS includes pre-service training for new caseworkers and supervisors; an online Learning Management System (LMS); practice and

organizational coaching services; and an extensive selection of in-service training. CWTS offers more than 140 courses in its in-service library and maintains four regional training centers. All training is reviewed using an established matrix to ensure that it is in alignment with trauma-informed practices, inclusive of sexual orientation, gender identity and gender expression language and best practices, and representative of diverse cultural perspectives.

Family First-Related Training Plan and Strategy

Colorado currently offers specific learning opportunities that are in alignment with Family First requirements. In addition, the L&D team has been working with the Family First Implementation Team and workgroups and with CWTS to both revise existing offerings and design new learning opportunities for those across the child welfare system, including mandatory reporters, those who screen referrals of child abuse and neglect, child welfare supervisors/managers/administrators, and those whose role will be primarily focused on prevention casework.

Due to the significance of Family First and the transformational change that Colorado is moving toward, CDHS hired a Family First-dedicated Training & Development Specialist. Training and communications products released in the last year include the following:

- Family First 101 web-based training for all child welfare professionals;
- Candidacy Tipsheet (described in more detail below);
- A comprehensive Family First Implementation Guide for County Directors, which was developed in partnership by CDHS and the Colorado Human Services Directors Association (CHSDA);
- A series of four Lunch & Learn sessions hosted in partnership by CDHS and CHSDA on Understanding Financial Claiming for Prevention Services under Family First;
- Colorado's Family First Implementation Dashboard;
- Family First Implementation Digest, which is a bi-monthly email with updates from the Family First Prevention Services Implementation Team; and
- A multitude of county conversations, town halls and trainings with key stakeholders around Family First and the role of prevention services.

IDENTIFYING CANDIDATES AND DEVELOPING CHILD-SPECIFIC PREVENTION PLANS

Colorado has developed Family First 101 web-based training as a learning activity for workers and supervisors to understand the purpose of prevention candidacy, how to identify candidates, and what is required for prevention candidacy. Live presentations covering candidacy with opportunity for question & answer discussion have been offered to supplement and support understanding of candidacy criteria. A Candidacy Tipsheet has been designed to support and guide all county staff with accurate identification and entry of prevention candidates within the Trails system.

Colorado is choosing to use its existing treatment plan as the format for the child-specific prevention plan. A tipsheet is being developed as a reference guide for child welfare staff in how to create a new prevention case, indicate the specific child's participation category, select the type of prevention service being received and develop a prevention plan for each child within Trails.

For children and youth outside the child welfare system, as described above, providers will be required to track and submit the necessary child-specific documentation for CDHS to make the final determination of candidacy eligibility. Providers will develop individualized treatment plans based on the protocols of the specific EBP and needs of the child, youth and family (see Appendix A for more information).

ENGAGING FAMILIES IN THE ASSESSMENT OF STRENGTHS, NEEDS AND THE IDENTIFICATION OF APPROPRIATE SERVICES

Engaging children, youth and families to comprehensively assess their unique strengths and needs is included in the Fundamentals (pre-service) classroom training for all caseworkers.

LINKING FAMILIES WITH APPROPRIATE, TRAUMA-INFORMED, EVIDENCE BASED SERVICES TO MITIGATE RISK AND PROMOTE FAMILY STABILITY AND WELL-BEING

These topics are included in the Fundamentals (pre-service) classroom training for all caseworkers. In addition, numerous in-service trainings are available that focus on supporting families when specific issues are present, such as substance use, housing insecurity, domestic violence and sexual abuse. The L&D team is exploring ways to further bolster current training offerings to ensure effective family-centered prevention planning, appropriate referrals to evidence-based services, and coordination with other child and family services.

CDHS and the Colorado Lab recently hosted a series of informational sessions on the mental health services proposed in this five-year plan for all counties and providers in the state. These sessions were recorded and aimed to provide foundational information on each service, including the model approach, target population, intended outcomes, and how various services differ and complement each other. CDHS is exploring compiling this information in a written guidebook as well to further ensure that all child welfare professionals have a base level of knowledge around evidence-based prevention services and how best to match them with specific child, youth and family needs. In addition to general knowledge about Family First-eligible services, CDHS and CHSDA have encouraged and supported individual counties in cataloging and communicating the prevention services available in their communities. As more and more counties engage in community planning around Colorado's Child Maltreatment Prevention Framework for Action (discussed above), this will become more formalized and comprehensive.

OVERSIGHT AND EVALUATION OF THE CONTINUING APPROPRIATENESS OF THE SERVICES

This topic is included in the Fundamentals (pre service) classroom training for all caseworkers. The L&D team will build upon existing training to ensure caseworkers are evaluating the ongoing appropriateness of fit of the referral, assessing ongoing safety and risk, determining if modification to a child's prevention plan is warranted to support child and caregiver well-being, and determining if the child/youth/family are meeting the goals they identified and meeting their full potential.

For services to children, youth and families outside the child welfare system, referrals can come from a number of different sources. It is the responsibility

of each service provider to ensure that a service is appropriate, and continues to be appropriate, based on assessment data, the established target population and/or eligibility criteria. Appendix A provides service-specific details on these processes and the associated training for providers. Each individual service also has specific training, assessment tools and/or processes in place to monitor child/family safety (see details in Appendix A). All service providers are trained mandatory reporters. If there are concerns for a child or youth's safety, providers will file a report through the Colorado statewide child abuse and neglect Hotline.

JUDICIAL AND COURT PARTNERS

The Court Improvement Program (CIP) is working collaboratively with CDHS, the Colorado County Attorney Association, the Office of Respondent Parents Counsel, and the Office of the Child's Representative to maintain alignment and consistent messaging with Family First requirements.

CIP has partnered with local and national level subject matter experts to offer live and recorded training/informational videos to educate judicial officers, attorneys and county partners, utilizing the multidisciplinary team members who participate on a Best Practice Court Team (BPCT) to help share information. The first video released provided information on what Family First is, why it is important, and how to prepare for implementation in Colorado. Since then, the CIP has offered content for all professional roles on the QRTP process within the courtroom and has partnered with the American Bar Association (ABA) to provide information specific to judicial officers on how to translate the law into courtroom practice. Additionally, the CIP developed a training series for judges and attorneys on specific content relevant to each phase of a case (Before a Petition is Filed, After a Petition is Filed and a Child or Youth Enters Foster Care, and During a Child or Youth's Transition from Foster Care) to be delivered in September 2021. Lastly, the CIP has encouraged and supported local level conversations and information gathering, again

In Focus: Prevention Caseloads

In August 2014, Colorado's Office of the State Auditor (OSA) released the Colorado Child Welfare County Workload Study. The purpose of the study was "to establish a comprehensive picture of the state's county child welfare workload, case management, and staffing levels and identify estimated workload and staffing levels to accomplish child welfare goals." It focused on actual time spent by case aides, caseworkers, and supervisors on tasks to evaluate efficiencies, develop workload standards, and determine the need for additional resources. The study concluded that counties would need 610 additional child welfare staff to meet program goals and achieve outcomes. The Colorado legislature has worked to address this shortage of child welfare staff over the last five years. To date, 418.5 new full-time equivalent (FTE) county child welfare positions have been appropriated and funded.

In 2016, the state contracted with ICF International to conduct a study concerning the child welfare caseload by county, as opposed to the OSA workload study, which provided estimated hours per case by service for county child welfare caseworkers. The 2016 Child Welfare Caseload Study built upon the workload study results by further supporting the need for additional child welfare staff, creating a framework for requesting additional resources, and providing suggested caseload ratios. This study created the Colorado Division of Child Welfare Caseworker Allocation Tool (DCAT). The DCAT tool provides a framework for determining the allocation of appropriated funds to the counties and for county child welfare positions based upon allocation formula factors such as referrals, assessments, out-of-home placements, and in-home services.

The 2016 caseload study also recommended specific ratios of supervisor to caseworker (1:5) and caseworker to case (1:10). CDHS uses these ratios to justify funding requests and allocate new child welfare staff to counties. Colorado believes that these ratios will continue to support effective and engaging casework practice moving forward under Family First, and therefore intends to use this established caseload ratio for prevention cases unless otherwise specified by the evidenced-based service provider. This past legislative session, SB21-277 required an updated workload study, which will help identify any significant shifts that would warrant adjusted ratios. For the purposes of this five-year plan, all caseworkers are considered prevention caseworkers and may work with Family First prevention-eligible children, youth and caregivers.

using the BPCT infrastructure, to prepare for the implementation changes ahead. Colorado created a website specifically for judicial/legal resources, training and messaging (see https://co4kids.org/family-first/legal).

Evidence-Based Practice (EBP) Provider Workforce

Colorado's EBPs are provided by community-based agencies that receive their training either from the developer of the EBP or someone officially trained as a trainer. Although CDHS is not the direct purveyor of training to providers, the Department will continue partnering with state intermediaries and community-based agencies to ensure that all EBP providers for Family First have the skills and capacities necessary to deliver the selected EBPs with fidelity to the model.

Each EBP selected for this five-year plan has its own staff qualifications and training requirements specific to the intervention's service delivery model (see Appendix A for service-specific details). For most services in this initial plan, state intermediaries will have primary responsibility for ensuring staff qualifications and training requirements are met. There are two services proposed in this plan without a state intermediary. For Functional Family Therapy, FFT LLC oversees the clinical training, supervision training and ongoing consultation for all sites in Colorado. For Parent-Child Interaction Therapy, PCIT International trains and certifies all IV-E-eligible providers in Colorado. The state-wide CQI Platform described above will also help ensure that there is state infrastructure and capacity for providers to access clinical supervision through telehealth platforms where needed, and systematize processes for collecting and monitoring fidelity data to promote high-quality delivery of services. Additionally, CDHS will provide guidance to county departments on how to hold all EBP service providers accountable through contracts to implement each intervention to fidelity, including requirements of staff training.

EBP WORKFORCE DEVELOPMENT AND CAPACITY BUILDING

Colorado understands that in order to expand the availability of and access to prevention services across the state, we need to invest in our EBP workforce and continuously build capacity. Colorado will be strategically investing a portion of the state's Family First transition funds in prevention service capacity building based on the recommendations found in the Colorado Lab report. Colorado has also developed a mechanism by which Title IV-E prevention services reimbursements will be pooled together in the Colorado Child Abuse Prevention Trust Fund and reinvested in Family First-eligible services for future growth and workforce development.

ENSURING THE PROVIDER WORKFORCE IS TRAUMA-INFORMED

As described above, Colorado has developed a multi-year required curriculum around trauma-informed service delivery for all Title IV-E prevention service providers. As part of the procurement process, county departments will specify the requirement to incorporate trauma-informed service delivery into all Family First EBP services.

CASELOADS FOR EBP PROVIDERS

Specified prevention caseloads for each service proposed in this plan are documented in Appendix A. Whether a child/youth/family is or is not known to child welfare at the time they receive prevention services, Colorado will follow the recommended caseload size according to the provided service.

Implementation Planning

From the beginning, Colorado's approach to planning for Family First implementation has been an inclusive and integrated one that fully leverages the interest, experience and expertise of a broad-based and diverse group of state and county staff, Tribes and stakeholders, including families.

Beginning in March 2018, Colorado mobilized a collaborative effort, with facilitation and support from Casey Family Programs, to create a Family First roadmap that identifies critical decisions, actions, time frames and recommendations around the state's initial implementation. In early 2019, a statewide Family First Implementation Team was launched with the responsibility of further defining and prioritizing areas of focus and developing and implementing a detailed action plan aligned with Colorado's Family First roadmap. The 27-member Implementation Team includes representatives from multiple county departments of human services (reflecting diversity of regions and sizes across the state), CDHS, CDPHE, HCPF, judicial/ legal, providers, constituents and research/ evaluation.

The main challenge of the Implementation Team was to strive toward the visionary goal of system transformation, while simultaneously attending to the technical details of implementation requirements. In order to delve deeper into the details of Family First, the team initially prioritized six key implementation workgroups: Assessment, Qualified Residential Treatment Programs (QRTP), Services Continuum, Child and Family Plans, Juvenile Justice and Communications. An American Indian/Alaska Native workgroup was added to ensure that all aspects of Family First implementation are culturally responsive and inclusive of community voice.

Colorado's Family First Implementation Core Values

Road Map development included a process of articulating a set of values that would ground Colorado's Family First discussion, decisions, and recommendations:

- Family and youth voices are the loudest—heard, considered, and respected.
- Children, youth, and families are best served by a systemic and community-engaged, integrated approach to identify and meet their needs.
- Children, youth, and families are served through collaboration, partnership, and engagement with all parties and human services programs.
- Shared accountability and responsibility by an integrated community of care that surrounds youth and family to support success.
- Improve policy, practice, and quality of services based on scientific evidence.
- Strengthen and embrace natural supports.

Continued Engagement with Partner Agencies, Private Providers, and Community Organizations

To make bold and sustainable improvements to the larger child welfare system, deepening collaboration with sister agencies, providers, judicial/legal partners and community-based organizations will continue to be a high priority at the state and county levels. Collaboration and consultation with other state agencies responsible for administering mental health services, substance abuse prevention and treatment, and in-home parenting services, and with other public and private agencies, began early on in Colorado's planning for Family First implementation. This will continue beyond initial implementation to ensure accessibility of services, avoid duplication and maximize and leverage resources.

DELIVERY OF CHILD WELFARE SERVICES TASK FORCE

In May 2018, Colorado's General Assembly showed significant support for Family First with the passage of the Child Welfare Reform Bill, which created the Delivery of Child Welfare Services Task Force. The Task Force includes representatives from CDHS, county departments of human services, HCPF, the Colorado Judicial Branch, and providers

of behavioral health services, prevention services and out-of-home placements. Among other things, the Task Force will be making recommendations on a child welfare funding model, incentives structure, and performance and outcome measures. It is also responsible for ensuring child welfare laws and rules align with Family First, and for determining methods through which the state can maximize federal revenue to support Colorado's children, youth and families. In addition, the Child Welfare Reform Bill created a cash fund that can be used by child welfare agencies to fund prevention and intervention services. Family First implementation efforts will continue to be a standing agenda item at all Task Force meetings.

BEHAVIORAL HEALTH TASK FORCE

In April 2019, Colorado Governor Jared Polis directed CDHS to spearhead the Governor's Behavioral Health Task Force. The Task Force was charged with authoring a statewide strategic plan to transform Colorado's behavioral health system with the goal of enabling every Coloradan with a behavioral health condition or in crisis to receive the services and support they need to live safe, productive lives in their own communities. In September 2020, the Task Force released its "Behavioral Health Blueprint", which outlines detailed recommendations and goals established by the Task Force. A Children's Behavioral Health subcommittee developed recommendations specifically addressing how the state delivers and manages children's behavioral health. For Family First, substance use prevention and treatment efforts in particular will be catalyzed by a new Behavioral Health Administration and other behavioral health recovery efforts detailed in the Blueprint.

PREVENTION SERVICES TASK GROUP

In Colorado, general fund dollars (Core Services Program) can be used for services that prevent out-of-home placement and/or entry into the child welfare system. This opportunity, in addition to Family First and other funds and processes, make up a complex network of programs, services and funding streams to prevent involvement or deeper involvement with the child welfare and/or juvenile justice systems. In an effort to coordinate

and streamline these programs and services, and to develop processes for maximizing funding sources, the Child Welfare Prevention Task Group ("Prevention Task Group") was created in Summer 2021. The purpose of the Prevention Task Group is to act as the child welfare prevention practice advisory group, to develop processes for expanding, implementing and identifying prevention programs and services, and to build a statewide cohesive prevention framework.

For Family First specifically, the Task Group will be responsible for recommending updates to this five-year state prevention plan through the development of processes to equitably identify appropriate services and supports to be included in future amendments. In addition, there are three subcommittees that have convened since June 2021 and are charged with making recommendations to streamline and align prevention processes, services and funding streams; inform prevention capacity-building, implementation and service delivery; and leverage data, research and evaluation in influencing prevention strategies. With close to three years of planning around Family First, the Task Group

will build from a strong foundation of Colorado's established vision and many efforts to date, and will pave a path forward that takes Colorado's prevention efforts to the next level.

REGIONAL PARTNERSHIP GRANT

In 2019, the Colorado Judicial Department and CDHS were awarded a five-year, Round 6 Regional Partnership Grant through the Children's Bureau. This grant, which is currently in the planning phase, will evaluate the effectiveness of the Circle of Parents Expansion (COPE) intervention in increasing family well-being, improving permanency, and enhancing the safety of children who are in, or at risk of, an out-of-home placement due to a parent's or caregiver's opioid or other substance abuse. The COPE intervention integrates Circle of Parents in Recovery—an evidence-informed model that strengthens families, prevents child maltreatment, and supports recovery through a pro-social peer network—within counties that have implemented the Dependency and Neglect System Reform Program (DANSR) to manage dependency and neglect cases following the principles of Family Treatment Drug Courts. The work of COPE includes those within the child welfare court system, but it may be utilized for prevention or as a support to help prevent re-entry.

