Colorado Five-Year Family First Prevention Services Plan

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Introduction

Colorado's child welfare system has undergone 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 kin homes. 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. The Family First Prevention Services Act ("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.

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 its prevention services continuum. Critical elements of this strategy include continuing to invest in strong foundational 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.

Realizing this vision requires the active participation of partners beyond child welfare agencies; Colorado recognizes this limitation. Colorado has approached Family First implementation as a broad systems transformative and collaborative effort that cuts across multiple agencies, including the Division of Child Welfare (DCW), the Colorado Department of Early Childhood (CDEC), and Office of Economic Security (OES) to name a few. Other state agencies, including the Colorado Department of Health Care Policy and Financing (HCPF), the Behavioral Health Administration (BHA), and the Colorado Department of Public Health and Environment (CDPHE), have been essential in ensuring a holistic approach to implementation. As a state-supervised, county-administered human services system, Colorado's 64 county departments of human services have been critical partners in co-designing the future of child welfare, along with private providers, community-based organizations, and families with lived child welfare experience.

Colorado continues to carefully assess where Family First interventions are most appropriate along our prevention services continuum, while also progressively expanding their reach—both in terms of at-risk populations served and the variety of

[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 impacted by maltreatment (e.g., family preservation services, parent mentoring and support groups, and mental health services).

evidence-based practices tailored to the unique needs of Colorado communities and Tribes. Colorado has intentionally designed a broad definition of candidacy for prevention services that pushes to serve children, youth and families as early as possible and, ideally, before a report of alleged abuse or neglect is made to the child welfare system that meets criteria for assessment.

Outcomes

Colorado incorporates our Family First prevention plan into a broader strategy to provide appropriate services to children, youth and families, at the appropriate level of intensity, for the appropriate length of time. Toward that end, Colorado has made efforts to ensure that families involved in our system have what they need to prevent maltreatment occurring in their homes and that families experience out-of-home care only when necessary to ensure safety or address acute clinical needs that cannot be met in the home. Colorado strives to keep children/youth safely in their home or with family/kin whenever possible.

As a result of these measures, Colorado will see a decrease in the number of children/youth entering out-of-home care as measured by state data.

Colorado's Prevention Landscape

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 key components of this foundation, each serving to strengthen and amplify the impact of Family First in the state.

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 human services departments are the main provider of direct services to Colorado's families. County

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 support, 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

Beginning in 2019, the Colorado Human Services Directors Association (CHSDA), which represents all 64 counties, identified Child Maltreatment Prevention 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. Colorado human services continues 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.

Colorado’s Family Preservation Act

Colorado’s Family Preservation Act, known as Core Services, was passed by the Colorado General Assembly in 1994 to provide funding for strength-based resources and support to families. The program’s goals are to safely maintain children and youth in their home, return children and youth home as quickly and safely as possible following placement, promote the least restrictive setting for children and youth, and provide services for families at risk of involvement or further involvement with 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, and funds

are set aside for them. The Core Services Program is a $55-million distinct funding stream, essential to the service continuum in Colorado.

In calendar year (CY) 2022, a total of 20,965 distinct clients were served by the Core Services Program. Annual evaluations have shown that the Core Services Program is an effective approach to strengthening families and keeping children and youth at home. In 2022, 99% of children/youth who received Core Services remained home, and only 4% of children/youth had a subsequent placement after benefiting from Core Services.[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 2022, county-designed services represented the most common type of service provided through Core Services funding, accounting for 36% of all service episodes statewide. Examples of county-designed services include, but are not limited to, family engagement meetings, mental health support not covered by Medicaid or private insurance, and mentoring. Many of these services will likely not meet the Family First evidence standards and qualify for federal reimbursement. 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. CDHS is committed to collaborating with both the Southern Ute Indian and Ute Mountain Ute Tribes

[2] Core Services Program Annual Evaluation Report: Calendar Year 2022. Social Work Research Center, Colorado State University.

individually to evaluate and adapt prevention services to meet the needs of their communities, when either Tribe expresses interest in doing so.

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 IV-E 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. 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]

Waiver and Family First

Colorado's 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 support have become embedded 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

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

long-term sustainability. Thus, similar to Core Services, the question is not how Family First will replace the IV-E 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. 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.

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. 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, Division of Youth Services, school districts, public health, behavioral health safety net providers, domestic violence providers, managed service organizations for the treatment of drugs and alcohol, and regional accountable entities. Of the 64 Colorado counties, 50 are currently implementing CMP.

Collaborative Management Program and Family First

Findings from the 2023 independent evaluation of CMP indicate multiple benefits to structured collaboration, including efficacy in coordination of resources and serving

multisystem-involved families, staying informed on community-specific practices, and learning from other partner agencies regarding shared successes and challenges. As such, CMP is a critical asset to implementing approved Family First practices in coordinated and meaningful ways, with a shared commitment to keeping families together.

Consultation and Coordination

In addition to the building blocks described above, Colorado has a robust system across state agencies, departments, offices and community programs to define a continuum of programs and services to meet the needs of families through primary, secondary and tertiary prevention and early interventions. Colorado utilizes mixed funding streams to provide prevention services beyond those identified as IV-E reimbursable and included in the plan, creating a broader continuum of services.

The Colorado Department of Early Childhood (CDEC)

CDEC's Division of Community and Family Support houses several of the state's primary and secondary prevention programs, with several included in this prevention plan (Child First, Nurse-Family Partnership, Parents as Teachers, and SafeCare® Colorado). CDEC administers the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) funding; Family Support Primary Prevention (FSPP) funding; and Colorado's Fatherhood Network funding. In addition, there are state funding streams supporting home visiting, family resource centers, parenting education, and other child abuse and neglect prevention programs. Additionally, Family Resource Centers are overseen by CDEC and receive funding to support Motivational Interviewing (MI) training and use by all community-facing staff. See Appendix J for details about Motivational Interviewing and the Community Pathway through Family Resource Centers.

Colorado Child Maltreatment Prevention Framework for Action

Colorado uses the Child Maltreatment Prevention Framework for Action (Framework) as a road map to guide statewide investments, programs, and policies related to maltreatment prevention, resulting in alignment of strategies to maximize the impact on shared outcomes. This includes the development of county level child maltreatment prevention plans. The Framework and accompanying community planning toolkit were jointly developed by CDHS's Office of Early Childhood (predecessor to CDEC), 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.

In response to Family First requirements, Colorado's Child and Family Services Plan (CFSP) called for revisions to the Framework to include additional strategies to serve as the state's Child Maltreatment Fatality Prevention Plan. CDEC is leading a range of stakeholders to update the Framework to incorporate the latest research, progress, and learning. A tremendous amount of early childhood and youth systems-building work has happened in response to Family First. Colorado's CFSP also includes a goal to ensure that counties have support to develop and implement local child abuse prevention plans using the Framework. Federal Community-Based Child Abuse Prevention (CBCAP) and other funds are being used to support local planning and implementation of identified strategies.

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 around social support, expansion of an early touchpoints service array, and systems alignment in family strengthening investments (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 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. The Partnership has incorporated family voice representatives and created a Family Caregiver Space to support professionals in authentically engaging families and caregivers in decision-making.

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 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 use. 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, and it may be utilized for prevention or as a support to help prevent re-entry.

Updates and learnings from the COPE evaluation will be included in future iterations of Colorado's prevention plan.

Community-Based Child Abuse Prevention

Community-Based Child Abuse Prevention (CBCAP) grant funding supports direct services in communities through evidence-based and evidence-informed parenting programs including Nurturing Parenting Programs, The Incredible Years, and Circle of Parents. Other activities implemented through the child maltreatment prevention plans funded in Colorado include increasing community and family awareness around strengthening protective factors, a two generational model of parent education and financial literacy, and the creation of a data sharing system to offer enhanced supportive services to families.

Promoting Safe and Stable Families (PSSF)

CDEC oversees Colorado's PSSF program. The overarching objectives for Colorado's program include:

- Secure permanency and safety for children by providing support to families in a flexible, family-centered manner through collaborative community efforts;
- Enhance family support networks to increase well-being;
- Prevent unnecessary separation of children from their families;
- Reunite children with their parents or provide other permanent living arrangements through adoption or kin; and
- Support preservation efforts for families in crisis who have children at risk for maltreatment or re-abuse.

These objectives are addressed through the provision of services in four service

categories or areas: Family support, family preservation, time-limited family reunification, and adoption promotion and support services. CDEC spends approximately 20 percent of PSSF funding in each service category, and 10 percent to support special projects, planning, training, and service coordination.

Children and their families receive services through local sites after first engaging with PSSF providers to determine needs and set goals with the family. Services are administered by county departments of human/ social services, community organizations, and eligible American Indian Tribes through awarded grants. These grants allow local control of the selection and provision of services contributing to the prevention continuum.

Colorado's Differential Response (DR) Model

Child safety is the focus of Colorado's Differential Response (DR) Model, and partnership with families is a goal for all of Colorado's child welfare practices. These outcomes are achieved by maximizing Colorado's values for transparent communication and collaborative engagement with families. Administrative rules (Volume 7) require all Colorado counties to implement three DR organizational processes: enhanced screening to increase detail in referrals taken by screeners; Review, Evaluate and Direct (RED) Teams, a group decision-making process for dispositioning referrals; and Family Engagement Meetings (FEM) at certain points in the case or when certain risk factors are present.

Colorado's DR Model includes organizational shifts that affect the way counties operate, including:

- Embedding family centered practices (i.e., individual and group supervision and family engagement processes throughout involvement); and
- A strengthened and enhanced set of social work practices to promote direct actions, supervision and support, and ongoing continuous quality improvement (CQI) process for reflection. Practices include engaging families in assessments,

solution-focused planning, and building support networks for children, youth and families.

DR systems seek to shift away from adversarial and punitive methods found in traditional child protective services by separating screened in referrals into two response tracks: Family Assessment Response (FAR) or High-Risk Assessment (HRA). In both cases, the assessment response to an allegation is individualized and comprehensive with each family throughout the life of their child welfare involvement. Colorado counties are encouraged to accept and use the FAR track with families where the allegations reported present low to moderate risk. When there are immediate concerns for safety or the referral provides a high risk concern, a family receives a traditional HRA. HRA includes a determination of evidence that maltreatment did or did not occur (findings) and an identified person responsible for abuse/neglect. FAR allows workers to have flexibility in interviewing children with parents present, and FARs do not have a finding at the close of the assessment. 63 of Colorado's 64 counties have fully implemented or are in process of implementing Colorado's DR Model.

DR and Family First

A FAR provides an opportunity for short-term involvement by creating a plan to mitigate or reduce risks through family-centered services and by bolstering the family's support network to avoid further child welfare involvement. Any services that the family might benefit from are front-loaded to ensure they receive what they need quickly.

Family First 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 with lived experience.

Beginning in March 2018, Colorado, with Casey Family Programs' support, developed a Family First roadmap outlining critical decisions and actions. In early 2019, a 27-member Family First Implementation Team launched, including representatives from county departments, CDHS, CDPHE, HCPF, judicial/legal, providers, constituents, and research/evaluation. This team focused on defining priorities and executing a detailed action plan aligned with the roadmap.The 27-member Implementation Team included representatives from multiple county departments of human services, 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. To delve deeper into the details of Family First, the team initially prioritized six key implementation workgroups: Independent 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 inclusive of community voice.

Colorado’s Family First Implementation Core Values

Development of the Road Map 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.
- Improved policy, practice, and quality of services based on scientific evidence.

- Strengthen and embrace natural support systems.

Continued Engagement

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, in-home parenting services, and other public and private agencies, began early 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 included 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 was responsible for ensuring that state child welfare laws and rules aligned with Family First, and for determining methods through which the state can maximize federal revenue to support Colorado's children, youth and families. While the Task Force sunsetted in June 2023, the recommendations from many of its subcommittees have been integrated into the ongoing structures and work across the child welfare system.

Behavioral Health Task Force

In April 2019, Colorado Governor Jared Polis directed CDHS to spearhead the Governor's Behavioral Health Task Force (BH Task Force). The BH 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 BH Task Force released its "Behavioral Health Blueprint," which outlined detailed recommendations and goals established by the BH Task Force, with creation of a Behavioral Health Administration (BHA) at its core. The BHA launched in July 2022, and in 2024 the BHA released a comprehensive implementation plan specifically addressing recommendations from the Children's Behavioral Health subcommittee that was part of the Task Force. Creation of the BHA and its prioritization of children and youth will help transform how the state delivers and manages a continuum of mental health and substance use prevention and treatment services.

Child Welfare Prevention Task Group

The Child Welfare Prevention Task Group (CWPTG) launched in Summer 2021 to continue the work of the Services Array Subcommittee that was part of the initial Family First planning efforts. Its purpose is to continue building statewide and county infrastructure to fully operationalize and evolve the elements of this Family First Prevention Services Plan. CWPTG adopted a tri-chair structure, with a state, county, and community partner representative sharing leadership responsibilities. The group's appointed membership consists of representatives from across state agencies/offices, counties from each region, community organizations, research and evaluation, and family voice.

CWPTG continues to meet every two months to work towards its three identified goals: scaling existing Family First services, expanding Colorado's prevention services array, and expanding the operationalization of Family First candidacy.

Collaboration with Tribes

CDHS consults, collaborates, and coordinates with federally recognized Tribes within

Colorado and 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 1,500 enrolled members. The Ute Mountain Ute Tribe (UMUT) is located primarily in Montezuma County with another community in White Mesa, Utah, and land in San Juan County, New Mexico. There are approximately 2,100 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, the Denver Indian Center, and the 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 Tribal Affairs Specialist and an Indian Child Welfare Act (ICWA) Specialist 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 can provide services they feel best meet the needs of their communities. The implementation of Family First has not caused a change for Tribal Social Services and programs—both Tribes have continued forward with their Child Welfare contracts 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 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 relationship-building consultations with the SUIT and UMUT in 2023, reviewing the impact of Family First and future opportunities. CDHS is continuing to

develop and implement a coordinated ongoing consultation process focused on intentional in-person and collaborative conversations with each tribe at their tribal offices regarding preventative services that best meet the needs of children, youth, and families in their respective tribes.

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.

Juvenile Justice Workgroup

Due to Colorado's unique system, a Juvenile Justice workgroup was explicitly included in Family First implementation planning. This group provided recommendations on specific evidence-based placement prevention services that are well suited for this population. 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 so youth can remain safely at home.

The Division of Youth Services (DYS)

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."

Juvenile Justice Reform Act

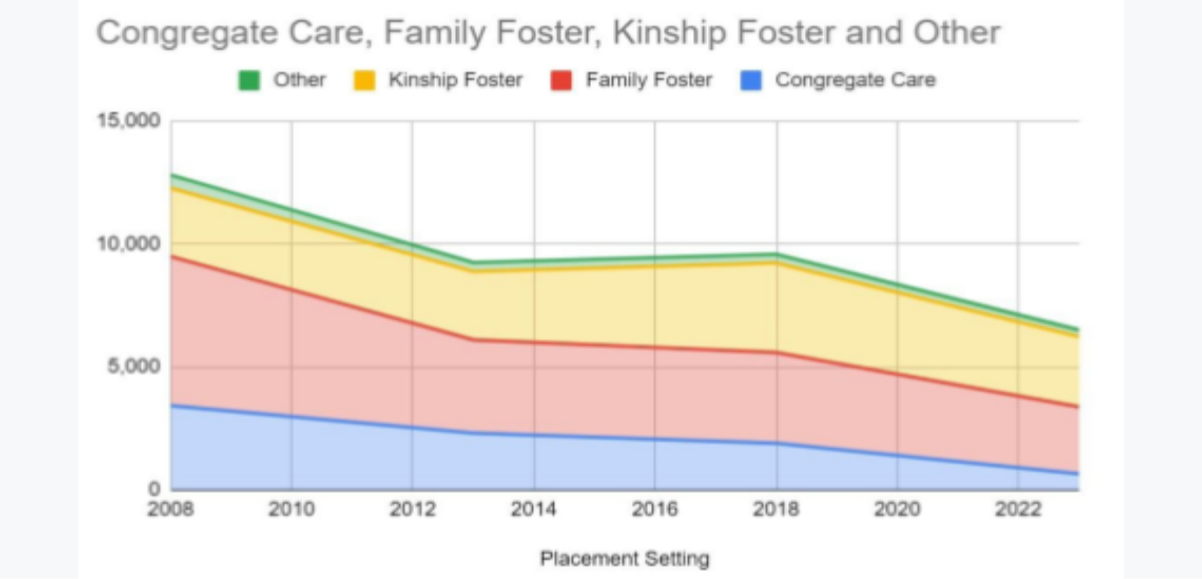
Colorado's Juvenile Justice Reform Act (Senate Bill 19-108) was signed into law in May 2019 to help improve outcomes for youth, strengthen public safety and use resources more efficiently. Among other things, the legislation expands opportunities to divert youth from the juvenile justice system, and requires implementation of a validated risk and needs assessment tool to inform court decision-making and case planning.

CDHS is 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.

Data to Inform Decisions

Reports to Colorado's child welfare system have increased by 60% since 2008, but the percentage of those referrals screened in for assessment has decreased, from 52% in 2008 to 28% in 2023. Despite increases in the number of reports, Colorado continues to decrease the overall number of open child welfare cases while emphasizing keeping children and youth at home safely, with their families, whenever possible. The total number of children and youth in out-of-home care has decreased by 50% since 2008. Of those in out-of- home care, the percentage of kids in kinship and family-like settings now makes up 85%, with 10% in congregate settings.

These promising trends reflect shifts in Colorado's child welfare practice and priorities, and the state's commitment to keeping families safely together through prevention-oriented services and support. As additional prevention services are implemented and scaled through Family First, protective factors for Colorado families will increase, resulting in a further decline in the need for foster care to ensure the safety of children and youth.



Characteristics and Colorado Population-Level Data

Below are some of the key characteristics describing families who may benefit from prevention services, along with state-level data describing the targeted population.

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 nation-wide engages in binge drinking, according to 2022 data (“BRFSS Prevalence & Trends Data,” CDC).
- From the 2021-2022 National Survey on Drug Use and Health (NSDUH) State-Specific Tables (SAMHSA):
    - An estimated 991,000 adults in Colorado used illicit drugs in the past month.

- An estimated 12,000 adults in Colorado had past-year heroin use.
- An estimated 40,000 adults in Colorado has past-year methamphetamine use.
- An estimated 149,000 adults in Colorado had past-year misuse of prescription pain relievers.

Substance Use - Infants Exposed

Parental substance use is impacting newborn development in Colorado as well.

- According to Colorado's Pregnancy Risk Assessment Monitoring System (PRAMS) data from 2022, about 15% of mothers nation-wide drank alcohol during the last three months of pregnancy, and 6.5% of mothers used marijuana or hashish at any time during pregnancy.
- In 2022, there were 1,578 newborns reported for substance exposure in Colorado (CDHS).
- In 2020, Colorado's Child Fatality Prevention System found that 18% of child maltreatment deaths of children under age 1 involved drug impairment at the time of the incident.
- From the Colorado Evaluation and Action Lab's (CO Lab) 2021 Legislative Report, "Progress on the Perinatal Substance Use Data Linkage Project"[4]:
    - Families involved in child welfare due to prenatal substance use care for infants that tend to be more medically fragile at the time of birth and are admitted to the neonatal intensive care unit at three times the rate of the general population. Infants who are medically fragile are at higher risk of infant removal by child welfare.

[4] Clemens, E.V., Moses, S., Everson, C.L., McElhinney, C., Hwang, S., LeBoeuf, W., and Hokkanen, J. (March 2021). Part One: Prenatal Substance Use and Improving Family Health. (Report No. 19-08B). Denver, CO: Colorado Evaluation and Action Lab at the University of Denver.

Mental Health - Parents

An increasing number of Colorado adults report having a mental health illness.

- Just over a quarter of adults in Colorado reported having a mental illness in the past year; 7% of adults in Colorado reported experiencing a serious mental illness in the past year, and 10% reported experiencing a major depressive episode (“2021-2022 NSDUH State-Specific Tables,” SAMHSA)

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.

According to the 2023 Health Kids Colorado Survey:

- 27% of Colorado students ages 15 years and younger reported having poor mental health during the past 30 days either “most of the time” or “always.”
- 11% seriously considered attempting suicide during the past 12 months; and 6.6% attempted suicide one or more times during the past 12 months.

Lack of Parenting Skills

The following indicators provide information about the scope of the population in Colorado that may need parenting skills support (“2022 National Survey of Children’s Health”, Data Resource Center for Child and Adolescent Health).

- An estimated 39,855 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 76,971 parents in Colorado felt aggravation “usually” or “always” in the past month from parenting.

Limited Capacity to Function in Parenting Roles

- In Calendar Year (CY) 2023, there were 10,431 children/youth who experienced substantiated abuse or neglect in Colorado.
- In CY 2023, there were 16,916 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 State Fiscal Year (SFY) 2022-2023, there were 2,828 youth newly admitted to detention, which was an increase of 23% from the previous year.
- In SFY 2022-2023, there were 560 youth served in commitment.

