



Colorado Title IV-E Waiver Final Evaluation Report

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List of Acronyms and Key Words

ACS	American Community Survey
BOS	Balance of State (small counties)
CANS	Child and Adolescent Needs and Strengths
CDHS	Colorado Department of Human Services
CFMS	County Financial Management System
CMHC	Community Mental Health Center
CPSS	Child PTSD Symptom Scale
CWRC	Seven-County Child Welfare Resiliency Center
DCW	Division of Child Welfare
ESC	Waiver Evaluation Subcommittee
FCDA	Multistate Foster Care Data Archive
FFE	Facilitated Family Engagement (meetings)
GAL	Guardian ad litem
KS	Kinship Supports
KSNA	Kinship Supports Needs Assessment
LINKS	Listening to the Needs of Kids
MSC	Medium Size Counties
OBH	Office of Behavioral Health
OPPLA	Other Planned Permanent Living Arrangement (goal)
PRT	Permanency Roundtable
TSAT	Trauma-informed Screening and Assessment and Trauma-focused Treatment
TLC	Ten Large Counties
TOP	Treatment Outcome Package
TSCYC	Trauma Symptom Checklist for Young Children
Trails	Colorado Statewide Automated Child Welfare Information System

Executive Summary



Overarching Conclusion

Overall, the independent, third-party evaluation findings detailed in this report indicate that Colorado's Title IV-E Waiver benefited child welfare-involved children and youth and their families and kinship caregivers. The Waiver interventions were far-reaching, with 53 of 64 counties in the state receiving funds to implement one or more of the five interventions during the five-year Waiver period and almost 30,000 children and youth receiving one or more interventions. Taken together, in the counties that received funding to implement one or more Waiver interventions in each Waiver year, including all of the ten large counties in the state, the percentage of all out-of-home removal days in kinship care increased, while the percentage of foster and congregate care days, as well as the total expenditures for out-of-home care, decreased. At the same time, children and youth who received the interventions, especially those who received the interventions with high adherence to the specified intervention models, generally had better permanency and safety outcomes than matched children and youth who did not receive the interventions.

Background

Through federal Title IV-E Waivers, child welfare jurisdictions were given the opportunity to implement Waiver demonstration projects to flexibly use funds traditionally allocated solely for foster care maintenance and administration. The Colorado Department of Human Services (CDHS) initiated its five-year Waiver on

July 1, 2013, building on the momentum of the second phase of the state's child welfare plan, *Keeping Kids Safe and Families Healthy 2.0*. Among other actions, the plan expanded differential response, introduced new prevention programs, and allocated additional dollars to Core Services prevention funding.

The Colorado Waiver was expected to catalyze additional service delivery shifts to ultimately improve safety, permanency, and well-being outcomes for children, youth, and families in the child welfare system. Counties that opted into the Waiver and implemented Waiver-funded interventions were expected to decrease out-of-home placement rates, and, when out-of-home placements were necessary, counties were expected to direct their efforts toward finding kin placements or a lower level of care than congregate care. County efforts were also directed to more completely and positively engage and support families to address the safety, permanency, and well-being of their children/youth, in part through in-home services offered earlier in the family's involvement with the county department of human/social services and through locating kin to support the family.

Waiver Interventions

To meet the goals of the Waiver, county departments of human/social services could apply to implement one or more CDHS-specified interventions, including:

- *Facilitated family engagement meetings*, sometimes called family engagement meetings, which targeted all open child welfare cases and any child or youth beyond control of parents, at risk of harm to themselves or others, or for whom there was an allegation of abuse/neglect;
- *Kinship supports*, which targeted all kin caring for children and youth for whom a referral had been made to the county department of human/social services;
- *Permanency Roundtables*, which targeted all youth with an Other Planned Permanent Living Arrangement (OPPLA) goal and all children and youth who were in out-of-home care for longer than 12 months;
- *Trauma-informed screening and assessment*, which targeted all children with an open child welfare case for screening and all children who screened positive for trauma symptoms for assessment; and
- *Trauma-focused treatment*, which targeted all children with an assessed need for treatment services.

Collectively, the interventions were designed to engage families in services to prevent child entry and re-entry into out-of-home care, increase permanency options for youth in long-term out-of-home care, provide needed supports to kinship caregivers, and increase the use of trauma-informed assessments and treatments for children involved with child welfare, as well as their parents or caregivers. In addition to service delivery shifts, CDHS expected that counties implementing the interventions

would alter expenditure patterns by achieving reductions in admissions to out-of-home care, lengths of stay in foster care, and the use of high-cost placements.

Waiver Design

Beginning with the first year of the Waiver, CDHS opened the Waiver interventions to all 64 counties in its state-supervised, county-administered child welfare system. Counties were invited to apply each year for funding to implement one or more of the interventions, and they could apply independently or as part of a region. Regions generally included one or more small or rural counties that bordered one another and were equipped to share Waiver resources, such as a facilitator for facilitated family engagement meetings.

The annual application process was administered by CDHS each spring. Each county or region requesting funding was required to submit a CDHS-developed application that specified the number of Waiver dollars requested for each intervention, staffing and services that would be covered by the funding, the plan for implementing the intervention as specified by CDHS, barriers to implementation, support needed from CDHS, and capacity and plans to sustain the intervention without Waiver funds. Once a county received funding for an intervention, CDHS generally expected the county to submit an annual continuation application and implement the intervention in all subsequent years of the Waiver, though changes in amounts requested and staff or services covered by the request were expected.

County Participation

County participation in the Waiver was widespread, though participation varied by year, county, and intervention. While counties were generally expected to continue implementation once they received Waiver funds, a few of the ten large counties implemented interventions without Waiver funds, some counties became self-sustaining and no longer required Waiver funds for particular interventions, and, in a few rare instances, counties determined an intervention was no longer a good fit or that their target population was too limited—for example, there were not enough eligible youth for Permanency Roundtables within the county.

During year one of the Waiver, 41 of Colorado's 64 counties applied for and were granted Waiver intervention funding to implement one or more of the interventions; by the end of the Waiver, 53 counties had received funding in one or more years. The state's 10 large counties all joined during year one, with all 10 implementing at least two interventions in the first year, and all 10 implementing at least three interventions over the course of the Waiver.

Facilitated family engagement was the intervention implemented by the most counties, and participation rose slightly across the Waiver period, from 35 counties in year one to 41 counties by year five. Participation in kinship supports decreased over the Waiver period, from 29 to 22 counties. And while implementation of Permanency Roundtables grew from 21 to 31 counties, peak implementation occurred in years two

and four, with 35 counties implementing the intervention. The trauma-informed screening and assessment and trauma-focused treatment interventions were not rolled out until year two of the Waiver; because the interventions produced an added layer of complexity, resulting from the need for cross-system collaboration with the behavioral health system, Waiver funds were limited in year two to the 10 counties in the state that were already Trauma-Informed System of Care Communities. The trauma-informed screening and assessment and trauma-focused treatment interventions remained the least-implemented of the Waiver interventions, with 19 counties implementing by year five.

Evaluation Design

The fundamental purpose of the evaluation was to examine whether flexible Waiver funds enabled CDHS, through the counties, to alter expenditure patterns and make changes in service delivery through the five Waiver interventions—ultimately to improve the safety, permanency, and well-being of child welfare-involved children and youth. There were three primary components of the evaluation: a Process Study, an Outcome Study, and a Fiscal Study. Each addressed Waiver implementation across and within the interventions at the state, county, family, and child levels. Data and findings within each study were connected to the data and findings within the other two studies when connections were meaningful and practical (e.g., safety and permanency outcomes for children and youth identified in the Process Study as having received an intervention with higher levels of adherence were examined separately in the Outcome Study).

The Process and Fiscal Studies were primarily descriptive, including analyses across the five years of the Waiver and comparisons within and between each Waiver year. The Outcome Study included comparisons of out-of-home removal day trends by placement restrictiveness and an analysis of placement type at removal, stability, duration, and re-entry in the pre-Waiver and Waiver years. The Outcome Study analyzed each intervention with quasi-experimental matched case comparisons of permanency and safety outcomes between children and youth who received each Waiver intervention and matched children and youth from prior to the Waiver who did not receive the intervention.

The overarching research questions that guided each study are included below:

Process Study

- What is the policy, organizational, and service delivery context that supports or surrounds Waiver implementation?
- How are CDHS and the counties implementing the Waiver overall and in terms of each intervention?
- What is the case-level fidelity (or, adherence) of each intervention, as defined by CDHS?

Outcome Study

- What is the overall impact of the Colorado Waiver on county out-of-home care use?
- What is the impact of the Colorado Waiver interventions on child and youth safety, permanency, and well-being outcomes?

Fiscal Study

- What effect does the Waiver have on child welfare expenditures in participating counties?
- What are the costs of Waiver intervention services received by children and families?

Data Sources

The evaluation relied on a range of data sources to address the research questions, including existing secondary data entered by the counties and administered by CDHS, as well as primary data collected by the evaluation team.

Existing secondary data sources included:

- Trails (Colorado's statewide automated child welfare information system): Case and client characteristics, risk assessments, placements, services, and Waiver intervention specific datasets
- Multi-State Foster Care Data Archive based on Trails: Out-of-home removal entries and exits by placement type in state fiscal years 2009 through 2018
- County Financial Management System: CDHS and county child welfare expenditures and revenue, including Waiver intervention expenditures

Primary data sources included:

- County Implementation Index: Annual intervention-specific measures of county-level implementation of each Waiver intervention in five core domains, including target population, staffing and roles, training, tools, and policies
- Office of Behavioral Health Survey: trauma-informed screening and assessment and trauma-focused treatment assessments and services
- Kin caregiver survey: Responses to a one-time survey of caregiver experiences with kinship supports, as well as their perceptions of the intervention's impact on their caregiving knowledge and capacity to care for children
- State administrator interviews: Information on preliminary Waiver planning processes, implementation and intervention progress, challenges and

successes, and technical assistance and ongoing monitoring provided to counties

- County department of human/social services annual site visits: Interviews with child welfare managers, directors, and intervention leads and community mental health agency clinicians and administrators, as well as focus groups with child welfare caseworkers, community partners, parents, kin caregivers, and youth

Findings

Process Study

Colorado's Waiver design was broad, inclusive, and adaptable by county; that is, counties could opt into Waiver interventions over time. Across the five-year Waiver period, 53 counties implemented Waiver interventions:

- Almost 14,500 children and youth were in families that received facilitated family engagement meetings;
- Just over 10,000 were placed with kinship caregivers who received kinship supports;
- Almost 2,000 received Permanency Roundtables;
- Just over 7,500 received a trauma-informed screening;
- Just over 1,200 received a trauma-informed assessment; and
- Almost 750 received a trauma-focused treatment.

The County Implementation Index conveyed variance in implementation based on intervention, Waiver year, county size, and implementation domain. Variation was expected since counties added—or, less frequently, ceased implementation of—interventions throughout the Waiver. And since stakeholders agreed that intervention training was the richest during the first year of the Waiver, implementation challenges may have emerged for counties that implemented interventions after the initial year. Overall, however, each of the Waiver interventions was implemented at a moderate or high level every year of the Waiver, when looking at mean implementation scores.

Smaller agencies generally demonstrated lower levels of implementation, and the ten large counties demonstrated higher levels of implementation. Smaller counties had the lowest mean implementation scores, particularly for the Permanency Roundtables and kinship supports interventions. However, lower scores in smaller counties may be an indication that the core components measured through the Implementation Index, which were rooted in implementation science, were more reflective of the processes necessary for implementation in larger agencies than an indication that the interventions were not well-implemented in smaller counties.

Across interventions and county size groups, policies and procedures remained the least implemented area, as measured by the Implementation Index, reflecting challenges across agencies with implementing formalized, solidified, and documented referral and service policies.

Reflecting the varying capacity of counties to implement the interventions, intervention reach and adherence rates also varied by intervention. Just over 80% (8,932 out of 10,964) of eligible families whose children were placed out-of-home received at least one facilitated family engagement meeting. Of these:

- 33% had their first meeting on time (within 7 business days of case open);
- 63% had more than half of their held meetings on time (within 90 days of each other);
- 54% had consistently held meetings throughout the entirety of their cases (more than half of every 90-day span from case open to close included a held meeting); and
- 83% had more than half of their meetings with the minimally required participants in attendance (parent, caseworker, facilitator, and parent-identified support).

Just over 70% (6,280 out of 8,889) of eligible families whose children remained at home received at least one facilitated family engagement meeting. Of these:

- 38% had their first meeting on time (within 7 business days of case open);
- 94% had more than half of their held meetings on time (within 180 days of each other);
- 86% had consistently held meetings throughout the entirety of their cases (more than half of every 180-day span from case open to close included a held meeting); and
- 91% had more than half of their meetings with the minimally required participants in attendance (parent, caseworker, facilitator, and parent-identified support).

Just over 80% (6,328 out of 7,664) of eligible kinship caregivers received at least one kinship supports service. Of these:

- 78% received a kinship supports needs assessment;
- 56% received their first kinship supports needs assessment on time (within 7 business days of placement begin date); and
- 59% received a kinship supports service for more than half of every assessed need.

Just over 75% (480 out of 633) of eligible youth with an OPPLA goal received at least one Permanency Roundtables meeting, and of the 480 youth who received at least one meeting:

- 70% had more than half of their held meetings on time (within 90 days of each other);
- 66% had consistently held meetings (more than half of every 90-day span from their first meeting to end removal included a held meeting);
- 67% attended more than half of their Youth-Voice Permanency Roundtables (one held meeting every 180 days); and
- 27% had more than half of their meetings with the minimally required participants in attendance (facilitator, internal and external consultant, caseworker, supervisor, and administrative staff).

Just over 30% (1,356 out of 4,484) of eligible children and youth in care 12 months or longer received at least one Permanency Roundtable meeting, and of the 1,356 who received at least one meeting:

- 88% had more than half of their held meetings on time (within 90 days of each other);
- 81% had consistently held meetings (more than half of every 90-day span from their first meeting to end removal included a held meeting);
- 32% attended more than half of their youth-voice meetings (one held meeting every 180 days); and
- 52% had more than half of their meetings with the minimally required participants in attendance (facilitator, internal and external consultant, caseworker, supervisor, and administrative staff).

For the trauma interventions, 37% (7,784 out of 20,867) of eligible children and youth received a trauma-informed screening. Although almost all children and youth who screened-in were referred for an assessment, data limitations made it difficult to calculate an accurate rate of those who screened-in and were referred who also received a trauma-informed assessment and, subsequently, a trauma-focused treatment, if indicated by the assessment.

While there was variance in implementation capacity, reach, and adherence, county stakeholders reported strengthened and enhanced relationships with community partners and the courts as a result of all five Waiver interventions. Broad and intentional efforts were made to collaborate with these partners—from meetings with judges to agency-sponsored trauma trainings. The Waiver interventions were seen as mechanisms for enhancing partnerships, and, largely, community partners shared buy-in and investment. Further, each of the interventions impacted organizational

structures and capacity, allowing counties to grow their workforces, their service arrays, and provide more support or smaller caseloads for caseworkers.

Outcome Study

Comparing the five years immediately preceding the Waiver to the five Waiver years:

- The percentage of non-certified and certified kinship care days increased from 19% in the pre-Waiver years to 33% in the Waiver years; and
- The percentage of foster and congregate care days decreased from 72% in the pre-Waiver years to 62% in the Waiver years.

Moreover, a child or youth coming into care for the first time in the three years prior to the Waiver had a 34% chance of initially entering a kinship placement; during the Waiver, this likelihood increased to 46%. Comparing these same periods, the probability of reentering care within one year went down slightly, from 16% to 15%.

At the same time, the percentage of children who moved within six months increased slightly from 33% to 35% and the probability of exiting care within six months declined from 53% to 47%. The probability of exiting care within 12 months declined from 70% to 65%.

The findings from the intervention-specific analyses pointed to a range of permanency and safety outcomes that were associated with the interventions, particularly among children and youth who received the interventions with higher levels of adherence. Compared to matched children and youth whose families did not receive facilitated family engagement meetings, children and youth who were placed out-of-home and whose families did receive the intervention:

- Had shorter case lengths;
- Were more likely to be placed and remain with kin during their cases;
- Were more likely to have no more than one placement disruption, if they received the intervention with higher levels of adherence;
- Were more likely to achieve permanency, if they received the intervention with higher levels of adherence; and
- Were less likely to experience subsequent child welfare involvement due to a subsequent substantiated report of abuse and/or neglect.

In addition, children and youth whose kin caregivers received kinship supports and whose families received facilitated family engagement meetings with higher levels of adherence were more likely to reunify with their parents at case close, and children and youth in care 12 months or longer who received Permanency Roundtables and facilitated family engagement meetings with higher levels of adherence and youth 16 years and older with an OPPLA goal who received both interventions, regardless of

facilitated family engagement meetings adherence level, were more likely to reunify at the end of their out-of-home removal.

Compared to matched children and youth whose families did not receive facilitated family engagement meetings, children and youth who remained at home and whose families did receive the intervention had shorter case lengths, if they received the intervention with higher levels of adherence.

Compared to matched children and youth whose kin caregivers did not receive kinship supports, children and youth whose kin caregivers did receive the intervention:

- Had longer stays in kinship care and were more likely to have subsequent placements in kinship care;
- Were more likely to achieve permanency; and
- Were less likely to have subsequent child welfare involvement due to a subsequent substantiated report of abuse and/or neglect.

Compared to matched youth with an OPPLA goal who did not receive Permanency Roundtables, youth with an OPPLA goal who received the intervention:

- Were more likely to have step-downs in placement restrictiveness, if their removal began during a PRT funded year or they received the intervention with higher levels of adherence, and
- Were less likely to emancipate, if their removal began during a PRT funded year.

In addition, youth with an OPPLA goal who received Permanency Roundtables had more permanent connections after they received the intervention. The mean number of permanent connections for these youth increased significantly, from 1.60 at the start of the intervention to 3.00 by the end of their removal or the end of the evaluation observation period.

Compared to matched children and youth in care 12 months or longer who did not receive Permanency Roundtables, children and youth with an OPPLA goal who received the intervention:

- Were more likely to spend the majority of their out-of-home days in kinship care, and
- Were more likely to be living with guardians or adoptive parents at case close, if they reached 12 months in care during a PRT funded year or received the intervention with higher levels of adherence.

Children and youth in care 12 months or longer who received Permanency Roundtables has more permanent connections after they received the intervention.

The mean number of permanent connections for these children and youth increased significantly, from 1.58 prior to the start of the intervention to 2.34 by the end of their removal or the end of the observation period.

Compared to matched children and youth who did not receive trauma-informed screening and assessment and trauma-focused treatment, children and youth who received the interventions:

- Were more likely to spend the majority of their out-of-home placement days in kinship care;
- Were more likely to have no more than one placement disruption;
- Were more likely to achieve permanency; and
- Were less likely to re-enter out-of-home care after their cases closed.

Fiscal Study

The Fiscal Study provides a way to make a few fundamental statements about the county fiscal experience and decision-making during the Waiver:

- Controlling for inflation, counties increased total child welfare expenditures while holding steady or decreasing out-of-home care board and maintenance expenditures.
- Increases in child welfare spending were funded in part, though not completely, by flexible Title IV-E dollars passed to the counties through intervention-specific funding streams or by increases to “The Block,” the annual allocation from the State that bundled federal and state funding sources.
- The category of spending that increased the most (by 18% over the course of the Waiver) was Direct County spending, reflecting a state-wide push to explore and encourage services and supports for children and families beyond out-of-home placements and county choices to primarily invest in county staff to deliver these services rather than purchasing those services from contract providers.
- Within the category of out-of-home expenditures, reduction in average daily unit costs was the most consistent, with reductions in every year of the Waiver except the last year.
- The decrease in average daily unit cost was a likely source of savings, estimated at \$69.8 million over the course of the Waiver.

When coupled with the results of both the Outcome Study and Process Study, it can be hypothesized that the Waiver interventions were drivers or contributors to the reduction in average daily unit costs through changing placement type mix; the kinship supports intervention supported and sustained both certified and non-

certified kinship placements and, under the intervention, children spent more days in kinship care than more restrictive placements. Facilitated family engagement meetings enhanced this impact, serving as a platform for the identification of kin and the assessment of their needs to support them. Further, the Permanency Roundtables intervention was associated with step-downs from restrictive placements, like congregate care, while the trauma-informed screening and assessment and trauma-focused treatment interventions enhanced placement stability.

Yet there were no changes in the likelihood of placement overall, and the likelihood of exit to permanency in six and 12 months went down during the five years of the Waiver, suggesting a longer case length during the Waiver period. The finding that family engagement reduced case lengths for children placed out-of-home was significant for all children but was primarily driven by the difference observed between the high adherence group (19% of all families who participated in family engagement) and their matched comparisons. As a result, it is possible the impact on this minority of children was not detectable at the county level (i.e., for all children and youth in out-of-home placements in the counties that received funding to implement one or more interventions in each year of the Waiver).

In addition to detailing the information presented in this Executive Summary, the full report includes lessons learned, next steps in light of the evaluation findings, and recommendations for the transition from the Title IV-E Waiver to the Family First Prevention Services Act.

Introduction & Overview



Background and Context

In 2013, the State of Colorado embarked on the second phase of its child welfare plan, *Keeping Kids Safe and Families Healthy 2.0*. Among other actions, the plan solidified a common practice approach across the state (the Colorado Practice Model), expanded differential response, introduced new prevention programs, and allocated additional dollars to Core Services prevention funding. Building on this momentum, the Colorado Department of Human Services began its five-year Title IV-E Waiver child welfare demonstration project in 2013. Colorado's Waiver was expected to catalyze additional service delivery shifts to ultimately improve safety, permanency, and well-being outcomes for children, youth, and families in the child welfare system.

Nationally, Waivers allow states and counties to align their funding with their practice priorities. Through Title IV-E Waivers, administered by the Children's Bureau, jurisdictions can implement demonstration projects to flexibly use funds that are traditionally allocated solely for foster care maintenance and administration. Colorado's Title IV-E Waiver Demonstration Project was approved for a five-year period, from July 1, 2013 through June 30, 2018; the State has been granted a one-year extension to continue its Waiver through June 30, 2019.

This report presents the evaluation of Colorado’s Waiver, which was conducted by the Human Services Research Institute, Chapin Hall at the University of Chicago, and the Social Work Research Center at Colorado State University.

Purpose of the Waiver Demonstration

The Colorado Department of Human Services had several goals for its Waiver: Counties were expected to decrease out-of-home placement rates, and, when out-of-home placements were necessary, counties were expected to direct their efforts toward finding kin placements or a lower level of care than congregate care. County efforts would also be directed to more completely and positively engage and support families to address the safety of their children/youth, in part through in-home services offered earlier in the family’s involvement with the county department and through locating kin to support the family.

To meet the stated goals, the Colorado Department of Human Services, through its counties, implemented five primary interventions: facilitated family engagement meetings or FFE (often referred to by CDHS and county departments of human/social services as family engagement meetings or FEMs), kinship supports or KS, Permanency Roundtables or PRT, trauma-informed screening and assessment, and trauma-focused treatment. The last two interventions are collectively referred to as TSAT in this report.

The overarching service goals of these interventions were:

- to engage families in services to prevent child entry and re-entry into out-of-home care;
- to increase permanency options for youth in long-term out-of-home care;
- to provide needed supports to kinship caregivers; and
- to increase the use of trauma-informed assessments and trauma-focused treatments for children involved with child welfare and their parents or caregivers.

In addition to service delivery shifts, the Waiver was expected to alter expenditure patterns, such as reducing foster care expenditures.

Target Populations

The target populations for the demonstration varied by intervention.

Facilitated Family Engagement Target Population

FFE meetings and services targeted the broadest population of any of the Waiver interventions: all open child welfare cases (including Family Assessment Response). The demonstration sought to address several key challenges faced by these populations, such as removals of children/youth from their homes for placement

durations of two weeks or less (short stays) and re-entry to out-of-home placement that occurred for one in five children/youth prior to the Waiver.

Permanency Roundtables Target Population(s)

PRT meetings and services targeted all youth with an Other Planned Permanent Living Arrangement (OPPLA) goal and all children and youth who were in out-of-home care for longer than 12 months. The vast majority of OPPLA youth were age 16 years or older; the intervention attempted to address low rates of legal permanency for older youth, high use of congregate care across the state, and inconsistent permanency planning for this population.

Kinship Supports Target Population

The KS intervention broadly targeted all kin caring for children and youth for whom a referral had been made to the county department of human/social services. However, some counties served more narrow populations of kin caregivers, such as only non-certified kin caregivers caring for children in placements or living arrangements.^a The intervention attempted to address high rates of more restrictive care by enhancing the likelihood of kin placements and sustainability of those placements.

Trauma-Informed Screening, Assessment, and Treatment Target Population

Trauma-informed screening targeted all children with an open child welfare case; trauma-informed assessment targeted all children who screened positive for trauma symptoms; and trauma-focused treatment targeted all children with an assessed need for treatment services. Some counties screened more narrow populations of children and youth, such as those in congregate care, those lingering in out-of-home care, or those within certain age ranges. Some counties expanded the target population and provided assessments and/or treatment for foster parents, kin providers, and/or adoptive parents. The intervention addressed several challenges, including the unmet behavioral and mental health needs of children and youth involved with child welfare.

Colorado's Waiver Design

Colorado is a state-supervised, county-administered child welfare system. CDHS opened the Waiver to all 64 counties in the state. Counties could apply each year for funding to implement one or more of the interventions, and they could apply independently or as part of a region. Regions generally included one or more rural counties that bordered one another and were equipped to share Waiver resources, such as an FFE facilitator.

The annual application process was administered by the State each spring. The county or region was required to submit a State-developed application that specified the amount of Waiver funding requested for each intervention, what the funding request

^a Many counties in Colorado do not always take legal custody or open an out-of-home removal when children are placed with kinship caregivers. These placements may be considered informal living arrangements. In this report, we refer to any kinship placement (informal or otherwise) as an out-of-home placement.

would cover, the plan for implementing the intervention, barriers to implementation, support needed from CDHS, and capacity and plans to sustain the intervention without Waiver funds. Once a county received funding for a particular intervention, CDHS generally expected the county to submit an annual continuation application and implement the intervention in all subsequent years of the Waiver; however, changes were expected in terms of the amounts requested and the staff or services covered by the request.

CDHS reserved the license to fund county requests for intervention funds at 100 percent, less than 100 percent, or not at all; these decisions were based on a scoring rubric and Waiver-allowable expenditures. Counties reported the expenditures for each Waiver intervention separately in their State-required County Financial Management System (CFMS) submissions.

County Participation

County participation in the Waiver was widespread, though participation varied by year, county, and intervention. While counties were generally expected to continue implementation once they received Waiver funds, a few large counties implemented interventions without Waiver funds, some counties became self-sustaining and no longer required Waiver funds for particular interventions, and, in a few rare instances, counties determined an intervention was no longer a good fit or that their target population was too limited—for example, there were not enough eligible youth for Permanency Roundtables within the county. For a comprehensive table of county Waiver intervention participation by year and intervention, see Appendix A.

During year one of the Waiver, 41 of Colorado's 64 counties applied for and were granted Waiver intervention funding to implement one or more of the interventions; seven additional counties joined in year two. The state's ten large counties (TLC), which account for 79% of the child welfare population, all joined during year one, with all 10 implementing at least two interventions the first year, and all 10 implementing at least three interventions over the course of the Waiver. Eleven counties did not apply for intervention funding during any year of the Waiver.

FFE was the intervention implemented by the greatest number of counties, and participation rose slightly across the Waiver period, from 35 counties in year one to 41 counties by year five. Participation in KS decreased over the Waiver period, from 29 to 22 counties. And while PRT grew from 21 to 31 counties, peak implementation occurred in year two and year four, with 35 counties implementing. The TSAT interventions were not rolled out until year two of the Waiver; because the interventions produced an added layer of complexity, resulting from the need for cross-system collaboration with the behavioral health system, Waiver funds were limited in year two to the 10 counties in the state that were already Trauma-Informed System of Care Communities. The TSAT interventions remained the least-implemented of the Waiver interventions, with 19 counties implementing by year five.

Interventions and Components

Facilitated Family Engagement

The philosophy and practice of family engagement calls for child welfare staff to work with families to establish common goals for safety, well-being, and permanency. FFE meetings are collaborative meetings in which both family members and professionals are present. Led by a neutral facilitator, these meetings are held on a regular and ongoing basis over the life of the case and are where goals are established, and families are linked with services. Meetings are attended by parents, facilitators, caseworkers, and supervisors as well as parent-identified supports (such as family and friends), extended family members, foster parents or kin caregivers, and service providers. Family preparation is a required component of FFE.

Initial FFE meetings are supposed to be held within seven business days of case opening—and every 90 days thereafter for out-of-home cases and every six months thereafter for in-home cases. FFE meetings can be held at the agency or in the community; some counties also hold them at the courthouse. For the FFE intervention checklist, see Appendix B.

Within the parameters above, the Waiver FFE intervention provided flexibility in the implementation: counties could determine which established meeting model(s) fit county-specific philosophy and goals. Some counties implemented more than one meeting model. Family Team Meetings were the most commonly implemented model, followed by Team Decision-Making.

Table 1. FFE Model^b

Family Meeting Model	# of Counties Implementing
Family Team Meetings (FTM)	20
Team Decision Making (TDM)	18
Family Group Decision Making (FGDM)	16
Partnering for Safety/ Safety Organized Practice	7
Family Group Conferencing (FGC)	6
Listening to the Needs of Kids (LINKS)	4

Source: Implementation Index

Through the Waiver, counties requested FFE funding for facilitator or coordinator positions, support and scribe positions, meeting expenses, transportation expenses for families, child care coverage during FFE meetings, and contracts for facilitation or other services.

^b Data taken from year five implementation indexes.

Permanency Roundtables

PRTs are facilitated formal meetings and case presentations designed to develop a Permanency Action Plan for each child or youth to expedite legal permanency. PRTs foster collaborative and creative approaches to achieving permanency for children and youth who no longer have the option of returning home and/or have been in out-of-home care for lengthy periods of time.

Colorado's Youth-Centered PRT model includes quarterly Youth Voice meetings that are facilitated by a Master Practitioner/facilitator and attended by a variety of people. Youth are present or represented at each PRT (after an initial Caseworker PRT) and are given a voice; because the target population for PRTs is broad, however, PRTs for younger children or youth may involve a representative—such as a family member or guardian ad litem (GAL)—rather than the child or youth themselves.

The PRT intervention attempts to secure relational, if not legal, permanency through increased connections and resiliency. Multiple staff are involved in the implementation of Permanency Roundtables, including the Master Practitioner/facilitator, youth, child welfare administrator, supervisor, caseworker, internal consultant, external consultant, and, sometimes, scribe. The youth's family, friends, and service providers may also participate in PRTs. PRTs have six phases: welcome and overview, case presentation, clarification and exploration, brainstorming, permanency action plan creation, and debrief. For the PRT intervention checklist, see Appendix B.

Through the Waiver, counties requested PRT funding for facilitator or Master Practitioner positions, meeting expenses, meeting incentives, refreshments, and travel expenses for youth or families including airline tickets and hotel rooms for out-of-state relatives.

Kinship Supports

The KS intervention is designed to support kin caregivers, including non-certified kin caregivers, across the state. The intervention includes administration of a kinship supports needs assessment and coordination of corresponding services and supports so that children can remain with relative caregivers and placements can be sustained. In many counties, Waiver-funded kinship supports workers or Kinship Navigators provide tangible and emotional support for kin. Kin may receive good and services such as food, clothing, cribs and car seats; utility or rent assistance; mental health services; funds for child activities or extracurricular fees; and support groups.

The initial kinship supports needs assessment (KSNA) (Appendix C) was administered within seven days of a child being placed with kin; follow-up assessments were completed on an ongoing basis thereafter. For the KS intervention checklist, see Appendix B.

Through the Waiver, counties requested KS funding for Kinship Navigators or kinship supports workers, family finding staff, visitation support staff, visitation transportation, basic needs and hard goods for kin caregivers, respite services, and contracts for services.

Trauma-informed Screening, and Trauma-informed Assessment and Treatment

The TSAT interventions reflect a growing body of knowledge related to the short-term and long-term effects of adverse childhood experiences, as well as an understanding of the resiliency and healing that can come from trauma-related approaches and treatment. The TSAT interventions bring children and families access to trauma screening, assessment, and treatment tools. These cross-system interventions rely on collaboration between the county department of human/social services, the local community mental health center (CMHC), and, in some counties, other independent mental health providers. The child welfare caseworker screens the child for symptoms of trauma and, if necessary, refers the child to the CMHC or other entity for additional trauma assessment. Clinicians assesses the child and, if needed, recommend and initiate appropriate trauma-focused treatment.

Initial trauma screens were done at case opening, and ongoing trauma assessments were conducted every 90 days for children or youth receiving trauma treatment. Some counties also re-screened children for signs or symptoms of trauma.

Through the Waiver, counties requested TSAT funding for trauma care coordinators, behavioral health navigators, funding and finance navigators, well-being assessments, trauma assessments not covered by Medicaid, and treatment expenses not covered by Medicaid or insurance.

Waiver Expansions

As the Waiver progressed, CDHS allowed counties to apply for and initiate intervention expansions. Expansions were initiatives or projects that fit within the scope and purpose of the Title IV-E Waiver and aligned with the Waiver interventions. In the fifth year of the Waiver, five expansions were funded. These ranged from additional supports for kin caregivers and foster parents to use of a level of care tool. One notable expansion of the TSAT intervention was the Child Welfare Resiliency Center (CWRC). The CWRC was funded for three years of the Waiver and is presented as a substudy of Colorado's Waiver evaluation.

Evaluation Framework



Waiver Theory of Change and Logic Models

Prior to the start of the Waiver, CDHS, in collaboration with the counties, developed an overarching Waiver theory of change, as well as individual intervention theories of change, to articulate the goals of the Waiver. Underlying CDHS's plan was the basic belief that the lack of comprehensive family and kin involvement causes additional harm to the child or youth due to unnecessary out-of-home placements. In addition to changing agency culture, the implementation of the Waiver through use of FFE, PRT, KS, and TSAT was expected to result in better long-term safety and permanency outcomes for children and youth.

For children and youth in their own home, the theory of change articulated enhanced engagement of families, a fuller service array, and agency and community ability to meet the mental health needs of children and youth. For children and youth in out-of-home placement, the theory of change articulated early engagement of permanency resources, enhanced services and supports for families, and a focus on kin. For a copy of the overarching Waiver theory of change, and intervention-specific theories of change, see Appendix D. The theories of change were not modified during the demonstration.

In addition to the theories of change, logic models accompany each of the five Waiver interventions. The models were developed collaboratively by CDHS and county

representatives to reflect the core components of the interventions described in CDHS's Initial Design and Implementation Report. Each model includes the intervention target population and the services received by the target population as well as the outputs and outcomes associated with the intervention. For copies of the Waiver logic models, see Appendix E.

Overview of the Evaluation

The state-level analysis of out-of-home removal trends (assessing the impact of the Waiver on child welfare outcomes) was done using longitudinal analysis comparing groups of children who entered out-of-home care prior to the Waiver to those who entered during the Waiver period. The analysis of care days and expenditure patterns was done similarly by comparing care days and expenditures from prior to the Waiver to care days and expenditures during the Waiver. The evaluation of each of the interventions was done with a matched case comparison design. Matched case comparisons were used to examine the impact of the individual Waiver interventions on child-level safety and permanency. This technique matches each member of the group being studied (children receiving Waiver interventions) with a virtually identical member of a comparison group (children involved with child welfare prior to the implementation of the Waiver interventions), and lets researchers test the effects of exposure to the interventions

Data Sources and Data Collection Methods

A variety of data sources and collection methods were used to evaluate Colorado's Waiver. All data, with the exception of CDHS child welfare administrator interviews, were at least collected at the county level. Each of the three evaluation studies—Process, Outcome, and Fiscal—utilized a mix of county-, case-, client-, and child-level data. Additionally, State administrator interviews were used for the Process and Fiscal Studies.

More specifically, the data sources and purpose of their use within the respective studies were:

- **Process Study:** County-level data from an annual county Implementation Index and site visits to county departments of human/social services; case- and child-level data from Trails (Colorado Statewide Automated Child Welfare Information System); a survey of kin caregivers; and an Office of Behavioral Health (OBH) survey for the trauma assessment and treatment intervention. These data describe implementation of and adherence to the Waiver interventions.
- **Outcome Study:** Child-level data from Trails, the Multistate Foster Care Data Archive (FCDA) based on Trails, and an OBH trauma assessment and treatment survey. Outcomes were primarily examined through an analysis of child welfare outcomes over time and matched case comparisons.

- Fiscal Study: County-level data from CFMS to determine county child welfare expenditures and revenue; case-, provider-, or child-level data from Trails were merged with CFMS expenditures to determine the average intervention Waiver spending per unit of service.

All data collection activities for the evaluation were reviewed by the Institutional Review Board at the Human Services Research Institute.

Sampling Plan

Although the target populations varied by Waiver intervention, the target populations combined across all five interventions included all children, youth, and families with an open child welfare case and certified and non-certified kinship caregivers with a child welfare-involved child or children placed with them.

The treatment sample for the evaluation of Waiver outcomes in this report included all children and youth who received services, or whose parents or kinship caregivers received services, through one or more of the five Waiver interventions. Although the Colorado Waiver officially began on July 1, 2013, the Trails frameworks that house the data for the interventions were not fully functional until the end of January 2014. Consequently, Feb. 1, 2014 was selected as the start date for the treatment sample. The end date for the sample was set as June 30, 2018, the conclusion of the five-year demonstration.

The comparison sample for each intervention also varied depending on the intervention under analysis. Combined across all five interventions, however, the sample for this report was drawn from a pool of children and youth whose child welfare case opened between February 1, 2009 and June 30, 2013 and who did not receive, or whose parents or kinship caregivers did not receive, services from one or more of the five Waiver interventions. Because of the widespread rollout of the Waiver interventions and the high county-level implementation of the most widespread of the interventions, it was necessary to draw the comparison sample from this historical pool of children and youth that were in cases that opened prior to the start of the Waiver.

The sample for the state-level out-of-home removal trends analysis was all first placements into out-of-home care from July 1, 2011 through June 30, 2018, three years prior to the Waiver and the five years of the Waiver. For the re-entry analysis, the sample included all children exiting out-of-home care from July 1, 2011 through June 30, 2018.

Data Analysis Plan

The data analysis plan consisted of a mix of qualitative and quantitative analysis methods. Grounded theory and content analysis were generally utilized to identify persistent themes from the qualitative data derived from CDHS administrator interviews and county site-visit interviews and focus groups. Because of the large amount of data from the site visit interviews and focus groups, these data were uploaded into the qualitative software analysis program Dedoose for cleaning and

Descriptive, inferential, and effect size statistics were utilized to analyze the data from CFMS, the Implementation Index, Trails, FCDA, and the OBH survey to describe county child welfare expenditures, Waiver intervention implementation and costs, intervention reach and adherence, and child-level outcomes. Propensity score matching was also utilized to evenly match children in comparison pools to children in treatment groups on a range of demographic, case, and risk covariates. Microsoft SQL Server was utilized to prepare Trails data for analysis, and the Statistical Package for the Social Sciences (SPSS) and the Statistical Analysis System (SAS) were utilized for all other data preparation, as well as all quantitative data analyses.

Well-Being & Trauma Assessment Substudy

As part of the evaluation, the Colorado State University Social Work Research Center conducted a substudy of the Child Welfare Resiliency Center (CWRC). As previously noted, the CWRC represents a Waiver expansion. In 2015, seven counties submitted a proposal as a consortium to expand their trauma-informed child welfare practice to include a unique assessment model and several well-being measures including the Treatment Outcome Package (TOP) and the Child and Adolescent Needs and Strengths (CANS) assessment. This proposal was funded and led to the CWRC. The goal of the CWRC was to expand trauma-informed practice to include in-depth assessment of trauma and to enable counties to serve more children and youth safely at home, with kin or in foster care, rather than in congregate care settings. The substudy employed an outcomes and process evaluation, which included baseline to post assessment of youth well-being data. The CWRC substudy (CWRC Program Evaluation Report) can be found at the end of this report, as an annex.

Limitations

Although the evaluation includes a variety of quantitative and qualitative measures and the most rigorous design and analysis procedures feasible, there are limitations to the study. These are outlined below.

Methodological Limitations

The most significant methodological limitation of the state-level analysis of out-of-home removal trends is that it relies on assumptions about how historical trends in outcomes would have continued in the absence of the Waiver. This historical comparison, while unable to definitively present causal relationships for changes in

the outcomes of interest, does provide a descriptive look at the way outcomes have changed over time.

The most significant methodological limitation relates to the matched case comparison component of the Outcome Study. Because of the unscheduled rollout of the Waiver interventions, widespread county participation (both initial and ongoing), and the high and moderate levels of implementation across counties receiving Waiver intervention funding for FFE, PRT, and KS, a sufficient natural and concurrent comparison pool, such as from similar Colorado counties not implementing the Waiver interventions or from counties implementing the interventions at lower levels (as measured by the Implementation Index) was simply not available. Therefore, the evaluation team made use of a historical comparison pool, which has the same limitations as the state-level Outcome Study described above.

Logistical or Data Collection Limitations

Within the Evaluation Plan, it was proposed that wherever possible, individual-level cost data from Trails would be used in the Fiscal Study to report on the type, amounts, and costs of services received by children and families served by Waiver interventions and to compare these to the type, amounts, and costs of services prior to the start of the Waiver. However, it was determined through discussions with State staff who manage the Trails data system and CFMS data system that Colorado does not track individual-level financial details for the Waiver interventions. The counties view the interventions as county-provided services and treat them similarly to other direct county services, and counties do not generally input direct county services cost data into Trails.

Additionally, not all costs for the Waiver interventions were possible to disaggregate. Spending on Waiver interventions funded by federal Title IV-E dollars or by State funds set aside for Waiver activity was carefully coded and tracked in CFMS. However, counties also fund these interventions through additional expenditure codes which could not be disaggregated from other child welfare expenditure types. Therefore, the full cost of the Waiver interventions could not be determined from current CFMS data. These limitations impacted the possibilities of the individual-level study for the Fiscal Study. Due to a lack of individual cost data in Trails and the lack of access to total intervention costs in CFMS, the individual-level substudy instead presents counts and average Waiver spending data for the interventions undertaken through the demonstration project.

Evaluation Time Frame

The evaluation progressed as planned and integrated well with the implementation of the five-year demonstration, with the exception of the necessary data frameworks not being fully completed and established in Trails until the end of January 2014. Colorado's five-year demonstration concluded on June 30, 2018, allowing six months to complete the evaluation and this final evaluation report (due December 31, 2018). CDHS adhered to the year-by-year county rollout of the interventions, allowing the

evaluation to study and report on the annual evolution of the Waiver as more counties participated and as participating counties implemented additional Waiver interventions. Throughout the Waiver, CDHS and the counties were invested in the success of the demonstration and evaluation and committed substantial resources to ensure that the evaluation team had the data necessary for the evaluation.

The Process Study



The Process Study examined the overall implementation of the Waiver interventions across Colorado counties, including the context surrounding the Waiver, the shifts in practice that occurred in participating counties, and the experiences of Waiver administrators, service providers, and child welfare-involved families and youth. This report reflects final process analyses which describe how the demonstration and five interventions were implemented; factors such as partnerships and implementation challenges are discussed.

Key Process Study Research Questions

Process Study findings relate to intervention-specific and contextual data, as well as intervention reach and adherence. The Process Study addresses implementation at the system level, such as the state and counties, and at the child and family level. At the system level, the array of available services, co-occurring initiatives, the nature of interagency partnerships, and the implementation of the five primary Waiver interventions were explored. At the case level, the range of interventions and services received by target children and families and the level of fidelity (referred to in this report as adherence) of the interventions received under the Waiver were examined.

In the Interim Evaluation Report, the Process Study focused on detailed descriptions related to service delivery of and organizational factors influencing the five Waiver-funded interventions; more attention is given in this report to the broader shifts

within counties over the five-year demonstration and the context surrounding the Waiver.

The overarching questions guiding the Process Study are:

- What is the policy, organizational, and service delivery context that supports or surrounds Waiver implementation?
- How are CDHS and the counties implementing the Waiver overall and in terms of each intervention?
- What is the case-level fidelity (or, adherence) of each intervention, as defined by CDHS?

Key Process Study Outputs

Below are the key outputs of the Process Study, with details about the implementation measures or corresponding indicators. The Process Study results section is organized by the following outputs.

County Capacity to Implement Waiver Interventions

The Implementation Index—an annual, online survey which catalogued Waiver intervention implementation by county—allowed for an understanding of county capacity to implement the core components of the Waiver interventions (as identified by the State), as well as some of the variability that occurred within counties from year to year and across or between counties each year. Because of Colorado’s staggered rollout of multiple Waiver interventions, there was considerable variability and flexibility in how and when counties applied to participate in Waiver interventions. The Implementation Index was accordingly structured to inquire about a set of domains, or Process Study indicators, related to the core implementation components of each of the Waiver interventions. These domains were: target population, staffing and roles, training, tools, and policies. Five separate modules were included in the Index, including one that addressed general functions and activities of the counties with regard to the IV-E Waiver and one for each of the Waiver interventions.^c The content of each domain varied but included specific activities that were likely to occur as the intervention was implemented. Site visits and State administrator interviews provided additional context and depth to the understanding of county capacity to implement the Waiver interventions.

Waiver Intervention Reach and Case-level Adherence

Intervention reach and case-level adherence are calculated for each intervention as part of the Process Study.

The FFE meetings penetration rate across the counties with Waiver funding for this intervention includes the percentage of all child welfare cases opening in those counties (i.e., the target population) on or after Feb. 1, 2014 through June 30, 2018

^c TSAT intervention data were collected in one Implementation Index module.

that received at least one FFE meeting during that time period. The adherence measures for FFE meetings include the percentage of cases with an initial meeting occurring within seven business days of the case open date; the percentage of cases with subsequent meetings occurring every 90 days for out-of-home cases and every 180 days for in-home cases until case closure; and the percentage of cases with meetings that included the minimally required participants in attendance (i.e., parent, caseworker, parent-identified support, and facilitator).

The PRT penetration rate across the counties with Waiver funding for this intervention includes the percentage of all youth age 16 and older with an OPPLA goal in those counties (i.e., the target population) at some point from February 1, 2014 through June 30, 2018 who received at least one PRT meeting during that time period. The adherence measures for Permanency Roundtables include the percentage of youth with at least one PRT meeting who have subsequent meetings every 90 days (youth is only required to attend a meeting every 180 days) after the first meeting until permanency is achieved or emancipation occurs and the percentage of youth with meetings that included the required participants (i.e., youth every 90 days, facilitator, internal and external consultant, caseworker, supervisor, and administrative staff).

Beginning in year two, PRT also targeted all children and youth in out-of-home care for longer than 12 months and all children and youth under 16 years of age with an OPPLA goal. The penetration and adherence measures for this target population are the same as the 16 and older with an OPPLA goal target population. However, the rates for the measures were examined separately for each target population.

The KS penetration rate across the counties with Waiver funding for this intervention includes the percentage of all kinship caregivers in those counties (i.e., the target population) with a child living with them and in their care at some point from February 1, 2014 through June 30, 2018 in those counties who received at least one KSNA or other service during that time period. The adherence measures for KS include the percentage of caregivers with a KSNA occurring within seven business days of the kinship placement, the percentage of caregivers receiving a placement end or case close needs assessment, and the percentage of caregivers indicating a low to urgent need in one or more need categories who received at least one corresponding support service for each category of expressed need.

Reach rates for trauma assessment could not be calculated due to data limitations; however, descriptive data about the number of assessments completed is included in the “Results” section of this report. The reach rate for trauma treatment included the percentage of children for whom at least one type of trauma treatment was recommended who received trauma treatment, regardless of the type of treatment or the dosage or frequency of the treatment received. The adherence measure for the

TSAT intervention included the percentage of children who received the recommended trauma treatment or at least one of the recommended treatments.^d

To convey findings related to intervention reach and adherence, the Process Study results section includes tables for each intervention.

State and County Context & Practice During the Waiver

During the Waiver, topics related to community and local context, departmental structures, and Waiver intervention processes, successes, and opportunities were explored through interviews and focus groups. The intent was to help uncover activities that occurred during and because of the Waiver at the county and state level and the context (organizationally, socially, politically, etc.) surrounding the Waiver. Indicators included themes uncovered and explored during interviews and focus groups. Themes were generally considered rich or relevant (and therefore reportable) if: data were heard repeatedly in multiple interviews or by multiple parties; data were heard from only one or two counties or interviews but had general relevance to other counties and Waiver implementation; data were not so narrowly case- or county-specific as to be tangential or identifiable. To convey learnings, narrative summaries, visual depictions, and a county case study are included.

Client Perspective and Caregiver Knowledge and Capacity

During the Waiver, focus groups and a survey were conducted to explore topics related to client satisfaction, engagement, services received, and knowledge and capacity to provide care. To capture client perspective on the Waiver, focus groups were conducted with parents in those counties implementing FFE, with kinship caregivers in those counties implementing KS, and with youth in those counties implementing PRT to understand their experience with the intervention. Indicators included themes uncovered and explored during focus groups. A one-time survey of kin caregivers who received the KS intervention was also conducted; indicators included Likert-scale and open-ended survey question responses. To convey learnings related to client perspective, narrative summaries and tables of mean survey responses are included.

Process Study Data Sources and Data Collection

To address the overarching Process Study research questions, data collection included a variety of sources. Taken together, these sources provided a broad mix of qualitative and quantitative data for examining the implementation of the Waiver. Process study data sources included: Trails; OBH Survey; County Implementation Index; State Administrator Interviews; County Site Visits; and a Kin Caregiver Survey. Each data source is described below.

^d Because some children and youth received additional trauma treatments which were not initially recommended, this penetration rate actually exceeded 100%.

Trails

CDHS delivered, through the evaluation team’s secure file sharing website, 14 separate Trails datasets in Microsoft Excel semiannually, all of which could be linked on case and client identification numbers. The datasets included child welfare case and client characteristics, risk and safety assessments, placements, and services; family engagement meeting dates, participants, and services; dates of PRT meetings, participants, and permanency barriers and connections; KS caregivers and services; and trauma screening responses and referrals to CMHCs for assessment and treatment. Each database was uploaded to HSRI’s secure relational database management system, Microsoft SQL Server Management Studio, for the purposes of storing, managing, and relating the data for analysis. Data stored in the secure management system were protected by a two-step authentication process using a least-privileged user account approach, and only members of the evaluation team who worked directly with the data had access.

Office of Behavioral Health Survey

The purpose of the web-based OBH survey was to collect information over time—in those counties receiving Waiver funding for the TSAT intervention—for children who screened positively for signs and symptoms of trauma and were then referred to a community mental health center (CMHC) for trauma assessment and treatment as needed. The primary assessment tools used by each CMHC to track children’s progress were the Trauma Symptom Checklist for Young Children (TSCYC for children ages 3 to 7 and the Child PTSD Symptom Scale (CPSS) for children and youth ages 8 to 18.

County Implementation Index

The Implementation Index, included in Appendix F, was a tool for assessing and cataloguing the degree of implementation of the Waiver interventions in each county. The Index was administered annually to assess baseline practices at the beginning of the Waiver as well as the degree to which counties were implementing the core components of the interventions and program activities to support Waiver interventions each year. It was also used to assess the timing of implementation in each county.

The evaluation team developed the Index in collaboration with State and county staff and in adherence with research findings in implementation science, a body of knowledge about the factors that help or hinder the implementation of social programs. A primary source for this knowledge is the comprehensive review of implementation research by Fixsen and colleagues.^e Fixsen et al. identify a set of “core implementation components” that are characteristic of successful efforts to install evidence-based programs with high fidelity.

^e Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

For the Process Study, the Implementation Index was used to track systems-level implementation over the course of the Waiver, describing the variability within and between interventions and counties. For additional details about the Implementation Index design and administration procedures, see Appendix G.

The Implementation Index was administered to all 64 counties across Colorado, including those not receiving Waiver intervention funding (though those counties were less likely to complete the Index).

State Administrator Interviews

Key informant/stakeholder interviews were held over the course of the Waiver period with State personnel who held specific Waiver-related responsibilities or were knowledgeable about Waiver interventions. These interviews were the sole source of state-level process and implementation information. Key informant interviews were semi-structured and conducted either with a single individual or with pairs of individuals to decrease staff burden; interviews were primarily conducted over the phone. Staff from both the Department of Child Welfare (DCW) and OBH, both within CDHS, were interviewed. The protocols were adapted throughout the Waiver. In the first year of the Waiver, information was gathered around preliminary Waiver planning processes. As the Waiver progressed, questions centered around implementation and intervention progress, challenges and successes, and technical assistance and ongoing monitoring provided to counties or regions in the Waiver. By the fifth year of the Waiver, information on intervention sustainability became the focus.

County Department of Human or Social Services Site Visits

To capture county and region-specific information on how the Waiver interventions were being implemented, county departments of human/social services were visited over the course of the Waiver period. While counties across Colorado have varying structures, the evaluation team generally met with child welfare administrators and managers, intervention leads or supervisors, caseworkers, community partners including representatives from CMHCs, and/or families. Each site (such as a county or group of counties) was visited by one to three members of the evaluation team, depending on the number of interventions the site was implementing. During the first year of site visits, representatives from the State participated in an entrance interview to kick off each site visit; in future years, CDHS staff were available by phone if needed.

To guide all interviews and focus groups, site visit protocols based on the evaluation questions and the intervention logic models were developed. The site visit process and protocols were reviewed by the Institutional Review Board at HSRI. Adaptations were made to the protocols each year of the Waiver, reflecting lessons learned and implementation progress.

Over the course of the Waiver, the following interviews and focus groups were conducted:

- Group interviews with managers and directors to gain an understanding of the overall perception of the Waiver and its purpose in each county or region.
- Interviews or group interviews with the staff member(s)/ intervention lead(s) responsible for the implementation of each intervention to gather detailed information about how each intervention was implemented by the county department of human/social services. Often, intervention leads were supervisors.
- Group interviews with CMHC representatives (clinicians, administrators) in those counties implementing TSAT to gain an understanding of the assessment and treatment phases as well as cross-system collaboration.
- Focus groups with caseworkers to understand their role in each intervention and their successes and challenges.
- Focus groups with community partners to understand the role of community partners/providers in each intervention and the successes and challenges they observed.
- Focus groups with parents in those counties implementing FFE to understand their experience with the intervention.
- Focus groups with kin caregivers in those counties implementing KS to understand their experience with the intervention.
- Focus groups with youth in those counties implementing PRT to understand their experience with the intervention.

In one site, a focus group was conducted with guardians ad litem at the request of the Colorado Office of the Child’s Representative.

Kin Caregiver Survey

In 2017, an online survey to kinship caregivers was administered in all counties receiving Kinship Supports (KS) funding through the IV-E Waiver in Colorado. The purpose of the survey was to hear directly from caregivers about their experience of the KS Waiver intervention and to assess the impact the KS intervention had on caregivers’ knowledge and capacity to provide care to children. The survey was designed after a review of current literature in the field and adapted from existing validated instruments. The online survey included demographic questions, Likert-scale questions, and open-ended questions. A draft of the survey was reviewed by the Evaluation Subcommittee, the Title IV-E Waiver Administrator, and the Kinship Care Program Administrator; revisions were made based on their feedback. After being pilot tested and finalized, the caregiver consent form, recruitment materials, and survey were submitted and approved by the Institutional Review Board at HSRI. This process insured that potential survey respondents understood that the survey was voluntary, confidential, and would not have any influence on their case. In addition,

kin caregivers were given an opportunity to opt out of receiving the survey and any related communications. A copy of the survey is included in Appendix H.

Before administration, a memo was sent to the directors of county departments of human/social services notifying them that the survey would be taking place. Caregivers were given advance notice of the survey from DCW. This email provided caregivers the opportunity to opt out of receiving the survey and any additional communication from the evaluation team related to the survey. The survey was administered electronically via Qualtrics. Caregivers had five weeks to respond. Two reminder emails were sent out to caregivers who had not yet started or completed the survey. Kin caregivers who completed the survey were emailed a \$5.00 gift card.

Process Study Samples

Trails

The intervention samples included in the Process Study were identified through case and client characteristic and intervention-specific data modules in Trails. The FFE meetings sample included child welfare cases opening on or after Feb. 1, 2014 through June 30, 2018 who were in cases that received at least one FFE meeting during a year in which their county received Waiver funding to implement FFE meetings; the PRT samples included youth 16 and older with an OPPLA goal at any point from Feb. 1, 2014 through June 30, 2018 and children and youth who were in an out-of-home removal for 12 months or longer at any point from July 1, 2014 through June 30, 2018 who received at least one PRT meeting during a year in which their county received Waiver funding to implement PRTs; the KS sample included kinship caregivers with a child welfare involved placement on or after Feb. 1, 2014 through June 30, 2018 who received at least one KS service during a year in which their county received Waiver funding to implement KS; and the TSAT screening sample included children and youth with child welfare cases opening on or after July 1, 2014 through June 30, 2018 who received a TSAT screen during a year in which their county received Waiver funding to implement TSAT.

Office of Behavioral Health Survey

The Office of Behavioral Health Survey was designed to be completed by clinicians at Community Mental Health Centers for each trauma assessment and reassessment (either a TSCYC or CPSS) completed for children referred from the county department of human/social services, as well as for each treatment instance. County departments had varying target populations for trauma screenings, but when children screened in, they were referred to CMHCs for assessment and, if recommended, trauma-related treatment.

IDENTIFYING, COLLECTING AND CLEANING DATA

Mental health clinicians entered trauma assessment and treatment data for referred children into an evaluation-specific survey housed in Google Forms; the final survey

was migrated from an earlier version in SurveyMonkey.^f The clinicians also indicated whether the PTSD Checklist for adults was administered to each child's caregiver. For children whose initial assessment at the CMHC indicated no need for treatment, no other assessment or treatment information was collected. For children whose initial assessment indicated a need for treatment, the appropriate assessment measure (i.e., the TSCYC or CPSS) was repeated and entered at a target interval of every 90 days and at the conclusion of treatment, along with data pertaining to the types of treatments recommended and received.

For HIPAA compliance, client numbers (e.g., Medicaid or Trails identification numbers) that are linked to personally identifiable information must be transferred and maintained securely. These identifiers could not be directly entered into and transmitted through the assessment and treatment records included in the earlier SurveyMonkey tool. Therefore, each CMHC received a spreadsheet from OBH that included a list of generic identification numbers specific to that CMHC. When creating an assessment and treatment record for a child in SurveyMonkey, the mental health clinician assigned one of the generic identification numbers to the record and entered a Colorado Client Assessment Record (CCAR) identification number next to the generic number on the spreadsheet. The spreadsheets were securely provided to OBH periodically, where an OBH staff member matched each generic identification and CCAR number with a Medicaid identification number. When compiling the trauma assessment and treatment data from SurveyMonkey into a spreadsheet, the OBH staff member would include a Medicaid identification number for each record. Once this process was completed for each record, the spreadsheet was securely provided to a DCW research staff member who connected each Medicaid number with a Trails identification number and then transmitted the data to the evaluation team via the team's secure file sharing server.

The data collection process using the SurveyMonkey tool and associated spreadsheets was migrated to a Google Forms process during the third quarter of 2016. By this point in time, a secure Google forms application was built by the Colorado Department of Human Services Office of Behavioral Health data management personnel, with guidance from Google. The new application was HIPAA compliant so that Medicaid identification numbers could be entered directly into the Google forms application along with the child's trauma assessment and treatment information, and the CCAR linking process was no longer needed. The text of the survey remained largely the same, except for a few clarifying changes to improve the accuracy of data entry and a few additional questions to better track case closure. The Google forms survey was used to continue collecting trauma assessment data throughout the Waiver, with data collection ending on April 30, 2018.

^f The transition from SurveyMonkey to Google Forms happened in Fall 2016; data utilized for the Interim Evaluation Report were from assessment and treatment records entered into Survey Monkey.

DATA AND SAMPLE CHALLENGES

There were considerable data limitations related to the Office of Behavioral Health Survey, resulting in limited samples for the Process Study. Evaluating the TSAT interventions involved additional data collection challenges resulting from the complex cross-system structure of the trauma interventions. Because DCW and OBH house data separately, Trails could not be utilized to store trauma assessment and treatment data collected by mental health clinicians. Because clinicians at CMHCs who conducted trauma assessments and delivered trauma treatment could not access or enter their data into Trails, OBH built an online survey for CMHC clinicians to enter assessment and limited treatment data at the beginning of the Waiver (as discussed above). Granting evaluation team access to these data (even though they were designed specifically for the evaluation) required a formal, separate data-sharing agreement between OBH, DCW, and HSRI.

During the first half of the Waiver, the two-step CCAR linking process required for SurveyMonkey records (as discussed above) became a challenge, as some of the generic IDs entered into SurveyMonkey either did not correspond with the generic IDs listed on an associated encrypted spreadsheet, or the spreadsheets were not maintained by CMHCs and/or sent to OBH. This issue was reported in the interim evaluation report and in semiannual progress reports.

In response to these challenges, during the second half of the Waiver trauma intervention (October 2016 through April 2018), the SurveyMonkey process was replaced by the HIPAA-compliant process using Google Forms, which removed the need for separate transmission and storage of assessment data from child identifiers; the goal was that this would decrease the chances of unusable and unidentifiable child assessment and treatment records. The Google Form was implemented with training for the CMHCs and substantially addressed the challenges with linking child assessment data to child identifiers (the purpose of linking with ID was to enable later linking of assessment data with a specific child's child welfare outcomes). However, even though the linking process was no longer necessary, there were still limitations with the data which came out of Google, such as missing Medicaid IDs, incorrect Medicaid IDs which could not be linked with Trails IDs, assessments without dates, and subsequent assessments for children where no initial assessments were recorded. Further, some CMHCs were considerably underrepresented in the data.