COLLABORATION WITH TRIBES

CDHS consults, collaborates and coordinates with both federally recognized Tribes within Colorado, as well as with Colorado-based organizations that serve the state's American Indian urban communities. There are two federally recognized Tribes with land bases in Colorado. The Southern Ute Indian Tribe (SUIT) is located primarily in La Plata County and includes approximately 1,510 enrolled members. The Ute Mountain Ute Tribe (UMUT) is located primarily in Montezuma County with another community in White Mesa, Utah, and includes approximately 2,143 enrolled members.

In addition to the two federally recognized tribes, CDHS partners with organizations such as the Colorado Commission of Indian Affairs, the Denver Indian Family Resource Center, Denver Indian Health and Family Services, Denver Indian Center, and Haseya Advocate Program to address ongoing and emerging human services concerns for the state's American Indian urban populations. To facilitate communication and collaboration, CDHS employs a County and Tribal Liaison, an Indian Child Welfare Specialist, and a Behavioral Health Tribal Liaison who are responsible for nurturing and strengthening the department's relationship with the Tribes and organizations that serve the state's American Indian urban communities.

To support both Tribes in providing direct services to children, youth and families, contracts are executed between the Tribes and CDHS to provide funding for service provision. Through these contracts, the Tribes are able to provide services they feel best meet the needs of their communities. The implementation of Family First will not cause a change for Tribal Social Services and programs - both Tribes will continue forward with the Child Welfare contract as they have in previous years. Nonetheless, the State of Colorado and the Tribal governments within the state see Family First as an opportunity to further build on their relationships in order to support Tribal youth and families. SUIT and UMUT have had in the past and continue to have the option to opt into a State-Tribal IV-E agreement at any time, and continue to have the option to create a direct IV-E plan with the Federal government if they wish.

CDHS held a consultation with the Southern Ute Indian Tribe on the impacts of Family First and opportunities for future collaboration. CDHS will be delivering a second overview to Social Service and Behavioral Health staff later this fall, and is working to schedule a presentation to the Ute Mountain Ute Tribe as well.

ASSURANCE ON PREVENTION PROGRAM REPORTING

See the Attachment for assurance that CDHS will report to the Secretary such information and data as the Secretary may require with respect to the Title IV-E prevention program, including information and data necessary to determine the performance measures.

Evidence-Based Prevention Services

Program or Service Name	Program or Service Area	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
COLORADO INITIAL PROPOSED SERVICE ARRAY					
Nurse-Family Partnership (NFP)	In-Home Parent Skill-Based	First-time, low-income mothers. Participation of fathers and other family members encouraged.	Mothers enroll early in pregnancy and may continue until child turns two. One-on-one visits by registered nurses in the home or a location of the mother's choice. Goal is to complete 60 visits, lasting 60-90 minutes each.	Well-Supported	· Child safety · Child well-being: Cognitive functions and abilities · Child well-being: Physical development and health · Adult well-being: Parent/caregiver physical health
SafeCare®	In-Home Parent Skill-Based	Parents of children ages zero to five at risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse.	Weekly sessions of approximately 1 to 1.5 hours for a duration of 18-20 weeks. Typically conducted in the home.	Supported	· Child safety · Child well-being: Behavioral and emotional functioning · Child well-being: Cognitive functions and abilities · Child well-being: Educational Achievement and Attainment · Adult well-being: Positive parenting practices · Adult well-being: Parent/caregiver mental or emotional health · Adult well-being: Family functioning

Program or Service Name	Program or Service Area	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
COLORADO INITIAL PROPOSED SERVICE ARRAY					
Parents as Teachers (PAT)	In-Home Parent Skill-Based	Families with an expectant mother or parents of children up to kindergarten entry (usually five years) in possible high-risk environments. Families with an expectant mother or parents of children up to kindergarten entry (usually 5 years) Families with an expectant mother or parents of children up to kindergarten entry (usually 5 years)	Starts prenatally and continues until child reaches kindergarten. Parent educators meet with families, usually in the home, biweekly to monthly based on need. Recommended duration is at least two years.	Well-Supported	· Child safety · Child well-being: Social functioning · Child well-being: Cognitive functions and abilities
Healthy Families America	In-Home Parent Skill-Based	New and expectant families with children at risk for maltreatment or adverse childhood experiences.	Home-visiting services begin as early as prenatally and continue until child is three to five years old.	Well-Supported	· Child safety · Child well-being: Behavioral and emotional functioning · Child well-being: Cognitive functions and abilities · Child well-being: Educational Achievement and Attainment · Adult well-being: Positive parenting practices · Adult well-being: Parent/caregiver mental or emotional health · Adult well-being: Family functioning

Program or Service Name	Program or Service Area	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
COLORADO INITIAL PROPOSED SERVICE ARRAY					
Parent-Child Interaction Therapy (PCIT)	Mental Health	Children ages two to seven with behavior and parent-child relationship problems.	Typically delivered in playroom settings where therapists can observe behaviors via one-way mirror and provide verbal direction and support to caregiver. Average number of sessions is 14.	Well-Supported	· Child well-being: Behavioral an emotional functioning · Adult well-being: Positive parenting practices · Adult well-being: Parent/caregiver mental or emotional health
Fostering Healthy Futures for Preteens (FHF-P)	Mental Health	Children ages 9 to 11 who have previous or current child welfare involvement due to one or more adverse childhood experiences.	30-week program delivered through one-on-one mentoring conducted by graduate students with weekly skills groups that reinforce individual mentoring sessions.	Well-Supported **Colorado independent systematic review*	· Child well-being: Behavioral and emotional functioning · Child permanency
Fostering Healthy Futures for Teens (FHF-T)	Mental Health	8th and 9th graders who have previous or current child welfare involvement due to one or more adverse childhood experiences.	30-week program delivered through one-on-one mentoring and skills training.	Supported **Colorado independent systematic review*	· Child permanency

Program or Service Name	Program or Service Area	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
COLORADO INITIAL PROPOSED SERVICE ARRAY					
Multisystemic Therapy (MST)	Mental Health, Substance Abuse	Youth between the ages of 12 and 17 and their families. Youth have possible substance abuse issues and are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system.	Intensive family and community-based treatment. Multiple weekly visits between the therapist and family, over an average of three to five months. Intensity of services varies based on clinical needs.	Well-Supported	· Child permanency · Child well-being: Behavioral and emotional functioning · Child well-being: Delinquent behavior · Adult well-being: Positive parenting practices · Adult well-being: Parent/caregiver mental or emotional health · Adult well-being: Family functioning
Functional Family Therapy (FFT)	Mental Health	At-risk youth ages 11 to 18 who have been referred for behavioral or emotional problems, and their families.	Therapists spend 90 minutes face-to-face and 30 minutes over the phone with each family weekly. Average duration is three to five months.	Well-Supported	· Child well-being: Behavioral an emotional functioning · Child well-being: Substance use · Child well-being: Delinquent behavior · Adult well-being: Family functioning

Program or Service Name	Program or Service Area	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
ANTICIPATED FUTURE PROPOSED SERVICES					
Child First **Pending ongoing rigorous evaluation plan*	In-Home Parent Skill-Based, Mental Health	Children from the prenatal stage through 5 years of age who have experienced disruption in secure attachment with their parent.	A mental health clinician and care coordinator visit families in the home over the course of 6 to 12 months, with a focus on stabilizing and connecting the family to services and supports.	Supported	· Child safety · Child well-being: Behavioral and emotional functioning · Child well-being: Cognitive functions and abilities · Adult well-being: Parent/caregiver mental or emotional health · Adult well-being: Family functioning
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) **Pending ongoing rigorous evaluation plan*	Mental Health	Children and youth (ages three to 18) who have experienced trauma and their caregivers.	Includes separate and then conjoint psychotherapy sessions for child and parent. Weekly sessions over 12 to 18 weeks.	Promising	· Child well-being: Behavioral and emotional functioning · Child well-being: Social functioning · Adult well-being: Positive parenting practices · Adult well-being: Parent/caregiver mental or emotional health
Motivational Interviewing (MI)	Colorado considers MI a cross-cutting intervention that can be used to promote behavior change with a range of target populations and for a variety of problem areas.	Can be used to promote behavior change with a range of target populations and for a variety of problem areas.	MI is typically delivered over one to three sessions, and ongoing through the life of a case. There are no minimum qualifications, and MI can be used by a variety of different professionals.	Well-Supported	· Adult well-being: Parent/caregiver substance use · Adult well-being: Parent/caregiver mental or emotional health

Program or Service Name	Program or Service Area	Target Population	Program or Service Delivery and Implementation	Evidence Rating	(Select) Intended Outcomes
ANTICIPATED FUTURE PROPOSED SERVICES					
High Fidelity Wraparound (HFW) **Pending approval of independent systematic review and ongoing rigorous evaluation plan*	Mental Health	Children and youth (ages four to 17) with severe emotional, behavioral, or mental health difficulties and their families.	Typically delivered in home, foster care, or community-based organization over an average of 14 months. Engagement is more intensive in the early stages (one or more meetings per month) and decreases thereafter.	Promising	· Adult well-being: family functioning
Colorado Community Response (CCR) **Additional evidence needed*	In-Home Parent Skill-Based	Families that have been reported for child abuse or neglect but are either screened out or have their cases closed following assessment.	Comprehensive case management services with a focus on assisting families to access concrete services, including one-time cash assistance (i.e., flex funds), by leveraging both formal systems and informal resources.	TBD	· Child safety · Adult well-being: family functioning
Colorado Differential Response (DR) **Additional work needed around fidelity monitoring*	Colorado considers DR a cross-cutting antervention.	Families (with children under the age of 18) who were reported for child abuse or neglect and have a low to moderate risk of maltreatment.	Provides comprehensive case management by connecting families with services and supports to build strengths and protective capacities.	Well-Supported **Via independent systematic review*	· Child safety · Adult well-being: Family functioning · Adult well-being: Parent/caregiver mental or emotional health

Appendix A

Healthy Families America

Healthy Families America (HFA) is a home visiting program for new and expectant families with children who are at-risk for maltreatment or adverse childhood experiences. HFA is a nationally accredited program that was developed by Prevent Child Abuse America. The overall goals of the program are to cultivate and strengthen nurturing parent-child relationships, promote healthy childhood growth and development, and enhance family functioning by reducing risk and building protective factors. HFA includes screening and assessments to identify families most in need of services, offering intensive, long-term and culturally responsive services to both parent(s) and children, and linking families to a medical provider and other community services as needed.

The HFA model is based upon 12 Critical Elements. These Critical Elements are operationalized through a series of standards that provide a solid structure for quality, yet offer programs the flexibility to design services specifically to meet the unique needs of families and communities.

Enrollment begins prenatally and continues up to three months after birth. Most families are offered services for a minimum of three years, and receive weekly home visits at the start. After six months, families receive visits less frequently depending on their needs and progress.

SERVICE DESCRIPTION AND OVERSIGHT

a. Implementation Manual:
Healthy Families America. (2018) Best practice standards. Prevent Child Abuse America.

b. Implementation of HFA

i. Service providers receive intensive training specific to their role to understand the essential components of family assessment, home visiting and supervision. HFA Core training is required for all Family Support Specialists, Family Resource Specialists, supervisors and program managers within six months of hire. This training must be provided by a nationally certified HFA Core trainer. Supplemental wrap-around training occurs within 3 months, 6 months, and 12 months of hire. There is annual training on child abuse and neglect and cultural humility. Family Support Specialists receive weekly reflective supervision as ongoing support.

While all training is provided by certified HFA trailers, as the state office/state intermediary for HFA, Illuminate Colorado provides additional support and follow-up as needed for sites.

b. Target Population in Colorado

i. Families who are at-risk for child abuse and neglect and other adverse childhood experiences. Home visiting services are initiated prenatally or within three months after the birth of the baby

ii. Standardized screening and assessment tools are used to systematically identify and assess families most in need. The Parent Survey (formerly the Kempe Family Stress Checklist) or another HFA-approved tool is used to assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.

c. Sites in Colorado

i. There is currently one community-based organization implementing HFA in Colorado: the Family Visitor Program Healthy Families Aspen to Parachute program (Family Visitor Program) serves families in that Colorado region.

ii. As of March 2021, Illuminate Colorado became the state office/state intermediary for Health Families America. Illuminate provides outreach to potential sites in Colorado and participates in conversations with the national office to explore expansion opportunities.

iii. At the time a provider seeks to affiliate with HFA, they are required to submit an implementation plan that discusses how they intend to carry out model requirements. There is an accreditation guide for potential affiliates.

d. Fidelity Monitoring & CQI

HFA requires implementing sites to utilize the HFA Best Practice Standards and to demonstrate fidelity to the standards through periodic accreditation site visits. The HFA Best Practice Standards serve as both the guide to model implementation and as the tool used to measure adherence to model requirements. There are 153 standards and each is coupled with a set of rating indicators to assess the site's current degree of fidelity to the model.

All HFA affiliated sites are required to complete a self-study that illustrates current site policy and practice. An outside, objective peer review team uses this in conjunction with a multi-day site visit to determine the site's rating (of exceeding, meeting or not yet meeting) for each standard.

During the accreditation on-site visit, the team reviews participant records and supervision notes, and conducts interviews with clients, staff and board of directors. Feedback is provided directly to site leadership daily, covering the site's strengths and areas of improvement identified through the review.

Additionally, quarterly and annual site reviews are conducted to inform the improvement process and make adjustments or corrections as needed. A full re-accreditation is required by the site every few years.

e. CQI

i. Quarterly learning calls are conducted with each site to:

1. Review, strategize and support progress toward addressing recommendations made by the site team and challenges identified by the sites; and
2. Review child safety performance management data that are routinely collected and opportunities to build capacity for routinely collecting and using child and adult well-being data.

CDHS will coordinate with Illuminate to receive relevant fidelity data which will then be translated into the standardized statewide metrics of fidelity and moved into the Colorado CQI Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

ELIGIBILITY

Expectant or new parents screened and/or assessed as moderate to high risk for child maltreatment and/or poor early childhood outcomes (e.g., mental health issues, domestic violence, substance abuse, poverty, housing, lack of education, lack of social support, etc.).

A screening tool that is completed by the Family Support Specialist is used to determine whether parents may qualify for services. A core component of the HFA model is the Parent Survey, which is a therapeutic interview that the visitor conducts with the family and is scored. The survey narrative helps identify each family's strengths, risk factors and needs. Families can screen into the signature HFA program or qualify for accelerated services. Families are eligible for accelerated services if they score as "low-risk" on their initial assessment. Instead of serving families for a minimum of three years, families in HFA Accelerated can move through the program at their own pace and graduate sooner. For families involved with child welfare, there are additional protocols related to enrollment, caseload management, and establishing a formal MOU with child welfare in order to best serve families. If a family is not eligible for HFA, reduced services may be provided, or they may be referred to other services or programs.

REQUEST FOR EVALUATION WAIVER

Colorado is seeking an evaluation waiver for HFA and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation.

HFA is rated well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with 22 studies qualifying as eligible for review by the Clearinghouse.

Colorado-Specific Information

Healthy Families America begins prenatally and enrolls families through the first three-months

postpartum. Colorado has identified this perinatal time period as an essential entry point for reducing the risk of out-of-home removal. A recent Colorado study, specific to infants affected by substance use, found that removal risk was higher when mothers had less than adequate prenatal care, did not participate in WIC, lower household income, and greater medical fragility of the newborn. Furthermore, the Colorado Home Visiting Coalition indicates that there is a compelling need for expanding our array of home visiting services - currently only 19% of families living in poverty and with children under the age of six are participating in a homevising program.

MONITORING CHILD SAFETY

Within the HFA Best Practice Standards, all Safety Standards must be met in order to be accredited, as they impact the safety of the families being served and the staff serving them. Safety standards include personnel background checks (9-3.B), orienting staff on child abuse and neglect indicators, role as a mandated reporter and reporting requirements (10-2.D), supervision of direct service staff (12-1.B), and child abuse and neglect policy and procedures that include reporting criteria, definitions and practice (GA-6.A, GA-6.B).

WORKFORCE SUPPORT AND TRAINING

There are standard requirements for training in HFA and training logs are kept to track training for the workforce. All staff receive HFA core training plus intensive role-specific training. There are two training tracks for direct services staff - parent survey (assessment) and integrated strategies (home visiting). Three day advanced clinical and reflective practice training is required for supervisors. Family Support Specialists receive weekly reflective supervision as ongoing support.

All HFA site staff will be held to the trauma-informed care prevention service provider requirements designed by the Colorado Department of Human Services and included in Colorado's 5-year Prevention Plan. Individual sites will be responsible for ensuring compliance with the standards.