Youth Beyond Control of the Parent

- In CY 2023, there were 1,100 youth who had Program Area 4, Youth in Conflict status during the year.

At Risk of Re-Entry

- In CY 2023, 2017 children/youth exited foster care to reunification, guardianship, or adoption.
- Of those children/youth, there were 971 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 2023, 11,995 children/youth received in-home services.

Summary/Next Steps

By continuing to analyze the 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 the Core Services Program, the Collaborative Management Program, Title IV-E Waiver interventions, and specific prevention services such as SafeCare®. Colorado has access to large amounts of data through these studies, 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 using solely historical data to predict future needs, and is committed to addressing these concerns by ensuring that communities participate in all levels of candidacy implementation and by including family and community stakeholder voice when using data to inform investments. Colorado strives to be a leader in enhancing access to services for communities and families.

Desired Outcome

Over the next five years, Colorado will safely reduce the number of children/youth entering out-of-home care as measured by state data, starting with a baseline of 4,123 children/youth in out-of-home placement on October 1, 2021.

Bold 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 can 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 are 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[5] 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

Colorado's vision is that all children, youth, parents or kin caregivers with these risk factors will be eligible for prevention services—both those who are involved in the child welfare system and those who have not been the subject of a child

[5] For purposes of the provision of services, "Kin" is defined as 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 continuity of significant relationships with the child/youth. The Indian Child Welfare Act (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.

maltreatment report but share characteristics that deem them at serious risk of out-of-home placement.

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 because of identifying at-risk children, youth and families. 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.

Colorado acknowledges that broad definitions of candidacy require greater intentionality in building systems and structures that allow the state and its component systems to successfully implement this definition. Simultaneously, the expansive and geographically diverse nature of Colorado—encompassing both metropolitan regions and the plains—necessitates broad definitions of candidacy to address variations across regional needs.

Prevention in Practice

To understand how Colorado's candidacy definition will be operationalized, it is important to recognize that Colorado is a county-administered, state-supervised system. This means that 64 unique counties 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 involved in the child welfare system.

Implementation

As the IV-E agency, CDHS is responsible for ensuring that all requirements for monitoring, implementing and reporting are met. CDHS is responsible for ensuring data accuracy and transferring data files to the Children's Bureau as required by the federal legislation. Annual updates will be included in the Annual Progress Services Report (APSR) or other reports as determined through federal program instructions. CDHS will be responsible for state level program implementation, fidelity and CQI. CDHS will update and amend Colorado's Family First Five Year Prevention Plan as necessary including any program, service additions, or changes in protocols. The following describes Colorado's implementation processes for required activities.

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 (See the Attachment IV for the assurance).

Phased Approach

Colorado will implement Family First Prevention in a phased approach.

Phase One - Initial Implementation

To build and test reporting and claiming processes and structures, Colorado will define initial candidates for reimbursable Family First services as those families with open child welfare or juvenile justice involvement.

Phase Two - Expanding Implementation

To more fully realize its bold vision of positively and proactively supporting children, youth, and families, Colorado is building community pathways for individual evidence-based services in its Prevention Plan. These pathways will help ensure that families who meet the candidacy criteria, but do not have open child welfare or

juvenile justice involvement, are able to proactively access evidence-based prevention services.

Establishing community pathways involves coordinating with community-based providers, state program intermediaries, and other state agencies to meet Family First and Title IV-E claiming requirements, while respecting the needs and rights of families who are not currently system-involved. Colorado coordinates data sharing agreements to identify candidates and determine their eligibility, and develops robust processes to monitor candidates' safety through individualized, child-specific prevention plans.

To date, Colorado has established a community pathway for one service: SafeCare® Colorado. Please see Appendix I for further details on how this community pathway is being operationalized. Colorado plans to expand its community pathway network in 2026 by incorporating programs that utilize Motivational Interviewing (MI). This expansion specifically targets Family Resource Centers and their public-facing staff, who will be trained in MI to serve as a community pathway. Please see Appendix J for further details.

Phase Three - Adding Evidence-Based Services and Programs

Colorado will continuously evaluate community needs, service gaps, opportunities, and service capacity to add programs and services to the prevention plan. Colorado will continue to make technical modifications to support appropriate data collection as new services, sub-populations, and programs are incorporated. Colorado anticipates identifying additional community pathways while becoming more skilled in identifying and crosswalking current programs in the state against those listed on the Title IV-E Prevention Services Clearinghouse.

Evidence-Based Service Array

One of the key workgroups of the Colorado Family First Implementation Team was the Services Array workgroup, comprising representatives from 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 prevention services.

In selecting services to propose for Colorado's initial five-year plan, the state considered services collectively as part of a broader continuum of care. The state also prioritized the evidence-based services that are currently in place and being implemented successfully in Colorado. This strategy allows Colorado to build upon existing capacity, continue to assess program efficacy, make efforts to scale where appropriate, and minimize start-up costs for initial implementation. Therefore, Colorado's proposed prevention services are all currently being implemented in communities across the state, although to varying degrees.

CDHS contracted with the Colorado Evaluation and Action Lab (CO Lab) to provide recommendations for short- and long-term strategies for implementing and scaling evidence-based practices that both meet the unique needs of Colorado communities and maximize Title IV-E reimbursement. The report utilized a data-driven, community-informed approach, and the final report[6] recommends a phased strategy to implementation and capacity-building 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 live in the state.

Colorado's initial proposed service array of evidence-based practices focuses on the early critical years and mental health services. Colorado acknowledges that evidence-based prevention services are needed at every life stage and must address other critical needs including substance use treatment services for parents and youth, and expanded services for the juvenile justice population. Considerations for such service expansions will continue as Colorado's prevention infrastructure is further developed. Colorado is also certain that the current landscape will continue to change

[6] Clemens, E.V., Everson, C.L., Henninger, J., & Moses, S. (June 2021). Strategy for the evidence-based aspects of the Family First service continuum (Report No. 20-07A). Denver, CO: Colorado Evaluation and Action Lab at the University of Denver. Strategy for the Evidence-Based Aspects of the Family First Service Continuum (PDF)

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.

Colorado is formally proposing ten services for implementation in this five-year plan. The following section summarizes the services being proposed with more detailed information on each service in Appendices A-J.

Children Ages Zero to Five

Colorado understands the specific risk factors that increase vulnerability to maltreatment and subsequent removal for children age five and under, including:

- Parental challenges (ex. substance abuse, mental health issues, intimate partner violence);
- Parental characteristics (ex. young age, low income, low education, and social isolation);
- Child behavioral and developmental challenges; and
- Lack of parenting knowledge and skills.

Nationally, children in their first year of life have the highest rate of victimization at 22.2 per 1,000 children. In comparison, the national rate of child maltreatment victimization across all ages is 7.7 per 1,000 children.[7] Children who die from abuse and neglect are overwhelmingly young. During CY 2022 in Colorado, 36.4% of maltreatment fatalities were children under the age of one and 63.6% were under the age of three; 50% of near fatalities were under the age of one and 76.9% under the age of three.[8]

Based on the data referenced above, it is vital to proactively identify and support

[7] U.S. Department of Health & Human Services, Administration on Children, Youth and Families. Children's Bureau. Child Maltreatment 2022. Available from https://acf.gov/cb/data-research/child-maltreatment.

[8] Colorado Child Maltreatment Fatality Annual Report, 2022. 2022 Colorado Child Maltreatment Fatality Annual Report (PDF)

families with infants and young children who are at the greatest risk of maltreatment leading to out-of-home placement. Meeting the prevention needs of families with young children requires a suite of in-home parent programs in each county and tribal community across Colorado. Colorado is proposing five services in this area.

Child First

Child First is a two-generation mental health intervention offered in the home to serve young children and families. Child First is initially being launched by 24 agencies serving 13 Colorado counties with support from Invest in Kids as the state program 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 five years of age who have experienced disruption in secure attachment with their parents. Child First is a Clearinghouse-rated supported practice, and a rigorous evaluation plan is included in this submission.

Healthy Families America (HFA)

Healthy Families America (HFA) 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. HFA 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, there is one community-based organization providing the HFA home visiting model in three counties, but plans for expansion are underway with support by Illuminate Colorado as the state program intermediary and endorsement by Colorado's Home Visiting Investment Task Force.

Nurse-Family Partnership

Nurse-Family Partnership (NFP) is a home visiting program that serves young,

first-time, low-income mothers. 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 program intermediary. NFP is a Clearinghouse-rated well- supported practice that aims to improve the health, relationships and economic well-being of the mother and child.

Parents as Teachers (PAT)

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 33 counties and is supported by Parent Possible as the state program 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. PAT provides additional support to families and is often an extension of services provided through NFP.

SafeCare®

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 included its well-designed and rigorous evaluation plan in Appendix I. The service is being implemented in Colorado through a partnership between CDEC and county departments of human services, with support from the Kempe Center as the state program intermediary. SafeCare® is currently provided as a resource for families by 33 counties and both of Colorado's federally recognized Tribes.

Promoting Mental Health Well-Being

There is growing evidence that children and youth across Colorado are reporting higher levels of emotional distress. According to Colorado's 2020 Statewide Behavioral Health Needs Assessment, 22.6% of children/youth ages 3 to 17 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.[9]

It has been estimated that up to 80% of children/youth in foster care in the US have a significant mental health issue, which is about four times the incidence found within the general population.[10] In Colorado, parental substance use was identified as a condition in 41-50% of all removals of children. When breaking out the age of the child, parental alcohol or drug abuse was identified as a condition for removal of children under the age of one over 60% of the time.

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 "nonsystem-involved youth," half go on to formally enter the child welfare or juvenile justice system within 18 months.

BHA and partners are continuing to develop a comprehensive continuum of services to address the mental health needs of Colorado's children, youth and families. The programs identified in this plan are one small subset of those initiatives.

To build 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, and
2. Services designed to improve family functioning.

[9] Colorado Department of Human Services Office of Behavioral Health, (2020), *2020 Statewide Behavioral Health Needs Assessment*. 2020 Statewide Behavioral Health Needs Assessment: Children and Youth with Complex Behavioral Needs (PDF)

[10] National Conference of State Legislatures. (2019, November 1). *Mental health and foster care* [Issue Brief]. National Conference of State Legislatures Brief: Mental Health and Foster Care

Mental Health Needs of the Child or Youth

Colorado is proposing three services to address the mental health needs of children and youth.

1. Fostering Healthy Futures® for Preteens (FHF-P)
2. Parent-Child Interaction Therapy (PCIT)
3. Child First

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

Fostering Healthy Futures® for Preteens (FHF-P)

Fostering Healthy Futures® for Preteens (FHF-P) is a mentoring and skills group program for preadolescent children (ages 9 to 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 eight counties and is supported by the Kempe Center as the state program intermediary. As a Clearinghouse-rated supported practice, Colorado's rigorous evaluation plan is included.

Parent-Child Interaction Therapy (PCIT)

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 55 providers in Colorado providing PCIT within 10 counties. PCIT Colorado, affiliated with PCIT

International, serves as the program intermediary. PCIT is a Clearinghouse-rated well-supported practice. 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 two to seven years of age and experiencing frequent, intense emotional and behavioral problems.

Improving Family Functioning

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

1. Functional Family Therapy
2. Multisystemic Therapy
3. Motivational Interviewing

Functional Family Therapy (FFT)

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 14 Colorado counties, and FFT LLC serves as the designated state program intermediary.

Multisystemic Therapy (MST)

Multisystemic Therapy (MST) is an intensive community-based, family-driven treatment for addressing antisocial/delinquent behavior in youth. MST is currently available in 46 counties in Colorado. Implementation is supported by the Rocky Mountain MST Network located at the Kempe Center, which serves as the state program intermediary. MST is a Clearinghouse-rated well-supported practice that 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.

Motivational Interviewing (MI)

Motivational interviewing (MI) is a client-centered practice designed to enhance clients' intrinsic motivation to change behavior, decrease substance use disorder, and increase engagement and retention in services. MI can be used in a variety of settings including adolescent behavioral needs and individuals with substance use disorder. MI has also demonstrated its effectiveness in being integrated in casework practice. [Sterrett, Jones, Zalot, & Shook, 2010; Damashek, Doughty, Ware, & Silovsky, 2011] Colorado plans to implement Motivational Interviewing (MI) as a multifaceted child welfare service. It will be used with both youth and adult parents/caregivers who have substance use concerns. MI will also serve as a client engagement tool for caseworkers, facilitating open conversation to assess safety concerns and to engage parents or caregivers in services. MI will be used, regardless of eligibility or the development of a child-specific prevention plan, but both will be required when Colorado begins to seek reimbursement for use. MI is used within multiple disciplines statewide, including child welfare, Family Resource Centers, juvenile justice,and mental health.There is not an existing statewide process for training, fidelity monitoring, or data collection tools to support implementation and oversight of MI in child welfare agencies at this time. Implementing MI within Colorado's Prevention

Plan provides an opportunity to enhance service delivery and build a statewide infrastructure that monitors fidelity and building statewide training opportunities. See Appendix J for more detailed information on the MI pilot project to meet these needs.

Target Population

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

- Program Area 3 (PA3): Prevention services are voluntary and based on a human services professional decision regarding the family's need and on youth and family choice. Services that reduce risk and increase protective factors to decrease the likelihood of child abuse and neglect when the child's circumstances meet the definition of safety.
- 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, and for older youth in transition (ages 18-21) who reenter care to receive services.

As previously described, Colorado has a strong foundation and history of providing prevention and early intervention services using federal, state and local funds and implemented through Core Services, IV-E Waiver interventions, CMPs and integrated

human services delivery practices. Children/youth in any of the program areas may be eligible for an individualized prevention plan and Family First prevention services if they meet the candidacy requirements.

Initial Phase of Target Population

The pathways for determining IV-E prevention candidates for the purpose of claiming include open cases within the child welfare system and in the juvenile justice system.

Open Child Welfare Involvement

Candidacy determinations may be made in all case types—PA4, PA5 or PA6—including the following open involvements:

- In-home cases (court involved)
- In-home cases (non-court involved)
- Voluntary cases with child/youth in the home (non-court involved)
- Child/youth placed with kin (without removal; court involved or non-court involved)
- Child/youth in an open case after reunification (court involved)
- Adoption case with imminent risk of child entering out-of-home care
- Relative Guardianship Assistance case with imminent risk of child entering out-of-home care
- Parenting teen in foster care
- DR FAR open for services with identified risk of out-of-home placement
- Youth in Transition cases

Open Juvenile Justice Involvement

Services identified in this prevention plan can be accessed in juvenile justice cases to prevent out-of-home placement or re-entry into placement for delinquent youth.

Expansion Phase of Target Population - Community Pathways

As Colorado builds community pathways for individual evidence-based services, it is important to note that the eligibility criteria, assessments, data systems, and partners differ for each service. Therefore, Colorado is approaching community pathways in a service-specific way.

To date, Colorado has established a community pathway for SafeCare Colorado. For more information on how candidacy is determined; please see Appendix I. Colorado has also identified a community pathway to claim on Motivational Interviewing services through Family Resource Centers; please see Appendix J.

Statewide Monitoring and Oversight

Program Fidelity

For each service or program included in Colorado's Prevention Plan, CDHS will ensure that the statewide model being implemented is consistent with the approved model on the Clearinghouse. CDHS partners with the program intermediary for each service to monitor fidelity for promising, supported, and well-supported programs included in the plan. State program intermediaries upload adherence data to the Statewide Fidelity Monitoring Dashboard so that CDHS can monitor trends across services and geographic areas and identify targeted areas for CQI.

The Statewide Fidelity Monitoring Dashboard[11] serves as the central mechanism for

[11] Colorado Family First Fidelity Monitoring Dashboard (PDF)

meeting federal Family First fidelity monitoring requirements. The platform was informed by a series of design sessions with providers, counties, state program intermediaries, and state-level partners, as well as national guidance from the Family First Learning Collaboratives hosted by Casey Family Programs.

To ensure meaningful and comparable data, the State of Colorado has entered into contracts with a state program intermediary for each service that includes a requirement to work with the CO Lab to translate service-specific fidelity measures (as described in Appendices A-J) into a three-point standardized scale of “not met, approaching, and met” fidelity for the service. For example, Multisystemic Therapy uses Therapist Adherence Measure (TAM) scores as their fidelity measure, and cut scores have been established that translate the TAM scores into “not met, approaching, and met” fidelity. Service-specific business rules have also been 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 by state program intermediaries and providers of services that do not have existing infrastructure and capacity to monitor fidelity. The state platform will allow these services to systematize processes for collecting fidelity data 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.

Continuous Quality Improvement

Robust continuous quality improvement (CQI) processes and fidelity monitoring ensures that Colorado children, youth and families are receiving high quality services that have been shown to drive positive outcomes. CQI processes use qualitative and quantitative data to determine program efficacy and provide support to ensure that adherence to the model is sustained.

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 (1) identify strengths and weaknesses in program delivery utilizing actionable fidelity data and program feedback; and (2) make adjustments and 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. Finally, the ongoing CQI work will inform the development of a services expansion strategy and additions to Colorado's prevention plan.

Trauma-Informed Practice

Colorado is committed to ensuring a trauma-informed and trauma-responsive child welfare system. During its planning phase, Colorado convened a cross-disciplinary team to create a multi-year curriculum specifically for Title IV-E prevention service providers targeting all levels of agency employment, from board members and administrators to direct care staff. In the initial years of implementation, Colorado has focused on building a robust foundation with agencies, setting the expectation to have a trauma-informed vision and meet basic training requirements through Colorado's child welfare training gateway.

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 child and family 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, 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 the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive, (Creating Trauma-Informed Systems).[12]"

With the BHA, Colorado continues to strengthen its infrastructure and expertise to ensure that Title IV-E prevention services are provided under a trauma-informed organizational structure and treatment framework. CDHS will provide assurance that programs are incorporating trauma-informed service delivery (see Attachment III).

COACT Colorado

COACT Colorado: Colorado's Trauma-Informed System of Care, is supported by a cooperative agreement between CDHS and the Substance Abuse and Mental Health Services Administration (SAMHSA), administered by the BHA in partnership with the Office of Children, Youth, and Families, and other local partners. A statewide goal for the system of care is to develop a sustainable infrastructure to coordinate and fund services for families of children and youth with complex needs. 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.

Colorado Cross-Systems Training Institute (CSTI)

The Colorado Cross-Systems Training Institute (CSTI) is a partnership between BHA/ 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

[12] The National Child Traumatic Stress Network. "Creating Trauma Informed Systems." https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

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.

State Program Intermediaries

To promote consistent service and program delivery within Colorado's decentralized county-administered, state-supervised system, CDHS will identify state program intermediaries for each service in this prevention plan.

Program Fidelity

CDHS will enter into a contract with each state program intermediary with a clear scope of work detailing the expectations for oversight and supervision. The state program intermediary will be responsible for program implementation and monitoring including: selection of local sites and providers; readiness assessments for expansion sites; and, program fidelity utilizing program specific instruments and processes.

Trauma-Informed Training and Service Delivery

The state program intermediaries will ensure that local provider staff are trained in trauma-informed practice aligned with the expectations outlined in the trauma-informed section of this plan.

Program Level Child Safety Monitoring

The state program intermediaries will monitor and attest that local service providers/sites have safety monitoring protocols, are trained in mandatory reporting, and that programs include safety monitoring in program delivery. Any concerns or suspicion of abuse and neglect identified by the program intermediary or local providers will be reported to the Colorado statewide child abuse and neglect hotline.

Continuous Quality Improvement (CQI)

State program intermediaries will gather data and feedback to conduct regular analysis for ongoing CQI processes to quickly identify areas of needed support for quality service delivery at the local or programmatic level. The state program intermediaries will be the liaison between the Colorado IV-E agency and the local providers. They will contribute valuable input into the development of the infrastructure and analysis for program efficacy and service delivery, as detailed in Appendices A-J, for each service proposed in this initial five-year prevention plan.

Local Program Providers

Program Delivery and Continuous Quality Improvement (CQI)

Programs will be delivered at the local level and will be supervised by the state program intermediary. Local providers are responsible for delivering services in adherence to the approved model on the Clearinghouse; attesting that staff are trained in trauma-informed practices; coordinating, as needed, with the county caseworker; keeping appropriate records for tracking progress; and developing processes for CQI including gathering feedback and other information, and analyzing and improving practices.

Local Child Safety Monitoring

Service providers are responsible for ensuring that all staff participate in training to recognize signs of possible abuse and/or neglect, mandated reporter responsibilities, and access to the statewide child abuse and neglect reporting hotline. Each individual service proposed in this plan includes program-specific training, assessment tools, and/or processes to monitor child safety (Appendices A-J). If there are concerns for a child or youth’s safety, providers will notify the child/youth caseworker and 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.