In the final OBH survey assessment and treatment file used for the analyses in this report, there were a total of 1,104 assessment and treatment records. The 1,104 itself was likely an undercount of the children and youth who received assessments and treatment, as OBH could not recover many of the linking spreadsheets required for the SurveyMonkey data (in addition to the other data limitations noted above). Of those records, the evaluation team was able to determine that 780 children between the ages of 3 and 18 received a trauma assessment. While the data limitations impacted some of the Process Study analyses, they were considerably more limiting for the Outcome Study; while some records that did not have Trails IDs could be used for the adherence and reach analyses for the Process Study, no records without Trails

IDs in the Outcome Study could be used as the IDs were required to match children for the matched case comparison.

County Implementation Index

The Implementation Index was administered annually to all 64 counties across the state. The Index was emailed to the director of human or social services and/or the director of child welfare. Directors were then encouraged to collaborate with their staff most familiar with the interventions to complete the Implementation Index. Therefore, each county completed one index, but multiple staff members may have participated within counties and across years. Implementation index completion rates increased from the first to the final year of the Waiver, with the highest response rate in year five at 92% or 59 counties.

Table 2. Implementation Index Response Rates

Year	Number of Colorado Counties That Completed the Index (n=64)	Percentage of Colorado Counties That Completed the Index (n=64)
Year One	47	73%
Year Two	54	84%
Year Three	58	91%
Year Four	56	88%
Year Five	59	92%

Source: Implementation Indexes

State Administrator Interviews

Sampling for State administrator interviews was purposive, with the evaluation team interviewing those staff with direct knowledge and oversight related to Colorado's Waiver. Over the course of the Waiver, 23 interviews were conducted with 12 staff members from DCW and OBH, including research staff, program and intervention staff, Waiver administrators, and CDHS/DCW leadership.

County Department of Human or Social Services Site Visits

Like key informant interviews, county-level sampling for site visits was purposive in nature, based on a number of factors. The sites that received visits were purposively selected to represent the range of variability of specific factors of interest. These factors included but were not limited to: county or region size, location, foster care population, number of and type of interventions implemented, level of intervention implementation, and geographic proximity to other counties. These factors were flexible to allow the evaluation team to remain adaptable to current implementation progress. For example, in year two, particular attention was paid to counties implementing TSAT; these interventions were not implemented at the time of the year one site visits and, therefore, there were fewer data related to that intervention. Additional flexibility was incorporated into regional site visits, as levels of collaboration and staffing structures varied by region; the visits were often centralized in one county (typically the fiscal officer county), but representatives from other counties joined in person or via phone. In sum, 30 counties during the five-year

demonstration were visited. Nineteen counties were visited in multiple years of the Waiver period, so 49 visits in total were conducted.

Recruitment of appropriate staff and clients was left up to county directors, managers, or other site visits contacts, though the evaluation team provided guidance. Therefore, sampling for staff interviews and focus groups (such as those with intervention leads and caseworkers), as well as community partner and CMHC staff, was purposive—those staff with relevant knowledge related to the Waiver were invited. Client focus group sampling was somewhat purposive in that clients needed to receive the Waiver intervention(s), but it was also convenience-based as county staff recruited clients who they were able to reach and confirm. Table 3 displays the total number of site visit participants by interview or focus group type. Some representatives were duplicated from year to year, as the same staff participated in interviews or focus groups as the Waiver progressed. Of the 202 total clients who participated in focus groups, 71 were parents or others involved in FFE, 95 were kinship caregivers involved in KS, and 36 were youth involved in PRT.

Table 3. Site Visit Participants by Role

Interview or Focus Group Type	Total Participants
Directors and Administrators	154
Intervention Leads/Supervisors	212
Caseworkers	204
Community Partners, including GALs ^g	103
CMHC Representatives	25
Clients	202
Total	900

Source: Site visit participant counts

Kin Caregiver Survey

The sample for the kin caregiver survey was purposive. Recruited caregivers were those who had completed at least one KSNA, which was logged in Trails as a contact type being KSNA, at any time since the beginning of the Waiver and were from a county receiving Title IV-E Waiver intervention funds for KS. The sample was also limited to only those caregivers who had an email address in Trails, as an electronic survey was considered the most appropriate administration method and the least burdensome to county staff. These parameters resulted in 750 caregivers who received an invitation to complete the survey via email; 232 surveys were completed, for a response rate of 31%.

SAMPLE CHALLENGES

Based on the caregiver demographic and characteristic results, it appears that the sample was likely not representative of all kin caregivers in Colorado. For example, caregiver income was higher for this sample than for all caregivers as reported in the literature. This could be the result of our sampling method which required caregivers

^g One focus group was conducted with Guardians ad Litem (GALs).

to have active email addresses in Trails and was, of course, then limited to caregivers who checked their email and had time to complete the survey. Although 750 active caregiver email addresses were pulled out of Trails, a total of 4,913 caregivers received a KSNA throughout the Waiver; consequently, 15% of caregivers who received an assessment were sampled.

KIN CAREGIVER CHARACTERISTICS

The following figures display the demographics of the caregivers who responded to the survey. On the following pages, the sample characteristics, including caregiver sex and race, relationship and employment status, age, income, number of children in care, and relationship with kin children, are displayed. In addition, 43% of caregivers had temporary court ordered custody, 12% had permanent court ordered custody, 15% had no legal status, and 30% of caregivers had other forms of legal status with the kin child(ren) in their care. The majority of kin caregiver respondents had one child in their care.

Figure 1. Caregiver Sex, Race, Relationship Status, and Employment Status (N=211)

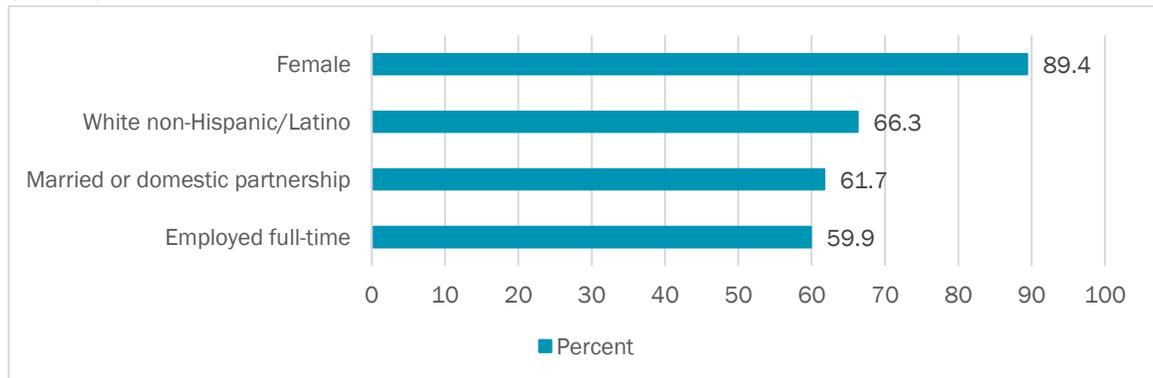


Figure 2. Caregiver Age (N=188)

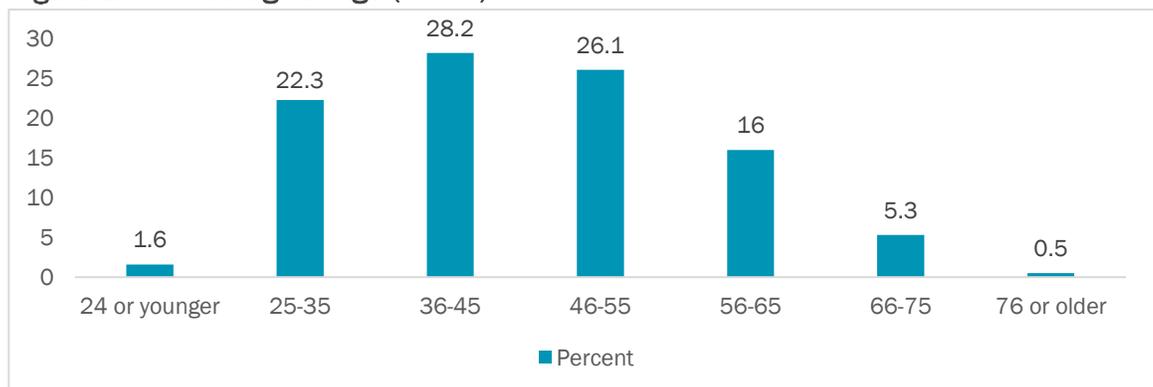


Figure 3. Caregiver Income (N=186)

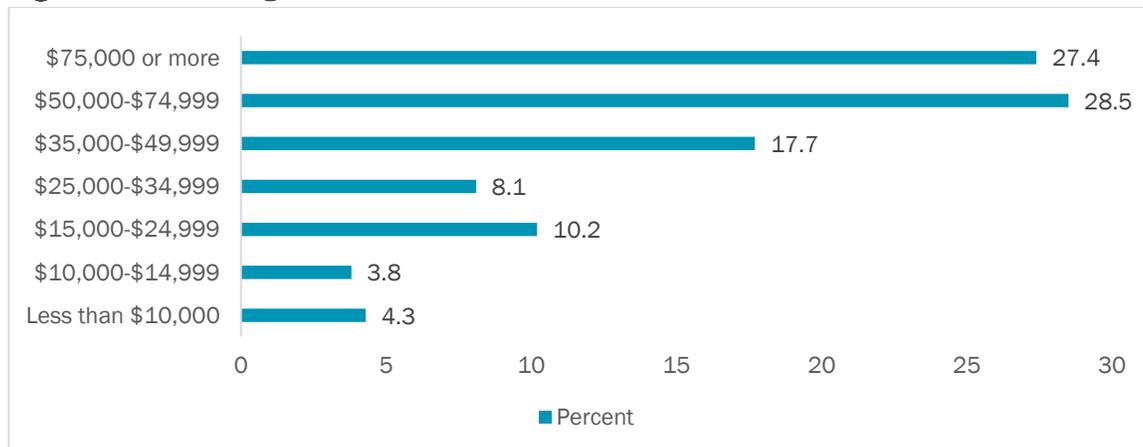


Table 4. Relationship of Caregiver to Kin Children

Relationship	Percent (n=211)
Grandparent	39%
Aunt/Uncle	31%
Non-relative	21%
Other relative (e.g., cousin, sibling)	9%

Process Study Data Analysis

Multiple data analyses were conducted for the Process Study; methods varied by data source.

Trails

The Process Study analyses of Trails data for this report included the calculation of target population reach and case-level adherence measure rates for cases receiving each intervention. The adherence rates for each intervention encompass the major components of the intervention as detailed in CDHS’s Initial Design and Implementation Report and are calculated across counties receiving funding for the intervention. The rates calculated for this report are based on Trails data spanning from Feb. 1, 2014 through June 30, 2018. As previously mentioned, though the Colorado Waiver officially started on July 1, 2013, it was necessary to establish the begin date for the time span as Feb. 1, 2014 because the Trails frameworks that house the data for the interventions were not completed until that time. The end cutoff date for the time span was set as the last day of the five-year Waiver period, June 30, 2018.

Office of Behavioral Health Survey

The Process Study analyses of the OBH survey for this report included descriptive rates and means for cases receiving trauma assessment and treatment services, as

well as trauma treatment reach and adherence rates. Four trauma assessment and treatment descriptive measures were examined, including the number of children who received an initial assessment, the number of children who received a follow-up assessment, the mean number of days between initial and first follow-up assessment for those children receiving a follow-up assessment, and the percentage of children with an initial assessment whose caregiver was also administered a Post-Traumatic Stress Disorder Symptom Checklist for Adults. The rates calculated for this report were based on assessment and treatment data spanning from July 1, 2014 through April 30, 2018. The begin date was established for the analyses because the trauma interventions started at the beginning of year two of the Waiver, and the end date was established to include assessment and treatment data for children who were screened and referred by child welfare throughout as much of the Waiver time period as possible; data collection ended two months before the actual end of the five-year demonstration project since linking between OBH and DCW was required unlike the other Waiver interventions.

County Implementation Index

Each item on the Index pertained to a specific component of implementation and was scored as one point. For yes-or-no response items, a “no” response (meaning the component was not in place) received a score of zero and a “yes” response (meaning the component was in place) received a score of one. Likert scale response scores ranged from zero to one, depending on the degree to which the component was in place. For example, items with possible responses ranging from “none of the time” to “all of the time” received a score of 0.00 if “none of the time” was indicated, 0.25 if “some of the time” was indicated, 0.75 if “most of the time” was indicated, and 1.00 if “all of the time” was indicated. The items within each implementation domain were then weighted equally depending on the number of items pertaining to the domain and summed for a total score of up to 20 points for the domain. Because there were five core implementation domains for each intervention, a county could receive a score that ranged from 0 to 100, with higher scores indicating greater overall levels of implementation of the core components than lower scores.

Analysis of the Implementation Index primarily focused on variability across years, interventions, intervention domains, and county size groupings. For all counties receiving Waiver funding for the intervention, the following was calculated: the mean implementation scores for each of the Waiver interventions by year; the mean implementation scores for each of the Waiver interventions by year and county size groupings; and the mean implementation scores for each of the Waiver interventions by year and domain for each of the county size groupings.

ANALYSIS LIMITATIONS

Given the complexity of county participation in the Waiver interventions, the intervention by cohort—such as those counties that opted into FFE during the first year of the Waiver, second year of the Waiver, etc.—were not examined. Therefore, the index measured implementation each year for all counties implementing the intervention, whether it was an individual county’s first year, second year, third year,

etc. Therefore, implementation scores each year are somewhat impacted by those counties in the first year of implementation. However, this effect is likely minimal as the majority of counties opted into interventions earlier on.

State Administrator Interviews

State administrator interview data were cleaned (or notes transcribed) and prepared for analysis; administrator interview data were coded by hand to enable coder familiarity with the data. Relying on content analysis and constant comparison method, theme identification was used to look at the interviews across Waiver years to identify information related to Process Study research questions and areas of inquiry, such as organizational and structural aspects of the demonstration, contextual factors influencing the intervention, and co-occurring initiatives.

County Department of Human or Social Services Site Visits

Site visit data were cleaned (or notes transcribed) and prepared for analysis. Notes were uploaded to the Dedoose online qualitative software package to facilitate qualitative axial and thematic coding. Grounded theory and content analysis methodologies guided the analysis, comparing themes that emerged across counties. Themes related to the type of staff involved in interventions at the county level, service delivery and intervention factors, the role of the courts in the demonstration, and the relationships between local county departments of human/social services and partner agencies were identified. Client focus group data were analyzed for client perspective on service delivery, array of available services, and experience with child welfare.

Site visit data were analyzed by year. Site visit data from five selected counties, which received multiple site visits over the Waiver, were also analyzed longitudinally.

Kin Caregiver Survey

The survey data were analyzed using descriptive statistics including frequencies, percentages, and means for the demographic, characteristic, and survey responses for the KSNA, financial support, and kin caregiver experiences. Inferential statistics including t-tests and ANOVAs were used in the sub-analyses for caregiver demographics/characteristics and the survey responses.

Process Study Results

In this section, the results of the process analyses are presented, organized by the four primary Process Study outputs: county capacity to implement the Waiver interventions; Waiver intervention adherence and reach; state and county context and practice during the Waiver; and client perspective and caregiver knowledge and capacity. These outputs incorporate and integrate the data sources described previously. This section is followed by a discussion and synthesis of the findings.

County Capacity to Implement the Waiver Interventions

The annual County Implementation Index allowed for an exploration of county capacity to implement the core components of the five Waiver interventions. Below, implementation variability across Waiver years, interventions, and county size groupings is demonstrated. Possible implementation scores ranged from 0-100, where emerging implementation was considered the lower-third and high implementation was considered the highest third. The figures on the following pages show mean scores for overall implementation across the interventions, intervention-specific implementation by county size, and then intervention domain implementation by county size, beginning with FFE and concluding with TSAT.

The index captured core Waiver components across five domains:

- Target population, which measured which populations counties were serving through their interventions, case events that triggered intervention services, intervention models used, and the extent to which or frequency with which populations were served.
- Staffing and roles, which measured the staff positions in place to deliver Waiver intervention services and job descriptions related to Waiver staff positions.
- Training, which measured the type of, quantity of, and content of trainings received by key intervention staff and caseworkers.
- Tools, which captured county use and frequency of use of intervention-specific frameworks (such as Trails), measures or assessments (such as the KSNA or trauma screen).
- Policies, which captured county development and use of policies and procedures to guide the delivery of the intervention, intervention adherence, staff responsibilities, documentation, and service authorization.