PREVENTION CASELOADS

The Best Practice Manual provides guidance on caseload sizes. The importance of a manageable caseload size ensures families will be afforded the time, energy and resources necessary to help build protective factors, reduce risk and impact positive change. Caseload size provides the maximum number of families and maximum case weight that can be carried by a full-time Family Support Specialist. HFA allows sites to factor in circumstances that will weigh more heavily for many families, including high risk issues, extensive travel, multiple births, translation needs, etc. Guidance regarding assigning case weight based on level of service (frequency of home visits) can be referenced in standard 4-2.A, and in HFA's Level Change forms.

A site's policy and procedures regarding caseload size cannot exceed 15 families at the most intensive level, and no more than 25 families at any combination of service levels, and a maximum case weight of 30 points, per full-time (40 hours/week) FamilySupport Specialist.

Nurse-Family Partnership

Nurse-Family Partnership (NFP) is a program of intensive prenatal and postnatal home visitation by nurses, designed to empower mothers experiencing poverty and their first-borns. NFP has three goals: (1) to improve pregnancy outcomes by helping women improve their prenatal health, (2) to improve child health and development by helping parents provide more sensitive and competent care, and (3) to improve parental life-course by helping parents plan future pregnancies, complete their educations, and find work. By design, NFP helps parents to understand how their behaviors influence their own health and their child's health and development. It supports them in choosing to change their lives in ways that protect themselves and their children more effectively.

The expectant moms benefit by getting the care and support they need to have a healthy pregnancy. At the same time, new mothers develop a close relationship with a nurse who becomes a trusted resource they can rely on for advice on everything from safely caring for their child to taking steps to provide a stable, secure future for them both. Through the partnership, the nurse provides new moms with the confidence and the tools they need not only to assure a healthy start for their babies, but to envision a life of stability and opportunities for success for both mom and child.

NFP is delivered within a 1:1 therapeutic relationship with a personal nurse. Visits occur at the client's home or at an alternative location based on the needs of the client and may include virtually through telehealth. Nurses use their judgment to apply the NFP visit guidelines across 6 domains: Personal Health, Environmental Health, Life Course Development, Maternal Role, Family and Friends, and Health and Human Services.

SERVICE DESCRIPTION AND OVERSIGHT

a. **Implementation Manual:**
   Colorado's NFP program utilizes the 'Nurse-Family Partnership Visit-to-Visit Guidelines', which is approved by the Title IV-E Prevention Services Clearinghouse.

b. **Implementation of Nurse-Family Partnership:**

All of Colorado's NFP staff and home visitors receive the same training on the NFP model elements., The Community Planning Guide provides a 5-chapter series as a resource for implementing NFP: Building Partnerships, Based in Evidence, Funding & Financing, Your Staff, and What to Expect in Your First 6 Months. Additional resources are available on the Implementation Plan Guidance page.

NFP requires highly skilled NFP Nurses and Supervisors so that they may work effectively with the families participating in the program, many of whom are experiencing multiple complex issues. All NFP nurses participate in a comprehensive program of education designed to support them in developing: (1) strong communication, personal relationship building and problem-solving skills; (2) a deep understanding of all facets of the NFP program model; (3) skill in delivering all components the NFP program with fidelity; and (4) the ability to adapt the program as necessary to "make it work" for each client and family.

The NFP National Service Office (NSO) develops and delivers initial education for nurse home visitors and nurse supervisors. Initial education is required as part of model fidelity as outlined in agency contracts. The initial education training policy can be found at: https://www.nursefamilypartnership.org/wp-content/uploads/2018/12/NFP-Initial-Education-Policy-07.24.2018.pdf

One-on-one weekly clinical supervision occurs for each nurse with the nurse supervisor. NFP nursing teams meet regularly for team meetings and case conferences at least twice per month, where they receive guidance from supervisors and colleagues to help them deliver the best possible care to their clients. Reflective supervision (RS) in NFP is based on a collaborative relationship between NFP nurses and their supervisors. Effective RS is also a protective factor in preventing burnout or compassion-fatigue for the NFP nurse, and is encapsulated in model element #14. The use

of RS in NFP implementation has also been shown in several studies to significantly increase program retention, reduce attrition and provide nurses with a positive modeling framework that ultimately cascades down to the client and her baby. Nurse supervisors conduct joint home visits with each nurse three times a year.

c. Target Population

Nurse-Family Partnership focuses on first-time mothers experiencing poverty — a population disproportionately impacted by systemic barriers that sometimes has limited access to role-models. Women voluntarily enroll as early as possible with nurse home visits, ideally beginning by week 16 of pregnancy.

d. Sites in Colorado

Currently, NFP is implemented in 22 sites across 64 counties, including service provision to the two Federally recognized tribal communities in Colorado through county partners.

FIDELITY MONITORING AND CQI

Fidelity is the extent to which there is adherence to the model elements. Applying the model elements in practice provides a high level of confidence that the outcomes achieved by families who enroll in the program will be comparable to those achieved by families in the three randomized, controlled trials and outcomes from ongoing research on the program. In addition to applying the model elements to implementation, fidelity includes agency and nurse uptake and application of new research findings and new innovations, as well as adjusting NFP practice to the changing context and demographics of NFP clientele.

C.R.S § 26-6.4-102 details how the University of Colorado is responsible for the programmatic and clinical support, evaluation and monitoring for the program. The Colorado Coordination Team (CCT) is a partnership between the NFP NSO, the University of Colorado, Invest in Kids (IIK), and the Colorado Department of Human Services (CDHS). The CCT has well-established processes for monitoring fidelity and engaging in continuous quality improvement in urban, rural, and frontier counties. IIK is charged with ensuring all 22 NFP implementing agencies accurately input data from every home visit into a national data-collection system. Once the data are collected, IIK assists NFP teams in using the data to assess their program fidelity according to 19 model elements and to track progress toward outcome achievement. IIK employs a full-time data analyst to oversee this work. IIK also employs a program director and two nurse consultants to work with NFP teams daily on all aspects of implementation, including using the data to guide nursing practice given individual NFP site context.

As statutorily required in C.R.S § 26-6.4-106 (e), all NFP teams submit a progress report to the CCT for review annually. This review results in a feedback letter to every NFP team detailing their successes on maintaining fidelity and achieving outcomes, as well as guidance to improve areas of fidelity and progress toward outcomes that IIK will support them with throughout the following year. IIK's work to support fidelity is financed through two contracts with the University of Colorado, with the funding coming from the administrative portion of the Master Tobacco Settlement to the Nurse Home Visitor Program and a smaller portion from the administrative portion for Colorado's Maternal Infant and Early Childhood Home Visitation funding.

CDHS will coordinate with IIK to receive relevant fidelity data which will then be translated into the standardized statewide metrics of fidelity and moved into the Colorado CQI Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

ELIGIBILITY

Per C.R.S § 26-6.4-104 (2), "A mother shall be eligible to receive services through the program if she is pregnant with her first child, or her first child is less than one month old, and her gross annual income does not exceed two hundred percent of the federal poverty level".

REQUEST FOR EVALUATION WAIVER

Colorado is seeking an evaluation waiver for NFP and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation.

NFP is rated well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with 10 studies qualifying as eligible for review by the Clearinghouse.

Colorado-Specific Information

Much of the national research demonstrating NFP's efficacy has included samples from Colorado. The Pacific Institute for Research and Evaluation (PIRE) published a fact sheet in 2019, titled "Life status and financial outcomes of Nurse-Family Partnership in Colorado", using a published systematic review of more than 30 NFP evaluations. Based on statistically significant life status and financial changes it documented, the fact sheet estimates NFP outcomes as implemented in Colorado.

Table 1. Expected Life Status and Financial Outcomes When First-Time Low-Income Mothers Receive Nurse-Family Partnership Home Visitation Services in Colorado

Outcome	Change
Smoking During Pregnancy	25% reduction in tobacco smoked
Complications of Pregnancy	33% reduction in pregnancy-induced hypertension
Preterm First Births	15% reduction in births below 37 weeks gestation (17 fewer preterm births per 1,000 families served)
Infant Deaths	48% reduction in risk of infant death (3.0 fewer deaths per 1,000 families served)
Closely Spaced, High-Risk Pregnancies	37% reduction in closely spaced, high-risk pregnancies within 15 months postpartum during 4 years after the first birth
Very Closely Spaced Births	25% reduction in second births within 15 months postpartum
Subsequent Preterm Births	28.6 fewer subsequent preterm births per 1,000 families served
Breastfeeding	12% increase in mothers who attempt to breastfeed
Intimate Partner Violence	17% reduction in assaults, prenatal to child age 5
Child Maltreatment	33% reduction in child maltreatment through age 15
Childhood Injuries	34% reduction in injuries treated in emergency departments, ages 0-2
Language Development	41% reduction in language delay; 0.14 fewer remedial services by age 6
Youth Criminal Offenses	25% reduction in crimes and arrests, ages 11-17
Youth Substance Abuse	56% reduction in alcohol, tobacco, & marijuana use, ages 12-15
Immunizations	14% increase in full immunization, ages 0-2
TANF Payments	7% reduction through year 13 post-partum; no effect thereafter
Food Stamp Payments	10% reduction through at least year 15 post-partum
Person-months of Medicaid Coverage Needed	8% reduction through at least year 15 post-partum due to reduced births and increased program graduation
Costs if on Medicaid	12% reduction through age 18
Subsidized Child Care	Caseload reduced by 3.0 children per 1,000 families served

The Colorado Evaluation and Action Lab engaged in an extensive review of Colorado needs assessment to inform the selection of services. The resulting strategy report is linked here: https://coloradolab.org/wp-content/uploads/2021/07/Strategy-for-the-Evidence-based-Aspects-of-the-Family-First-Service-Continuum.pdf. NFP was selected as a prevention service because the national literature on NFP creates a compelling case for meeting local needs. In addition to living in poverty, NFP moms are also often experiencing, or at risk of experiencing, addiction or substance misuse; involvement with child welfare or juvenile or criminal justice systems; intimate partner violence; severe developmental disabilities; and/or behavioral or mental health needs. All of these risk factors are closely aligned with Colorado's proposed definition of candidacy.

MONITORING CHILD SAFETY

During home visits, the NFP nurse provides structured support and guidance across the six program domains: personal health, environmental health, life course development, maternal role, family and friends, and health and human services.

The NFP Strengths and Risks (STAR) Framework is designed to help NFP nurses and supervisors systematically characterize levels of strength and risk exhibited by the mothers and families they serve. STAR is intended to inform and support consistent clinical decisions made by NFP nurses and supervisors regarding visit content and dosage (time spent on the six domains). In addition, STAR promotes identifying stages of behavioral change and appropriate corresponding actions and intervention to improve maternal and child health. By attending to specific strengths that mothers and family members bring to the program, STAR helps the NFP nurse to identify families who are doing so well on their own that they may not need to be visited as frequently as called for in the current program guidelines and to identify those that need more visits due to greater risk or need. Information organized within the STAR informs NFP nurses' ways of working with families and helps them align the program content and frequency with mothers' (and other family members') abilities and interests in engaging in the program.

In addition, all NFP nurses and supervisors are mandatory reporters. If there are concerns for a child's safety, they will file a report through the Colorado statewide child abuse and neglect hotline. If a child is in imminent danger, providers will call 911.

WORKFORCE SUPPORT & TRAINING

Detailed information on NFP's initial education policy can be found here: https://www.nursefamilypartnership.org/wp-content/uploads/2018/12/NFP-Initial-Education-Policy-07.24.2018.pdf

Nurses and supervisors participate in a 9-month comprehensive training program to learn how to conduct in-home visits.The training incorporates a combination of a self-study workbook, web-based training activities, and two onsite training sessions at the NFP NSO in Denver. Ongoing education and training occurs for both new nurse home visitors and supervisors hired to implement the program. Supervisors receive ongoing consultation to help them develop strong skills with respect to reflective supervision, along with coaching from experienced program consultants.

All NFP site staff will be held to the trauma-informed care prevention service provider requirements designed by CDHS and included in Colorado's 5-year Prevention Plan. Individual sites will be responsible for ensuring compliance with the standards.

PREVENTION CASELOADS

NFP Model Element 12 states that a full-time nurse home visitor carries a caseload of 25 or more active clients. Nurses must be at least half-time employed in order for nurses to be proficient in the delivery of the program model. Caseload size may vary, but may not exceed 30 clients without approval from the NSO.

SafeCare

SafeCare® is an internationally recognized, evidence-based in-home parent support program that provides direct skills training to parents and caregivers. The parenting model was developed in 1979 and is currently being provided at more than 177 sites across 19 states in the United States. In 2007, the National SafeCare® Training and Research Center (NSTRC) was created through Georgia State University, where it remains today. Although SafeCare® Colorado uses a local intermediary for implementation, NSTRC is responsible for helping sites throughout the United States and other countries implement SafeCare® effectively.

SafeCare® Colorado is a flexible, free and voluntary parent support program for parents and caregivers with children ages five and under who need extra support to keep their families safe and healthy. Parent support providers use a proven process to help at-risk parents and caregivers build on their existing skills in three topic areas: home safety, child health and parent-child interactions. The home safety topic targets risk factors for environmental neglect and unintentional injury by teaching parents and caregivers how to identify and remove common household hazards. This topic also emphasizes the importance of proper supervision. The child health topic teaches parents and caregivers how to prevent, identify, and respond to common childhood illness and injuries. This topic also promotes keeping sound medical records and the importance of preventative care including routine vaccines and well checks, which will help reduce incidences of medical neglect. During the parent-child interaction topic, parent support providers teach parents and caregivers ways to increase positive behaviors, prevent difficult behaviors and have a stronger relationship with their children. Parents and caregivers learn ways to help their children make good decisions and develop routines so family time can be more enjoyable and less stressful.

SafeCare® was implemented in Colorado in 2013 as part of Governor Hickenlooper's Child Welfare Plan, "Keeping Kids Safe and Families Healthy 2.0". The Colorado Office of Early Childhood partnered with the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe) to support the implementation of SafeCare® Colorado through the three-year pilot period (2013-2016).

SERVICE DESCRIPTION AND TRAINING

a. **SafeCare® Colorado Implementation Manual**
SafeCare® Colorado Implementation Manual (2015, Latest revision 2021). Implementation Manual

SafeCare® Provider Manual (2019

b. **Implementation of SafeCare® Curriculum & Training**

i. **SafeCare® Orientation**
Every provider will attend a SafeCare® Orientation, typically one to two weeks before the SafeCare® Provider Workshop. All SafeCare® trainees are required to attend. Orientation provides an overview of the SafeCare® model and implementation process.

Provider Workshop
The purpose of the Provider Workshop is to give a foundational knowledge of the SafeCare® curriculum, how to deliver it to families, and how to assess and train parents in the four module skills. Participation in the four-day Provider Workshop in its entirety is mandatory. Before working with families, providers must complete all workshop activities, including quizzes, by the conclusion of workshop training.

Provider Certification
Once providers complete workshop training, they will begin delivering SafeCare® with families, which should be no later than two weeks after the workshop. Providers will work closely with their Coach to build their proficiency and competency in delivering the SafeCare® model. To do this, a provider will record all sessions for their Coach to observe. All session recordings are to be uploaded to the SafeCare® Portal within 48 hours of session completion. The Coach will listen to the audio and schedule a coaching

session with the provider, typically before their next appointment with the family. To achieve Provider Certification, providers must demonstrate strong fidelity in three sessions for each of the three modules (Parent-Infant/ Child Interaction, Home Safety, and Health) with families — nine sessions total (with a combination of assessment & training sessions).

Provider Certification Maintenance
Once certified, providers will maintain their certification through monthly fidelity checks and coaching sessions, to document their ongoing quality of services. If fidelity is low, additional sessions will be reviewed with coaching until strong fidelity is achieved on two consecutive sessions.

Multilingual SafeCare Providers
If a provider delivers SafeCare® in multiple languages, they must achieve fidelity in at least one session in each module per language to be considered proficient in that language as part of their SafeCare® provider certification.

SafeCare® Coach
The role of a provider's coach is to support them as a provider and conduct quality assurance, a requirement for SafeCare® delivery. Coaches observe provider's sessions, score fidelity and provide feedback. They also convene team meetings with providers to provide an opportunity to support and learn from each other.

c. Target Population in Colorado

i. Families referred to SafeCare® are at risk of becoming, or already have been, involved in the child welfare system. SafeCare® Colorado serves a specific population in Colorado:

- Families with children ages five and under
- Families that reside in one of the 40 counties or two tribal nations currently offering the program in the state
- Families with an open but non-court involved child welfare case at the time services begin

Families must meet certain high-risk eligibility criteria:

- Being a single parent
- Have multiple children ages five and under in the home
- Be receiving public assistance
- Have a child with special needs
- Have mental health or substance abuse issues
- Have less than a high school education
- Be under the age of 20
- Have an unstable or hazardous housing situation
- Have a stepfather or other unrelated male caregiver in the home
- Have prior reports on the parent or caregiver to child welfare
- Have childhood experience of abuse or neglect on the part of the parent or caregiver
- Have a history of violence in the home

d. Sites in Colorado

i. SafeCare® Colorado sites are currently located within community-based and county public health agencies. The goal in identifying SafeCare® Colorado site locations has been to target communities with the highest need for SafeCare® services, as well as community and organizational readiness for implementation.