County Caseworker

Assessing for Imminent Risk of Out-of-Home Placement

County caseworkers will complete the safety and risk assessments as required in administrative rules to determine if a child/youth meets the criteria for “imminent risk of out-of-home placement,” The caseworker will determine if the level of risk can be mitigated through the provision of in-home services.

County caseworkers will be responsible for working with the family to complete the child specific individualized prevention plan and make referrals to services. Services will be documented in Colorado’s statewide database (Trails) and through open service authorizations. An individualized prevention plan will be designed to meet the needs of the family and may include services that are not included as reimbursable through Colorado’s Family First Prevention Plan.

Individualized Prevention Plans/Data Collection

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 an individualized 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 align or incorporate the individualized prevention plan with broader case and service planning efforts.

The county caseworker will continue reassessment of the child-specific prevention plan and progress toward meeting the child, youth and families’ stated goals 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.

The individual prevention plan will be reviewed in a family engagement conference with the family, the caseworker and supervisor, service providers and others as necessary to address the following:

- The safety needs of the child/youth, including if a new referral was received and if it was accepted for assessment;
- Identification of family strengths and protective factors that move the family forward and away from systems involvement;
- 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;
- Review of specific services included in the individual prevention plan provided to child/youth and family; and
- Evaluation of progress to meeting goals and the service(s) to determine if they remain appropriate.

Child Safety Monitoring

Monitoring the child-specific plans within open child welfare involvement will include strong casework practices to ensure child/youth safety and well-being and move the case toward achieving stated goals. A formal safety assessment will be conducted by a certified caseworker or supervisor per the CO Safety Assessment Instructions which are listed in 12CCR 2509-2, 7.107.11.

This includes:

- Whenever there is a significant change in household circumstances or situations that might pose a new or renewed threat to the safety of child(ren)/youth;
- Prior to reunification;
- Prior to end-dating a safety plan; and/or

- Case Closure.

Informal safety will be assessed at every face-to-face contact with all parties involved. If the caseworker feels a situation might pose a new or renewed threat, a formal safety assessment will be completed.

The county department is responsible for:

- Completing the Colorado Family Safety Assessment as required by 12CCR 2509-2;
- Making face-to-face contact with the children/youth on at least a monthly basis;
- Visiting the child/youth in the home;
- Making face-to face contact with parents/caregiver as often as needed (while meeting the minimum monthly expectation); and
- Contacting collaterals, as appropriate, to reasonably ensure safety, permanency and wellbeing of the child/youth.

When a safety concern is identified, the caseworker will make a referral to the statewide child abuse and neglect hotline. The county responsible for the open involvement is responsible for ongoing safety monitoring.

Evaluation Strategy

Colorado will continue to approach the rigorous evaluation 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 in order to expand the service array to further meet the needs of Colorado's diverse communities throughout all regions of the state. Formal evaluations will also be conducted to meet the ongoing rigorous evaluation requirements of services included in Colorado's Five Year Prevention Plan that are rated as promising and supported or

where a waiver for rigorous evaluation is not yet granted. The CO Lab's Strategy for the Evidence-Based Aspects of the Family First Service Continuum[13] contains recommendations for Colorado's short and long term priorities for evaluation.

Below is a description of Colorado's evaluation capacity and general approach to evaluation design for promising and supported practices. Each program write up (Appendices A-J) provides detailed descriptions of fidelity monitoring specific to each prevention service being proposed in this initial plan, and the service-specific evaluation plans for promising and supported practices. 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 will 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

[13] Clemens, E.V., Everson, C.L., Henninger, J., & Moses, S. (June 2021). *Strategy for the evidence-based aspects of the Family First service continuum* (Report No. 20-07A). Denver, CO: Colorado Evaluation and Action Lab at the University of Denver. Strategy for the Evidence-Based Aspects of the Family First Service Continuum (PDF)

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 for Formal Evaluation with the Colorado Evaluation and Action Lab (CO Lab)

The CO Lab is a strategic research partner to the Colorado government and works under the Governor's priorities to perform policy and program evaluations. CDHS will partner with the CO Lab to function as a coordinating hub for rigorous evaluations of promising and supported practices. The CO Lab will do the following in supporting Colorado's Prevention Plan:

- 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 evaluations for each promising or supported practice that does not already have a study underway. Evaluation designs will:
    - Be developed in accordance with Administration for Children and Families (ACF) guidance on evaluation planning and rigorous design standards set forth by the Clearinghouse;
    - Build on the existing evidence base for a given intervention

    - 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.
- Ensure Institutional Review Board (IRB) approval and ethical human subjects research.
- 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 CO 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 the government and the academic and scientific community. As the coordinating hub, the CO 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 to meet readiness factors, emergent opportunities, and state needs.

Program or Service-Specific Rigorous Evaluation Teams

As noted above, the CO 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, the current Clearinghouse designation, 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 practice will consist of two studies: a process evaluation and an outcomes evaluation. Descriptions of both are provided below.

Building Period

The building period is service-specific and intended to (1) assess the type of evaluation design that is most appropriate; (2) identify Colorado's learning and decision-making goals associated with the evaluation (e.g., cultural responsiveness for unique populations, scaling to new geographic areas); and (3) ensure sites/providers are delivering the models to fidelity before launching a causal study. The research questions and designs will be fully scoped out during the building period and address the relevant components of the ACF's Evaluation Plan Development Tip Sheet, as well as be cross-walked with the Clearinghouse evaluation design and execution standards.

The outcome of the building period will be a program- or service-specific rigorous evaluation plan that is publicly registered and reviewed by ACF. CDHS and the CO Lab will ensure that there is coordination across the multitude of rigorous evaluations so that counties, Tribes and providers are clear about expectations, and the requirements are reasonable.

Process Evaluation

For each supported and promising program, a process evaluation will be conducted. The research questions will be tailored to specific services and Colorado's learning and decision-making goals for each service.

Findings from research questions 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.

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 targeted for 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, within a given promising or supported practice);
- The theory of change and/or logic model underpinnings of 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 eligible outcomes and Colorado's overarching vision for healthy families.

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 that align 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.

Evaluation Waiver Requests & Ongoing Rigorous Evaluation Plans

As described in section 471(e)(5)(C)(ii) of the Act, Colorado is requesting evaluation waivers for the well-supported programs in this plan. Please see Attachment II for Colorado's Request for Waiver of Evaluation Requirements for each well-supported practice in this plan. Service-specific justifications for each waiver request can be found in the corresponding appendices.

Rigorous evaluation plans are included for the following programs: SafeCare®; Child First; and Fostering Healthy Futures for Preteens. Colorado's ongoing rigorous evaluation plans are also included in the corresponding appendices.

Child Welfare Workforce Training & Support

The CDHS Division of Child Welfare (DCW)'s Learning and Development (L&D) team 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 collaborates 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 practices.

The L&D team is responsible for the 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.

Colorado's training for caseworkers, supervisors and other staff is provided through the Child Welfare Training System (CWTS). The CWTS is delivered through a contracted agreement with the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe) at the University of Colorado Denver. 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. All training is reviewed using an established matrix to ensure that it is in alignment with trauma-informed practices.

Family First-Related Training Plan and Strategy

Colorado currently offers specific learning opportunities that are in alignment with Family First requirements. The L&D team worked with the Family First Implementation Team 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 during the initial phases of implementation. Training and communications products released 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 with the Colorado Human Services Directors Association (CHSDA);
- A series of Lunch & Learn sessions hosted in partnership with 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;
- A multitude of county conversations, town halls and training with key stakeholders around Family First and the role of prevention services.

Identifying Candidates and Developing Child-Specific Prevention Plans

Colorado developed the 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 and answer discussion have been offered to supplement and support understanding of candidacy criteria. A Candidacy Tipsheet was 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 was developed as a reference guide for child welfare staff on how to create a new prevention plan for each child within Trails.

Prevention specific training and reference guides have also been created to ensure county staff understand all the minimum requirements to support children, youth and families receiving prevention services and how to properly document this into Trails. DCW monitors county data entry and service utilization to assess whether additional

resources and learning opportunities need to be created.

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. For example, CDHS and the CO Lab 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 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.

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 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). Lastly, the CIP has encouraged and supported local level conversations and information gathering, again using the BPCT infrastructure, to prepare for changes related to Family First implementation. Colorado created a website specifically for judicial/legal resources, training and messaging.

Evidence-Based Practice (EBP) Provider Workforce

Colorado's EBPs are provided by community-based agencies that receive 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, CDHS will continue partnering with state program intermediaries to ensure that all local 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 Appendices A-J for service-specific details). The statewide 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 to expand the availability of and access to prevention services across the state, investment in the EBP workforce is needed to build capacity. Colorado strategically invested a portion of the state's Family First transition funds in prevention service capacity building based on stakeholder recommendations.

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.

Prevention Caseloads

Senate Bill 21-277 required CDHS and counties to create a funding model to inform the state of how much money is needed overall for counties to provide child welfare services to children, youth and families across Colorado. This bill also funded a workload study to inform a portion of the funding model.

In 2022, CDHS contracted with consulting firm ICF International to conduct the workload study. Using a standard methodology across all counties, the study included an initial finding that Colorado's child welfare system as a whole would benefit from an additional 284 total child welfare staff to meet current caseloads, which includes caseworkers, supervisors, case aides, and case support staff positions working on specific case types.

Importantly, this study may not reflect true county-by-county staffing needs. Therefore, CDHS is seeking input from counties to get their individual and collective feedback on the methodology, the data and results to refine the number of FTE and inform the overall funding model.

Colorado conducted two caseload studies in 2016 and 2023, which recommended specific ratios of supervisor to caseworker (1:5), and recommended ratios for caseworker to case can vary based upon case complexity. CDHS will continue to use these ratios to justify funding requests and allocate new child welfare staff to counties. Colorado believes that these ratios are appropriate for supporting 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.

As the updated workload study and funding model continue to unfold, any significant shifts that would warrant adjusted ratios will be noted in future prevention plans. 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. Counties may determine how to assign prevention caseloads.

Based on data analyzed, approximately 60% of all children with a child welfare involvement remain at home or with kin and the average number of cases per caseworker is 14. Half of all in-home cases may be eligible for one or more prevention services.

Prevention Reinvestment and Capacity Building

Colorado has designed a process to capture and pool together IV-E prevention reimbursement funds to build capacity and expand programs in Colorado's prevention plan. The Colorado Child Abuse Prevention Trust Fund (Trust Fund) Board will manage and oversee processes for the strategic distribution of funds in the pool.

The Trust Fund Board is made up of 19 cross-system representatives at county and state levels alongside family leadership. The Board is a Type II Advisory Board within CDEC, which means that the Board advises the CDEC Executive Director on policy, programmatic changes, budgeting, and other matters to accelerate alignment of prevention investments across Colorado. CDEC and the Trust Fund Board worked with the CO Lab to develop and adopt a Data-Informed Prevention Investment Strategy to promote better data-informed decision-making and smart state investments in child maltreatment prevention.

The Trust Fund Board will continue to consult with CDHS, the Child Welfare Prevention Task Group, county and community partners, state program intermediaries, and research and evaluation to refine recommendations specifically around reinvestment of Title IV-E reimbursement to align with this five-year prevention plan. The Board is

committed to identifying and addressing gaps in services and opportunities for expansion across the state.

In mid 2025, the Trust Fund Board released the first opportunity to reinvest Title IV-E prevention reimbursement funds. CDHS, in partnership with CDEC, local department of human service agencies, and the Child Welfare Prevention Task Group (CWPTG) submitted a proposal to pilot Motivational Interviewing (MI) with a subset of county child welfare staff, as well as a community pathway via Family Resource Centers. The proposal was accepted and the anticipated start date for the pilot is May 2026. See Appendix J for more information about the pilot program.

Building Community Pathways Capacity

In Colorado, the intent of placement prevention services is to proactively strengthen and support families as early as possible, before they are in crisis. 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. 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.

As Colorado continues to build statewide prevention infrastructure, CDHS will work to develop processes and pathways to expand the operationalization of candidacy and maximize Family First reimbursements through community pathways. One strategy will be reimagining and building out additional opportunities for prevention touchpoints. This would encourage county workers to explore other options to meet the needs of children, youth, and families without systematically involving them in the child welfare or juvenile justice systems. This would also provide county workers instructions on how to meet the basic requirements of Family First IV-E oversight.

Colorado aims to reimagine and build out such prevention touchpoints through Program Area 3 (PA3), which is discussed in the section below.

Program Area 3 (PA3)

Colorado's House Bill 11-1196: Flexible Funding for Families redefined family preservation services in the state 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 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 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 limited and inconsistent across the state.

In 2023, the Core Services Program served 9,781 children and youth across the state. 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 and to rethink the structures in place to not only prevent out-of-home placement but to build a system that reduces all child maltreatment. With Colorado's 5-year resubmission plan due in 2026, PA3 is being explored to determine if a community pathway exists to add as an approved prevention path.

Conclusion

Colorado is committed to developing a broad infrastructure to support families, prevent circumstances that lead to child maltreatment, and to intervene when

maltreatment has been identified to ensure that children and youth remain safely in their homes or with kinship caregivers whenever possible. Family First is one component of the plan

Appendix A: 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 Master's prepared 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, domestic violence, and trauma.

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).

Program Selection and Outcomes

For Family First, the eligible target outcome domains for Child First in Colorado are:

- Child well-being: Behavioral and emotional functioning
- Adult well-being: Family functioning
- Adult well-being: Parent/caregiver mental or emotional health

Child Well-Being: Behavioral and emotional functioning

Colorado will be targeting and tracking decreased externalizing behaviors in this

domain. This outcome is measured by providers using the Brief Infant-Toddler Social & Emotional Assessment (BITSEA), which is administered within the first 30 days, at 6 months, and at the end of the designated age range (35 months). Providers have the option of administering the more comprehensive Infant-Toddler Social & Emotional Assessment (ITSEA) as well. Statistically significant effect sizes were found in Clearinghouse "highly rated" studies, as measured by the ITSEA.[14]

This outcome specifically links back to Colorado's candidacy definition by targeting 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.

Adult Well-Being: Family Functioning

Colorado will be targeting and tracking parenting stress in this domain. This outcome is measured by providers using the Parenting Stress Index-4th Edition Short Form (PSI-4-SF) at intake, 6 months, and at the conclusion of services. Statistically significant effect sizes were found in Clearinghouse "highly rated" studies, as measured by the PSI Total Score, Difficult Child, Parent-Child Dysfunction and Parent Distress.[15]

This outcome targeted through Child First specifically links back to Colorado's candidacy definition by addressing parents' lack of parenting skills and limited capacity or willingness to function in parenting roles.

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[14] Lowell, D. I., Carter, A. S., Godoy, L., Paulicin, B., & Briggs-Gowan, M. J. (2011). *A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice*. Child Development, 82(1), 193-208. https://doi.org/10.1111/j.1467-8624.2010.01550.x

[15] Lowell, D. I., Carter, A. S., Godoy, L., Paulicin, B., & Briggs-Gowan, M. J. (2011). *A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice*. Child Development, 82(1), 193-208. https://doi.org/10.1111/j.1467-8624.2010.01550.x

Adult Well-Being: Parent/Caregiver Mental or Emotional Health

Colorado will be targeting and tracking parent/caregiver depression in this domain. This outcome is measured by providers using the Center for Epidemiology Scale-Depression (CESD-R) at intake, 6 months, and at the conclusion of services. Statistically significant effect sizes were found in Clearinghouse "highly rated" studies, as measured by the CESD-R.[16]

This outcome targeted through Child First specifically links back to Colorado's candidacy definition by targeting parent/caregiver mental illness.

Service Description and Oversight

Implementation Manual

Lowell, D., Parilla, R., Soliman, S., & DiBella-Farber, K. (2019). *Child First training manual*. Child First, Inc.

Lowell, D., Parilla, R., Quieroga, S., Theriault, A., & Davino, A. (2020). *Child First toolkit*. Child First, Inc.

Implementation of Child First

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

[16] Lowell, D. I., Carter, A. S., Godoy, L., Paulicin, B., & Briggs-Gowan, M. J. (2011). *A randomized controlled trial of Child FIRST: A comprehensive home-based intervention translating research into early childhood practice*. Child Development, 82(1), 193-208. https://doi.org/10.1111/j.1467-8624.2010.01550.x

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).

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

1. 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.
2. 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.

3. 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.

1. 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.

2. 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.[17]

Target Population in Colorado

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. Delinquent/justice-involved youth who are pregnant or are young parents may also be eligible if they meet the other eligibility criteria.

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.

Sites in Colorado

Child First is currently available in the following counties: Adams, Alamosa, Arapahoe, Bent, Boulder, Broomfield, Chaffee, Clear Creek, Conejos, Costilla, Crowley, Custer, Douglas, El Paso, Fremont, Gilpin, Lake, Jefferson, Mineral, Moffat, Otero, Rio Grande, Routt, and Saguache. Programming is provided through the following organizations:

1. Savio House
2. Aurora Mental Health & Recovery
3. San Luis Valley Behavioral Health Group
4. Paragon Behavioral Health Connections
5. Solvista Health

[17] Changenet. *Child First*, 2025. https://changent.org/what-we-do/child-first/

Fidelity Monitoring

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:

- Process data or metrics
- Outcome data

The Child First NSO has a tool called the "Child First Benchmarks (2018 version)," which consists of 10 benchmarks encompassing both process and outcome 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.
- 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.

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 Fidelity Monitoring Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

Continuous Quality Improvement (CQI)

As part of the CQI process, Child First sites collect and monitor data such as:

- Child Functioning in areas of language, cognition, gross motor, fine motor, and personal-social skills
- Child's social-emotional development
- Child's emotional/behavioral competencies/challenges
- Traumatic events in the life of the child
- Caregiver-child relationships
- Psycho-social risk factors for the child & family
- Stress that parents experience from the parenting role
- Parental depressive symptoms
- Traumatic events in the life of the parent

- Parental PTSD symptoms
- Conditions of the home environment
- Health status of the child and family
- Service Needs for the family

For further details, please see the Child First assessment protocol.[18]

CQI data is collected through the Child First Comprehensive Clinical Record and the Assessment Scoring Database, which is operated by the National Service Office. This data is shared with the Child First Affiliate Agencies on a quarterly basis.

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

[18] Child First Assessment Protocol (PDF)

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.[19]

Eligibility for Federal Claiming

For Family First IV-E claiming purposes, only children and families in an open child welfare case are eligible for federal reimbursement to the Colorado's Children's Trust Fund.

Research and Ongoing Rigorous Evaluation

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

[19] https://changent.org/why-it-works/

Child First website.[20]

Plans for Ongoing Rigorous Evaluation

Publication of the Title IV-E Prevention Services Clearinghouse Handbook, Manpower Demonstration Research Corporation (MDRC), a non-partisan, non-profit social policy research firm dedicated to conducting rigorous research to improve the lives of low-income children and families, launched a randomized controlled trial of Child First in two states. The trial was paused during the pandemic, and re-initiated in Winter 2022. Colorado was included in the study with the participation of Aurora Mental Health & Recovery teams, and one team from the San Luis Valley Behavioral Health group. This project presents a unique opportunity to strengthen the evidence base for Child First, provide useful information to the Child First community, and may position Child First to continue to expand its capacity to serve more families who can continue to benefit from the program.

The pre-analysis plan[21] was revised in January 2022. Staff will continue to enroll families through the end of 2024. Results from the study will be shared with sites and key stakeholders in 2025-2027.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for ongoing safety monitoring.

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

[20] Child First: Research, Child First National Program Office, 18 Dec. 2020, https://changent.org/why-it-works/outcomes/

[21] Randomized Control Trial of Child First Pre-Analysis Plan

all Child First programs that include key components to help staff monitor child safety, such as:

- Gathering information from the parents/caregivers through discussion
- Observation of the child in interaction with caregiver(s) and other significant others
- Interactive play with the clinician and child
- Observations in the early care or school setting
- Developmental observations and assessments
- Gathering health information
- 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. The Child First Toolkit contains details on assessment tools and schedules for assessments based on child development and age.

Workforce Support and Training

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.

Through the intensive training process, Child First site staff are trained to identify individual child and family needs using the Service Needs Inventory for Families (SNIFF) 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. The SNIFF is completed on a quarterly basis to ensure that newly identified needs are included in the families' plan of care.

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 training on trauma is 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

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 (the goal is 12 home visits per week). Based on that requirement, site staff in Colorado average a caseload of one to ten families per team. To determine appropriate caseload size, the site Clinical Supervisor, in coordination with IIK, considers factors such as:

- Family need
- Distance of travel from site office to family home
- Staff capacity threshold.

Appendix B: Fostering Healthy Futures® for Preteens

Fostering Healthy Futures® for Preteens (FHF-P) is a mentoring and skills group program for pre-adolescent children 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-P uses a combination of structured individual mentoring and group-based skills training to promote prosocial development and to address the consequences of ACEs.