COUNTY IMPLEMENTATION INDEX RESULTS

Figure 4. Overall Implementation of Waiver Interventions

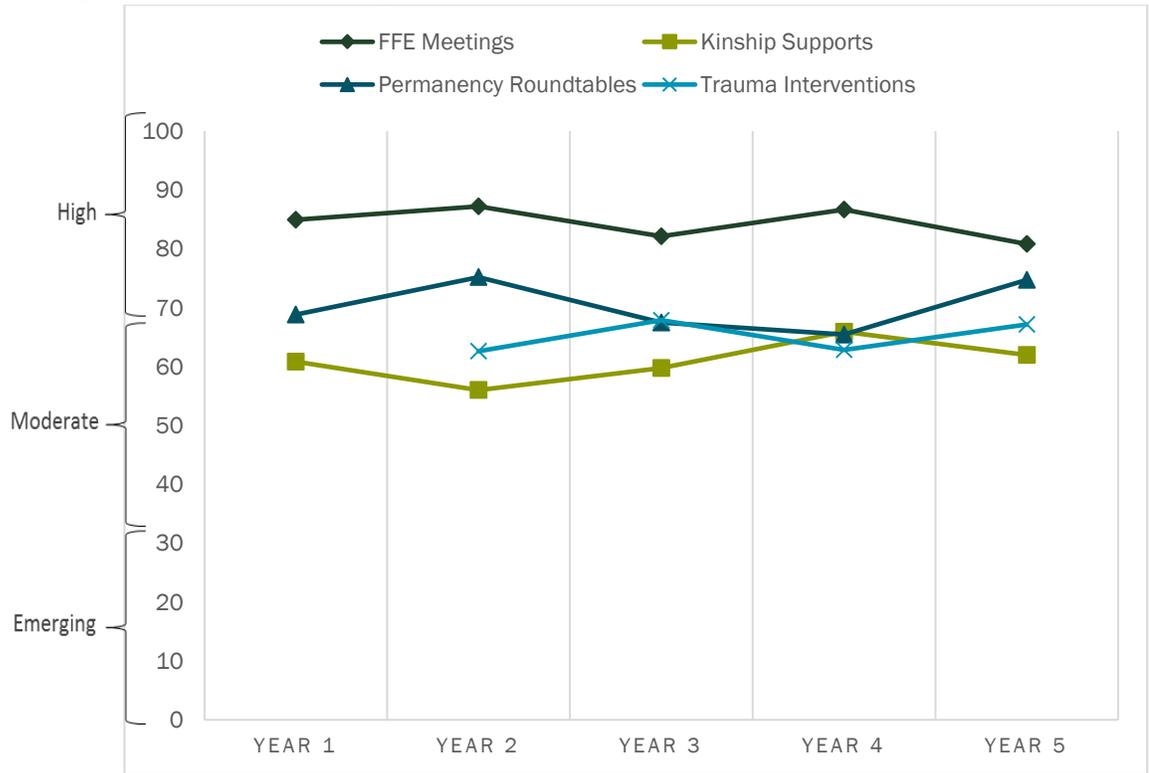


Figure 5. Overall Implementation of FFE by County Size

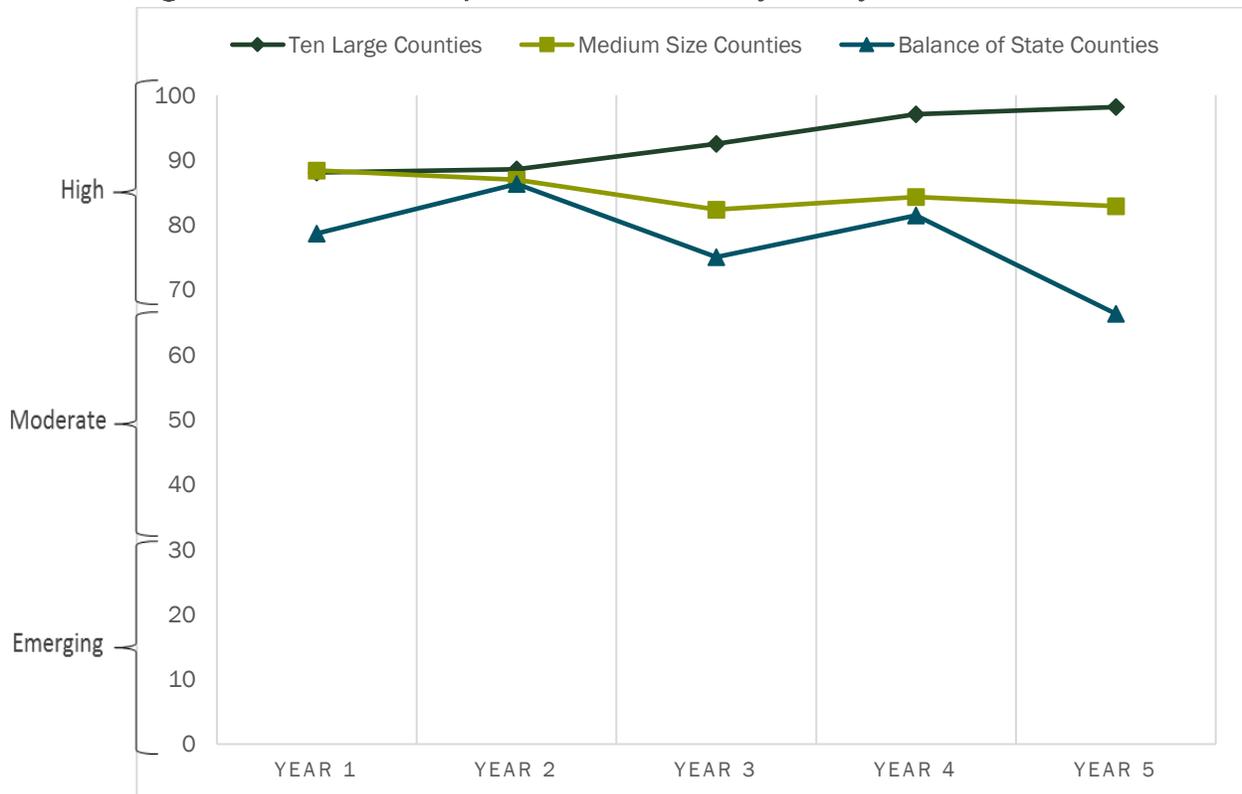


Figure 6. Implementation of FFE by Domain in Large Counties

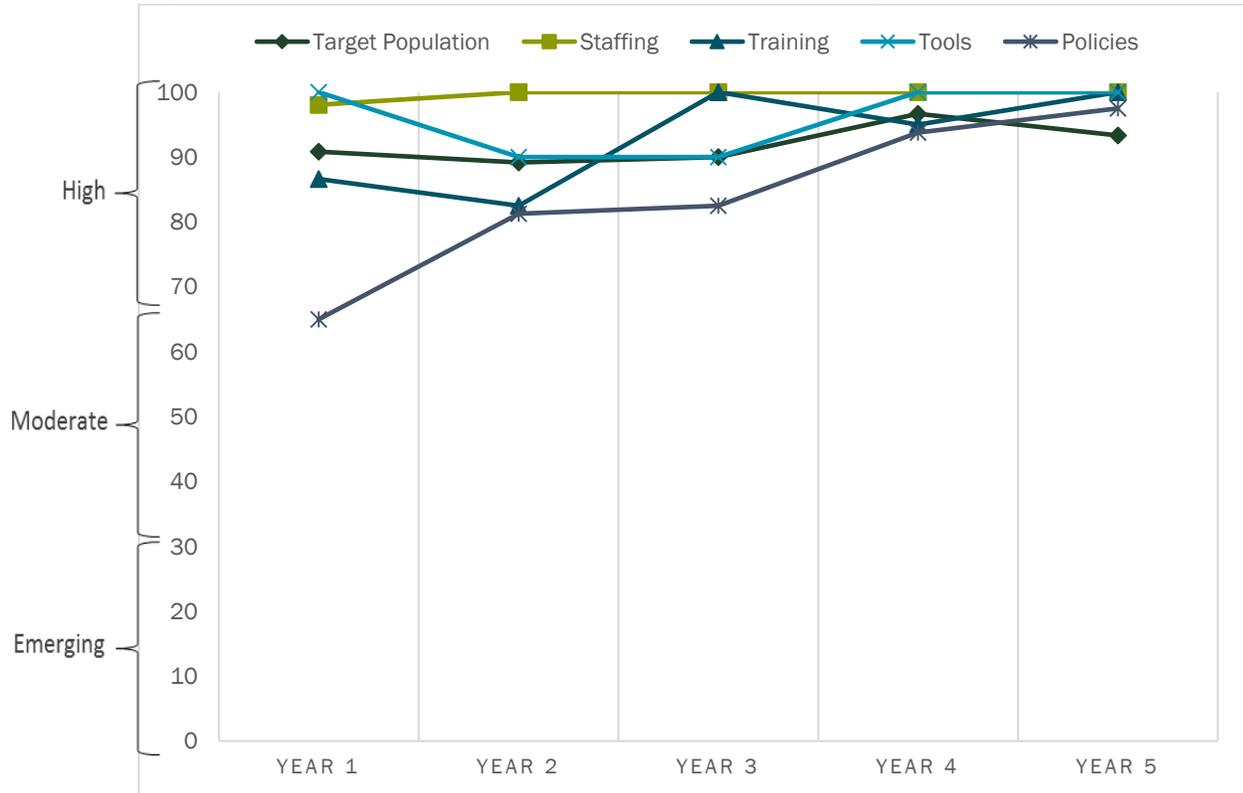


Figure 7. Implementation of FFE by Domain in Medium Counties

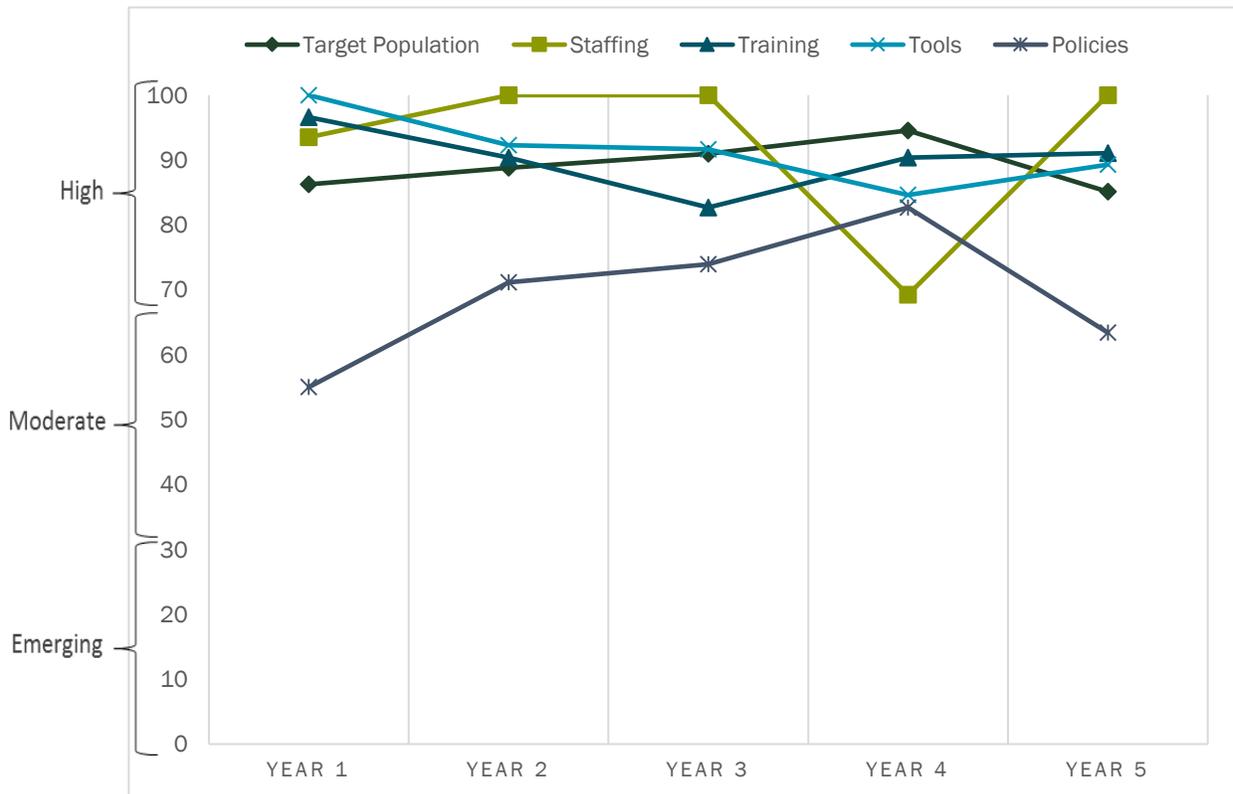


Figure 8. Implementation of FFE by Domain in Small Counties

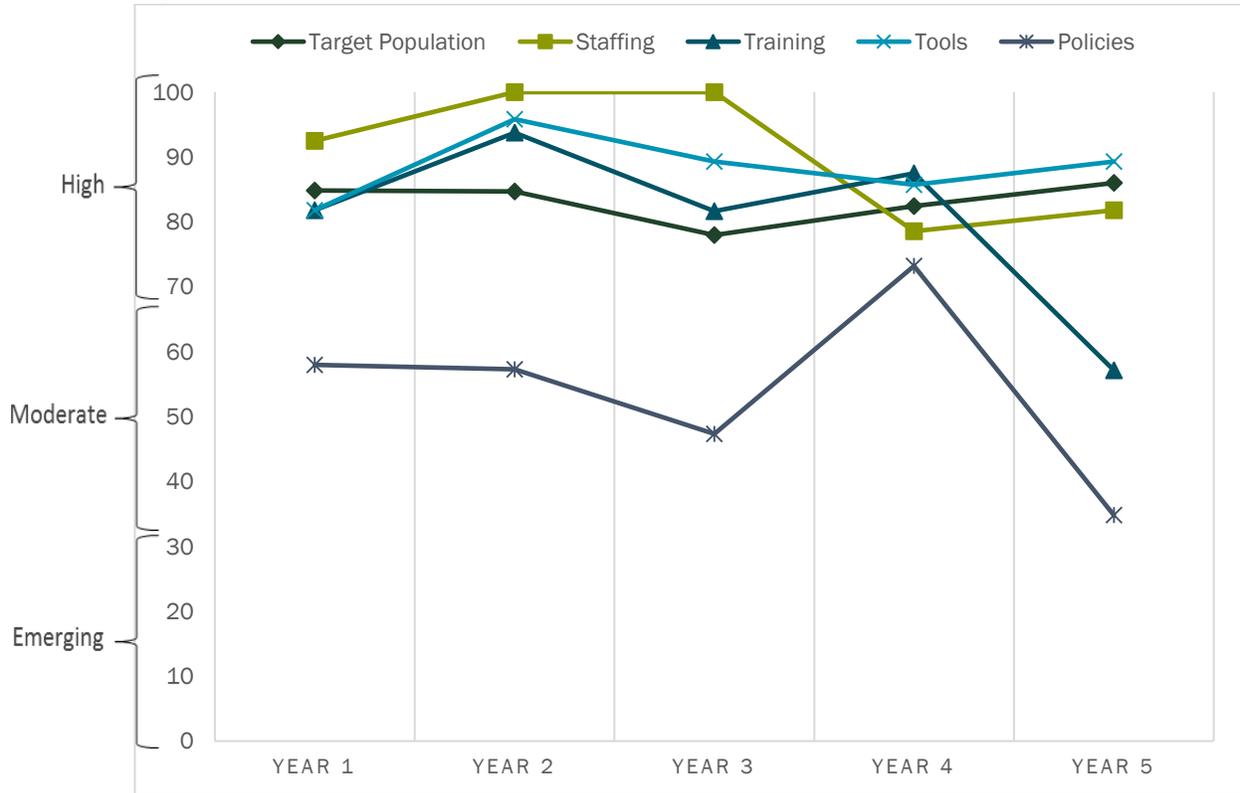


Figure 9. Overall Implementation of KS by County Size

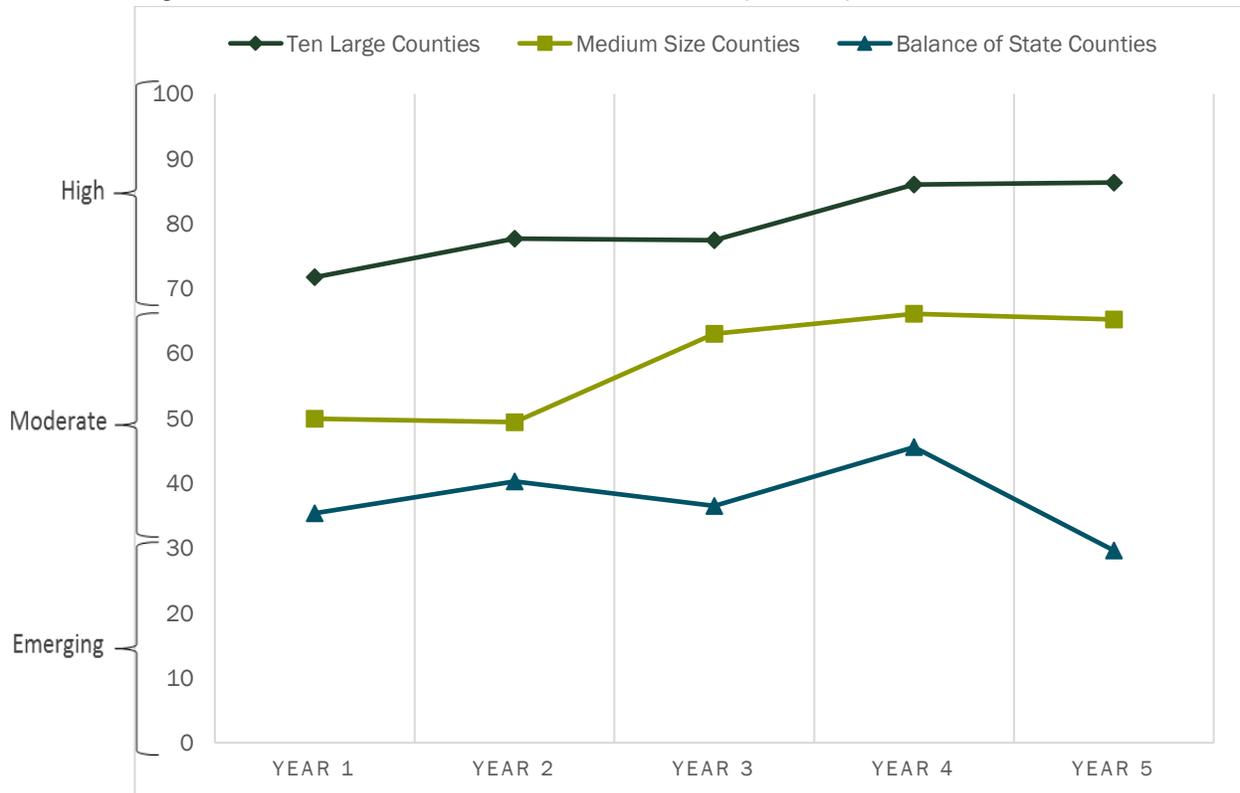


Figure 10. Implementation of KS by Domain in Large Counties

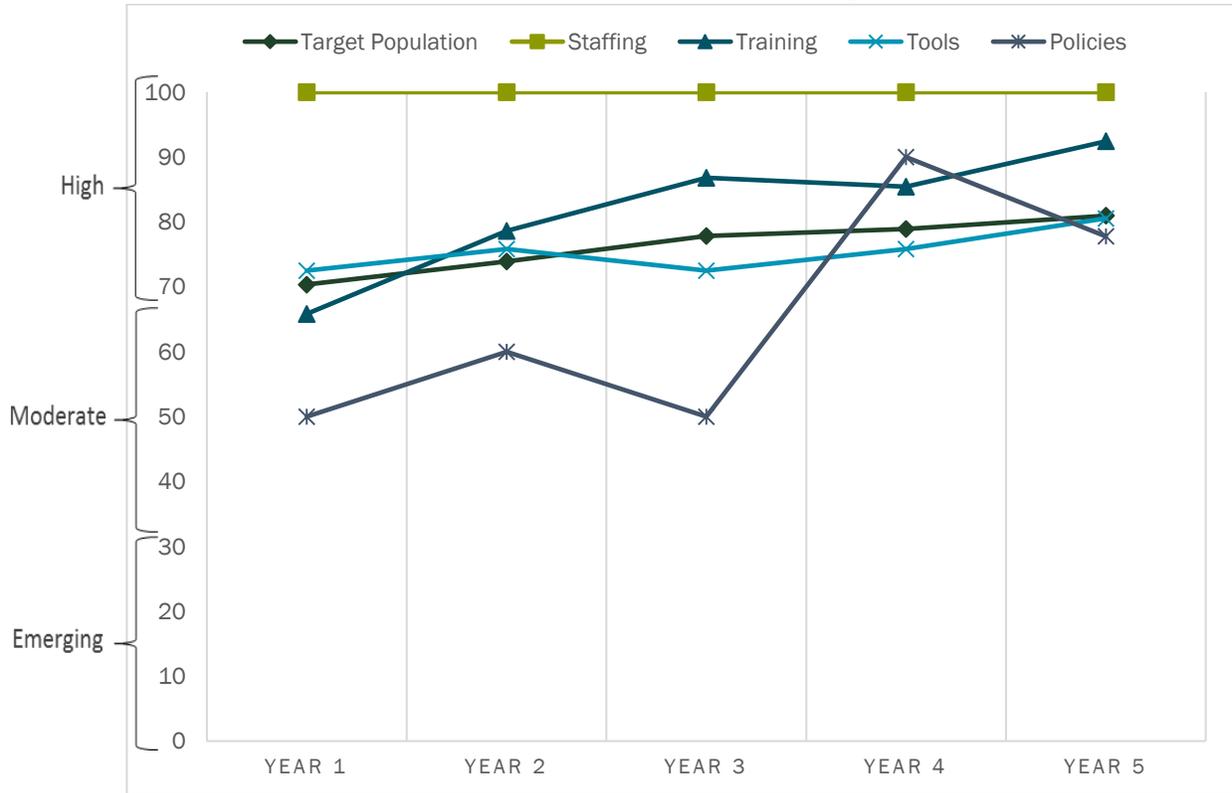


Figure 11. Implementation of KS by Domain in Medium Counties

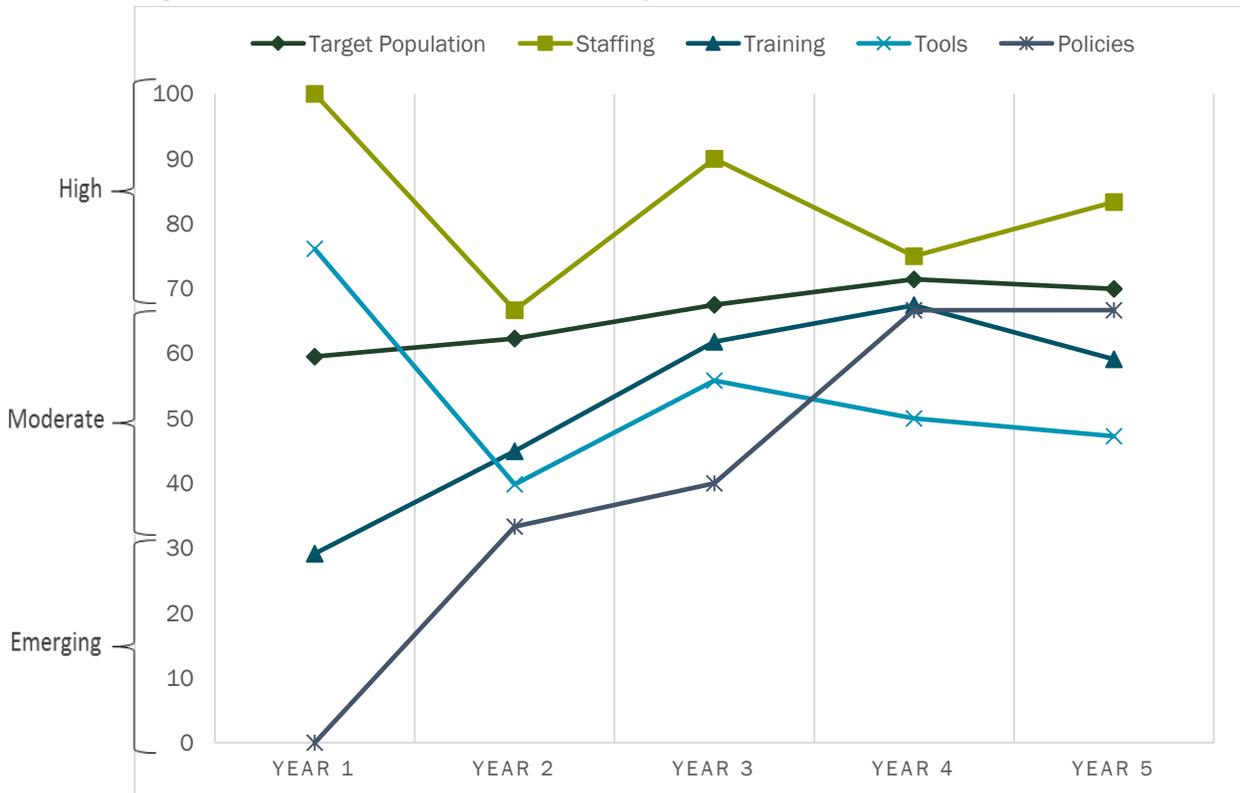


Figure 12. Implementation of KS by Domain in Small Counties

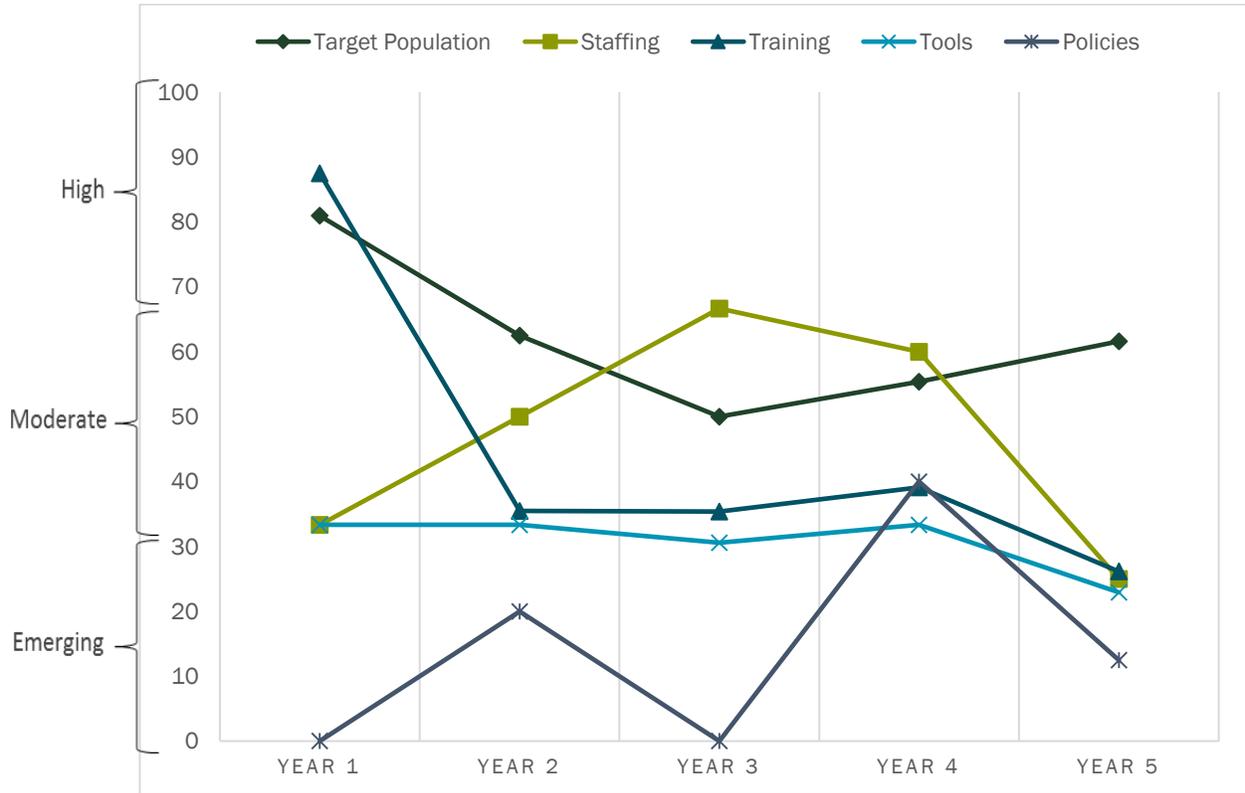


Figure 13. Overall Implementation of PRTs by County Size

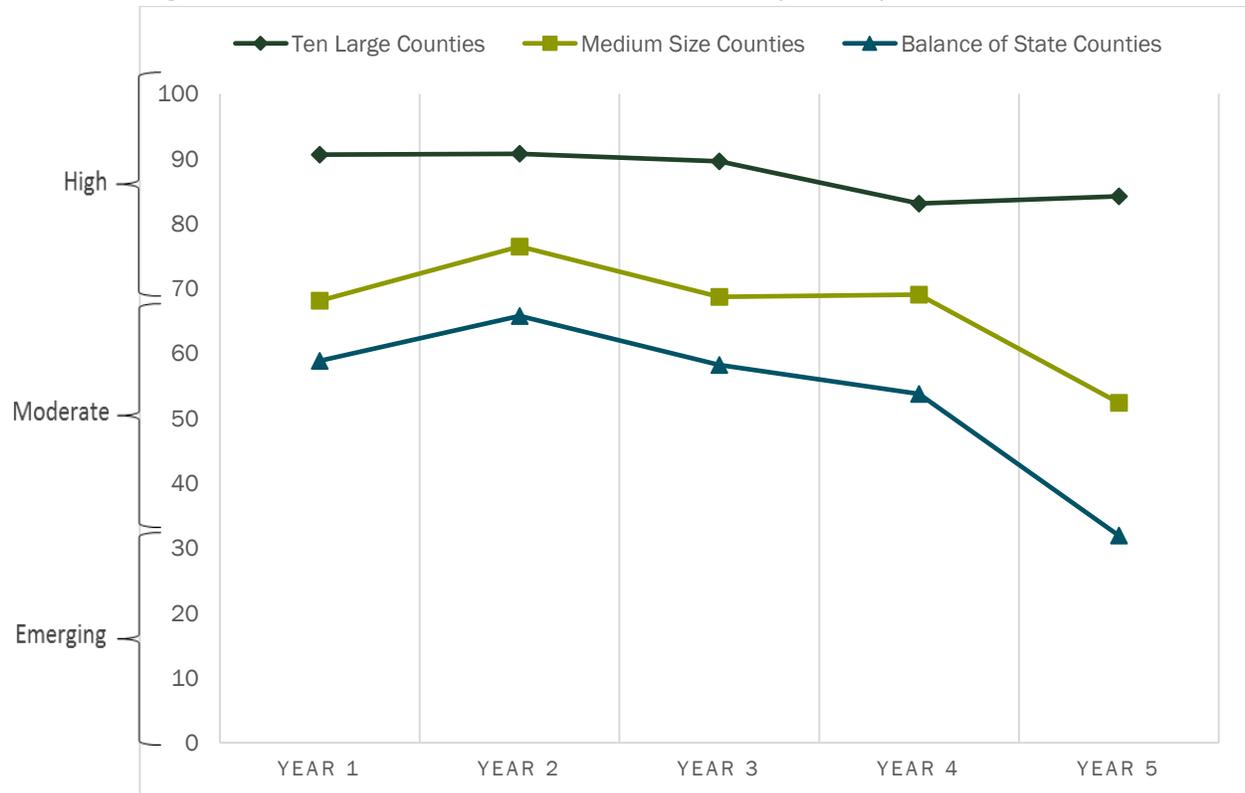


Figure 14. Implementation of PRTs by Domain in Large Counties

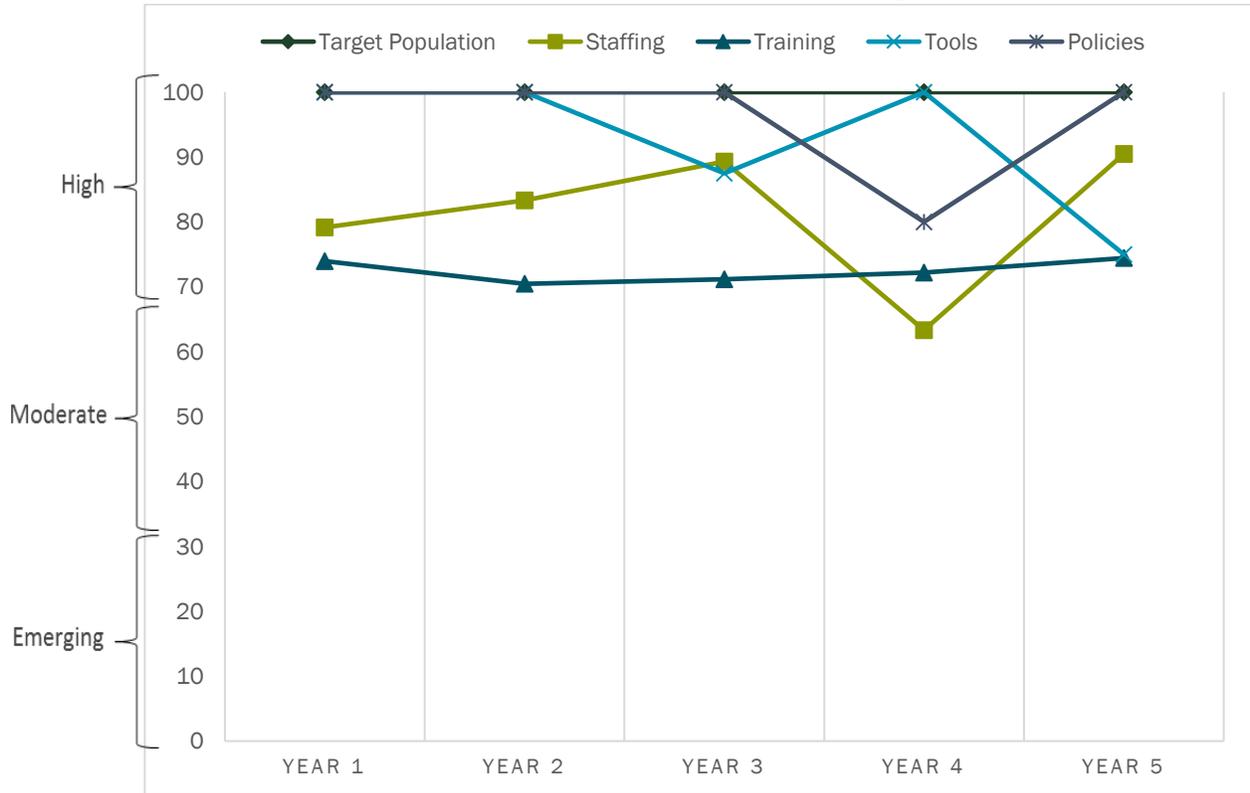


Figure 15. Implementation of PRTs by Domain in Medium Counties

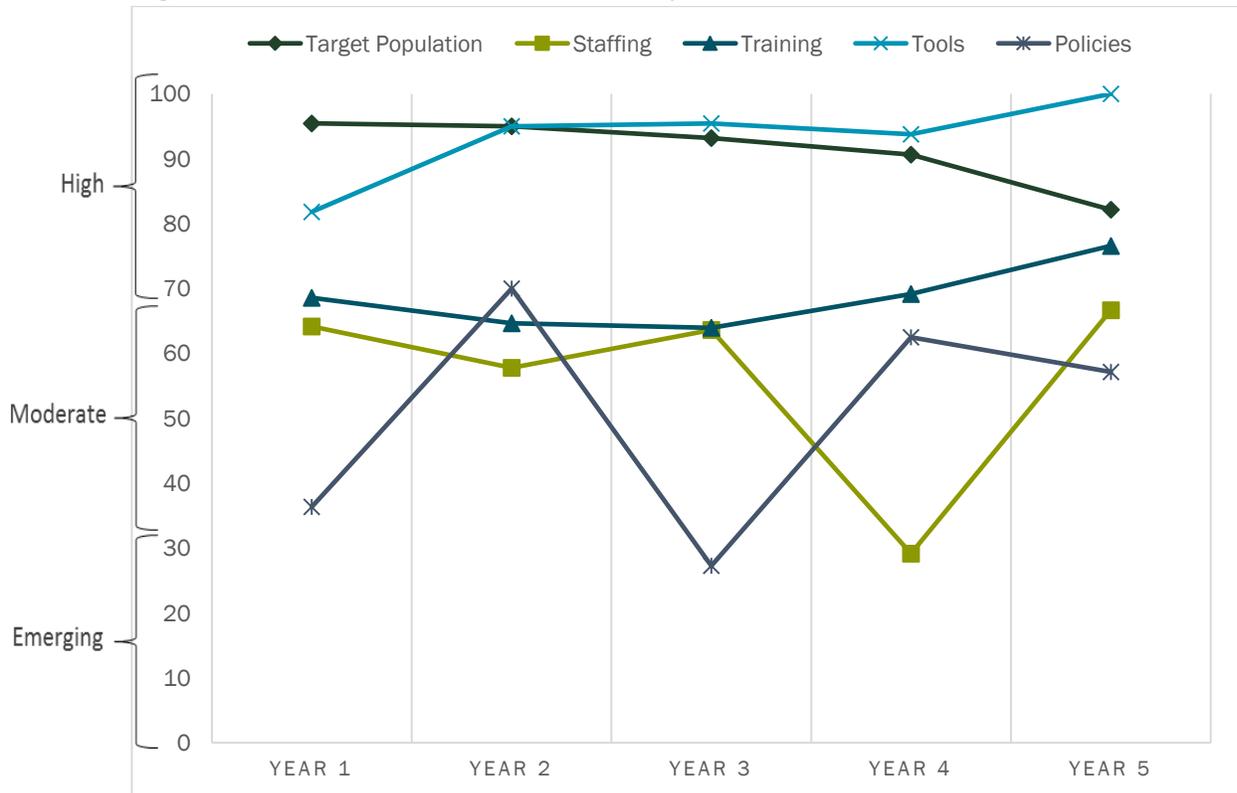


Figure 16. Implementation of PRTs by Domain in Small Counties

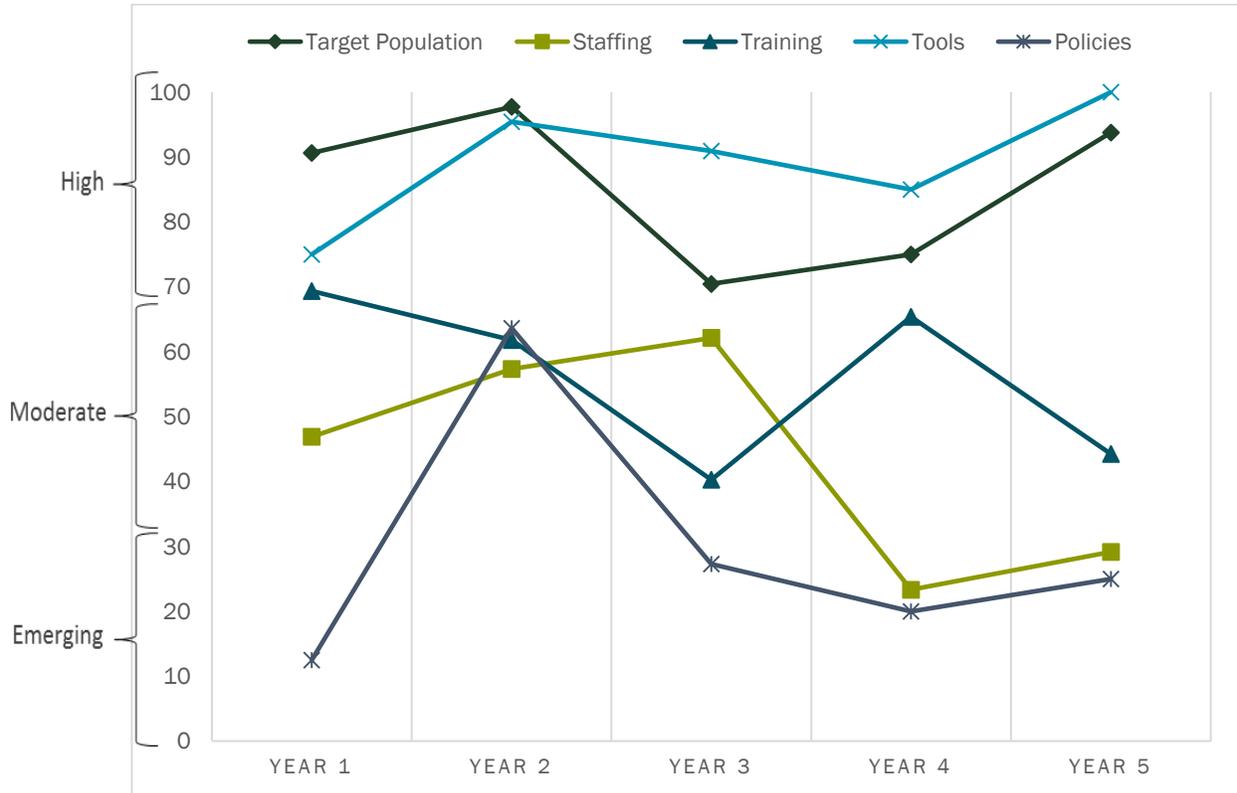


Figure 17. Overall Implementation of TSAT by County Size

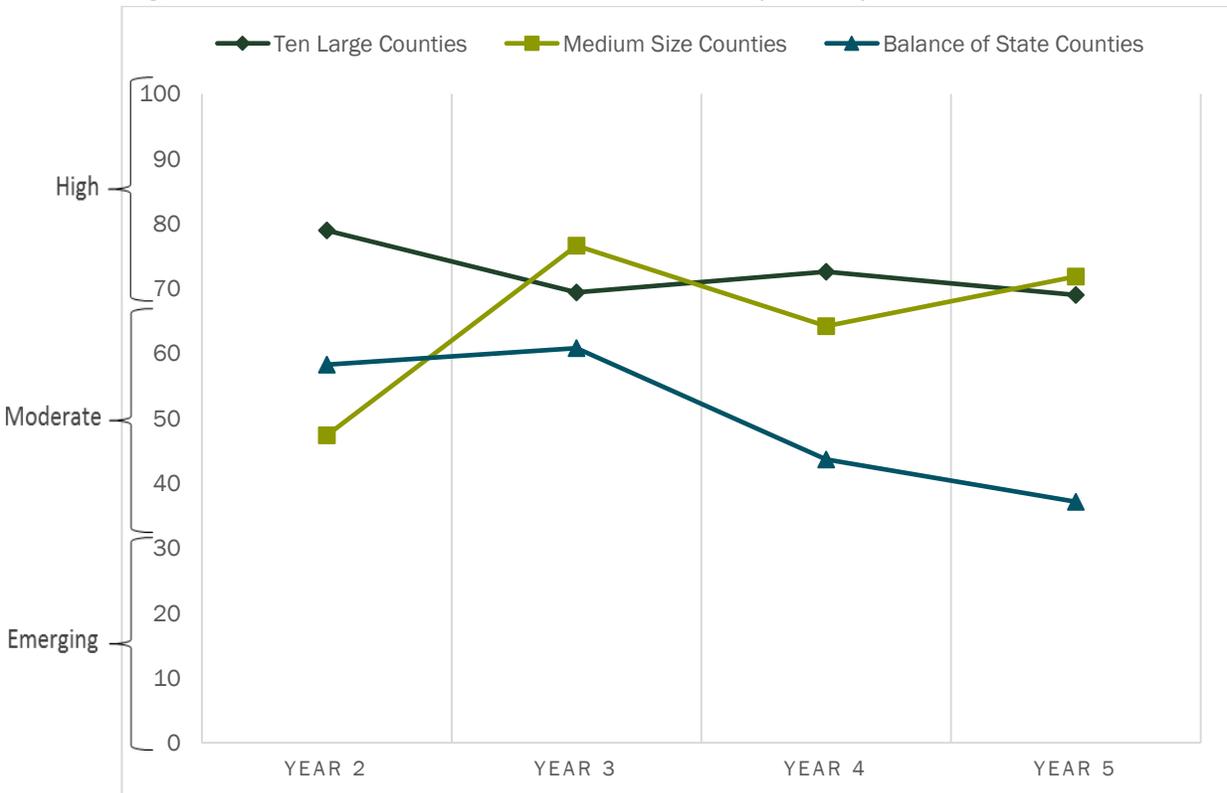


Figure 18. Implementation of TSAT by Domain in Large Counties

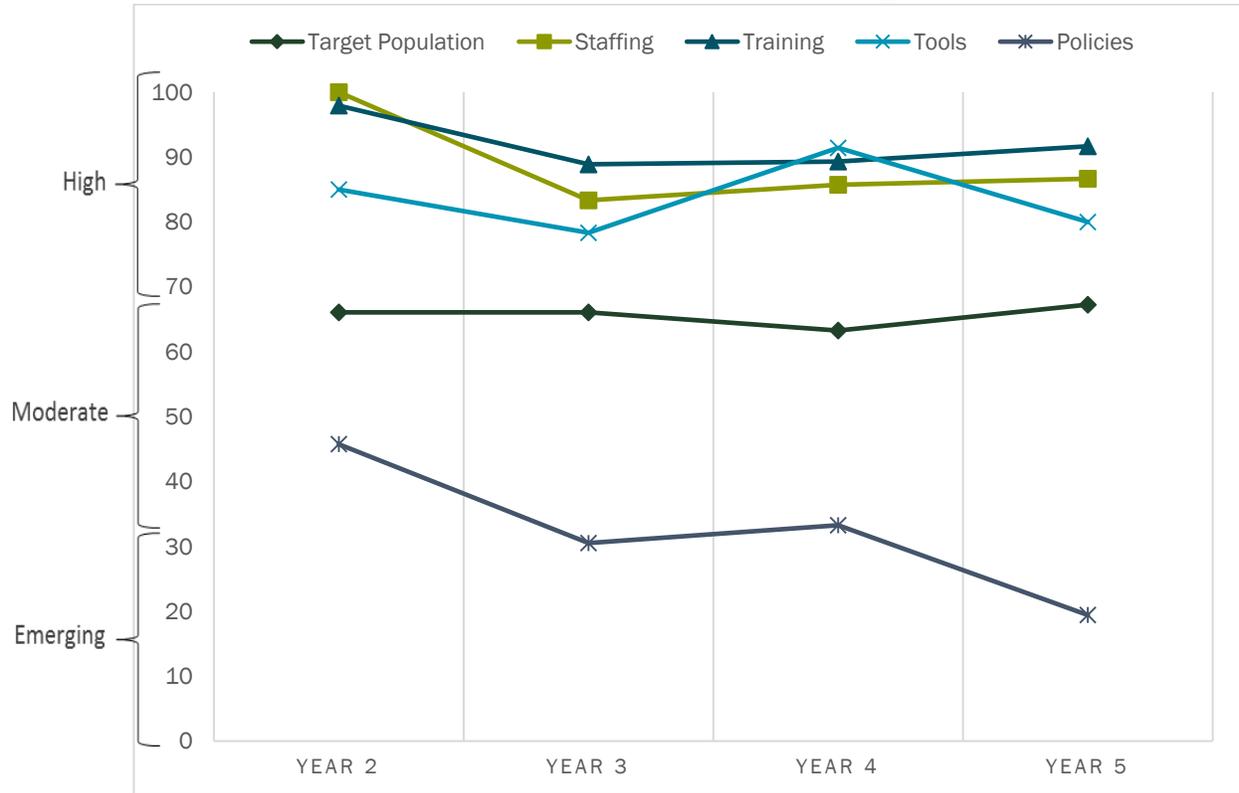


Figure 19. Implementation of TSAT by Domain in Medium Counties

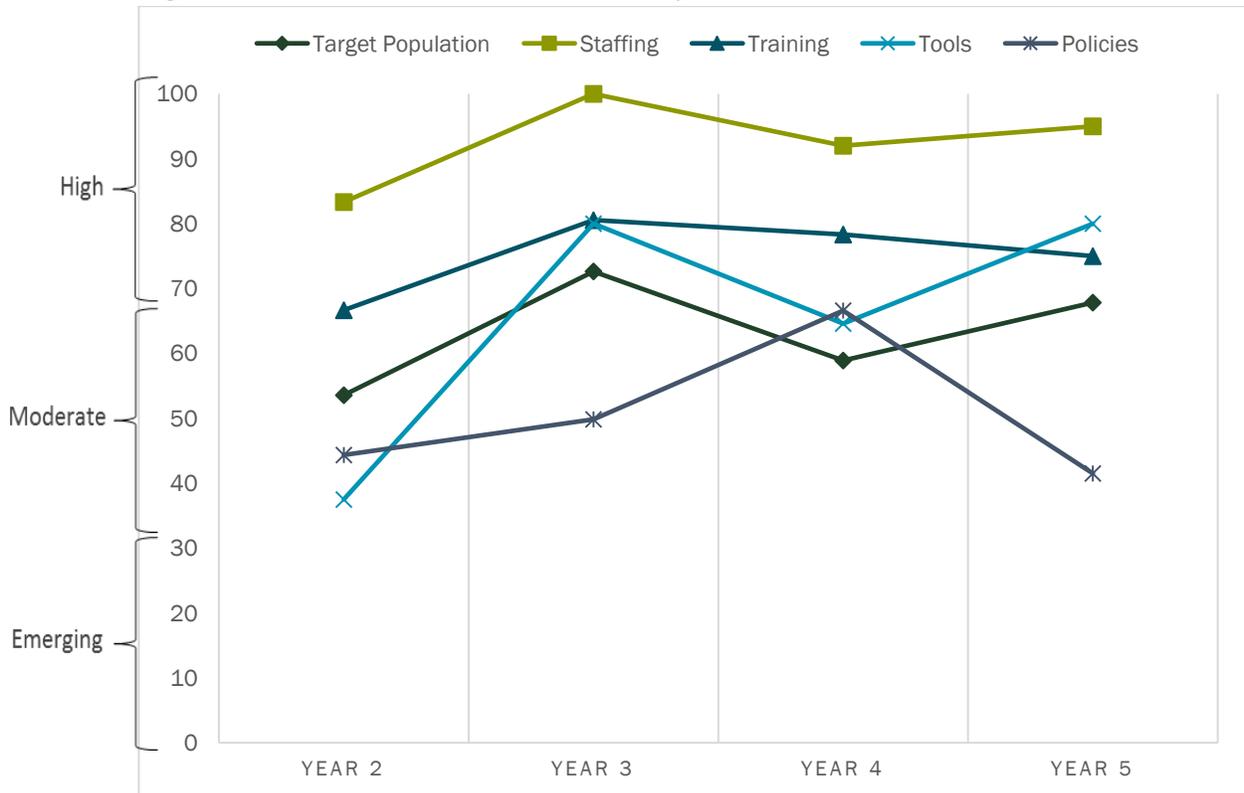
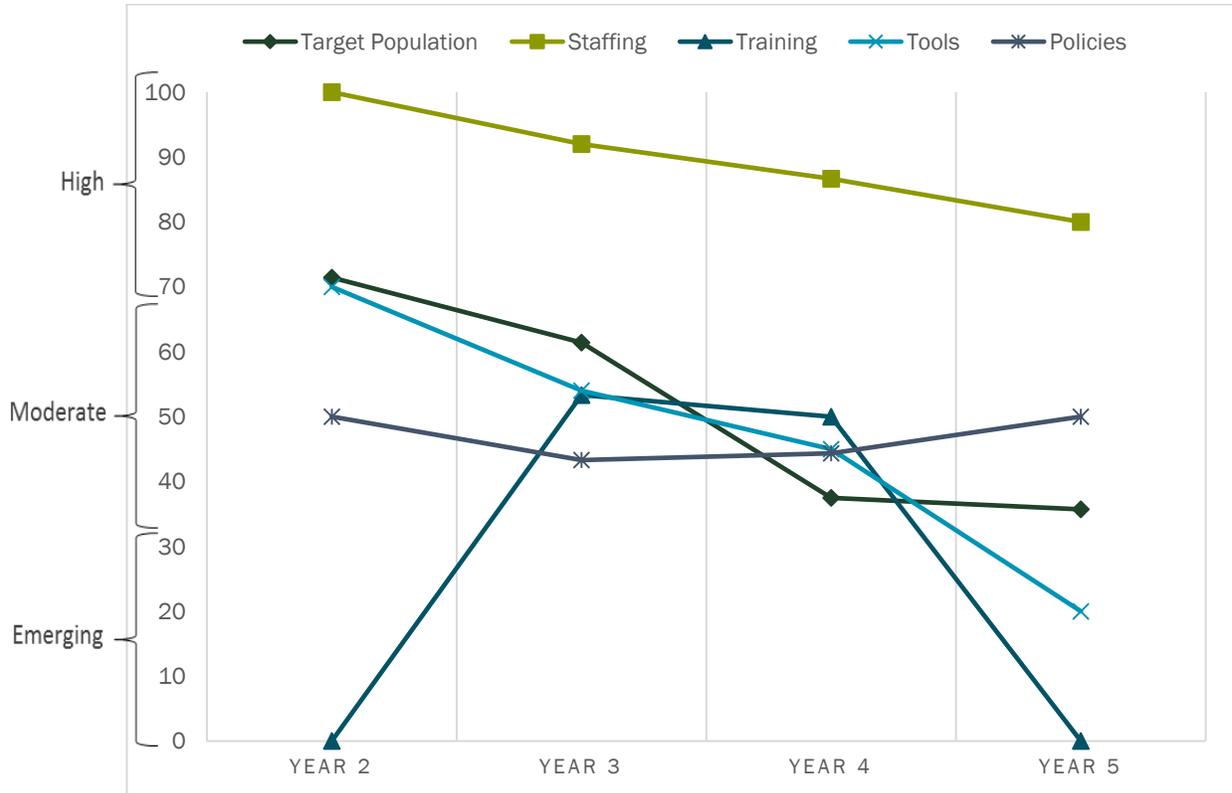


Figure 20. Implementation of TSAT by Domain in Small Counties



Waiver Intervention Reach and Adherence

The following results are related to intervention adherence and reach, organized by intervention. Data from Trails and the OBH Survey are used to calculate the results.

FACILITATED FAMILY ENGAGEMENT

The following tables show FFE reach and case-level adherence rates; Table 5 includes all out-of-home children and youth who were eligible for the intervention and received at least one FFE meeting, and Table 6 includes all in-home children and youth who were eligible for the intervention and received at least one FFE meeting.

Table 5. FFE Adherence and Reach for Out-of-Home Children and Their Families

Adherence Measure	Families Served		Children in Families Served	
	#	%	#	%
Intervention Reach (eligible¹ who received at least meeting)	8,932	81.5%	14,442	84.4%
Initial Meeting Timeliness (days after case open)				
Within 7 business days	2,915	32.6%	4,780	33.1%
8 to 15 business days after the case opening date	897	10.0%	1,445	10.0%
16 to 30 business days after the case opening date	889	10.0%	1,422	9.8%
More than 30 business days after the case opening date	4,231	47.4%	6,795	47.1%
Subsequent Held Meeting Timeliness (within 90 days of each other)²				
100%	1,892	27.0%	3,029	25.9%
75% to 99%	809	11.5%	1,539	13.1%
50% to 74%	1,737	24.8%	3,007	25.7%
< 50%	2,574	36.7%	4,137	35.3%
Consistency (every 90-day time window from the initial meeting to case close³ with a held meeting)				
100%	1,004	12.2%	1,588	11.8%
75% to 99%	672	8.2%	1,239	9.2%
50% to 74%	2,777	33.7%	4,664	34.7%
< 50%	3,777	45.9%	5,968	44.3%
Required Participants (held meetings with at least a parent, caseworker, facilitator, and parent identified support in attendance)⁴				
100%	4,865	54.5%	7,681	53.2%
75% to 99%	1,160	13.0%	2,118.0	14.7%
50% to 74%	1,391	15.6%	2,376.0	16.5%
< 50%	1,516	16.9%	2,267.0	15.6%
Overall Adherence Score⁵				
100%	302	3.4%	448	3.1%
75% to 99%	259	2.9%	443	3.1%
50% to 74%	1,091	12.2%	1,900	13.2%
< 50%	7,280	81.5%	11,651	80.6%

¹17,119 children were in 10,964 eligible families.

²11,712 children in 7,012 families had at least one subsequent meeting following their initial meeting.

³Or end of the treatment group observation timeframe (i.e., 6/30/18), whichever comes first; 13,459 children were in 8,230 families with a held meeting prior to 90 days elapsing from the initial meeting or had 90 or more days elapse from the initial meeting date to case close or the end of the observation period.

⁴Overall Adherence = [(initial and subsequent meeting timeliness rate + required participant attendance rate) / 2] * consistency rate].

⁵Facilitators were always considered present since meetings in Trails were categorized as Facilitated Family Engagement Meetings. Therefore, facilitator attendance did not vary, but parent, caseworker, and parent identified support did.

Table 6. FFE Adherence and Reach for In-Home Children and Their Families

Adherence Measure	Families Served		Children in Families Served	
	#	%	#	%
Intervention Reach (eligible¹ who received at least meeting)	6,280	70.6%	12,417	68.5%
Initial Meeting Timeliness (days after case open)				
Within 7 business days	2,405	38.3%	4,764	38.4%
8 to 15 business days after the case opening date	661	10.5%	1,294	10.4%
16 to 30 business days after the case opening date	804	12.8%	1,607	12.9%
More than 30 business days after the case opening date	2,410	38.4%	4,752	38.3%
Subsequent Held Meeting Timeliness (within 180 days of each other)²				
100%	3,135	83.4%	6,189	83.7%
75% to 99%	188	5.0%	343	4.6%
50% to 74%	221	5.9%	464	6.3%
< 50%	217	5.7%	400	5.4%
Consistency (every 180-day time window from the initial meeting to case close³ with a held meeting)				
100%	2,750	65.4%	5,485	66.2%
75% to 99%	154	3.7%	295	3.6%
50% to 74%	690	16.4%	1,325	16.0%
< 50%	613	14.5%	1,180	14.2%
Required Participants (held meetings with at least a parent, caseworker, facilitator, and parent identified support in attendance)				
100%	4,787	76.3%	9,642	77.7%
75% to 99%	358	5.7%	723	5.8%
50% to 74%	587	9.3%	1,111	8.9%
< 50%	548	8.7%	941	7.6%
Overall Adherence Score⁴				
100%	1,403	22.3%	2,842	22.9%
75% to 99%	314	5.0%	619	5.0%
50% to 74%	1,135	18.1%	2,283	18.4%
< 50%	3,428	54.6%	6,673	53.7%

¹18,119 children were in 8,889 eligible families.

²7,396 children in 3,761 families had at least one subsequent meeting following their initial meeting.

³Or end of the treatment group observation timeframe (i.e., 6/30/18), whichever comes first; 8,285 children were in 4,207 families with a held meeting prior to 180 days elapsing from the initial meeting or had 180 or more days elapse from the initial meeting date to case close or the end of the observation period.

⁴Overall Adherence = [(initial and subsequent meeting timeliness rate + required participant attendance rate) / 2] * consistency rate].

PERMANENCY ROUNDTABLES

The following table shows PRT reach and case-level adherence rates; the table includes all children and youth who were eligible for the intervention and received at least one PRT. The two PRT target populations are presented separately.

Table 7. PRT Adherence and Reach

Adherence Measure	16 & Older with an OPPLA Goal		12 Months & Longer in Care	
	#	%	#	%
Intervention Reach (eligible who received at least one meeting)	480	75.8%	1,356	30.2%
Subsequent Held Meeting Timeliness (within 90 days of each other)¹				
100%	94	24.3%	578	49.9%
75% to 99%	78	20.2%	189	16.3%
50% to 74%	100	25.8%	252	21.7%
< 50%	115	29.7%	140	12.1%
Consistency (every 90-day time window from the initial meeting to case close with a held meeting)²				
100%	70	15.6%	510	40.6%
75% to 99%	76	16.9%	226	18.0%
50% to 74%	149	33.2%	282	22.5%
< 50%	154	34.3%	238	18.9%
Youth Participation (attend one subsequent meeting every 180 days)³				
100%	120	28.1%	146	12.5%
75% to 99%	43	10.1%	47	4.0%
50% to 74%	123	28.8%	184	15.7%
< 50%	141	33.0%	793	67.8%
Required Professional Participants (held meetings with at least a facilitator, internal and external consultant, caseworker, supervisor, and administrative staff)				
100%	44	9.2%	282	20.8%
75% to 99%	21	4.4%	196	14.5%
50% to 74%	65	13.5%	226	16.7%
< 50%	350	72.9%	652	48.0%
Overall Adherence Score⁴				
100%	5	1.4%	17	1.6%
75% to 99%	23	6.3%	72	6.7%
50% to 74%	78	21.2%	359	33.4%
< 50%	262	71.1%	626	58.3%

¹Includes youth who had a subsequent meeting

²Includes youth who had at least 90 days elapse from their initial PRT meeting or who had a subsequent meeting prior to 90 days elapsing.

³Includes youth who had at least 180 days elapse from their initial PRT meeting or who had a subsequent meeting prior to 180 days elapsing.

⁴Overall Adherence = [(subsequent meeting timeliness rate + required professional attendance rate + youth participation rate) / 3] * consistency rate].

KINSHIP SUPPORTS

The following table shows KS reach and case-level adherence rates; the table includes kinship providers who were eligible for the intervention and received at least one service contact.

Table 8. KS Adherence and Reach

Adherence Measure	Kinship Providers		Children Placed with Kinship Providers	
	#	%	#	%
Intervention Reach (eligible¹ who received a contact or service)	6,328	82.8%	10,114	83.4%
Received Kinship Supports Needs Assessment				
Received KSNA at any point during placement	4,913	77.6%	7,926	78.4%
Received at least one follow-up KSNA	2,047	32.3%	3,341	33.0%
Received a placement end KSNA	937	14.8%	1,484	14.7%
First Kinship Supports Needs Assessment Timeliness (days after placement begin date)				
Within 7 business days	2,735	55.7%	4,453	56.2%
8 to 15 business days after the case opening date	933	19.0%	1,529	19.3%
16 to 30 business days after the case opening date	684	13.9%	1,079	13.6%
More than 30 business days after the case opening date	561	11.4%	865	10.9%
Needs and Services (at least one corresponding service received for each assessed need on first assessment)				
Service received for 100% of all needs	640	27.8%	1,046	27.7%
Service received for 75% to 99% of all needs	104	4.5%	178	4.7%
Service received for 50% to 74% of all needs	624	27.1%	1,056	27.9%
Service received for < 50% of all needs	933	40.6%	1,499	39.7%
High Adherence³	2,182	34.5%	3,552	35.1%

¹12,132 children were placed with 7,644 eligible kinship providers

²Assessment was categorized in Trails as a placement end needs assessment.

³Received first assessment within seven days and at least one service for 50% or more assessed needs or had no assessed needs

TRAUMA-INFORMED SCREENING, ASSESSMENT AND TREATMENT

The following table shows TSAT descriptive rates. As noted earlier in the report, there were multiple data collection challenges related to this cross-systems intervention that limited our ability to calculate reach and adherence rates. Table 9 displays a variety of descriptive measures for the assessment component of the intervention. Assessment refers to either the TSCYC for children ages 3 to 7 or the CPSS for children or youth ages 8 to 18.

Table 9. TSAT Assessments at CMHCs

Number of children who received an initial CMHC assessment	Number of children who received a follow-up CMHC assessment	Number of children who received any CMHC assessment	Mean number of days between initial and first follow-up CMHC assessment dates (n=168)	Percentage of children whose caregiver received a PTSD assessment through a CMHC ³
612 ¹	336 ²	780	170 days (SD=107 days)	47.2% (289 ⁴ /612 ⁵)

¹ This is likely an undercount, as some children were coded as having only received a follow-up assessment.

² This number is subject to data limitations; since some children were coded as having only received a follow-up assessment, it may be that some of the follow-up assessments were actually initial assessments. Additionally, these children were not necessarily in the group that had started treatment, although with more children receiving treatment than being coded as having a follow-up assessment, it is likely that reassessed children were also treated.

³ Where the child received at least one assessment.

⁴ Number of caregivers with trauma assessment.

⁵ Number of children with an initial assessment.

Table 10 displays trauma treatment reach and adherence rates for year two through year five of the Waiver, based on data input by clinicians or support staff at CMHCs. Based on the collected data, more children received trauma treatment than were recommended for trauma treatment; it is likely that the rate of 106.4% is due to data entry anomalies for children for whom treatment was “recommended.” There were nine specific trauma-focused treatments that were tracked, including: child parent psychotherapy; trauma-focused parent-child interaction therapy; trauma-focused cognitive behavioral therapy; Alternatives for Families – a cognitive behavioral therapy; adolescent dialectical behavioral therapy; sensory integration and the neuro-sequential model of therapeutics; complementary supports addressing goals from the assessment; eye movement desensitization and reprocessing; or experiential play therapy. The latter two were explicitly tracked only during the second half of the Waiver period. Not all treatment modalities were available at each CMHC, nor were these nine treatments appropriate for all children who might need trauma-focused treatment. Therefore, an “other” box remained available on the survey. Examples of those other recommended treatments (based on comments from the survey) included art therapy, individual therapy, family preservation therapy and psychoeducation.

Table 10. TSAT Treatment Reach and Adherence

	Trauma Treatment Penetration Rate	Children Who Received Any of the Nine Specific Treatments
CMHC Trauma Treatment of Children Referred from Child Welfare	106.4% (630 ¹ /592 ²)	69.8% (440 ³ /630 ¹)

¹ Number of children receiving any CMHC trauma treatment.

² Number of children for whom any CMHC treatment was recommended, including any of the nine specific treatments or treatments marked “other.”

³ Number of children who received one of nine trauma-specific treatments; this is likely an undercount of EMDR and experiential play therapy, as those were only explicitly tracked during the second half of the Waiver.

State and County Context and Practice During the Waiver

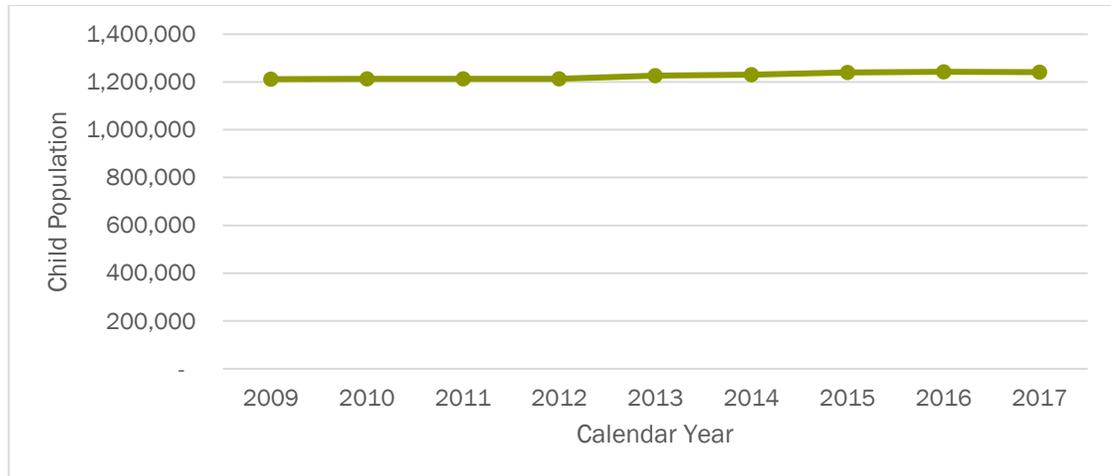
The following results illuminate the context of the Waiver and the practices and activities that occurred during the demonstration Project; the results of the State administrator interviews and county department of human/social services site visit interviews and focus groups are included. The overarching contextual factors that illuminate Colorado’s Waiver environment and shifts that have occurred during the Waiver are presented first, including child population and referral trends. Several county snapshots that demonstrate implementation, learnings, and sustainability planning among a handful of selected counties that implemented multiple Waiver-funded interventions are presented next. Following those, intervention-specific findings are presented; these convey practices related to each of the Waiver interventions, organizational aspects, and collaborations that occurred during implementation.

COLORADO’S CHILD POPULATION AND CHILD WELFARE REFERRAL TRENDS

One contextual factor that impacts the child welfare system is the child population in the state of Colorado. Figure 21 uses One Year Population Estimates for children aged 0 to 17 from the American Community Survey^h (ACS) to map the child population trend for calendar years 2009 through 2017.

^h United States Census Bureau / American FactFinder. “B17001 - POVERTY STATUS IN THE PAST 12 MONTHS BY SEX BY AGE.” 2009 – 2017 American Community Survey. U.S. Census Bureau’s American Community Survey Office, 2016. Web. 6 September 2018 <<http://factfinder2.census.gov>>.

Figure 21. Colorado Child Population, Aged 0-17, by Calendar Year



Source: American Community Survey One Year Population Estimates

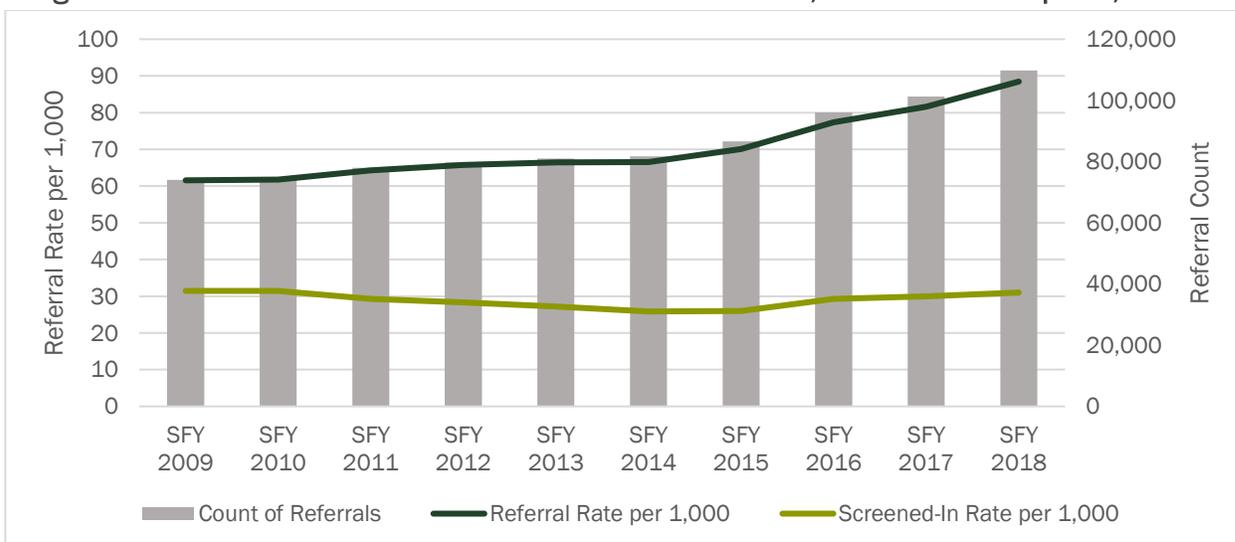
Overall, the ACS estimates show that the population of children aged 0-17 living in Colorado increased by 1.2% in the four years prior to the Waiver, from CY 2009 to CY 2013 (by 14,170 children, which is within the margin of error). However, this upward trend is not statistically significant at the $\alpha = 0.10$ level.ⁱ Another small, non-significant increase (1.3%) occurred during the Waiver period, from CY 2013-CY 2017. When looking over the span of the nine years from CY 2009 through CY 2017, however, the increase in child population (2.4%) does rise to statistical significance. Thus, the conclusion is that, at the state level, the child population increased slightly during this nine-year period.

Colorado's ten large counties (TLC) account for approximately 79% of the child population in the state; consequently, population trends in those counties will have the largest impact on statewide trends. Within the TLC, child population trends have varied by county, and the statewide increase in child population appears to be primarily attributable to four of the TLC. When looking at the period of CY 2009-CY 2017, three of the TLC experienced a significant increase in the population of children aged 0-17: Adams (8.6%), El Paso (7.6%), and Weld (12.3%). Four counties experienced a decrease in child population, though not at a significant level (Boulder, Jefferson, Mesa, and Pueblo). The remaining two counties saw a nonsignificant increase.

Beyond the underlying child population—and perhaps, related to it—another driver impacting the overall child welfare system is the level of child welfare referrals. Figure 22 displays the count of all referrals for Colorado from SFY 2009 through SFY 2018 alongside the rates per 1,000 child population for referrals and screened-in referrals.

ⁱ The test for significance can be carried out by making several computations using the estimates and their corresponding standard errors (SEs). When working with ACS data, these computations are simple given the data provided in tables in the American FactFinder. See <https://www.census.gov/content/dam/Census/library/publications/2008/acs/ACSGeneralHandbook.pdf> for details.

Figure 22. Colorado Referral Trends – Count of Referrals, Referrals Rates per 1,000^j



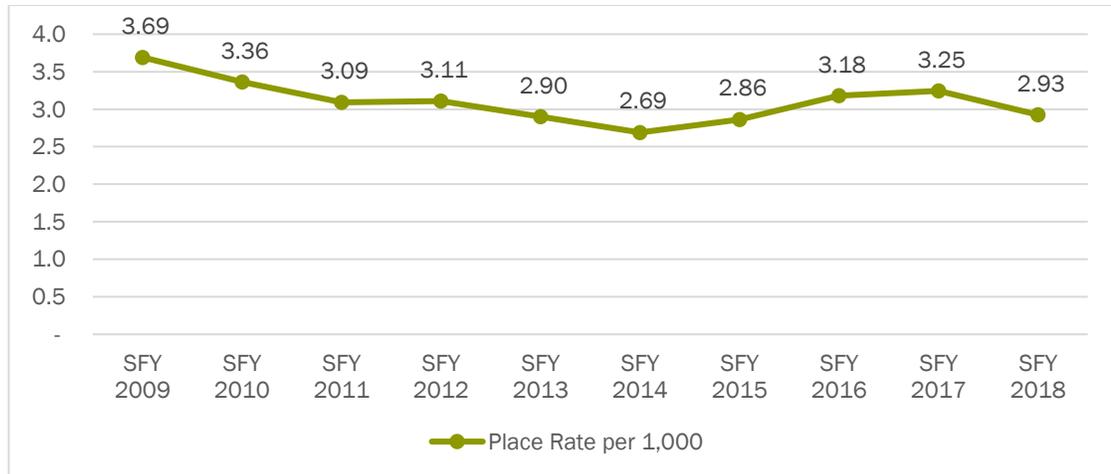
While underlying child population trends have changed slightly, the number of referrals and the rate of referrals per 1,000 children in the population have risen by approximately a third from SFY 2013 to SFY 2018. In SFY 2018, approximately 89 children were referred for every 1,000 children in the state population. This increase is likely due primarily to the implementation of the Colorado Child Abuse and Neglect Hotline, which became operational on Jan. 1, 2015. The hotline was designed to provide a single, easy-to-remember toll-free phone number for individuals to use statewide to report suspected child abuse and neglect. The implementation of this hotline occurred in the middle of SFY 2015, which is where the largest increase in referrals begins.

Not all referrals to the child welfare system rise to the level of investigation or assessment, and Figure 22 above presents the screened-in rate per 1,000. The discrepancy between the rising referral rate and the more stable screened-in rate shows that although children in Colorado were more likely to be referred to the child welfare system, their likelihood of being screened in did not rise as dramatically. While the referrals rate increased by 33% from SFY 2013 to SFY 2018, the screened-in rate increased by half that, 14%.

Another area to look to understand system involvement is the placement rate. Figure 23 looks at the rate of out-of-home placement per 1,000 children in the population over the last 12 fiscal years, highlighting the pre-Waiver and Waiver years. Although there has been some variation, the placement rate has only risen by 1% from SFY 2013 to SFY 2018—mostly due to the reduction in SFY 2018 after the high of 3.25 in SFY 2017. From this, it is evident that the increase in referrals has not led to a consistent increase in the rate of out-of-home placements.

^j Referral rates were taken from DCW-provided annual reports, “All Child Protection Reports by Screening Decision.” Population figures used for the referrals rates were taken from ACS One Year Population Estimates through 2017 referenced above. 2018 population levels were estimated at 2017 levels.

Figure 23. Colorado Placement Rate per 1,000



Overarching Contextual Findings

The following are broad, non-intervention-specific contextual findings, including the social, economic, and political forces that may have a bearing on the replicability of the five Waiver interventions or may have been responsible for implementation challenges, including co-occurring systems reforms and interventions. This section was informed by State administrator interviews and county site visits. The findings are presented as narrative descriptions, followed by county snapshots.

STATE PLANNING AND OVERSIGHT

During the pre-Waiver period and the early stages of the Waiver, CDHS and counties engaged in planning efforts. Meetings were held, and communications and outreach was conducted; the planning stage also involved the development of the contractual and financial aspects of the award and application process. To allocate Waiver intervention funds, the State engaged in an annual application process and MOUs with counties (and regions of counties). Oversight of the Waiver was primarily managed by the CDHS Division of Child Welfare Title IV-E Waiver Administrator and the CDHS Division of Child Welfare Associate Director of Operations as well as several committees formed for the Waiver, including the Executive Oversight Committee, the Evaluation Subcommittee, and the Planning, Operations and Fiscal Subcommittee, all three composed of county and State representatives.

Additionally, each intervention had a designated staff person at the state level, within DCW or OBH, who provided support and technical assistance and training to counties during intervention implementation and throughout the demonstration project; these staff also carried non-Waiver responsibilities. Designated staff led quarterly intervention teleconferences and forums as well as supplemental trainings. A key mechanism of Waiver oversight was the Trails ad hoc report, compiled by the State and shared with counties, highlighting key intervention outputs and adherence measures. In the last year of the five-year demonstration, the State implemented a practice group focused on the sustainability and integration of FFE and PRT;

facilitators and intervention leads across the state volunteered for the monthly practice group.

At the start of the Waiver, CDHS developed a system of supports for counties participating in the Waiver and an information dissemination process for counties interested in participating. State administrators provided community education for Waiver partners and stakeholders at the state level (within and external to State departments), as well as initial technical assistance to the counties. CDHS conceptualized that State intervention leads would monitor and provide oversight on the interventions, including monitoring Trails data to assess case-level adherence and desired outcomes. Conversely, counties were to monitor their own fiscal operations, interventions, and outcomes.

WAIVER COUNTY CONTEXT: SOCIAL, POLITICAL, AND ECONOMIC FACTORS

Population Diversity. Colorado has a diverse population, including racial and ethnic diversity, as well high proportions of military families, politically conservative communities, and families struggling with poverty or otherwise inadequate employment and resources, in both urban and rural areas. Colorado's Front Range (or I-25 Corridor) houses Colorado's denser, urban counties and communities including Denver and Colorado Springs. Many services in Colorado are concentrated in counties in these areas. Counties not along the Front Range have less population density.

Child welfare families often lacked transportation (especially in more rural areas) and were homeless, housing insecure, or at risk of homelessness; this created challenges in terms of service access and for child welfare staff to locate and contact families. Individual communities varied in the relative transience or stability of their populations, with some counties having stable communities and generations of families living locally and other counties having shifting populations, such as families serving in the military or tourism-based economies which influenced the influx of seasonal workers.

County departments of human/social services across the state continued to grow their bilingual and bicultural workforces to meet the needs of Hispanic and Latino communities, as well as a number of Unaccompanied Refugee Minors. Some counties also discussed continued efforts to address the overrepresentation of African American youth among families they served.

Housing & Economic Barriers. While poverty rates varied across Colorado's counties, poverty, homelessness and lack of affordable housing continued to challenge nearly all county departments of human/social services. Disparities were evident both within and among counties, exacerbated by factors such as unemployment, lack of access to mental health care, and a rising prevalence of substance use disorders. Lack of housing stock and/or affordable housing emerged as an issue in nearly every county visited during site visits. These issues were statewide; the Title IV-E Waiver Administrator noted, "The cost of living has skyrocketed yet wage growth has not."

Substance Use and Dependency. Opiate (heroin) and methamphetamine use were highlighted as challenges across the state, with recreational cannabis use not observed as having a large impact on service needs. While additional substance use treatment providers were needed for all ages, services tailored for adolescents were especially lacking.

Small and Rural County Environment. Smaller and rural areas of the state faced unique challenges; service gaps existed in many rural pockets, with some communities remaining segregated in their access to services. Long wait lists for services impacted parent access to needed resources. Smaller (balance of state) counties tended to underspend their child welfare Core Services dollars, which was likely a reflection of service gaps. A lack of public transportation and need to travel long distances to access services and resources continued to challenge agencies and families alike. Traveling service providers and telemedicine for physical and mental health services helped some rural areas to address these issues.

Not all smaller communities were alike, however. Some included ski resorts and affluent residents and others are composed predominantly of working-class families. Some county department staff also described high rates of workforce turnover in their rural communities, and losing staff due to low salaries, lack of affordable housing, or lack of cultural fit; caseworkers might get their start in smaller communities and then settle into more urban counties along the Front Range.

Contemporaneous Initiatives and Interventions. Throughout the Waiver period, CDHS and county departments of human/social services implemented or continued a range of additional activities and programs alongside the Waiver-funded interventions. In addition to an increased attention to the workloads of child welfare caseworkers, examples of statewide initiatives included:

- Statewide Child Abuse and Neglect Hotline, which provided one phone number statewide to report suspected child abuse and neglect, and rolled out in 2015;
- New safety and risk assessment tool(s);
- FAR/ Differential Response;
- RED (Review, Evaluate, Direct) Teams within counties that vetted reports of abuse and neglect and determined the appropriate response;
- Colorado's Practice Model, an effort to develop a clear, consistent, and cohesive approach to child welfare practice.
- Collaborative Management Program and Individualized Services and Support Teams, designed to improve outcomes for children, youth, and families involved with multiple agencies;
- Family Partnership Program designed to serve youth in the juvenile justice population and to keep them out of congregate care;

- Safe Care Colorado, an in-home parent education program;
- Not One More Child, a cross-system initiative designed to enhance child safety; and
- Colorado Community Response, community-based child abuse prevention services led by the Office of Early Childhood and Children.

County-specific initiatives included:

- Developing a continuum of care for youth placed in residential treatment care;
- Developing a crossover youth practice model targeted to serving youth with long histories in care;
- Annie E. Casey reform efforts aimed at reducing numbers of youth in congregate care;
- Serving unaccompanied refugee minors, and helping them transition out of care and locate family in the U.S.;
- Developing targeted initiatives to support younger and older youth with developmental disabilities; and
- Providing more prevention and in-home services, such as coaching or parenting programs.

Collaboration and Partnerships. In addition to strengthening existing relationships, many new collaborations emerged under the Waiver. Family finding and diligent search services were common reasons that counties formed new partnerships or contracted for services. Other examples of collaborations include co-locating “benefits navigators” within child welfare to assist kin providers in applying for benefits such as Medicaid or SNAP or partnering with community providers to facilitate family engagement meetings. Many counties also reported partnering more closely with their community mental health agencies and local courts and court representatives.

Courts and the Judicial System. Counties reported varying experiences in working with the courts and judicial system, sometimes forming strong partnerships and other times finding it difficult to identify common ground. Some counties found that their Waiver interventions, especially FFE, helped to strengthen their relationship with the courts. Some county representatives met regularly with judges to discuss interventions being implemented. In some counties, judges rotated frequently—every two years—making it difficult to consistently develop strong relationships between the county department of human/social services and the courts.

Counties encountered challenges in working with the courts, especially when serving adolescents. While county departments of human/social services made efforts to use

congregate care as a last resort, participants observed that judges sometimes chose to place youth in such settings due to concern over community safety and the ability to “contain” and provide 24-hour supervision, as well as in-residence treatment. Some counties did report courts becoming more trauma-informed through the TSAT intervention, with judges even speaking and interacting with caseworkers in trauma-sensitive ways. Overall, child welfare agencies reported stronger and more frequent communication with the courts during the Waiver.

Community Partners and Foundations. Collaboration with community partners under the Waiver was strong. These collaborations included co-locating service providers in one location or developing processes to help expedite access to services and resources. One county created a “family resource pavilion,” which housed an array of services in one location and involved all youth-serving agencies in the community. Partnering with community providers also plays a critical role even in providing traditional child welfare services, such as case management or certifying and licensing foster homes.

Behavioral and Mental Health. Under the TSAT intervention, all counties involved with this intervention reported partnering more closely with their community mental health agencies. Counties also joined with behavioral health in other ways, such as to provide in-home mental health support and services to youth. One county partnered with its CMHC to develop an in-home management team, which they believe has helped kids to stay at home longer and step down to in-home care more quickly. Tele-therapy has also emerged in some more rural parts of the state.

Collaboration between the State and counties. The structure of Colorado’s Waiver required considerable partnership between the State and counties—in the form of annual applications and MOUs as well as joint State and county oversight committees. Both county and State representatives believe the Waiver enhanced the relationship between CDHS and county departments of human/social services. The Title IV-E Waiver Administrator said, “A really happy [output of the Waiver] has been the county-State collaborations. I think we see a great deal of eagerness from counties to partner up with the State on opportunities—learning opportunities and growing opportunities...that energy seems to have only built over the five years of the Waiver.”

Counties also collaborated with one another through the Waiver demonstration. In addition to smaller or more rural counties partnering to pool funding and resources, some counties collaborated to develop or strengthen their Waiver interventions. For example, counties observed one another’s FFE meetings and consulted on best practices. Counties often hosted trainings and opened them to practitioners across the state.

Organizational Factors Influencing the Waiver. Counties pointed to organizational factors potentially having an impact on Waiver implementation, namely workforce stability and staff turnover. In discussing other initiatives being implemented at the same time as the Waiver, some counties reported focusing on

strategies to limit staff attrition, especially in “case-carrying” units. Some counties reported a decrease in staff turnover under the Waiver, as positions that provide support for caseworkers—such as family engagement facilitators—increased and as efforts under the TSAT interventions encouraged attention to staff burnout. Some counties purposely lowered caseloads and hired new workers under the Waiver.

Oversight and Monitoring. Counties reported both successes and challenges related to monitoring Waiver implementation. Some counties developed internal processes and data systems to help address difficulties with pulling reports and data out of Trails. Some counties created internal data systems to coordinate with the Trails database, so that any data entered into Trails automatically fed into their data system. This allowed staff to pull their own reports with relative ease. “Flags” or “ticklers” built into the internal systems reminded staff to enter data and helped to increase consistent and timely data entry. The internal systems also helped to support coordination with other providers, through the ability to create and securely send referrals outside of the child welfare system.

For counties that largely relied on Trails to monitor implementation, the State’s support was especially helpful. Counties appreciated the State’s ad hoc reports and having regular communication with CDHS about data of interest. Smaller counties reported less capacity to purchase and maintain additional data management systems outside of Trails. Larger counties sometimes helped smaller counties run reports or access data, since smaller counties had less monitoring capacity and fewer designated data or evaluation staff.

WAIVER IMPACTS

County administrators discussed broader impacts of the Waiver interventions they observed in their practice with children and families and within their communities.

Approach to Practice. Overall, counties reported that the Waiver helped shift practice in multiple ways, including how practitioners approached their work with families. Participants at one county stated, “I think whatever we become, it can’t be without giving credit to the Title IV-E [Waiver]. I’m not just saying that because we’re funded...we started chasing that carrot and I think it forced us all to grow with that. We didn’t have that flexibility, and we weren’t right-sized financially, so we had to make choices...now we really get to square up our values and the finances. It’s been wonderful.”

Similarly, child welfare staff in other counties believed that, through the Waiver, they had the ability to better the lives of children, youth and families. The leadership team in one of these counties reported that they wanted “staff to understand that this is a cohesive set of principles...part of a whole. They’re not discrete tasks that people need to do. This really is a holistic way to engage families differently. And that’s how we marketed and talked about it. And frankly, I think our staff got it.”

Counties also reported shifts toward a greater focus on working with and sharing responsibility with families, including more consciousness about how cases close and

ending services and having closure FFE meetings. Counties also recognized an increase in teamwork among staff throughout the Waiver; instead of leaving individual divisions and units to deal with challenges on their own, it became more common for staff to take a shared approach to decision-making. The Title IV-E Waiver Administrator said, “So I think, big picture, I think there’s just been a not-so-subtle shift in the way that workers, supervisors and administrators are thinking about how Child Welfare practice can happen. And I think that’s going to be really healthy as we try to shift into whatever Family First [Prevention Services Act] environment is going to come by.”

COUNTY IMPLEMENTATION SNAPSHOTS

To demonstrate the progression and evolution of implementation, snapshots highlighting Waiver activity were developed for individual counties or regions of counties that participated in two site visits over the course of the Waiver. While the snapshots vary in design, they each demonstrate the context in those counties, the practice shifts, implementation challenges, community partnerships, and, if relevant, plans for sustaining Waiver intervention activities post-Waiver are highlighted. Four counties are represented through individual county snapshots, represented in Figures 24 through 27.

Figure 24. County Snapshot One

County context

This large county is regarded as a leader in the state in implementation of FFE; its implementation preceded Colorado’s Waiver. The County also has a high capacity to conduct internal evaluation and outcomes monitoring through a customized database. The County prioritizes relationships with community partners; the County has invested many resources into training staff at community agencies. In addition to human services, the County child support office and child-only TANF have funding to provide resources to non-certified kin caregivers.



Philosophical and Practice Shifts

This county was at the forefront of making large philosophical and practice shifts many years prior to the start of the Waiver. Notably this County was one of the first in the state to implement Differential Response and Partnering for Safety. Prior to the Waiver, the County made a commitment to increasing non-certified relative care despite the fact that it is not IV-E reimbursable. As a result, the County has seen an increase in sustainable kin placements and a decrease in congregate care—two of the most notable goals of the Waiver. The County has witnessed a resource savings and has been able to reallocate those dollars across the organization.

“What the Waiver did by coming in behind [these other efforts] is that it allowed us then to use those dollars in really creative ways. It validated the value of the work that we had already made a commitment to doing and it’s just so cool to be able to be creative with families.”

– County Administrator

Intervention-Specific Successes

Kinship: For a number of reasons the kinship supports intervention is considered very successful in this county. There are now more children in kinship care than foster care in the county. The vast majority of kinship caregivers are non-certified, and the agency has been able to build supportive networks with families. Caseworkers are able to easily provide for the basic needs of families; through the Waiver, the agency has provided thousands of dollars of hard goods to kinship caregivers and navigation support for getting services in place quickly. The County was also able to hire additional family finding staff through the Waiver, allowing the agency to serve more families and prioritize permanency.

Family Engagement: The family finding staff hired through the Waiver allowed caseworkers to focus on building trust, decreasing barriers, and problem solving with the families together. Additionally, FFE meeting scribes were hired through the Waiver to free up facilitators to focus efforts on finding permanency for youth in long-term foster care. Previously, facilitators spent a lot of time recording meetings. It is noteworthy that this County had explored the idea of implementing PRT but decided against it because it did not align with the County’s specific family engagement meeting model. They found that the PRT intervention lacked flexibility and that the family engagement meetings already have a process to support long-term youth.

Trauma Screening and Assessment: The County was able to add a mental health liaison through the trauma screening and assessment intervention and co-locate this staff member at DHS. This was helpful in moving children from screening to assessment to treatment, and a community mental health center staff person was able to help troubleshoot assessment- and treatment-related issues.

Staffing Hiring and Retention

This County saw an impact of the Waiver on staff hiring and retention. This County used Waiver funds (with additional State and County funding) to assist with new staff hiring. The County gradually added 40 sustainable positions over the course of the past five years. There has been no elimination of staff members, and the County plans to make these positions sustainable post-Waiver. Additional family finding staff help support caseworkers by providing emotional support and the ability to find a placement more quickly.

The caseworkers are then able to do safety planning and spend more time with families. And, as a result, caseworkers do not feel as alone—their role has a sense of shared responsibility and support from the broader team. Together the family finding staff and caseworkers work toward creating permanent connections for kids, even if it doesn't mean permanent placement. Because caseworkers can be creative and more accommodating to families with the flexible use of IV-E funding, caseworkers are more satisfied in their jobs and, as a result, the agency has seen increased retention under the Waiver.

In addition to the support from family finding staff, caseworkers also benefited from the County redesigning the roles of administrative support staff. By assigning some deskwork/paperwork (that is traditionally completed by caseworkers) to administrative staff, caseworkers are able to spend more time responding to the needs of families.

Source: County site visit data

“One of the things that’s made a big impact is our administrative support team and embedding some of them within permanency or intake [units]. We utilize our support staff to help our workers, which has freed their ability to be able to go and engage with family. So that’s been something that’s definitely increased over the last few years that has made an impact on retention, as well as workload.”

– County Supervisor

Figure 25. County Snapshot Two

Employing a Regional Approach to Waiver Intervention Implementation

Background

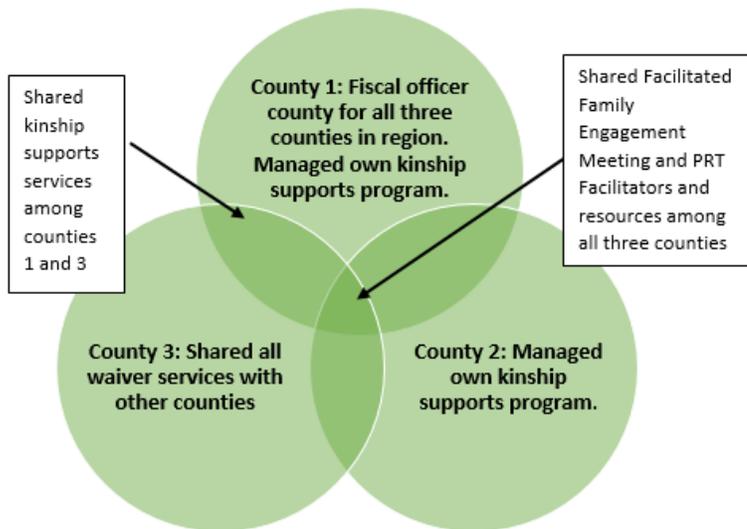
This region of small and medium sized counties embraced practice and philosophical shifts under the Waiver and implemented several Waiver interventions collaboratively; this approach enabled them to share Waiver-funded resources and staff positions—such as family engagement and PRT meeting facilitators—and created opportunity for services that the smaller counties would not have been able to support independently. The largest county serves as the fiscal officer for the Title IV-E Waiver intervention funds.



Contextually, this region has experienced income inequality, unemployment and limited jobs, and a generally limited social support and social services system. Located outside of Colorado’s I-25 corridor, services are slim within this region, and DHS is considered the largest service provider in this rural area.

Differential response rolled out simultaneously with the Waiver in these counties; the values of DR and the Waiver aligned, creating momentum toward front-loading services and identifying informal supports, though the simultaneous implementation of multiple Waiver interventions, DR, and other initiatives created initiative fatigue among caseworkers,

Regional Organization



supervisors and managers within the region.

Waiver Impacts

The Waiver interventions, especially FFE, increased the workload during the initial implementation stages; as casework practice shifted with the family engagement intervention, more time was spent front-loading services and providing rapid meetings after removal or during assessment. Ultimately, the county found that casework time savings were realized as

implementation progressed, cases closed more rapidly, and reunification was expedited. In terms of intervention challenges, counties experienced tension around holding initial family engagement meetings in accordance with timeliness fidelity benchmarks (such as initial meetings within seven business days) or having a robust group of family members, family supports, and professionals around the table; scheduling meetings at times that worked for all of these participants often required more than seven days.

This region relies on a network of agencies to effectively support families. Enhanced community partnerships, including a sense that “it’s not just DHS anymore” serving families emerged under the Waiver. Further, Waiver interventions have changed practice. The interventions have emphasized and supported a culture of checking in with families and being open with them, including teaching caseworkers how to be “transparent, honest, and hopeful.” Parents served by the counties agreed both at the start of the Waiver and toward the conclusion that practice—especially

We have shifted our practice so much... we really embraced those prevention kind of approaches, that culture of working with families truly around engagement practices. And so, we’re not going to go backwards as a community, as an agency.

– County Administrator

through FFE meetings—was family-centered and supportive. Family engagement meetings, for example, focused practically and collaboratively on “what we need to do and who can help.” Parents viewed FFE facilitators as capable of navigating and managing challenges and interpersonal conflicts during meetings, due to their expertise and training. Facilitators served as key liaisons with the agency—representatives who parents trusted to have their child’s best interests at heart even when meeting agendas or topics were difficult to discuss.

Waiver Sustainability

Even during the second year of the five-year Waiver demonstration, administrators and staff within this region were concerned about sustaining Waiver interventions after the Waiver concluded, having seen positive impacts on engaging families and timely reunification. And in year four, there was renewed concern over Waiver funding, coupled with fiscal shortage within the region, as well as concern that relationships with community partners would suffer if the agency was less responsive or flexible once the Waiver concluded. Having embraced interventions above and beyond mandatory target populations (including serving voluntary cases through family engagement and non-certified kin through kinship supports) the county anticipated providing fewer family engagement meetings to fewer families post-Waiver, as well as fewer creative supports and hard goods for kin caregivers.

County Snapshot Two: Examples of IV-E Waiver Impacts Beyond Outcomes

Regional Shifts from the Start to the Conclusion of the Waiver

	<p>Facilitators in the region were cross-trained in both FFE and PRT under the Waiver. They received both pre-implementation and mid-implementation training. This cross-training was perceived as a benefit of the Waiver and a benefit of the regional approach, allowing facilitators to gain valuable skills in conflict management, negotiation, and consensus building that could be used across interventions. Since smaller counties can support fewer staff positions, cross-training was a necessity in this region and it became a strength. Families spoke highly of the county’s facilitation capacity.</p>
	<p>Under the Waiver, a practice norm shifted from a tendency to write treatment or case plans for families, to writing them with families. This was perceived as a valuable return to social work roots.</p> <p style="border-left: 1px solid black; padding-left: 10px;"><i>The Waiver brought us back to social work 101.</i> – County Administrator</p>
	<p>By the conclusion of the Waiver, county staff were using more open, accessible, and transparent language with families rather than jargon (e.g., “I’m worried that Johnny is going to fall down the stairs when mom goes into the bathroom and shuts the door and shoots up heroin” vs. “It’s an injurious environment”).</p>
	<p>In small communities, confidentiality and dual relationships can be an issue for child welfare staff and families. Because the facilitators in this region often traveled out-of-county to facilitate meetings (traveling to the smaller counties in the region), it ensured they were less likely to know a family and could be perceived as neutral.</p>
	<p>A noticeable shift over the course of the Waiver was that caseworkers expressed more engagement in the interventions and less concern that families weren’t being held accountable enough during family engagement meetings. They trusted the process of enhanced family involvement.</p>
	<p>The region had difficulty pulling intervention-specific data from Trails. In response to this challenge, the region became strong at tracking its own meeting and case level data as needed to report. Even so, the capabilities in these smaller counties for customized databases and additional reporting are substantially lower than in larger counties in the state.</p>

Source: County site visit data

Figure 26. County Snapshot Three

Intervention Specific Challenges and Successes

This medium-sized county, relatively rural and agricultural, implemented several Waiver interventions, and also participated in other initiatives and interventions, including the Collaborative Management Program.

Kinship Supports: Through the flexible dollars available through the kinship supports intervention, caseworkers were able to make decisions in a timely manner by being able to quickly put resources in place for families. The ability to provide hard goods and services eliminated the need for caseworkers to look into multiple funding sources before being able to meet an urgent need. The ability to say ‘yes’ to

family members assists with building rapport. Additionally, through the IV-E Waiver, the County has been able to hire a Kinship Navigator. The additional kinship navigator position has taken responsibility from the caseworkers; caseworkers are able to connect kin with the Navigator when there’s a need. Of all Waiver-funded interventions, the County has seen the most impact from kinship supports

which has helped drastically. Even so, the County experienced tension around family-driven case processes, with caseworkers perceiving that families feel stigmatized and resistant to engaging with the County and that some families don’t take personal responsibility.

PRT: Leveraging the partnerships developed through the

Collaborative Management Program, the County relies on Interagency Oversight Group members to participate in FFE and PRTs (such as external consultants). This allows for a reduction in duplication of services to children and families, increased communication between agencies, and more effective service delivery. These partnerships are powerful for generating new thinking and resources. One facilitator said, “There are a lot of different ideas and different resources and so that’s been nice to have that time where you’re kind of thinking outside of the box and coming up with some new ideas, having some people who are on the case come up with some new ideas. Like our one kiddo, we did find some new resources for him that we wouldn’t have thought of, I think, or known of on our own [without community partners].”



“So that flexibility has been really nice - just having the financial support to say yes. Because sometimes that is enough to support a family and help build that rapport with them. Now we’re able to say, ‘The kids are going back to school and you’d like to get them some new things and their shoes have a few holes in them.’ And now they can get what they need.”
– Caseworker

Waiver Sustainability

In this county, the ability to continue the Waiver interventions after funding is no longer provided is in question. Other sources of funding have already been reduced or are slated to be reduced; there has already been a reduction in the block allocation and in TANF funding in the county. There is concern that staffing levels won't meet the needs of families.

“So I just have to say categorically right now, we don't know how we would be able to sustain kinship supports and Permanency Roundtables, although we'd like to [maintain] family engagement somehow.”

– County Director

Source: County site visit data

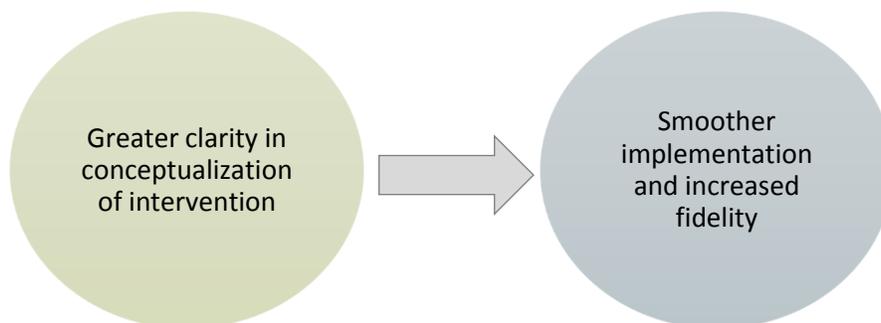
Figure 27. County Snapshot Four

County Context as the Waiver Progressed

This medium county participated in the Waiver from the start, implementing multiple interventions alongside other programs and initiatives. The county is characterized by a diverse population, and the department of human/social services received strong support from the Board of County Commissioners throughout the Waiver.

Year Two Factors	Present Throughout Waiver	Year Four Factors
<p>Multiple practice initiatives rolled out alongside Waiver interventions</p> <p><i>At least two other major initiatives were also implemented in the county when Waiver interventions began: Differential Response and Partnering for Safety. Thus, the initial rollout of the Waiver occurred while planning and introducing multiple large-scale initiatives.</i></p> <p>Among lowest rates of out-of-home placement</p> <p><i>At the start of the Waiver, the county self-reported one of the lowest rates of out-of-home placements in the state.</i></p> <p>Natural disaster recovery</p> <p><i>The county was still in the midst of recovering from damage by floods and wildfires when the Waiver began. These disasters impacted the availability of housing in the county.</i></p>	<p>Diverse general population</p> <p><i>The county’s general population was described as diverse in two primary ways: in wealth and ethnicity.</i></p> <p><i>Some areas of the county are considerably more affluent than others, and immigrant communities are scattered throughout. Ways in which more and less affluent families interact with child welfare services also differ, with affluent families often quickly acquiring their own legal representation.</i></p> <p>Strong support of County commissioners</p> <p><i>The department of human services in this county receives strong support from its Board of County Commissioners.</i></p> <p>Availability of affordable housing is a major challenge</p> <p><i>This varies by community across the county.</i></p>	<p>More complex cases</p> <p><i>Families coming to the attention of child welfare services have increasingly more complex cases, involving issues such as mental illness, substance use and traumatic brain injuries. From the perspective of agency staff, the complexity of cases has increased over the course of the Waiver.</i></p> <p>Increase in out-of-home placements</p> <p><i>In this county, out-of-home placements began to increase near the end of the Waiver. The rise is attributed to the increase of more complex cases described above, as well as an increase in opioid use in the community, which emerged toward the conclusion of the Waiver.</i></p>

Monitoring Implementation and Adherence



County staff voiced frustration at the lack of training and limited guidance related to some interventions at the start of the Waiver. Limited guidance led to subsequent challenges and decreased clarity around roles, processes, and responsibilities—such as which tasks to assign to new staff hired with Waiver intervention funding. Lack of clarity regarding a given intervention, including duration and frequency of delivery, led to confusion around implementation. Without a clear conceptualization of the intervention, collecting data and monitoring progress were also difficult. Participants reported much greater clarity around the interventions by the end of the Waiver, and highlighted issues specific to the model for kinship supports, discussed further below.