Kempe has supported multiple rounds of site/ county expansions in the implementation of SafeCare® Colorado, for a total of 14 sites across 40 counties and two tribal nations, constituting a variety of communities, including rural, urban, frontier, and tribal. Many of these areas are home to families with some of the state's highest resource needs and, in some areas, no previous access to home-based parent support services existed.

ii. Site Expansion
Kempe requires an interested site to supply

them with current statistical data relative to the number of families in their proposed community that possess characteristics of high need and/or meet SafeCare® eligibility criteria. In addition, since a major referral source for the program is the child welfare system, they require a prospective site to supply them with recent child welfare statistics for the communities proposed to serve.

To assess capacity and readiness, Kempe examines several different site characteristics that have been found in the literature to predict the successful implementation of a program. Examples of these characteristics include: a site's prior experience implementing evidence-based programs, a site's existing relationships with possible referral sources in their community, a site's leadership structure, and a site's infrastructure (e.g., physical, and technological resources).

e. Fidelity Monitoring & CQI

i. **Coaching**

In the eight years since SafeCare® was introduced to Colorado, Kempe has built a monthly coaching program that includes coaches at both Kempe and select sites. SafeCare® Colorado currently has seven sites with coaches who deliver fidelity monitoring and coaching services to all providers at their respective sites, including two sites with Spanish coaches who also serve state-wide bilingual/Spanish speaking providers (in addition to their own site).

As only SafeCare® certified trainers can train and coach a SafeCare® coach, Kempe trainers also provide ongoing coaching and fidelity monitoring to site coaches for maintenance of their certification.

SafeCare® Colorado Coaches participate in monthly coaches meetings to share information, collaborate, and identify trends in fidelity delivery of the SafeCare® model. Coaches connect with their peers throughout the state and have been able to develop an ongoing working relationship to address the changing needs of providers in the state.

Addressing Fidelity Concerns

Coaching focuses heavily on the monitoring of each provider's fidelity to the SafeCare® model. To complete fidelity monitoring, each provider is asked to audio record (with the family's permission) their visits. As part of each coaching session, a provider's recording is listened to and scored by his/her coach in advance, and issues concerning fidelity are addressed in the coaching session. Each provider is required to pass fidelity by a minimum of 85%, as determined by the National SafeCare Training and Research Center (NSTRC), on any submitted and scored visit.

Should a provider not achieve 85% or higher fidelity ratings, they will need to submit additional recordings until they meet that threshold for two consecutive recordings. If the provider does not meet the minimum fidelity benchmarks or struggles in other areas of fidelity monitoring (e.g., timely recording uploads) coaches implement a provider support plan that identifies Specific, Measurable, Achievable, Relevant, Time-bound (SMART) goals to address the fidelity or coaching concerns and increase coaching frequency. The provider support plans are designed to be supportive in nature to improve provider performance and participation in the coaching process and are not intended to be punitive. Once a provider completes the parameters of a support plan, they resume regular monthly coaching

Fidelity Reports

The Kempe team utilizes an internal Coaching Tracking Form as well as the NSTRC Portal to collate quarterly and annual fidelity outcomes. These resources provide information on outcomes and percentages for individual providers, sites and SafeCare® Colorado as a whole, in a fidelity graphs document. The graphs also denote the previous year's composite data for comparison.

ii. CQI

The current CQI process includes three steps. First, data is obtained from sites and entered the Salesforce system. The second step in the CQI process is assisting sites in transforming collected data in a way that allows a site to compare and interpret their performance in several different areas to establish benchmarks. This is currently done through Salesforce and then entered by site supervisors into a site aggregate excel document, which allows site leadership and supervisors to see data over time. There is work currently underway to create a dashboard in Salesforce, which will allow sites to pull all this data in one report, eliminating the need for the excel site aggregate. The third step in the current CQI process involves sitting down with sites and reviewing reports with supervisors and site leadership to devise strategies for improving a site's and provider's performance toward their contract benchmarks.

This process occurs monthly with Kempe site managers and site supervisors, and on a quarterly basis with the Office of Early Childhood (OEC) SafeCare® Program Manager, Kempe Center leadership and site leadership. Additionally, it is the role of the Kempe site managers to communicate with their individual sites on a regular basis and to be available for real time technical assistance. During the at-least-monthly contact, Kempe site managers help sites synthesize and make sense of data and performance trends at their sites. Finally, a monthly site supervisor conference call between all site supervisors is facilitated by Kempe. This call offers a forum for sharing updates, ideas and solutions to frequently arising concerns from all participants including site supervisors, OEC and Kempe.

CDHS will coordinate with Kempe to receive relevant fidelity data which will then be translated into the standardized statewide metrics of fidelity and moved into the Colorado CQI Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

ELIGIBILITY

SafeCare® depends on partners in the community to help identify at-risk families in need of parent support services. Referrals to SafeCare® Colorado are received from multiple pathways, and therefore the program has the potential to impact more families along the entire prevention continuum in local communities across Colorado.

- SafeCare® receives referrals from child welfare staff, community organizations, and self-referring parents and caregivers.
- Counties have the opportunity to offer SafeCare® Colorado services to at-risk families in need of support before they are ever referred to the child welfare system.
- SafeCare® has increased service opportunities for families who have non-court involved child welfare involvements, thereby increasing the availability of voluntary services for Colorado children and families.
- SafeCare® gives counties the opportunity to provide services to families after child welfare involvement is closed to prevent future interactions with the child welfare system.

RESEARCH AND ONGOING RIGOROUS EVALUATION

SafeCare® has a long history of success, and the program's effectiveness has been evaluated in numerous studies during the past 40 years. SafeCare® has high child welfare relevance, and is rated as a supported practice in the Title IV-E Prevention Services Clearinghouse.

Colorado State University (CSU) Social Work Research Center (SWRC) serves as the independent evaluator for SafeCare® Colorado. An independent evaluation of SafeCare® Colorado has been conducted by the Social Work Research Center at CSU since 2014, with a focus on performance management outcomes, qualitative experiences of families and providers, and child welfare outcomes.

CSU/SWRC, in collaboration with the CDHS OEC SafeCare Program Administrators, have crafted a new evaluation design which began in Fiscal Year 2021. This plan reflects stakeholder envisioned directions for SafeCare® Colorado research

innovations as well as the emergent Family First requirements for ongoing rigorous evaluation. The evaluation uses a quasi-experimental design (QED) measuring at least two contrasts from eligible outcome domains (namely, child well-being and adult well-being), per the Title IV-E Prevention Services Clearinghouse standards and procedures handbook. Eligible contrasts included in the QED will be prioritized for follow-up measurement at 12 months after program completion in order to examine sustained effects of SafeCare® Colorado and build the evidence base for SafeCare as a "well supported" practice.

See the attachment for the SafeCare® Colorado Evaluation Plan, FY2021-2022.

MONITORING CHILD SAFETY

A key component of the SafeCare® program is the proven session structure for each topic, which includes a baseline assessment, training sessions, and follow-up assessments to monitor change. Throughout the training, providers use a set of observation checklists for each topic and conduct observational assessments to gauge current skills and areas in need of improvement.

WORKFORCE SUPPORT & TRAINING

The Kempe SafeCare® Colorado Coach/Trainer/Site Managers (SMs) have completed extensive SafeCare® Training through the National SafeCare® Training and Research Center (NSTRC). The Kempe SMs provide training for, and continuous fidelity monitoring of all providers, keeping them up to date on topics such as barriers to delivery and needs for further training. To maintain their certification as Trainers, the Kempe SMs actively participate in an annual accreditation process through NSTRC by attending training workshops and having their training and coaching services observed for fidelity monitoring and feedback.

Not only do the current SafeCare® Colorado SMs have extensive experience with the delivery of the standard SafeCare® training, but also have developed supplemental training to help meet identified training needs of providers and supervisors. Development of these trainings was in response to data collected through CSU's evaluation as well as direct requests from the sites to Kempe. These trainings include:

- General SafeCare® Colorado Orientation
- Safety and Boundaries for Home Visitation Training
- Site Kickoff and Onboarding
- Various outreach trainings tailored to current and changing marketing plans for SafeCare® Colorado
- Continuous Quality Improvement
- Supervision
- SafeCare® Curriculum Booster Training
- Child Development Learning Series
- New Site Coach Workshops with Certification & Ongoing Support
- Mandated Reporting ECHO Series
- SafeCare® Support and Empowerment Series
- Creation of, and enhancement to, in-person and virtual outreach toolkits
- Site Supervisor Training and Support
- Diversity trainings

All SafeCare® Colorado site staff will be held to the trauma-informed care prevention service provider requirements designed by CDHS and included in Colorado's Five Year Prevention Plan. Kempe SMs will assist individual sites with ensuring compliance with the standards.

PREVENTION CASELOADS

Providers are encouraged to start with two to three families to build proficiency and competency before expanding their caseload. Once fully trained it is recommended that providers hold a caseload of 12-20 families, with an average of 15, depending on the family service need and intensity.

Parents as Teachers

The Parents as Teachers (PAT) program is an evidence-based early childhood home visiting model that builds strong communities, thriving families, and children who are healthy, safe, and ready to learn. Certified parent educators implement the PAT model, using its fundamental approach: partner, facilitate and reflect. There are four integrated components to the PAT model: personal visits, group connections, screening and resource network. Parent educators emphasize parent-child interaction, development-centered parenting and family well-being across all four components.

The PAT model is designed to achieve four primary goals:

- Increase parent knowledge of early childhood development and improve parenting practices;
- Provide early detection of developmental delays and health issues;
- Prevent child abuse and neglect; and
- Increase children's school readiness and school success.

Personal visits of approximately 60 minutes take place at a minimum once per month, depending on family needs. Parents engage in at least 12 group connections (or meetings) annually, and there is annual screening of children for developmental, health, hearing, and vision issues.

Parent Possible serves as the Colorado state intermediary for PAT.

SERVICE DESCRIPTION AND OVERSIGHT

a. **Implementation Manual:**
Parents as Teachers National Center, Inc. (August 2020). *2020 Parents as Teachers Affiliate Implementation Manual*.

b. **Implementation of PAT:**
The Affiliate Implementation Manual (AIM) outlines how to design and deliver the PAT model with fidelity and quality, incorporating both the PAT Essential Requirements and the PAT Quality Standards.

All new parent educators and supervisors attend the Foundational and Model Implementation Trainings before delivering Parents as Teachers. Only nationally certified PAT trainers are allowed to train others in the PAT model. There is not a train-the-trainer option.

The main components of Parents as Teachers include:

Personal Visits: Home visitation is a key component of the Parents as Teachers model, with personal visits of approximately 60 minutes delivered at a minimum once a month, depending on family needs. Parent educators share research-based information and use evidence-based practices by partnering, facilitating, and reflecting with families. Parent educators use the Parent as Teachers curriculum in culturally sensitive ways to deliver services that emphasize parent-child interaction, development-centered parenting, goal setting and family well-being.

Group Connections: Another component of the Parents as Teachers model is monthly or more frequent group connections, which parents can attend with their child to obtain information and social support and share experiences with their peers. Group connections formats include family activities, presentations, community events, parent cafes, and ongoing groups.

Screenings: Annual child health, hearing, vision, and developmental screenings, beginning within 90 days of enrollment, are a component of the model. Many programs also carry out adult screenings to identify parental depression, substance abuse, and intimate partner violence.

Resource Network: Additionally, Parents as Teachers maintains ongoing relationships with institutions and community organizations that serve families. Parent educators help families identify needs, set goals, connect with appropriate resources, and overcome barriers to accessing services.

Each month, parent educators participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings. All parent educators are observed delivering a personal visit at least once during the program year, conducted by a supervisor or lead parent educator using a structured observation tool. Observations occur more often for new parent educators. In addition, the supervisor observes at least one group connection at least every six months using a structured observation tool, and reviews the planning and delivery documentation for each.

Parent educators obtain competency-based professional development and renew certification with the National Center annually. 20 hours of annual professional development is required for all parent educators.

c. **Target population in Colorado:**
PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. PAT affiliates select the eligibility criteria for the target population they serve. This may include children with special needs, families at risk for child abuse, teen parents, first time parents, immigrant parents, low-income families, parents with mental health or substance abuse issues, or families experiencing unstable housing or homelessness.

d. **Sites in Colorado:**
There are currently 28 PAT program sites in 36 counties across Colorado. Parent Possible serves as the Colorado state intermediary for PAT.

FIDELITY MONITORING AND CQI

The Parents as Teachers National Center has established 21 Essential Requirements that are deemed fundamental to replicating and implementing the Parents as Teachers model with fidelity. An organization must adhere to these Essential Requirements to become and remain a PAT affiliate. Data that addresses these requirements are reported annually on the Affiliate Performance Report (APR) to determine model fidelity. Additional resources such as the Model Implementation Guide, the Quality Standards, and TA Briefs provide guidance and best practices recommendations for high-quality replication of the Parents as Teachers model.

Affiliates are also expected to participate in the Quality Endorsement and Improvement Process (QEIP) in their fourth year of implementation, and every fifth year thereafter. This process consists of four main steps:

1. Essential Requirements Review- front end: Parents as Teachers National Center reviews whether the affiliate is meeting the Essential Requirements
2. The Affiliate Self-Study: the affiliate prepares and submits a written self-study describing how they meet the quality standards
3. Review of the Affiliate Self-Study: Parents as Teachers National Center reviews family files, conducts a supervisor interview and assesses the affiliate's self-study
4. Essential Requirements Review – back end. PAT National Center reviews whether the affiliate has continued to meet the Essential Requirements.

Parent Possible, the state intermediary for PAT, has a well-established process for monitoring fidelity and ensuring sites engage in continuous quality improvement throughout the state. Parent Possible ensures that all 26 implementing agencies accurately input data from every home visit into the statewide data collection system. Once the data is collected, Parent Possible uses the data along with each site's Annual Performance Report and in-person site visits to assess program fidelity and adherence to PAT's 21 Essential Requirements. In addition to fidelity monitoring, Parent Possible has a well-established evaluation process that tracks parent growth, literacy, school readiness, and parent-child interaction. Parent Possible employs a director of research and evaluation, a data manager, and a program director to work with PAT sites on a daily basis on all aspects of implementation, data collection, and evaluation.

All PAT sites set CQI goals annually and those not meeting all of the PAT Essential Requirements are required to create Success Plans that formally lay

out their goals and plans for meeting the goals. Parent Possible's work to support PAT fidelity is funded through the federal Maternal Infant Early Childhood Home Visiting program, the state Tony Grampsas Youth Services program, and private funding from foundations.

CDHS will coordinate with Parent Possible to receive relevant fidelity data which will then be translated into the standardized statewide metrics of fidelity and moved into the Colorado CQI Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

ELIGIBILITY

The PAT affiliates select the eligibility criteria for the target population they serve. This may include children with special needs, families at risk for child abuse, teen parents, first time parents, immigrant parents, low-income families, parents with mental health or substance abuse issues, or families experiencing unstable housing or homelessness.

PAT affiliates may include usage of Colorado's Family Safety Assessment (CFSA) tool, the Ages and Stages Questionnaires (ASQ), as well as housing, food, mental health, substance use, and income factors to determine eligibility.

The Parents as Teachers model is designed to serve families from pregnancy through kindergarten entry. Families can enroll at any point along this continuum. Curriculum materials provide resources to continue services through the kindergarten year if an affiliate chooses to do so.

REQUEST FOR EVALUATION WAIVER

Colorado is seeking an evaluation waiver for PAT and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation.

PAT is rated well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with 6 studies qualifying as eligible for review by the Clearinghouse.

Colorado-Specific Information

Colorado's Office of State Budgeting and Planning and the General Assembly partnered with the Pew-MacArthur Results First Initiative to implement the Results First Initiative in Colorado. The Pew-MacArthur Results First Initiative works with jurisdictions to implement an innovative benefit-cost model. The Colorado Results First report examined PAT and described a positive cost-benefit of continuing to implement this service in Colorado. Furthermore, the research on PAT is compelling and relevant to Colorado because the positive effects on preventing child maltreatment occur with a staffing model that is feasible in our rural areas and culturally relevant in our Tribal communities. Parent educators are more practical to recruit and retain than master's level clinicians in some areas of Colorado and this is particularly true in our Tribal communities, which is essential because there is disproportional representation of American Indian/Alaska Native children in child welfare. PAT is used in multiple Tribal communities across the country and at both the Ute Mountain Ute and Southern Ute Indian Tribes in Colorado. This service was recommended for inclusion in our Plan by Colorado's Family First American Indian and Alaska Native workgroup.