Program Selection and Outcomes

Colorado conducted an independent systematic review, with a determination of FHF-P as a well-supported practice in a review by the CO Lab (see documentation starting on page 6 of this Appendix for full documentation of this review), and found that FHF-P has a medium positive effect on child well-being outcomes (behavioral and emotional functioning) and a large positive effect on child permanency in Colorado. Since this review, the Title IV-E Clearinghouse has also completed their review and has rated the program as a "supported" practice, with favorable outcomes observed in child well-being (behavioral and emotional functioning) and permanency.

For Family First, the eligible target outcome domain for FHF-P in Colorado is:

- Child Permanency: Out-of-Home Placement

Colorado will be tracking the stability of and any changes in each youth's living situation both throughout the service period and 12 months following the service end date. Statistically significant effect sizes for this domain were found in Colorado's independent systematic review.

This domain specifically links back to Colorado's overall goals for Family First

prevention services by decreasing the number of children/youth entering out-of-home care as measured by state data.

Service Description and Oversight

Implementation Manuals

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

Taussig, H.N., Wertheimer, R., Raviv, T., Fireman, O., Malen, A., & Culhane, S. (2021). Fostering Healthy Futures - Preteen Implementation and Mentor Orientation Manual.

Hettleman, D., Wertheimer, R., Holmberg, J., Gennerman-Schroeder, R., Hambrick, E., Malen, A., & Taussig, H.N. (2021). Fostering Healthy Futures - Preteen Skills Group Manual.

Implementation

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 technical assistance, and monitor fidelity to the models.

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, 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 a 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.

Target Population in Colorado

FHF-Preteen enrolls children ages 9 - 11 who have previous or current child welfare involvement due to one or more adverse childhood experiences

Referral sources may include schools, child welfare and juvenile justice agencies, as well as community agencies.

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

- Children are at least 9 and not more than 11 years of age by the first week of group
- Children and their families have current or past child welfare involvement (defined broadly) due to maltreatment
- Children's involvement with child welfare must be a result of maltreatment prevention/intervention and not due solely to their own emotional/behavioral issues.
- Children have one or more of the following adverse childhood experiences (ACEs):
    - Maltreatment

    - Placement in out-of-home care
    - Exposure to violence
    - Parent/caregiver with severe mental illness, substance use, and/or incarceration
    - Parental death or abandonment
    - Multiple caregiver changes, moves and/or homelessness
    - Multiple school changes
- Children live less than 35 minutes away from location of skills groups at the start of program
- Children have behavioral control to be safe during transport to, and participation in, group and mentoring activities
- Children are cognitively able to participate in, and benefit from, group
- Children with sexual behavior problems, those in residential placements, and those with very mild developmental delays can be enrolled, assuming they meet all other criteria
- Children have age-appropriate adaptive and self-care skills. Children with physical disabilities are eligible for participation provided that they do not have to be lifted in and out of a wheelchair, are not incontinent, can feed themselves, and can otherwise fully benefit from participation in the program. Eligibility for children with visual and hearing impairments, as well as those with chronic illnesses, is evaluated on a case-by-case basis.
- Children speak enough English to benefit from group (caregivers can be monolingual speakers in another language as long as there are mentors and program staff who speak their language)
- Child can continue in the program for the full duration even if they change

living situations (e.g., reunify, are placed in out-of-home care), or have a change in child welfare case status (open/closed)

Sites in Colorado

In September 2019, FHF hired a Director of Dissemination to identify the need for FHF- Preteen across the state and to 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 2013-2018. FHF-P is being implemented by Adoption Options and Lutheran Family Services in the following counties: Adams, Arapahoe, Denver, Douglas, El Paso, Elbert, Jefferson, and Teller.

Fidelity Monitoring

Kempe, as the FHF intermediary, in conjunction with agencies implementing the FHF-P 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 and mentor supervision are videotaped, 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 22 (Implementation Consultation and Fidelity Tracking Materials) in the Preteen Implementation and Mentor Orientation Manual[22] for the fidelity tracking instruments (Intern Supervisor Fidelity Form, Group Supervisor Fidelity Form, Skills Group Topics Fidelity Form) and a schedule of training consultation activities (Implementation Consultation Schedule).

CDHS will coordinate with Kempe to receive relevant fidelity data which will then be

[22] Fostering Healthy Futures. *Preteen implementation and mentor orientation manual,* 2021.Mentor Orientation Manual (PDF)

translated into the standardized statewide metrics of fidelity and moved into the Colorado Fidelity Monitoring Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

Continuous Quality Improvement (CQI)

As part of the CQI process, Fostering Healthy Futures for Preteens sites collect and monitor data such as:

- Children's program attendance, including skills groups to develop social skills in engaging in prosocial relationships, resisting antisocial relationships, reducing stigma associated with experiencing major life stressors and child welfare involvement, processing of challenging emotions with trauma and transition, and coping with difficult emotions
- All stakeholders' engagement and satisfaction, with a focus on positive behavioral changes in child, ability to cope with difficult emotions, and child relationships
- Staff and intern adherence to the program model components and competence in implementing the program
- Staff and intern adherence to the program model components and competence in implementing the program

CQI data for the FHF-P program includes the following:

- Program sites' staff complete the following weekly forms in an online database: Intern Supervisor Fidelity Form, Group Supervisor Fidelity Form and Skills Group Form to track all program activities and attendance.
- Kempe Trainers review videotapes of skills groups and mentor supervision to provide regular feedback to staff.
- Kempe trainers complete weekly fidelity forms for the Group Supervisor and Intern Supervisor after watching videos and meeting with each staff member.

- Kempe talks with each site's Agency Administrative Lead on a monthly basis to discuss program implementation strengths and challenges.
- Kempe talks with program staff and Agency Administrative leads when there are concerns about an agency's practice and also increases the frequency of video monitoring and consultation as needed.

Eligibility for Federal Claiming

For Family First IV-E claiming purposes, only preteens in an open child welfare case are eligible for federal reimbursement to the Colorado's Children's Trust Fund. In order to receive FHF-P services, preteens may not be in current out-of-home placement.

Evaluation Strategy

FHF-P is rated by the Title IV-E Clearinghouse as a "supported" practice. As such, it requires ongoing rigorous evaluation. Colorado is working with Dr. Heather Taussig at the University of Denver and Kempe Center at the University of Colorado to conduct an evaluation for the Fostering Healthy Futures-Preteen (FHF-P) Program. This evaluation will be conducted as a follow-up to these trials, with clinical trial registries found available upon request. This follow-up RCT analysis will evaluate the program's potential impact on child well-being, specifically suicide rates (behavioral and emotional functioning) and substance use. This will help contribute to evidence-building on FHF-P with a goal of a study design that meets standards of the Title IV-E Prevention Services Clearinghouse and can contribute to Clearinghouse review and evidence ratings for this program/service

The rigorous evaluation strategy for FHF-Preteen can be found in Section I of attachments.

All FHF-P's research to-date, including the proposed evaluation strategy, is conducted in Colorado; as such, the findings that FHF-P 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, based on the needs assessment data in Colorado, it is clear that there is a need for this particular intervention. For example, Colorado's 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.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for ongoing safety monitoring.

FHF works to build relationships with all professionals involved in the preteen's life to support preteens and their families. Throughout the program delivery, mentors are meeting with youth two times per week. Mentors are trained to observe behaviors and assess verbal responses, as safety protocols are embedded in program activities. All interactions are documented in progress notes, and FHF collects data through a HIPAA-compliant web-based system (REDCAP) that tracks data as part of the individualized prevention plans for youth. Program staff and Kempe intermediaries capture data such as demographic data, children's, mentors' and program staff's attendance at program activities, and and permanency indices throughout the duration of FHF service delivery. Monthly summary of interactions and progress are shared with the assigned caseworker in open child welfare involvements. Mentors also meet with the youth's supportive/involved adults, such as parents/caregivers, teachers, coaches and therapists, on a regular basis.

Concerns that do not raise suspicion of abuse or neglect are often discussed with the family and caseworker to focus on constructive solutions. In cases where abuse or neglect is suspected, reports are made both to the caseworker (in open child welfare involvements) and to the child abuse and neglect statewide hotline.

Workforce Support and 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 five-year Prevention Plan. Individual sites will be responsible for ensuring compliance with the standards.

Prevention Caseloads

Each mentor is assigned no more than two to four preteens, and prevention caseloads are tracked and monitored by Kempe staff.

Appendix C: 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 youth between the ages of 11 to 18, who have been referred for behavioral or emotional problems. The program is organized in multiple phases and focuses on developing a positive relationship between the therapist and the 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 three to six months. Typically 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.[23]

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. Behavioral Change: The goal of this phase is to reduce or eliminate referral problems by improving family functioning and individual skill development.

[23] Administration for Children and Families (ACF). *"Functional Family Therapy."* Title IV-E Clearinghouse, 2020, December. https://preventionservices.acf.hhs.gov/programs/652/show

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.[24]

Program Selection and Outcomes

Research partners at the Colorado Evaluation and Action Lab engaged in an extensive review of Colorado needs assessment to inform the selection of services. 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. Research shows that 46.2% of children and adolescents indicate a low commitment to school, with 37.4% reporting academic failure.[25] 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.[26] 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. The family-based model addresses the whole family. The specific outcome to be tracked and measured for this service in Colorado is youth will remain home and family functioning will improve based on the Family Functioning Assessment scale.

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

[25] Colorado Department of Public Health & Environment. (2018). 2017 Colorado Healthy Kids Survey. Retrieved from https://spl.cde.state.co.us/artemis/hemonos/he191002h342017internet/

[26] Colorado Department of Public Health & Environment. (2018). 2017 Colorado Healthy Kids Survey. Retrieved from https://spl.cde.state.co.us/artemis/hemonos/he191002h342017internet/

For Family First, the eligible target outcome domains for FFT in Colorado are:

- Child Well-Being: Behavioral and emotional functioning
- Adult Well-Being: Family functioning

Child Well-Being: Behavioral and emotional functioning

The specific outcome Colorado will be targeting and tracking in this domain is decreased depression symptomatology. This outcome is measured by providers using the following pre/post assessments: OQ®-45.2 Outcome Questionnaire, Y-OQ® 2.01 Youth Outcome Questionnaire, and Y-OQ® SR 2.0 Youth Outcome Questionnaire. Statistically significant positive effect sizes were found in Clearinghouse "highly rated" studies.[27]

This outcome specifically links back to Colorado's candidacy definition by targeting the youth's mental health.

Adult Well-Being: Family functioning

The specific outcome Colorado will be targeting and tracking in this domain is improved family conflict management. This outcome is measured by providers using the Family Risk and Protective Factors assessment.Statistically significant effect sizes were found in Clearinghouse "highly rated" studies.[28]

This outcome targeted through FFT specifically links back to Colorado's candidacy definition by targeting parents' lack of parenting skills and parents' inability, or need for additional support, to address serious needs of a child/youth or related to the

[27] Slesnick, N., & Prestopnik, J. L. (2009). *Comparison of family therapy outcome with alcohol-abusing, runaway adolescents.* Journal of Marital and Family Therapy, 35(3), 255-277. doi:10.1111/j.1752-0606.2009.00121.x

[28] Slesnick, N., & Prestopnik, J. L. (2009). *Comparison of family therapy outcome with alcohol-abusing, runaway adolescents.* Journal of Marital and Family Therapy, 35(3), 255-277. doi:10.1111/j.1752-0606.2009.00121.x

child/youth's behavior or physical or intellectual disability.

Service Description and Oversight

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.

Implementation of FFT:

FFT LLC utilizes a multi-phased approach to implementation. Sites must purchase three clinical assessments licenses utilized during FFT: the Outcome Questionnaire (OQ), the Youth Outcome Questionnaire (YOQ), and the Youth Outcome Questionnaire Self Report (YOQ SR); these must be purchased outside of the standard costs of implementation through FFT LLC.

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. Periodically during Phase I, FFT LLC personnel provide the implementation site with feedback to identify progress toward Phase I implementation goals and steps toward beginning Phase II. Phase I includes a two-day initial clinical training, three two-day follow up trainings and a second two-day clinical training for the full team and an externship training series for the person identified to become the site supervisor in 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 supervisor will attend two 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 year-long 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.[7]

Target Population in Colorado:

Youth between the ages of 11 and 18 with behavioral issues, who are not currently in out-of-home placements, are eligible to receive FFT services.

Referral sources to FFT may include schools, community-based organizations, hospitals, child welfare and juvenile justice agencies, and self-referrals. In order to be a candidate for FFT services, families must meet at least one of the following criteria:

- 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
- Youth with externalized behavioral concerns
- Reunification, adoption or guardianship arrangements that are at risk of disruption

Sites in Colorado

FFT is currently being utilized in 14 counties across Colorado; Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Jefferson, Larimer, Weld, Pueblo, and Teller. Programming is provided through the following organizations:

1. Savio House
2. Mental Health Partners

Fidelity Monitoring

FFT LLC is the intermediary for the FFT provision of services across the state. Fidelity for each site is monitored through the national Clinical Service System (CSS) database. The CSS is designed to build therapists' 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. 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 Tri Yearly Performance Evaluation to sites three times a year reviewing outcomes and model fidelity.

The following instruments are used in monitoring fidelity:

- WSC – Weekly Supervision Checklist (weekly fidelity ratings):
    - Following every clinical staffing and individual supervision staffing, the clinical supervisor completes a fidelity rating for each case that was reviewed for each therapist. The fidelity rating reflects the degree of clinical adherence and competence for that therapist's work in that case in a specific session. Adherence is on a four point Likert scale and ratings are based on the extent (frequency) to which therapists engage in FFT-model specific behaviors.
- GTR – Global Therapist Rating (provided three times per year) and its Learning and Growth Plan:
    - Three times a year the clinical supervisor rates each therapist's overall performance in their practice of FFT (clinical fidelity, dissemination adherence and general clinical skills).
- FSR – Family Self Report (done throughout intervention):
    - The FSR is a 7 item self-report inventory completed by all family members participating in FFT sessions. The main purpose of the FSR is to give the family an opportunity to tell the therapist how they view the counseling process and therapist.
- TSR – Therapist Self Report (done throughout intervention):
    - The TSR is a 6 item self-report inventory completed by the FFT therapist each time FSRs are completed by the family members. The purpose of TSR is to provide therapists, supervisors and/or consultants with a measure of how the therapist perceives the family members' perception of relational quality with the therapist.

Continuous Quality Improvement (CQI)

As part of the CQI process, FFT LLC's sites collect and monitor data such as:

- Therapists on the team (name and number)
- Cases: Referral, Active, Closed
- Referral information
- Demographics
- Contacts
- Sessions
- Successfully Closed Ratings
- Non-completed reasons
- Never-Began reasons
- Outcome Assessments and Questionnaires
    - Pre and Post Outcomes (OQ.45.2) of individual functioning: symptom distress, interpersonal relationship, social role
    - Pre and Post Outcomes (YOQ 2.01) of caregivers'/parents' perception of their child's behavior in a context: interpersonal distress, somatic, interpersonal relations, critical items, social problems, behavioral dysfunction
    - Pre and Post Outcomes (YOQ SR 2.0) of youth's self report of their behavior in a context: interpersonal distress, somatic, interpersonal relations, critical items, social problems, behavioral dysfunction
    - Pre and Post Risk and Protective Factors of: family love and support, family closeness, opportunities for involvement, conflict management,

degree of supervision, degree follows the rules, degree of consistent/ appropriate punishment, available of appropriate rewards for good behavior

    - Ultimate outcomes (caregiver, youth, and therapist): family functioning, youth behavior change

- Fidelity and Adherence ratings (weekly by Site Supervisor for Phase 2 & 3 teams, weekly by FFT National Consultant for Phase 1 teams)
- Global Therapists Ratings (Tri-Yearly by Site Supervisors for Phase 2 & 3 teams, FFT National Consultant for Phase 1 teams)
- Process Assessments
    - Family Self Reports (conducted throughout intervention, 7-item self-report)
    - Therapist Self Reports (conducted throughout intervention, 6-item self-report)

CQI data will be collected by FFT LLC through the Client Service System's (CSS) Reports and monitoring of the system. These include Weekly Supervision Checklists (WSC) which contain Fidelity and Dissemination Adherence Ratings, Tri-Yearly Performance Evaluations (TYPE) which contain benchmarks and national standards for implementation, TYPE Performance Review Plans (PRP) which provide Quality Assessment and Improvement Plans based on the TYPE, Global Therapist Ratings (GTR) which contain therapist knowledge and performance in the model. These are monitored by the National FFT Supervisors, FFT Clinical Director, and Implementation Specialists.

Therapists are required to enter case information (assessments, contacts, and sessions) into the CSS. National Consultants/Supervisors are required to enter information related to their monitoring of therapists/cases into CSS at each consultation and evaluation which is brought together in a 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. In addition, the sites receive ongoing feedback from families on the benefits and areas for improvement of the program, providing an opportunity for real time correction to service delivery. Results from all data sources 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.

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.

Eligibility for Federal Claiming

For Family First IV-E claiming purposes, only youth in an open child welfare case are eligible for federal reimbursement to Colorado's Children's Trust Fund. Per FFT service eligibility, youth may not be in current out-of-home placements in order to receive FFT services.

Request for Evaluation Waiver

Colorado is seeking an evaluation waiver for Functional Family Therapy (FFT) and, upon approval, will assess program implementation and fidelity through a robust

continuous quality improvement (CQI) process rather than through formal, independent evaluation. 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.

Studies conducted to-date on FFT have demonstrated efficacy of the program on outcomes in several domains, including child well- being (Celinska et al., 2013; Slesnick & Prestopnik, 2009) and adult well-being (Slesnick & Prestopnik, 2009). Studies have also demonstrated favorable outcomes measured after the end of treatment, including favorable child well-being and adult well-being outcomes sustained at seven and 13 months after treatment (Slesnick & Prestopnik, 2009). These outcomes have been demonstrated for several populations, including among adolescents with a primary alcohol problem (Slesnick & Prestopnik, 2009) and at-risk youth identified as having a history of aggressive behavior, destruction of property, or chronic truancy (Celinska et al., 2013). Outcomes demonstrated and populations reached with efficacy are aligned with Colorado's stated outcomes for this service and the target populations prioritized for candidacy.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for ongoing safety monitoring.

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.

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.

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.

Assessment in FFT occurs throughout the treatment period, and 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:

- The 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 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 of the youth and parental figures.
- After the initial pretreatment formal assessments, FFT uses formal assessments when necessary to answer specific questions that cannot be answered in direct clinical contact, or when additional information is 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.

FFT therapists are all trained and required to use the CSS database to collect demographic data, case tracking information, progress and assessment notes, and outcome measures. Individualized session plans are documented in the CSS. The CSS keeps 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
- Process Tracking
- Outcome Assessment

As FFT is administered weekly, and the frequency and intensity of treatment vary depending on risk and protective factors, reassessment for the risk of out-of-home placements occurs on a regular basis. Risk factors are targeted through the duration of treatment, which typically last from three to five months. In the final phases of FFT treatment, therapists create a general plan with the family, to ensure the continuation of addressing risk factors, and maintaining support for the family post-treatment.

Workforce Support and Training

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.

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 five-year Prevention Plan. Individual sites will be responsible for ensuring compliance with the standards.

Prevention Caseloads

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.

Appendix D: 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. 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 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.

The HFA program begins at birth and enrolls families through the first three months postpartum. Families initially receive weekly home visits, and the frequency of home visits may change depending on their needs and progress. Most families are offered services for a minimum of three years, or until the child turns five years of age.

Program Selection and Outcomes

Healthy Families America was selected as a model program to address the lack of home visiting resources for families living in poverty in non-metro Colorado communities. The program was also recently endorsed by Colorado's Home Visiting Investment Task Force. 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 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and a lower household income, resulting in an increase in medical fragility of the newborn.

The Colorado Home Visiting Coalition indicates that there is a compelling need for

expanding the array of home visiting services - currently only 19% of families living in poverty with children under the age of six are participating in a home visiting program.

For Family First, the eligible target outcome domains for HFA in Colorado are:

- Child Well-Being: Behavioral and emotional functioning
- Adult Well-Being: Positive parenting practices
- Adult Well-Being: Parent/caregiver mental or emotional health

Child Well-Being: Behavioral and emotional functioning

Colorado will be targeting and tracking increased developmental progress and social-emotional health in this domain. This outcome is measured by providers using the Ages and Stages Questionnaires (ASQ), administered twice per year for children under the age of three and annually for children ages three through five years, and the ASQ-Social Emotional, administered once per year for children birth through age five. Statistically significant positive effect sizes were found for this domain in Clearinghouse "highly rated" studies.[29]

This outcome specifically links back to Colorado's candidacy definition by targeting developmental delays and 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.

[29] Duggan, A., Caldera, D. Rodriguez, K., Burrell, L., Shea, S., & Rohde, C. (2005). *Evaluation of the Healthy Families Alaska program: Final report*. Juneau, AK: Alaska State Department of Health and Social Services.