Intervention Spotlight – Kinship Supports

During early implementation, participants pointed to a lack of guidance and little to no training around Kinship Supports. While the benefits of kinship placements were made clear, the nuances of delivering the Kinship Supports intervention were less clear. Near the end of the Waiver, participants spoke more of challenges related to the certification of kinship caregivers rather than staff training, and indicated a need for training specific to kinship providers: *“As we’re placing more and more with kin, the skill level of kin is all over the place...So trying to be really creative about how do we help families move along in their parenting skills in a way that doesn’t feel really intrusive to them.”*

One staff member noted that it can be difficult for kinship providers to participate in training alongside non-relative foster parents: *“Sometimes it’s great for them [kin] to sit in a room with foster families and they realize they’re not quite so scary. But then sometimes hearing foster families talk about the birth parents—and that’s their kids—it can be challenging.”*

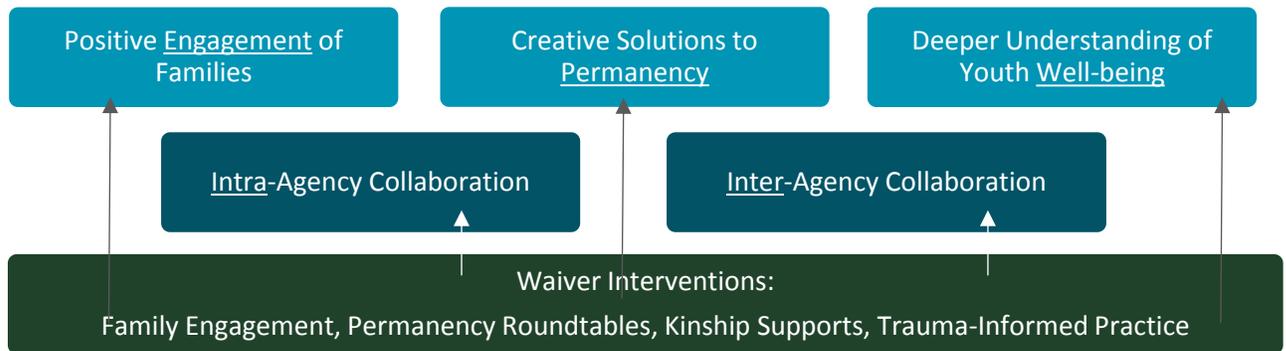
This staff member also pointed to differences in choice between kinship and non-relative foster care providers, which can impact their engagement with training and service requirements: *“...the certification process is built around motivated foster parents, it’s not built around more reluctant kin who are now parenting...some [kin] are so incredibly system-wary, and really want to be in as little touch with us as possible. It’s a struggle to get them through the foster parent training, comply with all the rules and regulations...So I think definitely one of our biggest struggles is how do we help kin families fit into the foster care system that isn’t built around kin families.”*

Kin caregivers also alluded to the unique dynamics of caring for a child as a relative, affirming staff observations that while it was their choice, they had not planned to become a foster caregiver. They took on caring for their kin child out of “necessity” and wanting to support their family.

Kin caregivers who attended non-relative foster parent training stated that it was helpful. However, more than one caregiver voiced dissatisfaction with the certification process, finding it “*very intense,*” “*very invasive,*” and the requirements to maintain certification overwhelming.

Practice Shifts, System Shifts

In addition to further developing practice, the Waiver interventions also supported progress toward multiple practice goals. Waiver interventions influenced more positive engagement of families, encouraged more creative thinking around permanency, increased deeper understanding of youth well-being and strengthened collaborative relationships both within and outside of the agency.



Practice Shift: Positive Engagement of Families

Staff, community partners, and family members pointed to how helpful the Waiver interventions have been in facilitating greater positive engagement of both parents and children in the case process. Caseworkers, as well as the agency’s community partners, agreed that facilitated family engagement (FFE) meetings were family-centered and strengths-based, and allowed families to lead and have a say in their own case plan. Parents and caregivers also voiced appreciation for FFE, especially praising FFE facilitators and commenting that they were always supportive and respectful, and “*really good at what they do.*”

Practice Shift: Creative Solutions to Permanency

Participants also view the Waiver interventions as having improved attainment of permanency, especially in scenarios where permanency may have previously been difficult. One participant stated,

“The [Waiver] interventions for me really get much more at the ‘how.’ I think the system dictates a lot of the ‘what’ and I know I’m over-generalizing, but it’s allowed us to look much more deeply at the ‘how’...how do we do this? How do we establish permanency?”

Permanency Roundtables (PRTs) were viewed as especially helpful for achieving permanency. Participants stated that PRTs provide opportunities to think creatively around solutions for young people who previously seemed to have limited options for permanency. Participants also value the platform PRTs provide for youth to have greater say in decisions related to permanency.

Practice Shift: Deeper Understanding of Youth Well-being

Understanding youth well-being was also enhanced by the Waiver interventions, particularly the TSAT interventions. Since beginning the TSAT interventions, participants have increased efforts to raise awareness among staff and the community about trauma, such as abuse or neglect, and its impact on development and functioning. Increased awareness has helped alter discussions among staff and community partners, and participants are optimistic that this shift in thinking will continue to positively shape practice going forward.

The trauma assessments have been enhanced by staff and partner consideration of trauma in understanding a young person's functioning and well-being. Staff also observed a similar shift in thinking among parents, *"...Especially when we do a trauma assessment and they get the results and participate in the meeting following up, they can start to see it, the families and the entire treatment team. That definitely has helped parents to take some accountability and to see their role in the impact of the trauma and how that has affected their parenting and how they can see that in their kids."*

Systems Shift: Intra- and Inter-Agency Collaboration

A final shift discussed by participants involved strengthened collaborative relationships both within and outside of the agency. Participants also pointed to learning where greater attention to collaboration may be needed. Waiver interventions helped to increase intra-agency collaboration by creating opportunities for divisions across the agency to work together: *"I sit on those community review team meetings, and I've seen a big shift since I've started in the way we do that meeting, in our level of collaboration, and aligning on philosophy."*

Participants discussed how the Waiver interventions also helped to strengthen collaborations with external partners. Several participants highlighted how FFE meetings and PRTs helped build on already regular communication with GALs. Moreover, some partners, including local schools, have gone to the extent of modeling their own services after some of the Waiver interventions. Participants described strong relationships with the court system, and often agree on case decisions and recommendations. In instances where perspectives differ, participants reported that their strong collaborative relationship allows for open discussion regarding ways they may serve children and families that meet the goals and requirements of all system partners.

Strategies for Sustaining Waiver Interventions

As the Waiver neared its conclusion, county staff spoke of both philosophical and financial supports in place to sustain Waiver interventions.

Philosophical	Financial
<ul style="list-style-type: none">➤ Ensure communication with all levels of staff regarding potential and planned changes or continuation of practice➤ Articulate a narrative regarding impact of the intervention to support staff and help advocate for continuation of practice	<ul style="list-style-type: none">➤ Explore other funding avenues➤ Determine areas where resources and work may be joined and shared➤ Identify interventions that could be more narrowly targeted to reduce service need

While the ending of Waiver funding was expected, the county director noted it is still a difficult transition for staff. This observation was reiterated by a supervisor, *“...the barrier is what do we do next — I think we have a great program and I think that we’ve really built it up over the past couple years, but now what?”*

Concrete strategies that were discussed for sustaining Waiver interventions included examining where practices across the agency might be similar or overlap. This may help to identify areas where resources and/or work could be shared and joined. Another strategy involves identifying interventions that could be more narrowly focused and targeted to reduce service need. One supervisor described plans to conceptualize a narrative highlighting benefits resulting from the Waiver interventions in order to better advocate for its continuation: *“...what I’m doing in my role is trying to make sure that I have a clear story to present to senior management of the values of this program...since I’m not the decision-maker financially, I need to advocate for my program so that we can continue at the same level...this is who we’re serving, this is the benefit to the larger community as a whole, this is how we’re keeping families out of the child welfare system, so that we can get continued funding.”*

Intervention-Specific Findings: Facilitated Family Engagement

While the snapshots above provide individual county or region context and findings, the section below highlights findings from site visits related to the FFE meeting intervention. Generally, the findings synthesize what was heard from county administrators, managers, supervisors and intervention leads, facilitators, caseworkers and community partners during visits to county departments of human/social services. Parent perspective on FFE is highlighted in the “Parent Focus Group” section later in the report.

FAMILIES SERVED AND FREQUENCY OF MEETINGS

FFE was the farthest-reaching intervention under the Waiver, in terms of families reached, meetings held, and number of counties implementing. In part this was due to the number of counties in Colorado who were implementing some sort of family meeting practice prior to the Waiver; the Waiver offered an opportunity to grow, develop, and augment practice. Additionally, FFE fit both with the existing and growing sentiment throughout the state that parents and families should be viewed as partners in decision-making. Further, Colorado's Social Service Rules (Volume 7) included expectation around county departments of human/social services engaging with families, and many counties opted into the FFE intervention to meet this rule. Throughout the Waiver, supervisors, facilitators, caseworkers, and community partners indicated broad support for FFE, viewing it as a helpful and necessary intervention that engaged families, a means of moving toward a more collaborative philosophy and approach broadly, and a mechanism of stronger collaboration within the agency and with community partners.

The target population for FFE was broad during the Waiver, consisting of all open cases, including FAR cases with service plans and both in-home and out-of-home cases. However, there were differing frequency expectations for in-home and out-of-home cases; out-of-home cases received a meeting every 90 days and in-home cases received a meeting every 180 days. As the Waiver progressed, though, counties reported serving more families outside of the target population and serving cases more frequently than required. Counties indicated often trying to conduct FFE meetings for in-home cases much more frequently than every 180 days; an analysis of in-home cases and meeting frequency confirmed this^k—many counties were holding meetings for in-home cases with almost as much frequency as out-of-home cases. Some families with in-home cases requested meetings more frequently than every 90 days, too, or counties held them more frequently for higher-risk cases. In one county, seeing the strengths of the model encouraged staff to aim to hold meetings every 30 days rather than 90 days.

Further, some counties extended meetings to families during the assessment phase, particularly families with high risk-assessment scores or families for whom a meeting might help avoid a placement. This shift was in part related to a change in one of Colorado's Social Service Rules (Volume 7) that occurred during the Waiver period; it indicated that counties should engage with high-risk families in the assessment phase, and some counties used FFE meetings to meet this requirement. Some counties also extended FFE meetings to adult protection cases, while others facilitated juvenile delinquency court cases (non-child welfare cases).

The FFE intervention criteria allowed for considerably flexibility. Colorado's FFE intervention was purposely loose to allow county flexibility in adopting specific family meeting models such as LINKS, Partnering for Safety, or Team Decision Making, as long as counties maintained the few timeliness and attendee parameters outlined by

^k Using Trails data

the State. Some counties reported using multiple meeting models depending on the timing or purpose of the meeting—such as Team Decision Making at key decision points. Some even practiced flexibility during meetings, switching the model (including structure or purpose) during a meeting if appropriate.

STAFF AND PROFESSIONAL BUY-IN TO FFE

As the Waiver progressed, buy-in to FFE grew. At the interim point, some community partners reported ambivalence about FFE; by the conclusion of the Waiver, they expressed engagement and appreciation for the intervention. And while some caseworkers at the start of the Waiver felt meetings were almost too family-centric and feared families would not be held accountable, caseworkers in the same county had seen positive results of meetings and were more bought-in as the Waiver concluded.

In some instances, caseworkers continued to feel targeted or called out during meetings, which inhibited buy-in. There was a general sense by the conclusion of the Waiver, however, that family meetings were practice as usual—a sentiment underscored by the number of counties who expressed commitment to maintaining some degree of FFE post-Waiver.

Administrators and facilitators expressed excitement and engagement with the intervention. Some counties reported more meetings each year of the Waiver, viewing this as a success. Buy-in was evidenced by community providers, family members, and caseworkers asking for meetings.

MEETING TIMELINESS AND ATTENDEES

Throughout the Waiver, initial meeting timeliness remained challenging for some counties (though not all). Some counties felt adherence at the initial meeting was a tradeoff: they could either hold the initial meeting on time within seven days *or* get a robust group of attendees, but meeting both adherence expectations was difficult. In some instances, counties held an initial meeting with just the facilitator, caseworker, and parents—sometimes at court, right before an initial hearing—and then scheduled a fuller meeting within several weeks rather than waiting 90 days. Some counties felt initial meetings could be overwhelming if held so early in the case (within seven days), whereas others viewed them as helpful. In general, counties believed that having a diverse group of attendees was beneficial for parents and for children.

Some counties felt more at ease with coordinating and scheduling FFEs as the Waiver progressed, but some felt it became more difficult with workers no longer prioritizing meetings as much or accommodating each other's schedules. In some counties, it remained particularly challenging to accommodate professional schedules, or community partners needed to leave meetings early; facilitators struggled with this, believing it was beneficial for providers to come even for some of the meeting but also wanting to demonstrate to families that professionals were invested in the case.

We had a practice before FFE and now we're never going back to that old way again. No way. Awful.

FFE Facilitator

Attendees were often a combination of family-identified participants and agency-identified participants; the agency would recommend, for example, providers or school representatives, and the parent might identify additional family or friend supports. Parents were often ultimately deferred to if they did not want a particular provider in attendance, but generally there was consensus.

Required participants for FFE meetings included the facilitator, caseworker, parent, and parent-identified support person. However, meetings often and ideally included many more participants, such as:

- Child welfare supervisors or other staff, such as family finding staff;
- Extended family members, including grandparents;
- Significant others or spouses;
- Kin caregivers or foster parents;
- Family friends;
- Therapists and other providers;
- Teachers or school representatives;
- CASAs; and
- Probation officers.

In addition to the attendees above, legal representatives sometimes attended FFEs, especially GALs. Facilitators expressed ambivalence about the attendance of legal representatives at FFEs throughout the Waiver, especially respondent parent attorneys/respondent parent council, noting that meetings seemed more like legal proceedings when they were present. Some counties had policies in place guiding attorney participation.

FFE AND THE COURTS

The courts, and court representatives, were important partners in the FFE interventions. Judges especially had considerable influence; those who were seen as bought into FFE were appreciated by counties, but judges could also disrupt the FFE process. For example, in at least one county, a judge was uncomfortable with bio parents and foster parents attending FFE together, so foster parents were not invited to FFEs during the judge's tenure. Conversely, many counties reported that judges engaged with the

Our judge is very big on reunification and parents. He really likes the family meeting process. He tells parents, 'Go to your family meeting, go to your family meeting, go to your family meeting!'

FFE Facilitator

process, checking in with families to see if they attended FFEs or requesting that families speak with FFE facilitators.

Some judges continued to mandate or court-order meetings, sometimes even for non-child-welfare cases, such as adult protection. And while there was some sense that court-ordering or mandating meetings defeated the purpose of families voluntarily collaborating with the agency, there wasn't a clear sense that families were any more or less engaged based on whether the meeting had been court-ordered or not.

The timing of FFE was also sometimes dictated by court schedules. For example, some counties preferred to hold initial meetings before shelter hearings, and judges were accommodating. This was seen as ideal because, in cases of emergency removals, the agency often felt children could be returned home within 72 hours if there was an FFE to address safety concerns.

Over the Waiver period, county administrators and FFE facilitators worked to bring legal partners on board—joining collaborative best practice teams, attending attorney lunches and providing updates on Waiver interventions, and sending FFE meeting notes to legal partners even if they didn't attend meetings.

ENGAGING WITH FAMILIES

When asked about the benefits of the intervention, supervisors, facilitators and caseworkers almost universally discussed collaborating with families, making decisions together, and getting all those involved in the case on the same page. FFE meetings were seen as a platform for transparency and to demystify the case trajectory and likelihood of or time to reunification. Even though a primary strength of the intervention was engaging with families on an ongoing basis, there remained some sense of ambiguity around how to engage those families who were hesitant or resistant beyond explaining the purpose of the meeting, attempting to schedule a meeting, and offering flexibility in meeting locations and times.

For those families that agreed to attend, however, meeting preparation techniques and meeting agendas were designed to be engaging. Caseworkers or facilitators explained the meeting processes to families. Some counties even invited parents and family members to arrive early, so they could be oriented to the meeting room and space, the meeting process, and how and where notes would be taken. During meetings, engagement techniques included: inviting the family to speak first, sharing family strengths, praising the family for working the case plan, inviting those who weren't speaking to share their thoughts. One facilitator stated, "even when the department or the GAL or the professional disagrees with the family, what they are saying is being heard and we are able to talk about some of those things or discuss barriers."

Additional engagement methods included accommodating family schedules by holding brief FFE meetings during parent lunch breaks, or holding meetings after the workday, scheduling meetings right after visitation when families were already at the agency, or allowing participants who couldn't attend in person to call in by phone.

Counties provided childcare during meetings (some even paid for daycare) and helped parents with transportation. Additionally, counties collaborated with jails and sheriffs' offices to engage with parents who were incarcerated; sometimes these parents participated by phone.

Food and snacks were seen as a way to engage families and create a comfortable and welcoming environment; facilitators in one county mentioned it made meetings feel like meeting around a "kitchen table." However, in the last site visits of the Waiver, several counties mentioned that funding for food or snacks had been eliminated as Waiver intervention funds had decreased. This was viewed as a detriment to engagement. One facilitator estimated that attendance had decreased when food was not available, since many families were living in poverty and snacks were an incentive.

FFE MEETING REPORTS AND NOTES

Meeting documentation and notes were also meant to engage families. Many counties projected notes during the meeting, so the families were clear on what was being documented. And whether or not notes were projected, all counties indicated that summary notes and action items (sometimes called an action plan) were disseminated to all meeting attendees following the meeting. Parents could receive this via hard copy or email, according to their preference. In some counties, facilitators sent notes to caseworkers to review before the notes were disseminated.

These plans were viewed as a strength of the family engagement intervention, keeping parties accountable for their tasks: "That way it keeps the caseworkers accountable. It keeps the GAL accountable. It keeps the family members accountable. It's that accountability piece that I think people really value."

REFERRING FAMILIES FOR FFE AND SERVICES

As the Waiver neared its conclusion, facilitators reported that the process of referring families for FFE was working well and had become efficient and streamlined. Notably though, internal referral processes differed from county to county; large counties tended to have solidified processes, such as forms for caseworkers to fill out or joint calendars for caseworkers to schedule meetings, whereas smaller counties were more informal. In some small counties, facilitators simply "knew" about all cases opening and handled scheduling without direct referrals from caseworkers: "We're so small that we know our families. We know our clients. We know when somebody has or has not had a family engagement meeting or a PRT." When there were complications with referrals, the complications were viewed as the result of one particular worker rather than a process issue. In those cases, facilitators relied on supervisors to work with caseworkers to refer families promptly.

Some counties reported firewalls or checks and balances to ensure meetings occurred. In some instances, counties pulled reports on a weekly basis to ensure all eligible families had been served, or prevented county legal teams from filing with courts until an FFE occurred; some even prevented placement staff from searching for placements until the first FFE.

One primary goal of FFE was to connect families with services. Meetings avoided duplication of services or too many services, since families could provide direct input on their capacity to manage multiple services. Some counties relied heavily on the attendance or participation of service providers, too. To approve services, supervisors or administrators either attended meetings or were available by phone or email during meetings. This often allowed families to leave meetings with referrals in hand, or it at least expedited the service approval process within the county. During the first half of the Waiver period, there still seemed to be substantial barriers to services; some counties had complicated service authorization processes which took weeks. However, many of those barriers were addressed during the Waiver and, more so than at the start of the Waiver, caseworkers had been given more authority to approve routine services during meetings to expedite service delivery. FFEs were an opportunity to connect families with appropriate services. Some facilitators asked, “What do you think would work for your family?” as a way of honoring family voice in choosing services and making sure services were relevant for families.

While FFE served as a gateway to services, a host of contextual factors influenced access to services. Across counties, there were housing shortages (including emergency housing), lack of Spanish-speaking providers, waitlists for mental health services, and a dearth of mental health and substance use treatment providers. These service gaps were especially problematic in more rural counties and for families who were undocumented or otherwise marginalized. Additionally, a family’s insurance or Medicaid eligibility sometimes limited access to services, depending on which Core Services providers counties contracted with.

ROLES OF FFE MEETING ATTENDEES

The core professional FFE attendees—facilitators and caseworkers—carried differing roles in the implementation and delivery of FFE services. In general, facilitators organized and led meetings, took and disseminated meeting notes, mediated conflict, and ensured everyone had a turn to speak. Facilitators participated in naming family strengths (as did all attendees) and recommending services. Facilitators served as neutral parties; many facilitators preferred not to have too much background about the case prior to a meeting to maintain their neutrality.

In smaller counties, facilitators sometimes maintained additional roles, such as carrying small caseloads of FAR cases, managing visitation, or facilitating PRTs. In some counties, facilitators operated in a caseworker support capacity, providing feedback and guidance on cases. As an output of FFE, some counties started doing more staffings and group supervision prior to FFEs to bring everyone on the case together, especially supervisors—and facilitators often played a role in these activities. Additionally, facilitators held responsibility for training new caseworkers on the FFE process and providing unit-level practice or data updates or reminders, often during staff meetings, to workers.

During meetings, caseworkers were typically responsible for communicating about specific safety concerns including highlighting why the agency was involved with the family. During subsequent meetings, caseworkers updated attendees on the family’s

progress with their treatment or case plan. Caseworkers also participated in goal-setting, service planning, and service referrals; intake caseworkers played a lead role in initial FFEs, while ongoing caseworkers were typically responsible for subsequent FFEs.

Both caseworkers and facilitators believed they were responsible for engaging with and developing relationships with families. At times, caseworkers experienced challenges around pursuing this goal while also sharing the safety concerns or risks; caseworkers sometimes felt like the “bad guy” during meetings, though this sentiment seemed to decrease as the Waiver progressed. When supervisors attended meetings, they provided support for caseworkers, helped with service approval, and sometimes served as scribes. Other times, facilitators scribed for one another in counties with more than one facilitator.

FFE TRAINING

Like the other Waiver interventions, initial and pre-service training for facilitators was perceived as strong. State representatives provided trainings on facilitation, and some counties received or participated in trainings on specific models. During rollout, facilitators attended intensive trainings and Annie E. Casey Foundation–sponsored trainings; some facilitators even traveled out of state for skills institutes. There were fewer training opportunities following the rollout, especially for those counties not along the Front Range. Additional trainings, such as The Art and Heart of Facilitation, were provided through the Colorado Child Welfare Training System, delivered through four Regional Learning Centers. And facilitators also had opportunities to shadow facilitators in other counties, especially when counties were trying to implement the same model. Some facilitators even attended Colorado Bar Association Mediation Training to gain skills in neutrality. Toward the conclusion of the Waiver, there was effort at the state level, with county involvement, to standardize and recommend the types of training required to become a facilitator; at least one county created an internal facilitator certification process.

Because many counties implemented FFE during the first year of the Waiver, facilitators who came on board after this period experienced fewer opportunities for training. And when new facilitators were hired, especially in more rural counties, there were few immediate training opportunities.

Overall, facilitators reported a need for greater family engagement training, education, and information sharing. However, a quarterly family engagement forum which began prior to the Waiver—led by the State, with input from counties—was identified as an opportunity for learning and engaging with other facilitators. Staff reported appreciation for the FFE intervention lead at the State and the learnings that occurred during the forum. Counties not on the I-25 corridor—those with fewer opportunities for in-person collaboration with other counties—noted that forums were especially helpful. One facilitator said, “But the forums, oh gosh, being able to collaborate with other facilitators, being able to get some training hours, being able to learn about what other interventions other counties are using. They’re wildly beneficial. I truly try and make a point to go.” Some facilitators had such positive

experiences through the forum that they truncated and replicated it within their own counties through supervisor meetings—discussing issues such as helping caseworkers engage with families, barriers to effective meetings, and what was working well.

Caseworkers also participated in pre-service trainings and benefited from within-county trainings. Throughout the Waiver, new workers observed meetings; some counties had worksheets that new caseworkers completed during meetings to identify engagement techniques, and a family engagement meeting quality assessment tool was also developed through State and county collaboration. Some counties integrated family engagement training into their mandatory new worker training and ensured that each unit received tailored family engagement training.

FFE AND OTHER WAIVER INTERVENTIONS

FFE meetings overlapped with each of the other Waiver interventions. For information on the overlap between FFE and PRT, see the “PRT and other Waiver interventions” section of this report. In those counties implementing TSAT and FFE, FFE meetings were sometimes used as a platform to discuss results of the trauma assessment and recommendations around trauma-focused treatment. Often, trauma clinicians were present at FFE. And in those counties implementing KS and FFE, meetings were often attended by kin caregivers and sometimes seen as an opportunity to connect caregivers with services. In addition, family finding staff attended FFE meetings (and were hired through FFE intervention funding), especially initial meetings, to document family members for later searches (such as through LexisNexis), and some facilitators and counties developed genograms during the family meeting process. So, FFE was sometimes the mechanism to find kin caregivers who were then eligible for kinship supports. Meetings also served as a platform to mediate relational or visitation issues between kin and bio parents.

FAMILY ENGAGEMENT DATA SYSTEMS AND ONGOING MONITORING

Trails is and was the primary system to track FFE meetings; facilitators or support staff entered meeting data into the FFE-specific framework. In some counties, data were entered into the Trails FFE framework during meetings, whereas other counties entered data after meetings; this depended, in some counties, on if a scribe was available during meetings. When meetings and meeting data were not entered during meetings, facilitators noted it could be challenging to have time to enter meeting data around their other facilitation and coordination responsibilities.

In addition to Trails, many counties reported using ancillary systems or mechanisms to run reports, such as Crystal Reports, to track meeting information. Some counties didn't have other systems but used Excel to track meetings due, meetings cancelled, reason for cancellation, type of case, etc. CDHS provided a quarterly ad-hoc report to counties which outlined intervention-specific data and some adherence measures; this was seen as quite useful by county staff, who would use it to double-check their own tracking. CDHS also provided monthly case level stats on an ongoing basis to counties that requested them. Staff mentioned that some data—such as the number of families eligible for family engagement—were not easy to pull out of Trails, which is

why some counties used ancillary systems. Some counties also received assistance from the Annie E. Casey Foundation, or other entities, to monitor and track data through project-specific databases.

Some counties also collected meeting data from families to improve the delivery of services, though this was heard less frequently during the second half of the Waiver period; one county mentioned its family meeting survey was not resulting in substantive information.

Intervention-Specific Findings: Permanency Roundtables

The following are findings from site visits related to the PRT intervention. Generally, the findings synthesize what was heard from county administrators, managers, supervisors and intervention leads, facilitators, caseworkers, and community partners during visits to county departments of human/social services. Youth perspective on PRT is highlighted separately in the “Youth focus group” section.

YOUTH SERVED & INTERVENTION BUY-IN

PRT facilitators, caseworkers, and community partners were generally bought into the PRT intervention, particularly the importance and efficacy of PRTs for older youth with OPPLA goals. However, as the target population expanded during the second year of the Waiver to include all youth in care for longer than 12 months, staff were less convinced that PRTs were necessary or appropriate for that population, especially for younger children, adoptions cases, or children with developmental disabilities. However, some counties did find PRTs particularly helpful for youth with developmental disabilities (DD) in preparation for transition to adult DD services or to address other non-permanency goals. Some caseworkers indicated that PRTs would be more productive if held on an as-needed or case-by-case basis rather than over the life of the case—and this seemed to be the direction counties were planning on moving after the Waiver concluded. When asked to identify a specific target population for whom PRTs were most useful, caseworkers in one county settled on adolescents age 13 and above in congregate care who likely would not reunify with their parents. There was general agreement across counties that PRTs were especially useful for older youth.

Some child welfare staff perceived that GALs or other partners were not fully invested in the PRT intervention, a sentiment that was confirmed during the GAL focus group. Caseworker buy-in to the intervention varied between counties and among workers within counties. Caseworker buy-in may have impacted the number of youth who received PRTs, since, in some counties, caseworkers were responsible for referring youth for PRTs. When a caseworker was burned out with working with a family, the PRT process was seen as helpful, however, since it brought in other people to assist with the case. Overall, departmental messaging and buy-in to the importance of permanency, connections, and relationship-building may have also influenced caseworker engagement in the intervention.

REFERRALS FOR PRT

Referral processes varied within counties or regions to assure eligible youth received timely PRTs. Some counties, particularly smaller counties with low numbers of youth in the eligible population, did not have formalized processes. Other counties had formalized platforms for referrals, such as monthly permanency planning team meetings during which staff identified and communicated about eligible youth. Some counties had forms—paper or electronic—for caseworkers to turn in to facilitators. As the Waiver progressed, counties noted that the ad hoc report received from CDHS helped them identify those youth who were eligible.

PRT STAFF

PRTs brought together a robust group of child welfare and non-child welfare professionals, family members, and youth. Staff roles within PRTs are described below.

Master Practitioners/Facilitators. The Waiver enabled counties to hire dedicated facilitators or Master Practitioners; facilitators generally had a master’s degree in social work and prior experience as caseworkers. Some also served as FFE facilitators; rarely, but sometimes, facilitators held other roles within their agencies, too. As the primary staff who facilitated, organized, and managed PRTs, facilitators held many roles, ranging from organizing and scheduling the PRT, to keeping the PRT focused on youth and permanency, to checking in with caseworkers to ensure they were prepared for case presentations.

Caseworkers. Ongoing or permanency workers played a pivotal role in PRTs since they typically had the most knowledge of the case, what had been tried before, and often, the strongest and/or longest relationships with youth. Intake workers did not play a substantial role in PRTs. While caseworkers were primarily responsible for preparing and sharing the case presentation, many also prepared youth for the PRT and, in some counties, caseworkers traveled to neighboring counties to serve as external consultants.

Internal and External Consultants. The external consultant was meant to bring a fresh perspective and to challenge staff to think creatively or revisit options that were not feasible earlier in the case or when the youth was younger. The external consultant did not have prior involvement with the case and was often a community provider or a caseworker from another county. However, while this role was cited as important, it was also noted as one of the more challenging PRT roles to fill; sometimes counties couldn’t find external consultants or the youth-serving system in a county was so small that nobody was truly external to the case. Further, counties sometimes didn’t bring in external consultants for those cases that were deemed more straightforward—for example, a secure placement with adoption pending—wherein creative solutions to permanency were not seen as needed. The internal consultant role—someone with agency familiarity, but not working directly on the case—was often filled by another staff member within the child welfare agency, such as the supervisor.

Supervisors, Managers, and Administrators. Supervisors and managers were also often present at PRTs, as it was important to counties to have at least one administrator who could approve services or creative solutions during the PRT and help the PRT team remove barriers to permanency or youth success. In some counties, managers or administrators also scribed during PRTs so that the facilitator could focus on active facilitation rather than documentation.

PRT STAFF TRAINING

Pre-service PRT training was perceived as strong; staff in those counties that implemented PRTs at the start of the Waiver recalled comprehensive and rich training on the model, data entry, and youth needs. Some counties indicated that PRT training was adequate and that the State provided ongoing trainings since the start of the Waiver, while others indicated there were not many trainings for caseworkers or master practitioners after the first few years of the Waiver. This variance could be due to county location, size, and other factors that influenced access to trainings.

The PRT teleconference and forum—facilitated by CDHS—were highlighted as helpful ongoing opportunities for learning and training, including opportunities for counties to learn from one another and receive evaluation updates. Yet, the ability of staff to attend forums in-person varied by county. Participants also noted that in-state conferences such as the annual Kempe Center Conference on Innovations in Family Engagement were helpful for gaining engagement skills for FFE and PRT.

YOUTH VOICE IN PRT & ENGAGING YOUTH IN PRT

Youth voice and perspective was integral to successful Permanency Roundtables and particularly to Colorado’s Youth-Centered Permanency Roundtables model. As such, counties utilized a variety of methods to enhance and highlight youth perspective and to facilitate youth comfort and engagement during PRTs. Colorado’s Youth-Centered PRT model centered on youth participation, meaning that

youth were involved in, or represented at, the roundtables. However, younger youth were sometimes represented but not present at PRTs. While counties consistently held Youth Voice meetings for youth 16 and older with an OPPLA goal, there was variance for youth under age 16 who had been in care for 12 months or longer. One county, for example, generally didn’t invite youth to PRTs if they were under 15 years old, while others generally invited youth older than 12. Counties also had creative approaches to involving younger youth—some invited those youth to the first portion of the PRT only; one facilitator noted “We’ve had the most success with one particular

With PRTs sometimes we have a permanency pact, which is an agreement made up of people who the youth has identified as a support, and we help identify the specific ways that each person is able to provide support for the youth. **Sometimes the pact is just about helping to set boundaries within relationships to help support youth.**

PRT Facilitator

family, a sibling group of five. We split our PRT into two and we had kids come for the first section and they told us all their goals and hopes and dreams for how their life will be when the department case closes. And then they go get ice cream with the visitation supervisor while we talk about how we make those hopes and dreams a reality.”

Counties employed a variety of mechanisms that enhanced youth engagement such as providing snacks or meals during or after PRTs and letting the youth choose his or her own seat during the meeting. In at least one county, the PRT facilitator took youth out to dinner prior to the PRT to prepare the youth and demonstrate to the youth that the county was committed to their permanency and well-being. Across counties and participants, the strengths-naming segment of PRTs (sometimes called “strengths bombardment”) was seen as particularly engaging. During this segment, meeting participants verbalized and documented youth strengths. These lists were often given to youth; some counties even laminated them. As an additional mechanism to engage youth and mitigate power differentials, some PRT facilitators preferred to be called facilitators or coordinators rather than master practitioners, feeling this title was intimidating to youth or families.

PRT PHASES AND ACTION PLANNING

Colorado’s PRTs were divided into six phases: welcome and overview, present the case, clarify and explore, brainstorm, create a permanency action plan, and debrief. With the exception of debrief, counties reported largely following this structure. While the facilitators led the majority of the PRT, the ongoing or permanency worker took responsibility for the case presentation. Across counties, the brainstorming and permanency action planning phases were

PRTs are so unique in that they’re all about the youth. It’s not the GAL’s agenda or the caseworker’s agenda. It’s nobody else’s agenda but the youth’s, and about really **empowering them to take the reins in their life and tell us where they’re going to go.**

PRT Facilitator

perceived as the richest components of the meeting. Counties reported the action planning phase as youth-driven; for example, if a community partner or other attendee wanted a particular action item on the plan but the youth didn’t, the county would defer to the youth’s preference. Action steps were related to tasks to move toward the youth’s goals; these could be college or employment or placement related, as long as the goals were measurable and concrete with buy-in.

Per the CDHS PRT checklist, action steps were supposed to be divided across attendees so that the caseworker and youth did not leave with the majority of tasks and responsibility was shared. Counties reported varying levels of success with dividing tasks among participants. One reason caseworkers suggested their engagement in the intervention was sometimes low was when there was unequal

distribution of permanency action plan tasks and caseworkers left PRTs with long to-do lists. Facilitators in most counties visited indicated they disseminated the action plan to the meeting participants following the meeting. Across counties, caseworkers and facilitators reported varying successes with following through with the action steps in a timely manner, though typically steps were completed by the following PRT.

PERMANENCY, CONNECTIONS & RELATIONSHIP-BUILDING

While one goal of PRTs was legal permanency, meetings were also focused on relational permanency, such as increasing the number of permanent connections youth had and growing connections with family or friends who could provide tangible support for the youth even if not a placement. During the first two years of the Waiver, counties discussed how it was challenging to move beyond initial thinking about barriers or a sense that “everything has been tried”; as the Waiver progressed, however, counties reported creative thinking about relational permanency as an output of PRTs. For example, counties more frequently engaged in permanency pacts, which were formalized agreements between the youth and trusted adults which outlined what the youth could expect relationally from the adult, such as help with car maintenance or an invitation to Thanksgiving each year.

Staff in one county noted that PRT successes “are as individual as the cases are” — varying from legal permanency such as adoption or guardianship to increased connections to planning for college. Some youth found permanent connections through PRTs, including previous foster parents, who weren’t documented in Trails. PRTs were influential in uncovering permanency options for youth who otherwise were deemed as having no options; as a result of PRTs, options were considered that had not been tried before in practice, including reinstating parental rights if appropriate and revisiting relatives who perhaps weren’t able to provide support when the youth was younger. One facilitator said “there’s pretty good work that can be done in PRTs, like increasing permanent connections, increasing community involvement, working on the transition to emancipation” even when legal permanency was unlikely.

Some counties talked about deciding to pursue emancipation because of opportunities it allowed. For example, one youth needed to transition to adult protective services and the associated developmental programs; to do so, the youth could not have legal permanency. Because the PRTs helped plan for this youth’s care even though there was not legal permanency, a worker noted “we consider this a success, Trails considered it a failure.” PRTs were also viewed as a platform for transparency and realistic planning. For instance, because it is common for youth to reinitiate contact with their bio parents when they become adults, some counties encouraged this contact as part of the PRT process so that the youth could make contact safely and with the support of child welfare staff.

Part of the PRT process was explaining what “permanency” means to youth. Sometimes youth interpreted “permanency” to mean adoption, which was not always a favorable option to youth. PRTs were also seen as platforms for myth-busting,

because sometimes youth carried misinformation about county rules or guidelines that could be addressed during roundtables.

PRT & COLLABORATION

Strong community partnerships translated to PRT roles being filled, as external consultants were often recruited from community-based agencies. However, when there was turnover at community agencies, new external consultants had to be trained. Beyond serving as external consultants, other community partners also participated in PRTs; these included youth advocates, GALs, Chafee workers, Independent Living program staff, Fostering Futures staff, family finding staff, CASAs, probation officers, and others. Even though county departments of human/social services maintained strong partnerships with providers, some counties experienced a lack of resources and services available for youth, even when existing resources were pooled and accessed creatively. For example, workers noted that not all counties had designated Chafee workers or Independent Living programs during the Waiver. Further, shortages in affordable housing or limited public transportation really impacted youth independence and employment plans and opportunities.

Collaboration with the Courts. Collaboration with the courts was seen as key to successful PRTs and permanency action planning, since the courts might approve plans or placements. GALs were cited as common partners in the PRT process. As the Waiver initially rolled out, counties worked diligently to educate the court system about the need to provide permanency for youth. Staff conducted trainings for the courts, brown bag lunches (bringing examples of successes), and conversations before and after PRTs. While GALs and attorneys were not required PRT attendees per CDHS's model, they were perceived as strong community partners and attendees. As the PRT process progressed, judges became more bought-in in some counties. In one county, for example, a judge indicated that if the caseworker and GAL agreed on a plan for a youth through a PRT, they could file a motion with the judge and no new hearing or court orders would be required, which allowed the county considerable flexibility in meeting the needs of the youth.

GUARDIAN AD LITEM FOCUS GROUP

Because of the role of the courts in pursuing legal permanency for youth, a focus group with GALs on their experience collaborating with county departments of human/social services through the Waiver interventions was conducted. During the focus group, most of the conversation centered around PRTs. Notably, both child welfare practitioners and GALs themselves reported generally high GAL buy-in to and enthusiasm for FFE after initial implementation kinks. However, as the Waiver progressed, it remained challenging for some counties to find common ground and alignment between child welfare practitioners and GALs around PRTs. County department of human/social services efforts to engage GALs, and to explain the goals of the intervention, varied considerably by county, as did GAL perceptions of the appropriateness and efficacy of PRTs. After conducting a focus group with GALs from several counties and interviewing PRT facilitators (or Master Practitioners) across many Colorado counties, themes related to areas of agreement and areas of

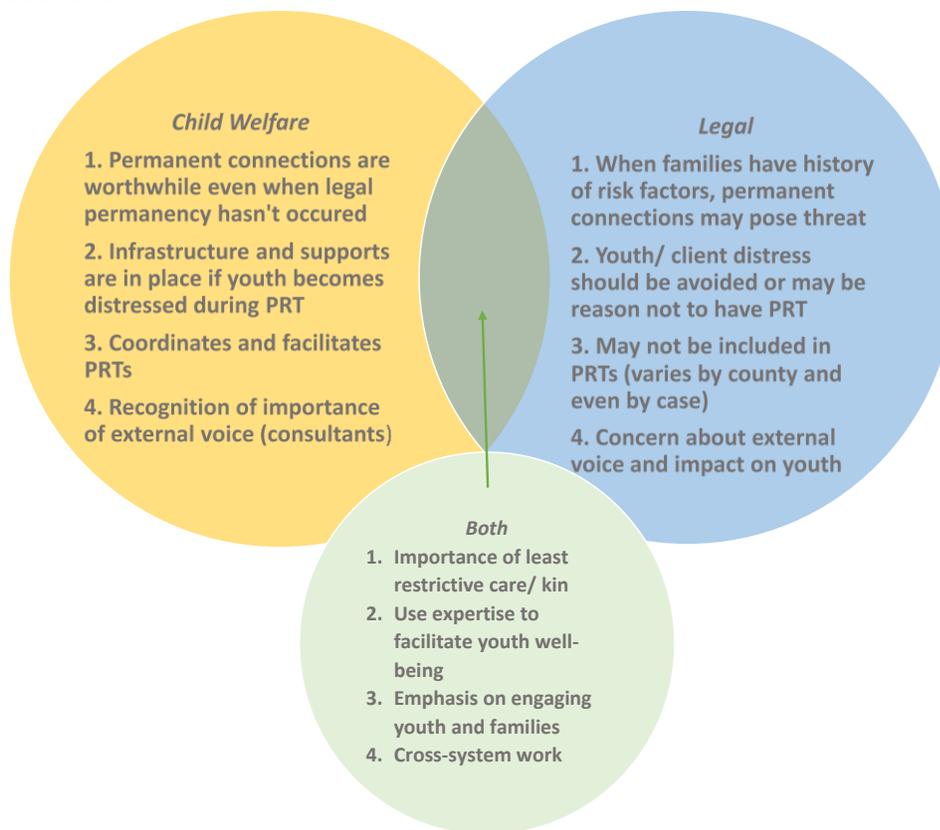
dissonance emerged between the two systems related to the intervention. Those are highlighted below.

Dissonance. Since the goal of PRTs was not just legal permanency but relational permanency and enhanced permanent connections, child welfare practitioners utilized the intervention to engage with relatives who may not have been appropriate for legal permanency; GALs, who represent the best interests of the child, expressed concern about youth being in contact with their family members with historical child welfare involvement or risk factors. Similarly, GALs also expressed concern that youth might become distressed or agitated at PRTs during challenging conversations about, for example, the youth having few permanency options; GALs wondered if it was in the youth's best interests to revisit or relive those realities. On occasion, child welfare caseworkers felt the same way, but facilitators largely felt that youth, especially older youth, were able to tolerate difficult conversations for the sake of action planning and permanency seeking. Youth themselves, during focus groups, did not indicate having experienced much distress during the PRT process, but they did talk about other painful experiences with adults in their lives.

Since the PRTs were organized and managed by child welfare staff, there was variance in whether counties invited GALs to PRTs—and sometimes this had to do with who the youth wanted present. This could vary by county or even by PRT. GALs desired to be involved in PRTs so they could better partner with the county and youth. GALs expressed some reticence and confusion about the role of external consultants in PRTs, preferring to keep meetings to those who knew the youth well, whereas child welfare practitioners viewed external consultants as bringing in new and valuable perspectives and encouraging exploration of creative permanency options.

Alignment. Despite their different perspectives, there were several key ways in which child welfare practitioners and GALs aligned in their views of PRTs. They agreed on the importance of least restrictive placements and the importance of family and kin involvement either through legal permanency or permanent connection in another way. Both wanted to use their skillsets to enhance youth experience and well-being and desired to engage with youth in decision-making. And, through the Waiver, both child welfare staff and GALs expressed commitment to furthering cross-system work for the enhancement of youth well-being and permanency.

Figure 28. PRT Perception Between Child Welfare Staff and Legal Representatives



Source: GAL focus group and interviews with child welfare practitioners

PRT AND OTHER WAIVER INTERVENTIONS

As the Waiver progressed, there was variance in how counties that were implementing both PRT and FFE approached serving cases eligible for both. In some counties, the determination of which intervention a family received was largely left to a meeting facilitator. In some counties, if the goal was to reunify/return home, FFE meetings and not PRTs were held even if the child or youth was in the PRT target population: “If you’re returning home we try and keep you in the FFE world just because the model works better to have those kinds of conversations, but once you’re not going home you’re eligible and open for a PRT.”

Some counties combined PRTs and FFEs into one extended meeting with distinct phases focused on engagement and permanency. This route was seen as less burdensome for families, youth and community partners (since they only had to attend one meeting quarterly) though it sometimes was challenging to really focus on permanency and action planning. Combined meetings were also perceived as “awkward” when the goal was no longer reunification.

Another approach involved determining which meetings would be held on a case-by-case basis. When combined meetings were held, sometimes the meetings were entered into both the FFE and PRT Trails frameworks, but not always. Participants

reported that they thought families were able to distinguish between the two types of meetings and their functions, but community partners had a harder time understanding the difference, and many preferred FFE to PRT; youth themselves, as noted below, did sometimes feel confused about the differences between FFEs and PRTs.

PERMANENCY ROUNDTABLE DATA SYSTEMS AND ONGOING MONITORING

The primary data system for tracking PRTs is and was Trails. Within the system, there is a specific framework dedicated to the intervention. Counties reported that, for PRT, data entry practices improved over the course of the Waiver. Case aides or facilitators entered data from PRTs into the Trails framework either during PRTs or following PRTs; one county found it created awkwardness for youth and families when data were entered directly into Trails during meetings. The PRT framework action plan section was brought up as a concern, with staff noting it was difficult to maneuver and not very user-friendly. In addition to entering meeting data, staff also tracked permanent connections over the life of the case and permanency ratings in Trails.

Some counties—larger counties in particular—that had their own data systems in addition to Trails had the capacity to create “flags” and “ticklers” which alerted the PRT coordinator when a youth had reached the seven- or eight-month mark in an out-of-home placement. This facilitated timely planning and implementation of the first PRT when the child or youth reached the 12-month mark in out-of-home care. Not all counties had their own data systems outside of Trails though, and some just used Microsoft Excel to track meeting dates to ensure timeliness. As the Waiver progressed, the State also provided an ad hoc point-in-time report that helped counties track who was eligible for PRTs, when meetings were due, and other measures.

Intervention-Specific Findings: Kinship Supports

The findings presented here are from site visits related to the KS intervention. Generally, the findings synthesize what was heard from county administrators, managers, supervisors and intervention leads, kinship supports workers, and community partners during visits to county departments of human/social services. Kin caregiver perspectives on KS are highlighted separately in the “Kin Caregiver Focus Group” section.

KS INTERVENTION COMPONENTS

The key intervention KS components common across counties included the hiring of staff specifically designated to support kin placements; the use of flexible funding to address short-term needs of kinship families; and the implementation of a kinship caregiver needs assessment to help determine the needs of kin caregivers.

Counties provided financial support to kin caregivers in various ways depending on the needs and resources in their respective areas. Examples included gas vouchers, clothing, food, utility payment support, car seats, diapers, formula, high chairs, school supplies, children’s furniture, etc. Waiver funds also supported kinship caregivers

with costs related to certification (for example, health evaluations or window well covers); costs associated with family therapy; parenting and other classes for kin caregivers; child care; and respite care.

One challenge that was noted related to services was that critical support such as child care or respite is typically discontinued once the family's case is closed, and this placed a significant financial burden on kin caregivers, even serving as a disincentive for guardianship or adoption. Another challenge was coordinating TANF benefits and ensuring kin caregivers were receiving child-only TANF. Some staff reported that kin caregivers do not apply for this benefit because of the requirement that child support payments be made by the parents; grandparents, especially, were hesitant to place burden on parents in this way.

KS STAFFING STRUCTURE

Over the five years of the Waiver, many counties successfully added staff specifically dedicated to support kinship placements. Staff reported that having designated kinship caseworkers to work with kin families was “huge progress.”

Initially, staff reported that role clarity with caseworkers was a challenge; as staff structures evolved over the course of the five years, however, staff reported such challenges less frequently. Staff noted it was beneficial to have someone dedicated solely to the needs of kin caregivers rather than balancing multiple priorities: “Having that kind of buffer where the kinship caregiver can go to the kin support worker to get their support needs met versus going to the caseworker who's trying to work on reunification, it just—it provides that buffer, provides that kind of more neutral person—I think that that is helpful.”

The types of staff structures varied by county, with larger counties having designated kinship teams and smaller counties assigning workers to kin placements. Titles used for the positions varied and included Kinship Navigators; Kinship Support workers and supervisors; Benefits Navigators; Kinship Coordinators; and Kinship Foster Care Coordinators. While these roles varied, they all conducted outreach efforts with community partners in order to find or coordinate resources for kinship families, and worked directly with kin to meet their needs: “They may only have contact once every six months, sometimes it may be once a month, sometimes once a week—it really is dependent on the needs of each kinship family and also the wishes of the kinship family: some of them don't necessarily want to have contact frequently with the workers and don't necessarily need it but also want to have that option to give somebody a call if that need were to come up.”

There were many counties who didn't necessarily have kin workers prior to the Waiver or had very few. **We have seen our counties increase the number of Kinship Support workers that they have on staff through the use of Waiver dollars. We have one county that had one unit and doubled in size. They went to two full units better supporting kin.**

Kinship Care Program Administrator

STAFF TRAINING

Training caseworkers and kinship support workers was noted as a “constant challenge” due to turnover. Providing adequate training regarding background checks and other critical processes continued to be a need as the Waiver progressed. Staff requested additional training on best practices related to kin placements, with one staff member stating: “It seems like overall we could use more training and awareness on how we best support kin families.”

The State administrator began offering monthly, and then quarterly, KS teleconferences, and these were viewed as helpful by staff, providing a forum for peer-to-peer learning, discussion of best practices, resource sharing, and cross-county collaboration opportunities. A statewide training was also provided on use of the KSNA and data entry expectations. Further, the Kinship Alliance meetings, which were held in the state prior to the Waiver, provided opportunity for KS updates. A more general training on working with kin providers was developed in collaboration with the Kempe Center. One supervisor stated what others also expressed: “Having more access to trainings like that I think would be beneficial to everybody.”

SERVICE DELIVERY SYSTEM

Counties reported that all families with an open kinship case, whether voluntary or court-ordered, were generally eligible for kinship supports. Notably though, some counties limited their use of hard good funds for non-certified kin families. Referrals for kinship

supports primarily came through caseworkers. Some participants noted that high caseworker turnover and limits on capacity impacted timely referrals to the kinship staff. Some counties were able to combine funding from other sources to serve families referred by community partners.

Throughout the Waiver, counties maintained different practice philosophies on the certification of kinship families. In some counties, kinship placements were with non-certified caregivers; other counties had a longstanding practice to certify kin families, and the majority of kin families were certified. The vast majority of kin caregivers across the state choose to be non-certified, and the majority of Kinship Support was reported as being provided to non-certified families.

The Kinship Support Needs Assessment was used across counties to determine the needs of kin caregivers and to prioritize resources. Designed to be completed within seven days of the referral, staff reported the assessment as a helpful tool. One staff member noted: “We do use the needs assessment, which can be helpful to get the

We get referrals from teachers, from different community agencies, senior centers...we're really open about wanting to provide support to families in our community, knowing that if they can stay with grandma they're not coming to foster care – so let's see what we can do.

Kinship Navigator

conversation going around certain areas that families might be more reluctant to talk about. It gives us a way to do that.” Once the needs of kin caregivers were identified through the assessment, KS staff worked to find appropriate resources. Primary services provided to kinship caregivers included crisis intervention; applying for benefits such as TANF or SNAP; short term flexible funding for a variety of needs such as furniture, diapers and formula, clothing, or school supplies; information and support; and advocacy in navigating the court and child welfare systems.

THE ROLE OF THE COURTS

Counties consistently reported that judges and other court personnel were very supportive of and placed value on kinship providers and favored kinship placements over traditional foster care. Staff described several ways in which the courts demonstrated support of kin placements. Judges asked, “Did you look at any family members?” or thanked family members for volunteering to care for the children. This was reported as a cultural shift from more traditional foster care placements prior to the Waiver to less restrictive placements during the Waiver, as well as a shift toward active support and appreciation of kin caregivers during court. As one KS supervisor stated: “I supervise seven different programs... but this program gets by far the most positive feedback from the community. GALs are typically very critical... but kinship, they don’t complain about that at all. They really appreciate it. The judge does too.”

Our judicial system really likes the kinship program and feels like we are offering a very good service.

Kinship Support Supervisor

Staff noted that kin caregivers are the only party in court without legal representation. KS workers accompanied kin caregivers to court to help them understand the proceedings.

OVERLAP WITH OTHER INTERVENTIONS

The primary overlap between KS and other Waiver interventions occurred between FFE and KS. For more information on this overlap, see the “FFE and other Waiver interventions” section previously presented in this chapter.

ONGOING MONITORING AND OVERSIGHT

Kinship placement and services data are tracked in Trails, like the other interventions. The primary monitoring tool used within the KS intervention is the KSNA. In 2016, the tool was added into the Trails system so that workers could document not just that the assessment was completed but also the data from the assessment. Administrators reported being able to track families receiving kinship supports better because of this. The State administrator noted the needs assessment as a success of the Waiver early on: “So having that process of being able to assess what the kin family needs and then make a plan for how to help them meet those needs, I think, is huge, and that we did fairly early on... in probably years one and two, and haven’t really made any changes to that—we have a fairly well-implemented tool, which is really helpful.”

Intervention-Specific Findings: Trauma Interventions

The following are findings from site visits related to the TSAT and CWRC interventions. Generally, the findings synthesize what was heard from county administrators, managers, trauma care coordinators, clinicians, and caseworkers during visits to county departments of human/social services. While the CWRC evaluation was a Waiver substudy (included as an annex to this report), some counties implemented both the TSAT and CWRC interventions, so qualitative data related to both interventions were captured. In this section, the interventions are described and contrasted. Table 11 provides an overview of the alignment of intervention components between TSAT and CWRC. Following this section is case study of a county that implemented both the TSAT and CWRC interventions for a deeper look at implementation challenges and successes.

Table 11. TSAT and CWRC Intervention Crosswalk

	TSAT Only	TSAT + CWRC	CWRC Only
Number of Implementing Counties (in year five)	7 counties	5 counties	3 counties
Screening Protocol	Complete Southwest Michigan screening tool for target population, as determined by county	Complete Southwest Michigan screening tool for target population, as determined by county	Complete Southwest Michigan screening tool for target population, as determined by county
Data Collection - Screens	Trails	Trails	Trails
Referral Process	Primarily refer children who screen-in to CMHCs (or sometimes independent providers) for assessment	Refer children who screen-in to CMHC or independent providers for assessment, including the Colorado State Child Trauma and Resilience Assessment Center or others trained in in-depth and multidimensional assessment.	Refer children who screen-in to independent providers for assessment, especially the Colorado State Child Trauma and Resilience Center or others trained in in-depth and multidimensional assessment.
Data Collection - Referrals	Trails	Trails	Trails
Pre-Assessment Protocol	Clinician reviews referral from child welfare	Clinician reviews referral from child welfare OR →	Review of abuse/neglect history; interviews with caseworker, caregiver, and others; caregiver forms
Assessment Protocol	CMHC completes initial and follow-up TSCYCs (ages 3 to 7) or CPSSs (ages 8 to 18) for referred children	CMHC completes initial and follow-up TSCYCs (ages 3 to 7) or CPSSs (ages 8 to 18) for referred children OR →	Referred child receives range of assessments which take 5-6 hours: neurodevelopment testing, psychosocial interview, cognitive testing, language screening, parent/child observation, etc.
Data Collection – Assessments	Google Survey	Google or Lime Survey	Lime Survey
Assessment Review/ Family Meeting	Conversation with caregiver	Conversation with caregiver OR →	Discuss results and recommendations of trauma assessment during FFE Meeting attended by family, child welfare, clinician and others
Treatment Protocol	Treatment provided by provider who completed assessment, if indicated	Trauma treatment or non-traditional services provided by independent provider or assessing clinician	Trauma treatment or non-traditional services provided by independent provider, typically non-assessing clinician
Data Collection – Treatment	Google Survey	Google or Lime Survey	Lime Survey
Track Child Well-Being	Pre/post reduction in assessed trauma symptoms	TOP or CANS completed	TOP or CANS completed

INTERVENTION SUMMARIES

Key components of both the TSAT and CWRC interventions involved comprehensive trauma screening and assessment and engaging with youth and families from a trauma-informed perspective. Participating counties defined their own target populations eligible for each intervention. Seeking to utilize expertise from both child welfare and behavioral health, the interventions relied heavily on coordination and collaboration between county departments of human/social services, CMHCs, and independent providers.

Across both interventions, the Southwest Michigan Children's Trauma Assessment Center Trauma Screening Checklists were used to screen children and youth for signs and symptoms of trauma. Screens were completed by intake caseworkers who screened all children and youth for trauma at the open of a case and referred youth who met screen-in criteria to a mental health service partner for a trauma assessment.

Trauma Informed Screening, Assessment, and Treatment (TSAT). The TSAT utilized two measures to assess trauma, including the Trauma Symptom Checklist for Young Children (ages 3 to 7) and the Child PTSD Symptom Scale (ages 8 to 18). Results of the assessment were incorporated into a family's case plan. Assessing clinicians recommended youth for further services and treatment based on trauma assessment results, and ongoing child welfare caseworkers rescreened for trauma throughout the life of a case and at case closure. Treatment was provided primarily by CMHC clinicians, and children and youth receiving treatment were reassessed every 90 days. While clinicians could recommend any treatment, the State identified specific treatments that had been shown to reduce trauma symptoms. These included: Child Parent Psychotherapy, Trauma-Focused Parent-Child Interaction Therapy, Trauma-Focused Cognitive Behavioral Therapy, Alternatives for Families – A Cognitive Behavioral Therapy, Adolescent Dialectical Behavioral Therapy, sensory integration and the neuro-sequential model of therapeutics, EMDR, and experiential play therapy. The TSAT interventions prioritized discrete trauma-informed assessment as well as ongoing trauma-focused treatment over comprehensive psychosocial or developmental assessments.

Child Welfare Resiliency Center (CWRC). Distinguishing it from the TSAT, the CWRC intervention also collected data on child and youth well-being and utilized different methods for assessing trauma. The Treatment Outcome Package (TOP) and Child and Adolescent Needs and Strengths (CANS) instruments were used to collect data on child and youth well-being. These data were collected at case open and closure and throughout the life of a case to help examine the intervention's relationship to youth well-being.

The CWRC intervention also employed a different assessment model than that used in the TSAT. Clinicians at the Child Trauma Resilience and Assessment Center (CTRAC) at Colorado State University tailored an assessment model to use for CWRC, adapting methods developed at the Southwest Michigan Children's Trauma Assessment Center at Western Michigan University.

Child welfare intake caseworkers screened youth for trauma at case open and referred youth who met screen-in criteria to a mental health service partner who conducted an in-depth trauma assessment following the CWRC model. CWRC assessments were comprehensive and required several hours to a full day to complete. The assessment included neurodevelopment testing, psychosocial interviews, cognitive testing, language screening, and parent/child observation; a comprehensive list of tools and measures used for the CWRC assessment may be found in the appendix of the CWRC Program Evaluation Report, included as an annex to this report. Assessing clinicians provided a summary report of results from the assessment to the child, family and child welfare caseworker, which included recommendations addressing a comprehensive range of needs and in-home parenting strategies.

FROM A TRAUMA-INFORMED INTERVENTION TO TRAUMA-INFORMED PRACTICE

From frontline staff and clinicians to supervisors, managers and directors, what began as an implementation of a delineated intervention transformed into an overall shift that reshaped practice. Knowledge of complex trauma and its impact on child brain development helped shift how caseworkers viewed children's difficult behaviors and relationships with their parents. Agencies realized how intervening in the lives of families itself could be traumatic for children. These shifts in understanding led to changes in language used in discussions with families and service partners. Changes were also made in decision-making and in the types of services and treatments recommended to families. Greater understanding of trauma subsequently led to a greater appreciation of secondary traumatic stress and the indirect effects that working so closely with families affected by trauma had on caseworkers and frontline staff.

Shifts at the ground level were accompanied by shifts at community and systems levels. The close coordination and collaboration between child welfare and behavioral health in implementing the interventions required greater interaction between the two systems, which resulted in greater understanding and appreciation of each other's practices, roles, and expertise. Knowledge of complex trauma and its impact on child development also spread to other system partners, such as the court system, and led to changes in interactions, decision-making, and case planning discussions. Shifts were made in the language used during court hearings, and specific requests for trauma assessments and trauma-informed supports for families increased.

COLLABORATING ACROSS SYSTEMS TO PROVIDE CROSS-SYSTEM TRAUMA-INFORMED CARE

Because of the coordination and collaboration between child welfare and behavioral health that was required to implement TSAT, partnerships between the two systems were largely reinforced during implementation. Increased knowledge of one another's practices and system

What I've heard or heard reported is **that families are feeling like somebody finally got them or heard them.**

Trauma intervention staff

processes also helped to identify barriers that could be addressed to facilitate smoother coordination and collaboration.

In addition to strengthening existing partnerships, implementing the trauma interventions helped to develop more collaborative relationships with other partners. In particular, relationships were strengthened with partners affiliated with the court system, such as judicial officers and guardians ad litem. While initially resistant to the trauma interventions, many of these system partners came to embrace trauma-informed practices by the Waiver's end. Increased understanding of how trauma and system interventions themselves can cause traumatic experiences for young people and their families contributed to greater coordination between systems and alignment of practices to serve and support families.

I think we quickly learned that it was really important to have **models to address the complexity of child welfare kids** and that some of the more traditional models of trauma intervention just weren't really enough for a lot of these kids.

Trauma intervention staff

TRAINING AND PREPARING STAFF

The State provided trainings related to trauma during initial implementation of the interventions, and counties focused on providing training related to specific aspects of the intervention, such as completing a trauma screen with a family. Select counties and sites were also able to help facilitate trainings about trauma for community partners and providers. Clinicians who conducted trauma assessments as part of the CWRC intervention were required to first undergo training related to the CWRC assessment model and participate in clinical coaching and observation. The training and certification of clinicians involved in completing trauma assessments under the CWRC intervention was initially challenging in that guidelines for certifying new clinicians to conduct assessments were unclear and not well defined. Lead clinicians for the CWRC intervention worked to delineate the training and certification process and led the training and certification of clinicians in the seven counties where the CWRC intervention was implemented. TSAT intervention clinicians were not required to undergo similar training to conduct the TSAT assessment, as standard methods were used to assess trauma. Clinicians providing treatment services under either intervention also received training to deliver trauma-informed services.

TRAUMA SCREENS, REFERRALS, ASSESSMENTS AND ENGAGEMENT OF FAMILIES

Processes for conducting trauma screens and sending referrals for trauma assessments between systems were developed and tailored to work across county departments of human/social services and community mental health centers. Children and youth already engaged in mental health treatment or services at the time of their involvement with child welfare services were still screened for trauma, and efforts were made to allow families to continue with their existing service provider to

prevent instability or disruption for children. There were some initial referral system challenges, wherein referrals were not being sent to and/or received by CMHCs. Later challenges that did arise with screening and referral occurred infrequently and typically involved miscommunication regarding required paperwork and documentation, and subsequent delays in connecting with families and bringing them in for assessment and treatment.