MONITORING CHILD SAFETY

As part of Essential Requirement 15, a child health review must be completed within 90 days of family enrollment or child's birth, and at least annually thereafter. The Child Health Record contains safety elements that must be completed as part of the review. Additionally, some affiliates use the Colorado Family Safety Assessment (CFSA) tool as part of their process in determining eligibility, which identifies whether there are any current or impeding dangers. One-time training is required for the CFSA tool; this is completed on an agency by agency basis. Parent Possible is focusing on formalizing this requirement in the near future. During virtual service delivery, affiliates should outline safety practices in their policies, procedures and protocols which apply during virtual visits as well.

In addition, all parent educators and supervisors are mandatory reporters. If there are concerns

for a child's safety, they will file a report through the Colorado statewide child abuse and neglect hotline. If a child is in imminent danger, providers will call 911.

WORKFORCE SUPPORT AND TRAINING

All new parent educators who will deliver PAT services will attend the Foundational and Model Implementation Training before service delivery begins. These trainings are now available as a 40-hour virtual certification training. Only nationally certified PAT trainers are allowed to train others in the PAT model.

To renew certification, the PAT National Center requires that parent educators complete a minimum of 20 hours of professional development during the first year, 15 hours the second year, and 10 hours per year thereafter.

All PAT site staff will be held to the trauma-informed care prevention service provider requirements designed by the Colorado Department of Human Services and included in Colorado's 5-year Prevention Plan. Individual sites will be responsible for ensuring compliance with the standards.

PREVENTION CASELOADS

PAT does not have a minimum or maximum caseload size, as it may depend on different factors that make the optimal caseload size different for each individual affiliate, as well as each parent educator. Instead, the PAT Essential Requirements set the maximum number of visits per month. Essential Requirement 13 regulates that "full-time first year parent educators complete no more than 48 visits per month during their first year and full-time parent educators in their second year and beyond complete no more than 60 visits per month. The number of visits completed monthly is decreased proportionately when a parent educator is part-time." Factors that must be considered when determining the maximum number of visits completed monthly include:

- Parent educator responsibilities.
- Frequency of visits.
- The families the affiliate serves and their family experiences and stressors.
- Number of children per family.
- Travel time and geography.
- Languages spoken.

One way that affiliates can determine parent educator caseload size is by a point system. Supervisors can assign point values for each family on a caseload based on the above considerations, and the point total should be 50 or less.

The maximum number of parent educators that can be assigned to each supervisor is 12, regardless of whether the parent educators being supervised are full-time or part-time employees.

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) is a parent coaching program that aims to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the parent-child relationship. PCIT targets families with children who are 2 to 7 years of age and experiencing frequent, intense emotional and behavioral problems. Children and their caregivers are seen together in PCIT.

PCIT is conducted through coaching sessions during which the parent(s) and child are in a playroom while the therapist is in an observation room watching through a one-way mirror and/or live video feed. The parent wears a "bug-in-the-ear" device through which the therapist provides in-the-moment coaching.

There are two treatment phases. The first phase of treatment focuses on establishing warmth in the parent-child relationship through learning and applying skills proven to help children feel calm, secure in their relationships with their parents, and good about themselves.

The second phase of treatment equips the parent in managing the most challenging of the child's behaviors while remaining confident, calm and consistent in the approach to discipline. In this phase, proven strategies are taught to help the child accept limits, comply with directions, respect house rules, and demonstrate appropriate behavior in public.

Sessions can be completed in the home, at outpatient clinics, via telehealth or at a community-based agency/provider. Treatment is not session-limited. Treatment averages 3 to 5 months (12 to 20 weekly sessions total). Treatment length varies to ensure parental attainment of goal competencies.

SERVICE DESCRIPTION AND OVERSIGHT

a. Implementation Manual

Eyberg, S.M. & Funderburk, B.W. (2011) Parent-child interaction therapy protocol. Gainesville, FL, PCIT International.

b. Implementation of Child First

PCIT International works with Colorado-based agencies and providers to follow an extensive protocol to launch and sustain PCIT-certified therapists. Components of the protocol are as follows:

Training Requirements for Certified PCIT Therapists

In order to apply for certification as a PCIT therapist, therapists must document applicable graduate education, basic PCIT training, and consultation training which includes completing two cases as described below.

Graduate Education requirements: Therapists must have a master's degree or higher in a mental health field, and be a licensed mental health service provider (for example, licensed psychologist, psychiatrist, licensed clinical social worker, etc.) or be working under the supervision of a licensed mental health service provider. Psychology doctoral students who have completed the third year of training and are conducting clinical work under the supervision of a licensed mental health service provider also meet this requirement.

Basic Training: 40-hours of face-to-face training with a PCIT Regional or Global Trainer is required. This basic training includes an overview of the theoretical foundations of PCIT, Dyadic Parent-Child Interaction Coding System (DPICS) coding practice, case observations and coaching with families, with a focus on mastery of child-directed interaction (CDI) and parent-directed interaction (PDI) skills, and a review of the 2011 PCIT Protocol.

Consultation Training: The applicant must serve as a therapist for a minimum of two PCIT cases to graduation criteria as defined by the 2011 PCIT Protocol. Until the two PCIT cases meet graduation criteria, the applicant must remain in contact via real-time consultation (e.g., telephone conference or live, online, or telehealth observation) or video review with a certified PCIT Trainer at least twice a month.

Skill Review: Applicants must have their treatment sessions observed by a certified PCIT Trainer. Observations may be conducted in real time (e.g., live or online/telehealth) or through video recording. The PCIT Trainer reviews a variety of sessions and determines whether the applicant has demonstrated mastery of each skillset. By the end of the training process, the applicant should be able to 1) Administer, score, and interpret the required standardized measures for use in assessment and treatment planning; 2) Administer behavioral observations from the DPICS-IV Coding System; and 3) Achieve a minimum of 80% agreement with a PCIT Trainer using the DPICS-IV during 5 minutes of either live coding or continuous coding with a criterion video recording.

Final decisions about certification of PCIT Therapists will be made by PCIT

International. Certified PCIT Therapists are required to obtain at least 3 hours of PCIT Continuing Education credit every 2 years through educational activities sponsored by the PCIT International Task Force on Continuing Education.

Additional information on training requirements for initial certification can be found here: http://www.pcit.org/therapist-requirements.html

c. Target Population in Colorado

The target population for PCIT is families with children who are between two and seven years old with challenging behaviors and experiencing conflict in the caregiver-child relationship.

d. Sites in Colorado

Currently, there are 13 agencies across Colorado offering PCIT International with 21 providers. There are also six within-agency trainers and one regional trainer available to scale the service. Because this model uses an individual therapy approach, there is no state intermediary.

e. Additional Sites

New sites interested in providing PCIT in Colorado will work with PCIT International to assess readiness. Readiness factors include whether an agency currently serves families with children between the ages of 2 and 7 years old, there are established referral pathways for PCIT, agency-level commitment to manualized intervention, PCIT equipment, and therapists available to provide weekly sessions. There is also an optional Certification Preparation Workshop for interested agencies/therapists.

FIDELITY MONITORING & CQI

a. Each session type (CDI Teach, CDI Coach, PDI Teach and PDI Coach) has an associated PCIT International Protocol Treatment Integrity checklist that is used to assess teaching and coaching competencies and fidelity to the model during the rigorous certification process.

b. PCIT is an assessment-driven treatment, guided by weekly data from the ECBI and DPICS (described below). These standardized instruments are supplemented by additional measures the clinician may select for careful tracking of individual presenting complaints of families during treatment. Below are descriptions and references for key assessment tools used in PCIT.

Eyberg Child Behavior Inventory (ECBI)[1]

The ECBI is a 36-item parent report instrument used to assess common child behavior problems that occur with high frequency among children with disruptive behavior disorders. It is sensitive to changes with treatment and used to monitor weekly progress in PCIT. The ECBI manual and scoring sheets may be purchased online from Psychological Assessment Resources, Inc. Some criticism of this instrument, however, is that the

1 Eyberg, S.M., & Pincus, D. (1999). Eyberg Child Behavior Inventory and Sutter-Eyberg Student Behavior Inventory-Revised: Professional Manual. Odessa, FL: Psychological Assessment Resources.

Funderburk, B.W., Eyberg, S.M., Rich, B.A., & Behar, L. (2003). Further psychometric evaluation of the Eyberg and Behar rating scales for parents and teachers of preschoolers. Early Education and Development, 14, 67-81.

Rich, B.A., & Eyberg, S.M. (2001). Accuracy of assessment: The discriminative and predictive power of the Eyberg Child Behavior Inventory. Ambulatory Child Health, 7, 249-257.

literacy rate required to complete it may be too high for some families. As such, we may select to use the Weekly Assessment of Child Behavior (WACB) as an alternative to the ECBI.The WACB is a valid alternative to the ECBI, as described in Bennet's 2019 article.

Dyadic Parent-Child Interaction Coding System (DPICS)[2]

The DPICS is a behavioral coding system that measures the quality of parent-child social interactions. It is used to monitor progress in parenting skills during treatment and provides an objective, well-validated measure of changes in child compliance after treatment. The manual presents many studies documenting the reliability and validity of individual DPICS categories. The DPICS (4th edition) is available in the PCIT Store.

Other key assessments tools often used in PCIT include Sutter-Eyberg Student Behavior Inventory-Revised (SESBI-R), Therapy Attitude Inventory (TAI), Revised Edition of the School Observation Coding System (REDSOCS), and Child Rearing Inventory (CRI).

c. Since PCIT does not have a state intermediary, CDHS is working with PCIT International to utilize Colorado's statewide CQI Platform (discussed in the five-year prevention plan) to build additional infrastructure and capacity around fidelity monitoring and CQI. The state CQI Platform will allow PCIT to systematize processes for collecting fidelity data, ensure all therapists can access ongoing clinical supervision through telehealth platforms, and develop reports that can help sites, counties and state take a data informed approach to continuous quality improvement and shoring up fidelity to the PCIT model.

ELIGIBILITY

d. The target population for PCIT is families with children who are between two and seven years old with challenging behaviors and experiencing conflict in the caregiver-child relationship.

Referral sources can include child welfare caseworkers, pediatricians, case managers, psychological assessment or self-referral.

Child-focused referrals: Children ages two to seven with frequent temper tantrums, aggressive behavior, or oppositional behavior that impacts caregiver-child functioning and/or school functioning; children with co-morbid diagnoses of intellectual disability, autism spectrum disorder, attention-deficit/hyperactivity disorder (ADHD), callous and unemotional traits, anxiety disorders and/or depressive disorders. Children can have open cases with child welfare.

Parent-caregiver-focused referrals: Kinship caregivers, foster caregivers, adoptive parents, and biological parents are appropriate referrals; parents or caregivers at-risk or with histories of physical abuse towards a child or coercive parenting interactions; parents that need help with behavior management. PCIT currently excludes families where the primary caregiver has allegations around sexual abuse, or if the parent is actively engaging in substance abuse.

RESEARCH AND EVALUATION WAIVER REQUEST

e. Existing Research.

Colorado is seeking an evaluation waiver for PCIT and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation.

PCIT is rated well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with 21 studies qualifying as eligible for review by the Clearinghouse.

The most comprehensive review of PCIT to date can be found in the Lieneman, Brabson, Highlander, Wallace & McNeil (2017) article Parent-Child Interaction Therapy: Current Perspectives. In this article, they summarize

2 Eyberg, S.M., Nelson, M.,M., Ginn, N.C., Bhuiyan, N., & Boggs, S.R. (2013). Dyadic Parent-Child Interaction Coding System: Comprehensive Manual for Research and Training (4th ed.). Gainesville, FL: PCIT International.

treatment effectiveness research with the following:

> *"As the efficacy of PCIT has been well established,[11,14] research over the past decade has focused on testing the effectiveness of PCIT within various community treatment settings. This substantive body of literature is summarized in Table 1. Several studies have demonstrated improvements in child behavior as well as increases in positive parenting skills and decreases in negative parenting skills for families receiving standard PCIT for disruptive child behaviors in community treatment settings in the US.[15–18] Similar positive outcomes have been noted with PCIT delivered in child welfare settings [19–22] and with in-home delivery.[23,24] More novel treatment settings for PCIT have included a time-limited modified version delivered in a managed care company,[25] a PCIT-based parenting program for incarcerated women,[26] PCIT delivered in a domestic violence shelter,[27] and group-based PCIT delivered by a community outreach agency.[28] Each of these studies noted similar decreases in child behavior problems and increases in positive parenting skills. It is interesting to note that several studies have also shown PCIT to be effective with nonparental caregivers such as foster parents [29,30] and participants in a kinship care program.[31]"*

In addition, PCIT has demonstrated effectiveness with a variety of cultures and countries including Mexican-American (McCabe & Yeh, 2009; McCabe, Yeh, Lau, & Argote, 2012), African-American (Butler & Eyberg, 2006; Fernandez, Butler, & Eyberg, 2011); Puerto Rican (Matos et al., 2006, 2009); Australian (Nixon, et al., 2003; Phillips, et al., 2008); Dutch (Abrahamse et al., 2012), and Chinese (Leung et al., 2009; Yu et al., 2011) families; and PCIT was culturally adapted for American Indian and Alaska Native families (Bigfoot & Funderburk, 2011).

f. **Colorado-Specific Information.**
Research partners at the Colorado Evaluation and Action Lab engaged in an extensive review of Colorado's needs assessment to inform the selection of services. The resulting strategy report can be found here. PCIT was selected as a prevention service because the national literature on PCIT creates a compelling case for meeting local needs. For example, the evidence cited above indicating that PCIT is effective across a variety of delivery settings is important for our geographically diverse state. Traditional out-patient service delivery is impractical in some parts of our state, and Colorado has identified a need for services that can go to families, as opposed to assuming families can travel to a service provider. Furthermore, as of September 25, 2021, 38 percent of our children/youth in out-of-home care were Hispanic, and PCIT research has shown that this intervention is culturally responsive and effective for this population.

MONITORING CHILD SAFETY

g. As described above, PCIT is an assessment-driven treatment, guided by weekly assessment data. The ECBI is a validated measure administered weekly to monitor treatment gains. DPCICS observational coding is also used and completed weekly. As part of the certification process, all therapists are required to achieve a minimum of 80% agreement with a PCIT Trainer to DPCICS.

h. In addition to ongoing weekly assessments, all PCIT therapists are mandatory reporters. If there are concerns for a child's safety, they will file a report through the Colorado statewide child abuse and neglect Hotline. If a child is in imminent danger, providers will call 911.

WORKFORCE SUPPORT & TRAINING

i. As described above, in order to apply for certification as a PCIT therapist, therapists must document applicable graduate education, attend basic PCIT training, and complete consultation training. To maintain certification, therapists are required to obtain at least 3 hours of PCIT Continuing Education credit every 2 years through educational activities sponsored by the PCIT International Task Force on Continuing Education.

j. All PCIT therapists and agency staff (if applicable) will be held to the trauma-informed care prevention service provider requirements designed by CDHS, as described in the five-year prevention plan.

PREVENTION CASELOADS

k. There are no limitations for the number of cases that a clinician can carry for PCIT. It is most common that ⅓ of a clinicians caseload consists of PCIT cases, but this depends on the agency and individual preferences of the clinician.

Fostering Healthy Futures

There are two versions of Fostering Healthy Futures: Fostering Healthy Futures for Preteens (FHF-P) and Fostering Healthy Futures for Teens (FHF-T).

FHF-P is a mentoring and skills group program for preadolescent children who have current or previous child welfare involvement due to one or more adverse childhood experiences (ACEs). These ACEs may include the experience of maltreatment, out-of-home placement, housing, caregiver or school instability, violence exposure and/or parental substance use, mental illness, or incarceration. FHF-P uses a combination of structured individual mentoring and group-based skills training to promote prosocial development and to ameliorate the consequences of ACEs.

FHF-T is a mentoring and skills training program for 8th and 9th graders with current or previous child welfare involvement due to one or more adverse childhood experiences (ACEs).These ACEs may include the experience of maltreatment, out-of-home placement, housing, caregiver or school instability, violence exposure and/or parental substance use, mental illness, or incarceration. FHF-T's outcomes are being examined in an ongoing randomized controlled trial, but effects on permanency have already been demonstrated in a published paper.

Colorado reviewed both FHF-P and FHF-T via an independent systematic review process.

SERVICE DESCRIPTION AND OVERSIGHT

a. **Implementation Manuals:**

Taussig, H. N., Wertheimer, R., Fireman, O., Raviv, T., & Holmberg, J. (2015). *Fostering Healthy Futures implementation manual*. University of Denver.

Hettleman, D., Wertheimer, R, & Taussig, H. N. (2005). *Fostering Healthy Futures skills group manual*. University of Denver.

Taussig, H.N., Wertheimer, R., Corvinus, J., Fireman, O., & Malen, A. (2021). Fostering Healthy Futures for Teens Pre-Implementation Documents.