Caldera, D., Burrell, L., Rodriguez, K., Crowne, S. S., Rohde, C., & Duggan, A. (2007). *Impact of a statewide home visiting program on parenting and on child health and development*. Child Abuse & Neglect, 31(8), 829-852. doi:http://dx.doi. org/10.1016/j.chiabu.2007.02.008

Adult Well-Being: Positive parenting practices

Colorado will be targeting and tracking improved praise and decreased criticism in this domain. This outcome is measured by providers using the HFA CHEERS Check-In Tool, which assesses parent-child interaction and is administered twice annually from birth through 36 months of age. Statistically significant positive effect sizes were found in Clearinghouse "highly rated" studies.[30]

This outcome targeted through HFA specifically links back to Colorado's candidacy definition by targeting parents' lack of parenting skills.

Adult Well-Being: Parent/Caregiver Mental or Emotional Health

Colorado will be targeting and tracking maternal depression in this domain. This outcome is measured by providers using a depression screening tool (sites are able to choose a standardized tool) at least once prenatally, at least once postnatally within three months of the baby's birth, and at least once postnatally within three months of any subsequent births. Statistically significant positive effect sizes were found in Clearinghouse "highly rated" studies.[31]

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[30] DuMont, K. A., Mitchell-Herzfeld, S. D., Kirkland, K., Rodriguez, M., Walden, N., Greene, R., et al. (2008). E*ffects of Healthy Families New York on maternal behaviors: Observational assessments of positive and negative parenting.* Rensselaer, New York: New York State Office of Children and Family Services.

[31] Duggan, A., Fuddy, L., Burrell, L., Higman, S. M., McFarlane, E., Windham, A., & Sia, C. (2004). *Randomized trial of a statewide home visiting program to prevent child abuse: Impact in reducing parental risk factors.* Child Abuse & Neglect, 28(6), 623- 643. doi:http://dx.doi.org/10.1016/j.chiabu.2003.08.008

Duggan, A., Caldera, D., Rodriguez, K., Burrell, L., Rohde, C., & Crowne, S. S. (2007). Child Abuse & Neglect, 31(8), 801-827. doi:http://dx.doi.org/10.1016/j.chiabu.2006.06.011

McFarlane, E., Burrell, L., Crowne, S., Cluxton-Keller, F., Fuddy, L., Leaf, P., & Duggan, A. (2013). *Maternal relationship security as a moderator of home visiting impacts on maternal psychosocial functioning.* Prevention Science, 14(1), 25-39.

This outcome targeted through HFA specifically links back to Colorado's candidacy definition by targeting caregiver mental illness.

Service Description and Oversight

Implementation Manual

Healthy Families America: Healthy Families America. (2018) Best practice standards. Prevent Child Abuse America, in conjunction with Healthy Families America. (2018). State/multi-site system central administration standards. Prevent Child Abuse America. Supporting materials from Healthy Families America National.

Implementation of HFA

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 three months, six months, and 12 months of hire. There is annual training on child abuse and neglect. Family Support Specialists receive weekly reflective supervision as ongoing support.

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

Target Population in Colorado

Child welfare involved families and non-child welfare involved families are eligible to access HFA. For families currently involved in child welfare, referrals often come from

the county child welfare agency. Families may also self-refer to HFA, and other referral sources may include community agencies and hospitals.

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 prior to or within four visits after enrollment to assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences. New parents are eligible for the HFA program if they have been 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.). Sites began using the HFA Family Resilience and Opportunities for Growth (FROG) Scale in 2022. The FROG scale is a one-time assessment used to create a family service plan, which is monitored and updated throughout the course of services.

Based on the results of the Parent Survey (or another HFA-approved tool), 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.

Sites in Colorado

As of March 2021, Illuminate Colorado became the state office/state program intermediary for Healthy Families America.

HFA is implemented by Great Expectations in Glenwood Springs serving families from Aspen to Parachute, as well as by the Genesis Program (an HFA affiliate) in Boulder

County.

Fidelity Monitoring

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. The HFA site must meet a minimum of 85% threshold of adherence to the "HFA Best Practice Standards," which is the standardized tool used for monitoring fidelity.

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 every four years to determine the site's rating 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 four years.[32]

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 Fidelity Monitoring Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

[32] Healthy Families America Site Development Guide (revised 2014). Chicago, IL: Prevent Child Abuse America

Continuous Quality Improvement (CQI)

As part of the CQI process, HFA sites collect and monitor data such as:

- Number of referrals and eligibility status
- Timeframes for initial engagement of families referred
- Age of the focus child at the time of the first home visit
- Acceptance rates and retention rates
- Home visit completion rates
- Children connected with a pediatrician
- Immunization rates
- Well-child visits
- Caseload monitoring and staff retention
- Adherence with staff training requirements
- Frequency and duration of supervision

Quarterly learning calls are conducted with each site to:

- Review, strategize and support progress toward addressing recommendations made by the site team and challenges identified by the sites; and
- 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.

In combination between HFA and local HFA sites, Illuminate will serve to be a centralized collection point for the QCI metrics and work with HFA to ensure data is available and in alignment with HFA standards.

Eligibility for Federal Claiming

For Family First IV-E claiming purposes, only children and families in an open child welfare case are eligible for federal reimbursement to Colorado's Children's Trust Fund.

Request for Evaluation Waiver

Colorado is seeking an evaluation waiver for Healthy Families America (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.

Studies conducted to-date on HFA have demonstrated efficacy of the program on outcomes in several domains, including child safety (Duggan et al., 2004; Mitchell-Herzfeld et al., 2005), child well-being (Caldera et al., 2007; Duggan et al., 2005; DuMont et al., 2010; Kirkland et al., 2012), and adult well-being (Bair-Merritt et al., 2010; Duggan et al., 2004, 2007; DuMont et al., 2008; McFarlane et al., 2013). Studies have also demonstrated favorable outcomes measured after the end of treatment, including favorable child well-being outcomes sustained at 24 months after treatment (DuMont et al., 2010; Kirkland et al., 2012). These outcomes have been demonstrated for several populations of families with newborns at-risk for child abuse and neglect, including children of mothers with poor mental health, maternal substance use, and partner violence (Bair-Merritt et al., 2010; Caldera et al., 2007; Duggan et al., 2004); and women with less than a high school diploma, under 19 years of age, and first-time mothers (DuMont et al., 2010; Mitchell-Herzfeld et al., 2005). Outcomes demonstrated and populations reached with efficacy are aligned with Colorado's stated outcomes for this service and the target populations prioritized for candidacy.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for ongoing safety monitoring.

After enrollment, all sites complete the following screens/assessments at the minimum frequency indicated below:

- HFA CHEERS Check-In Tool (assesses parent-child interaction) – twice annually from birth through 36 months of age
- ASQ – twice per year for children under the age of three and annually for children ages three through five years
- ASQ-SE – once per year for children birth through age five
- Depression screening (sites are able to choose a standardized tool) – at least once prenatally, at least once postnatally within three months of the baby's birth, and at least once postnatally within three months of any subsequent births.

One of the foundational principles of HFA is to prevent child abuse and neglect. 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 core trainings that direct hires must complete within 6 months of hire: Foundations for Family Support (FFS), which is required for family support specialists (who conduct home visits), and Parent Survey for Community Outreach (PSCO), which is required for family resource specialists (who conduct the initial assessment/parent surveys). Supervisors must complete both FFS and PSCO core training, and stay for one additional day of core training, within 6 months of employment. Program managers must complete FFS and PSCO core training, as well as an Implementation Training, within the first 18 months of employment.

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 weights 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) Family Support Specialist.

Appendix E: Multisystemic Therapy (MST)

Multisystemic Therapy (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, truancy, school refusal, 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 and increase the likelihood that they can remain successfully in their home.

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 4-5 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.

The program intermediary for Colorado is the Rocky Mountain MST Network.

Program Selection and Outcomes

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. The results showed that treatment under the MST Expansion Program was associated with a 15.6% reduction in youth out-of-home placements in a group setting.[33]

For Family First, the eligible target outcome domains for MST in Colorado are:

- Child Well-Being: Delinquent Behavior
- Child Well-Being: Educational Achievement and Attainment
- Child Permanency: Out-of-Home Placement

All outcomes are assessed using a standardized data collection instrument called the MSTi. Therapists input information into the MSTi database about youth when they are enrolled in MST and again at case closure. At the time of case closure, therapists indicate whether there has been improvement or lack of improvement in domains of functioning. The MST expert then converges with the therapist on outcome ratings to ensure accuracy based on clinical knowledge of the case. This system is standardized for all licensed MST teams across the country.

Child Well-Being: Delinquent behavior

The specific outcome Colorado will be targeting and tracking in this domain is decreased offending behavior. This outcome is measured by the MSTi around any new

[33] Klopfenstein, K. (March 2023). *Expanding Multisystemic Therapy to Underserved Regions: Final Results of a Pay for Success Project*. (Report No. 18-01A). Denver, CO: Colorado Evaluation and Action Lab at the University of Denver. Expanding Multisystemic Therapy to Underserved Regions: Final Results of a Pay for Success Project (PDF)

youth arrests.[34] Statistically significant effect sizes for this domain were found in multiple Clearinghouse "highly rated" studies.

This outcome specifically links back to Colorado's candidacy definition by targeting 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.

Child Well-Being: Educational Achievement and Attainment

The specific outcome Colorado will be targeting and tracking in this domain is educational attainment. This outcome is measured by the MSTi at the end of treatment to identify if the youth is in school or working.[35] Statistically significant effect sizes for this domain were found in multiple Clearinghouse "highly rated" studies.

This outcome specifically links back to Colorado's candidacy definition by targeting 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.

[34] MSTi definition: Youth has not been arrested since the beginning of MST treatment, for an offense committed during MST treatment.

[35] MSTi definition: Youth is attending school (is not truant,) or vocational training or, if of the legally appropriate age to not attend school, has a paying job (at least half-time). Youth is attending school, a high school equivalency program (GED program,) or a vocational program in the youth's natural ecology, or working. The primary objective of the program is educational or vocational. A youth in a correctional facility or treatment setting in which educational or vocational activities are provided, where the primary objective is treatment or correction, will NOT count as a "yes" for this item. If the youth is in school, youth is attending frequently enough to meet expectations placed on youth by the school system or court. If the discharge occurs during the summer when school is not in session, it is recommended that the response "yes" be selected if the youth was attending school at the end of the last school year, or is working.

Child Permanency: Out-of-Home Placement

The specific outcome Colorado will be targeting and tracking in this domain is decreasing the number of children/youth entering out-of-home care. This outcome is measured by the MSTi at the end of treatment to identify if the youth is living at home.[36] Statistically significant effect sizes for this domain were found in multiple Clearinghouse "highly rated" studies.

This domain specifically links back to Colorado's overall goals for Family First prevention services by decreasing the number of children/youth entering out-of-home care as measured by state data.

Service Description and Oversight

Implementation Manual

Henggeler, Schoenwald, Borduin, Rowland, & Cunningham (2009) *Multisystemic Therapy for Antisocial Behavior in Children and Adolescents*. The Guildford Press.

Implementation of MST

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, 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 the community and how the MST treatment model can become an

[36] MSTi definition: Home is defined as a private residence that is approved by the youth's guardian. This could include a parent's home, the home of an approved relative or friend of the family. Foster homes or other types of placement would not be included in the definition of "home." Youth who are on runaway status would not be at home.

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 policies, 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.[37]

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,

[37] Our Services: MST, CEI Services | Graduate School of Social Work | University of Denver, 2021, socialwork.du.edu/ effectiveinterv ons/our-services.

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.[38]

Target Population in Colorado

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 abuse and/or are at risk of becoming, or already have been, involved in the child welfare or juvenile justice system.

Child welfare involved families and non-child welfare involved families are eligible to receive MST services. Referrals can be accepted from a range of sources, including but not limited to: community agencies, juvenile justice and child welfare agencies, mental health centers, schools, hospitals, faith-based community resources, and self-referrals.

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

- Verbal Aggression
- Physical Aggression
- Substance Use/Abuse
- Police Involvement/Criminal Behaviors
- Threatening/Posturing Behavior

[38] MST Services (2018). Multisystemic Therapy® (MST®) Organizational Manual. Charleston, SC

- Engagement with Negative Peers
- Significant Property Destruction
- Running Away/Chronic Leaving Home without Permission
- Truancy/Suspension/Expulsion
- Risk of Failure at School due to Behaviors

Sites in Colorado

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:

- North Range Behavioral Health
- Savio House
- Southern Colorado Community Action Agency
- Four Feathers Counseling
- Health Solutions - Multisystemic Therapy
- Mind Springs Health - Multisystemic Therapy
- Synergy Outpatient Services - Multisystemic Therapy

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.

Fidelity Monitoring

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 ethically, accurately and to the specifications outlined.

Fidelity to MST in Colorado will be assessed by the Therapist Adherence Measure – Revised (TAM-R). 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. 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.

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.

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[39] 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.[40]

A secondary way in which MST agency sites ensure fidelity to the national MST model

[39] www.msti.org
[40] https://msti.org/training-and-education

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.

Continuous Quality Improvement (CQI)

As part of the CQI process, Multisystemic Therapy (MST) sites collect and monitor data such as:

- Number of clients served
- Client-level, therapist level and team level fidelity (TAM-R scores)
- Team utilization rates
- Implementation Outcomes: Average length of stay, % completing treatment, % discharged due to lack of engagement, % youth placed outside of home
- Number of active FTE therapist positions
- Average number of cases per therapist
- Client-level outcomes: Ultimate Outcomes, % living at home at end of treatment, % in school or working at end of treatment, % no new arrests at end of treatment
- Instrumental outcomes: % with parenting skills necessary to handle future problems, % with improved family relations, % improved network of supports, % success in educational/vocational setting, % involved with prosocial

peers/activities, % cases where changes have been sustained

- Substance use outcomes (for portion that SU was a treatment target): % youth with reduced SA (any measurement option), % youth with reduced SA as measured by objective means (i.e., drug screen)

CQI data will be collected by:

- Therapists will enter client-level data into the MSTi database at intake and discharge
- Fidelity data are collected in various ways, including use of an independent call center, use of agency-specific call centers, and client completion via an online portal. The fidelity questions are the same regardless of the methods used, and are entered and analyzed through the MSTi database.
- MST Experts assigned to each team will collaborate with each team supervisor to create a Program Implementation Review (PIR) twice a year. The PIR consists of an evaluation of all clinical and implementation outcomes as well as an assessment and goal setting of any areas that are below standard benchmarks.

Data will be monitored by Rocky Mountain MST in several different ways. First, the MST Expert that is assigned to each team regularly reviews data for each team on an approximately monthly basis and co-creates a PIR twice/year. The MST Expert and therapist, along with the supervisor converge on outcome reporting at the end of each case and this is monitored by the MST Expert. Additionally, the Colorado MST Co-Director will review dashboards for all teams in Colorado on a monthly basis and identify any anomalies in reporting and support any data collection challenges. The RMM Network Partner Director will review data on a quarterly basis.

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.[41]

Eligibility for Federal Claiming

For Family First IV-E claiming purposes, only children and families in an open child welfare or juvenile justice case are eligible for federal reimbursement to the Colorado's Children's Trust Fund.

Request for Evaluation Waiver

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

[41] MST Services (2018). Multisystemic Therapy® (MST®) Organizational Manual. Charleston, SC

Studies conducted to-date on MST have demonstrated efficacy of the program on outcomes in several domains, including child permanency (Vidal et al., 2017), child well-being (Asscher et al., 2013, 2014; Borduin et al., 1995; Butler et al., 2011; Dekovic et al., 2012; Fonagy et al., 2018; Henggeler et al., 1993, 1997; Manders et al., 2013; Ogden & Halliday-Boykins, 2004; Ogden & Hagen, 2006; Vidal et al., 2017), and adult well-being (Asscher et al., 2013; Borduin et al., 1995; Dekovic et al., 2012; Fonagy et al., 2018). Studies have also demonstrated favorable outcomes measured after the end of treatment, including favorable child well-being outcomes sustained at 14 months (Fonagy et al., 2018), 16 months (Henggeler et al., 1997), 18 months (Butler et al., 2011; Ogden & Hagen, 2006), and 48 months (Borduin et al., 1995) after treatment; as well as favorable adult well-being outcomes sustained at 2, 8, and 14 months after treatment (Fonagy et al., 2018). These outcomes have been demonstrated for several populations, including youth involved in the juvenile justice system and being treated for antisocial behavior (Asscher et al., 2013, 2014; Borduin et al., 1995; Butler et al., 2011; Henggeler et al., 1997; Manders et al., 2013; Vidal et al., 2017;); and adolescents with various types of serious antisocial behavior (Deković et al., 2012; Ogden & Halliday-Boykins, 2004; Ogden & Hagen, 2006) or moderate-to-severe antisocial behavior (Fonagy et al., 2018). Outcomes demonstrated and populations reached with efficacy are aligned with Colorado's stated outcomes for this service and the target populations prioritized for candidacy.

Child Safety and Individual Prevention Plan

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for ongoing safety monitoring.

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. The MST analytical process includes the individual, school, peer, and community perspectives in order to determine the intervention

process. Overall MST program efficiency and effectiveness depend on the effective implementation of this process, so it is rigorously monitored.

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 and experts, which is then coded and entered into the MSTI website.

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 and monitoring for child safety throughout the youth and family's involvement.

Workforce Support and Training

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 group supervision is provided by the MST site supervisor as an

additional support to individual therapists. MST experts also provide weekly group consultations. 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.[42]

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. Further training around trauma-informed

[42] MST Services (2018). Multisystemic Therapy® (MST®) Organizational Manual. Charleston, SC

principles within MST can be addressed at quarterly booster trainings as frequently as team-specific need indicates.

Prevention Caseloads

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 4-5 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.

Appendix F: 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.

Program Selection and Outcomes

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. 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.

For Family First, the overarching domain for NFP in Colorado is:

- Child Safety: Child welfare administrative reports

Child Safety: Child welfare administrative reports

Colorado will be targeting and tracking subsequent referrals made regarding suspected child abuse and neglect. This outcome will be measured by the assigned caseworker analyzing Trails data within a minimum of 6 months after the family's last NFP visit. Statistically significant positive effect sizes were found for child safety in Clearinghouse-rated studies.[43]

Service Description and Oversight

Implementation Manual

Nurse Family Partnership. (2020). Visit-to-visit guidelines.

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.

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

[43] Mejdoubi, J., van den Heijkant, S. C. C. M., van Leerdam, F. J. M., Heymans, M. W., Crijnen, A., & Hirasing, R. A. (2015). *The effect of VoorZorg, the Dutch Nurse-Family Partnership, on child maltreatment and development: A randomized controlled trial*. PLoS ONE, 10(4), e0120182. doi:10.1371/journal.pone.0120182

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.[44]

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.

Target Population in Colorado

Nurse-Family Partnership focuses on first-time mothers experiencing poverty — a population that sometimes has limited access to role-models. Women voluntarily enroll as early as possible with nurse home visits, ideally beginning at birth through two years of age. In Colorado, NFP will serve pregnant and parenting teens in foster care. This population has been identified to need additional prenatal and parenting support. Family First will claim post-birth program delivery costs.

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.”

[44] https://changent.org/what-we-do/nurse-family-partnership/

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.

Fidelity Monitoring

Fidelity is measured through the Nurse-Family Partnership Model Elements instrument, which assesses the extent to which there is adherence to the model elements CDHS will coordinate with IIK to receive relevant fidelity. 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 Early Childhood (CDEC). 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 Fidelity Monitoring Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

Continuous Quality Improvement (CQI)

As part of the CQI process, Nurse-Family Partnership sites collect and monitor data such as:

- NFP Model Fidelity
- Maternal Health including pregnancy and birth outcomes
- Child health and development outcomes
- Family economic self-sufficiency outcomes

CQI data will be collected by the utilization of the NFP National Service Office Data Collection System as is already part of NFP program implementation; and monitored through current data reporting measures and established CQI processes including the annual NHVP Continuation Application.

Eligibility for Federal Claiming

Colorado has determined that due to the parameters of Family First legislation, and NFP model design, the target population for Family First is narrow. Parenting teens, who are in an open child welfare case, and in foster care, will be eligible for Colorado to claim federal IV-E reimbursement. As NFP can be provided up until the child is the age of two, Colorado will work with NFP and the Children's Bureau to create a waiver extending services for this population.

Request for Evaluation Waiver

Colorado is seeking an evaluation waiver for Nurse-Family Partnership (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.