Trauma assessments for either intervention were conducted by clinicians at partnering community mental health centers and independent providers. Clinicians who conducted trauma assessments under the CWRC intervention also facilitated meetings with families after an assessment to convey the results. Efforts were made to incorporate the debrief meeting into the case planning process with caseworkers to avoid duplication and overwhelming families with multiple meeting requirements. Accordingly, trauma assessment results were discussed during FFE meetings at the county department of human/social services, so that they could be integrated into the family's case plan while discussing services, and clinicians attended FFE meetings. However, families' schedules and availability made implementing this component challenging and difficult to implement consistently.

Once screening for trauma became a regular component of daily practice, agencies began to consider how the screening measure itself could be further utilized as a tool for better engaging with young people and families. The screen became a tool to facilitate conversations with families regarding traumatic events experienced by their children and how current behaviors of their child could be the result of these traumatic experiences. For counties implementing the CWRC intervention, the TOP and CANS measures also provided opportunities to facilitate conversations with families regarding trauma and how its impact can manifest through different behaviors in children.

Clinicians involved in conducting trauma assessments voiced support for the trauma interventions. One clinician stated that they wished they could implement the same measures for all children who came to them for treatment and services.

CHALLENGES: RESOURCES AND CAPACITY

TSAT and CWRC differed in the resources required to develop and maintain implementation of each intervention. Trauma screens were implemented consistently across both interventions and are viewed as most likely to continue after Waiver funding ends. Capacity to implement trauma assessments differed by intervention, however, with fewer challenges reported with implementing assessment methods used for the TSAT intervention. The assessment model used for the CWRC intervention required considerable resources across the implementation continuum. For example, the assessment model itself first had to be finalized and clearly operationalized—and was developed under the Waiver before its use for the CWRC intervention. The TSAT intervention, in comparison, employed standard CPSS and TSCYC assessments.

As previously mentioned, the training and certification processes also had to be developed for the CWRC assessment to certify clinicians and build capacity to conduct assessments across participating counties. Conducting the actual assessment typically took several hours to a full day and called for two clinicians to be present throughout. Due to the delay in readiness to implement the assessment model and training at the start, implementing to full capacity and in a timely manner remained a challenge for counties implementing the CWRC intervention.

Finally, trauma-focused treatment and services remained limited across the state by the Waiver's end, posing a challenge for both interventions. Providing transportation support to families helped to alleviate access barriers for some; however, it was not feasible to do in all situations. Relatedly, efforts to find alternative sources of funding to fund trauma-informed services highlighted challenges in identifying treatments and services that would qualify as trauma-informed and also be eligible for available funding, such as Medicaid. Eligibility for funding was also a challenge for recommended services and components of the CWRC intervention assessment due their categorization not falling within areas traditionally considered to be under the purview of mental health, such as yoga or tai chi.

This has really shifted our casework practice toward trying to be more trauma-informed with families and understanding what the parents have experienced and why they might be where they are right now with their capacity to parent. It's **really shaped how we have conversations** with the families. It's not just that we have this Waiver and we're doing screens... it's a whole practice that our agency has done over the course of the last three to four years.

Trauma intervention staff

CHALLENGES: CROSS-SYSTEM DATA COLLECTION AND SHARING

Data for trauma screens, referrals, assessments and treatment services were collected for both TSAT and CWRC interventions. Due to the close coordination and collaboration required between child welfare and behavioral health, counties planned to collect and share data across systems to help facilitate implementation and monitor adherence. Complications arose with both collecting and sharing data across systems. Despite both being housed within CDHS, each service system manages its own database into which data regarding practice and service provision are entered and securely stored. These databases are not easily amendable, and external data collection and storage systems were created to collect data for the interventions under the Waiver. Extensive training was provided for both child welfare and behavioral health staff on how to access and enter data into the external databases. These external data entry processes were not well integrated with existing practice and data entry processes, however, and repeated reminders were required to promote consistent data entry throughout the Waiver. Staff turnover and technical difficulties, such as system updates, also contributed to challenges in collecting data. Perhaps due to the difficulties with simply entering and collecting data, sharing data between systems remained a challenge throughout implementation and did not occur as consistently as planned.

Shifting Toward a Trauma-informed Approach: A Colorado County Case Study

Background.

As Colorado's Title IV-E Waiver Demonstration Project progressed, the trauma-focused work implemented under the Waiver also evolved. The trauma-informed screening and assessment, and treatment focused-treatment interventions (TSAT), which began in July 2014, were expanded to include additional in-depth and multidimensional assessments and trauma systems work through the Child Welfare Resiliency Center. Unlike the other IV-E Waiver interventions, the TSAT interventions represented a cross-system collaboration between child welfare and behavioral health, which resulted in both opportunities and challenges.

Even as Colorado counties began implementing the interventions, trauma-informed child welfare work remained in its infancy nationally¹, with counties, states, and jurisdictions still wrestling with how to address the impacts of trauma and adverse childhood experiences and how to avoid retraumatization of children and families. Further, while agencies may implement trauma-focused *interventions*, becoming a truly trauma-informed system— moving beyond intervention to

Moving from a traditional child welfare approach to one that is more trauma informed requires members of the workforce at all levels to *make certain paradigm shifts*. Children's Bureau Issue Brief, 2015



philosophical and paradigm shift— is even more challenging.

In Colorado, several counties sought to leverage Title IV-E Waiver funds to truly shift and overhaul their existing systems and practice orientations to become more trauma-informed. One large, urban county's work is highlighted in this case study, informed by multiple interviews with child welfare and behavioral health staff over the course of the Waiver. This county was selected because of its implementation of TSAT and CWRC, its use of the Treatment Outcome Package (TOP) and its early and progressive emphasis on trauma-informed care. This county is considered a leader in the state and has allocated considerable resources (through the Waiver and otherwise) to this system shift.

In examining this agency's implementation of trauma-informed processes, several core issues emerged as salient— and as learning opportunities for other jurisdictions that might seek to become more trauma-informed^m:

- Shifts in Thinking & Practice Cross-System Collaboration

¹ Walsh, C.R., Conradi, L., & Pauter, S. (2018). Trauma-informed child welfare. *Journal of Aggression, Maltreatment and Trauma*, 1-18.

^mThe Children's Bureau's issue brief *Developing a Trauma-Informed Child Welfare System* served as a guide for this case study, as it highlights many relevant issues.

- Trauma Screening, Assessment & Treatment
- Funding
- Data Collection Systems & Data Use

Each issue is discussed, including intra-county shifts that occurred during the Waiver. Intervention components will be discussed, but more detailed process explanations of the TSAT and CWRC interventions are available elsewhere in the Colorado Title IV-E Waiver Final Evaluation Report.

Shifts in Thinking and Practice.

Through this trauma systems work, the agency embraced shifts not just in practice, but in thinking— thinking differently about families and what they’ve experienced, thinking critically about agency processes, and thinking intentionally about the needs of staff as they work with families who have experienced trauma.

Trauma Lens

What began as a single, delineated intervention turned into a fundamental overall shift in the way families were viewed, treated, and served— a shift informed by a trauma lens, one wherein what has happened to families was discussed more than family “deficiencies”—that is, families were no longer characterized or talked about in terms of short-comings or viewed as deficient in some way because of the trauma they’d experienced. It was a step beyond family-centered practice, to honoring family strength and resilience, and to recognizing

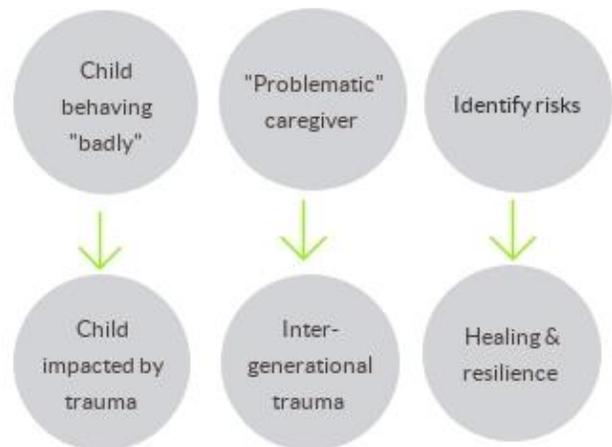
This is some of the more important work that we’ve done as an agency. It gives you hope and a path to *get to kids and families healing and getting better*. I think this philosophical approach is great. It’s the right work that we should be doing with our families.

County child welfare administrator

and speaking openly with families about the impact of trauma, historical and current.

While staff anticipated that considering the impact of trauma in their practice would shift how the agency related to children—through screening, assessment, treatment and an emphasis on permanency— it also shifted how the agency related to parents. For example, changing language used with and for families, and adapting processes to become more sensitive to trauma, allowed staff to build more empathy and connection with families, rather than focusing on diagnoses or problems.

Figure 29. System Shifts that Occurred at the Child & Family Level



Over the course of the Waiver, the agency shifted toward treating the whole family system, recognizing that even if home environments are physically safe for children, their trauma-related symptoms could still be triggered by reminders of their trauma. This meant agency staff approached families with a greater understanding of how trauma may have shaped families and caseworkers worked with the entire family, especially parents, to recognize child and youth behaviors as potentially the result of their trauma. In an effort to begin recognizing intergenerational trauma, some caregivers received adult PTSD assessments, too.

Using a trauma lens also allowed the agency to prioritize child and youth-involvement in case planning, which was empowering for children and youth and helped promote their resiliency. For example, children and youth (as well as other

raters) completed the Treatment Outcome Package. And, during the comprehensive trauma assessment, children and youth were invited to tell their own stories through indoor and outdoor play, discussion, and creative activities. Youth were also the first to receive results from their assessment and given the choice to speak for themselves when meeting to discuss assessment results with parents or caregivers and other adults.

Caseworker Training

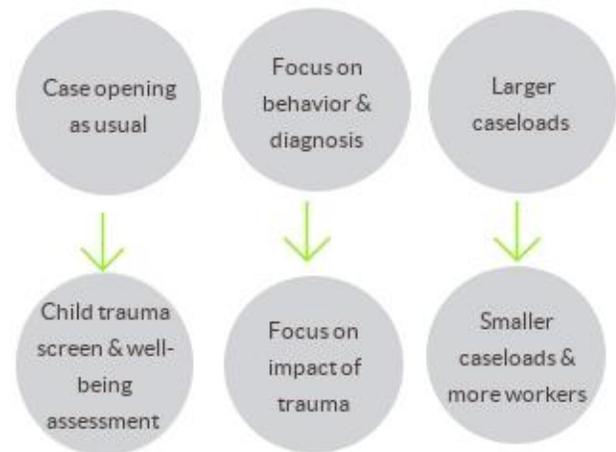
An important element to underscore these shifts in thinking and practice was pre- and in-service training. Training was a major emphasis throughout this county. To underscore the systems-change, staff received training in both the intervention components and more broadly on the impacts of trauma on families and on the brain. Through training, caseworkers learned how to screen children for trauma, refer children who screened-in for further assessment and treatment, and how to work with children and families who have been traumatized. The county also encouraged staff to attend trauma-related conferences and a monthly trauma-related book club for ongoing training, which community and system partners were also invited to attend. Even with substantial training resources, the agency still struggled with enough treatment-specific training, and training for newly on-boarded workers as regular turnover occurred.

Caseworker Support & Attention to Secondary Traumatic Stress

Beyond training, the county recognized the need for enhanced supervision and support for workers. The agency decreased caseload sizes during the Waiver, to allow for more supervisor attention and less caseworker burn-out, even though reduction in caseload size and hiring of new caseworkers came at considerable cost. Supervisors helped caseworkers with role identification and boundaries and distinguished the caseworker role in delivery of the intervention, versus the role of mental health clinicians who conducted assessments and

delivered treatment, to prevent caseworkers from taking on the role of therapist. There was also more group-level support, a resilience alliance for child welfare staff, and more explicit efforts to encourage and celebrate workers. A trauma-coordinator also provided additional support to caseworkers in helping to plan and coordinate trauma-focused treatment and services for families.

Figure 30. System Shifts that Occurred at the Casework/Practice Level



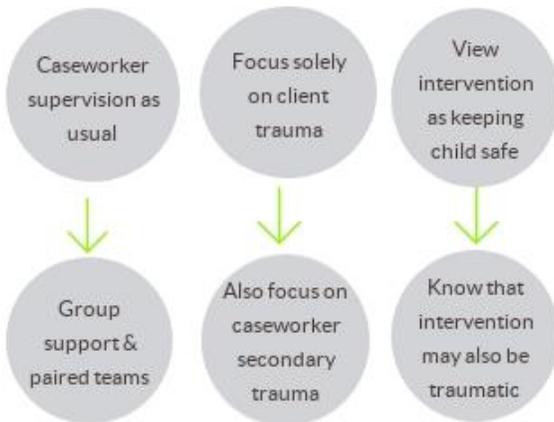
A hallmark of this agency’s work was recognition of the impact that working with families who have experienced trauma can have on caseworkers and that, for caseworkers to practice trauma-informed practice, they must have opportunity for their secondary trauma to be addressed. The agency recognized that secondary trauma from a case may not emerge immediately, so caseworkers need ongoing support, sometimes months after a difficult case has opened or closed. In this way, supervisors kept difficult conversations open and recognized that secondary trauma might occur much later even during cases perceived as standard. In the same way the county recognized that families may experience the impacts of trauma weeks, months, and years after an event, the effects of secondary traumatic stress among caseworkers may also be delayed.

Even with these supports in place, caseworkers were challenged by the fast-paced changes under the Waiver— adapting to both fidelity to the trauma interventions and new ways of working with

families. The agency identified that caseworkers who are resilient and supported were the core of the interventions since they had the most direct contact with families. The agency was careful not to exploit caseworker resilience by “rewarding” strong and engaging caseworkers with a slew of difficult cases—a phenomenon often present in child welfare which can lead to burn out of the skilled workers agencies want to retain.

Implementation was a “heavy lift” due to the multiple practice changes and additional workload components for caseworkers; over the course of the Waiver, administrators learned that orienting the changes around positive impacts on practice was an imperative precursor to caseworker and supervisor buy-in and engagement.

Figure 31. System Shifts that Occurred at the Child Welfare Agency Level



Cross-System Collaboration.

What the agency initially expected to be a simple intervention in collaboration with behavioral health developed into an effort that spread countywide, leading schools, community agencies, and the courts and justice systems to move toward a trauma-informed lens in their work. The agency realized early on that if other partnering agencies—schools, courts, and local nonprofits—were still operating from a traditional lens, rather than principles of trauma-informed care, the TSAT or CWRC interventions would be limited in their ability to impact the well-being of families. Despite high costs and limited funding for training, the

agency committed to increasing awareness of complex trauma throughout the community. The agency provided numerous trainings for community partners and continue to facilitate various interdisciplinary groups that meet regularly to discuss the implications of complex trauma in the context of practice. These efforts led to increased dialogue across system partners about how to consider the impact of trauma in work with children and families and eventually gained the buy-in even of partners initially slow to embrace the trauma-informed approach.

Tools from the trauma-informed interventions themselves were also useful in strengthening collaborative relationships, particularly the well-being assessment (TOP). The agency brought data from the TOP to meetings with service partners, and with county commissioners, to help describe the trauma interventions and their targeted impact on the well-being of youth receiving agency services. The team and multi-rater perspective provided by the TOP helped with monitoring how a youth was faring, and also aided in service planning with collaborating partners.

Figure 32. System Shifts that Occurred at the Community Level



Trauma Screening and Assessment.

As noted by the Children’s Bureau, “A trauma-informed child welfare system relies heavily on initial and ongoing screening and assessment to

identify children’s trauma-related needs and assess their progress.”ⁿ This county engaged in screening and multiple assessments under the trauma interventions.

Trauma Screening

The Southwest Michigan Children’s Trauma Assessment Center trauma screening checklist for children was completed with children in all open child welfare cases to learn about their exposure to trauma and need for further services. Intake caseworkers generally conducted the initial trauma screen; some children received subsequent or case closure screens, which were conducted by ongoing workers. The checklist supplemented existing, comprehensive child welfare assessments, such as the risk and safety assessment. Families were involved in completion of the trauma screening; when the checklist indicated traumatic exposure, children were referred for additional assessment.

Well-being Assessment

This county utilized the Treatment Outcome Package (TOP) to collect data on youth well-being with children and youth whose screenings indicated trauma exposure. The TOP, a multi-rater tool, was completed at case open, every 90 days thereafter, and at case close by at least the ongoing caseworker, caregiver or parent, and youth and one other person, such as the therapist; initially, more raters were recommended but that was not realistic for caseworkers to coordinate, especially with such frequency. The TOP measures 12-13 domains of well-being ranging from violence to sleep and school functioning. The TOP has been used elsewhere by community-based providers and child welfare agencies to assess child well-being, identify trauma exposure and mental health needs, and aid in service planning^o. The county also used the TOP as an engagement tool, facilitating conversations with the child or youth about their experience. The

TOP helped to facilitate cross-system conversations; for example, promoting further discussion if raters greatly differed in their rating of a youth with the TOP. Data from the TOP also drove treatment decisions.

Trauma Assessment

The child welfare agency referred children to clinicians for trauma assessments. At the start of the Waiver, children and youth were referred to the local community mental health center for standard trauma assessments through the TSAT intervention. As the Waiver progressed and community capacity increased, children were referred to the local university trauma assessment center for comprehensive family interviews and in-depth, multidimensional assessments. Both assessment models included the Trauma Symptom Checklist for Young Children (TSCYC; for children ages 3 to 7) or the Child PTSD Symptom Scale (CPSS; for children and adolescents ages 8 to 18).

The in-depth trauma assessments included a clinician interview with the ongoing caseworker, a separate clinician interview with the caregiver or caregivers, and additional information-seeking with teachers, mentors, therapists, and other family members. The trauma assessment with the child or

The assessment really individualizes treatment. Clinicians actually speak to the kiddo and ask what they want and what they enjoy and incorporate that into treatment. You do your best, but some information you’re never going to find out without a trauma assessment.

County child welfare administrator

ⁿ Children’s Bureau (2015). Issue Brief: Developing a Trauma-Informed Child Welfare System

^o Rosenbalm, K.D., Snyder, E.H., Lawrence, C.N., Coleman, K. Frey, J.J., van den Ende, J.B., & Dodge, K.A. (2016). Child wellbeing assessment

in child welfare: A review of four measures. Children and Youth Services Review, 68, 1-16.

adolescent included cognitive testing, IQ testing, visual motor screening, and surveys to get at the impact of trauma, such as an executive functioning survey. A comprehensive, psychosocial interview was also conducted through a variety of creative and age-appropriate activities.

The assessment resulted in a resilience-based report focused on recommendations to address functioning and trauma. The results were reviewed with the family by the clinician and then a cross-system family meeting was held at child welfare to review the results and discuss action steps.

Assessments were valuable because they gathered and summarized useful, pertinent information that caseworkers do not have time to gather within typical case processes. While the assessment process became fairly streamlined, the transition from completing assessment to connecting with services remained challenging. The assessments sometimes resulted in lengthy lists of services which were overwhelming for both the family to attend and the caseworker to coordinate.

Trauma Treatment

Following assessment, clinicians recommended and provided appropriate treatment for children, youth, and in some cases, families. Sometimes, trauma-focused treatments were recommended, such as Trauma-Informed Cognitive Behavioral Therapy or Trauma-Systems Therapy, while other times Parent Child Psychotherapy or Play Therapy were recommended and implemented. Less traditional therapies, such as Equine Therapy, were seen as especially relevant for youth who had experienced trauma— but were also especially expensive and non-reimbursable. Because of their differing perspectives, caseworkers and mental health clinicians sometimes had different expectations of therapy. Caseworkers, working toward closing cases, expected tangible and prompt results, whereas clinicians expected slow changes over time

especially if the child or youth had experienced sustained and complex trauma.

The big shift for those doing the trauma intervention is that they have a much healthier understanding of how to interact with children and families and understanding that behaviors that come up are related to something bigger and deeper, and that we're not powerless. The agency can do screening, assessment, and specific work rather than just say 'This kid is a problem, we have a behavior problem, change the placement.'

Title IV-E Waiver administrator

Funding.

The Children's Bureau noted, "The field has yet to reach consensus on whether developing a trauma-informed child welfare system will require additional funding and what a successful approach to funding this work will entail."^p This county has found the cost of transforming its system to be high – with resources required for training staff and community partners, funding staff positions, and paying for assessments and treatment. The county estimated start-up agency and community trainings costs alone were \$60,000, for example.

To implement these practices, the agency leveraged Title IV-E Waiver funds and a separate SAMHSA grant, and supplemented those resources with its own funding for training and other non-Waiver eligible expenses. The Waiver was seen as the major facilitator of this work; without being able to use front-end dollars for building infrastructure and practice, and then re-investing savings, shifting the system would not have been possible. Therefore, how this work will be sustained once the IV-E

^p *Developing a Trauma-Informed Child Welfare System*

Waiver concludes remains unknown. The county conducted up to 200 trauma assessments annually under the Waiver, which they estimate could drop to as low as 30 per year after the Waiver concludes. Further, caseload sizes were substantially reduced under the Waiver so that caseworkers could engage in quality, trauma-informed work, but sustaining smaller caseloads in a traditional IV-E reimbursement environment will be challenging.

Medicaid funds were leveraged during the Waiver for some assessment and treatment costs, but the county estimated that only about 35% of the children and youth served were Medicaid-eligible, and reimbursement rates for assessment and treatment were considered by the agency as inadequate.

Data-Systems and Data Use.

A consistent challenge throughout implementation involved data collection and sharing. Specifically, a major barrier that the agency was unable to fully resolve related to sharing data between the Division of Child Welfare and Office of Behavioral Health systems. Privacy and confidentiality restrictions made sharing data outside of each respective system difficult, and the agency was unable to develop a process that would allow data to be securely shared more easily between the two systems. As such, an ad hoc system was built to capture data on referrals, assessments and follow up services, and it was not linked with the State's SACWIS system, Trails. Frontline workers and clinicians were impacted the most by these barriers, infrequently or never receiving data reports at the case level regarding a particular client or family and the trauma-related services and care they received. The lack of data precluded its use to help inform practice, and decreased motivation to enter data.

Conclusion: Future Directions.

Post Waiver, the county presumes the shifts in thinking and ideology that occurred under the Waiver—such as talking about family experiences differently and focusing on intergenerational

trauma— will be sustained. The agency anticipates continuing implementation of the trauma interventions, to some degree, in coordination with partners across the county. Future steps include continuing to focus on better integrating a trauma-informed perspective into everyday practice, rather than viewing it as an intervention separate from caseworkers' daily work with families.

The agency is also focused on increasing the capacity of partners involved in the interventions to not only increase the number of families served, but also to reduce wait times for accessing affiliated services and resources. Due to the intense resources required for the intervention it was targeted to a limited population during the Waiver, which the agency would like to not only maintain, but also expand in order to serve more families; by continuing to provide trainings and increasing awareness, the agency hopes to also increase the number of service partners in the community working from a trauma-informed approach. Utilizing the different expertise of collaborating partners will also help to increase the intervention's efficacy and impact, for example, allowing clinicians and providers to tailor treatments and services to individual youth and family needs, rather than promoting a standardized model of trauma practice for all. Partnerships and collaborations will be necessary, since child welfare funding is limited.

While the agency plans to continue implementation, there are also worries about its financial sustainability. The agency engaged in efforts throughout the Waiver to secure alternative sources of funding with limited success and will continue to focus on locating long-term funding support. Securing funding will help to not only sustain the current interventions, but also support expanding its scope to serve a broader population of clients and connect young people and their families to resources and services in a more timely and expedient manner. However, if these practices are not underscored with flexible funding streams, the system shifts that have occurred could stall.

Client Perspective, Caregiver Knowledge & Capacity

The results presented here illuminate the client perspective of the Waiver interventions. They were derived from client focus groups conducted during site visits at county departments of human/social services and from the kin caregiver survey. Client focus groups reflect the perspective of parents or others who receive FFE, kin caregivers who received KS, and youth who received PRT. Following the focus group findings, findings that illuminate caregiver knowledge and capacity to provide care are included.

Parent Focus Groups

Over the Waiver, focus groups with parents across the state who had participated in at least one FFE were conducted. (Many had participated in multiple FFEs.) Their experiences and perceptions are highlighted below.

MEETING ATTENDEES

Parents appreciated being encouraged to invite support people to FFEs, though not all parents recalled being told they could. Parents liked bringing their attorneys to meetings (though staff had complicated feelings about attorneys attending); CASAs and family advocates were perceived as particularly supportive by parents. GALs, attorneys, and therapists were the most challenging professionals to schedule, from the perspective of parents. Ultimately, having a range of support persons present helped mitigate tension between the parent and caseworker and made the meetings feel less “investigative” and more helpful. Parents valued meeting facilitators, viewing them as mediators and feeling like they were on the parent’s side.

ACTION PLANNING

Parents felt very positively about goal-setting and action planning during FFEs. Identifying and meeting goals over the course of multiple meetings built confidence, and parents noted that goals felt increasingly realistic as meetings progressed and parents observed their own progress. Parents appreciated that they were active participants in setting services goals, as opposed to goals being merely dictated by the county. Parents liked the action planning component; creating the plan helped guide and focus the meetings.

SERVICES AND RESOURCES

Some parents felt overwhelmed by the number of services and programs they, and their children, were involved in at once, sometimes wishing for a central hub through which they could access multiple services. While meetings were generally seen as a gateway to services, they were not necessarily helpful in procuring all services the parents desired, such as job readiness services, particularly if there were service gaps within the community. Parents commented on the lack of resources available within their communities, especially housing, but parents also expressed surprise at the services they did gain access to during their involvement with child welfare, such as therapeutic services. Housing shortages caused frustration, particularly when

procuring housing was part of the parent’s case plan. Meetings allowed all attendees to brainstorm about resources and services.

PARENT ENGAGEMENT

Parents identified factors that contributed to feeling engaged during meetings. Meetings led to transparency about what parents needed to do to facilitate reunification. Parents felt that they had an active voice in meetings and that professionals weren’t dictating what parents should do. FFEs felt more relaxed to parents than other types of meetings, and parents appreciated when staff mediated between bio parents. Parents saw meetings as an opportunity to provide input on the child’s needs and to demonstrate their knowledge as parents even when their child was out of home.

It was always uplifting to be able to see **all the positives written down and acknowledged by everybody.**

Parent who attended FFEs

Seeing positives acknowledged and documented during meetings made it easier for parents to also accept areas for growth, and meeting ground rules helped parents feel like they could engage safely in meetings. Parents appreciated when their schedules were accommodated; this made them feel central to the meeting process and facilitated their engagement even before the meeting occurred.

Youth Focus Groups

Over the Waiver, focus groups with youth across the state who had received at least one—but often more—PRT were conducted. Their experiences and perceptions are highlighted below.

MEETING FREQUENCY

Youth held conflicting views on whether meetings should be every 90 days or more frequently (even every month); these preferences may have depended on whether the youth were also attending monthly staffing or other meetings. Youth believed they would have benefitted from meetings beginning earlier in their cases, with additional placements being prevented or reunification with a bio parent occurring sooner. Youth also thought earlier meetings would have helped them learn to navigate the child welfare system more effectively earlier on.

There’s not as much opportunity for me to say what I would like [in the monthly staffing meetings]. At the PRTs, we have a chance to talk about **how I’m doing** in the placement, **how I’m doing in school,** and **where I want to go next.**

Youth who attended PRTs

MEETING PREPARATION

Youth received differing levels of preparation for PRTs. Some recalled being prepared and others indicated that they were not prepared. For example, one youth recalled a caseworker visiting the youth at home and explaining what PRTs were and the

expected outputs, while another youth remembered being given one to two hours' notice of the PRT and not being prepared.

MEETING ATTENDEES

There was variance in whether youth recalled being told they could invite support people. Some youth reported inviting quite a few people over the course of their PRTs. Even when told they could invite attendees, youth did not necessarily know everyone at the PRT. In general, youth felt especially supported by foster parents during the meetings. Youth particularly liked attendance by community members as this created an environment of shared, collective knowledge during goal-setting.

OTHER MEETINGS

Youth noted that PRTs feel more positive than staffings and more focused on the youth's needs. Youth reported getting "mixed up" between FFE and PRT when they attended both; county practice varied over the Waiver period in terms of combining these meetings.

YOUTH VOICE

Since Colorado's PRT model prioritized youth voice, youth were asked about their involvement in PRTs. Youth expressed that they liked the experience of PRTs, they felt heard during meetings, and believed their feedback was listened to. Some youth juxtaposed this with their experience in court, where their voice was not always centralized or heard. One youth indicated that PRTs were hard for him because he had "stage fright" and much of the attention was on him; in this way these meetings feel different than staffings, but not necessarily positively so.

ACTION PLANNING

Permanency action plans were a key process output of PRTs; youth were asked about their experience creating the plans. Youth felt that their ideas were respected and affirmed, though some youth were unsure their presence at the PRT made a difference in the action plan. Youth reported being very involved in the creation of the permanency action

PRTs really made me focus on my goals. They just made me think about the future and how do I get there... and what do I want when I get there?

Youth who attended PRTs

plans and feeling positively about the plans, especially the deadlines attached to tasks and goals. Some youth felt confident that tasks were completed, while others were less confident that tasks were followed through on by caseworkers and other PRT attendants. Youth viewed the action planning as a way to set both longer- and shorter-term goals. Seeing the permanency action plan written down was especially important to youth, and they felt the documentation helped with goal attainment.

PRT OUTPUTS AND BENEFITS

Youth reported varying benefits of the intervention, including: better understanding of their family history, including development of family trees; increased capacity for emotional regulation; and enhanced relationships with providers. Youth also felt more organized after PRTs and understood next steps in moving toward goals. Youth felt that child welfare and permanency processes were more straightforward and understandable after PRTs. Youth also noted that they were linked with supports and resources through PRTs, such as Chafee workers and Independent Living programs. Youth gained access to clothing and supplies as a result of PRTs, as well as transportation to school and work. For some youth, PRTs played a role in their decision and ability to attend college.

Kin Caregiver Focus Groups

Over the Waiver period, focus groups with caregivers across the state who had received KS services were conducted. Their experiences and perceptions are highlighted below.

RECEIVING SERVICES THROUGH KINSHIP SUPPORTS

The Kinship Supports intervention was designed to provide access to needed services and supports to sustain and maintain kinship placements; counties had considerable flexibility in the types of services provided, criteria for eligibility, and dollar amounts they spent per caregiver or family. While some counties only utilized funds for hard goods and services (primarily smaller counties), others also hired KS staff to provide direct support to kin caregivers in addition to caseworkers. Throughout focus groups with kin caregivers, kin discussed the variance in their experiences, with some receiving considerable emotional and tangible support and others receiving very little.

One caregiver stated, “My kinship caseworker was amazing and provided everything that I needed” while another caregiver reported, “The county said they would provide support with a service but didn’t follow through.” As the evaluation team conducted focus groups, almost every focus group became an opportunity for caregivers to share and discuss resources with one another—and sometimes to compare the services or supports they had received. Caregivers often thought they weren’t getting available services other caregivers were receiving. It is difficult to know if this was due to county practice, other eligibility criteria (such as for TANF), certification status, or if some counties left it up to kin to ask for help rather than proactively offering assistance. Kin reported that they were hesitant to *ask* for support, both because they felt prideful about being able to care for the children in their home and because some feared that their need for support would be taken as a sign they were unable to successfully care for the kin children. In general, kin were responsive to services and supports proactively offered by the county: “The kinship workers should be coming out and telling us about the money that is available or food stamps that are available. It seems like don’t ask, don’t tell. I shouldn’t have to ask about the monetary benefits that are available. They should come out with the forms necessary to complete to get it.”

TYPES OF SERVICES AVAILABLE FOR KIN CAREGIVERS

Even though services varied, kin reported receiving an array of services through the intervention. For kin caregivers the most desired yet unmet need was that of childcare or daycare. This emerged as a pressing need in all years of the Waiver. Another highly requested or desired service was therapy both for children and for caregivers themselves; caregivers talked at length about the importance of mental health services, therapy, and in-home therapy, as well as specific therapies for the kids in their care, such as play therapy and equine therapy.

Other services available were:

- Referrals for therapy, medical services, speech therapy, and other tangible resources;
- Therapy and in-home therapy;
- Gas cards or assistance, transportation support;
- Diapers;
- Clothing or vouchers for clothing, school uniforms;
- Beds, bunk beds, cribs;
- School supplies;
- Playpens;
- Car seats;
- Daycare;
- Assistance with home safety repairs;
- Assistance paying rent or utilities;
- Car maintenance and new tires; and
- Assistance navigating benefits such as TANF or SSDI or WIC.

KINSHIP SUPPORTS NEEDS ASSESSMENT

Some caregivers recalled completing the KSNA with their kin worker, while others did not remember the form—or they simply recalled “a lot of paperwork” being done at the county office or during a home visit. One caregiver noted that the KS worker went through the assessment “line by line” with her; some noted that the assessment was comprehensive, but that the county wasn’t able to meet all the needs that were identified. Other kin said their workers asked more informally, but frequently, about their needs. Some kin that had closed cases did not remember doing a closure needs assessment, noting “It just ended for me.”

CAREGIVER CHALLENGES

Even though counties provided services, caregivers still faced burdens. For example, caregivers talked about the challenges of navigating full-time employment and appointments for themselves, the children in their care, and with child welfare, such as family meetings: “I know people don’t want to work at night and stuff and certain things don’t go on at night, but that was a little frustrating, how many things we had to attend during the day—during our workday.”

Kin caregivers discussed the challenges they experienced navigating and procuring needed services. For example, one grandparent was in Section 8 housing but had to give it up once her grandchildren lived with her, as she was over the maximum occupancy, making her housing insecure. Other caregivers talked about losing counseling services for themselves once children were no longer receiving them—for example, if caregivers were receiving family counseling with their kin child.

KINSHIP STAFF AND EMOTIONAL SUPPORT

Caregivers had varying experiences with counties and workers. This makes sense based both on individual caregiver experience and the fact that county staffing structures varied—some had specific kin workers or units, and others didn't. In general, though, caregivers who had kin workers reported overwhelmingly positive experiences with them, stating that kinship staff were responsive, supportive, and helpful, going out of their way to help caregivers. Sometimes, more than hard goods and support, kin wanted someone to listen, validate, and support, and they often turned to their kin worker for this. Several caregivers who had prior involvement with child welfare before the Waiver noted that support from kin workers represented a change in practice, that they felt more supported during the Waiver than before, and that the array of services to help them maintain the placement had substantially increased. To mitigate the stress of caregiving, kinship caregivers also expressed a desire for support groups to be established for themselves and other kinship families; some caregivers were attending county-run or community-based support groups during the Waiver.

[Kinship supports worker] would do anything for anyone. We would not have made it without her. **She is definitely an advocate for us. She represents us.**

Caregiver receiving kinship supports

RELATIONSHIPS WITH PARENTS

Often kinship families felt a familial obligation to come forward and provide care for the children in need, and there were complicated family dynamics at play before, during, and after a child welfare case was opened, especially for grandparents. Grandparent caregivers discussed the difficult position of being a caregiver, especially in cases where their child had substance use issues, and their simultaneous willingness to care for their grandchildren coupled with their own fear about financial stability and about their children. Further, while counties were working with biological parents toward reunification, caregivers sometimes wished that termination, guardianship, or adoption proceedings could happen more quickly, perceiving this as best, noting it was hard for both caregivers and children to remain in “limbo.” It was also sometimes difficult for relative caregivers to set boundaries for visitation. And beyond just relationships with parents, caregivers discussed how caregiving also complicated their other family relationships and strained their relationships with partners or spouses.

HOME VISITS AND CERTIFICATION

Some caregivers had become certified, others had not. Depending on the county, some had not been told about certification. Caregivers expressed frustration with the certification process: how it required those who interacted with the children to be fingerprinted or receive a background check, which felt like it isolated the caregiver socially. Some caregivers joked that parents themselves should have to go through the certification process. Beyond the initial process of becoming certified, caregivers also addressed the ongoing training required for certification, feeling like the expectation was quite high. Both the certification process and home visits sometimes made kin feel like they were “under a microscope.”

KIN CAREGIVERS AND FFES

During site visits, the evaluation team sometimes spoke with caregivers who had attended FFES. Kin caregivers who had attended meetings reflected on their experience in their roles as providers, noting that FFES were a good opportunity for caregivers to learn important information about the children in their care—such as information they didn’t learn during an emergency or sudden placement, or key information the parent might have about the child, such as favorite foods, toys, or ways to be soothed. At times, kin felt surprised by what they learned during meetings about the children in their care and wished they had received that information at the time of placement.

Some caregivers thought their needs were addressed during FFES, but others did not; this seems to accurately reflect differences in county practice, where some counties focused FFES on the parents and children, and others used meetings as an opportunity to also address the needs of kin, even completing the KSNA before or after meetings. Sometimes, kin felt at odds with the county about the

Social Services has been wonderful, but this is not a situation I wanted in my 70s, you know? But I would do anything for the kids to help them, they’re babies. When my kids were messing up, [social services] got ahold of me and I said, yes of course, I would.

Caregiver receiving kinship supports

focus of the meeting and the tone; caregivers viewed staff as not holding bio parent(s) accountable, which reflected the different perspectives and roles of the caregivers and county staff. If kin came to meetings and parents did not show up, this could increase the caregiver’s sense that parents were not being held accountable or were not responsible enough for reunification. If the relationship between parents and caregivers was conflictual, meetings could be tense, but caregivers still felt meetings were a good platform to receive updates about the case.

Kin Caregiver Survey

The following section displays the results of the kin caregiver survey. Additional results are presented as an infographic in Appendix I.

Table 12. Concerns with Raising Kin Child(ren)

Concern	Percent of Caregivers with Concern
Finances	26%
Kin child(ren)'s emotional health	23%
Legal issues	13%
Emotional support for caregiver	13%
Negative impact on caregiver's relationship with biological parent(s)	12%
Kin child(ren)'s physical health	7%
Caregiver's physical health	6%

Source: Kin Caregiver Survey

The following table displays the types of support that caregivers reported having; of those caregivers with a support system, 77% reported that it met their most important needs.

Table 13. Type of Support Reported by Caregivers

Support	Percent of Caregivers with Support
Family	40%
Friends	33%
Community based support	12%
None	8%
Formal kinship support group	6%
Online support group	1%

Source: Kin Caregiver Survey

Caregivers were asked to respond to the following statements on a 5-point Likert scale, with 5 indicating 'strongly agree' and 1 indicating 'strongly disagree'. As displayed in Table 14, there was agreement from the caregivers that the KSNA was clearly explained, that the assessment helped to identify needs related to providing care, and that they were able to identify their needs at the initial KSNA.

Table 14. Kinship Supports Needs Assessment

Statement	Overall Mean
The purpose of the kinship needs assessment was clearly explained to me.	3.8
The kinship needs assessment helped me identify what I needed for providing care to my kin child(ren).	3.7
I was able to identify my needs at the time my worker completed the first kinship needs assessment with me.	3.6

Source: Kin Caregiver Survey

As displayed in Table 15, there was less agreement from the caregivers that services and supports provided by county departments of human/social services helped them decrease financial stress and that they were satisfied with the financial support they had received as a kin caregiver.

Table 15. Financial Support

Statement	Overall Mean
The services and supports the county department has provided helped decrease my financial stress.	2.9
I was satisfied with the financial support I receive(d) as a kin caregiver.	2.7

Source: Kin Caregiver Survey

As displayed in Table 16, there was strong agreement from the caregivers that they felt supported by their coworkers, friends, and family. Caregivers were satisfied with the emotional support they received from kin caseworkers and with the information they received regarding services, resources, and hard goods. Caregivers were less satisfied with the legal support they had received and reported less agreement that the support provided by county departments of human/social services had led to more connections with other kin caregivers and/or parents. Even so, those statements with the least agreement still had an overall mean of almost 3. Overall, caregivers reported satisfaction with the kin caregiver experience.

Table 16. Kin Caregiver Experience

Statement	Overall Mean
My coworkers support my role as a kin caregiver.	4.2
I feel supported by my friends and family to care for my kin children.	4.2
If I had to do it all over, I would agree to care for my kin children again.	4.2
I felt comfortable that I could share my needs with my kin worker without my ability to provide care being questioned.	3.8
I was satisfied with the emotional support provided by my kin worker.	3.7
I was informed about what being a kin caregiver would be like.	3.6
The county department has helped me learn about services and resources available in the community.	3.6
The county department provided items (e.g., crib, bed, car seat) that helped me care for my kin children.	3.5
I was offered the opportunity to become a certified kin caregiver.	3.5
I feel supported by the county department to care for my kin children.	3.4
I was able to find the resources I needed in my community once children were in my care.	3.4
The kin children in my care have less stress because of the resources provided by the county department.	3.3
The county provided the right amount of contact with my family.	3.3
The support the county department has provided has increased my ability to continue as a kin caregiver.	3.3
I was surprised by what was expected of me as a kin caregiver.	3.2
I was satisfied with the legal support I receive(d) as a kin caregiver.	2.9
The support the county department has provided has led to more connections with other kin caregivers and/or parents.	2.7

Source: Kin Caregiver Survey

The following sub-analyses were conducted to determine if there were relationships between caregiver’s demographics/characteristics—including ethnicity, relationship status, income level, age, sex, employment status, and relationship to kin child(ren)—and the kin caregiver experience. There were no statistically significant findings on any of the kin caregiver experience questions for caregiver ethnicity, caregiver relationship status, and caregiver income level. This implies that all demographic groups were in agreement about the type of experience they were having as kin

caregivers in relation to the Likert-scale questions. There were three questions with statistically significant differences by caregiver age: ability to find community resources ($F = .020$), satisfaction with financial support ($F = .006$), and satisfaction with legal support ($F = .029$). For all three questions, kin caregivers ages 36-45 reported less access to resources and lower satisfaction with support than did older caregivers.

There were two questions with statistically significant differences by caregiver sex: support from family and friends ($T = .039$) and county contact with the family ($T = .039$). For these two questions, male caregivers reported less support and contact than did female caregivers. There were seven questions with statistically significant differences by caregiver employment status: service/resource information ($F = .011$), increased ability to care for child(ren) ($F = .035$), received hard goods ($F = .034$), child(ren) have less stress ($F = .002$), support from county department ($F = .019$), financial support ($F = .002$), and legal support ($F = .001$). For these seven questions, retired caregivers reported more satisfaction and support than did unemployed or employed caregivers. Lastly, there were two questions with statistically significant differences by caregiver relationship to kin child(ren): surprise with expectations ($F = .015$) and willingness to care for kin again ($F = .003$). For these two questions, grandparents who were kin caregivers reported less surprise and more willingness to care for kin than did aunts/uncles and non-related caregivers.

Process Study Discussion

Colorado's Waiver design was broad, inclusive, and adaptable by county; that is, counties could opt in to Waiver interventions over time, lending complexity to both measuring implementation and to county capacity to implement the interventions. The Implementation Index conveyed variance in implementation based on intervention, Waiver year, county size, and implementation domain. Variation was expected since counties added or, less frequently, ceased implementation of interventions throughout the Waiver. And since stakeholders agreed that intervention training was the richest during the first year of the Waiver, implementation challenges may have emerged for counties implementing interventions after the initial year. Overall, however, each of the Waiver interventions was implemented at a moderate or high level every year of the Waiver, when looking at mean implementation scores.

Smaller agencies generally demonstrated lower levels of implementation, and the TLC demonstrated higher levels of implementation. Across all interventions, smaller counties had the lowest mean implementation scores, hovering around emerging implementation levels for the PRT and KS interventions. However, lower scores in smaller counties may be an indication that the core components measured through the Implementation Index, which were rooted in implementation science, were more reflective of the processes necessary for implementation in larger agencies rather than an indication that the interventions were not well-implemented in smaller counties. Across interventions and county size groups, policies and procedures remained the least implemented domain, reflecting challenges across agencies with implementing

formalized, solidified, and documented referral and service policies. Within this domain, smaller counties demonstrated the lowest levels of implementation, which aligns with findings from site visits at county departments of human/social services wherein county staff in smaller counties reported less need for formalized processes due to fewer cases and fewer staff.

Reflecting the varying capacity of counties to implement the interventions, intervention reach and adherence rates also varied by intervention. Intervention reach ranged from more than 80% of eligible out-of-home children who received FFE meetings and 80% of eligible children whose caregivers received KS to 30% of youth in care for longer than 12 months who received PRTs. Adherence rates also varied by intervention and by measure, with 78% of kin caregivers receiving a KSNA for example and 53% of children in out-of-home cases receiving all subsequent FFE meetings on time.

While there was variance in implementation capacity, reach, and adherence, county stakeholders reported strengthened and enhanced relationships with community partners and the courts as a result of all five Waiver interventions. Broad and intentional efforts were made to collaborate with these partners—from meetings with judges to agency-sponsored trauma trainings. The Waiver interventions were considered mechanisms for enhancing partnerships, and, largely, community partners shared buy-in and investment. Further, each of the interventions impacted organizational structures and capacity, allowing counties to grow their workforces, their service arrays, and provide more support or smaller caseloads for caseworkers.

The Outcome Study



Key Outcome Study Research Questions

Two overarching questions guided the Outcome Study:

- What is the overall impact of the Colorado Waiver on county out-of-home care use?
- What is the impact of the Colorado Waiver interventions on child and youth safety, permanency, and well-being outcomes?

There were two primary approaches for addressing the questions, including:

- comparisons of *out-of-home removal trends* in the state fiscal years preceding the Waiver to removal trends during the Waiver across 35 counties that received funding to implement one or more Waiver interventions in each Waiver year; and
- intervention-specific *quasi-experimental matched case comparisons* between children and youth who received a Waiver intervention during a year in which their county received Waiver funding to implement the intervention and matched children and youth who did not receive the intervention.

Secondary approaches included pre-post analyses of targeted interventions within the intervention group and between-intervention subgroup comparisons of children or youth who received multiple interventions to those who did not. Findings and data from the Process Study are also utilized in the matched case comparisons to examine variability in outcomes by level of adherence to the State-specified components of the Waiver interventions. The only available measure of well-being included reduction of trauma symptoms for those children and youth who received more than one trauma assessment as part of TSAT. Additional well-being outcomes for children and youth who received the CWRC intervention are included in a separate evaluation report (see the annex for a copy of the report).

Key Outcome Study Outcomes

Removal Trends in Waiver Counties

The examination of out-of-home removal trends included a comparison of annual pre-Waiver to Waiver removal days by placement type at the state level (i.e., across 35 counties that received Waiver funding in each Waiver year), as well as comparisons of placement spell trends within first removal admission entry and exit cohorts of children and youth at the state level and between the TLC. A placement spell is the duration of a single placement (i.e., from a child’s placement begin to end date), and a removal admission is the combined duration of placement spells within a single out-of-home removal span (i.e., from a child’s removal begin to end date); thus, there may be multiple placement spells within a single removal admission.

The key state-level outcome variables and indicators of Waiver impact for the analysis of removal days over time are included in Table 17.

Table 17. Key Outcome Variables for the Analysis of Annual OOH Removal Day Trends

Outcome Variable	Variable Type	Indicator
Percentage of foster care placement days within each state fiscal year	Continuous	Decrease in Waiver implementation years compared to pre-Waiver years
Percentage of congregate care placement days within each state fiscal year		
Percentage of certified kinship care placement days within each state fiscal year	Continuous	Decrease in Waiver implementation years compared to pre-Waiver years
Percentage of non-certified kinship care placement days within each state fiscal year		

The key state-level and TLC-level outcome variables and indicators of Waiver impact for the analysis of placement spell trends among first removal admission entry and exit cohorts are included in Table 18. Due to the observation window necessary for each outcome, cohort-specific end dates are also provided.

Table 18. Key Outcome Variables for the Analysis of Placement Spell Trends Among First Removal Admission Entry and Exit Cohorts

Outcome Variable	Variable Type	Indicator	Cohorts
Rate of placement			
Rate per 1,000 children	Continuous	Number of first admissions into care per 1,000 children in the underlying child population	Pre-Waiver and Waiver quarterly entry cohorts through 6/30/18
Least restrictive out-of-home placement use			
Likelihood of entering an initial kin placement	Binary	First admission OOH spell has a first placement type of kinship or relative care	Pre-Waiver and Waiver entry cohorts through 6/30/18
Likelihood of entering an initial congregate care placement	Binary	First admission OOH spell has a first placement type of congregate care	Pre-Waiver and Waiver entry cohorts through 6/30/18
Out-of-home placement stability			
Likelihood of moving within six months of first placement	Binary	First admission OOH spell has a second placement within six months of spell start date	Pre-Waiver entry cohorts through 12/31/13 and Waiver entry cohorts through 12/31/17 observed through 6/30/18
Time to permanency			
Likelihood of exiting within six months of first placement	Binary	First admission OOH spell ends within six months of spell start date	Pre-Waiver entry cohorts through 12/31/13 and Waiver entry cohorts through 12/31/17 observed through 6/30/18
Likelihood of exiting within one year of first placement	Binary	First admission OOH spell ends within one year of spell start date	Pre-Waiver entry cohorts through 6/30/12 and Waiver entry cohorts through 6/30/17 observed through 6/30/18
Distal permanency outcome			
Likelihood of re-entering care within one year of exit from a first admission permanent exit	Binary	First admission OOH spell that exited to reunification, relatives, or guardianship re-enters care within one year of spell end date	Pre-Waiver exit cohorts of exits to reunification, relatives, or guardianship through 6/30/12 and Waiver exit cohorts of exits to reunification, relatives, or guardianship through 6/30/17 observed through 6/30/18

Intervention-Specific Matched Case Comparisons

The child-level matched case comparison proximal and distal outcome variables and indicators of Waiver impact for each Waiver intervention are included in Tables 19 and 20. A checkmark corresponding to a variable and intervention indicates inclusion of the variable in the matched case comparison analysis for the intervention.

Table 19. Key Proximal Permanency Outcome Variables for the Matched Case Comparison Analysis of Each Waiver Intervention

Outcome Variable	Variable Type	Indicator	FFE Mtgs	KS ¹	PRT ²	TSAT/CWRC
Proximal permanency outcomes						
Case days	Continuous	Fewer median days in the intervention group ³	✓	✓		✓
Out-of-home placement delay						
No placement at case open ⁴	Binary	Greater likelihood in the intervention group ³	✓			
Out-of-home placement stability						
No disruptions	Binary	Greater likelihood in the intervention group ³	✓	✓	✓	✓
< 2 disruptions						
< 3 disruptions						
Least restrictive out-of-home placement use						
Kinship placement days ⁵	Binary	More median days in the intervention group ³		✓		
First OOH placement with kin	Binary	Greater likelihood in the intervention group ³	✓			
All or most case OOH days in kinship care	Binary	Greater likelihood in the intervention group ³	✓	✓	✓	✓
Least 1 step-down in placement restrictiveness	Binary	Greater likelihood in the intervention group ³			✓	
No step-ups in placement restrictiveness						
More step-downs than step-up						
Permanent case close or end removal residence						
Birth parents	Binary	Greater likelihood in the intervention group ³	✓	✓	✓	✓
Non-adoptive kin						
Non-kin guardians						
Adoptive parents	Binary	Greater likelihood in the intervention group ³		✓	✓	✓
Kinship placement exit reason						
Return home	Binary	Greater likelihood in the intervention group ³		✓		
Another kinship placement						
Guardianship						
Adoption						
Emancipation						
OOH removal ended in emancipation ⁶	Binary	Smaller likelihood in the intervention group ³			✓	

¹Kinship supports intervention

²Permanency Roundtables intervention

³Compared to the matched no intervention group (i.e., the comparison group)

⁴The categories of no placement within one week, one month, three months, and six months were also examined

⁵For the kinship placement in which kinship support services were received or the kinship placement identified for the matched comparison group child or youth

⁶This outcome was only examined in the 16 & older with an OPPLA goal PRT intervention and matched case comparison populations

Table 20. Key Distal Safety and Permanency Outcome Variables for the Matched Case Comparison Analysis of Each Waiver Intervention

Outcome Variable	Variable Type	Indicator	FFE Mtgs	KS ¹	PRT ²	TSAT/CWRC
Distal safety outcomes						
Founded or inconclusive re-report of abuse and/or neglect with subsequent case open	Binary	Smaller likelihood in the intervention group ³	✓	✓		✓
Days to subsequent child welfare involvement, of those who experienced subsequent involvement	Continuous	More median days in the intervention group ³	✓	✓		✓
Distal permanency outcomes						
OOH placement re-entry after case close	Binary	Smaller likelihood in the intervention group ³	✓			✓
All or most post-case close OOH days in kinship care	Binary	Greater likelihood in the intervention group ³	✓			✓

¹Kinship supports intervention

²Permanency Roundtables intervention

³Compared to the matched no intervention group (i.e., the comparison group)

Within Intervention Groups

PRT PERMANENT CONNECTIONS

The key child-level outcome variables for analyzing the impact of the PRT intervention on permanent connections included the number of verified permanent connections known prior to the initial PRT, the number identified during the initial PRT, and the number identified after the initial PRT (i.e., in subsequent PRTs). The measurement level of each variable was continuous, and it was expected that children and youth who participated in PRTs would have an increase in the number of permanent connections beyond those already known prior to their initial PRT.

TSAT REDUCTION OF TRAUMA SYMPTOMS

The child-level and parent-level key outcome variables for assessing the impact of TSAT on the reduction of trauma symptoms included child composite scores on the TSCYC (ages 3 to 7), youth composite scores on the CPSS (ages 8 to 18), and caregiver composite scores on the PTSDC. The measurement level for each composite score variable was continuous, and a reduction of child, youth, and caregiver mean composite scores from initial assessment to the last follow-up assessment was expected.

Overlap of Waiver Interventions

The key child-level outcome variable for examining the overlap of Waiver interventions was permanent case close or end removal residence (i.e., living with birth parents, non-adoptive kin, non-kin guardians, or adoptive parents). The measurement level was binary, and it was expected that children and youth who received KS and FFE were more likely to be living in a permanent residence at case close than children and youth who only received KS and matched children and youth who did not receive KS. It was also expected that children and youth who received the PRT intervention and FFE meetings were more likely to be living in a permanent residence at removal end than children and youth who only received the PRT intervention and matched children and youth who did not receive the PRT intervention.

Outcome Study Comparisons/Cohorts

Removal Trends in Waiver Counties

The state-level outcome analyses of out-of-home removal trends used year-to-year and cohort comparisons, including outcome performance between pre-Waiver and Waiver state fiscal years and cohort groups. This historical comparison, while unable to definitively present causal relationships for changes in the outcomes of interest, provided a descriptive look at the way outcomes have changed over time. The pre-Waiver years provided a baseline, capturing removal days by placement type in the five fiscal years prior to the start of the Waiver (i.e., SFYs 2009 through 2013) and permanency outcomes of entry and exit cohorts with a first removal admission during the three fiscal years prior to the start of the Waiver (i.e., SFYs 2011 through 2013). Removal days during the Waiver fiscal years and the Waiver entry and exit cohorts comprised the five years of the Waiver (i.e., SFYs 2014 through 2018). All Waiver years are included based on the finding from the Process Study that each of the Waiver interventions was implemented at a moderate or high level every year of the Waiver, when looking at mean implementation scores. Focusing on first admissions into care, the cohorts either represent an entry cohort of children coming into care or an exit cohort of children exiting care within the given timeframe. Outcome-specific cohorts are detailed in Table 18.

Intervention-Specific Matched Case Comparisons

Table 21 provides the inclusion criteria for the historical comparison pool of children and youth for each Waiver intervention. Across the interventions, the full inclusion window for the comparison pools was 4.4 years, from February 1, 2009 through June 30, 2013, corresponding historically with the 4.4 year window of data collection and intervention group inclusion during the Waiver, from February 1, 2014 (i.e., the date of full functionality for the Trails intervention frameworks) through June 30, 2018 (i.e., the last day of the five-year Waiver demonstration period). The procedures for selecting children and youth from the comparison pools for the matched case comparison analysis groups are described following Table 21.

Table 21. Comparison Pool Inclusion Criteria for Each Waiver Intervention

Intervention	Comparison Pool Inclusion Criteria
Facilitated Family Engagement Meetings	Children and youth with child welfare cases opening on or after 2/1/09 through 6/30/13 ¹ who were in cases that did not eventually receive at least one FFE meeting during the Waiver period and were in counties that received Waiver funding to implement FFE meetings in one or more years of the Waiver
Kinship Supports	Children and youth in a child welfare kinship care placement on or after 2/1/09 through 6/30/13 ² whose kinship caregiver did not receive at least one KS service during the Waiver period and were in counties that received Waiver funding to implement KS in one or more years of the Waiver
Permanency Roundtables ≥ 16 years old with an OPPLA goal	Youth 16 and older with an OPPLA goal at any point from 2/1/09 through 6/30/13 ³ who did not eventually receive at least one PRT meeting during the Waiver period and were in counties that received Waiver funding to implement PRTs in one or more years of the Waiver
Permanency Roundtables ≥ 12 months in care	Children and youth who were in an out-of-home removal for 12 months or longer at any point from 2/1/09 through 6/30/13 ³ who did not eventually receive at least one PRT meeting during the Waiver period and were in counties that received Waiver funding to implement PRTs in one or more years of the Waiver
Trauma Informed Screening, Assessment, & Treatment	Children and youth with child welfare cases opening on or after 2/1/09 through 6/30/13 ¹ who did not receive a TSAT screen, assessment, or one of the State-specified treatments or a CWRC assessment and were in counties that received Waiver funding to implement TSAT or CWRC in one or more years of the Waiver

¹Regardless of whether the case had closed by this date

²Regardless of whether the kinship placement had ended by this date

³Regardless of whether the youth's removal had ended by this date

MATCHING PROCEDURE

To maximize the probability that observed differences in child and youth permanency and safety outcomes between the intervention and comparison groups were due to the Waiver interventions, propensity score matching was used to construct the comparison groups. Children and youth in the comparison pools with similar propensities to receive the intervention as children and youth in the intervention groups were selected for inclusion into the final matched case comparison analysis groups. Propensity scores were based on child and youth demographics, overall abuse and neglect risk, and case characteristics. Prior to conducting the match, missing data points within the categorical matching variables were recoded into a common arbitrary value and full information maximum likelihood estimation was used to impute values for missing data within the continuous level matching variables. The propensity score matching function in SPSS (v.24) and variables in Table 22 were used to calculate a propensity score for each child or youth in each intervention group and corresponding comparison pool and to match children and youth in the intervention group with children and youth in the comparison pool, using replacements if needed and a propensity score mismatch tolerance level of 0.10. The primary objective was to achieve the best possible balance between the intervention and comparison groups and subgroups while simultaneously retaining all children and youth in each treatment group.

Children and youth were also matched on the number of days in their outcome observation window to ensure that children and youth in the intervention and final matched comparison groups had similar amounts of time to experience outcomes. Outcomes were observed through June 30, 2013 in the comparison group and through June 30, 2018 in the intervention group; however, the start of the observation window varied by intervention and by child or youth. The beginning of the observation window for family engagement, TSAT, and CWRC in both the comparison and intervention groups was the case open approval date for each child or youth; for kinship supports, it was the kinship placement begin date for both groups; for the PRT *intervention groups*, it was the date of the first PRT; and for each child or youth in the PRT *comparison groups*, it was the date in the comparison group observation window that corresponded to the relative position of the first meeting date for the matched intervention child or youth within the intervention group's observation window (see Appendix J for a depiction of the logic used to assign this date).



Table 22. Propensity Score Matching Variables for Each Intervention

Child Matching Variable	Variable Type	FFE matching variable	KS matching variable	PRT matching variable	TSAT matching variable
Gender	Categorical	✓	✓	✓	✓
Age at Case Open	Continuous	✓	✓	✓	✓
Race/Ethnicity	Categorical	✓	✓	✓	✓
County	Categorical	✓	✓	✓	✓
Physical Abuse Allegation	Categorical	✓	✓	✓	✓
Sexual Abuse Allegation	Categorical	✓	✓	✓	✓
Neglect Allegation	Categorical	✓	✓	✓	✓
Overall Risk Level ¹	Categorical	✓	✓	✓	✓
Report Disposition ²	Categorical	✓	✓	✓	✓
Case Pathway ³	Categorical	✓	✓	✓	✓
Case Program Area ⁴	Categorical	✓	✓	✓	✓
Case Status ⁵	Categorical	✓	✓		✓
Observation Window ⁶	Continuous	✓	✓		✓
Child Placement Status ⁷	Categorical				✓
Kinship Placement Status ⁸	Categorical		✓		
OOH Removal Status ⁸	Categorical			✓	
Congregate Care Days	Continuous			✓	
Removal Days	Continuous			✓	

¹Low, moderate, or high risk as defined by the State’s child welfare risk and safety assessment

²Disposition types include family assessment response (i.e., Differential Response) – no findings; no abuse/neglect investigation; report founded; report inconclusive; report unfounded

³Case pathway types include adoption; family assessment response (i.e., Differential Response); traditional

⁴Case Program Areas include Program Area 4 – Youth in Conflict; Program Area 5 – Children in Need of Protection; Program Area 6 – Children in Need of Specialized Services; Other

⁵Open or closed at end of intervention group timeframe (6/30/18) or comparison pool timeframe (6/30/13).