Fireman, O., Bender, K., Wertheimer, R., Malen, A., & Taussig, H.N. (2021). Fostering Healthy Futures for Teens Training and Mentor Orientation Manual.

b. **Implementation of Fostering Healthy Futures:**

i. The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe) serves as the state intermediary to help scale the program, select sites and providers, provide training and ongoing TA, and monitor fidelity to the models.

ii. Kempe follows an extensive protocol to launch and sustain FHF partner agencies. Each agency that is considering implementing the FHF programming completes an FHF Readiness Assessment. After completing the assessment, agencies will discuss the ratings with the FHF Program Developers to see if their agency is a good fit for the program.

FHF-P consists of two main components:

- **Skills Groups:** Skills groups consist of eight children each and meet for 1.5 hours/week. The groups follow a manualized curriculum and are facilitated by mental health clinicians and graduate trainees. Topics addressed include emotion recognition, problem solving, anger management, cultural identity, change and loss, and peer pressure.

- **Mentoring:** Children are paired with graduate student mentors and receive 3-4 hours per week of 1:1 mentoring. Mentors help youth generalize the skills learned in skills group to real-world settings. They focus on engaging children in their communities and teaching them advocacy skills. Mentors also interface with other adults in the child's life and create a network of support.

FHF-T consists of 1:1 mentoring by graduate students and a series of 6 teen workshops. FHF-T builds on youth's strengths and interests by engaging teens in visioning and

goal-setting exercises, skills training, and workshops to build on their competencies and reduce adverse outcomes.

c. Target population in Colorado

i. The preteen program is designed for youth ages 9 to 11 who have current or previous child welfare involvement. The teen program is for 8th and 9th graders who have open child welfare cases, at least at time of referral. Many of those cases are closed throughout the program year.

d. Sites in Colorado

In September 2019, FHF hired a Director of Dissemination to identify the need across the state and increase the reach of programming. Part of this dissemination work is to enhance Kempe's role as an intermediary—to train local agencies in the program model and provide ongoing coaching and technical assistance. The FHF-P program was offered by the Kempe Center from 2002-2012 and 2018-2021 and by Aurora Mental Health Center from 2012-2019. In 2020-21 FHF-P is being implemented by Lutheran Family Services, Ariel Clinical Services and Adoption Options in four geographic areas (Denver Metro, El Paso County, Larimer County, and Mesa County). The FHF-T program was offered by the Kempe Center in 2012-2014 and by the University of Denver from 2015-2019. Current implementing agencies have expressed interest in running both FHF-P and FHF-T in 2022-23 and beyond.

FIDELITY MONITORING & CQI

Kempe, as the FHF intermediary, in conjunction with agencies implementing the FHF-P and/or FHF-T program, track multiple fidelity indices including children's program attendance, engagement and satisfaction, and implementing staff's adherence to the program model components. Program activities, including skills groups for FHF and mentor training and supervision for both programs, are videoed, and Kempe reviews the videotapes and provides feedback on a regular basis. Kempe also talks with the Agency Administrative Lead on a monthly basis to discuss program implementation strengths and challenges. See Appendix 10 (Implementation & Fidelity Tracking Materials) for the fidelity tracking instruments.

Intern Supervisors ensure that the program is being implemented with fidelity and serves as a liaison between the agency and the program developers/consultation team. They are responsible for completing program fidelity forms and tracking outcomes at the agency. For FHF-P, Group Supervisors are also responsible for completing fidelity reports and uploading videos for fidelity monitoring.

CDHS will coordinate with Kempe to receive relevant fidelity data which will then be translated into the standardized statewide metrics of fidelity and moved into the Colorado CQI Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

ELIGIBILITY

a. **Children must meet the following enrollment criteria in order to participate in FHF Preteen programming:**

- Be between the ages of 9 and 11 when the program begins
- Have experienced one or more of the Adverse Childhood Experiences (ACEs)
- Lives within a 35-minute drive of the implementation site
- Is able to commit to a (day of the week) group night for the 30-week program
- Has behavioral, emotional, and cognitive functioning sufficient to:
  - participate and benefit from groups and mentoring
  - be transported safely in a car with other children
  - allow other children to benefit from group (i.e. not extremely disruptive)

For FHF Teen, the criteria are as follows:

- Be entering 8th or 9th grade when the program begins

- Have experienced one or more of the Adverse Childhood Experiences (ACEs)
- Is able to commit to the 30 week program
- Have behavioral, emotional, and cognitive functioning sufficient to participate and benefit from mentoring

There is a liaison at every county who helps identify children who might be eligible, then caseworkers fill out a referral form that documents the child's risk. Although originally developed to serve children in out-of-home care, FHF-P has been expanded to include children who have experienced ACEs but have not necessarily been placed in out-of-home care. This programmatic change fits with Colorado's definition of candidacy that these children/youth are at serious risk of out-of-home placement.

REQUEST FOR EVALUATION WAIVER

Colorado is seeking an evaluation waiver for Fostering Health Futures Preteen and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation.

Colorado conducted an independent systematic review, with a determination of FHF Preteen as a well-supported practice (see the Attachment for full documentation of this review). All of this research was conducted in Colorado, as such the findings that Fostering Healthy Futures Preteen positively affects child well-being outcomes and permanency are relevant to Colorado youth, and there is a track-record of driving these outcomes in Colorado. Furthermore, when we look at the needs assessment data in Colorado, it is clear that there is a need for this particular intervention. For example, our state department of public health does an annual survey of kids and found that only 3.4% of school-aged children and adolescents would go to a teacher or other adult within schools for help, which suggests there is a need for mentoring programs.

Fostering Healthy Futures for Teens was rated as supported practice through our Independent Systematic Review and associated request for transitional payments. As such, it will require on-going rigorous evaluation to continue building evidence toward the goal of meeting criteria for a well-supported practice. The Colorado-based Kempe Center, under the leadership of Dr. Heather Taussig, has an exceptional track record of conducting rigorously designed randomized controlled trials to evaluate the efficacy of Fostering Healthy Futures Teen. Currently, there is an Arnold Ventures funded ongoing rigorous evaluation of the teen program, with a focus on delinquency outcomes. The pre-analysis plan is linked here: https://osf.io/n28ws/

Once new sites are on-boarded to deliver Fostering Healthy Futures for Teens in Colorado and it is confirmed that these sites are oversubscribed (i.e., waitlist for enrollment), we will model continued ongoing rigorous evaluation after Dr. Taussig's previous and current work. We anticipate we will replicate measuring sustained effects on child permanency and consider the additional inclusion of measuring child well being as well.

MONITORING CHILD SAFETY

Throughout the program, mentors are seeing youth one to two times a week, depending on whether they are in the teen or preteen program. Mentors write progress notes following every interaction. They also send monthly reports to the case worker (if applicable) on how children are doing, their attendance and their engagement in the program. Mentors are also regularly meeting with involved adults, including teachers, parents, caseworkers, coaches and pastors.

In cases where abuse or neglect is suspected, reports are made both to the caseworker and to the child abuse hotline. Non-reportable concerns are often discussed with the caseworker, but efforts are made to do so in ways that are respectful of the child or family's perspective, outline strengths as well as areas of concerns, and focus on constructive solutions.

WORKFORCE SUPPORT & TRAINING

FHF has implementation manuals, in-person training, and weekly ongoing training and coaching throughout the implementation year. Pre-implementation training is a 3-day in-person

training. Ongoing training and consultation during the program year ranges from 1-3 hours/week depending on the staff position in the first year of program implementation.

Mentors complete 24 hours of training and orientation before meeting with children. Mentors receive one hour of individual supervision, one hour of group supervision (during their mentees' skills group), and one hour of didactic seminar per week. Mentors also participate in a team meeting for one hour every other week.

All FHF site staff will be held to the trauma-informed care prevention service provider requirements designed by the Colorado Department of Human Services and included in Colorado's 5-year Prevention Plan. Individual sites will be responsible for ensuring compliance with the standards.

PREVENTION CASELOADS

Preteen: 1 mentor: 2 children (mentor time spent individually, not together)

Teen: 1 mentor: 3 teens (mentor time spent individually, not together)

Functional Family Therapy

Functional Family Therapy (FFT) is a short term prevention program for at-risk youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18 year old youth who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between therapist/program and family, increasing motivation for change, identifying specific needs of the family, supporting individual skill-building of youth and family, and generalizing changes to a broader context. Typically, therapists will meet weekly with families face-to-face for 60 to 90 minutes and by phone for up to 30 minutes, over an average of three to six months. Master's level therapists provide FFT. They work as a part of a FFT-supervised unit and receive ongoing support from their local unit and FFT training organization.[1]

The FFT model consists of 5 major components, each has its own goals, focus and intervention strategies and techniques.

1. Engagement: The goals of this phase involve enhancing family members' perceptions of therapist responsiveness and credibility.
2. Motivation: The goals of this phase include creating a positive motivational context by decreasing family hostility, conflict and blame, increasing hope and building balanced alliances with family members.
3. Relational Assessment: The goal of this phase is to identify the patterns of interaction within the family to understand the relational "functions" or interpersonal payoffs for individual family members' behaviors.
4. Behavior Change: The goal of this phase is to reduce or eliminate referral problems by improving family functioning and individual skill development.
5. Generalization: The primary goals in this phase are to extend the improvements made during Behavior Change into multiple areas and to plan for future challenges.[2]

SERVICE DESCRIPTION AND OVERSIGHT

a. **Implementation Manual:**
Alexander, J. F., Waldron, H. B., Robbins, M. S., & Neeb, A. A. (2013). *Functional Family Therapy for adolescent behavioral problems*. American Psychological Association.

b. **Implementation of FFT:**

i. FFT LLC utilizes a multiphased approach to implementation. Sites must purchase Phase I but have the option to purchase any phases above and beyond that. Sites must also purchase two clinical assessments utilized during FFT, the Outcome Questionnaire (OQ) and the Youth Outcome Questionnaire (YOQ); these must be purchased outside of the standard costs of implementation through FFT LLC. Specifics around the OQ and YOQ, including costs for licensing, can be found at their website, https://www.oqmeasures.com/.

Phase I - Clinical Training
The initial goal of the first phase of FFT implementation is to impact the service delivery context so that the local program builds a lasting infrastructure that supports clinicians to take maximum advantage of FFT training/consultation. The secondary objective of Phase I is for local clinicians to demonstrate strong adherence and high competence in the FFT model. Assessment of adherence and competence is based on data gathered through the FFT Clinical Service System (CSS) and through weekly consultations during Phase I FFT training activities. It is expected that Phase I be completed in one year, but not any longer than 18 months. Periodically during Phase I, FFT LLC personnel provide the

1 Administration for Children and Families (ACF). "Functional Family Therapy." *Title IV-E Clearinghouse*, Dec. 2020, preventionservices.abtsites.com/programs/252/show.

2 Functional Family Therapy LLC. "Clinical Model." *Clinical Model - About FFT Training - Functional Family Therapy*, fftllc.com/about-fft-training/clinical-model.html.

implementation site with feedback to identify progress toward Phase I implementation goals and steps toward beginning Phase II.

Phase II - Supervision Training
The objective of the second phase of implementation is to assist the site in creating greater self-sufficiency in FFT, while also maintaining and enhancing site adherence/competence in the model. Primary in this phase is developing competent onsite/virtual FFT supervision. During Phase II, FFT LLC trains a site's extern to become the onsite/virtual supervisor. This person attends two two-day supervisor trainings, then is supported by FFT LLC during monthly phone consultations. FFT LLC provides a one-day onsite/virtual training during Phase II for the full team. In addition, FFT LLC provides ongoing consultation as necessary and reviews the site's CSS database to measure site/therapist adherence, service delivery trends and outcomes. Phase II is a yearlong process.

Phase III - Maintenance Phase
The objective of the third phase of FFT implementation is to move into a partnering relationship to assure on-going model fidelity and impact issues of staff development, interagency linking and program expansion. FFT LLC reviews the CSS database for site/therapist adherence, service delivery trends and client outcomes, and provides a whole team, one-day, onsite/virtual training for continuing education in FFT (the same one-day training cited in Phase II). Phase III is renewed on an annual basis.[3]

c. Target population in Colorado:

i. In Colorado, FFT serves a specific population of pre-adolescents, 10-12 years old, with behavioral issues at risk of out-of-home placement, with both the child welfare and juvenile justice systems.

d. Sites in Colorado:

i. As of this writing, FFT is currently being utilized in five counties across Colorado; Boulder, Denver, Larimer, Weld, and El Paso. Programming is provided through the following organizations:

2. IMPACT Partnership, Boulder, CO
3. Jefferson Center for Mental Health, Wheat Ridge, CO
4. North Range Behavioral Health, Greeley, CO
5. Savio House, Denver & Colorado Springs, CO
6. Savio House FFT-G, Denver, CO

ii. Counties interested in FFT would complete the FFT LLC application process and submit all documentation to FFT LLC for review. CDHS will provide contact information and support to counties interested in implementing FFT in their communities.

e. Fidelity monitoring & CQI:

i. FFT LLC is the intermediary for the FFT provision of services across the state. Fidelity for each site is monitored by them through the national Clinical Service System (CSS) database. The CSS is designed to build therapist competence and skills in the application of FFT. The CSS is the implementation tool that allows therapists to track modalities essential for successful implementation: session process goals, comprehensive client assessments, and clinical outcomes. The goal of the CSS is to increase therapist competence and skill by keeping therapists focused on relevant goals, skills, and interventions necessary for each phase of FFT. The computer-based format allows the therapist to have easy access to a wide variety of process and assessment information in order to make good clinical decisions and complete outcome information to evaluate case success. The following pieces of functionality are built into the CSS system:

- Client Assessment
- Case Tracking

3 FFT LLC. Phases of FFT Implementation and Certification, FFT LLC. , 2006.

- Process Tracking
- Outcome Assessment

Therapists and supervisors are required to enter the information at each consultation and evaluation. FFT LLC reviews the CSS database for site/therapist adherence, service delivery trends and client outcomes, and provides a one-day onsite/virtual training for continuing education and fidelity in FFT yearly.[4]

ii. CQI:

1. Therapists and supervisors are required to enter information into CSS at each consultation and evaluation which is brought together in a Tri-Yearly Performance Evaluation (TYPE) report. The TYPE report is generated every four months from CSS which includes things like: utilization percentage, outcomes completed, treatment pacing, consultation attendance, and assessment completion. Results are then used by FFT LLC and the therapist to create quality assurance plans, impacting the efficacy of service provision.

   FFT LLC requires that individual therapists meet with a national consultant weekly, either virtually or over the phone during Phase I of training. In Phase II, the national consultant meets twice a month, virtually or over the phone, with the staff supervisor, while the supervisor then takes over the weekly consultations with their individual therapists. In Phase III, they move to monthly calls between the staff supervisor and the consultant. Consultation includes general topics, such as issues around documentation or caseloads and moves into being more clinical, utilizing the FFT model of supervision and staffing of cases. At a minimum, the weekly calls are considered a requirement for site certification, so attendance by individual therapists is mandatory.

2. FFT LLC will be the main point of contact for any service/provider level fidelity monitoring and CQI efforts through implementation and the TYPE report. CDHS will coordinate with FFT LLC to receive copies of the TYPE reports which will then be translated into the standardized statewide metrics of fidelity and moved into the Colorado CQI Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

ELIGIBILITY

In Colorado, FFT serves a specific population of pre-adolescents 10-12 years old with behavioral issues at risk of out-of-home placement, with both the child welfare and juvenile justice systems. Youth and families in Colorado who receive FFT are referred to an individual therapist or organization by child welfare, juvenile justice, or behavioral health staff at the county level.

REQUEST EVALUATION WAIVER

Colorado is seeking an evaluation waiver for FFT and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation.

a. Existing research. Since 2010, FFT LLC proprietary training and implementation has been evaluated in 20 published, peer-reviewed studies that show feasibility, acceptability, and positive outcomes. These studies were completed with samples from five different countries (Denmark, England, New Zealand, Singapore, and Scotland) and seven US States (California, Florida, Louisiana, New Jersey, Pennsylvania, Ohio, and Washington). Please see the FFT LLC Research Table for details on each specific study and the research outcomes.

   FFT is rated as well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with nine studies qualifying as eligible for review by the Clearinghouse.

4 James F. Alexander, Ph. D. Functional Family Therapy: Principles of Clinical Intervention, Assessment, and Implementation, FFT LLC, 2014.

b. **Colorado-specific inforation.**
Research partners at the Colorado Evaluation and Action Lab engaged in an extensive review of Colorado needs assessment to inform the selection of services. The resulting strategy report is linked here: https://coloradolab.org/wp-content/uploads/2021/07/Strategy-for-the-Evidence-based-Aspects-of-the-Family-First-Service-Continuum.pdf. FFT was selected as a prevention service because the national literature on FFT creates a compelling case for meeting local needs. For example, delinquent behavior, including academic failure, is a common issue with children and adolescents across Colorado. 46.2% of children and adolescents indicate a low commitment to school, with 37.4% reporting academic failure.[5]Healthy family functioning is a protective factor for managing delinquent behavior. Yet, 24.6% of children and adolescents indicate poor family management, with 12.9% indicating their parents would not know if they came home on time.[6]

Multiple studies referenced in the research table indicate improvements in defensive communication and externalizing behaviors.