Studies conducted to-date on NFP have demonstrated efficacy of the program on outcomes in several domains, including child safety (Mejdoubi et al., 2015), child well-being (Kitzman et al., 1997; Olds et al., 2014; Robling et al., 2016; Thorland & Currie, 2017), and adult well-being (Olds, 2002). Studies have also demonstrated favorable outcomes measured after the end of treatment, including favorable child safety outcomes sustained at 12 months (Mejdoubi et al., 2015) and 84 months (Olds et al., 2014) after treatment. These outcomes have been demonstrated for several populations of low-income first-time mothers, including among children of mothers with low education who were less than 26 years of age (Mejdoubi et al., 2015); children of African American mothers living in disadvantaged urban neighborhoods (Kitzman et al., 1997; Olds et al., 2014); children of teenage mothers 19 years of age and under (Robling et al., 2016); and mothers with sociodemographic risk factors such as being unmarried, having less than 12 years of education or being unemployed (Olds, 2002). Outcomes demonstrated and populations reached with efficacy are

aligned with Colorado's stated outcomes for this service and the target populations prioritized for candidacy.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for developing individualized, child-specific prevention plans and ongoing safety monitoring.

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 and Training

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. Colorado limits nurse home visitor caseload sizes to up to 25. 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.

Appendix G: 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 screenings are conducted annually for developmental, health, hearing, and vision issues.

Program Selection and Outcomes

The Parents as Teachers (PAT) program is currently being provided in over 50% of Colorado's counties and in both of Colorado's Tribes. As a model program that provides a soft touch for families and has positive, measurable outcomes, PAT was selected as a service in Colorado's plan. Additionally, 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. 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 and relevant to rural areas and Tribal communities. Parent educators are practical to recruit and retain in some areas of Colorado and in our Tribal communities. PAT is used in multiple Tribal communities across the country and at both the Ute Mountain Ute and Southern Ute Indian Tribes in Colorado.

For Family First, the eligible target outcome domain for PAT in Colorado is:

- Child Well-Being: Cognitive functions and abilities

Child Well-Being: Cognitive functions and abilities

The specific outcome Colorado will be targeting and tracking in this domain is school readiness. This outcome is measured by providers using a school readiness assessment for all children over 3 years old. Statistically significant positive effect sizes were found for this domain in Clearinghouse "highly rated" studies.[45]

This outcome specifically links back to Colorado's candidacy definition by targeting developmental delays and 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.

[45] Neuhauser, A., Ramseier, E., Schaub, S., Burkhardt, S. C. A., & Lanfranchi, A. (2018). *Mediating role of maternal sensitivity: Enhancing language development in at-risk families.* Infant Mental Health Journal, 39(5), 522-536. doi:http://dx.doi.org/10.1002/imhj.21738

Wagner, M. M., & Clayton, S. L. (1999). *The Parents as Teachers program: Results from two demonstrations.* The Future of Children, 9(1), 91-115

Service Description and Oversight

Implementation Manual:

Parents as Teachers National Center, Inc. (2016). Foundational curriculum.

Parents as Teachers National Center, Inc. (2014). Foundational 2 curriculum: 3 years through kindergarten.

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 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, 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, full-time parent educators participate in a minimum of two hours of individual reflective supervision and a minimum of two hours of staff meetings. Part-time parent educators are required to have one hour of individual reflective supervision per month. 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 their certification with the National Center annually. 20 hours of annual professional development is required for all parent educators.

Target Population in Colorado

PAT offers services to new and expectant parents, starting prenatally and continuing until their child reaches kindergarten. Child welfare involved families and non-child welfare involved families are eligible to access PAT. The referral process may differ between local sites, but most referrals come from community partners such as family resource centers, schools, preschools, hospitals, and family community events.

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 Support Assessment (CFSA) tool[46], the Ages and Stages Questionnaires (ASQ)[47], as well as an assessment of 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.

Sites in Colorado

There are currently 25 PAT program sites in 33 counties across Colorado. Parent Possible serves as the Colorado state program intermediary for PAT.

[46] Permission must be obtained from Family Resource Center Association before using or distributing the CFSA 2.0 matrix: info@cofamilycenters.org.

[47] https://agesandstages.com/

Fidelity Monitoring

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 25 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," which is the standardized tool for assessing 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): Parents as Teachers National Center reviews whether the affiliate has continued to meet the Essential Requirements.

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 Fidelity Monitoring Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

Continuous Quality Improvement (CQI)

In addition to fidelity monitoring, Parent Possible has a well-established evaluation process that tracks parent growth, literacy, school readiness, and parent-child interaction. As part of Essential Requirement 18, affiliates gather and summarize feedback from families at least annually to inform program improvements.

As part of the CQI process, PAT sites collect and monitor outcome data such as:

- Parent-child observation assessment, which includes parent-child interactions in domains of affection, responsiveness, encouragement, and teaching
- Parent survey – specific question about increased knowledge of positive parenting practices and specific questions about increased knowledge about child development

CQI data will be collected by:

- Parent-child observation assessment
    - Assessment to be completed within 90 days of enrollment and annually (typically Sept-Oct) thereafter on age eligible children (10 months old or older)
    - Home visitor to conduct the PICCOLO (Parenting Interactions with Children: Checklist of Observations Linked to Outcomes) Tool and complete required documentation in Visit Tracker data system
    - Parent Possible monitors compliance and sends reminders about completing the PICCOLO

    - Parent Possible conducts annual analysis of pre/post data
- Parent Survey
    - Annual retrospective survey (typically March-April) on all enrolled parents
    - Home visitor to request all enrolled parents complete survey online or on paper
    - Parent Possible monitors compliance and sends reminders about asking parents to complete the survey
    - Parent Possible conducts annual analysis of survey results

Eligibility for Federal Claiming

For Family First IV-E claiming purposes, only children and families in an open child welfare case are eligible for federal reimbursement to Colorado's Children's Trust Fund.

Request for Evaluation Waiver

Colorado is seeking an evaluation waiver for Parents as Teachers (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.

Studies conducted to-date on PAT have demonstrated efficacy of the program on outcomes in several domains, including child safety (Chaiyachati et al., 2018) and child well-being (Wagner & Clayton, 1999; Neuhauser et al., 2018). Studies have also demonstrated favorable outcomes measured after the end of treatment, including favorable child safety outcomes sustained at 37 months after treatment (Chaiyachati

et al., 2018). These outcomes have been demonstrated for several populations, including among children of first-time mothers (Chaiyachati et al., 2018), Latino parents (Wagner & Clayton, 1999; Wagner et al., 1999), teen parents in (Wagner & Clayton, 1999; Wagner et al., 1999), and in at-risk families (Neuhauser et al., 2018). Outcomes demonstrated and populations reached with efficacy are aligned with Colorado's stated outcomes for this service and the target populations prioritized for candidacy.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for ongoing safety monitoring.

Local sites are responsible for ensuring that staff have completed mandatory reporter training, and are required to provide their child safety policies to the PAT national site as part of the quality endorsement process every five years. If a provider identifies a safety concern, the concern will be reported to the child abuse and neglect hotline. In addition, all parent educators and supervisors are mandated reporters. If there are concerns of child abuse or neglect, 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.

As part of Essential Requirement 14, a child health screening 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, such as: health status, safety, vision, and hearing elements. Essential Requirement 15 requires a child developmental screening for all children within 90 days of family enrollment or birth, and at least annually thereafter. This screening encompasses developmental domains such as: language, cognitive, social-emotional, and motor development. Essential Requirement 20 asks affiliates to select two outcomes to measure with eligible families. One outcome will be from a list of

approved tools that measure parenting skills, practices, capacity or stress. The second outcome will be from an approved list of measures.

Additionally, some affiliates use the Colorado Family Support Assessment (CFSA) tool as part of their process in determining eligibility, and looks at the many domains in a family's life to help determine needed resources and to set family goals. One-time training is required for the CFSA tool; this is completed on an agency by agency basis. During virtual service delivery, affiliates should outline safety practices in their policies, procedures and protocols which apply during virtual visits as well.

PAT affiliates are required to use the Visit Tracker to collect specific data as required by PAT (and MIECHV, if this funding source is used). The visit tracker will be used to document the individualized prevention plan to record goals, progress and barriers to progress. This data can be accessed by the Program Intermediary for PAT, Parent Possible.

Workforce Support and Training

Per Essential Requirement 2, the minimum qualifications for parent educators are a high school diploma or equivalency and two years' previous supervised work experience with young children and/or parents. 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.

Essential Requirement 7 also states that parent educators must obtain competency-based professional development and training, and must renew their certification with the national office on an annual basis. To renew certification, the PAT National Center requires that parent educators complete a minimum of 20 hours of professional development annually.

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 depends on 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.

Appendix H: Parent-Child Interaction Therapy

Colorado is utilizing the Parent-Child Interaction Therapy International model. 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 two to seven years of age and experiencing frequent, intense emotional and behavioral problems.

PCIT is conducted through coaching sessions during which the parent(s) and child are together 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.

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

Program Selection and Outcomes

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. For more information about existing research around

PCIT, please see the Research and Evaluation Waiver Request section.

PCIT was selected as a prevention service in Colorado because the national literature on PCIT creates a compelling case for meeting local needs. Traditional out-patient service delivery is impractical in some parts of the state, and Colorado has identified a need for services that families can access without having to travel to a service provider. Furthermore, as of September 25, 2021, 38% of children/youth in out-of-home care were Hispanic, and PCIT research has shown that this intervention is effective for this population.

For Family First, the eligible target outcome domains for PCIT in Colorado are:

- Child Well-Being: Behavioral and emotional functioning
- Adult Well-Being: Positive parenting practices

Child Well-Being: Behavioral and emotional functioning

The specific outcome Colorado will be targeting and tracking in this domain is decreased oppositional and conduct problems. This outcome is measured weekly by providers using the Eyberg Child Behavior Inventory (ECBI). Statistically significant effect sizes were found in Clearinghouse "highly rated" studies[48], as measured by the ECBI Intensity Scale and Problems Scale.

This outcome specifically links back to Colorado's candidacy definition by targeting 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.

Adult Well-Being: Positive parenting practices

The specific outcome Colorado will be targeting and tracking in this domain is

[48] Leung, C., Tsang, S., Sin, T. C. S., & Choi, S. Y. (2015). *The efficacy of Parent-Child Interaction Therapy with Chinese families: Randomized controlled trial.* Research on Social Work Practice, 25(1), 117-128.

improved praise and decreased criticism. This outcome is measured weekly by providers using the Dyadic Parent-Child Interaction Coding System (DPICS). Statistically significant effect sizes were found in Clearinghouse "highly rated" studies, as measured by DPICS "Don't" Skills, DPICS Positive Practices and DPICS Command/Question/Negative Talk[49].

This outcome targeted through PCIT specifically links back to Colorado's candidacy definition by targeting parents' lack of parenting skills.

Service Description and Oversight

Implementation Manual

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

Implementation of PCIT

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.

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[49] Bjorseth, A., & Wichstrom, L. (2016). *Effectiveness of Parent-Child Interaction Therapy (PCIT) in the treatment of young children's behavior problems. A randomized controlled study.* PLoS ONE, 11(9), e0159845. doi:10.1371/journal.pone.0159845

Leung, C., Tsang, S., Sin, T. C. S., & Choi, S. Y. (2015). *The efficacy of Parent-Child Interaction Therapy with Chinese families: Randomized controlled trial.* Research on Social Work Practice, 25(1), 117-128.

Leung, C., Tsang, S., Ng, G. S. H., & Choi, S. Y. (2017). *Efficacy of Parent-Child Interaction Therapy with Chinese ADHD children: Randomized controlled trial.* Research on Social Work Practice, 27(1), 36-47

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 meet 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 five 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 three hours of PCIT Continuing Education credit every two 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 on the PCIT International website[50].

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.

For families involved with child welfare, referral sources may include child welfare caseworkers and case managers.

For families not involved with child welfare, referral sources may include but are not limited to pediatricians, psychological assessments, and self-referrals.

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.

[50] http://www.pcit.org/therapist-requirements.html

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 of sexual abuse, or if the parent is actively engaging in substance abuse.

Sites in Colorado

Currently, there are 40 sites, of which 6 are telehealth, with 55 providers. The Kempe Center and PCIT Colorado serve as the intermediaries at this time.

Fidelity Monitoring

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

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 individuals presenting complaints of families during treatment.

PCIT trainers may also use checklists, case consultation logs, and other fidelity-tracking instruments to ensure standardization within their agency and fidelity to the PCIT model.

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

Continuous Quality Improvement (CQI)

As part of the CQI process, PCIT sites collect and monitor outcome data such as:

- Weekly Eyberg Child Behavior Inventory scores to monitor behavior improvements in PCIT
- Weekly Dyadic Parent Child Interaction Coding System scores to monitor improvements in parent skills
- Weekly homework completion rates
- Weekly fidelity ratings to the PCIT essential elements of session

CQI data will be collected by clinicians in session as a part of the treatment delivery process. All measures are a part of weekly sessions and inform treatment progress and session goals. Data will be monitored by the in-house trainer to ensure fidelity to the program and then reported to the state intermediary. In cases where PCIT in-house trainers are not available, data will be reported directly to the state intermediary.

The Colorado Fidelity Monitoring 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 the state take a data informed approach to continuous quality improvement and shoring up fidelity to the PCIT model.

Eligibility for Federal Claiming

For Family First IV-E claiming purposes, only children and families in an open child welfare case are eligible for federal reimbursement to Colorado's Children's Trust Fund.

Research and Evaluation Waiver Request

Colorado is seeking an evaluation waiver for Parent-Child Interaction Therapy (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.

Studies conducted to-date on Parent-Child Interaction Therapy (PCIT) have demonstrated efficacy of the program on outcomes in several domains, including child well-being (behavioral and emotional functioning) (Bagner & Eyberg, 2007; Bagner et al., 2010; Bjorseth & Wichstrom, 2016; Leung et al., 2015, 2017; Matos et al., 2009; Schuhmann et al., 1998; Thomas & Zimmer- Gembeck, 2011) and adult well-being (positive parenting practices) (Bagner & Eyberg, 2007; Bagner et al., 2010; Bjorseth & Wichstrom, 2016; Leung et al., 2015, 2017; McCabe & Yeh, 2009; Schuhmann et al., 1998; Thomas & Zimmer- Gembeck, 2011). Studies have also demonstrated favorable outcomes measured after the end of treatment, including favorable adult well-being outcomes sustained at 13 months after treatment (Bjorseth & Wichstrom, 2016).

These outcomes have been demonstrated with dyads in various settings, including in community treatment settings (Budd et al., 2011; Danko et al., 2016; Lyon & Budd, 2010; Timmer et al., 2010) and child welfare settings (Hakman et al., 2009; Lanier et al., 2014; Naik-Polan & Budd, 2008; Self-Brown et al., 2012), as well as with several populations, cultures, and countries, including Mexican-American caregivers (McCabe & Yeh, 2009; McCabe, Yeh, Lau, & Argote, 2012); African-American caregivers (Butler & Eyberg, 2006; Fernandez, Butler, & Eyberg, 2011); Puerto Rican caregivers (Matos et al., 2006, 2009); Australian caregivers (Nixon, et al., 2003; Phillips, et al., 2008); Dutch caregivers (Abrahamse et al., 2012); Chinese caregivers (Leung et al., 2009; Yu et al., 2011); incarcerated mothers (Scudder et al., 2014); and American Indian and Alaska Native families (Bigfoot & Funderburk, 2011). Outcomes demonstrated and populations reached with efficacy are aligned with Colorado's stated outcomes for this service and the target populations prioritized for candidacy.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan. With all open child welfare cases, the county department is responsible for ongoing safety monitoring.

PCIT therapists are trained to observe behaviors that may be indicative or linked to child abuse and neglect. These observations occur during treatment sessions, where the therapist works with the parent on safe parenting skills. If a therapist observes negative parenting behaviors during treatment sessions, the therapist will interrupt the behavior and proceed with safety planning. In the event that a child is observed with signs of abuse or neglect, or if parents attend sessions with signs of intoxication, PCIT therapists will shift to safety assessment protocols, also known as crisis sessions. The therapist may talk to the parent and child individually to determine whether there are safety concerns. The therapist will make a report to the child abuse and neglect hotline if the therapists observes or learns of alleged abuse or neglect. If a child is in imminent danger, or reports feeling unsafe at home, the therapist may call the PCIT crisis hotline as well as 911 to request police reinforcement.

PCIT is an assessment-driven treatment, guided by weekly assessment data which contributes to the monitoring of safety. The ECBI is a validated measure administered weekly to monitor treatment gains. DPICS 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 DPICS.

Eyberg Child Behavior Inventory (ECBI)[51]

[51] 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.

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. Sites may also 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)[52]

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).

Workforce Support and Training

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.

[52] 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.

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.

See the Implementation of PCIT for further details on training requirements for certified PCIT therapists.

Prevention Caseloads

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

Appendix I: SafeCare® Colorado

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 wellness 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.

Program Selection and Outcomes

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 Department of Early Childhood (CDEC) 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).

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.

For Family First, the overarching domain for SafeCare® in Colorado is:

- Child Permanency: Out-of-home placement

Child Permanency: Out-of-home placement

Colorado will be targeting and tracking subsequent out-of-home placement for families engaged in this service. This outcome will be measured by analyzing Colorado's CCWIS (Trails) data within a minimum of 6 months after the family’s last SafeCare® visit. Statistically significant positive effect sizes were found for out-of-home placement in Clearinghouse-rated studies.[53]

Service Description and Training

SafeCare® Colorado Implementation

Lutzker, J. R. (2016). *SafeCare® provider manual* (version 4.1.1). Supporting materials from National SafeCare® Training and Research Center.

[53] Quick-Beachy, K., Lee, C., McConnell, L., Orsi, R., Timpe, Z., & Winokur, M. (2018). *SafeCare® Colorado program evaluation report 2014-2017*. Colorado Office of Early Childhood.

Implementation of SafeCare® Curriculum & Training

SafeCare® Orientation

All SafeCare® provider trainees are required to attend an Orientation, prior to the SafeCare® Provider Workshop. The orientation provides an overview of the SafeCare® model and implementation process.

Provider Workshop and Coaching

The purpose of the Provider Workshop is to provide foundational knowledge of the SafeCare® curriculum, delivery to families, and assessing and training parents in the skills modules. Participation in the four-day Provider Workshop is mandatory and trainees must complete all workshop activities, including quizzes, by the end of the workshop and before working with families.

Following completion of the workshop, providers begin delivering SafeCare® with families. Providers work closely with a coach to build proficiency and competency in delivering the SafeCare® model. The provider records all sessions with the family and the recordings are uploaded to the SafeCare® Portal within 48 hours of session completion for observation by the coach. The coach listens to the audio and provides feedback during a coaching session before the next appointment with the family.

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.

Provider Certification and Maintenance

To achieve Provider Certification, providers must demonstrate strong fidelity to the model 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 and training sessions).

Once certified, providers will maintain certification through monthly fidelity checks and coaching sessions, to document ongoing quality of services. This data is shared with CDHS on a quarterly basis for review. If fidelity is low, additional sessions will be reviewed with coaching until strong fidelity is achieved in 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.

Target Population in Colorado

Families referred to SafeCare® are at risk of becoming, or already have been, involved in the child welfare system. SafeCare® Colorado serves families with children ages five and under who reside in one of the 33 counties or two tribal nations currently offering the program in Colorado.

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, such as from child welfare staff, community organizations, and self-referring parents and caregivers. 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. Counties also 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, or after child welfare involvement has closed to prevent future child welfare involvement. Therefore, the program has the potential to impact more families along the entire prevention continuum in local communities across Colorado.

Families must meet at least three of the following high-risk eligibility criteria:

- Being a single parent

- Multiple children ages five and under in the home
- Be receiving public assistance (i.e. TANF, WIC, SNAP, Medicaid etc.)
- Child with special needs
- Parental/caregiver mental health issues
- Parental/caregiver substance abuse
- Parent/caregiver less than a high school education
- Parent/caregiver under the age of 20
- Unstable or hazardous housing
- Stepfather or other unrelated male caregiver in the home
- Prior reports on the parent or caregiver to child welfare
- Parental/caregiver history of of abuse or neglect as a child
- History of violence in the home.

Research shows that risk factors associated with child welfare involvement lead to a higher risk of out-of-home placement. These risk factors are demonstrated in the eligibility criteria for SafeCare®, and are consistent with the circumstances and characteristics for Colorado's definition of candidacy:

- 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

Colorado has determined that the following high-risk eligibility criteria for SafeCare® align with its definition of candidacy. Therefore, for Colorado's SafeCare® community pathway, CDHS has determined that families must meet one of the following SafeCare®' eligibility criteria listed below. This alignment in criteria will allow CDHS to claim federal reimbursement on SafeCare® services through a community pathway.

Crosswalk of Colorado' s Family First Candidacy Criteria to Safecare®'s Eligibility Criteria

(Please note, this list does not reflect all of SafeCare®'s eligibility criteria).