⁶Number of days to observe outcomes (e.g., re-reports and placement days); described in the paragraph preceding this table

⁷Never out-of-home or out-of-home at some point during case open

⁸Ended or not ended by the end of the intervention group timeframe (6/30/18) or comparison pool timeframe (6/30/13)

Within Intervention Groups

PRT PERMANENT CONNECTIONS

The baseline comparison for assessing increases in permanent connections among children and youth who received the PRT intervention was the number of verified permanent connections known prior to the initial PRT meeting.

TSAT REDUCTION OF TRAUMA SYMPTOMS

The baseline comparison for assessing reductions in trauma symptoms among children and youth who received TSAT was the initial assessment composite scores on the TSCYC (children ages 3 to 7), CPSS (youth ages 8 to 18), and PTSDC (caregivers).

OVERLAP OF WAIVER INTERVENTIONS

There were two comparison groups for examining the impact of receiving both KS and FFE meetings on permanency at case close. They included (1) children and youth in the KS comparison group who were matched to children and youth in the KS intervention group who also received FFE meetings and (2) children and youth in the KS intervention group who did not also receive FFE meetings.

Similarly, there were two comparison groups for examining the impact of receiving both PRT and FFE meetings on permanency at end removal. They included (1) children and youth in either PRT comparison group who were matched to children and youth in the PRT intervention groups who also received FFE meetings and (2) children and youth in either PRT intervention group who did not also receive FFE meetings.

Outcome Study Sample

Removal Trends in Waiver Counties

All removal days of any type during the five Waiver years in 35 counties that received Waiver funding for one or more intervention in each year of the Waiver (referred to from this point forward in the Outcome Study section as *full demonstration counties*) were included in the sample for the state-level descriptive comparison of pre-Waiver to Waiver removal days by placement type. For the pre-Waiver and Waiver cohort comparison of permanency outcomes, all first admission child-level spells in the full demonstration counties with a duration greater than five days were included in the sample. Models controlled for child-level demographic characteristics (i.e., child age at placement and race/ethnicity). The only exception to these sample criteria is for the re-entry outcome cohorts where the included spells were limited to those that exited to relatives, guardianship, or reunification.

Because Colorado is a State-supervised, county-administered child welfare system, CDHS rolled out the Waiver interventions by county or region. However, there was no predetermined schedule, and county participation varied at the discretion of CDHS and each county. The implementation of the interventions, including the timing, choice, and practice of each intervention, varied widely by participating county. This was addressed in our analysis by presenting the results at two levels:

- *State-level for full demonstration counties.* Results are presented at the state level for all full demonstration counties. For the state-level model, children are nested within counties, forming a child-county data structure. Outcomes for children in the same county are often correlated. This can introduce clustering (nested data structure) issues. For this nested structure, the county random

effects model was adopted. The random effects model treats county effects as random and the randomness is captured by county random variables.

- *County-level for the TLC.* Results are also presented by county for the TLC. As such, in our analysis, each county has its own model, so the covariates are allowed to vary by county. Meaning, there is not one estimate for the covariates that pools the estimates across all the counties.

Data from Adams County were excluded from the removal trend outcomes focused on placement type due to a data limitation involving kinship placement data. The practice of inputting kinship placement data in Trails varies by county; within each county, the method differs based on the child's legal custody and the kin provider's certification status. As such, the proportion of non-certified kinship care placements that transfer from Trails into the FCDA varies by county. For most of the TLC, this proportion remains steady, so changes over time can be tracked and outcome trends should not be impacted. However, Adams County is an exception, as data entry practices in that county changed significantly between SFY 2011 and SFY 2017, with the proportion of non-certified kinship placements being logged with an open removal and thus making it into the FCDA dataset rising from 27% to 93%. This county's variances in outcome measures across fiscal years are likely partially attributable to these data changes and not solely to substantive changes in child welfare outcomes.

Intervention Specific Matched Case Comparisons

Table 23 provides the inclusion criteria for the matched case comparison intervention groups. Across the interventions, the full inclusion window for the Waiver intervention groups was 4.4 years, from February 1, 2014 (i.e., the date of full functionality for the Trails intervention frameworks) through June 30, 2018 (i.e., the last day of the five-year Waiver demonstration period).

Table 23. Intervention Group Inclusion Criteria for Each Waiver Intervention

Intervention	Intervention Group Inclusion Criteria
Facilitated Family Engagement Meetings	Children and youth with child welfare cases opening on or after 2/1/14 ¹ through 6/30/18 ² who were in cases that received at least one FFE meeting during a year in which their county received Waiver funding to implement FFE meetings
Kinship Supports	Children and youth in a child welfare kinship placement on or after 2/1/14 ¹ through 6/30/18 ³ whose kinship caregiver received at least one KS service during a year in which their county received Waiver funding to implement KS
Permanency Roundtables ≥ 16 years old with an OPPLA goal	Youth 16 and older with an OPPLA goal at any point from 2/1/14 ¹ through 6/30/18 ⁴ who received at least one PRT meeting during a year in which their county received Waiver funding to implement PRTs
Permanency Roundtables ≥ 12 months in care	Children and youth who were in an out-of-home removal for 12 months or longer at any point from 7/1/14 ⁵ through 6/30/18 ⁴ who received at least one PRT meeting during a year in which their county received Waiver funding to implement PRTs
Trauma Informed Screening, Assessment, & Treatment	Children and youth with child welfare cases opening on or after 7/1/14 ⁵ through 6/30/18 ² who received a TSAT screen, assessment, and one of the State-specified treatments or a CWRC assessment during a year in which their county received Waiver funding to implement TSAT or CWRC assessments

¹The Trails Waiver intervention frameworks were not fully functional until this date

²Regardless of whether the case had closed by this date

³Regardless of whether the kinship placement had ended by this date

⁴Regardless of whether the youth's removal had ended by this date

⁵This population was targeted beginning in year two

The demographic and risk characteristics of each intervention group are included in Table 24.

Table 24. Characteristics of the Children and Youth in Each Intervention Group Sample

Characteristic	FFE Meetings (n = 26,859)		Kinship Supports (n= 10,114)		PRT ≥ 16 years OPPLA (n = 480)		PRT > 12 months in care (n = 1,365)		TSAT/ CWRC (n = 588)	
	\bar{x}	SD	\bar{x}	SD	\bar{x}	SD	\bar{x}	SD	\bar{x}	SD
Age										
Years	7.4	5.5	5.8	5.0	17.4	1.5	7.1	4.9	10.7	4.1
Gender										
Female	47.1%		48.8%		42.7%		43.7%		47.1%	
Male	52.9%		51.2%		57.3%		56.3%		52.9%	
Race/Ethnicity										
American Indian	0.4%		0.3%		0.6%		0.7%		0.2%	
Asian	0.6%		0.4%		1.3%		0.1%		0.2%	
Black	9.0%		9.0%		10.6%		5.1%		6.0%	
Hawaiian	0.2%		0.2%		0.0%		0.1%		0.0%	
Hispanic	37.6%		42.0%		27.9%		44.4%		34.4%	
Two or More	4.7%		5.8%		3.8%		3.8%		3.2%	
White	45.3		41.1%		55.6%		45.3%		55.6%	
Missing	2.3%		1.2%		0.2%		0.4%		0.5%	
County Size by Population Density										
Ten Large	85.5%		92.2%		75.2%		78.2%		89.3%	
Medium Size	12.4%		6.4%		20.8%		20.1%		5.9%	
Balance of State	2.1%		1.4%		4.0%		1.6%		4.8%	
Abuse Allegation Type										
Physical	9.2%		9.4%		12.7%		8.2%		12.9%	
Sexual	4.2%		3.2%		6.0%		4.2%		6.6%	
Neglect	58.3%		73.4%		40.2%		69.1%		56.6%	
Abuse & Neglect Overall Risk										
Low	2.7%		2.1%		1.3%		2.2%		4.1%	
Moderate	41.0%		41.7%		33.5%		41.7%		44.0%	
High	44.7%		50.7%		38.3%		47.6%		37.4%	
PA4/no risk assessment	6.1%		2.4%		13.8%		5.4%		2.2%	
Missing	5.5%		3.1%		13.1%		3.2%		12.2%	

Within Intervention Groups

PRT PERMANENT CONNECTIONS

The sample for the within group pre-post increase in permanent connections analysis included children and youth who met the inclusion criteria in Table 22 for either PRT matched case comparison intervention group.

TSAT REDUCTION OF TRAUMA SYMPTOMS

The sample for the within group pre-post reduction in trauma symptoms analysis included children and youth who met the inclusion criteria in Table 22 for the TSAT matched case comparison intervention group.

Overlap of Waiver Interventions

The sample for the analysis of the impact of receiving both KS and FFE meetings on permanency at case close included children and youth who met the inclusion criteria in Table 23 for both the KS and FFE meetings matched case comparison intervention groups. The sample for the analysis of the impact of receiving both PRT and FFE meetings on permanency at case close included children and youth who met the inclusion criteria in Table 23 for either PRT intervention group and the FFE meetings intervention group.

Outcome Study Data Sources and Data Collection

Removal Trends in Waiver Counties

Colorado data submitted to the Chapin Hall Multistate FCDA was utilized to examine the overall impact of the Waiver on out-of-home removal trends. The FCDA is a longitudinal database developed and maintained by the Center for State Child Welfare Data at Chapin. It contains decades of State data on millions of children in over two dozen states who have spent time in out-of-home placements. In 2009 Colorado submitted retroactive data spanning multiple decades and has since continued to submit placement data to the FCDA.

DCW provided copies of its FCDA out-of-home removal and placement event data files for use in the evaluation. These data included the following for each out-of-home placement event in the state: Trails child identification number; child gender, ethnicity, and date of birth; county in which the event took place; and the date and type of the placement event (e.g., foster, congregate, or kinship care) and the date and type of exit from care. Chapin Hall prepares the Colorado FCDA file for DCW semi-annually, after a DCW State administrator submits cumulative Trails placement data, usually within a month of the conclusion of the second and fourth quarters of each state fiscal year. Chapin Hall provides the standardized files back to the DCW administrator, who then makes an Excel database available to the evaluation team via the team's secure file sharing server.

Intervention-Specific Matched Case Comparisons

The intervention-specific matched case comparison analyses include case-level and client-level data from Trails. The Trails databases and data collection procedures utilized for the matched case comparisons were the same as those utilized for the Process Study. A detailed description of the databases and collection procedures are included the Process Study chapter of this report.

Within Intervention Groups

PRT PERMANENT CONNECTIONS

Data logged into the permanent connections module of the PRT intervention framework in Trails are used to conduct analyses on the impact of the intervention on the identification and verification of permanent connections. The procedures for collecting all Trails data are detailed in the Process Study chapter.

TSAT REDUCTION OF TRAUMA SYMPTOMS

Data from the OBH Survey were used to examine the reduction of trauma symptoms among children, youth, and caregivers who received TSAT. The procedures for collecting OBH Survey data, along with the challenges encountered in collecting the data, are described in detail in the Process Study chapter.

Overlap of Waiver Interventions

The Trails data used for the intervention-specific matched case comparisons are also used to examine the impact of receiving multiple interventions on permanency at case close and end removal. The procedures for collecting all Trails data are detailed in the Process Study chapter.

Outcome Study Data Analysis

Removal Trends in Waiver Counties

The analysis of annual pre-Waiver to Waiver removal days by placement type in the full demonstration counties was purely descriptive. For the 35 full demonstration counties combined in each state fiscal year from 2009 through 2018, the number of removal days for each placement type during the year was divided by the total number of all removal days during the year to determine the percentage of all removal days for each placement type during the year. The percentage of all removal days for each placement type across the five pre-Waiver years was also calculated and subtracted from the percentage of all removal days in each placement type across the five Waiver years to compare the differences in percentage of all removal days between each placement type in the pre-Waiver and Waiver years. A positive difference for a placement type indicated increased use of that placement type during the Waiver years and a negative difference indicated decreased use.

As a companion to the removal day by placement type analysis, the analysis of entry and exit cohorts over time provided a descriptive look at placement type, stability, duration, and re-entry in the pre-Waiver and Waiver years. This analysis utilized Colorado's child-level out-of-home spell data from the FCDA. The FCDA data was

censored as of June 30, 2018, and the analysis limits its focus to the data within the three years prior to the beginning of the Waiver (i.e., SFYs 2011 through 2013) and the full five years of Waiver activity (i.e., SFYs 2014 through 2018).

Using a logistic regression model, the findings present the odds ratios for each county and outcome. An odds ratio is a relative measure of effect that compares outcome likelihoods in the Waiver period to the pre-Waiver period. An odds ratio of one implies there is no difference, while an odds ratio above one implies a positive association with the outcome (for example, regarding duration, an increase in the likelihood of exiting within a specified window) and an odds ratio less than one implies a negative association (again, regarding duration, a decrease in the likelihood of exiting within the window).

The main model presented in this report compares the baseline pre-Waiver cohort to the Waiver cohort. Sensitivity analysis was also conducted utilizing two additional models. The first is a year-by-year model wherein each Waiver year was compared individually to the pre-Waiver baseline; results are mentioned within the discussion of significance of outcomes to enrich the understanding of what Waiver years may be driving the overall finding. The second is an interrupted time series (ITS) model wherein the baseline pre-Waiver cohort was compared to the Waiver cohort while controlling for the historical trend. Results from this ITS model are shared in the Discussion section as part of comments on overall trends and takeaways.

Intervention-Specific Matched Case Comparisons

The intervention groups of children and youth tested in the matched case comparison analyses for each intervention are included in Table 25. A checkmark corresponding to an analysis group and intervention indicates inclusion of the group in the matched case comparison analyses for the intervention.

Table 25. Intervention Analysis Groups for the Matched Case Comparisons

Analysis Group	FFE Mtgs	KS	PRT	TSAT/CWRC
All eligible children and youth who received the intervention		✓	✓	✓
Eligible out-of-home children and youth who received the intervention	✓			
Eligible in-home children and youth who received the intervention	✓			
Eligible children and youth who received or whose family or kinship caregiver received the intervention with higher levels of adherence	✓	✓	✓	
Eligible children and youth who received or whose family or kinship caregiver received the intervention with lower levels of adherence	✓	✓	✓	
Children and youth who began their removal or reached 12 months in care during a year in which the county received funding to implement the intervention			✓	
Children and youth who began their removal or reached 12 months in care prior to a year in which the county received funding to implement the intervention			✓	

Descriptive statistics, including percentages for the binary outcomes variables and medians for the continuous outcome variables were calculated for each intervention group or subgroup and its corresponding matched case comparison group. Medians were chosen as the most accurate measure of central tendency for the continuous level variables, as there was fairly large variability in the distribution of data points for these variables, and the distributions were positively skewed, meaning that the means were highly influenced by outliers at the greater end of the distribution for each variable. In other words, the means for these variables were not accurate representations of central tendency because they were being pulled up by a relatively small number of outlying data points.

The descriptive statistics for each outcome variable were examined to determine if the direction of the difference between the intervention group or subgroup and its matched comparison group indicated improved permanency or safety for the intervention group or subgroup (see Tables 18 and 19 for the indicators of intervention impact for the matched case comparison analyses). If the difference between groups indicated improved permanency or safety for a continuous outcome variable, a Mann-Whitney U test was conducted to determine if the difference between the medians was statistically significant. The test statistic was then used to calculate an effect size between the two groups by dividing the test statistic by the square root of the combined sample sizes of the intervention group or subgroup and its matched comparison group. Effect sizes provide a practical interpretation of the impact of an intervention, where effect sizes of 0.1-0.2 indicate a small intervention effect, 0.3-0.5 indicate a moderate effect, and ≥ 0.5 indicate a large effect.

If the difference between groups indicated improved permanency or safety for a binary outcome variable, a logistic regression model was used to determine if the difference was statistically significant while simultaneously controlling for any predictive variance in the matching variables not already accounted for in the propensity score matching procedures. An odds ratio for the intervention group variable beta coefficient in the logistic regression model was also produced to provide a more practical interpretation of the intervention's effect on the outcome.

Within Intervention Groups

PRT PERMANENT CONNECTIONS

A paired-samples *t* test was conducted for each PRT intervention group to determine if the mean number of verified permanent connections at end removal or the end of the observation period was significantly larger than the mean number of permanent connections known prior to the first PRT meeting.

TSAT REDUCTION OF TRAUMA SYMPTOMS

The mean change in trauma symptoms was calculated between the initial and follow-up assessments for children and youth who received one of the selected trauma treatments or another type of treatment and who had both an initial and follow-up assessment. The mean change in trauma symptoms for the caregivers who received both an initial and follow-up trauma assessment was also calculated. A mean

reduction in trauma symptoms from the initial to follow-up assessment for both groups was hypothesized, and within group t-tests were calculated to test the significance of any observed differences for the children and youth. However, very few children receiving treatment and who had an initial assessment also had a follow-up assessment (168 of 612) recorded in the OBH survey. And of these, only 98 had valid scores for both the initial and follow-up so that difference over time could be measured. Standard deviations for the difference in scores were very high, indicating substantial variability in score changes between initial and follow-up assessments. This may also suggest that changes for individual children were positive or negative, depending on the child. The OBH data received indicated that over 280 caregivers received some type of post-traumatic stress assessment. However, valid initial and follow-up scores for the adult instrument were only captured for 28 adults.

Overlap of Waiver Interventions

The analysis procedures for assessing the impact of receiving KS and FFE meetings and PRT and FFE meetings on permanency at case close or end removal were the same as those used for the binary outcome variables in the intervention-specific matched case comparison analyses.

Outcome Study Results

Removal Trends

The findings of the state-level analysis of pre-Waiver and Waiver removal days by placement type in the full demonstration counties are shown in Table 26 and Figure 33. Table 26 shows that the percentage of all out-of-home removal days in each of the most restrictive placement types decreased, whereas the percentage in each of the two least restrictive placement types increased. The combined percentage of foster and congregate care days decreased by 10.5%, while the combined percentage of certified and non-certified kinship care days increased by 10.5%. Between the two kinship care types, the percentage of non-certified kinship care days increased substantially, by 9.1%, compared to 1.4% for certified kinship care days. Looking at Figure 33, which shows the annual trends in the percentages of removal days in each placement type, there was an increase in the percentage of foster care days and a decrease in the percentage of non-certified kinship care days in the last year of the Waiver, reversing a seven-year trend (i.e., from SFYs 2011-2017) for each of these care types.

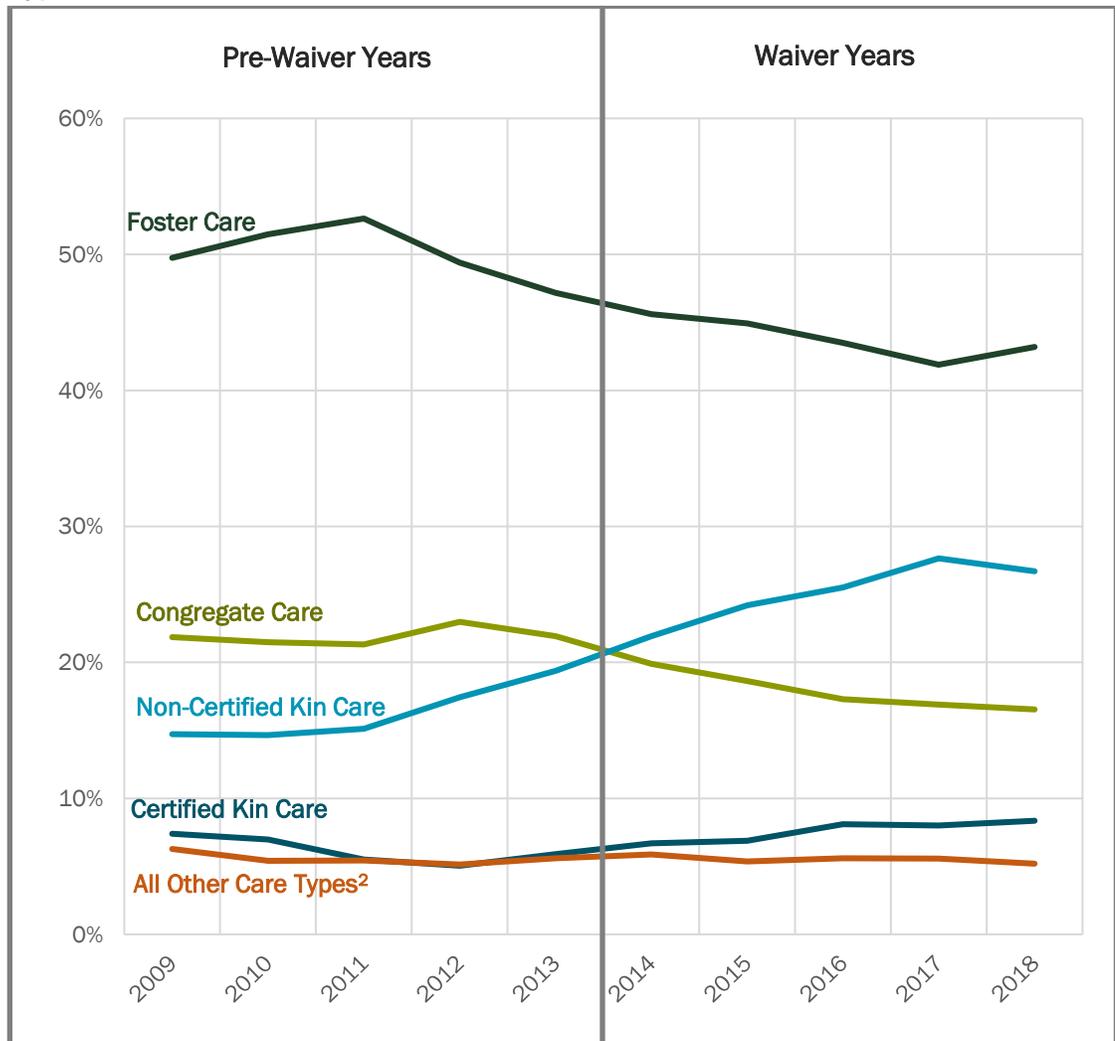
Table 26. Percentages of All Out-Of-Home Removal Days by Placement Type in the 35 Full Demonstration Counties¹

Placement Type	Pre-Waiver Years SFYs 2009-2013	Waiver Years SFYs 2014-2018	Change
Restrictive Placements			
Foster care	50.2%	43.8%	-6.4%
Congregate care	21.9%	17.8%	-4.1%
Least Restrictive Placements			
Non-certified kinship care	16.1%	25.2%	+9.1%
Certified kinship care	6.3%	7.6%	+1.4%
All other care types²	5.6%	5.5%	-0.1%

¹Counties receiving funding to implement one or more Waiver interventions in each of the five Waiver years

²Includes trial home visit, unknown, runaway, and other placement types

Figure 33. Annual Percentages of All Out-Of-Home Removal Days by Placement Type in the 35 Full Demonstration Counties¹



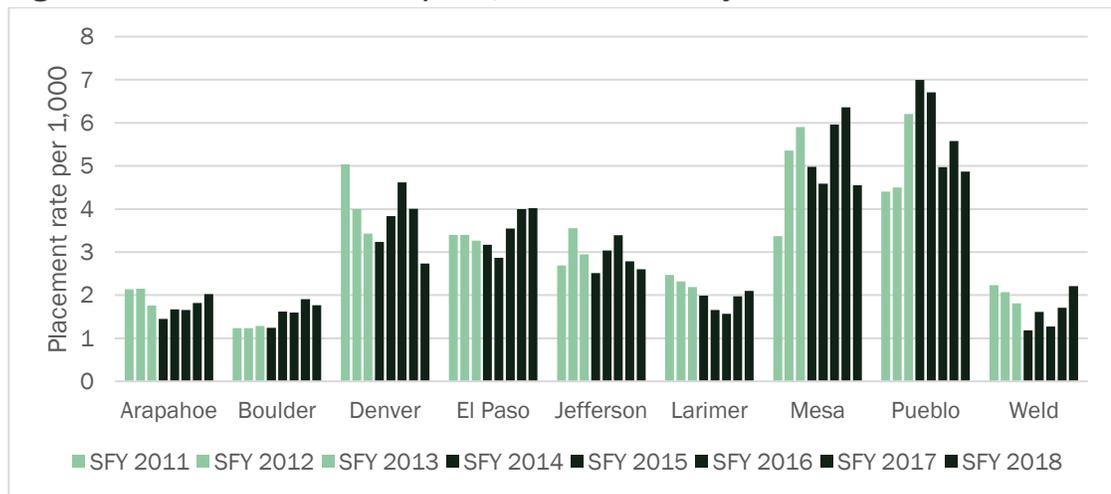
¹Counties receiving funding to implement one or more Waiver interventions in each of the five Waiver years; does not include Adams County (see page 124 for an explanation)

²Includes trial home visit, runaway, other, and unknown

OOH PLACEMENT RATES

The Process Study context section showed the placement rate per 1,000 for the state of Colorado in its entirety and saw that the placement rate rose by 1% from 2.90 in SFY 2013 to 2.93 in SFY 2018—mostly due to the reduction in SFY 2018 after the high of 3.25 in SFY 2017 – despite a steady increase in the rate of referrals (Figure 22 and Figure 23). This Outcome Trends section explores how the placement rate changed in the TLC, comparing a pre-Waiver baseline (SFYs 2011-2013) to the Waiver period (SFYs 2014-2018). Figure 34 below looks at the placement rate per 1,000 for the TLC, excluding Adams due to the kinship placement data limitations previously mentioned (see page 124). The placement rate analysis used the child population denominator from ACS One Year Population Estimates for children aged 0 to 17.

Figure 34. Placement Rate per 1,000 in the TLC by SFY



Within the TLC, the counties had a wide range of placement rates overall. In SFY 2018, placement rates ranged from a low of 1.92 in Boulder to a high of 6.29 in Pueblo. Furthermore, the trend in placement rates across time in the years observed varies count to county. Table 27 presents the results from a linear regression, looking at the placement rates in TLC, comparing pre-Waiver to Waiver quarterly placement rates.

Table 27. Regression Analysis: Waiver Impact on Placement Rates by the TLC

County	Estimate	Std Error	DF	t-Value	p
Arapahoe	-0.32	0.14	1.00	-2.24	0.0330
Boulder	0.35	0.16	1.00	2.19	0.0365
Denver	-0.13	0.29	1.00	-0.46	0.6492
El Paso	0.23	0.20	1.00	1.17	0.2508
Jefferson	-0.09	0.22	1.00	-0.42	0.6803
Larimer	-0.60	0.14	1.00	-4.32	0.0002
Mesa	0.31	0.52	1.00	0.60	0.5556
Pueblo	0.83	0.49	1.00	1.71	0.0979
Weld	-0.37	0.15	1.00	-2.51	0.0178

Arapahoe, Larimer, and Weld saw a significant decrease in placement rates when looking at all the Waiver years together. However, looking at Figure 34, although each county experienced a dip in the placement rates in the early years of the Waiver, later years showed an increase. Boulder experienced a significant rise in placement rates during the Waiver. The remaining counties did not have a significant change in placement rates.

OTHER KEY CHILD WELFARE OUTCOMES

This section includes an examination of the difference in likelihood of several key child welfare outcomes at the system level within the full demonstration counties as a whole and in the TLC, comparing a pre-Waiver baseline (SFYs 2011-2013) to the Waiver period (SFYs 2014-2018). The general trend of each outcome is graphically displayed, and the difference in likelihood is explored via logistic regression (Table 28).



Table 28. Logistic Regression Estimates¹: Full Demonstration Counties (Demo) & TLC

	Odds Ratio & Confidence Interval (CI)											
Period	All Demo.	Adams	Arapahoe	Boulder	Denver	El Paso	Jefferson	Larimer	Mesa	Pueblo	Weld	
Least restrictive out-of-home placement use²												
Likelihood of Entering an Initial Kin Placement												
Pre-Waiver	1.00		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
Waiver	1.47*		2.05*	1.34	1.40*	1.42*	1.42*	0.96	1.59*	1.37*	6.09*	
Upper CI	1.38		1.53	0.93	1.21	1.24	1.19	0.72	1.20	1.09	2.86	
Lower CI	1.57		2.75	1.93	1.61	1.63	1.68	1.26	2.09	1.73	12.96	
Likelihood of Entering an Initial Congregate Care Placement												
Pre-Waiver	1.00		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
Waiver	0.74*		0.62*	0.57	0.79	0.63*	0.56*	0.92	0.45*	0.86	0.94	
Upper CI	0.66		0.46	0.32	0.61	0.50	0.41	0.51	0.26	0.54	0.62	
Lower CI	0.82		0.85	1.01	1.03	0.80	0.77	1.66	0.77	1.38	1.42	
Out-of-home placement stability												
Likelihood of Moving Within Six Months of First Placement³												
Pre-Waiver	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
Waiver	1.11*	0.84	1.48*	1.60*	0.94	1.14	1.11	1.17	1.13	0.90	1.36*	
Upper CI	1.04	0.69	1.20	1.09	0.82	0.98	0.93	0.88	0.86	0.70	1.00	
Lower CI	1.18	1.03	1.82	2.33	1.09	1.32	1.33	1.57	1.48	1.16	1.85	
Time to permanency												
Likelihood of Exiting Within Six Months of First Placement⁴												
Pre-Waiver	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
Waiver	0.81*	1.29*	1.17	0.63*	0.67*	0.98	0.76*	0.78	0.43*	0.53*	0.86	
Upper CI	0.76	1.07	0.95	0.44	0.58	0.85	0.64	0.58	0.32	0.41	0.64	
Lower CI	0.86	1.57	1.45	0.91	0.78	1.13	0.91	1.04	0.57	0.68	1.16	
Likelihood of Exiting Within One Year of First Placement⁵												
Pre-Waiver	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	
Waiver	0.81*	1.33*	0.92	0.81	0.63*	1.09	0.70*	1.01	0.69*	0.36*	0.82	
Upper CI	0.75	1.08	0.73	0.53	0.54	0.92	0.57	0.71	0.51	0.26	0.58	
Lower CI	0.87	1.63	1.16	1.24	0.74	1.28	0.86	1.44	0.93	0.49	1.16	

Odds Ratio & Confidence Interval (CI)												
Period	All Demo.	Adams	Arapahoe	Boulder	Denver	El Paso	Jefferson	Larimer	Mesa	Pueblo	Weld	
Distal permanency outcome												
Likelihood of Re-Entering Care Within One Year of Exit from First Admission to Reunification, Relatives, or Guardianship⁶												
Pre-Waiver	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Waiver	0.94	0.79	0.82	0.96	0.83	0.81	0.96	1.63	1.15	0.93	1.49	
Upper CI	0.85	0.58	0.60	0.50	0.68	0.65	0.70	0.99	0.66	0.58	0.86	
Lower CI	1.04	1.09	1.14	1.84	1.02	1.01	1.33	2.70	1.98	1.50	2.57	

¹ The data have a censor date of June 30, 2018. Age at time of placement as well as race are included in the model as covariates. The demonstration county (All Demo.) model includes a county random effect while the TLC counties each have their own individual model. Significance is indicated (*) at the 0.05 level.

² Data from Adams County are excluded from placement type outcomes due to a kinship data inconsistency (see page 124).

³ Includes spells with a start date through December 31, 2017, observed through June 30, 2018.

⁴ Includes spells with a start date through December 31, 2017, observed through June 30, 2018.

⁵ Includes spells with a start date through June 30, 2017, observed through June 30, 2018.

⁶ Model uses exit cohorts with spells with an exit date through June 30, 2017, observed through June 30, 2018.

Table 29 below descriptively summarizes the change in outcomes between the two cohorts.

Table 29. Outcome Difference Summary: Average Proportion of First Admissions in Pre-Waiver and Waiver Periods

Outcome	Pre-Waiver (SFY 2011 - SFY 2013)	Waiver (SFY 2014 - SFY 2018)
Entering an initial kin placement	36%	44%
Entering an initial congregate care placement	17%	13%
Moving within six months of first placement	33%	35%
Exiting within six months of first placement	53%	47%
Exiting within one year of first placement	70%	65%
Re-entering care within one year of exit from first admission	16%	15%

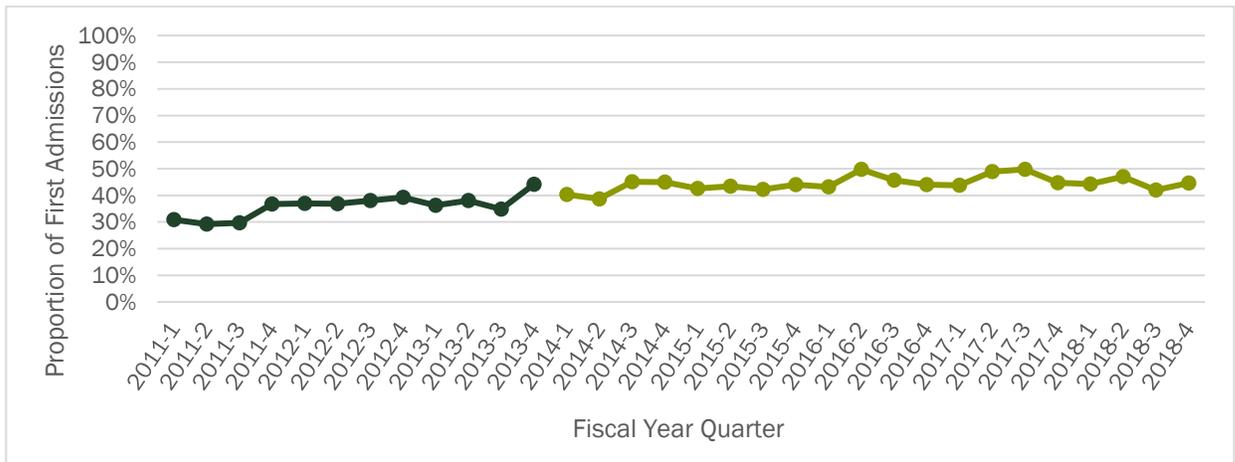
LEAST RESTRICTIVE OOH PLACEMENT

Children entering out-of-home care may be placed in different settings. Besides foster homes, group homes, and residential facilities, a child may also be placed with relatives (in kinship care). One goal of the Waiver was for county departments of human/social services to use kin placements and settings less restrictive than congregate care when placement is necessary. The hope was that children placed with relatives would see improved outcomes around permanency, safety, and well-being.

The placement types analyzed here are grouped in one of four settings: conventional foster care, kinship care (certified and non-certified), congregate care (e.g., group homes, residential care), and other settings (e.g., independent living). During an out-of-home care spell, a child may experience multiple placements and changes in placement settings. Analysis of placement type may examine either the first or predominant placement type of a child's time in care. The focus of this analysis is on the first placement type since across the TLC, the type of the placement between initial and predominant does not vary more than 10% for any of the three major placement types (foster care, congregate, or kinship).

Figure 35 presents the proportion of initial kin placement for first admissions in the full demonstration counties by fiscal year quarter. (For example, fiscal year quarter 2017-01 covers the period of July 1, 2016 through September 30, 2016.) The likelihood of first admissions being initially with kin rose in the few years prior to the Waiver. This trend continued into the Waiver, though not at the same velocity. Approximately 33% of all first admissions were initially with kin during the pre-Waiver period, and 46% during the Waiver period.

Figure 35. Proportion of First Admissions Initially Placed with Kin in the Full Demonstration Counties by Fiscal Year Quarter



To examine the significance of this difference, the results of the logistic regressions are examined. In Table 28, the odds ratios are presented for the likelihood of being initially placed in kinship placement settings between pre-Waiver and post-Waiver entry cohorts.

Table 29 show that when compared to the pre-Waiver period, first admissions during the Waiver had a significantly higher likelihood of initially entering a kinship placement. When examined in a year-by-year model, this significant increase was true in each individual Waiver year as well, with the impact growing each year. This significant increase in likelihoods between the periods held true for seven out of nine of the TLC counties.

Viewed from another perspective, the likelihood of entering the least restrictive placement type is impacted by the proportion of children entering a congregate care placement type. Like the kinship placement trends, the reduction in congregate care usage began prior to but continued during the Waiver period (Figure 36).

Figure 36. Proportion of First Admissions Initially Placed in Congregate Care in the Full Demonstration Counties by Fiscal Year Quarter

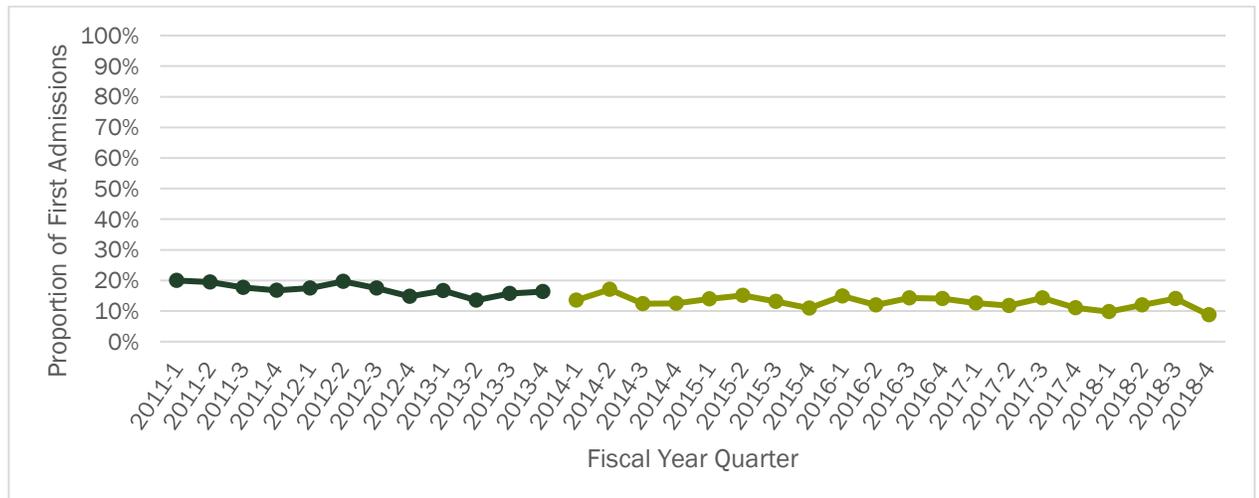


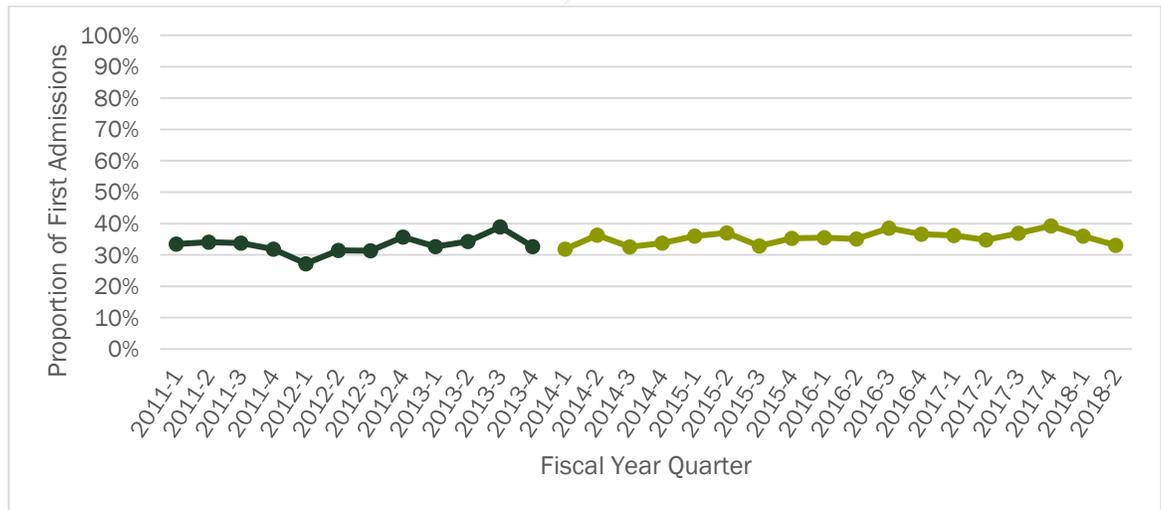
Table 29 shows that the full demonstration counties saw a significant decrease in the likelihood of being initially placed in congregate care. Among the TLC, four showed a significant decrease in the likelihood of being initially placed in congregate care on a first admission when comparing the pre-Waiver period (SFY2011-SFY2013) to the Waiver period (SFY2014-SFY2018), though all TLC showed a trend in the favorable direction, if not significant.

This decrease in the utilization of congregate care as a first placement type was paired with a significant increase in the likelihood of being initially placed in kinship care on a first admission in all four of these counties. Additionally, all four showed a decreased likelihood of congregate care placement from SFY2011 through SFY2013 levels during each Waiver SFY in the year-by-year model, though not every decrease was statistically significant.

PLACEMENT STABILITY

During their time in care, children may experience disruptions to their placement and move from one placement to another. These placement moves can be damaging to a child’s well-being and should be minimized. In Colorado, as in most jurisdictions, placement moves are most likely to occur in the first six months after placement. So, this section discusses the changes in the likelihood of moving during placement in the first six months of placement between pre-Waiver and Waiver entry cohorts.

Figure 37. Proportion of First Admissions That Experience a Placement Move Within the First Six Months of Placement in Full Demonstration Counties by Fiscal Year Quarter



At a glance (Figure 37), the likelihood of moving within the first six months of placement appears relatively unchanged. However, there is an increase in the overall average of first placements who moved within the first six months when compared to the pre- and Waiver periods, from 33% to 35% of placements (Table 29). The logistic regression analysis (Table 28) does show a slight, though significant, increase in placement movements for the full demonstration counties and three of the TLC. One county, Adams, shows a significant decrease in placement movement within the first six months of placement.

TIME TO PERMANENCY

The length of time that children spend in out-of-home care is a key outcome of interest in child welfare. The quantity of time that a child spends out of their home impacts both the child's well-being and the resources required to support that child's stay in care. The focus within this outcome analysis is on duration for children entering care for the first time, from a lens of likelihood of exit, within a six-month and one-year window.

Figure 38. Proportion of First Admissions Exiting Within Six Months in Full Demonstration Counties by Fiscal Year Quarter

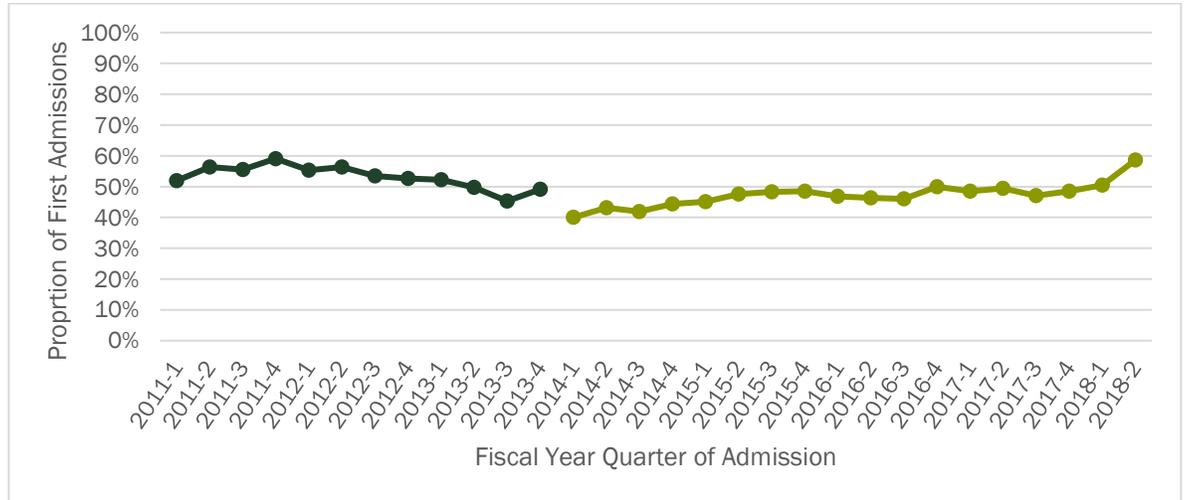
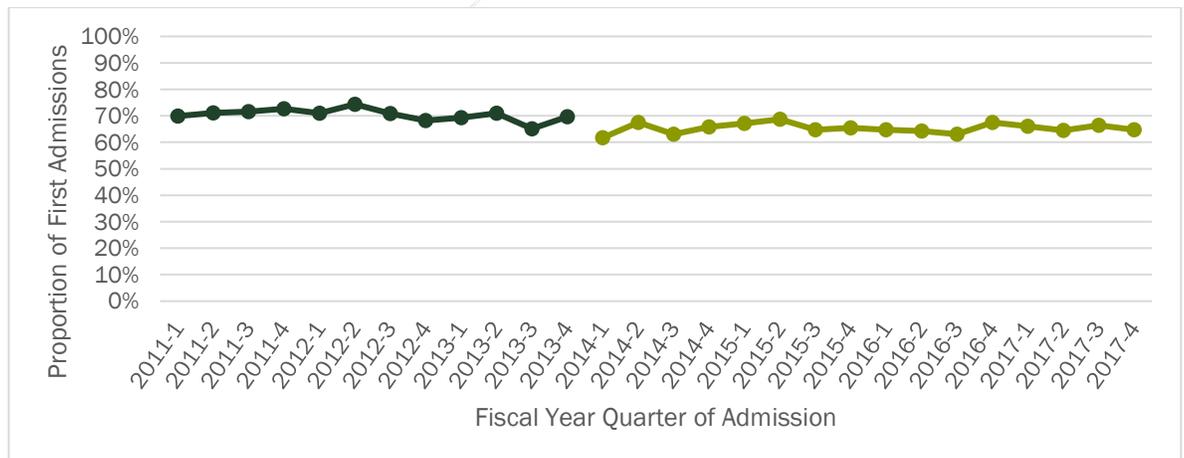


Figure 39. Proportion of First Admissions Exiting Within One Year in Full Demonstration Counties by Fiscal Year Quarter



Comparing the trends of the likelihoods of exiting within six months or a year, there is a greater variability in the likelihood of a child exiting care within six months of placement. Reaching a low with admissions in the first quarter of the Waiver at 40%, this proportion increased steadily until reaching a peak with admission in the last quarter of the Waiver at 58.4%. However, overall, the average proportion of children exiting within six months decreased from the pre-Waiver period (53%) to the Waiver period (47%).

The full demonstration counties and five of the TLC saw a significant decrease in the likelihood of exiting care within six months, and all but one of those groups also saw a decrease in the likelihood of exiting care within one year as well (Table 28).

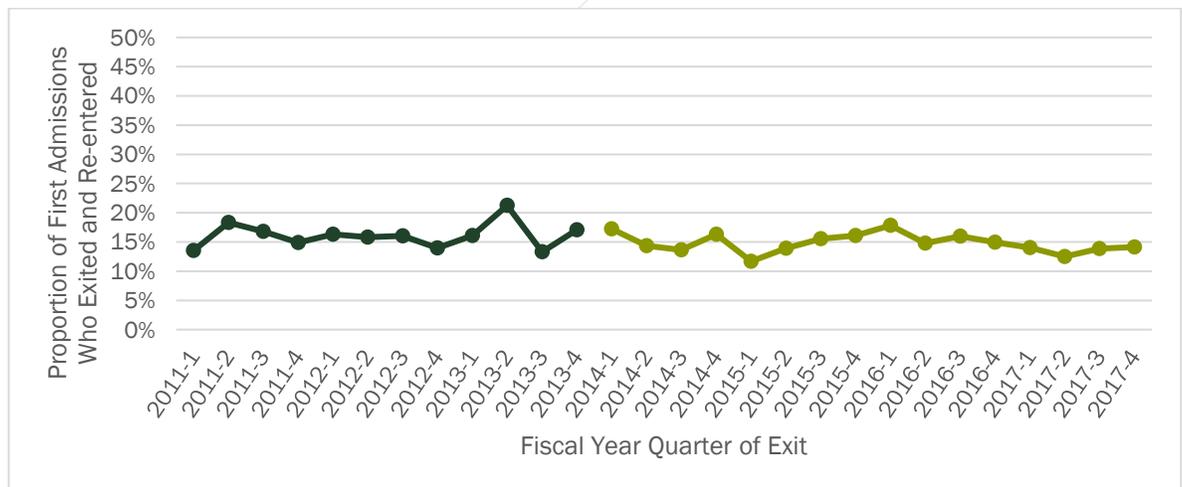
However, the uptick in likelihood seen in Figure 38 for SFY 2018 shows some movement in the right direction. For the full demonstration counties, though each Waiver fiscal year through SFY 2017 saw a significant decrease in likelihood of exiting within six months, the findings for SFY 2018 (though only for a half year of data), display a significant increase in the proportion of children leaving within the first six months.

Adams County is again an outlier, seeing a significant increase in the likelihood of exit for both observation windows.

RE-ENTRY

Especially in an environment with significant shifts in policy and practice, particularly around placement type, it is important to examine re-entries to gain insight into the apparent success or failure of the initial discharge from care. Re-entry may be a signal that the discharge was inappropriate or premature; however, from the available data, it cannot be determined why any given child is returned to care. Nonetheless, analysis of re-entry rates should help, at the aggregate level, to evaluate the success of discharges.

Figure 40. Proportion of Permanent Exits Re-Entering Care Within One Year in the Full Demonstration Counties by Fiscal Year Quarter



The difference in averages between the pre-Waiver and Waiver periods are slight, with a change from 16% to 15% of exits re-entering within a year. However, the logistic regression shows this as a significant change for the full demonstration counties. Eight of the TLC showed trends in the same direction, but only two counties rose to significance (Denver and El Paso). A reduction in re-entries is a positive sign that the changes to the system under the Waiver did not negatively impact the success of permanent exits.

Intervention-Specific Matched Case Comparisons

The results of all matched case comparison analyses are included in Appendix K, while the most notable findings are presented and discussed below. A table with the sample sizes for each intervention and corresponding comparison group or subgroup is presented initially in each of the intervention-specific sections, followed by the findings. Tables with descriptive statistics showing the post-match balance between each intervention and corresponding comparison group or subgroup are provided in Appendix M. As noted in the Outcome Study Data Analysis methods section, statistical test results are only provided for outcomes that demonstrated a positive intervention effect (i.e., for outcomes that were in the hypothesized direction between the intervention and comparison groups).

FACILITATED FAMILY ENGAGEMENT MEETINGS: OOH CHILDREN AND YOUTH

Table 30. Intervention and Matched Case Comparison Group Sample Sizes for FFE Children and Youth Placed OOH

Group	Intervention Group	Comparison Group
All children and youth whose families received FFE meetings	14,442	13,993
Children and youth whose families received FFE meetings with higher overall adherence ¹	2,791	2,700
Children and youth whose families received FFE meetings with lower overall adherence ²	11,651	11,293

¹In families with at least .50 overall adherence

²In families with lower than .50 overall adherence

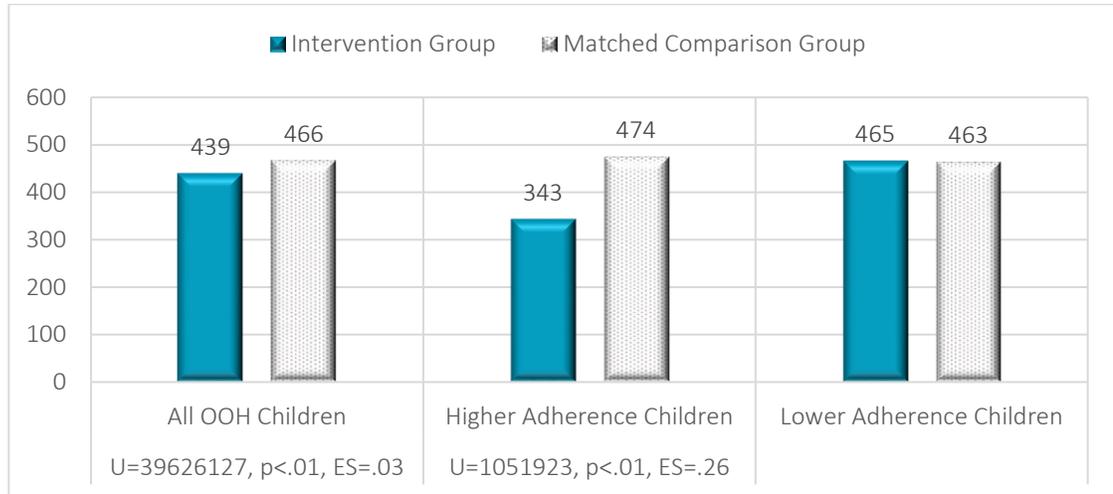
Table 31 provides an overview of the FFE meetings matched case comparison findings for children and youth who were placed out-of-home. A checkmark indicates a positive effect for the corresponding intervention group or subgroup and outcome. A detailed presentation of the findings follows.

Table 31. Overview of the FFE Meetings Matched Case Comparison Findings for Children and Youth Placed Out-of-Home

Outcome	Intervention Group		
	All OOH Children	Higher Adherence Children	Lower Adherence Children
Case length			
Fewer median case days in the intervention group	✓	✓	
Out-of-home placement stability			
Greater percentage of intervention group children & youth experienced no more than one placement disruption		✓	
Least restrictive out-of-home placement use			
Greater percentage of intervention group children & youth had their first out-of-home placement with kin	✓	✓	✓
Greater percentage of intervention group children & youth spent all or most case out-of-home placement days in kinship care	✓	✓	✓
Permanent case close residence			
Greater percentage of intervention group children & youth living with birth parents, non-adoptive kin, or non-kin guardians at case close	✓	✓	
Greater percentage of intervention group children & youth living with birth parents at case close		✓	
Subsequent child welfare involvement			
Smaller percentage of intervention group children & youth whose cases closed experienced a founded or inconclusive re-report of abuse and/or neglect with a subsequent case open	✓	✓	✓
Of the children & youth with a re-report, more median days to subsequent case open in the intervention group	✓		✓
Out-of-home placement after case close			
Of the children & youth who re-entered out-of-home placement, greater percentage of children & youth in the intervention group spent all or most out-of-home days in kinship care	✓	✓	✓

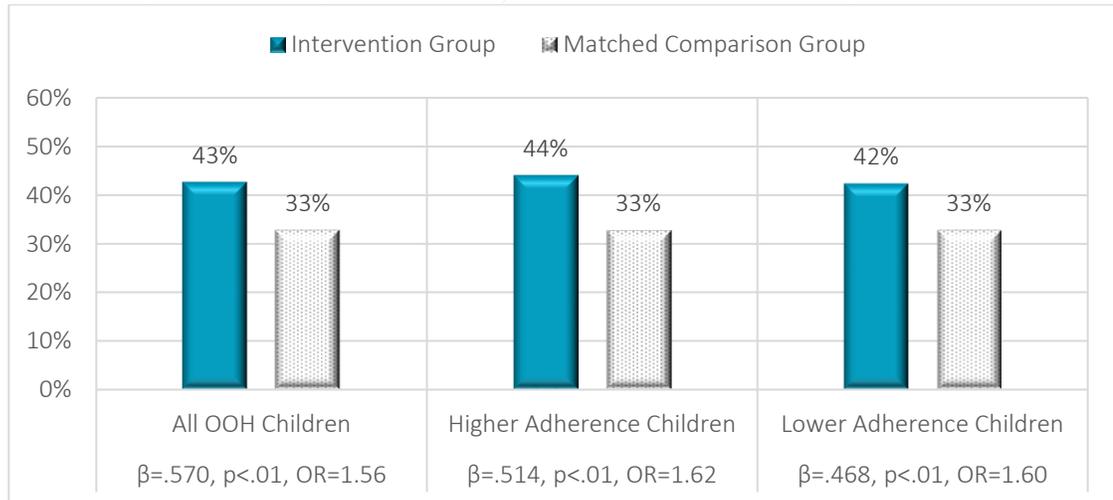
The figure below shows that the cases of all out-of-home children and youth whose families received FFE meetings were typically (i.e., based on medians) about one month shorter than the cases of matched out-of-home children and youth whose families did not receive the intervention. Controlling for the matching variables, the difference between the groups was statistically significant at the $p < .01$ level, but the effect size was very small. The median case length of the higher adherence group was, however, significantly shorter than its matched comparison group when controlling for the matching variables, and the difference resulted in a larger effect size. The cases of children and youth in the higher adherence intervention subgroup were typically 131 days, or just over four months, shorter than the cases of their matched comparisons, whereas the cases of children and youth in the lower adherence subgroup were typically two days longer than their matched comparisons.

Figure 41. Median Case Length Days Between the Intervention and Matched Case Comparison Groups



The figure below shows that a greater percentage of all out-of-home children and youth whose families received FFE meetings, regardless of adherence level, were first placed with kin compared to matched out-of-home children and youth whose families did not receive the intervention. Controlling for the matching variables, the difference between each out-of-home intervention and corresponding matched comparison group was statistically significant at the $p < .01$. The odds of having a first placement in kinship care were 1.56 times, or 56%, greater for children and youth in the full intervention group than for children and youth in the matched comparison group.

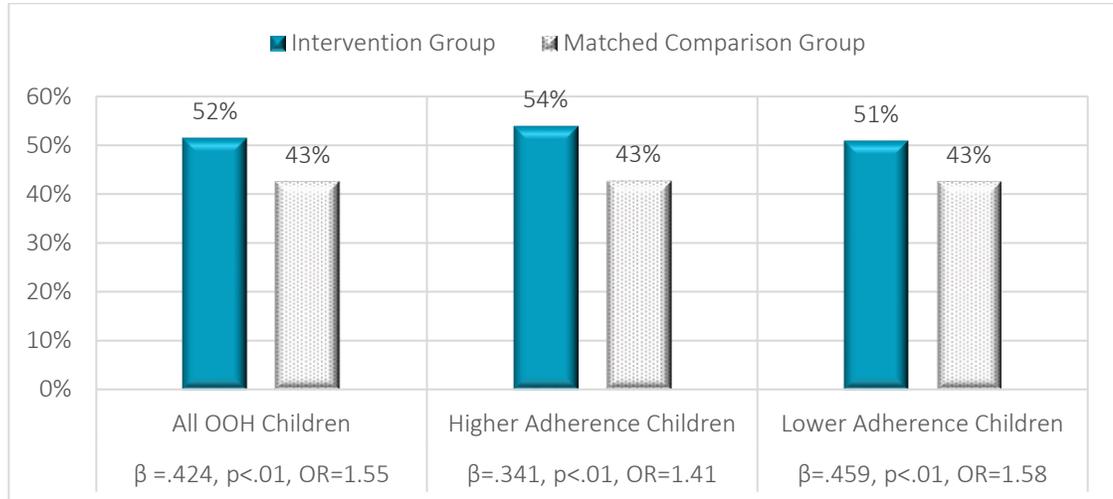
Figure 42. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups with a First OOH Placement in Kinship Care



The figure below shows that a greater percentage of out-of-home children and youth whose families received FFE meetings, regardless of adherence level, spent all or most out-of-home placement days during their cases in kinship care compared to matched out-of-home children and youth whose families did not receive the intervention. Controlling for the matching variables, the difference between each out-of-home intervention and corresponding matched comparison group was statistically

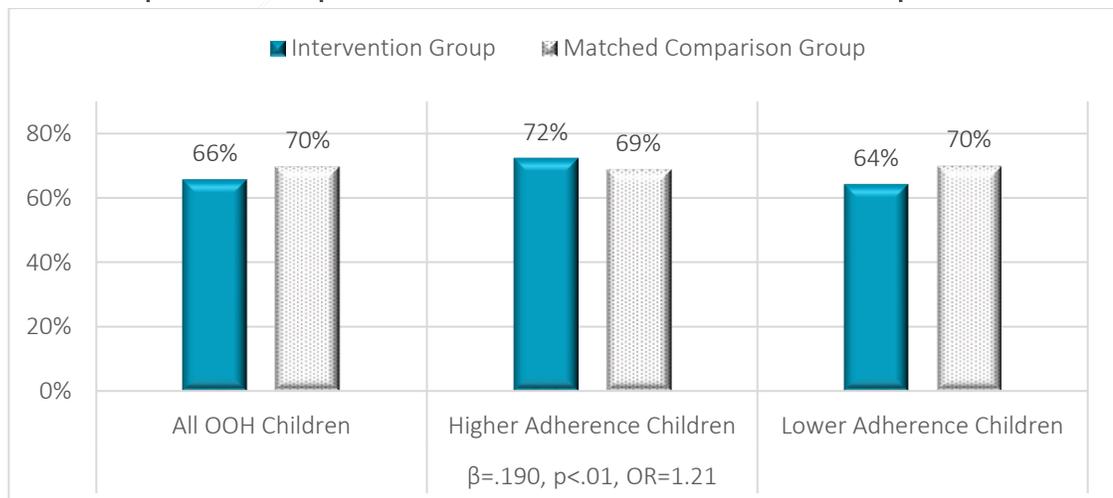
significant at the $p < .01$ level. The odds of spending all or most out-of-home days in kinship care were 1.55 times, or 55%, greater for children and youth in the full intervention group than for children and youth in the matched comparison group.