The national literature also indicates that FFT drives outcomes related to youth mental health and family functioning for individuals and families that meet Colorado's candidacy definition.

MONITORING CHILD SAFETY

a. All FFT sites in Colorado follow the rigorous training schedule and guidelines in the Functional Family Therapy Clinical Training Manual. Child safety is assessed at multiple points during a family's engagement with an FFT provider. The following are some examples of when specific monitoring may occur.

i. During the referral/engagement phase of FFT, resources are provided to help the therapist make assessments around the appropriate engagement of family members. This includes conversations with the referring agent (e.g., judge, probation officer, case worker, etc) and all relevant intake materials. The therapist will be able to further assess this on phone calls with the family before the first session. Part of this assessment decision-making includes gauging and monitoring the safety of the child/youth.

ii. During service provision for substance use treatment, targets of FFT include the reduction in family symptoms and referral symptoms (truancy, compliance with probation, family safety, etc) by enhancing family protective factors (appropriate parental monitoring, appropriate family communication, etc) and decreasing family risk factors (inappropriate parent skills, inappropriate family communication, inappropriate problem solving skills, etc). Part of enhancing family protective factors include gauging and monitoring the safety of the child/youth.

iii. Assessment in FFT is an ongoing, multifaceted process that reflects the phased and functional nature of FFT. Child safety is continually gauged during the assessment process. In general, important features of this assessment phase include:

- Pretreatment formal assessment often accompanies referrals to FFT; the FFT-specific assessment occurs once actual face-to-face intervention commences. As such, much of the important assessment focus is simultaneous with early session interventions.
- Beyond the generic assessment generally obtained in educational, juvenile justice, and social service/mental health contexts, FFT emphasizes the identification of the interpersonal impact of behavior for each

5 Colorado Department of Public Health & Environment. (2018). 2017 Colorado Healthy Kids Survey. Retrieved from https://cdphe.colorado.gov/healthy-kids-colorado-survey-archive.

6 Colorado Department of Public Health & Environment. (2018). 2017 Colorado Healthy Kids Survey. Retrieved from https://cdphe.colorado.gov/healthy-kids-colorado-survey-archive.

family member, usually determined on the basis of the characteristic patterns and processes that have characterized the family of late. The initial focus of this assessment is within the family and between the family members and the therapist. The assessment focus then broadens to include behavioral strengths and problems, not only of the youth but of the parent figures also. Child safety is continually monitored within this process.

- After the initial pretreatment formal assessments (stored in CSS), FFT uses formal assessment (e.g., diagnostic tests, formal self-report instruments) only when necessary to answer specific questions that cannot be answered in direct clinical contact, or when additional information necessary for legal and/or record keeping responsibilities (e.g., drug screens, documentation of reading scores to establish improvement or appropriate school placement) is required. This form of direct clinical contact allows for continual monitoring of child safety throughout the treatment period.

WORKFORCE SUPPORT AND TRAINING

a. Colorado's adherence to the rigorous design of the FFT implementation and certification model will ensure the successful replication of FFT programming across the state. This adherence further ensures the program's long-term viability at each individual site. The three main phases of this process: 1) Clinical Training, 2) Supervision Training, and 3) Practice Research Network, provide comprehensive support to each individual FFT site.

b. All FFT site staff will be held to the trauma-informed care prevention service provider requirements designed by the Colorado Department of Human Services and included in Colorado's 5-year Prevention Plan. Individual sites will be responsible for ensuring compliance with the standards.

PREVENTION CASELOADS

a. Family needs and distance traveled are important factors that go into caseload size determinations for FFT. The expectation is that FFT service providers have at least five families on their caseload at any given time. This averages out to approximately 20 hours of face-to-face work per week. There is potential for FFT service providers to reach 10-12 families per staff, but that is dependent on the site agency's location and the complexity of travel to access the family.

Multisystemic Therapy (MST)

MST is an intensive family- and community-based treatment program that addresses the multiple influences that contribute to youth risk of out-of-home placement, including serious antisocial or illegal behavior and substance use, in youth aged 12 to 17 years old. The MST approach views individuals as being part of, and influenced by, a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. In MST, this "ecology" of interconnected systems is viewed as the "client." To achieve successful outcomes with these youth, interventions are generally necessary within and among a combination of these systems. MST uses the strengths of each system to promote behavior change in the youth's natural environment.

The ultimate goal of MST is to empower parents, assuring that they have or can develop the skills and resources needed to address the difficulties that arise in raising children and adolescents, and to similarly empower youth to cope with family, peer, school, and neighborhood problems.

MST is provided using a home-based model of service delivery. This model helps to overcome barriers to accessing services, increases family retention in treatment, allows for the provision of intensive services, and enhances the maintenance of treatment gains. The usual duration of MST treatment is about 4 months, with multiple meetings between the family and therapist occurring each week. Frequency of contact is calibrated to family needs and progress, such that therapists see families more frequently early in treatment and less frequently as treatment goals are reached.

As of this writing, the program intermediary for MST has transitioned to the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect at the University of Colorado. They can be reached at rockymountainmst@ucdenver.edu.

SERVICE DESCRIPTION AND OVERSIGHT

a. Implementation Manual (If Applicable)

i. MST Services (2018). *Multisystemic Therapy® (MST®) Organizational Manual*. Charleston, SC

ii. Clinical manual used in conjunction with the operational manual listed above: Henggeler, Schoenwald, Borduin, Rowland, & Cunningham (2009) Multisystemic Therapy for Antisocial Behavior in Children and Adolescents. The Guildford Press.

b. Implementation of MST

i. The Rocky Mountain MST Network (RM Network) (formerly the Center for Effective Interventions) is the MST intermediary in Colorado and oversees the implementation, program evaluation, and training and licensing of MST providers across Colorado. As an MST Services network provider licensed to disseminate MST, the RM Network trains and licenses local provider teams to ensure they deliver the intervention with quality and fidelity. Becoming a licensed MST provider involves careful consideration of how systems operate in your community and how the MST treatment model can become an integral part of the system of services available to adolescents and their families.

Preparatory Process

Agencies participate in a preparatory process that encompasses topics such as securing funding, developing referral criteria, confirming agency policies and procedures for MST, and obtaining memoranda of understanding between agencies. This process maximizes the chances of having a sustainable program that reliably provides good clinical outcomes.

Practice Requirements

Certain practice requirements are important to ensure high-quality services. These requirements include identifying training and consultation expectations; the completion of all necessary adherence-measure

instruments; and creation of internal polices, such as flexible appointment schedules, maintaining caseloads of 4–6 families, monitoring duration of treatment, and other therapist supports.

Training

Once site readiness activities are successfully completed and the necessary contracts are signed, therapists may be trained in MST and begin serving clients.[1]

ii. Training in MST through the RM Network is intensive and ongoing. The basic elements of training for clinical staff include a week of orientation training, weekly consultation with an expert in MST, and quarterly booster training.

The MST supervisor at each agency site provides task-oriented, analytically-focused clinical supervision on-site. The overarching objective of MST Clinical Supervision is to facilitate therapists' acquisition and implementation of the conceptual and behavioral skills required to achieve adherence to the MST treatment model. These skills are critical to reducing or eliminating identified problems and achieving positive, sustainable outcomes for children and their families.

The RM Network acts as the MST expert, providing weekly consultation to each treatment team (therapists and MST supervisor). Consultation sessions focus on promoting adherence to MST treatment principles, developing solutions to difficult clinical problems, and designing plans to overcome any barriers to obtaining strong treatment adherence and favorable outcomes for youths and families.[2]

c. Target population

i. In Colorado, MST providers serve youth and the families between the ages of 12 and 17. Specifically, the programming is designed to support youth and families who have experiences with or are at risk of substance use (abuse) and/or are at risk of becoming, or already have been, involved in the child welfare or juvenile justice system.

d. Sites in Colorado

i. As of this writing, the RM Network supports MST in the following counties: Archuleta, Broomfield, Denver, El Paso, Huerfano, La Plata, Las Animas, Mesa, Park, Pueblo, Teller, and Weld. Programming is provided through the following organizations:

2. Four Feathers Counseling
3. Hilltop Family Resource Center
4. Health Solutions
5. North Range Behavioral Health
6. Savio House
7. Southern Colorado Community Action Agency
8. Synergy (note: this provider is not supported by the same program intermediary)

ii. Counties or agencies interested in MST implementation engage in a full process with the RM Network to ensure successful implementation. The process consists of ensuring readiness for program implementation and sustainability, understanding of all data and CQI requirements, and review of the financial sustainability model of the program proposal. The RM Network works closely with site agencies to support all aspects of program start-up, replication and sustainability. The RM Network can be reached at rockymountainmst@ucdenver.edu.

FIDELITY MONITORING & CQI

a. The RM Network follows the national guidelines for MST Therapist Adherence Measure - Revised (TAM-R) and works closely with the MST Institute (MSTI) to ensure that data are being collected

1 Our Services: MST, CEI Services | Graduate School of Social Work | University of Denver, 2021, socialwork.du.edu/effectiveinterventions/our-services.

2 MST Services (2018). Multisystemic Therapy® (MST®) Organizational Manual. Charleston, SC.

ethically, accurately and to the specifications outlined.

Fidelity to MST in Colorado will be assessed by the Therapist Adherence Measure – Revised (TAM-R), link provided above. The first measure is administered to parents/caregivers telephonically or via an online survey in the first two weeks of treatment and then monthly thereafter. The TAM-R contains 28 items that assess the primary caregiver's perception of treatment. Each item is rated on an adherence scale from 1 (not at all) to 5 (very much). The adherence score is calculated by the number of items rated as adherent (i.e., a 5) divided by the number of items that can be scored. Thus, adherence scores can range from 0 to 1, with a score of 0.61 considered the threshold for fidelity.

Under Family First, TAM-R will be administered by an independent call center run by MSTI. The call center will enter all data into a national MSTI database that will be used to create a feedback loop to providers and support the CQI process.

Therapist Adherence Measure-Revised (TAM-R) The Therapist Adherence Measure - Revised (TAM-R) is a 28-item measure that evaluates a therapist's adherence to the MST model, as reported by the primary caregiver of the family. The adherence scale was originally developed as part of a clinical trial on the effectiveness of MST. The measure proved to have significant value in measuring an MST Therapist's adherence to MST and in predicting outcomes for families who received treatment.

MSTI utilizes a secure data collection and reporting system that provides tools to enter, store, and manage the data collection process. Information can be accessed on the MSTI website, www.msti.org, to guide sites in the process of administering and interpreting the adherence measures. Logins are required to access the secure site and are restricted to individuals who are part of a licensed MST team. Training guides and online training sessions are available on how to use these tools. Information about the online training sessions can be found at https://www.msti.org/mstinstitute/services/training.html.

A secondary way in which MST agency sites ensure fidelity to the national MST model is through the use of Program Implementation Reviews (PIR), which are written reports completed every six-months by the site's MST supervisor and the RM Network's MST expert. The report details areas of strengths and areas needing improvement in implementation. The PIR also includes a review of critical program practices and characteristics; operational, adherence, and case closure data; and the statuses of previously recommended actions and plans.

The Colorado Department of Human Services will coordinate with the RM Network to receive reports from the MSTI system, which will then be reviewed and standardized in the state's CQI Dashboard, as described in the five-year prevention plan.

b. CQI

The MST site supervisor, in collaboration with agency leadership and the RM Network, is primarily responsible for ensuring that the MST quality assurance and improvement program is in place and functions as intended. The MST site supervisor manages the day-to-day business of the MST team so that each therapist can effectively implement MST with each youth and family being treated. While the RM Network supports the site's data collection and CQI efforts, measurement of the implementation of MST is a function of the MSTI, and is intended to provide all MST programs around the world with tools to assess the adherence to MST of therapists, supervisors, experts and organizations. The national MSTI provides comprehensive guidelines for their MST Program Quality Assurance/Quality Improvement (QA/QI) in their organizational manual.

As part of the national MST QA/QI Program implementation, information is gathered from caregivers, therapists, and supervisors. The families receiving MST will be asked to answer a few questions about treatment periodically. In addition, therapists will be asked to rate their supervisors and experts bimonthly. Finally,

supervisors report on the expert, as well as report on organizational practices in collaboration with the expert. MST experts, in collaboration with MST Supervisors and other MST program staff, will use this information to provide feedback to the MST program about how to improve adherence and program outcomes.[3]

ELIGIBILITY

a. Eligibility for MST services in Colorado are provided to youth, and their families, who display the following behaviors:

   i. Verbal Aggression
   ii. Physical Aggression
   iii. Substance Use/Abuse
   iv. Police Involvement/Criminal Behaviors
   v. Threatening/Posturing Behavior
   vi. Engagement with Negative Peers
   vii. Significant Property Destruction
   viii. Running Away/Chronic Leaving Home without Permission
   ix. Truancy/Suspension/Expulsion
   x. Risk of Failure at School due to Behaviors

   Youth who would not be considered appropriate for MST services are:

   i. Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregiver(s).
   ii. Youth referred primarily due to concerns related to active suicidal, homicidal, or psychiatric behaviors.
   iii. Youth whose referral behaviors are predominantly a result of their individual mental health diagnoses (ex. PTSD, Bi-Polar Disorder, Anxiety Disorders) and not primarily the result of external factors in their ecology.
   iv. Youth who are on the Autism spectrum or with pervasive developmental delays and low cognitive functioning youth. Youth diagnosed with Asperger's Syndrome may qualify for MST services, upon further case review.
   v. Juvenile sex offenders (sex offending in the absence of other delinquent or antisocial behavior).

REQUEST FOR EVALUATION WAIVER

a. Colorado is seeking an evaluation waiver for MST and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation.

b. MST is rated as well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with 16 studies qualifying as eligible for review by the Clearinghouse.

c. In addition to national research, Colorado has been evaluating the effectiveness of MST in the State through the Colorado State Pay for Success Initiative. The Pay for Success Initiative aims to expand MST to underserved regions of Colorado using a Pay for Success funding structure. The plan details the use of a propensity score analysis to match children/youth and track out-of-home placements and recidivism up to a year after receiving MST services. At the time of this writing, findings are not yet available, but will be inserted here once analysis is complete.

MONITORING CHILD SAFETY

a. MST utilizes a perpetual planning process throughout the treatment period. MST uses a structured, ongoing, logical treatment planning process, which includes the ongoing use of assessments that look at strengths and needs, appropriateness of treatment intervention, and prioritization. Overall MST program efficiency and effectiveness depend on the effective implementation of this process, so it is rigorously monitored.

3 MST Services (2018). Multisystemic Therapy® (MST®) Organizational Manual. Charleston, SC.

This analytic process calls for specific procedures to collect and assess data from multiple sources, develop goals with families, develop and implement interventions, assess outcomes, and adjust interventions as goals are met or new data become available. The MST Supervisor monitors the ongoing treatment planning and implementation process for each case to facilitate problem solving by the MST team and with individual clinicians as needed. Throughout this process therapists identify risk and protective factors for families and then personalize the interventions. Upon discharge, therapists submit documentation to supervisors, which is then coded and entered into the MSTI website. Post-intervention monitoring and tracking is a standard practice within the program.

MST therapists continuously assess and address safety needs with the family and assist caregivers in developing and implementing tailored safety plans. These plans involve the commitment from the caregivers to significantly increase the monitoring and supervision of their youth (with the support of others within their ecology). Together the MST therapist and caregivers closely monitor the effectiveness of the safety plan and immediately adjust the plan if barriers or loopholes are identified.

The MST guidelines for this process support staff monitoring for child safety throughout the youth and family's involvement in the program.

WORKFORCE SUPPORT AND TRAINING

a. MST agency sites participate in Program Implementation Reviews (PIR), which are written reports completed every six-months by the site's MST supervisor and the RM Network's MST expert. The report details areas of strengths and areas needing improvement in MST implementation. The PIR also includes a review of critical program practices and characteristics; operational, adherence, and case closure data; and the statuses of previously recommended actions and plans.

   Weekly clinical supervision is provided by the MST site supervisor as an additional support to individual therapists. These sessions are an opportunity to ensure that therapists are implementing the skills and competencies that adhere to the MST treatment model, and to provide them support and access to learning opportunities that may enhance their practice.

   Additionally, the national MST office has a MST Services branch that provides ongoing support to agency sites (teams) and intermediaries (network partners).

   - Team Support Services (TSS) Division: The objective of this section of MST Services is to provide direct program development and MST expert support to domestic and international MST teams and provider organizations. MST Services employs many experts and program developers, whose roles and functions are described above. Additionally, the TSS Division coordinates many of the MST trainings that are held worldwide.