- Substance use disorder or addiction - Parental/caregiver substance abuse
- Mental illness - Parental/caregiver mental health issues
- Limited capacity or willingness to function in parenting roles
    - Being a single parent
    - Multiple children ages five and under in the home
    - Unstable or hazardous housing
- Parent's inability, or need for additional support, to address serious needs of a child/youth's behavior or physical or intellectual disability - Prior reports on the parent or caregiver to child welfare
- Developmental delays - Child with special needs

In Colorado's state-supervised, county-administered child welfare system, CDHS, as the Title IV-E agency, holds ultimate responsibility for candidacy determinations. To protect family privacy and streamline service delivery, CDHS collaborates with

counties and contracted evidence-based service providers, delegating specific functions while maintaining oversight.

For families accessing SafeCare® services through community pathways, CDEC will submit quarterly reports to CDHS, documenting Family First eligibility. CDHS will review these reports to ensure compliance with federal requirements and make final determinations on eligibility for federal claiming. This approach aligns with federal guidelines, which permit Title IV-E agencies to contract administrative activities to public or private agencies, provided the Title IV-E agency supervises these activities and retains authority over candidacy determinations.

By leveraging the expertise of counties and service providers, CDHS ensures that candidacy determinations are conducted efficiently and in accordance with federal standards, while safeguarding the privacy of families served through community pathways.

Sites in Colorado

SafeCare® Colorado sites are currently housed within community-based and county public health agencies. SafeCare® Colorado site locations are identified by targeting communities with the highest need for SafeCare® services, as well as community and organizational readiness for implementation.

Site expansion is determined by the CDEC's Request for Proposal process. New sites must submit a proposal that demonstrates: organizational capacity and readiness to implement a new program; fit the scope and intent of the program; and, are perceived to have the ability to provide the greatest impact and verifiable return on available funds. Through the proposal, sites are also expected to demonstrate prior experience implementing evidence-based programs, existing relationships with possible referral sources in the community, a strong leadership structure, and adequate infrastructure (e.g., physical, and technological resources).

Although the CDEC may also issue a RFP to expand existing sites, a site may make a request to the CDEC to expand their services into other counties. If statistical data in

that county demonstrates characteristics of families with high need and/or that meet SafeCare® eligibility criteria, the site's capacity and readiness is deemed appropriate, relationships are established with possible referral sources including child welfare departments, and funding is available, the CDEC may grant the expansion request.

The CDEC has supported multiple rounds of site/county expansions in the implementation of SafeCare® Colorado, in partnership with SafeCare® Colorado's intermediary, The Kempe Center. Currently, SafeCare® Colorado services are provided at a total of 13 sites across 33 counties, and also serves two tribal nations. 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.

Fidelity Monitoring

Coaching

In the eleventh year since SafeCare® was introduced to Colorado, SafeCare® Colorado's intermediary, the Kempe Center has built a monthly coaching program that includes coaches at both Kempe and select sites. SafeCare® Colorado has six sites with trained coaches who monitor fidelity and provide coaching to providers. The cadre of coaches includes two sites with Spanish coaches who also serve state-wide bilingual/Spanish speaking providers. Kempe provides coaching to providers at sites without a trained coach.

As the program intermediary, Kempe employs SafeCare® certified trainers to train and coach SafeCare® coaches, and provides ongoing coaching and fidelity monitoring to site coaches for maintenance of their certification.

SafeCare® Colorado coaches participate in monthly coaching 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.

Monitoring and Addressing Fidelity Concerns

Coaching focuses heavily on the monitoring of each provider's fidelity to the SafeCare® model. The fidelity instruments used to monitor provider fidelity are the Provider Fidelity Checklist: Baseline Assessment, the Provider Fidelity Checklist: Training, the Provider Fidelity Checklist: End-of-Module. 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 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 Center 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.

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 Fidelity Monitoring Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

Continuous Quality Improvement (CQI)

As part of the CQI process, SafeCare® Colorado sites collect and monitor data from the referral source to family skills change. Data points include:

- Outreach activities and partner type referrals and from which source, intakes and by source,
- Sessions completed
- Topics completed
- Program completion
- Family demographics
- Caregiver satisfaction
- Caregiver skills change in home safety (to reduce household safety hazards and increase age-appropriate supervision); child health (to respond appropriately to child health needs, illness, and injury); and parent-child/parent-infant interaction (to promote positive parenting practices and appropriate responses to challenging child behaviors).

CQI data will be collected by each site, with the exception of coaching data (which is downloaded from the NSTRC data portal), and entered into a state database.

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. The third step in the current CQI process involves reviewing reports with site supervisors and 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 CDEC SafeCare® Program Manager, Kempe staff 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, Kempe and the CDEC is facilitated by a different site supervisor per conference call. This call offers a forum for sharing updates, ideas and solutions to frequently arising concerns from all participants including site supervisors, CDEC and Kempe.

Eligibility for Federal Claiming

Eligibility requirements for the SafeCare® Colorado program model under CDEC state that families can participate if they have child welfare involvement, except in cases where there is court involvement. Families who are receiving child welfare services and have court involvement cannot participate in the program until court involvement is closed or the services are funded through the local county child welfare CORE services block grant. Families who receive services using CORE block grant funding meet the candidacy definition and may be eligible for reimbursement through Family First Prevention Services.

The SafeCare® eligibility criteria overlaps with Colorado's identified 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. The SafeCare® intake process assesses eligibility for receiving the service, however CDHS, as the Title IV-E agency, will make the final determination on eligibility for federal reimbursement.

In establishing the SafeCare® community pathway, it is important to clearly distinguish between SafeCare®'s data system, and Trails in order to maintain confidentiality of the children and families receiving the prevention service. In order to ensure the separation of data, CDHS will use WILMA, a separate database server, to collect and report child-specific data using an encrypted, unique child identifier

number, and verify whether there is current child welfare involvement. WILMA will also be used to identify clients who enter child welfare within 12 months of receiving the service for reporting purposes.

Per data captured through over ten years of SafeCare® Colorado evaluation by CDEC and Colorado State University, up to 70% of families who receive SafeCare® Colorado have prior or current child welfare or juvenile justice involvement. As such, these families are included in the IV-E prevention population for federal claiming purposes, as they already have AFCARS record numbers. For this current version of Colorado's IV-E prevention plan, CDHS is defining its IV-E prevention population for this community pathway as SafeCare® clients with existing AFCARS record numbers.

There may be clients served by SafeCare® Colorado who do not have AFCARS record numbers, but have State Identification Numbers (State IDs) issued through other state systems (e.g. Health First Colorado, etc.). Colorado is exploring how to create AFCARS record numbers for these candidates, as AFCARS record numbers are based on State IDs. It is important to note that the creation of AFCARS record numbers for non-system-involved candidates will not be entered into Trails. Colorado will only be claiming for clients with AFCARS records numbers in accordance with federal guidelines.

As SafeCare® Colorado may not serve families in court-involved child welfare cases through the use of Department of Early Childhood funds, counties may use child welfare CORE funds to provide SafeCare® services to families in court-involved child welfare cases. This ensures a robust coverage of funding streams to provide SafeCare® across the target population of the program.

Research and Ongoing Rigorous Evaluation

The Social Work Research Center in the School of Social Work at Colorado State University (CSU) has been the independent evaluator of the SafeCare® program since 2013, measuring the implementation process, program outcomes and service delivery costs from 2014 to 2019. Previous evaluation findings include rates of children placed

into foster care during one year following program completion were lower for families who completed SafeCare® (0%) than for families in the comparison group who did not complete SafeCare® (7%), which is a statistically significant difference. Overall findings have shown a decrease in home safety hazards and an increase in knowledge of child health and parent infant/child interaction for participating families.

After an intentional pause in State Fiscal Year (SFY) 2020 to integrate the wealth of findings from six years of evaluation and to translate research into practice, CSU created a rigorous two-year evaluation plan, which reflects Family First requirements and includes two components. A descriptive evaluation assessed implementation activities, proximal impacts, and participant populations reached for families served by SafeCare® in SFY 2019, SFY 2020, and SFY 2021. The second component, a quasi-experimental study, rigorously evaluated the program's effectiveness at improving outcomes in four broad domains: child well-being, adult well-being, parenting practices, and protective factors. In partnership with all SafeCare® stakeholders, including the families SafeCare® serves, the rigorous evaluation will further build the evidence-base for SafeCare®, comprehensively demonstrate the holistic impact of SafeCare® for Colorado families, and pioneer new directions in child maltreatment prevention.

See the SafeCare® Colorado Evaluation Strategy for SFYs 2021-2022 in this Appendix.

Child Safety and Individual Prevention Plans

As described in Colorado's five-year prevention plan, child safety is an important component of the implementation plan.

During the intake phase, SafeCare® providers utilize an assessment form to gather information on child health, home safety, parent-infant/child interaction, identify parenting goals, and challenges with the target child. This initial assessment helps providers determine which focus area to target, as well as screen for the families needs.

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. SafeCare® also utilizes a change score tool as part of the individual prevention plan. The change score tool administered by SafeCare® providers will be used for families not currently involved in child welfare, and aligns with the requirements in the child welfare family services plan. Providers look for a decrease in hazards and changes in behavior as part of their monitoring. Outcomes are measured based on completion of the topics, and also measured based on improvements in change scores.

For families in an open child welfare case, a formal safety assessment will be conducted by a certified caseworker or supervisor per the CO Safety Assessment Instructions which are listed in 12CCR 2509-2, 7.107.11. This includes:

- Whenever there is a significant change in household circumstances or situations that might pose a new or renewed threat to the safety of child(ren)/youth
- Prior to reunification
- Prior to end-dating a safety plan
- Case Closure

Informal safety will be assessed at every face-to-face contact with all parties involved. If the caseworker feels a situation might pose a new or renewed threat a formal safety assessment will be completed.

In order to assure ongoing safety monitoring for those served through the SafeCare® community pathway, starting in SFY 2024-2025, all program service providers (PSP) of the SafeCare® Colorado program will be required to undergo training on using the Colorado Family Support Assessment (CFSA) 2.0. This tool will be used to fulfill the Safety Monitoring requirement for families who are receiving services through the

SafeCare® Community Pathway. The CFSA 2.0 is a tool that assesses a family's self-sufficiency across 14 domains of family functioning, and was designed as a practice tool by the Family Resource Center. The tool will be used by the PSP, together with the family, to identify the needs of families who are not currently involved in child welfare, set goals, and provide additional resource referrals to help the family achieve those goals. The service provider will administer the CFSA 2.0 at the time of intake, and a follow-up will be conducted every 90 days, unless the circumstances require a follow-up sooner, but must be administered more than 30 days from the last assessment.

SafeCare® funding is distributed to applicants through a competitive process via the state procurement process. As a required component of the solicitation, the applicant must provide a letter of support from each county department of child welfare services in the proposed service region. This letter serves as a commitment from each local county child welfare department and the applicant to serve families using the SafeCare® model.

Together, they comprise the "service region" for SafeCare® in that county or region. Those identified as being part of the service region are expected to collaborate in a manner that supports the SafeCare® program to ensure child safety. CDHS, as the Title IV-E agency, holds ultimate responsibility for monitoring child safety and ensures that all participating counties, evidence-based service providers, and other community partners adhere to established child welfare standards.

CDHS accomplishes this by leveraging a robust network of mandatory reporters and evidence- based service providers. All SafeCare® providers are mandatory reporters, required to complete the state's online child welfare mandatory reporter training. Through this training, providers are equipped to identify and report any safety concerns directly to the state's child abuse and neglect hotline.

In addition, CDHS provides ongoing oversight through the review of evidence-based service provider compliance with reporting requirements and adherence to evidence-based practice standards. This includes periodic audits, evaluations of

service outcomes, and collaborative case reviews with counties and providers when safety concerns arise. While evidence-based service providers play a critical frontline role in identifying and reporting safety risks, CDHS retains responsibility for ensuring that these systems function effectively to protect children and support families (Please see page 25 of this document for more information about Colorado's evidence-based service providers and "State Program Intermediaries").

By emphasizing mandatory reporting and evidence-based practices, CDHS upholds its commitment to child safety, even within the community pathway model, ensuring alignment with federal and state child welfare requirements.

Workforce Support and Training

SafeCare® Colorado Coach/Trainer/Site Managers (SMs) complete extensive SafeCare® Training through the NSTRC. Site Managers 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, SMs are required to 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, they also develop supplemental training to help meet identified training needs of providers and supervisors. Development of these trainings are requested from the CDEC, in response to data collected through CSU's evaluation as well as requests from the sites. 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 toolkit
- Site Supervisor Training and Support

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. Site Managers will assist individual sites with ensuring compliance with the standards.

Prevention Caseloads

Providers are encouraged to start with two to four 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 level of intensity.

Appendix J: Motivational Interviewing

Motivational Interviewing (MI) is a collaborative, goal-oriented method of communication that has been designed to empower behavioral change, and improve physiological, psychological, and lifestyle outcomes. Originally developed in the 1980s for treating substance use disorders (alcohol and drug addiction), MI is a well-supported, evidence-based service used across a wide range of fields, including healthcare, education, and criminal justice, to address desired behavior changes. MI's design engages individuals and assists them in the process and exploration of their ambivalence about change within an atmosphere of collaboration and compassion through five stages of change: Pre-Contemplation, Contemplation, Preparation, Action, and Maintenance. Colorado is adding MI to its Prevention Plan as both an EBS under open child welfare involvement, and a community pathway when families access a Family Resource Center to meet their needs.

Program Selection and Outcomes

MI has been selected as the newest evidence-based service on Colorado's Prevention Plan based on the Title IV-E Clearinghouse rating as a "Well-Supported" practice and its focus on empowering individuals to feel motivated and committed to positive

change. Motivational Interviewing (MI) has become an increasingly utilized and strategic communication approach within child welfare services, demonstrating the potential for significant positive impact on children and families. To ensure its success as an approach, however, proper implementation is absolutely essential. In addition to a designated MI training curriculum for child welfare staff, Colorado has planned two important components for implementation: fidelity monitoring and ongoing learning opportunities.

Lyssn is a cloud-based software as a service (SaaS) platform that provides training, supervision, and continuous quality improvement tools for health and human service settings. Lyssn is a classification-style artificial-intelligence training platform that uses gold-standard evaluation tools to assess and improve fidelity to evidence-based practices, such as MI. The Lyssn platform is a tool for building, improving, and assessing core skills and the demonstration of Motivational Interviewing (MI) in practice. This functionality is essential for meeting the fidelity oversight requirements of the Family First Prevention Services Act (Family First). Lyssn's algorithms are based on a combination of the Motivational Interviewing Skill Code (MISC), and Motivational Interviewing Treatment Integrity Inventory (MITI). In order for Lyssn to determine ongoing fidelity, the tool uses Skill Practice (SP) prompts as a proxy to determine fidelity to MI, without using sensitive client information or requiring staff to download software. Staff with a Lyssn license can engage with the SP prompts at a regular cadence to demonstrate skills and improvements over time. To be approved for the pilot program launching in 2026, detailed later in this section, Child Welfare and Family Resource Center staff must commit to using Lyssn at least quarterly. Relevant fidelity data will be received by CDHS and subsequently converted into standardized statewide fidelity metrics. This data will then be entered into the Colorado Fidelity Monitoring Platform. See the Colorado 5-year Prevention Plan for more details on the Platform.

Community organizations continue to report a range of severe personal and societal consequences of substance use by Colorado's adult population. Negative impacts include physical and mental health problems, addiction, fatal overdoses (especially

from fentanyl and methamphetamine), and legal issues. According to the State Unintentional Drug Overdose Reporting System (SUDORS),[54] Colorado experienced 1,380 deaths during calendar year 2024 that were attributed to overdose. Of those, 88% were identified as struggling with the use of a substance other than alcohol, 69% had opiates in their system, and 66% had the fatal overdose happen in their home. A review of Colorado's CCWIS system (Trails) shows that 1,523 children (aged 0-17) experienced an out-of-home placement through a child welfare removal for reasons of parental substance use (alcohol/substances) or substance exposure as a newborn. This is slightly up from 2024, during which 1,516 children of the same age experienced out-of-home placement for the same reasons. According to the 2024 Child Maltreatment Fatality Annual Report, completed by the Colorado Department of Human Services Child Fatality Review Team (CFRT), substance abuse was found to be a contributing factor to incidents in 2024. CFRT identified 58% (25 out of 43) of child fatalities reviewed in 2024 were related to substance use, with substance abuse itself identified as the contributing factor in 56% of incidents. Among those, Marijuana (44%), Fentanyl (32%), and Alcohol (28%) were the substances identified.

Given these sobering statistics, the use of MI in a community pathway for prevention and intervention, and as an essential skillset for child welfare staff assessing concerns of neglect, is promising. The nature of neglect often involves deeply entrenched behavioral patterns, environmental stressors, and a lack of resources or motivation, which traditional, confrontational approaches often fail to address effectively.

Adult Well-Being: Parent/caregiver Substance Use

Colorado's 5-Year Prevention Plan focuses on preventing out-of-home care by identifying key family characteristics that indicate a need for prevention services. These characteristics include parental substance use and substance exposure in infants. In Colorado's definition of candidacy, substance use disorder or addiction is explicitly recognized as a factor that puts a child or youth at risk of initial or

54 https://cohealthviz.dphe.state.co.us/t/HealthInformaticsPublic/views/SUDORS_Dashboard_FINAL/Story1?%3Aembed=y&%3Aiid=1&%3AisGuestRedirectFromVizportal=y

subsequent entry into out-of-home care.

Service Description and Oversight

Implementation Manual

Miller, W. R., & Rollnick, S. (2012). Motivational Interviewing: Helping people change (3rd ed.). Guilford Press.

Miller, W. & Rollnick, S. (2023). Motivational Interviewing: Helping people change and grow (4th Edition).

Although there are no specific qualification requirements for individuals who deliver Motivational Interviewing (MI), training can be administered by trainers who are certified by the Motivational Interviewing Network of Trainers (MINT). Details of how MI will be delivered in the child welfare system and Family Resource Centers, as well as oversight of the use, is detailed in each of those pathways in this appendix.

Research and Request for Evaluation Waiver

Colorado is seeking an evaluation waiver for Motivational Interviewing (MI) and, upon approval, will assess program implementation and fidelity through a robust continuous quality improvement (CQI) process rather than through formal, independent evaluation. MI is rated well-supported by the Title IV-E Prevention Services Clearinghouse. It has extensive and rigorous research behind it, with 75 studies qualifying as eligible for review by the Clearinghouse.

Studies conducted to date on MI have demonstrated favorable outcomes measured after the end of treatment within the adult well-being: parent/caregiver substance use subdomain (Carey et al., 2006; Field et al., 2014; Freyer-Adam et al., 2008; Gentilello et al., 1999; Marlatt et al., 1998; Rendall-Mkosi et al., 2013; Saitz et al., 2014; Stein et al., 2011). These outcomes have been demonstrated in various settings, including in primary care settings (Saitz et al., 2014), hospitals (Freyer-Adam et al., 2008), and trauma care settings (Gentilello et al., 1999). These outcomes have also been demonstrated for several populations, including college student drinkers (Carey

et al., 2006; Marlatt et al., 1998) and pregnant mothers (Rendall-Mkosi et al., 2013). Outcomes demonstrated and populations reached with efficacy are aligned with Colorado's stated outcomes for this service and the target populations prioritized for candidacy. Colorado is seeking an evaluation waiver for Motivational interviewing and, upon approval, will assess program implementation and fidelity through a robust continuous quality process rather than through a formal, independent evaluation. MI is rated as well-supported by the Title IV-E Prevention Services Clearinghouse.

Child Welfare

When child welfare intervenes with a family due to abuse or neglect concerns, especially those related to alleged substance use impacting parenting, parental ambivalence can significantly hinder meaningful engagement. Ambivalence can hinder a parent's willingness to engage, complicating decision-making for professionals, and potentially leading to biased or delayed outcomes. For parents, conflicting emotions like fear and a desire for help can lead to reluctance, while for professionals, balancing the need to protect a child with the desire to support the family can create tension and pressure, potentially affecting their objectivity. A parent's conflicting emotions, such as the desire for help mixed with fear, can result in an appearance of unwillingness to cooperate. For child welfare professionals, the internal conflict of needing to ensure child safety while also supporting the family creates pressure and tension that can threaten objectivity and negatively impact their relationship with family members.

Motivational Interviewing (MI) is a versatile approach that can be employed across various settings and populations. For child welfare professionals, MI may be the key strategy to enhance family engagement by addressing ambivalence, fostering action and habit changes, and increasing commitment to program participation. Using Motivational Interviewing (MI) establishes a collaborative partnership with parents, helping them explore their motivations for change. This approach avoids the adversarial dynamic that can otherwise arise. The foundation of the relationship is established from the initial meeting by employing techniques such as open-ended

questioning, reflective listening, and summarizing. It is also important to maintain a focus on parents' strengths and prior successes, avoid giving advice or lecturing, and help them identify the discrepancy between their present behavior and their desired outcomes.