Figure 43. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Spending All or Most Case Open OOH Days in Kinship Care



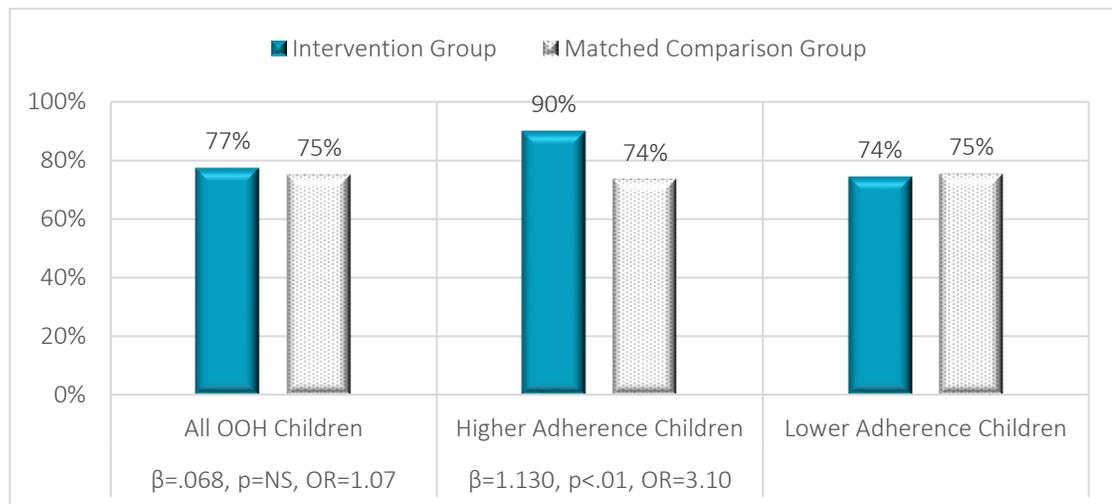
The figure below shows that a greater percentage of out-of-home children and youth whose families received FFE meetings with higher adherence experienced no more than one placement disruption compared to matched out-of-home children and youth whose families did not receive the intervention. Controlling for the matching variables, the difference between this intervention subgroup and its matched comparison group was statistically significant at the $p < .01$ level. The odds of experiencing no more than one placement disruption were 1.21 times, or 21%, greater for children and youth in the higher adherence subgroup, whereas children and youth in the lower adherence intervention subgroup were less likely than their matched comparisons to have no more than one disruption.

Figure 44. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups with No More than One Placement Disruption



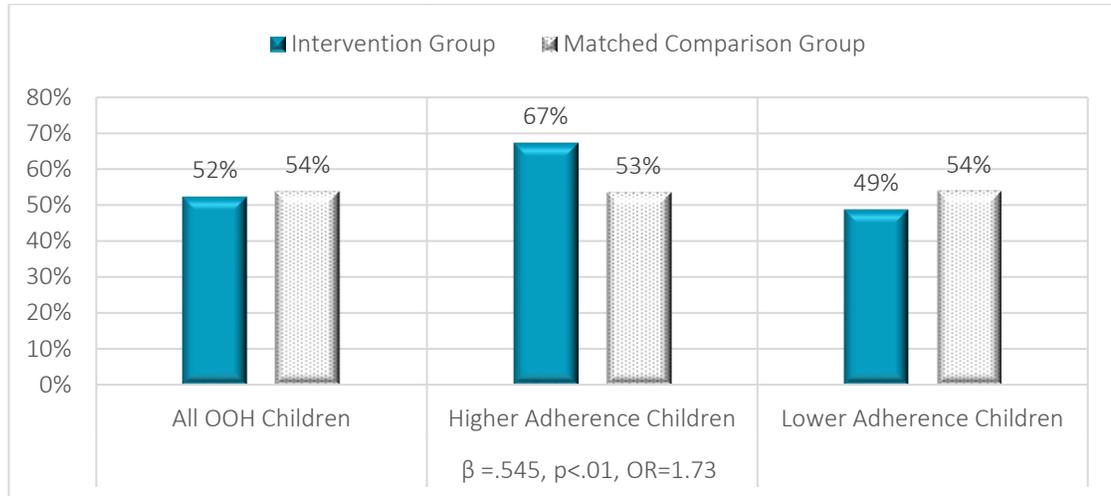
The figure below shows that a slightly greater percentage of all out-of-home children and youth whose families received FFE meetings achieved permanency (i.e., living with their birth parents, non-adoptive kin, or non-kin guardians) at case close compared to their matched comparisons whose families did not receive the intervention, but the difference was not statistically significant when controlling for the matching variables. However, a significantly ($p < .01$) greater percentage of out-of-home children and youth in the higher adherence intervention subgroup were living in a permanent residence at case close compared to children and youth in the corresponding matched comparison group. The odds of achieving permanency were 3.10 times, or 210%, greater for children and youth in the higher adherence intervention group. Conversely, children and youth in the lower adherence group were less likely than their matched comparisons to achieve permanency at case close.

Figure 45. Percentage of Children and Youth in The Intervention and Matched Case Comparison Groups Living with Parents, Non-Adoptive Kin, or Non-Kin Guardians at Case Close



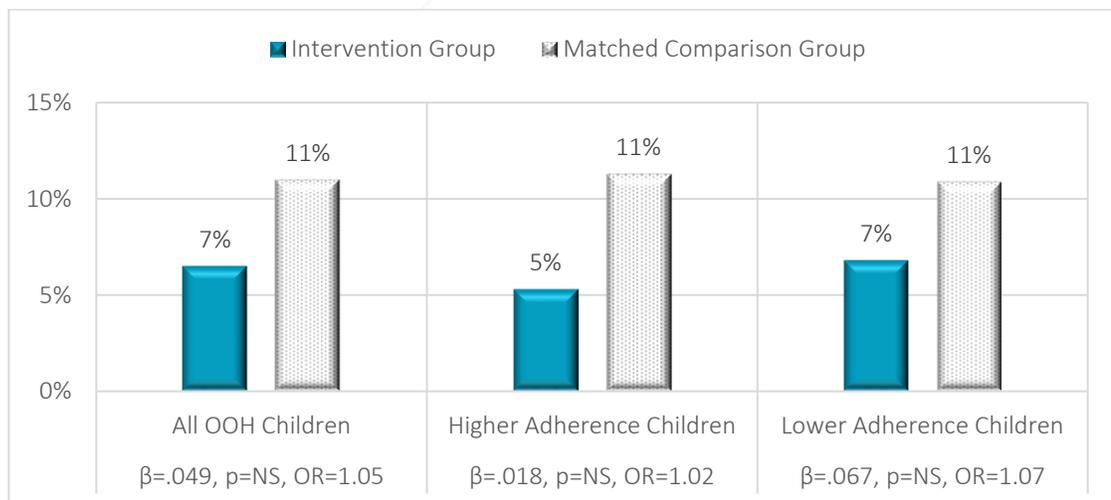
An exclusive analysis of the likelihood of returning home at case close (figure below) indicates that, when controlling for the matching variables, a significantly greater ($p < .01$) percentage of out-of-home children and youth whose families received the intervention with higher adherence were reunified with their birth parents at case close compared to matched out-of-home children and youth whose families did not receive the intervention. And, the odds of returning home were 1.73 times, or 73%, greater for children and youth in the higher adherence intervention subgroup. Children and youth in the lower adherence intervention subgroup, on the other hand, were less likely than their matched comparisons to reunify at case close.

Figure 46. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Living with Parents at Case Close



The figure below shows that a smaller percentage of out-of-home children and youth whose cases closed and whose families received FFE meetings, regardless of adherence level, experienced subsequent child welfare involvement compared to matched out-of-home children and youth whose cases closed but whose families did not receive the intervention. Controlling for the matching variables, the difference between each out-of-home intervention and corresponding matched comparison group was not statistically significant. The odds of subsequent child welfare involvement were 1.05 times, or 5%, less for children and youth in the full intervention group than for children and youth in the full matched comparison group.

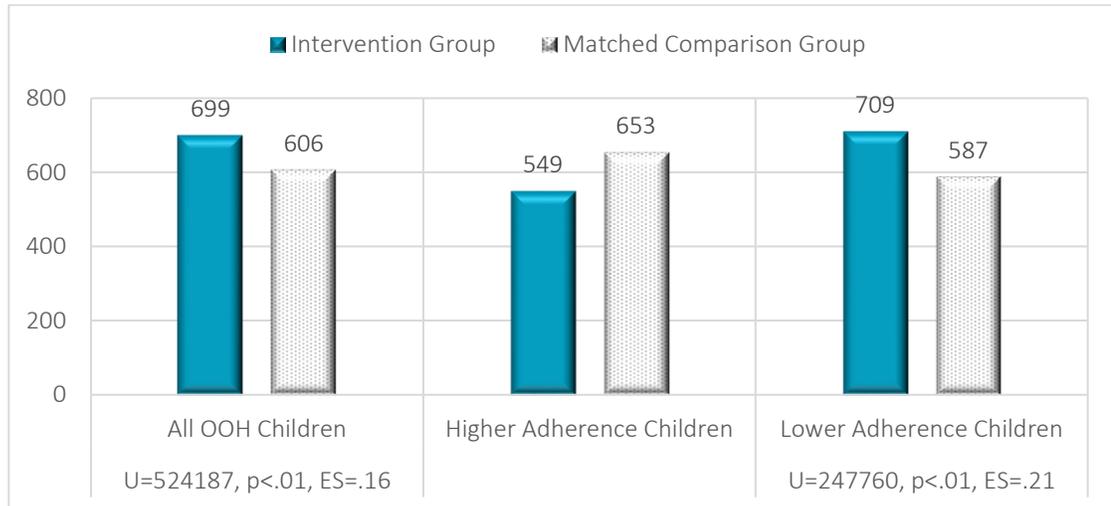
Figure 47. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups with Subsequent Child Welfare Involvement after Case Close



The figure below shows that all out-of-home children and youth with subsequent child welfare involvement and whose families received FFE meetings generally had about three additional months before subsequent involvement than matched out-of-home children and youth with subsequent involvement but whose families did not receive FFE meetings. Controlling for the matching variables, the difference between

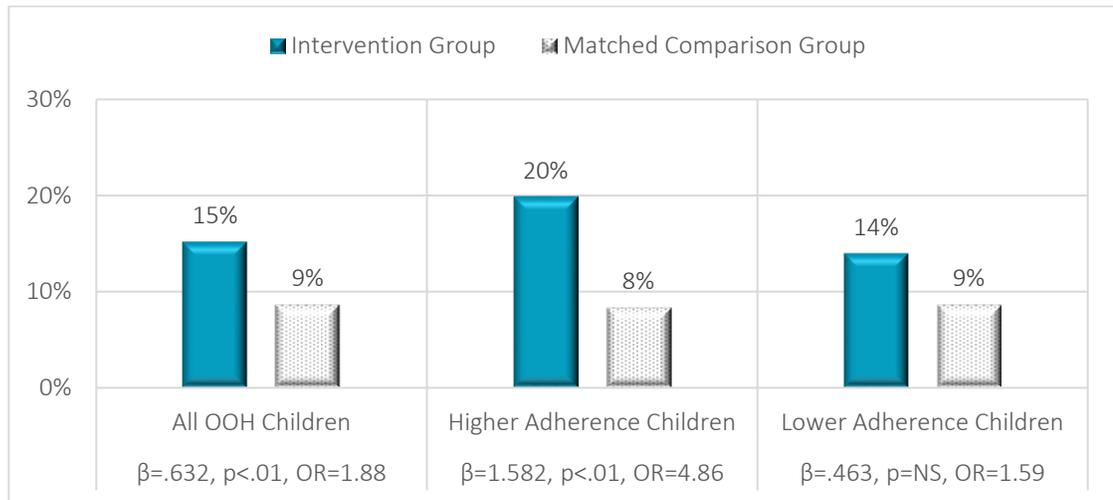
the groups was statistically significant at the $p < .01$ level; however, the effect size was somewhat small. Unexpectedly, out-of-home children and youth in the lower adherence intervention subgroup typically had about four months longer than their matched comparisons before subsequent involvement, while out-of-home children and youth in the higher intervention subgroup typically had subsequent involvement about three and a half months sooner than their matched comparisons.

Figure 48. Median Days from Case Close to Subsequent Child Welfare Involvement Between the Intervention and Matched Case Comparison Groups



The figure below shows that a greater percentage of all out-of-home children and youth who had an out-of-home placement after case close and whose families received FFE meetings, regardless of adherence level, spent all or most of their subsequent case out-of-home placement days in kinship care compared to matched out-of-home children and youth who had an out-of-home placement after case close but whose families did not receive the intervention. Controlling for the matching variables, the difference between the full intervention and matched comparison groups was statistically significant at the $p < .01$ level. The odds of spending all or most subsequent case out-of-home days in kinship care were 1.88 times, or 88%, greater for children and youth in the full intervention group. The odds for children and youth in the higher adherence intervention subgroup were 4.86 times, or 386%, greater than their matched comparisons, and the odds for children and youth in the lower adherence subgroup were 1.59 times, or 59%, greater than their matched comparisons.

Figure 49. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Spending All or Most Post-Case Close OOH Days in Kinship Care



FACILITATED FAMILY ENGAGEMENT MEETINGS: IN-HOME CHILDREN AND YOUTH

Table 32. Intervention and Matched Comparison Group Sample Sizes for FFE Meetings for In-Home Children and Youth

Analysis Group	Treatment Group	Comparison Group
All children and youth	12,417	12,417
Children and youth whose families received FFE meetings with higher overall adherence ¹	5,744	5,744
Children and youth whose families received FFE meetings with lower overall adherence ²	6,673	6,673

¹In families with at least .50 overall adherence

²In families with lower than .50 overall adherence

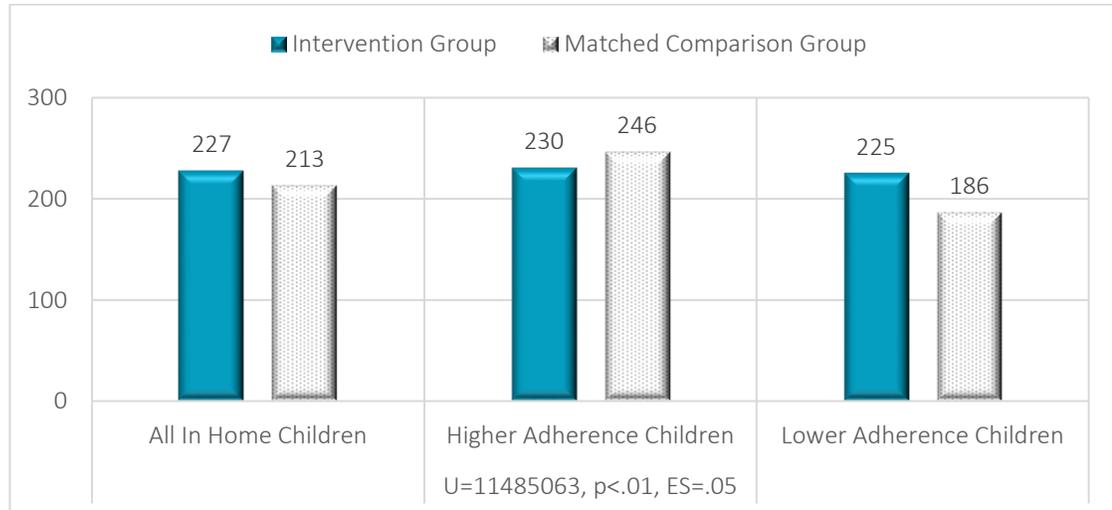
Table 33 provides an overview of the FFE meetings matched case comparison findings for children and youth who remained in-home. A checkmark indicates a positive finding for the corresponding intervention group or subgroup and outcome. A detailed presentation of the findings follows.

Table 33. Overview of the FFE Meetings Matched Case Comparison Findings for Children and Youth Who Remained In-Home

Outcome	Intervention Group		
	All In-Home Children	Higher Adherence Children	Lower Adherence Children
Case length			
Fewer median case days in the intervention group		✓	
Subsequent child welfare involvement			
Of the children & youth with a re-report, more median days to subsequent case open in the intervention group	✓	✓	✓

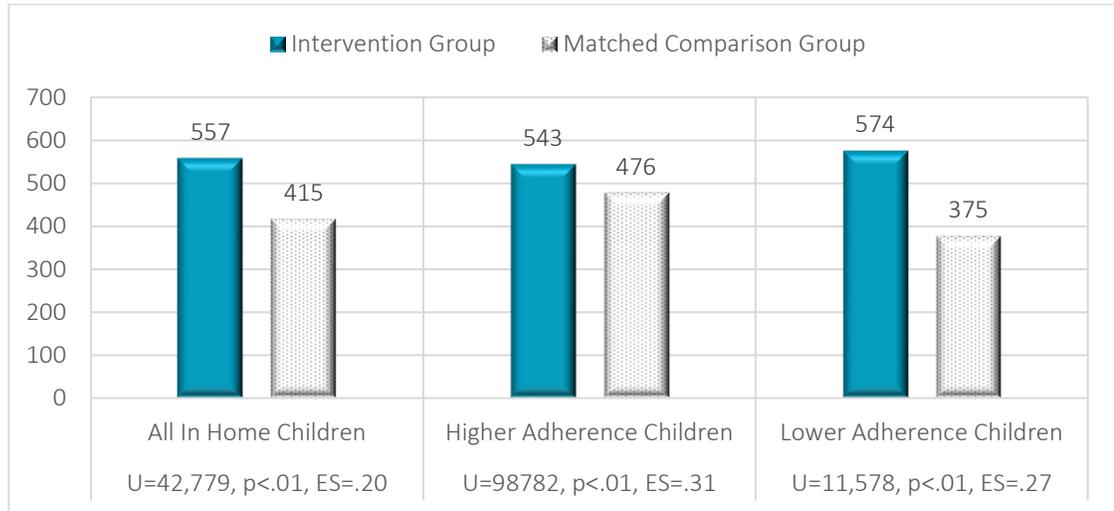
The figure below shows that the cases of in-home children and youth whose families received FFE meetings with higher adherence were generally about two weeks shorter than the cases of matched out-of-home children and youth whose families did not receive the intervention. Controlling for the matching variables, the difference between the groups was statistically significant at the $p < .01$ level, but the effect size was very small. Conversely, the cases of children and youth in the full intervention group and lower adherence intervention subgroup were typically longer than the cases of their matched comparisons.

Figure 50. Median Case Length Days Between the Intervention and Matched Case Comparison Groups



Although 10% of all in-home children and youth with closed cases and whose families received FFE meetings experienced subsequent child welfare involvement compared to 7% of matched in-home children and youth with closed cases, the figure below shows that in-home children and youth who received the intervention and experienced subsequent involvement, regardless of adherence level, generally had more days before experiencing subsequent involvement than their matched comparisons. Controlling for the matching variables, the difference between the full intervention and corresponding matched comparison groups was statistically significant at the $p < .01$ level and resulted in a modest effect size. Children and youth in the full in-home intervention group who experienced subsequent involvement generally had almost five months longer than their matched comparisons before subsequent involvement. Unexpectedly, children and youth in the lower adherence intervention subgroup typically had about six and a half months more than their matched comparisons before subsequent involvement, whereas children in the higher adherence intervention subgroup had about two months longer than their matched comparisons.

Figure 51. Median Days from Case Close to Subsequent Child Welfare Involvement Between the Intervention and Matched Case Comparison Groups



KINSHIP SUPPORTS: ALL CHILDREN AND YOUTH

Table 34. Intervention and Matched Comparison Group Sample Sizes for All KS Children and Youth

Analysis Group	Intervention Group	Comparison Group
All children and youth whose kinship caregivers received kinship supports	10,114	8,779
Children and youth whose kinship caregivers received kinship supports with higher overall adherence ¹	3,552	3,107
Children and youth whose kinship caregivers received kinship supports with lower overall adherence ²	6,562	5,672

¹Placed with kin who received their first assessment within seven days and at least one corresponding service for 50% or more assessed needs or had no assessed needs

²Placed with kin whose assessment and/or services did not meet the criteria for higher adherence

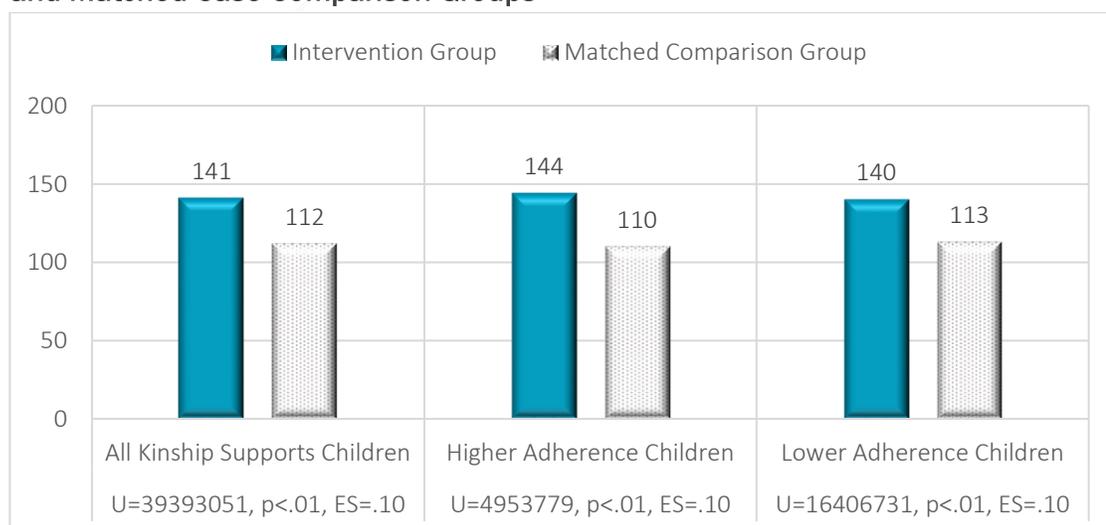
Table 35 provides an overview of the KS matched case comparison findings. A checkmark indicates a positive finding for the corresponding intervention group or subgroup and outcome. A detailed presentation of the findings follows.

Table 35. Overview of the KS Matched Case Comparison Findings

Outcome	Intervention Group		
	All Kinship Supports Children	Higher Adherence Children	Lower Adherence Children
Least restrictive out-of-home placement use			
Greater median kinship placement days in the intervention group	✓	✓	✓
Greater percentage of intervention group children & youth spent all or most out-of-home placement days in kinship care	✓	✓	✓
Permanent case close or end removal residence			
Greater percentage of intervention group children & youth living with kin, non-kin guardians, or adoptive parents at case close	✓	✓	✓
Kinship placement exit reason			
Greater percentage of intervention group children & youth exited their kinship placement to another kinship placement, guardianship, or adoption, if not returning home	✓	✓	✓
Subsequent child welfare involvement			
Smaller percentage of intervention group children & youth whose cases closed experienced a founded or inconclusive re-report of abuse and/or neglect with a subsequent case open	✓	✓	✓

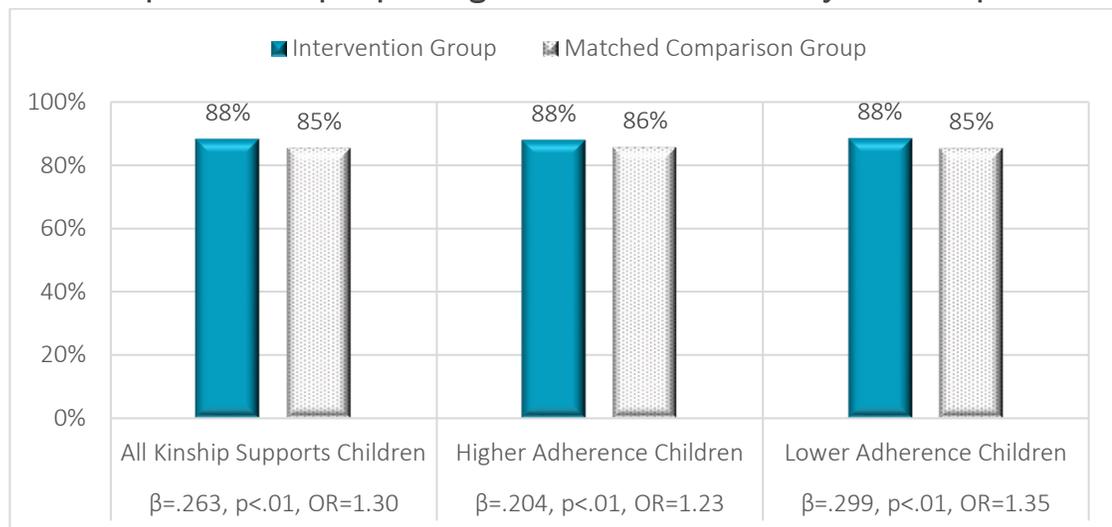
The figure below shows that the kinship placements of children and youth whose kinship caregivers received KS, regardless of adherence level, were typically about one month longer than the kinship placements of matched children and youth whose kinship caregivers did not receive the intervention. Controlling for the matching variables, the difference between the full intervention and matched comparison groups was significant at the $p < .01$ level; however, the effect size was small.

Figure 52. Median Kinship Placement Length in Days Between the Intervention and Matched Case Comparison Groups



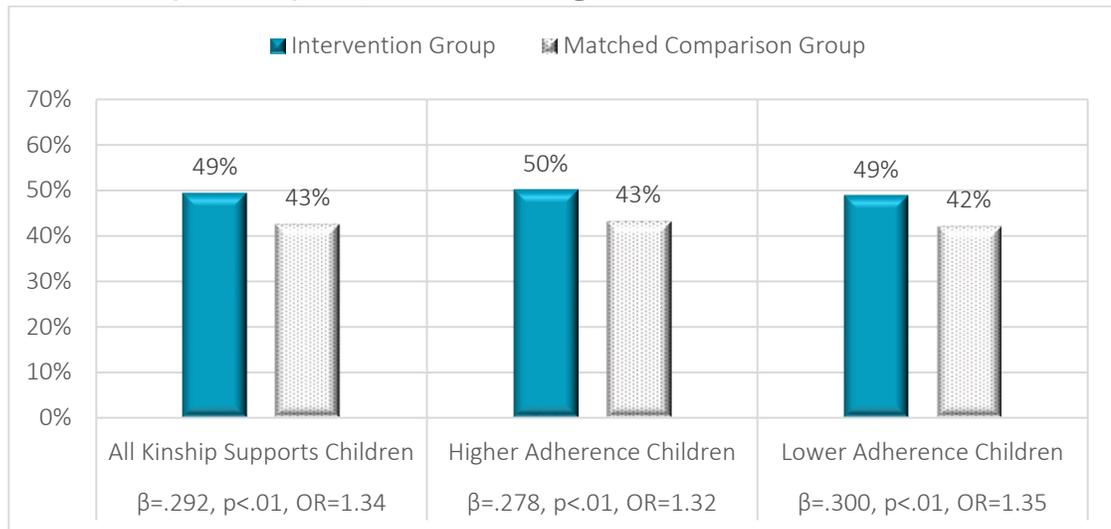
The figure below shows that a greater percentage of children and youth whose kinship caregivers received KS, regardless of adherence level, spent all or most out-of-home placement days during their cases in kinship care compared to matched out-of-home children and youth whose families did not receive the intervention. Controlling for the matching variables, the difference between each intervention and corresponding matched comparison group was statistically significant at the $p < .01$ level, and the odds of spending all or most out-of-home days in kinship care were 1.30 times, or 30% greater for children and youth in the full intervention group than for children and youth in its matched comparison group. The odds of spending all or most out-of-home placement days in kinship care did not vary substantially by lower or higher adherence.

Figure 53. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Spending All or Most Case OOH Days in Kinship Care



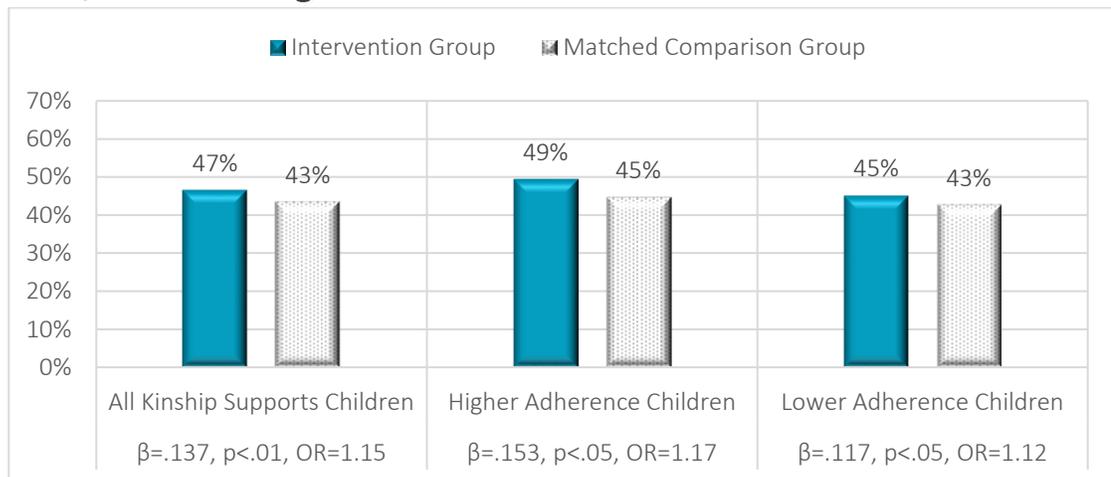
The figure below shows that a greater percentage of children and youth whose kinship caregivers received kinship supports, regardless of adherence level, exited kinship placement to another kinship placement or permanency (i.e., guardianship or adoption), if not returning home, than matched children and youth whose kinship caregivers did not receive kinship supports. The differences between each intervention and corresponding matched comparison group or subgroup were significant at the $p < .01$ level. The odds of exiting kinship placement to another kinship placement or permanency, if not returning home, was 1.34 times, or 34%, greater for children and youth in the full intervention group than for children and youth in its matched comparison group. The likelihood of exiting to another kinship placement or permanency did not vary substantially by lower or higher adherence.

Figure 54. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Exiting Kinship Placement to Another Kinship Placement, Guardianship, or Adoption, If Not Returning Home



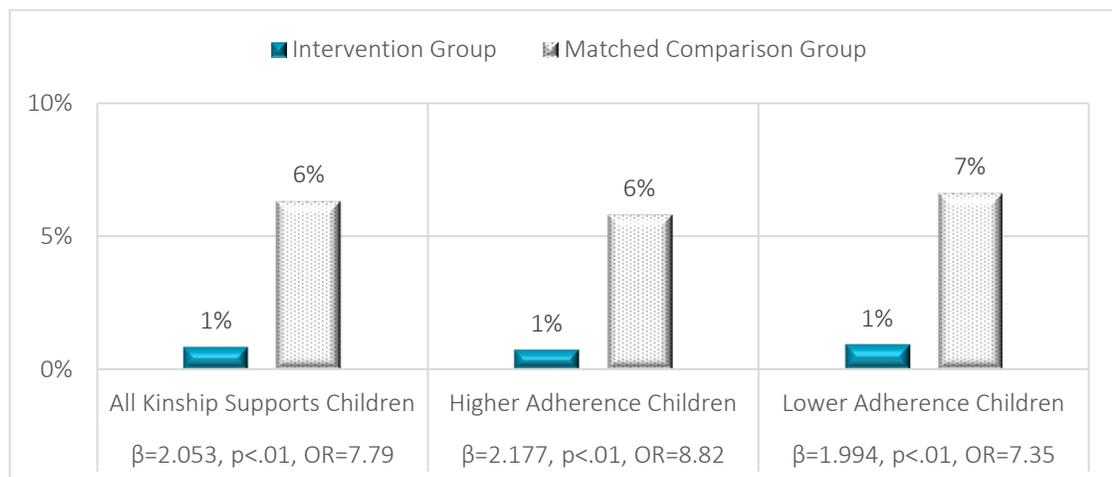
The figure below shows that a greater percentage of children and youth whose kinship caregivers received kinship supports, regardless of adherence level, achieved permanency (i.e., living with kin, guardians, or adoptive parents) at case close, if not returning home, than matched children and youth whose kinship caregivers did not receive kinship supports. The difference between the full intervention and corresponding matched comparison groups was significant at the $p<.01$ level. The odds of achieving permanency was 1.15 times, or 15%, greater for children and youth in the full intervention group than children and youth in its matched comparison group. The likelihood of achieving permanency, if not returning home, did not vary substantially by lower or higher adherence.

Figure 55. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Living with Kin, Guardians, or Adoptive Parents at Case Close, If Not Returning Home



The figure below shows that a lower percentage of children and youth with closed cases and whose kinship caregivers received kinship supports, regardless of adherence level, experienced subsequent child welfare involvement compared to matched children and youth with closed cases. Controlling for the matching variables, the difference between each intervention and corresponding matched comparison group was statistically significant, and the odds of subsequent involvement were 7.79 times, or 679%, less for children and youth in the full intervention group than children and youth in its matched comparison group. The likelihood of experiencing subsequent involvement did not vary substantially by lower or higher adherence.

Figure 56. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups with Subsequent Child Welfare Involvement After Case Close



PERMANENCY ROUNDTABLES: YOUTH 16 YEARS AND OLDER WITH AN OPPLA GOAL

Table 36. Intervention and Matched Comparison Group Sample Sizes for All 16 and Older PRT Youth with an OPPLA Goal

Analysis Group	Treatment Group	Comparison Group
All youth	480	315
Higher adherence youth ¹	106	76
Lower adherence youth ²	374	239
Youth who began OOH removal during a county Waiver funded PRT year	134	111
Youth who began OOH removal prior to a county Waiver funded PRT year	346	204

¹Youth with at least .50 overall adherence

²Youth with lower than .50 overall adherence

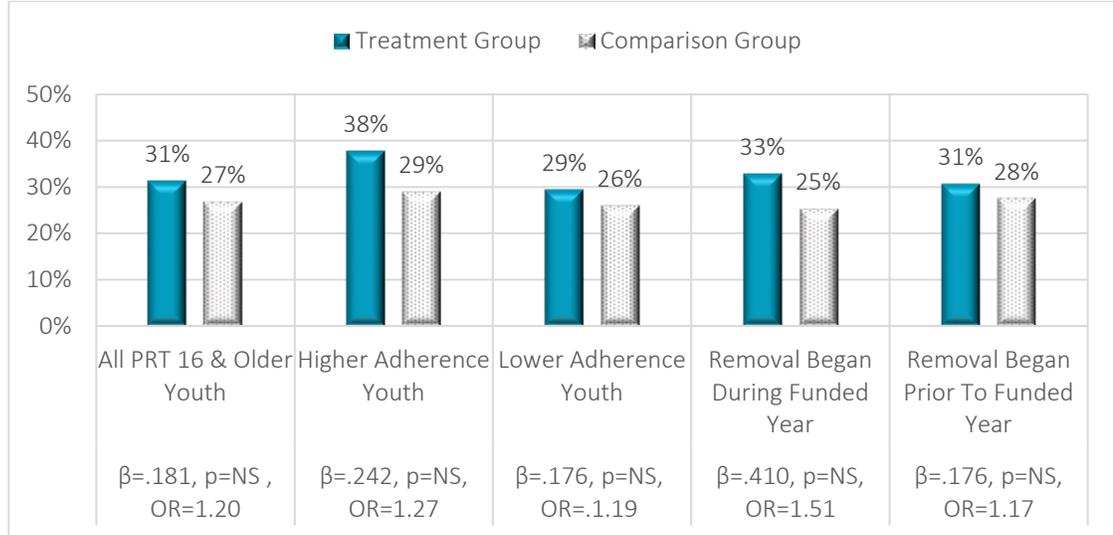
Table 37 provides an overview of the PRT matched case comparison findings for youth 16 and older with an OPPLA goal. A checkmark indicates a positive finding for the corresponding intervention group or subgroup and outcome. A detailed presentation of the findings follows.

Table 37. Overview of the PRT Matched Case Comparison Findings for Youth 16 & Older with an OPPLA Goal

Outcome	Intervention Group				
	All PRT 16 & Older Youth	Higher Adherence Youth	Lower Adherence Youth	Removal Began During Funded Year	Removal Began Prior to Funded Year
Least restrictive placement use					
Greater percentage of intervention group children & youth had at least one step-down in placement restrictiveness	✓	✓	✓	✓	✓
Greater percentage of intervention group children & youth had more step-downs than step-ups in placement restrictiveness	✓	✓	✓	✓	✓
Emancipation					
Smaller percentage of intervention group children & youth emancipated	✓		✓	✓	✓

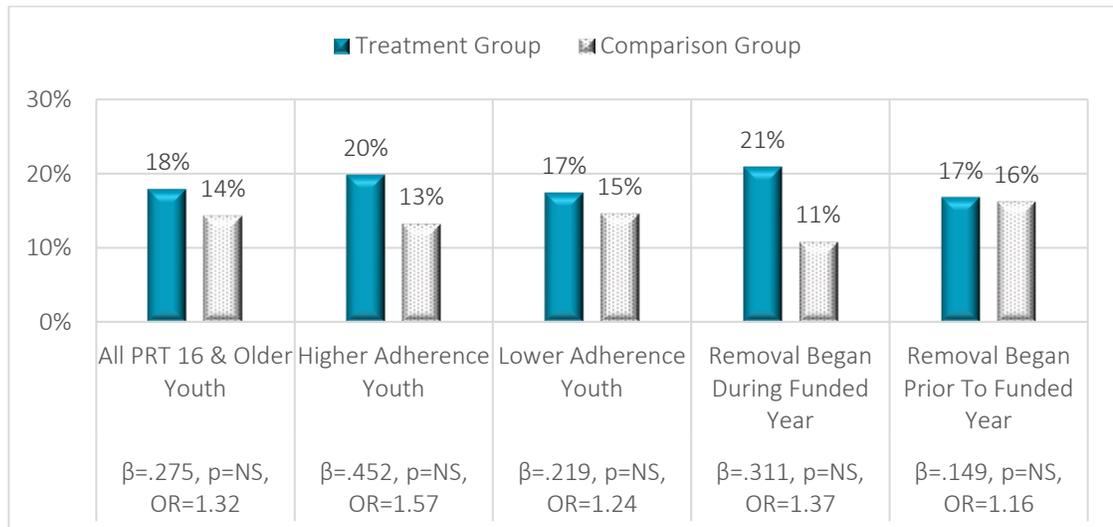
The figure below shows that a greater percentage of all youth 16 and older with an OPPLA goal who received PRTs, regardless of adherence level or when they began their out-of-home removal, had at least one step-down in placement restrictiveness after their first PRT meeting compared to matched youth 16 and older youth with an OPPLA goal who did not receive PRTs. Controlling for the matching variables, the differences between the intervention and matched comparison groups and subgroups were not statistically significant. However, the odds of having at least one step-down in placement restrictiveness was 1.51 times, or 51%, greater for youth whose removals began during a year in which their county was funded to provide PRTs than their matched comparisons, compared to only 1.17 times, or 17%, greater for youth whose removals began prior to a funded year. The odds of this outcome were 1.27 times, or 27%, greater for higher adherence youth, compared to 1.19 times, or 19%, greater for lower adherence youth.

Figure 57. Percentage of Youth in the Intervention and Matched Case Comparison Groups With At Least One Step-Down in Placement Restrictiveness



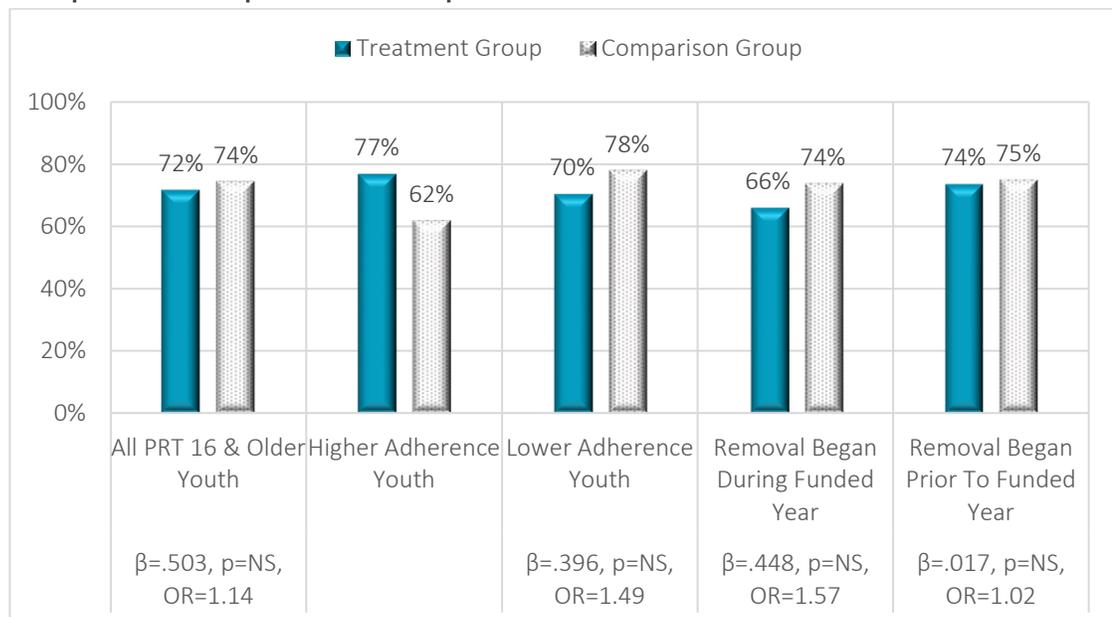
The figure below shows that a greater percentage of all youth 16 and older with an OPPLA goal who received PRTs, regardless of adherence level or when they began their out-of-home removal, had more step-downs than step-ups in placement restrictiveness after their first PRT meeting compared to matched youth 16 and older youth with an OPPLA goal who did not receive PRTs. Controlling for the matching variables, the differences between the intervention and matched comparison groups and subgroups were not statistically significant. However, the odds of having more step-downs than step-ups were 1.37 times, or 37%, greater for youth whose removals began during a year in which their county was funded to provide PRTs than their matched comparisons, compared to only 1.16 times, or 16%, greater for youth whose removals began prior to a funded year. And, the odds for this outcome were 1.57 times, or 57%, greater for higher adherence youth compared to 1.24 times, or 24%, greater for lower adherence youth.

Figure 58. Percentage of Youth in the Intervention and Matched Case Comparison Groups with More Step-Downs Than Step-Ups in Placement Restrictiveness



The figure below shows that a smaller percentage of all youth 16 and older with an OPPLA goal who received PRTs emancipated compared to matched youth 16 and older with an OPPLA goal who did not receive PRTs. Controlling for the matching variables, the difference between the groups was not statistically significant. However, the odds of emancipating were 1.57 times, or 57%, less for youth whose removals began during a year in which their county was funded to provide PRTs, while the odds were only 1.02 times, or 2%, less for youth whose removals began prior to a funded year. Unexpectedly, a greater percentage of the higher adherence youth compared to their matched comparisons emancipated, whereas the odds of emancipating were 1.49 times, or 49%, less for lower adherence youth compared to their matched comparisons.

Figure 59. Percentage of Youth in the Intervention and Matched Case Comparison Groups that Emancipated



PERMANENCY ROUNDTABLES: CHILDREN AND YOUTH IN OOH CARE FOR 12 MONTHS OR LONGER

Table 38. Intervention and Matched Comparison Group Sample Sizes for All PRT Children and Youth in Care for 12 Months or Longer

Analysis Group	Treatment Group	Comparison Group
All children and youth	1,356	1,015
Higher adherence children and youth ¹	448	334
Lower adherence children and youth ²	908	681
Children and youth who reached 12 months in an out-of-home removal during a county Waiver funded PRT year	1,117	877
Children and youth who reached 12 months in an out-of-home removal prior to a county Waiver funded PRT year	239	138

¹Children and youth with at least .50 overall adherence

²Children and youth with lower than .50 overall adherence

Table 39 provides an overview of the PRT matched case comparison findings for children and youth in care 12 months or longer. A checkmark indicates a positive finding for the corresponding intervention group or subgroup and outcome. A detailed presentation of the findings follows.

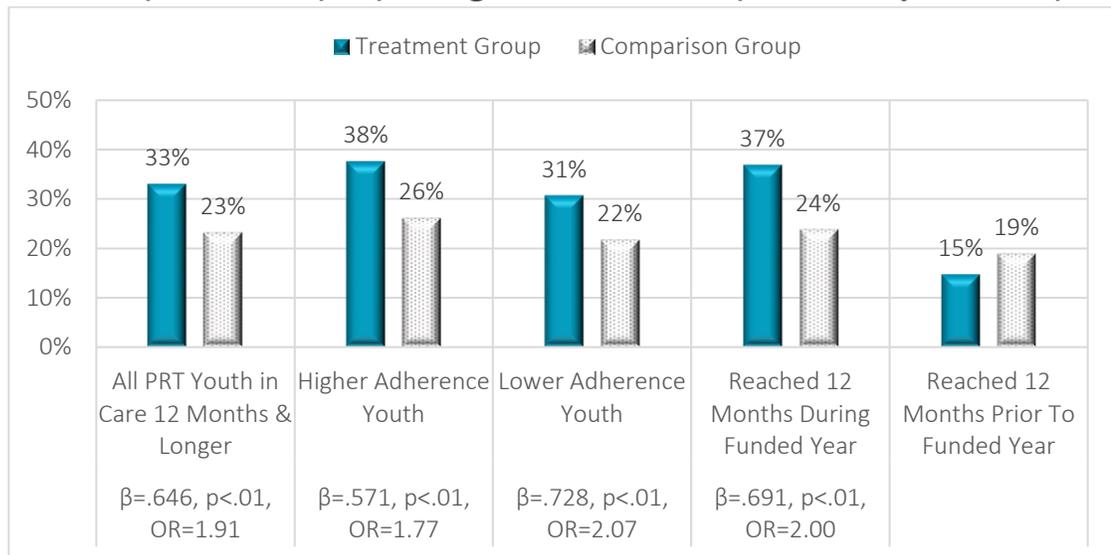
Table 39. Overview of the PRT Matched Case Comparison Findings for Children and Youth in Care 12 Months or Longer

Outcome	Intervention Group				
	All PRT Youth in Care 12+ Months	Higher Adherence Youth	Lower Adherence Youth	Reached 12 Months During Funded Year	Reached 12 Months Prior to Funded Year
Least restrictive placement use					
Greater percentage of intervention group children & youth spent all or most out-of-home placement days in kinship care	✓	✓	✓	✓	
Permanent end removal residence					
Greater percentage of intervention group children & youth living with guardians or adoptive parents at case close	✓	✓	✓	✓	✓

The figure below shows that a greater percentage of all children and youth in out-of-home care 12 months or longer who received PRTs spent all or most their out-of-home placement days after their first PRT meeting in kinship care compared to matched children and youth in care 12 months or longer who did not receive PRTs. Controlling for the matching variables, the difference between the full intervention

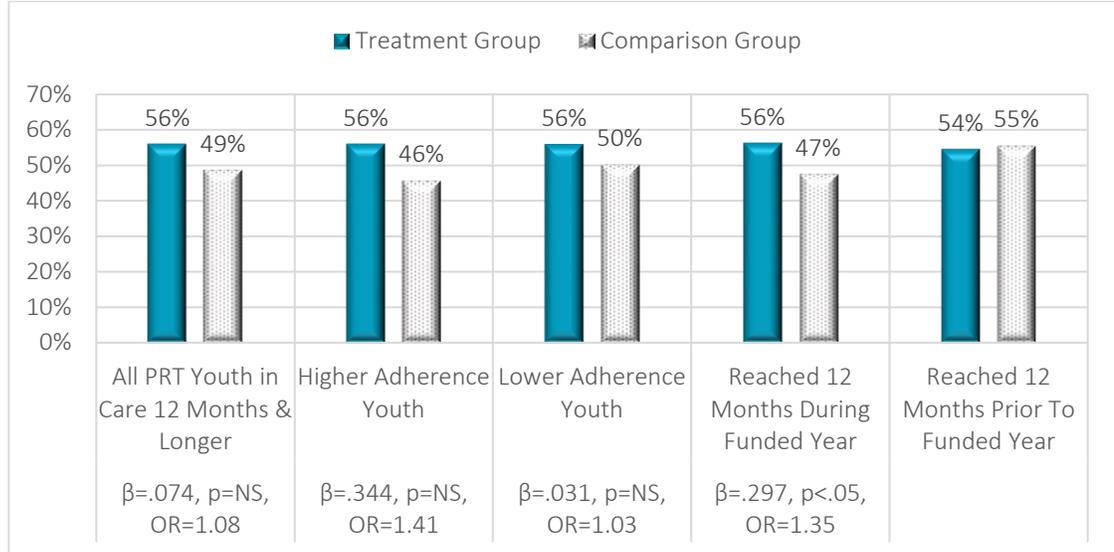
and matched comparison groups was statistically significant at the $p < .01$ level. The odds of spending all or most out-of-home days in kinship care were 1.91 times, or 91%, greater for children and youth in the full intervention group than for children and youth in the full matched comparison group. The odds were 2.00 times, or 100%, greater for children and youth who reached 12 months in out-of-home care during a year in which their county was funded to provide PRTs compared to their matched comparisons, while children and youth who reached 12 months in care prior to a funding year were less likely to spend all or most days in kinship care. The odds of spending all or most days in kinship care compared to matched children and youth did not vary substantially by adherence level.

Figure 60. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Spending All or Most Case Open OOH Days in Kinship Care



The figure below shows that a greater percentage of all children and youth in out-of-home care 12 months or longer who received PRTs were living with guardians or adoptive parents at case close compared to matched children and youth in care 12 months or longer who did not receive PRTs. Controlling for the matching variables, the difference between the full intervention and matched comparison groups was not statistically significant. However, the difference between the children and youth who reached 12 months in care during a year in which their county received PRT funding and their matched comparisons was significant at the $p < .05$ level. The odds of living with guardians or adoptive parents at case close were 1.35 times, or 35%, greater for children and youth in this intervention subgroup than their matched comparisons, while children and youth who reached 12 months in care prior to a PRT funded year were less likely than their matched comparisons to achieve this outcome. In addition, the odds were 1.41 times, or 41%, greater for children and youth with higher adherence, whereas the odds were only 1.03 times, or 3% greater, for children and youth with lower adherence.

Figure 61. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Living with Guardians or Adoptive Parents at Case Close



TRAUMA INTERVENTIONS: ALL CHILDREN AND YOUTH

Table 40. Intervention and Matched Comparison Group Sample Sizes for Trauma Informed Screening, Assessment, and Treatment Children and Youth

Analysis Group	Intervention Group	Comparison Group
Children and youth who received TSAT or CWRC Assessment	588	588
Children and youth who received TSAT Assessment and Treatment	158	158

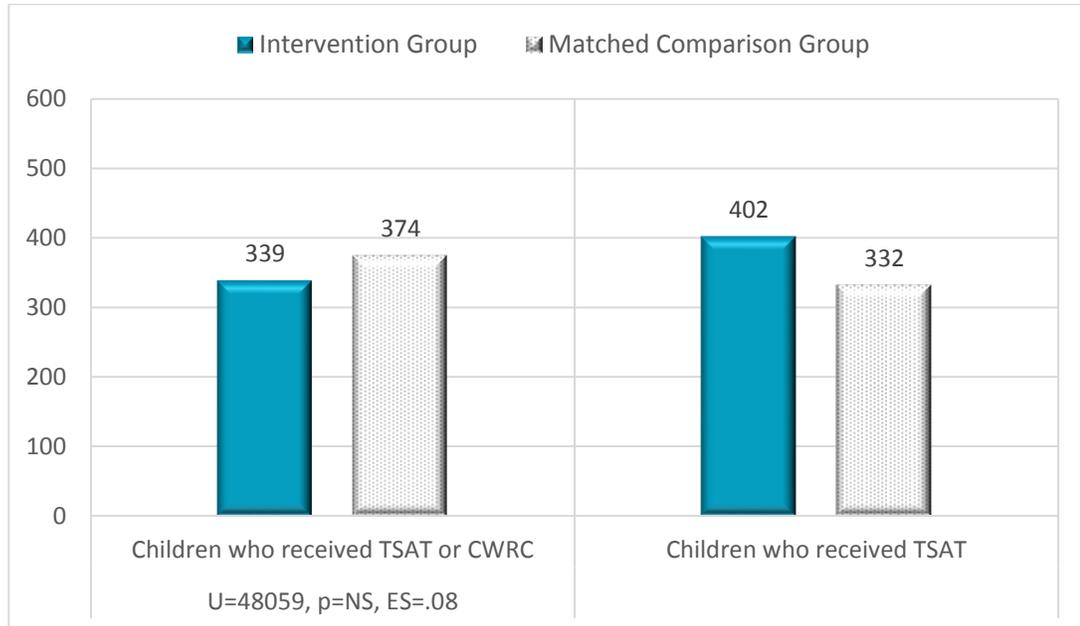
Table 41 provides an overview of the TSAT and CWRC matched case comparison findings. A checkmark indicates a positive finding for the corresponding intervention group or subgroup and outcome. A detailed presentation of the findings follows.

Table 41. Overview of the TSAT and CWRC Matched Case Comparison Findings

Outcome	Intervention Group	
	Children Who Received TSAT or CWRC	Children Who Received TSAT
Case length		
Fewer median case days in the intervention group	✓	
Out-of-home placement stability		
Greater percentage of intervention group children & youth experienced no more than one placement disruption		✓
Least restrictive OOH placement use		
Greater percentage of intervention group children & youth spent all or most case out-of-home placement days in kinship care	✓	✓
Permanent case close residence		
Greater percentage of intervention group children & youth living with birth parents, non-adoptive kin, non-kin guardians, or adoptive parents at case close		✓
Greater percentage of intervention group children & youth living with non-adoptive kin at case close		✓
Out-of-home placement after case close		
Of the children & youth whose cases closed, smaller percentage of intervention group children & youth re-entered out-of-home placement		✓
Of the children & youth who re-entered out-of-home placement, greater percentage of children & youth in the intervention group spent all or most out-of-home days in kinship care	✓	✓

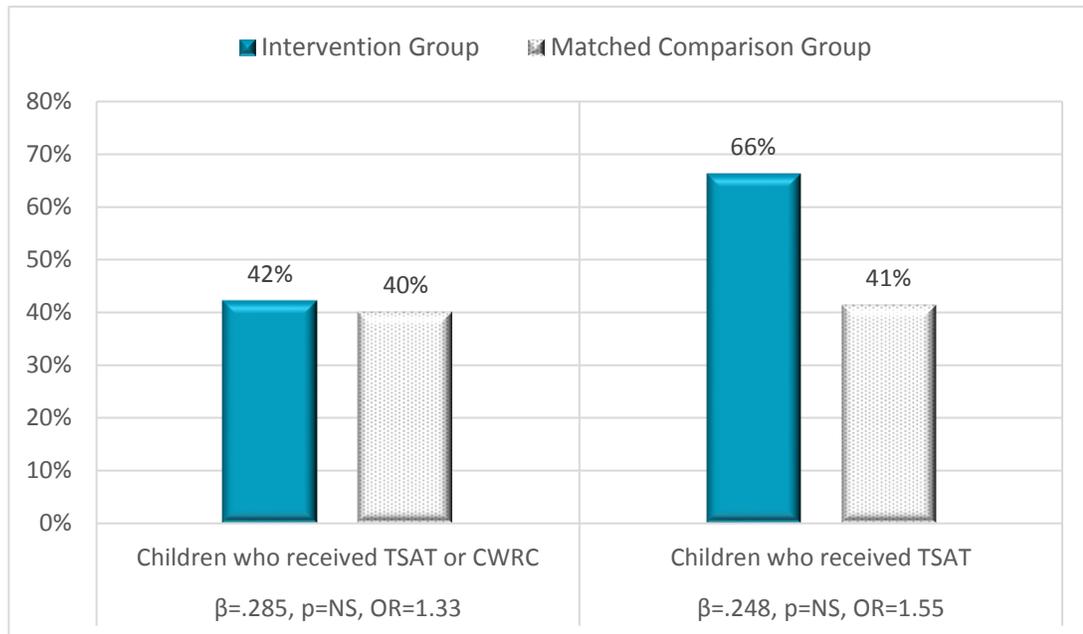
The figure below shows that the cases of children and youth who received TSAT or CWRC trauma services were typically about one month shorter than the cases of matched children and youth who did not receive these services. Controlling for the matching variables, the difference between the groups was not significant and the effect size was very small. Looking at just the TSAT children and youth, their cases were typically about two months longer than their matched comparisons.

Figure 62. Median Case Length Days Between the Intervention and Matched Case Comparison Groups



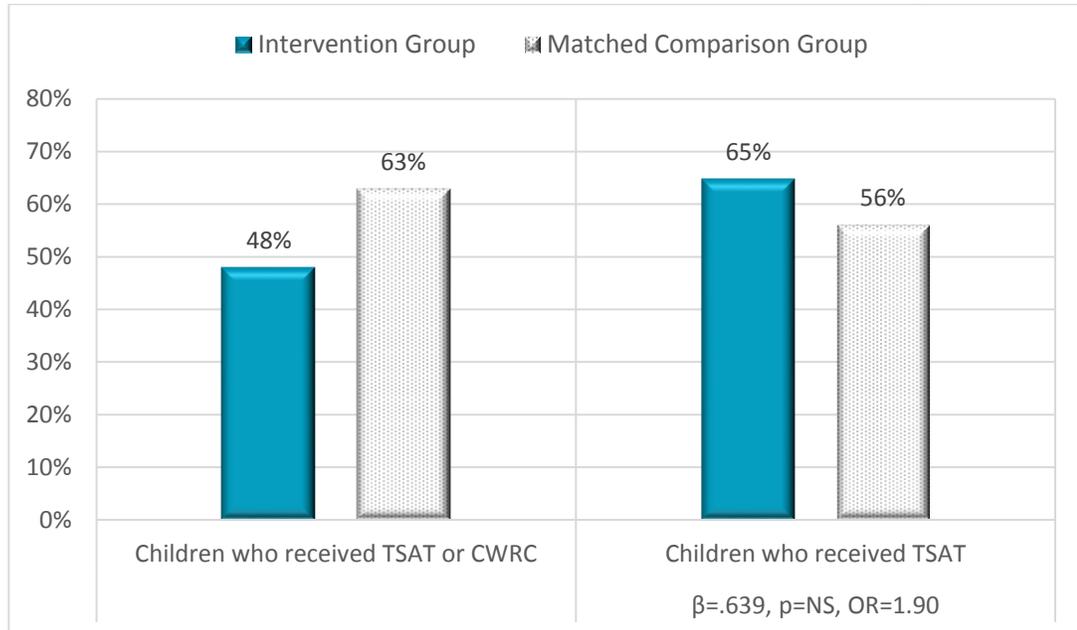
The figure below shows that a greater percentage of children and youth who received TSAT or CWRC services spent all or most out-of-home placement days during their cases in kinship care compared to matched out-of-home children and youth who did not receive either set of services. Controlling for the matching variables, the difference between the groups was not statistically significant. The odds of spending all or most out-of-home days in kinship care were 1.33 times, or 33%, greater for children and youth in the TSAT or CWRC intervention group than their matched comparisons. Looking at just the TSAT children and youth, their odds of spending all or most out-of-home days during their cases in kinship care were 1.55, or 55%, greater than their matched comparisons.

Figure 63. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Spending All or Most Case OOH Days in Kinship Care



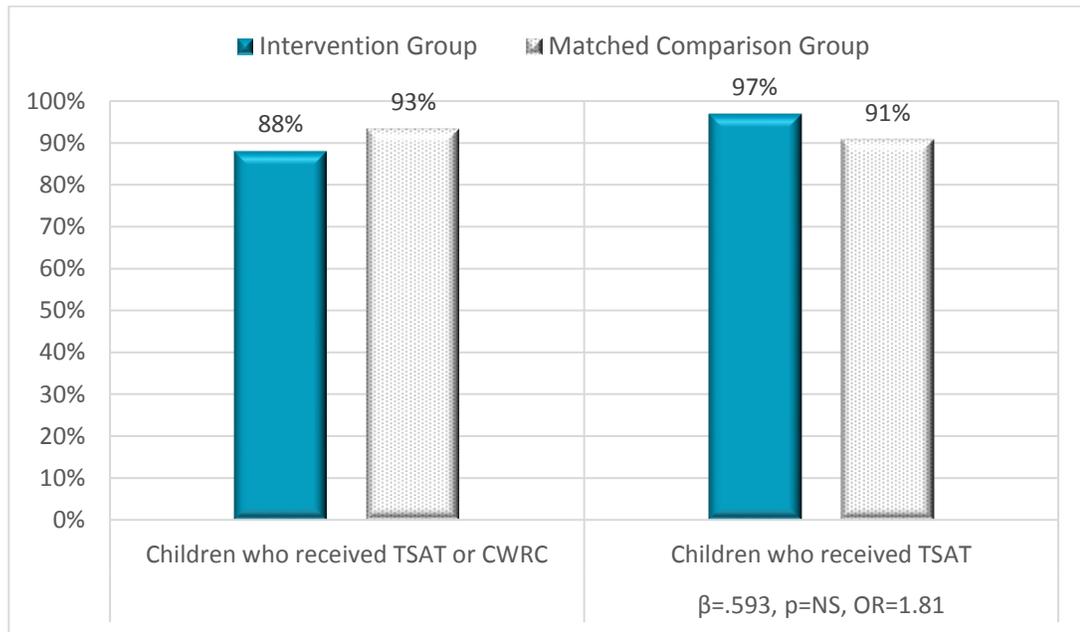
The figure below shows that a smaller percentage of children and youth who received TSAT or CWRC services had no more than one placement disruption compared to matched out-of-home children and youth who did not receive either set of services. Looking at just the TSAT children and youth, a greater percentage of them had no more than one placement setting change compared to their matched comparisons. Controlling for the matching variables, however, the difference between the groups was not statistically significant. The odds of having no more than one placement disruption were 1.90 times, or 90%, greater for children and youth in the TSAT intervention group than their matched comparisons.