   - Network Partner Support Division: This division of MST Services includes the Manager of Network Partnerships (MNP) role who acts as the primary liaison between MST Network Partnership organizations and MST Services. The MNP orients, trains and provides ongoing coaching to MST experts, and partners with Network Partner Directors and Program Developers in their efforts to maintain model fidelity and positive outcomes. The Network Partner Support Division provides leadership to the global MST community in continuous quality improvement endeavors via projects, task groups, conferences and workshops each year.

b. All MST agency sites and their staff will be held to the trauma-informed care prevention service provider requirements designed by the Colorado Department of Human Services and included in Colorado's 5-year Prevention Plan. In addition to meeting those requirements, training specific to trauma-informed therapy is also required of clinicians upon their hiring. The booster trainings, which occur every three (3) months represent additional opportunities in which to incorporate further training around trauma-informed service delivery.

PREVENTION CASELOADS

a. MST is provided using a home-based model of service delivery. This model helps to overcome barriers to accessing services, increases family retention in treatment, allows for the provision of intensive services (i.e., therapists are full-time staff with low caseloads of 4 to 6 families per therapist), and enhances the maintenance of treatment gains. The usual duration of MST treatment is about 4 months, with multiple meetings between the family and therapist occurring each week. Frequency of contact is calibrated to family needs and progress such that therapists see families more frequently early in treatment and less frequently as treatment goals are reached.

Child First

Child First is a national, evidence-based two-generation model that works with young children and families, providing intensive, home-based services.

Child First is delivered by a two-person team consisting of a licensed mental health clinician with experience in early childhood development, and a family support partner who works with the entire family unit on the sources of stress that impact their family and to connect them with resources. The program is unique because it combines two complementary approaches to healing from trauma and adversity: it directly decreases the stressors experienced by the family by connecting them to needed services and supports, and it also facilitates a nurturing, responsive parent-child relationship. Research has demonstrated that this approach protects the young developing brain and metabolic systems from the damaging effects of high stress environments such as poverty, homelessness and domestic violence.

Child First works with parents and young children together in their homes because that provides the best opportunity to strengthen families. In Colorado, Child First programming, as delivered by local affiliate agencies, is coordinated and supported by a Colorado-based intermediary agency, Invest in Kids (IIK).

SERVICE DESCRIPTION AND OVERSIGHT

a. **Implementation Manual:**
Child First National Service Office, (2019). Child First Training Manual.

b. **Implementation of Child First**

i. The Child First National Service Office (NSO) along with IIK, follow an extensive protocol to launch and sustain Child First affiliate agencies. Components of the protocol are as follows:

Learning Collaborative
Child First uses the Learning Collaborative methodology for start-up training at agencies new to Child First, or for major expansion of capacity. The training is provided by the Child First Clinical Faculty and is a 6-8 month process that brings together staff from multiple new affiliate sites in a single location to learn together. This includes current members of the National Service Office Clinical Training Leadership Team, Child First Clinical Faculty (who are guest presenters), and Colorado's Statewide Program Director (an IIK employee). The components of the Child First Learning Collaborative include:

Child First Affiliate Site Clinical Supervisor Training: This training is designed to help new Child First Clinical Supervisors learn the skills necessary to lead a Child First affiliate site. Training includes Fundamentals of the Child First model and underlying theory of change; roles of the Statewide Program Director and Site Clinical Supervisor; reflective clinical supervision; use of video in intervention and supervision; implementation of distance learning with on-site discussions, activities and observations; the referral process and prioritization; accessing community services; staff safety within the community; and the development of the Child First Community Advisory Board.

Learning Sessions:

- **Learning Session 1:** This is a 2-day training designed for new Child First providers to learn the basic components of the model, gain foundational knowledge around toxic stress and Adverse Childhood Experiences (ACEs), understand the importance of early relationships, and understand how Child First is integrated into the local early childhood system of care. It also provides training in the use of distance learning tools.

- **Learning Session 2:** This is an intensive 2-day session that follows a 3-week period of online learning (see Online Section 1 below) in which the staff learn fundamental content. This is a highly interactive training that includes attachment theory and the relationship-based, psychodynamic

approach used in infant- and child-parent psychotherapy. It covers the use of video in intervention with families, therapeutic and interactive play, executive functioning, mental health consultation in early care and education, understanding the strengths and vulnerabilities of families, and the development of the formulation and treatment plan. It also includes working with caregivers affected by depression, substance abuse, and interpersonal violence, with strategies to help them with emotional regulation.

- **Learning Sessions 3 and 4:** Reinforcement of basic model tenets and procedures, plus additional technical and theoretical didactic and experiential sessions constitute the core of these sessions.

Child-Parent Psychotherapy
Child-Parent Psychotherapy (CPP) is taught by a certified CPP trainer. There are three sessions (the first lasting four days and two "boosters" lasting two days each) which are embedded within a Learning Collaborative model of training over a 12-month period. The first day of the first session is provided for all staff and the subsequent training is for Clinicians and Clinical Supervisors only. The training also includes 18 months of phone consultation with the CPP trainer.

Distance Learning
Child First has developed a blended training model that incorporates distance learning using web-based technology between on-site Child First training Learning Sessions. During each Online Training Period, staff will utilize narrated powerpoints, videos, guided discussions, observations, exercises, activities, process notes and readings.

The Online Training Periods occur between Child First training Learning Sessions. These provide foundational knowledge that prepares all staff for the subsequent Learning Session and for the direct work with children and families. All modules are able to be reviewed at any future time to reinforce learning or when the topic is especially relevant to a specific family.

- **Online Training Period 1** is completed between Learning Sessions 1 and 2. It covers the Child First process, the roles of the Mental Health Clinician and Family Support Partner, infant and early childhood development and normal developmental challenges, the psychological transition into parenthood, attachment, executive functioning, psycho-social risk and protective factors, and the Child First Assessment Protocol.

- **Online Training Period 2** is completed between Learning Sessions 2 and 3. Training Period 2 will be covered immediately after Learning Session 2, prior to beginning work with families. It includes the Child First Fidelity Framework, quality enhancement, and safety for both staff and family.

Child First Reflective Clinical Consultation and Technical Assistance
Reflective, Clinical, Site-based Consultation: Each new Child First affiliate site receives reflective, clinical consultation by the Statewide Program Director weekly for 6 months and then biweekly for 6 months. After 12 months, the affiliate Clinical Supervisor assumes full responsibility for the ongoing group reflective supervision at their site. They will continue to receive biweekly individual consultation from the Statewide Program Director.

Clinical Supervisors' Network Meeting: All Clinical Supervisors meet on a monthly basis for a combination of clinical consultation around their own cases and the reflective supervisory process, and administrative consultation around the Child First implementation process. This is an opportunity for the Clinical Supervisors to share both their challenges and successes with their colleagues, in order to facilitate peer learning and quality enhancement. This meeting is facilitated by the Statewide Program Director.

Staff Accelerated Training (STAT)
The STAT program was developed to provide a comprehensive accelerated training curriculum for new staff of existing Child First agencies. With the support of experienced Clinical Supervisors and team partners, staff can access four trainings with the critical elements of each component of the Child First model. Using a combination of didactic and experiential activities, video review and case examples, staff acquire core knowledge in four distinct phases that mirror the Learning Session content, but are delivered in 1-2 day sessions over a period of 4 consecutive months.[1]

c. Target population in Colorado

i. In Colorado, Child First serves a broad array of families with children from the prenatal stages up to the child's sixth birthday at enrollment. Specifically, the programming is designed for children who have experienced trauma, have challenging behaviors, learning problems, are living with chronic stress, and are in need of mental health support. Child First is also designed for families whose caregivers are managing mental illness, substance use, incarceration, intimate partner violence or housing instability. Families referred to Child First are at risk of becoming, or already have been, involved in the child welfare system.

d. Sites in Colorado

i. As of this writing, Child First has been launched to support the following counties: Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache, Douglas, Boulder, Broomfield, Jefferson, El Paso, Adams, Arapahoe. Programming is provided through the following organizations:

2. San Luis Valley Behavioral Health Group
3. Aurora Mental Health Center
4. Tennyson Center for Children
5. Savio House

ii. Counties or agencies interested in Child First engage in an exploration process with IIK and the Child First NSO. This process consists of ensuring readiness for program implementation and sustainability, understanding of all data and CQI requirements, and of the financial sustainability model for the program in Colorado. IIK works closely with the Child First NSO to support all aspects of program start-up, replication and sustainability. IIK also employs a Child First Statewide Program Director to oversee all Child First sites across Colorado that supports the exploration and site implementation process.[2]

FIDELITY MONITORING & CQI

i. IIK is the intermediary agency for the provision of Child First services across the state of Colorado. All Child First affiliate sites report to the NSO on two types of data:

1. Process data or metrics
2. Outcome data

The Child First NSO has established benchmarks for both types of data. This data is used for ongoing assessment of implementation at the affiliate sites and for Child First Accreditation.

Monthly Metrics:

- The Child First NSO has established Metric Benchmarks, which include: the number of families served, the number of visits/ week, the number of missed appointments, ages of children, assessments completed, connection to community resources, early care mental health observations, supervision hours, length of service, goal completion, and prioritization of waitlist.

1 Child First: Model Structure - Affiliate Agencies, Child First National Program Office, 9 Aug. 2018, www.childfirst.org/about-us/model-structure.

2 Invest in Kids (IIK). "Child First®." Invest in Kids, 1 Sept. 2021, iik.org/programs/child-first/.

- Metric reports are made available to each Child First site on a monthly basis. Colorado's Statewide Program Director reviews these reports with each site to promote problem solving and the development of program-based quality enhancement strategies. Successful and innovative strategies are frequently shared with the Child First Network.

Assessment Data Collection and Analysis:

- All Child First sites must collect baseline, 6 month, and outcome assessment data according to the Child First Assessment Protocol. All assessment data must be entered into the Child First cross-site, web-based data collection system (or another system approved by the Child First NSO). Assessment data must be entered within one week of collection to promote use of scores in formulating treatment.

- Outcome reports are provided to all Child First affiliate sites (which include both site-level and team-level data) on a quarterly basis.

- Analysis of data by the Child First NSO provides opportunities for identifying challenges and problem solving, with enhanced training provided by the NSO, if needed. Effectiveness of variations in implementation across program sites are explored, leading to shared quality improvement strategies across the Child First Network.[3]

ii. CQI

A Quality Enhancement (QE) Team from the NSO works with IIK as the intermediary agency to provide CQI guidance to affiliate agencies. The QE team is responsible for working with IIK to ensure timely and accurate data collection and entry and to provide monthly metric and quarterly assessment outcome reports to all Child First sites.

Reflective Clinical Consultation: Reflective clinical consultation is provided to each affiliate agency site on an ongoing basis. IIK's Child First Program Director meets with each site's Clinical Supervisor every other week to discuss issues around specific clinical challenges, clinical fidelity and staff supervision.

Continuous Quality Improvement: IIK's Child First Program Director consults with each site on a monthly basis so that the staff understand the significance of their data and create strategies to continuously improve implementation and outcomes.

Performance Improvement Plans: If the monthly data review identifies difficulties in reaching appropriate benchmarks or lack of fidelity to the clinical model at a program site, a full meeting with the QE Team, IIK's Child First Program Director, the site's Clinical Supervisor and Senior Leader is held. At this time, a Performance Improvement Plan is created by the QE Team in collaboration with IIK and the affiliate agency, with specific goals and timelines. Progress in meeting the goals of this plan is monitored on a monthly basis. Success of this process is a critical element in the accreditation process.

Technical assistance: IIK's Child First Program Director conducts group meetings and conference calls with Child First Network Senior Leaders. Technical assistance from the Child First NSO may be requested at any time.[4]

CDHS will coordinate with IIK to receive relevant fidelity data which will then be translated into the standardized statewide

3 *Child First: Data & Quality Enhancement*, Child First National Program Office, 19 Feb. 2016, www.childfirst.org/our-work/data-and-quality-enhancement.

4 *Child First: Data & Quality Enhancement*, Child First National Program Office, 19 Feb. 2016, www.childfirst.org/our-work/data-and-quality-enhancement.

metrics of fidelity and moved into the Colorado CQI Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

ELIGIBILITY

a. The Child First program is designed as an intensive program that works alongside families who may not be served by other programs, as their needs may be more complex than other programs are prepared to serve. Children and families who are at risk of child welfare involvement are eligible for Child First services. This may include mothers with postpartum depression and/or substance use disorders, and caregivers and/or child(ren) who have experienced trauma. The target population includes children aged zero up to their sixth birthday upon enrollment, children with challenging behaviors who have experienced trauma, chronic stress and are in need of mental health support, and people living in poverty. Delinquent/justice-involved youth who are pregnant or are young parents may also be eligible if they meet the other eligibility criteria.

RESEARCH AND ONGOING RIGOROUS EVALUATION

a. **Existing Research**. Child First is rated "Supported" in the Title IV-E Prevention Services Clearinghouse. In 2001, Child First received a Starting Early Starting Smart federal grant from the Center for Substance Abuse Prevention (CSAP) of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS), to support a randomized controlled trial of the Child First model. This is one of the few randomized controlled trials to test the effectiveness of an integrated home-based, psychotherapeutic, family intervention embedded in an early childhood system of care with young, vulnerable children from high risk families. Funding for data analysis was provided by the Robert Wood Johnson Foundation.

   A summary of the results of this trial can be found in an article published in the January/February 2011 issue of the journal Child Development. There is an addendum to the initial publication that includes follow-up analyses, which can be found at the Child First website.[5]

a. **Plans for Ongoing Rigorous Evaluation**. Pre-pandemic and publication of the Title IV-E Prevention Services Clearinghouse Handbook, MDRC launched a randomized controlled trial of Child First in two states. The trial is currently paused and random assignment will not restart until at least 80 percent of the Child First services are being delivered in home (i.e., not a telehealth adaptation). This pandemic-induced pause is providing time for the analysis plan to be revised for alignment to Title IV-E Clearinghouse Standards and the goal of determining if Child First can move from a "supported" to a "well-supported" practice.

   Colorado plans to onboard to this randomized trial and expects that a revised analysis plan will be available by December of 2021 so that Colorado will be ready to begin onboarding into that study in January of 2022. Randomization is expected to begin occurring in the Spring of 2022, once Colorado sites have demonstrated delivery of Child First with fidelity (i.e., adherence to the model). IIK has confirmed there are Colorado sites with a waitlist.

MONITORING CHILD SAFETY

In all Colorado Child First affiliate sites, child safety is assessed at intake, at six months and again at termination of the program. This may vary slightly depending on how long the family is engaged in the program. Assessment protocols are in place for all Child First programs that include key components to help staff monitor child safety, such as:

i. Gathering information from the parents/caregivers through discussion
ii. Observation of the child in interaction with caregiver(s) and other significant others
iii. Interactive play with the clinician and child
iv. Observations in the early care or school setting

5 *Child First: Research*, Child First National Program Office, 18 Dec. 2020, www.childfirst.org/our-impact/research.

v. Developmental observations and assessments

vi. Gathering health information

vii. Gathering important information from other important service providers in the life of the child and family

Rigorous assessment protocols are also in place for all Child First programs, which ensure child safety is being monitored throughout the child and family's involvement in the program. Pages 68-75 of the Child First Toolkit have details on assessment tools and schedules for assessments based on child development and age.[6]

WORKFORCE SUPPORT & TRAINING

a. Child First training is administered through a Learning Collaborative model, as well as via distance learning. Clinical Supervisors at each Child First site are available to support staff and IIK's Child First Program Director is available for additional support when needed. Full details of the training process can be found in the Implementation of Child First section of this document.

b. Through the intensive training process, Child First site staff are trained to identify individual child and family needs using the SNIFF (Service Needs Inventory for Families) tool. This tool allows families to guide the identification of services that would be most appropriate for them and their individual needs. Families are asked to complete the SNIFF on their own or offered support via an interview/survey style discussion with their care coordinator/family resource partner.

c. IIK and all Child First site staff will be held to the trauma-informed care prevention service provider requirements designed by the Colorado Department of Human Services and included in Colorado's 5-year Prevention Plan. In addition to meeting those requirements, the Child First model was specifically developed for populations who have experienced trauma and adversity. Trauma-informed care and service delivery is embedded in all training curriculums for clinicians and for the family support partner. Specific trainings on trauma are available, and all clinicians who work in Child First are trained in Child-Parent Psychotherapy. The Child First NSO also received a grant to be part of the National Child Traumatic Stress Network, a national trauma training center around early childhood mental health and trauma.

PREVENTION CASELOADS

a. The intensity of family needs and distance traveled are important factors that go into caseload size determinations. There are requirements under the Child First model that the clinical staff complete a specific number of home visits each week. Based on that requirement, site staff in Colorado average a caseload of 12 families per team. To determine appropriate caseload size, the site Clinical Supervisor, in coordination with IIK, considers factors such as:

i. Family need

ii. Distance of travel from site office to family home

iii. Staff capacity threshold.

6 *Child First Toolkit*. Child First National Program Office, 2013.