Implementation of Motivational Interviewing

Motivational Interviewing (MI) is a strategy that has been implemented across various Colorado settings, such as local county departments of human services and community agencies. Although MI is not a mandatory component of training for new child welfare caseworkers or supervisors statewide, many counties have made MI training and utilization a requirement for employment. The scope of training varies, with some locations training all child welfare staff, while others focus their efforts on direct line staff. Counties interested in starting or broadening their MI training efforts face hurdles, including limited funding, the necessary time commitment from staff, practicing to fidelity, and the lack of a standardized statewide training curriculum or governing agency. As of December 2025, MI is actively used by casework staff in approximately 15 of the 64 counties in Colorado.

In early 2026, Colorado will undertake a one-year pilot of Motivational Interview (MI) training/use and fidelity monitoring software in county child welfare practice through the use of Family First Prevention Services Act (FFPSA) reimbursement. Up to 150 permanency and intake caseworkers/supervisors selected from interested departments of human services across the state will participate in the pilot. CDHS staff will screen applicants to assess their readiness, reasons, and commitment to participate as a vital part of the pilot program.

As part of preparation for the pilot to begin in early 2026, The Colorado Child Welfare Training System, the Colorado Department of Human Services, the Colorado Evaluation and Action Lab (CoLab) and Kempe Center are actively engaged in developing a standalone, state-wide training for child welfare staff (caseworkers/supervisors). The implementation manuals above, as well as training developed by other states such as Washington and Minnesota, is informing the

development.

Target Population in Colorado

The target population for the pilot includes any parent currently engaged with their local department of human services under an open Program Area 4 (Youth in Conflict) or Program Area 5 (Child Protection Services) concerning their child(ren). As previously detailed, Colorado departments of human services offer services and support across four Program Areas. The target group will include parents regardless of their age or the size of their family.

When a referral to the child abuse hotline is received, it is screened by the county in which the child resides. In order for a Program Area 4 or Program Area 5 to be opened for assessment and services, specific criteria must be met.

- Program for Youth in Conflict (PA 4) Program Area 4 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. The focus of services shall be on alleviating conflicts, protecting the child/youth, family, and the community, re-establishing family stability, and/or assisting the youth to emancipate successfully.
- Program for Children in Need of Protection (PA 5) Program Area 5 services are provided to protect children, 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, including a foster parents, an employee of a residential child care facility, and a provider of family child care or center-based child care. Target groups for Program Area 5 are children whose physical, mental, or emotional well-being is threatened or harmed due to the abuse or neglect and children who are subjected to circumstances in which there is a reasonable likelihood that they are at risk of harm due to abuse or neglect by their parents or caretakers which shall include

children who are alleged to be responsible for the abuse or neglect and are under the age of ten (10).

Program Areas 4 and 5 are consistent with Colorado's definition of candidacy as criteria for open involvement under those areas is often due to:

- Substance use disorder or addiction
- Mental illness
- 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
- Reunification, adoption or guardianship arrangements that are at risk of disruption

Sites in Colorado

Colorado comprises 64 counties, which are demographically and geographically unique. Approximately 3,000 child welfare staff are employed by the counties. In smaller counties, these staff often serve as generalist caseworkers and are fewer in number. During the 2026 pilot program, up to 150 pre-selected child welfare staff from across the state will participate in the newly developed Motivational Interviewing (MI) curriculum. This curriculum is expected to be integrated into the new Child Welfare Caseworker and Supervisor Fundamentals by 2027.

Continuous Quality Improvement (CQI)

Currently, among Colorado child welfare workers who use Motivational Interviewing (MI) in their practice, Continuous Quality Improvement (CQI) is integrated into their supervision process. At this time, no Colorado counties utilize a system for monitoring fidelity, such as Lyssn.

For those staff in the pilot, Lyssn will be integrated into the CQI process (Lyssn Training and Learning). Leveraging trained artificial intelligence models, Lyssn will provide immediate feedback on the use of Motivational Interviewing (MI) skills. It achieves this by automatically evaluating learner responses to structured vignettes against MI fidelity measures. No confidential or actual family information will be entered or used during this method of CQI.

Upon the pilot's conclusion, the Colorado Evaluation and Action Lab (CoLab) will undertake an assessment to determine whether MI can be implemented with fidelity, integrated into existing services, and scaled to support preventing out-of-home placement and family stabilization goals, along with increased worker retention and development of a child welfare MI training program.

Eligibility for Federal Claiming

Candidacy in Colorado is defined by characteristics or circumstances of a child/youth, parent, or kin caregiver that increase the risk of the child/youth entering or returning to foster care. When concerns of abuse or neglect meet the criteria for assessment, it leads to open involvement with child welfare under Program Area 4 or 5. This involvement inherently places the child at risk of out-of-home placement.

Colorado currently claims federal reimbursement for child welfare caseworker salaries and is actively investigating how to evaluate and claim for caseworkers' use of Motivational Interviewing (MI). This exploration includes meeting with multiple states that are successfully claiming MI-related costs. Colorado is considering various claiming methods, such as time tracking and service tracking, possibly through the Random Moment Sample (RMS) system, for applicable Title IV-E Prevention.

Child Safety and Individual Prevention Plans

Colorado's five-year prevention plan, as outlined, emphasizes child safety as a critical implementation component. For all open child welfare cases, the assigned county department staff must conduct ongoing safety monitoring. This includes required

face-to-face contact with the children, oversight of service delivery, and engagement with collateral contacts involved with the family.

For families in an open child welfare case, a formal safety assessment is mandated and conducted by a certified caseworker or supervisor per the CO Safety Assessment Instructions which are listed in 12CCR 2509-2, 7.107.11. This includes:

- Whenever there is a significant change in household circumstances or situations that might pose a new or renewed threat to the safety of child(ren)/youth
- Prior to reunification
- Prior to end-dating a safety plan
- Case Closure

Safety must be assessed during every face-to-face interaction with all involved parties. An additional formal safety assessment is completed if the caseworker perceives a new or renewed threat in the situation, which may also generate a new referral to the child abuse hotline if new concerns are identified.

Workforce Support and Training

Sustaining the effectiveness of Motivational Interviewing (MI) requires more than just initial training, as research consistently shows; it demands ongoing support and structured feedback. The most successful agencies prioritize the growth of MI skills by implementing systematic coaching, regularly monitoring fidelity, and fostering a supportive work environment.

Through the pilot project identified earlier in this appendix, CDHS is contracting with Kempe Center to develop an MI training to determine future strategies on incorporating MI training for the child welfare workforce. As that is being developed, counties may utilize local organizations providing MINT programming to support staff with training. Additionally, CDHS is exploring the development and leadership of community-centered learning exchanges for child welfare staff. The creation of this

space for staff and supervisors would allow for ongoing peer support, an exchange of learning, networking opportunities, and a sense of community. The Colorado Child Welfare Training System (CWTS) has developed and led community-centered learning exchanges to address supervision challenges, Family Assessment Response (FAR), and other topics specific to child welfare, so the prospect of an MI exchange is not a heavy lift.

Prevention Caseloads

Per the Code of Colorado Regulations (12 CCR 2509-4), staff caseloads are regulated by the intensity of service required for each family. Staff assigned to at-risk families must have a minimum of 2 and a maximum of 12 families. Life Skills staff are permitted a maximum workload of 20 families. Additionally, supervisors are restricted to overseeing no more than 6 caseworkers simultaneously.

Community Pathway: Family Resource Centers

Adverse social and economic circumstances during childhood cast long shadows, often resulting in profound and lifelong impacts on an individual's health, education, and overall well-being. To mitigate these effects and ensure that all children have the opportunity to thrive and reach their full potential, early intervention and consistent, comprehensive support systems are absolutely necessary. In Colorado, many families seek support from their local Family Resource Center.

The Family Resource Center Act, C.R.S. 26-18-101, established the Family Resource Center Program (FRC) in 1993 as a single point of entry to provide coordinated, integrated community-based family support services for families and children. The program services consist of family development and family support and parent education guided by the following principles:

- All families have strengths.
- Colorado needs healthy and cohesive families.
- Families are best served by a local family resource center who prioritizes their

community's needs.

- Family resource centers work best in collaboration with public and private entities.
- Family resource centers provide safe and engaging environments.

The process of seeking help is inherently difficult for parents. They frequently face significant barriers, among them being the pervasive societal issues of stigma and blame. These factors create an environment where parents feel judged or responsible for complex socioeconomic conditions that are often beyond their control, making them hesitant to reach out for assistance when they need it most.

When parents do overcome the initial hurdle of seeking support, they may encounter professionals who are disrespectful, dismissive, or unwilling to truly listen. Such interactions not only fail to provide the necessary support but actively damage trust, discourage future engagement, and reinforce the very stigma the parents are trying to overcome.

A key strategy for achieving this fundamental shift and enhancing family engagement is the adoption of Motivational Interviewing (MI). MI offers a client-centered, guiding method for eliciting and strengthening personal motivation for change. By strategically addressing ambivalence, fostering a collaborative environment for action and positive habit changes, and ultimately increasing the family's commitment to program participation, Motivational Interviewing holds the potential to be the crucial intervention needed to build a more supportive and effective service system for vulnerable families prior to involvement with the child welfare system.

Implementation of Motivational Interviewing

In contrast to child welfare staff, all community-facing staff at Colorado Family Resource Centers (FRCs) receive MI training during their onboarding process and use it daily as part of their engagement with families. As of December 2025, MI is actively used in 37 Family Resource Centers, collectively serving over 46 counties.

Family Resource Centers in Colorado offer MI training to their staff through a contract with the Financial Health Institute for Economic Wellbeing. This training is ongoing and meets the needs of this workforce, negating the need for a new curriculum with FRC staff. The Institute also provides ongoing coaching and supervision of MI-trained staff. For more information on MI training for FRC staff, please see the Workforce Support and Training section of this appendix.

The one-year pilot of Motivational Interviewing (MI) and fidelity monitoring software in county child welfare practice will be replicated at select Family Resource Centers, through the use of Family First Prevention Services Act (FFPSA) reimbursement. Up to 50 community-facing FRC staff will partake in the pilot. A key distinction in the implementation at the Family Resource Center (FRC) sites is that Motivational Interviewing (MI) training is already integrated into the onboarding process for new staff, and having an open child welfare case is not a prerequisite to meet candidacy.

Target Population in Colorado

Motivational Interviewing (MI) is a versatile approach that can benefit all children and families when integrated into robust case management, which is of critical importance to initial and ongoing engagement with families.

In Colorado, all community-facing Family Resource Center (FRC) staff utilize MI during case management work with parents. This history of practice aligns with the plan to establish Family Resource Centers, specifically the intensive case management track of Family Development Services (FDS), as a community pathway. Ongoing evaluation has demonstrated that families engaged in FDS show improvements in crucial areas for family and child well-being, which contributes to the prevention of child maltreatment.

The population captured in the proposed community pathway will include parents and caregivers, of any age or family size, seeking out supportive services at a Family Resource Center. Specifically, those completing a Colorado Family Support Assessment 2.0 (CFSA2.0) and scoring as being in crisis or a vulnerable situation on the Prevention

Line. This population meets Colorado's candidacy definition of:

- Substance use disorder or addiction
- Mental illness
- Limited capacity or willingness to function in parenting roles
    - Being a single parent
    - Multiple children ages five and under in the home
    - Unstable or hazardous housing

Sites in Colorado

Colorado currently has 37 Family Resource Centers (FRC) serving 46 counties. It is important to note that FRC services are not limited to the county of a client's residence. The 37 FRCs are found in various organizational structures to address the unique needs of the communities they serve in different geographic locations. For example, two FRCs are located within County Departments of Human Services, two are within school districts, and one operates inside a school-district-based Head Start program. The rest of the centers operate as nonprofit organizations.

Fidelity Monitoring

The Motivational Interviewing Competency Assessment (MICA) can be used to ensure model fidelity. This tool measures practitioner competence within a conversation between client and the practitioner. The MICA scoring system focuses on two microskills of MI (reflections and questions). Each MI strategy is scored on a 5-point likert-scale with differential ratings available. This tool allows staff to identify behaviors of the practitioner that are consistent or inconsistent with MI skills. The purpose of the MICA tool regarding fidelity metrics is to provide feedback in multiple areas, building MI skillset, while tracking adherence to the model. The decision to use

the MICA for workers is through the Chapin Hall Motivational Interviewing Guide[55]. The MICA tool is provided in 6 languages and takes approximately 20 hours of self-training to master. This tool is suggested for use by staff as it is a moderate complexity to utilize and only requires one pass (conversation) to score the practitioner. Reliability and validity testing shows good internal consistency, high correlation between related MICA and Motivational Interviewing Treatment Integrity (MITI) scores, and strong intercoder reliability.

Through the pilot project, Lyssn will also be used by those staff participating (Lyssn Training and Learning). Lyssn uses trained artificial intelligence models to automatically evaluate the content of the learner's response based on MI fidelity measures, and gives immediate feedback on the use of MI skills.

Continuous Quality Improvement (CQI)

The Family Resource Center Association (FRCA) is the intermediary for the FRC program across the state. FRCs receiving FRC funds may or may not be members of the FRCA, however, it is expected that sites collaborate with and follow the implementation and quality standards of FDS as outlined by FRCA. Additionally, as part of the contractual relationship between sites and CDEC, sites must adhere to the additional requirements, including but not limited to:

- Requirement for FRC Program grantees to attend monthly CDEC FRC Program meetings. These meetings are held for grantees to discuss updates and share opportunities for learning with other CDEC-funded FRCs
- Attendance at the biennial CDEC Family Strengthening Programs grantee meeting, and the biennial Strengthening Colorado Families and Communities Conference.
- FRC Program grantees are required to follow implementation standards as

[55] Motivational Interviewing: A Guide to Family First Implementation. March 2022. https://www.chapinhall.org/wp-content/uploads/Motivational-Interviewing-Guide_Chapin-Hall-and-PCG.pdf

designated by the FRCA to ensure high quality delivery of FDS services

- Performance metrics are required to be entered into Salesforce for auditing and evaluation purposes, and include
    - 80% of total families enrolled in FDS completing the initial (baseline) CFSA 2.0 and goal-setting
    - Of the total families with an initial (baseline) CFSA 2.0 and goal-setting, 80% have a completed follow-up CFSA 2.0 assessment within 31-90 days
    - At least one goal in the families' goal plan relates back to the CFSA 2.0 Part C Readiness to Change as indicated by the family
    - Goals are created with the family, and show positive progress over the course of participation in the FDS program.
- FRC Program sites are required to comply with CDEC data and reporting requirements. All required data is to be entered into Salesforce within 30 days of data collection.
- FRC Site Program Administrators are required to submit a final report to CDEC before the end of each state fiscal year.

Eligibility for Federal Claiming

Family Resource Centers use agency-specific intake forms to determine initial service eligibility. This form also serves to assess the urgency of a family's needs and their initial readiness for goal-setting, which helps guide the direction of their services.

CDEC FRC program grantees must implement the Family Pathways Framework (FPF) Model. This model specifically identifies the criteria families must meet to qualify for particular Family Development Services (FDS) programs. FRCA supports each center's Implementation Team in classifying programs into three distinct pathways.

1. General Services - these are typically one-time interactions where little to no

data is collected from a family (e.g. diaper pick-up)

2. Center Services - more intensive services that include some participant-level data entry (e.g. parenting classes)

3. Family Development - Family Development Services using the CFSA 2.0 where intensive, deeper work is happening with a family and comprehensive data is collected, including family demographics, goal setting and follow-ups. Family Development Services pathway is the model funded by CDEC's Family Resource Center Program

When enrolling in services at a Family Resource Center (FRC), a family may complete a screener tool. Based on their responses and identified unmet needs, a trained navigator may offer them voluntary participation in Family Development Services (FDS). FDS is the Family Resource Center Association's (FRCA) comprehensive case management family support model. Annual evaluations of FDS consistently show statistically significant improvements for participating families in key areas such as economic self-sufficiency, health, and strengthening family protective factors. The model focuses on establishing a goal-setting partnership between the family and a trained family development worker.

FDS workers use Motivational Interviewing to initiate strength-based relationships that facilitate trust and elicit readiness to set goals that address priorities identified through the interview. To effectively provide these services, FDS workers administer a comprehensive family assessment (CFSA 2.0) to identify family strengths, needs, and readiness to change in specific areas. Information from the assessment is used to identify referral or direct service delivery opportunities that meet families' unique, and often complex, needs. The CFSA 2.0 is typically administered within the first two weeks of partnering with a family (baseline assessment) and at one- to three-month intervals thereafter (follow-up assessments).

While the FRC intake process assesses eligibility for receiving FRC services like FDS, CDHS, as the Title IV-E agency, will make the final determination regarding eligibility

for federal reimbursement.

In establishing the MI community pathway with FRCs, similar to SafeCare® Colorado's community pathway (see Appendix I), it is important to clearly distinguish between the data system used by FRCs (Salesforce) and Colorado's CCWIS system (Trails) in order to maintain confidentiality of the children and families receiving services through FRCs. In order to ensure the separation of data, CDHS will use a separate database server, to collect and report child-specific data using an encrypted, unique child identifier number, and verify whether there is current child welfare involvement. This separate database server will also be used to identify clients who enter child welfare within 12 months of receiving the service for reporting purposes.

For this current version of Colorado's IV-E prevention plan, CDHS is defining its IV-E prevention population for this community pathway as FRC clients with existing AFCARS record numbers or individualized client identifiers.

Child Safety and Individual Prevention Plans

All family resource centers utilize the Colorado Family Support Assessment (CFSA) 2.0. The CFSA 2.0 is a tool that assesses a family's self-sufficiency across 14 domains of family functioning, and was designed as a practice tool by the FRCs. The tool will be used together with the family to identify a family's needs, set goals, and provide additional resource referrals to help the family achieve those goals. The CFSA 2.0 is typically administered within the first two weeks of partnering with a family (baseline assessment) and at one- to three-month intervals thereafter (follow-up assessments).

Similar to SafeCare®, the CFSA 2.0 will be used to fulfill the Safety Monitoring requirement for families who are receiving FDS services through the FRCs. Additionally, all FDS workers are mandatory reporters in the state of Colorado. Any concerns or suspicion of abuse and neglect identified by the program intermediary or local providers will be reported to the Colorado statewide child abuse and neglect hotline.

FDS workers provide family-centered case management to support families in setting

their own immediate, short- and long-term SMART goals (goals that are specific, measurable, attainable, realistic and time-based), which are documented and tracked in Salesforce. At least one of the goals that the family sets must align with the Readiness to Change Goal that is selected in Part C of the CFSA 2.0

On the CFSA 2.0, there is a Prevention Line that is also used to distinguish when a family is in a crisis or vulnerable situation, from one that is safe, stable, or thriving on a rating scale of 1-5. The Prevention Line sits between a score of 2-3, and through the use of the baseline and follow-up assessments, progress is measured through improvements in the domain scores.

Workforce Support and Training

The Family Resource Centers Association (FRCA) administers training on the CFSA 2.0 tool to all FRC workers who utilize this tool within 90 days of hire. The initial training is two days, and much of that time is spent on MI components (Stages of Change, Spirit of MI, Core Skills of MI using OARS, Change Talk of MI using DARN-CAT, Implementing and Eliciting Change Talk, Change Ruler, Knowledge Deficits, Planning Stage, and Tips on Using MI) to complement the use of the CFSA 2.0 tool. After a participant completes the class, they will receive a certificate of completion.

FRCA hosts monthly Community of Practice (CoP) sessions for FRC staff to continue practicing their MI skills, and share questions and lessons from peers about their experiences implementing the tool and use of MI. Topics include but are not limited to:

1. Using MI to build trust & rapport at the initial interaction with families;
2. MI to engage families in the 5 Protective Factors for Part B of the CFSA 2.0;
3. Reassess & reflect on how using MI to engage with families using the 5 Protective Factors has worked over the past month;
4. Interactive practice using MI to administer the CFSA 2.0; and

5. Role playing using scenarios to collaborate with families using MI.

The goal of the CoPs is to have participants implement what they have learned from the CoP, come back with successes and challenges, and continue brainstorming on strategies to engage and keep families engaged in services using MI. The FRCA requires that all staff trained in the CFSA 2.0 must attend at least 60% of the monthly Communities of Practice, and ensures that these staff follow the required training cadence and schedules.

All FDS workers in the FRCA network are required to also undergo the Standards of Quality for Family Strengthening and Support[56] training, which is owned by the National Family Support Network[57]. This is also recommended training for all staff at FRCs. This training has been adopted nationally to ensure that staff working in the family support field is approaching families from a shared strengths-based perspective. Additionally, all staff trained in the CFSA 2.0 must attend at least 60% of the monthly Communities of Practice during each state fiscal year.

All FRC 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

The FRC Program and Family Development Services do not have a set caseload expectation. Caseloads vary depending on the regions that each site serves, and the size of each FRC site. Each grantee organization determines what is manageable based on staffing and resources.

[56] https://www.nationalfamilysupportnetwork.org/standards-of-quality
[57] https://www.nationalfamilysupportnetwork.org/