Figure 64. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups with No More Than One Placement Setting Disruption



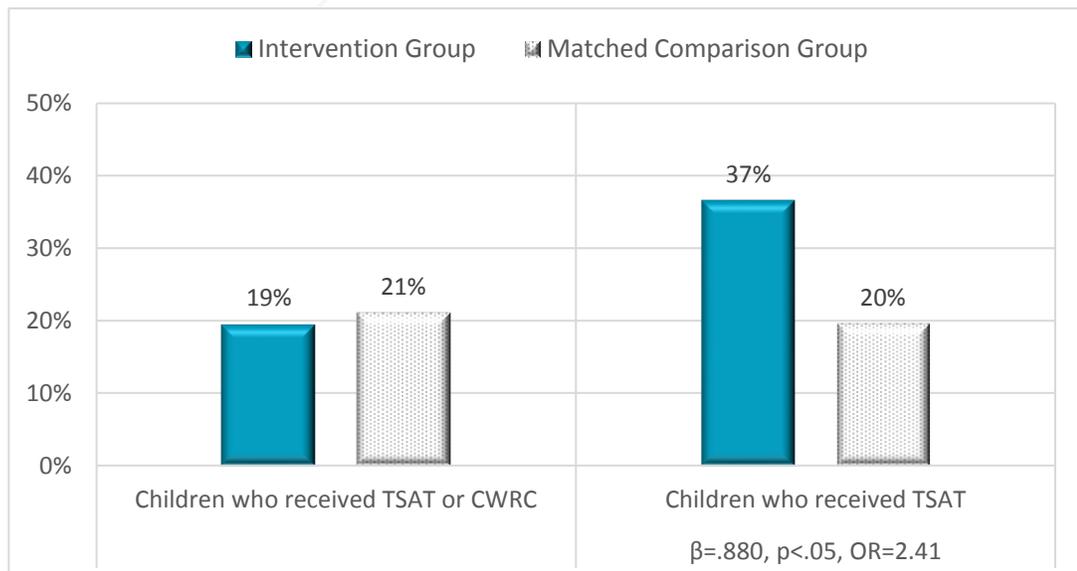
The figure below shows that a smaller percentage of children and youth who received TSAT or CWRC services achieved permanency (i.e., were living with parents, kin, guardians, or adoptive parents at case close) compared to matched out-of-home children and youth who did not receive either set of services. Looking at just the TSAT children and youth, a greater percentage of them achieved permanency compared to their matched comparisons. Controlling for the matching variables, however, the difference between the groups was not statistically significant. The odds of achieving permanency were 1.81 times, or 81%, greater for children and youth in the TSAT intervention group than their matched comparisons.

Figure 65. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Living with Parents, Kin, Guardians, or Adoptive Parents at Case Close



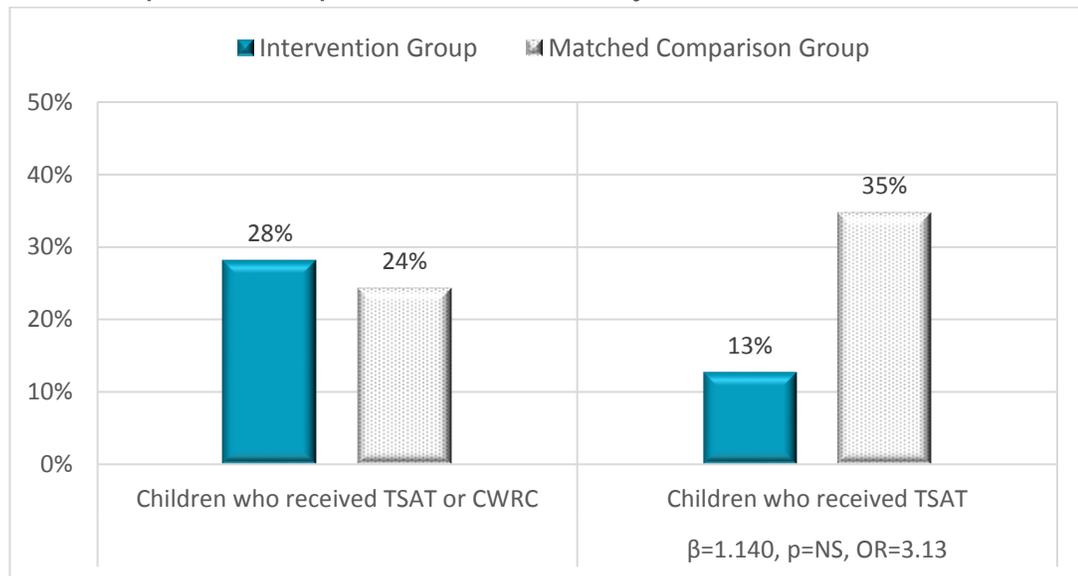
An exclusive analysis of achieving permanency with non-adoptive kin at case close in the figure below shows that a greater percentage of the TSAT intervention group were living with non-adoptive kin at case close compared to their matched comparisons. Controlling for the matching variables, the difference between the groups was statistically significant at the $p<.05$ level. The odds of living with non-adoptive kin at case close were 2.41 times, or 141%, greater for children and youth in the TSAT intervention group than their matched comparisons.

Figure 66. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Living with Non-Adoptive Kin at Case Close



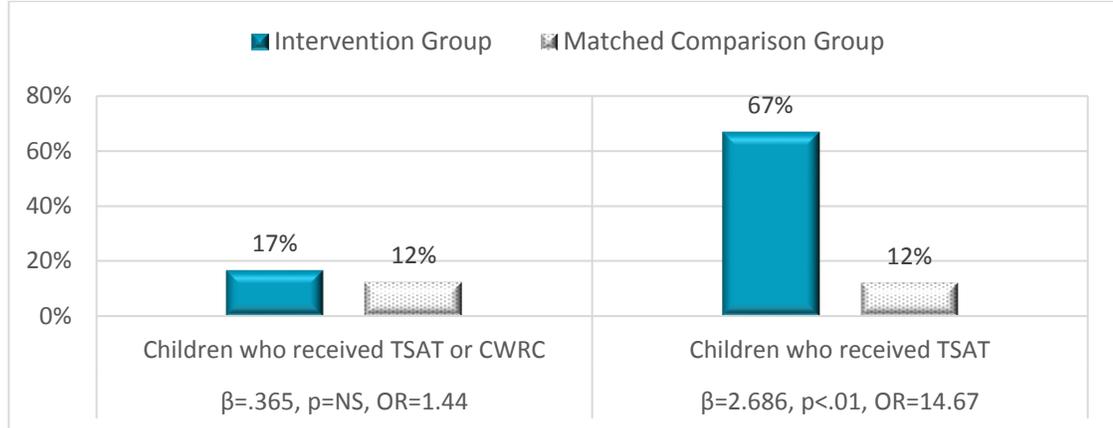
The figure below shows that a greater percentage of children and youth who received TSAT or CWRC services spent one or more days in out-of-home care after case close compared to matched out-of-home children and youth who did not receive either set of services. Looking at just the TSAT children and youth, a smaller percentage of them spent one or more days in out-of-home care after case close compared to their matched comparisons. Controlling for the matching variables, however, the difference between the groups was not statistically significant. The odds of spending one or more days in out-of-home care after case close were 3.13 times, or 213%, less for children and youth in the TSAT intervention group than their matched comparisons.

Figure 67. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups with One or More Days in OOH Care After Case Close



The figure below shows that a greater percentage of children and youth who received TSAT or CWRC services and had one or more placement days in out-of-home care after their case closed spent all or most of those days in kinship care compared to matched out-of-home children and youth who did not receive either set of services. Controlling for the matching variables, the difference between the groups was not statistically significant. The odds of spending all or most post-case-close out-of-home days in kinship care were 1.44 times, or 44%, greater for children and youth in the TSAT or CWRC intervention group than their matched comparisons. Looking at just the TSAT children and youth, a substantially greater percentage of them spent all or most post-case-close out-of-home days in kinship care, and the difference was significant at the $p < .01$ level. The odds of spending all or most post-case-close out-of-home days in kinship were 14.67, or 1,367%, greater for children and youth in the intervention group than their matched comparisons.

Figure 68. Percentage of Children and Youth in the Intervention and Matched Case Comparison Groups Spending All or Most Post-Case OOH Days in Kinship Care



Within Intervention Groups

PERMANENCY ROUNDTABLES: PERMANENT CONNECTIONS

On average, children and youth in both PRT intervention groups increased their number of verified permanent connections by one person. The mean number of permanent connections for PRT youth 16 and older with an OPPLA goal increased significantly from 1.60 (SD=1.70, Median=1) individuals prior to the start of the intervention to 3.00 (SD=2.19, Median=2) individuals by the end of their removal or the end of the evaluation observation period ($t(409)=18.04$, $p<.01$). And, the mean number of permanent connections for PRT children and youth in care for 12 months or longer increased significantly from 1.58 (SD=1.35, Median=1) individuals prior to the start of the intervention to 2.34 (SD=1.70, Median=2) individuals by the end of their removal or the end of the observation period ($t(1050)=19.60$, $p<.01$).

TRAUMA INFORMED SCREENING, ASSESSMENT AND TREATMENT: REDUCTION OF TRAUMA SYMPTOMS

Table 42 displays descriptive outcomes for the progress of children who received an assessment under the TSAT intervention during the Waiver. Scores on the TSCYS have a possible range of 0 to 75 points and scores on the CPSS have a possible range of 0 to 51 points, with greater scores for both instruments indicating greater severity in post-traumatic stress symptoms. The mean trauma symptom severity score for younger children increased by 3.1 points on the TSCYC from the initial to the last follow-up assessment, whereas the mean trauma symptom severity score for older children and youth decreased by 2.8 points on the CPSS. Given the possible range of scores on the assessments, these represent small changes in trauma symptom severity from initial to last follow-up assessment.

Table 42. Mean Differences Between Initial and Follow-Up Trauma Assessments for Children and Youth

Assessment	Initial Assessment Mean (SD)	Last Follow-Up Assessment Mean (SD)	Mean Difference (SD) Between Initial and Last Follow-Up Assessments
Total post-traumatic stress symptom score for children assessed with the TSCYC (ages 3 to 7) (n=32)	47.7 (15.6)	50.8 (17.1)	3.1 (10.2)
Total post-traumatic stress symptom score for children and youth assessed with the CPSS (ages 8 to 18) (n=66)	20.7 (12.3)	17.9 (10.9)	-2.8 (11.0)

Table 43 displays descriptive outcomes for the progress of caregivers who received an assessment under the TSAT intervention during the Waiver. Scores on the PTSD Checklist for adults have a possible range of zero to 80 points, with greater scores indicating greater severity in post-traumatic stress symptoms.

Table 43. Mean Differences between Initial and Follow-up Trauma Assessment Scores for Caregivers

Trauma Domain	Initial Assessment Mean (SD)	Last Follow-Up Assessment Mean (SD)	Mean Difference (SD) Between Initial and Last Follow-Up Assessments
Total post-traumatic stress score for caregivers assessed with the PTSD Checklist for adults (n=28) ¹	17.8 (8.8)	15.6 (10.5)	-2.1 (8.0)

¹It is unknown whether these 28 caregivers actually received trauma treatment, as this was not recorded in the OBH web-based survey. Although 289 caregivers were indicated as having some type of trauma assessment, only 28 caregivers had an initial assessment, at least one follow-up assessment and scores recorded for both. Tracking caregiver progress over time was not an original focus of the OBH data collection.

Overlap of Waiver Interventions

In the Implementation Index, counties that were implementing both PRT and FFE were asked about their practice approach when there was overlap between the target populations for the interventions;⁹ as shown in Table 44, some counties just held FFE, some just held PRT, and some held both. In those counties that held both meetings for eligible cases, meetings were sometimes combined or held back-to-back or meetings were not synchronized, and families simply received FFE and PRT separately.

⁹ This Implementation Index question was added in year two.

Table 44. County Approach to Serving Youth and Families in Counties Implementing Both PRT and FFE

Year ¹	Number of counties that held just FFE for cases eligible for both	Number of counties that held just PRT for cases eligible for both	Number of counties that held both interventions: meetings were scheduled back to back	Number of counties that held both interventions: meetings were not synchronized
Year Five	10	3	9	13
Year Four	7	2	12	14
Year Three	8	3	6	20
Year Two	4	8	3	20

¹Did not measure this in year one

Table 45 includes the total number of children and youth receiving at least one Waiver intervention, along with the number and percentage receiving different combinations of Waiver interventions.

Table 45. Children & Youth Receiving Multiple Waiver Interventions¹

Interventions	# of Children and Youth	% of Children and Youth
Total Number of Unduplicated Children and Youth Who Received At Least One Waiver Intervention	29,541	100%
FFE Meetings & KS	8,115	27%
FFE Meetings & PRT	1,052	4%
KS & PRT	700	2%
FFE Meetings, KS, & PRT	557	2%
FFE Meetings & TSAT and/or CWRC	528	2%
KS & TSAT and/or CWRC	228	1%
PRT & TSAT and/or CWRC	20	<.01%
All Interventions	5	<.01%

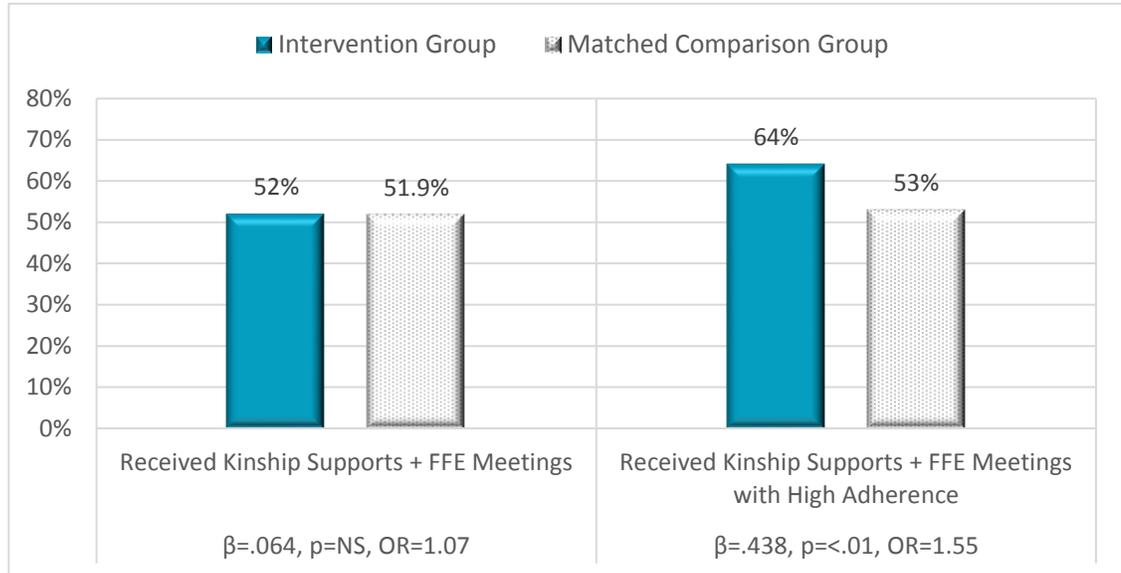
¹Includes children and youth in one or more intervention treatment groups for the matched case comparison; additional children and youth served who did not meet treatment group eligibility are not included

Tables with descriptive statistics showing the post-match balance between children and youth receiving multiple Waiver intervention and their matched comparisons are included in Appendix M.

The figure below shows that a slightly greater percentage of all children and youth whose kinship caregivers received KS, families received FFE meetings, and cases closed (n=5,329) reunified with their parents compared to matched children and youth in kinship placements who did not receive either intervention and were in cases that closed (n=4,853). However, a significantly (p<.01) greater percentage of children and youth whose kinship caregivers received KS, families received FFE meetings *with higher levels of adherence*, and cases closed (n=1,120) reunified with their parents compared to their matched comparisons who were also in kinship placements, but did not receive either intervention, and whose cases closed (n=1,059). The odds of reunification were 1.55 times, or 55%, greater for children and youth whose caregivers

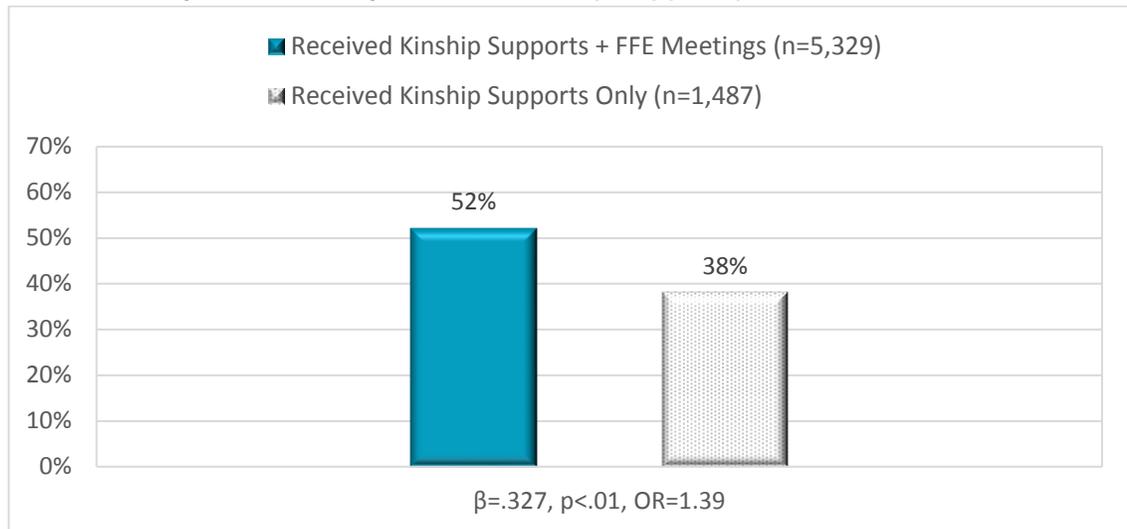
received KS and families received FFE meetings *with higher levels of adherence* than their matched comparisons.

Figure 69. Percentage of Children and Youth Who Received Kinship Supports and FFE Meetings and Reunified with Their Parents at Case Close (compared to matched children and youth who did not receive either intervention)



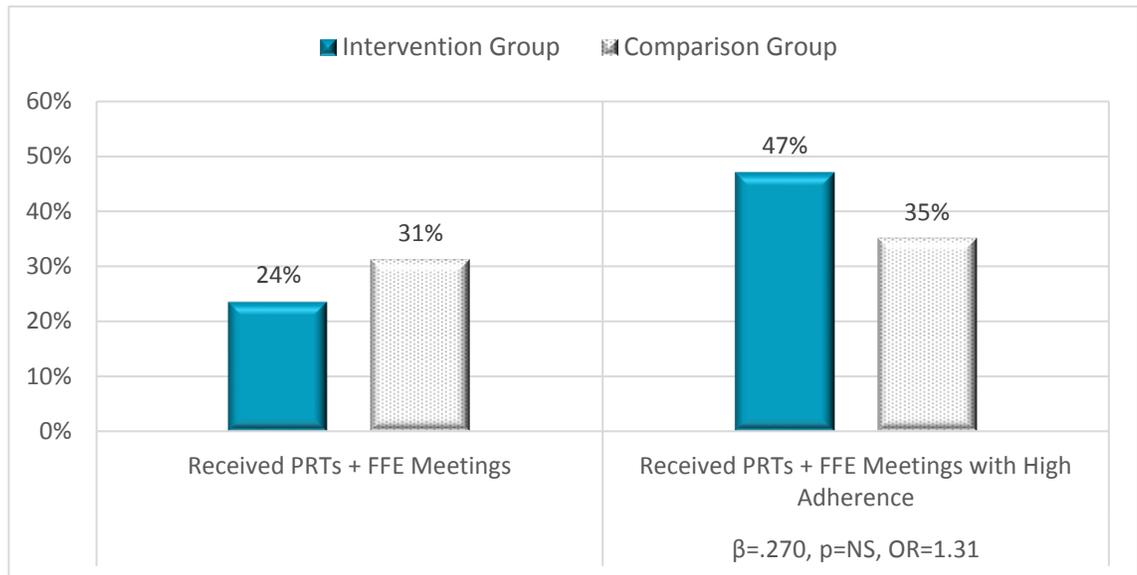
The between-groups comparison in the next figure should be interpreted with caution, as the groups are not matched on child and youth demographic, risk, or case characteristics. With that in mind, the figure shows that a greater percentage of children and youth whose kinship caregivers received KS and whose families received FFE meetings ($n=5,329$) reunified with their parents at case close compared to children and youth whose caregivers received KS but whose families did not receive FFE meetings ($n=1,487$). The difference between the groups was statistically significant at the $p < .01$ level, and the odds of reunification were 1.39 times, or 39%, greater for children and youth whose caregivers and families received the interventions than children and youth whose caregivers received KS, but families did not receive FFE meetings.

Figure 70. Percentage of Children and Youth Who Received Kinship Supports and FFE Meetings and Reunified with Their Parents at Case Close (compared to children and youth who only received kinship supports)



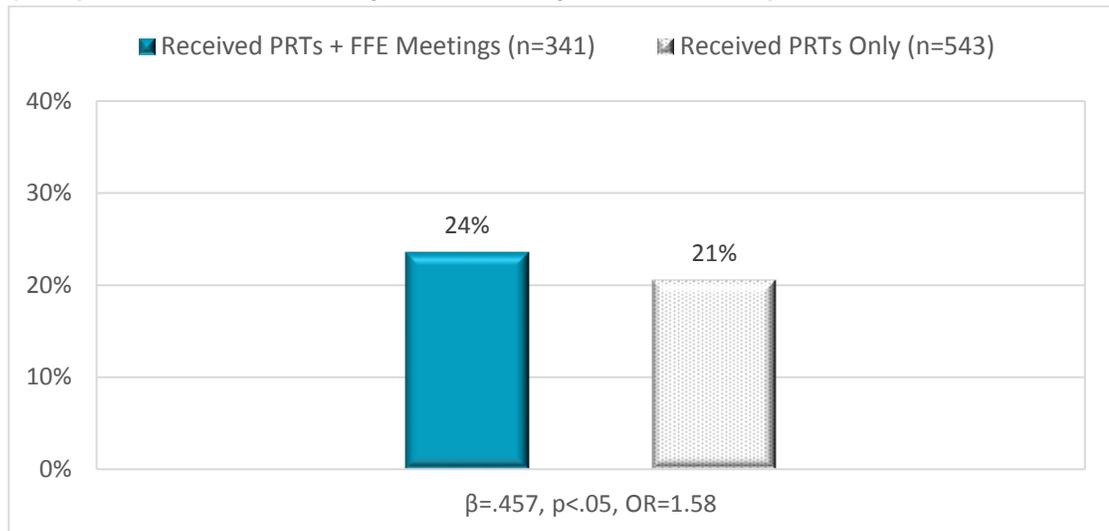
The figure below shows that a smaller percentage of children and youth who were in care for 12 months or longer, who received PRTs, and whose families received FFE meetings (n=543) reunified with their parents at the end of their removals compared to matched children and youth who were in care for 12 months or longer, who did not receive PRTs, and whose families did not receive FFE meetings (n=495). However, a greater percentage of children and youth who were in care for 12 months or longer, who received PRTs, and whose families received FFE meetings *with higher levels of adherence* (n=110) reunified with their parents at the end of their removals compared to matched children and youth who were in care for 12 months or longer, did not receive either intervention, and had removals that ended (n=105). The difference was not statistically significant, but the odds of reunification were 1.31 times, or 31%, greater for children and youth in care 12 months and longer who received PRTs and whose families received FFE meetings *with higher levels of adherence* than their matched comparisons.

Figure 71. Percentage of Children and Youth in Care 12 Months or Longer Who Received PRTs and FFE Meetings and Reunified with Their Parents at Case Close (compared to matched children and youth who did not receive either intervention)



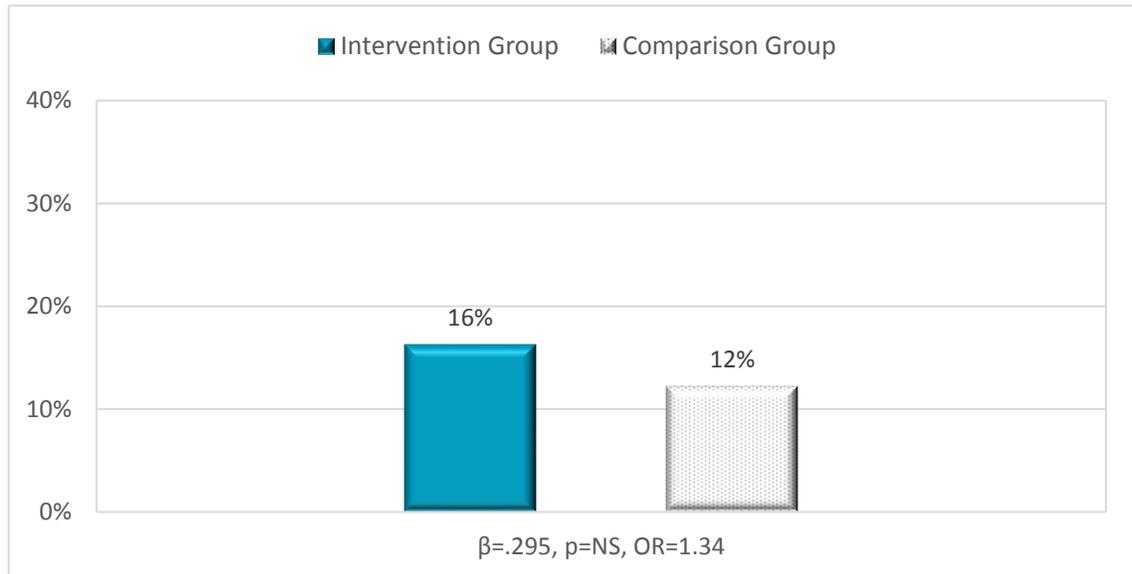
The between-groups comparison in the next figure should be interpreted with caution, as the groups are not matched on child and youth demographic, risk, or case characteristics. With that in mind, the figure shows that a greater percentage of children and youth in care 12 months or longer who received PRTs and whose families received FFE meetings (n=543) reunified with their parents at end removal compared to children and youth in care 12 months or longer who received PRTs, but families did not receive FFE meetings, and removals ended (n=341). The difference between the groups was statistically significant at the $p < .05$ level, and the odds of reunification were 1.58 times, or 58%, greater for children and youth who received PRTs and whose families received FFE meetings than children and youth who received PRTs, but families did not receive FFE meetings.

Figure 72. Percentage of Children and Youth in Care 12 Months or Longer Who Received PRTs and FFE Meetings and Reunified with Their Parents at Case Close (compared to children and youth who only received PRTs)



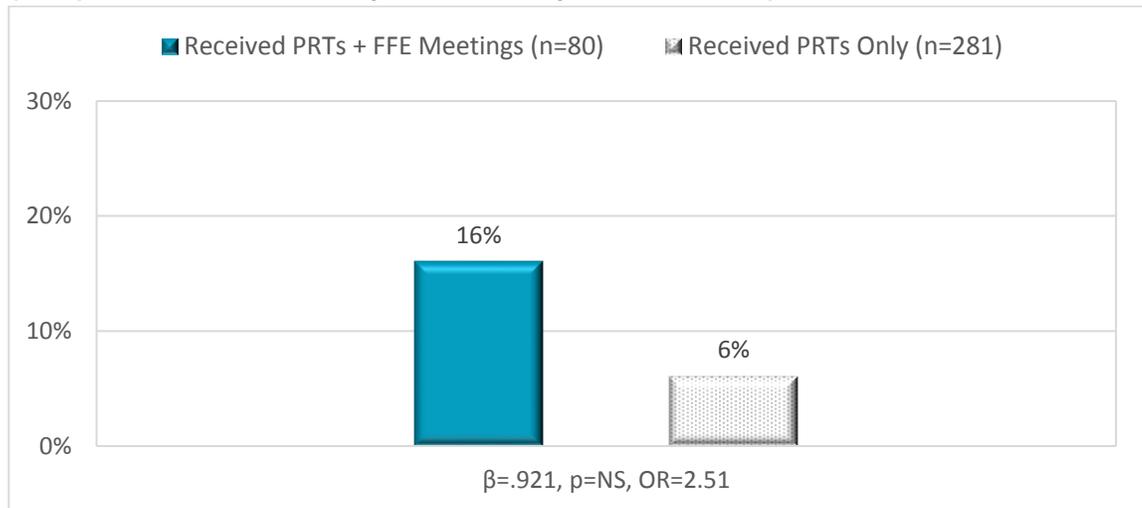
The figure below shows that a greater percentage of youth 16 years and older with an OPPLA goal who received PRTs and whose families received FFE meetings (n=80) reunified with their parents at the end of their removals compared to matched youth 16 years and older with OPPLA goal who did not receive PRTs and whose families did not receive FFE meetings (n=74). The difference between the groups was not statistically significant, but the odds of reunification were 1.34 times, or 34%, greater for youth who received PRTs and whose families received FFE meetings than youth who did not receive PRTs and whose families did not receive FFE meetings. A matched case comparison analysis of reunification for youth 16 years and older with an OPPLA goal who received PRTs and whose families received FFE meetings *with higher levels of adherence* was not conducted, as the number of youth in this group was small (n=13).

Figure 73. Percentage of Youth 16 Years and Older with an OPPLA Goal Who Received PRTs and FFE Meetings and Reunified with Their Parents at Case Close (compared to matched children and youth who did not receive either intervention)



The between-groups comparison in the next figure should be interpreted with caution, as the groups are not matched on child and youth demographic, risk, or case characteristics. With that in mind, the figure shows that a greater percentage of youth 16 years and older with an OPPLA goal who received PRTs and whose families received FFE meetings (n=80) reunified with their parents at end removal compared to youth 16 years and older with an OPPLA goal who received PRTs, but whose families did not receive FFE meetings, and removals ended (n=281). The difference between the groups was not statistically significant, but the odds of reunification were 2.51 times, or 151%, greater for youth who received PRTs and whose families received FFE meetings than youth who received PRTs, but families did not receive FFE meetings.

Figure 74. Percentage of Youth 16 Years and Older With an OPPLA Goal Who Received PRTs and FFE Meetings and Reunified with Their Parents at Case Close (compared to children and youth who only received PRTs)



Discussion

Removal Trends in Waiver Counties

The state-level descriptive analysis of pre-Waiver and Waiver removal days in the counties that received funding to implement one or more Waiver interventions in each Waiver year showed a shift in placement mix toward an increased use of kinship care, particularly non-certified kinship care, over foster and congregate care in SFYs 2011 and 2012. This shift began an upward trend in the use of kinship care and a decreased use in foster and congregate care that continued through the first four years of the Waiver, but then shifted again in the last year of the Waiver with a drop in the percentage of non-certified kinship days and an increase in the percentage of foster care days.

Without a comparable set of counties that did *not* receive funding for one or more interventions in each year of the Waiver, it is difficult to determine if the upward trend in kinship care and downward trend in congregate and foster care that began prior to the Waiver would have continued without the flexibility of Waiver funding. Regardless, when comparing the combined pre-Waiver to combined Waiver years, the percentage of non-certified and certified kinship care days increased from 19.4% in the pre-Waiver years to 32.8% in the Waiver years, while the percentage of foster and congregate care days decreased from 71.9% in the pre-Waiver years to 61.6% in the Waiver years.

Any discussion of the findings from the entry and exit cohort component of the state-level permanency outcomes must consider the limitations of the historical cohort model. Lacking a true control group at the system level, the state-level child welfare outcomes analysis employed longitudinal cohorts, comparing outcome performance between pre-Waiver and Waiver groups. This historical comparison is unable to scientifically support or refute a hypothesis of improved outcomes due specifically to

Waiver efforts and initiatives. However, the findings can provide a descriptive look at the way outcomes have changed over time.

Taking those limitations into account, the strongest findings of the cohort analyses were related to shifts in placement mix, reflecting the pre-Waiver to Waiver trends in removal days by placement type. The full demonstration counties (i.e., counties receiving funding to implement one or more interventions in each Waiver year) increased the proportion of children initially placed with kin. A child coming into care for the first time in the baseline period prior to the Waiver had a 34% chance of initially entering a kinship placement; during the Waiver, this likelihood increased to, on average, 46%. This finding is echoed in the observed increase in kinship placement day usage and the findings in the Fiscal Study section of shifts in out-of-home placement costs.

An important contextual factor to keep in mind when looking at these placement mix findings is the trend prior to the Waiver. Before the Waiver, Colorado was already experiencing an increase in kinship placement. There is an argument to be made that this trend may have continued without the Waiver initiatives. In fact, as a sensitivity analysis, an interrupted time series model was examined, testing the significance of the placement mix change when controlling for the trend (breaking the data into fiscal year quarter periods). When the trend is taken into account, the full demonstration counties did not show any significant increase in likelihood of kin placements. The odds ratio is one for the Waiver period, with no significance. The same is true for the trend in congregate care usage.

So, is the shift in placement mix due to the continuation of an existing trend or to new efforts under the Waiver? It is proposed that the answer may be somewhere between the two. There may have been some continuation of movement toward less restrictive placements without the Waiver initiatives, but possibly not at the magnitude observed. Under the Waiver, the demonstration counties invested resources and capacity into interventions that targeted this outcome, and as can be seen in the matched case comparison, when controlling for demographic, risk, and case factors, children who experienced those interventions saw an increase in kin placements compared to those who did not. For example, the likelihood of having a first placement in kinship care was 56% greater for the 14,442 children placed out of home who received FFE meetings compared to their matched comparisons who did not receive the intervention, and the likelihood of spending all or most out-of-home days in kinship care was 55% greater (for additional examples, see the summary of intervention-specific outcome findings below).

The other outcome which displayed a strong difference over time was duration, which increased during the Waiver period. The likelihood of exit decreased both within a 6-month and 12-month window both for the full demonstration counties as a whole and for a majority of the TLC when examined individually. Unlike the placement mix trends, the significance of this trend persisted even when controlling for it in an interrupted time series model. One possible reason for the increase in duration was the dramatic shift in placement mix toward kinship care. However, when re-running the logistic regression model while controlling for first placement type in addition to

age and race, a significant decrease in likelihood of exit for both the six-month and 12-month observation windows is still observed. Furthermore, median duration increased overall for first placements as well as by placement type for all placement types except congregate care.

Two outcomes—placement stability and re-entry—showed weak or no differences from before and during the Waiver. The probability of experiencing a move in the first six months increased during the Waiver period, though by a small amount—from 33% to 35%—and significantly in three counties (Arapahoe, Boulder, and Weld). However, as with the placement type analyses, the interrupted time series analysis did not reveal a significant change in the Waiver period in the likelihood of moving within the first six months when controlling for trend, except for in Boulder County. The likelihood that a child discharged to reunification or kin would re-enter has decreased slightly, though significantly, in the Waiver period.

Intervention-Specific Findings

A limitation of the intervention-specific component of the Outcome Study was the use of historical matched comparison groups. Because of the widespread rollout of the Waiver interventions across the state, concurrent matched case comparison groups with sufficient numbers of children and youth who were similar to the children and youth who received the interventions was not possible. As a result, it is difficult to rule out historical factors that may have influenced the observed differences in outcomes between the intervention groups and matched comparisons used for the evaluation. Another limitation was the inability to link a number of children and youth who received TSAT assessments and treatment to child welfare screening and outcome data due to missing identification numbers in the data received from OBH. Although the data collection procedures were eventually modified to better ensure consistent data linkage between the systems, a number of children and youth who received TSAT assessment and treatment ultimately had to be dropped from the matched case comparison analyses because they could not be linked with Trails IDs.

A strength of the intervention-specific component was the availability of a wide range of matching variables to control for factors other than the interventions that may have been associated with child welfare outcomes, including not only basic demographics but also other case and client characteristics, such as report disposition, case pathway and program area, and abuse and neglect risk assessment composite scores. In addition, the matching variables had few missing data points and were measured fairly consistently across the observation windows for both the comparison and intervention groups. Another strength was the ability to link intervention adherence levels to outcomes through intervention-specific frameworks that were added to Trails in the first year of the Waiver where child welfare service providers in the counties entered child- and case-level intervention activities related to the State-specified components of the interventions.

Keeping in mind these limitations and strengths, the findings from the intervention-specific analyses pointed to a range of permanency and safety outcomes that were

associated with the interventions, particularly among children and youth who received the interventions with higher levels of adherence. The major findings for each intervention are summarized here.

FFE MEETINGS: OOH CHILDREN AND YOUTH

- The cases of all out-of-home children and youth who received FFE meetings were typically (based on medians) about one month shorter than the cases of matched children and youth who did not receive the intervention. Children and youth who received the intervention with higher levels of adherence had cases that were typically about four months shorter than their matched comparisons, whereas the cases of children and youth who received the intervention with lower levels of adherence were typically two days longer than their matched comparisons.
- The likelihood (based on odds) of having a first placement in kinship care was 56% greater for children and youth in the full intervention group than children and youth in the matched comparison group.
- The likelihood of spending all or most out-of-home days in kinship care was 55% greater for children and youth in the full intervention group than children and youth in the matched comparison group.
- The likelihood of experiencing no more than one placement disruption was 21% greater for children and youth who received the intervention with higher levels of adherence, whereas children and youth in the lower adherence intervention subgroup were less likely than their matched comparisons to have no more than one disruption.
- The likelihood of achieving permanency was 210% greater for children and youth in the higher adherence intervention group. Conversely, children and youth in the lower adherence group were less likely than their matched comparisons to achieve permanency at case close.
- The likelihood of returning home was 73% greater for children and youth in the higher adherence intervention subgroup. Children and youth in the lower adherence intervention subgroup, on the other hand, were less likely than their matched comparisons to reunify at case close.
- A smaller percentage of all out-of-home children and youth whose cases closed and families received FFE meetings experienced subsequent child welfare involvement (7%) compared to matched out-of-home children and youth whose cases closed but whose families did not receive the intervention (11%).
- The likelihood of spending all or most subsequent case out-of-home days in kinship care was 88% greater for children and youth in the full intervention group. The likelihood for children and youth in the higher adherence intervention subgroup was 386% greater than their matched comparisons and

the likelihood for children and youth in the lower adherence subgroup was 59% greater than their matched comparisons.

- The likelihood of reunification with parents at case close was 55% greater for children and youth whose caregivers received KS and families received FFE meetings with higher levels of adherence than matched children and youth in kinship placements whose caregivers did not receive KS and families did not receive FFE meetings.
- The likelihood of reunification with parents at end removal was 31% greater for children and youth in care 12 months or longer who received PRTs and whose families received FFE meetings with higher levels of adherence than matched children and youth in care 12 months or longer who did not receive PRTs and whose families did not receive FFE meetings; the likelihood of reunification at end removal was 34% greater for youth 16 years and older with an OPPLA goal who received PRTs and whose families received FFE meetings, regardless of adherence level, than matched youth 16 years and older with an OPPLA goal who did not receive PRTs and whose families did not receive FFE meetings.

FFE MEETINGS: IN-HOME CHILDREN AND YOUTH

- The cases of in-home children and youth whose families received FFE meetings with higher adherence were typically about two weeks shorter than the cases of matched out-of-home children and youth whose families did not receive the intervention. Conversely, the cases of children and youth in the full intervention group and lower adherence intervention subgroup were typically longer than the cases of their matched comparisons.

KINSHIP SUPPORTS

- The kinship placements of children and youth whose kinship caregivers received KS were typically about one month longer than the kinship placements of matched children and youth whose kinship caregivers did not receive the intervention.
- The likelihood of spending all or most out-of-home days in kinship care was 30% greater for children and youth in the full intervention group than children and youth in the matched comparison group.
- The likelihood of exiting kinship placement to another kinship placement or permanency, if not returning home, was 34% greater for children and youth in the full intervention group than children and youth in the matched comparison group.
- The likelihood of achieving permanency was 15% greater for children and youth in the full intervention group than children and youth in the matched comparison group.

- The likelihood of subsequent involvement was 679% less for children and youth in the full intervention group than children and youth in the matched comparison group.

PERMANENCY ROUNDTABLES: 16 YEARS AND OLDER WITH AN OPPLA GOAL

- The likelihood of having at least one step-down in placement restrictiveness was 51% greater for youth whose removals began during a year in which their county was funded to provide PRTs than their matched comparisons, compared to only 17%, greater for youth whose removals began prior to a funded year. The likelihood of this outcome was 27% greater for higher adherence youth, compared to 19% greater for lower adherence youth.
- The likelihood of having more step-downs than step-ups was 37% greater for youth whose removals began during a year in which their county was funded to provide PRTs than their matched comparisons, compared to only 16% greater for youth whose removals began prior to a funded year. And, the odds for this outcome were 57% greater for higher adherence youth compared to 24% greater for lower adherence youth.
- The likelihood of emancipating was 57% less for youth whose removals began during a year in which their county was funded to provide PRTs, while the likelihood was only 2% less for youth whose removals began prior to a funded year.
- The mean number of permanent connections for PRT youth 16 and older with an OPPLA goal increased significantly from 1.60 (SD=1.70, Median=1) individuals prior to the start of the intervention to 3.00 (SD=2.19, Median=2) individuals by the end of their removal or the end of the evaluation observation period ($t(409)=18.04, p<.01$).

PERMANENCY ROUNDTABLES: 12 MONTHS AND LONGER IN OOH CARE

- The likelihood of spending all or most out-of-home days in kinship care was 91% greater for children and youth in the full intervention group than children and youth in the full matched comparison group. The likelihood was 100% greater for children and youth who reached 12 months in out-of-home care during a year in which their county was funded to provide PRTs compared to their matched comparisons, while children and youth who reached 12 months in care prior to a funding year were less likely to spend all or most days in kinship care.
- The likelihood of living with guardians or adoptive parents at case close was 35% greater for children and youth who reach 12 months in care during a year in which their county received PRT funding than their matched comparisons, while children and youth who reached 12 months in care prior to a PRT funded year were less likely than their matched comparisons to achieve this outcome. In addition, the likelihood was 41% greater for children and youth

with higher adherence, whereas the likelihood was only 3% greater for children and youth with lower adherence.

- The mean number of permanent connections for PRT children and youth in care for 12 months or longer increased significantly from 1.58 (SD=1.35, Median=1) individuals prior to the start of the intervention to 2.34 (SD=1.70, Median=2) individuals by the end of their removal or the end of the observation period ($t(1050)=19.60, p<.01$).

TRAUMA INTERVENTIONS

- The likelihood of spending all or most out-of-home days in kinship care was 33% greater for children and youth in the TSAT or CWRC intervention group than their matched comparisons.
- The likelihood of having no more than one placement disruption was 90% greater for children and youth in the TSAT intervention group than their matched comparisons.
- The likelihood of achieving permanency was 81% greater for children and youth in the TSAT intervention group than their matched comparisons.
- The likelihood of living with non-adoptive kin at case close was 141% greater for children and youth in the TSAT intervention group than their matched comparisons.
- The likelihood of spending one or more days in out-of-home care after case close was 213% less for children and youth in the TSAT intervention group than their matched comparisons.
- The likelihood of spending all or most post-case-close out-of-home days in kinship care was 44% greater for children and youth in the TSAT or CWRC intervention group than their matched comparisons.

The Fiscal Study



Introduction

The Fiscal Study examines two sets of questions of interest: One set of questions is about the Waiver's impact on county spending and State use of revenue. The second set of questions is at the intervention level, investigating the county cost of Waiver intervention services received by children and families. Specifically, the first question being addressed by the fiscal evaluation is whether the additional funds made available to counties for the five Waiver interventions and the associated guidance from the State on these interventions had an effect on system-level expenditure patterns in participating counties. The Fiscal Study presents the analysis of fiscal data collected from state fiscal years 2011, 2012, and 2013 (three years prior to the beginning of the Waiver) through state fiscal year 2018 (year five of the Waiver). To analyze the cost of Waiver intervention spending, this fiscal data is integrated with counts of intervention units.

The Title IV-E Waiver in Colorado was anticipated to reduce foster care expenditures across participating counties. Yet, Waiver participation posed both benefits and risks to the State and county administrators. The next section describes Colorado's child welfare funding structure, potential benefits and risks of the Waiver funding, and Colorado's Waiver fiscal management strategy.

Colorado's Child Welfare Funding Structure

Generally, Colorado funds its counties' child welfare activities through a block allocation to each county. The allocation bundles federal and state funding sources. Each fiscal year, the State awards the county a child welfare services allocation, known commonly as "The Block," (based on an allocations formula) and a Core Services Program allocation for family preservation services. A county's annual block allocation generally falls in line with previous funding levels, with perhaps an incremental step up or down, unless a major change is made to CDHS's allocation formula.

Operating within these funding blocks, counties had flexible revenue and limits on what they could spend—even prior to the Waiver. Counties made their own decisions about what to spend on child welfare programs and did not need to be concerned with which funding stream would reimburse those expenditures. However, counties could not necessarily expect to receive all the federal Title IV-E revenue CDHS claimed on the county's behalf. This county-level flexibility—and limits that accompany the flexibility—inherent in Colorado's funding model prior to the Waiver continued during the Waiver period. That is to say, the fiscal flexibility granted by the Waiver was only new at the state level.

By participating in a Waiver, Colorado, at the state level, traded guaranteed, unlimited, fee-for-service federal contributions to foster care board and maintenance costs for certain children for a fixed amount of money that could be used for all child welfare services for any child. The fixed amount was intended to be the same amount CDHS would have received under normal Title IV-E reimbursement rules in the absence of the Waiver. The amount was based on the average gross expenditures for foster care maintenance and foster care administration for state fiscal years 2008 through 2010.

This trade had three major implications at the state level. First, the Waiver gave CDHS the opportunity to treat federal Title IV-E revenue as a source of flexible funding that could be allocated to a range of child welfare services that normally could not be supported with Title IV-E funding. The Waiver addressed the prevailing belief that restricting the use of Title IV-E funding to foster care created a disincentive to reduce foster care expenditures. Without the Waiver, states would "lose" federal Title IV-E funding if the county departments of human/social services were able to reduce foster care expenditures. Under the Waiver, Colorado was able to retain this funding for other child welfare purposes.

Second, the Waiver made the amount of Title IV-E revenue more predictable for CDHS. Rather than fluctuating with the number of children in placement or the number of high-cost placements, the Waiver payment was predictable year to year according to a federal fixed payment schedule agreed to by CDHS and the Children's Bureau.

Third, the Waiver exposed CDHS to new risks. At a minimum, Colorado risked that the fixed amount of money received through the Waiver would be less than CDHS would have received under normal Title IV-E reimbursement rules. If foster care

expenditures did not change during the Waiver period at the rate predicted when calculating the Waiver allocation, CDHS would lose revenue as a result of Waiver participation.

At the state level, Colorado chose to take advantage of the Waiver's financial flexibility by distributing a portion of the Waiver funding to counties for Waiver-specified interventions through an annual application process. Counties opted into the Waiver by applying for and receiving intervention funding. CDHS's expectation was that these counties would achieve reductions in admissions to out-of-home care, lengths of stay in foster care, and the use of high-cost placements via these interventions. CDHS had the option to disburse those savings to further diversify investments in services other than foster care, strengthen families and communities, and continue reducing the need for foster care. (Details on CDHS's distribution of Waiver savings to counties are provided below.)

For county departments of human/social services, there was some risk that the intervention funding would not continue, even within the Waiver demonstration period. Funding each year during the Waiver was uncertain given the annual application process; in interviews, county administrators expressed concern over how these interventions would be funded after the termination of the Waiver and CDHS's targeted intervention funding. At the state level, if the Waiver did not generate sufficient savings through reduced foster care expenditures, CDHS may have chosen not to continue additional intervention funding, and the counties would have to find another way to fund intervention services.

Colorado's Title IV-E Allocation Structure and Management

During the Waiver, the expectation at CDHS was that counties would reduce spending on foster care expenses and generate federal Waiver savings under "The Block." CDHS's plan was to split 50/50 between CDHS and the counties the savings from the reduction in Traditional Title IV-E expenditures. CDHS expected to utilize savings to first cover any outstanding demonstration expenses and then to fund other child welfare services. Once the county's share of savings was identified, the expectation was that counties would receive a share of the savings based on each county's contribution to the reduction in foster care expenditures. During the Waiver, county savings were distributed based on CDHS's calculation of each county's share. Then, each county's portion of the savings was first applied to any county overspending of "The Block" for that year. After any overspending was managed, the counties used their savings for other child welfare services that they prioritized.

The amount of funds allocated to the demonstration expenses initially increased during the first few years of the Waiver, as more counties joined the Waiver and as counties implemented additional interventions, and then decreased in the last year to encourage sustainability planning.

Key Fiscal Study Questions

The Fiscal Study aims to illuminate cost impacts using system-level and intervention-level data across all demonstration counties. The overarching research questions are:

- What effect does the Waiver have on child welfare expenditures in participating counties?
- What are the costs of Waiver intervention services received by children and families?

At the system level (including both state and county levels), the primary research question is whether the fiscal stimulus and the associated guidance from the State on service interventions had an effect on expenditure patterns in participating counties when the cost of the Waiver interventions are included. The system-level look also tracks the use of different revenue sources.

At the intervention level, the counts of intervention services (which are available in Trails) and costs of intervention Waiver spending (reported by counties through the CFMS, or County Financial Management System) are utilized to calculate average Waiver spending for the interventions undertaken through the demonstration project by unit of service. The Fiscal Study's analysis and linkages to other parts of the evaluation are presented in more detail below.

Fiscal Study Data Sources and Data Collection

Data Sources

The Fiscal Study primarily utilize data collected from two existing sources: individual-level intervention data in Trails and county-level fiscal data as reported through CFMS. The core task of the system-level analyses of county expenditures and revenues is to create and populate a database of child welfare expenditures and revenues for each county. The database represents each county's revenues and expenditures for three years prior to the Waiver and for each year during the Waiver. Such a database provides the flexibility to compare the State and counties to their own history.

Data Collection

Key to the database creation preparatory work were interviews with State and county-level administrators in the first and second years of the Waiver; these interviews (and interviewees) are distinct from those key informant interviews utilized for the Process Study. These interviews illuminated the fiscal relationship between the State and individual counties as it relates to child welfare expenditures and revenues.

Discussions with the State administrators and analysis of financial summary reports also assisted the evaluation team in outlining the structure, reporting, and processes surrounding the administrative financial system (CFMS). The State tracks child welfare financial data in CFMS within a chart of accounts with a Program-Function-Account structure.

At the county level, qualitative data were collected to bolster the fiscal analysis. Three rounds of interviews were conducted with county fiscal officers from the TLC and a sampling of medium and small (balance of state) counties. These interviews provided information on the counties' fiscal relationship with the State, general fiscal

management, and county-specific context for shifting fiscal trends. In 2014, Denver, Mesa, Jefferson, Pitkin, and Garfield counties were interviewed. During the initial interviews, discussions centered on each county's fiscal relationship with the State, the annual budgeting process, and system integration between the county's financial system and CFMS. In 2015, Larimer, Jefferson, and Mesa counties were interviewed to provide some context to the initial fiscal trends observed. And, in 2016, all of the TLC in addition to Montrose, Logan, La Plata, Yuma, and Crowley were interviewed. These interviews focused on the counties' management of traditional Title IV-E expenditures, fiscal management of Waiver intervention expenditures, and county-specific fiscal trends.

Colorado counties track child welfare expenditures within county-operated financial systems and submit monthly data to the State, which is then used to populate the CFMS system. Although counties vary in their integration process with CFMS, the results for the applicability of the data were the same. That is, all county fiscal officers saw CFMS data as an integral data point for their county's fiscal management which had a direct impact on the county's receipt of revenue and reimbursement. In addition, it was found that all relevant county financial data are uploaded to CFMS, making it unnecessary for the system-level study to collect any additional county-level information for the aggregate cost data analysis. Most importantly, the interviews provided the confirmation of the availability of reliable and consistent cost data from CFMS.

For this Fiscal Study, coordination with State fiscal and information technology staff led to the creation of a reproducible data export from CFMS capturing the backbone of expenditure and revenue elements necessary for creating the database of child welfare expenditures and revenues for each county. (The data export provides fiscal detail at the Program-Function-Account level with monthly totals by county.) Subsequently, the interviews, in coordination with CFMS financial reports provided by CDHS, generated the information necessary for the Fiscal Study team to define the expenditure and revenue elements available and appropriate for the cost evaluation database creation.

Building on the data provided, Chapin Hall completed a basic database structure for the Fiscal Study that enables analysis of changes in expenditure and revenue patterns at the state and county levels. The database's structure contains the flexibility to compare financial data within and across counties, across fiscal years at the state level, and within child welfare-specific expenditure and revenue categories.

Colorado's chart of accounts is structured as Program-Function-Account. Descriptive variables were created for the data using schedules based on these COA codes. The schedules were provided by the Colorado State finance staff. At the highest level category, revenue splits between county, state, and federal funding. And, expenditures fall into categories which distinguish between Out-of-Home (primarily foster care maintenance), Adoption & Guardianship Subsidies, Other Purchased Services (expenses which were paid directly to a client or provider), and Direct County (all other child welfare expenses) expenditures.

Fiscal Study Data Analysis

Geographic Parameters and County Selection

Due to the staggered rollout structure of the Colorado Waiver, counties had the ability to begin and end Waiver participation each fiscal year. For consistency, this analysis includes only counties which have participated in each year of the Waiver. Counties (hereafter “demonstration counties”) are considered to have participated in the Waiver if they received Waiver intervention funding from the State for at least one of the Waiver interventions in each fiscal year. This includes all of the TLC and all but seven of the medium sized counties and 12 of the small (balance of state) counties.

The results reported in the main body of this report are aggregated at the state level for all demonstration counties to examine the overall cost and revenue trends during the Waiver period. The TLC represent approximately 81% of all child welfare expenditures at the state level each year, so trends in these counties drive the trends for the state. County-level fiscal reports for the TLC are included as Appendix L and will be referenced when county-level variances are discussed.

Variables for Analysis

Using the data available to date, the following dependent variables were examined:

- Total child welfare expenditures;
- Out-of-home expenditures and utilization;
- Out-of-home expenditures as a % of total child welfare expenditures;
- Average daily unit cost (total out-of-home expenditures divided by total placement days); and
- Waiver intervention spending.

For each dependent variable listed above, the change in the indicator in the Waiver is presented by comparing the pre-Waiver period SFY 2011 through 2013 to the Waiver period of SFY 2014 through 2018.

Title IV-E Waiver Revenue and Savings

A key benefit of Waiver financing is that counties could utilize savings on out-of-home board and maintenance (from reducing placement costs) for other child welfare activities. The expenditure analysis shows any spending reductions in out-of-home board and maintenance within participating counties. Another way to examine the question of how participating counties have used Waiver savings is to look simply at federal Waiver revenue received by each county from SFY 2014 through SFY 2018 and compare it to what would have been received under traditional IV-E reimbursement rules. To estimate the additional revenue each demonstration county received to spend on services other than out-of-home board and maintenance, the Fiscal Study team estimated the amount of Title IV-E reimbursement a county would have received for traditional Title IV-E expenditures during the Waiver period from SFY 2014 through SFY 2018. This amount was compared to the actual Waiver award to

determine how much was left over for flexible spending after paying what would have been the federal share.

Inflation Adjustment

An adjustment for inflation has been made to allow comparability of expenditures across years. All expenditures, unless otherwise noted, have been adjusted to constant dollars using SFY 2018 dollars as the base year and adjusting previous years' expenditures by the Consumer Price Index (CPI)^r.

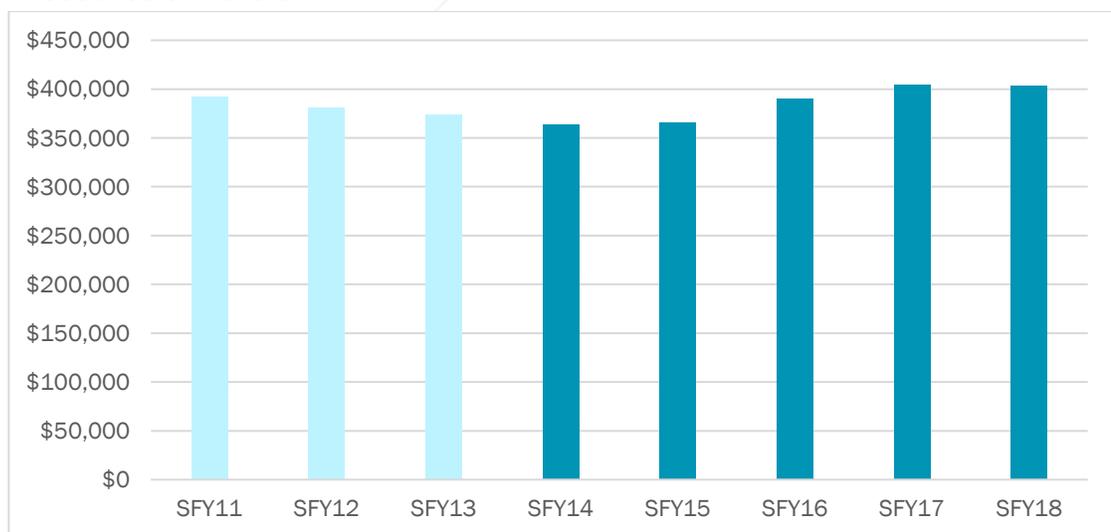
Fiscal Study Results

Overall Child Welfare Expenditures

TOTAL CHILD WELFARE EXPENDITURES

First, the total child welfare expenditures for demonstration counties is reported. These are displayed below in Figure 75 from SFY 2011 through SFY 2018 (which covers the period July 1, 2010 through June 30, 2018). In the observed pre-Waiver years, total child welfare expenditures were decreasing, reducing by 5% from SFY 2011 to SFY 2013. Child welfare expenditures reached a low point of \$363.8 million in the first year of the Waiver (SFY 2014). From there, during the rest of the Waiver, total child welfare expenditures steadily increased through SFY 2018. For demonstration counties, total child welfare expenditures increased by 8% from SFY 2013 levels, after adjusting for inflation. To understand where and why this increase occurred, the child welfare expenditures are broken down into major categories.

Figure 75. Total Child Welfare Expenditures by SFY – Adjusted for Inflation, in Thousands of Dollars



^r United States Department of Labor. (2018, Sep.). Consumer Price Index. Bureau of Labor Statistics. Retrieved September 23 from <http://www.bls.gov/cpi/>. Constant costs are calculated using the following equation: Current Year Real Cost = (Base Year CPI/Current Year CPI)*Current Year Nominal Cost. All constant costs are converted into SFY 2018 dollars, so the Base Year is SFY 2018. The CPI for SFY 2018 is calculated by taking the average CPI of the monthly CPIs for the period July 2017 through June 2018 (248.13).

EXPENDITURES BY MAJOR CATEGORY

As described in the data sources and data collection section, child welfare expenditures can be divided into four broad categories:

- **Out-of-Home Placement Costs** - These are expenditures for all out-of-home board and maintenance costs.
- **Adoption and Guardianship Subsidies** - These are expenditures for adoption and guardianship subsidies.
- **Other Purchased Services** - These are expenditures for services that are provided to families and children where the payment for the services is paid to a provider or directly to the client.
- **Direct County** - These are all remaining child welfare expenditures, and include general administration of all child welfare programs, as well the management and services provided under the adoption, out-of-home and in-home programs.

As seen in Figure 76, total child welfare expenditures have increased during the Waiver, but expenditure trends varied by category of expense. Direct County saw the largest increase, both proportionally and in terms of real dollars, with Direct County expenditures increasing by 18% from SFY13, after adjusting for inflation. SFY 2018 out-of-home placement costs were 5% less than SFY13 levels, however this category has been increasing for the last three fiscal years.

Figure 76. Child Welfare Expenditures by Major Category and SFY – Adjusted for Inflation, in Thousands of Dollars

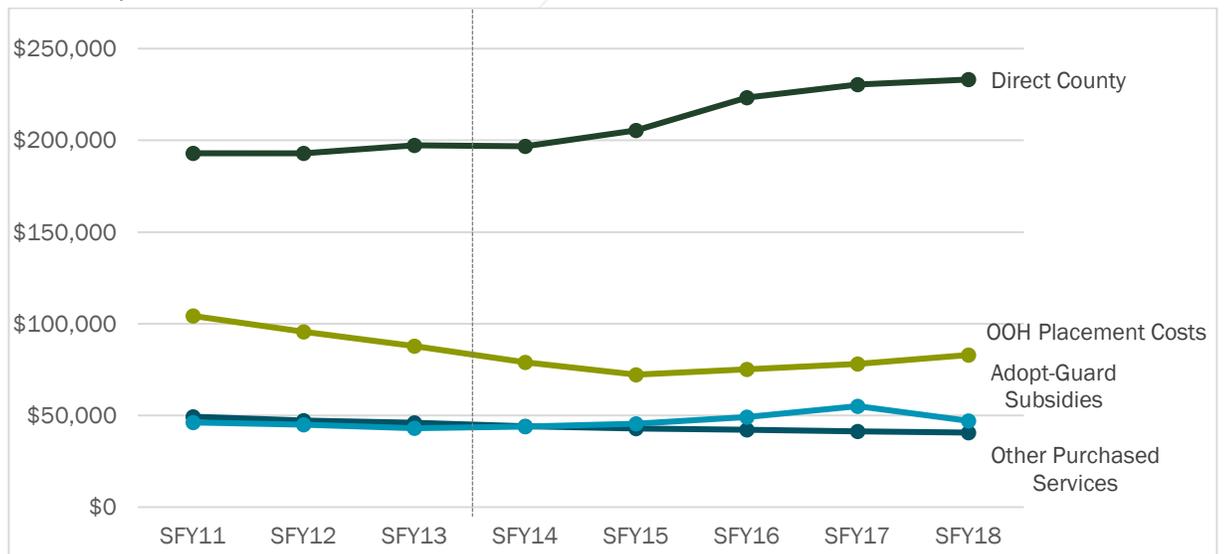


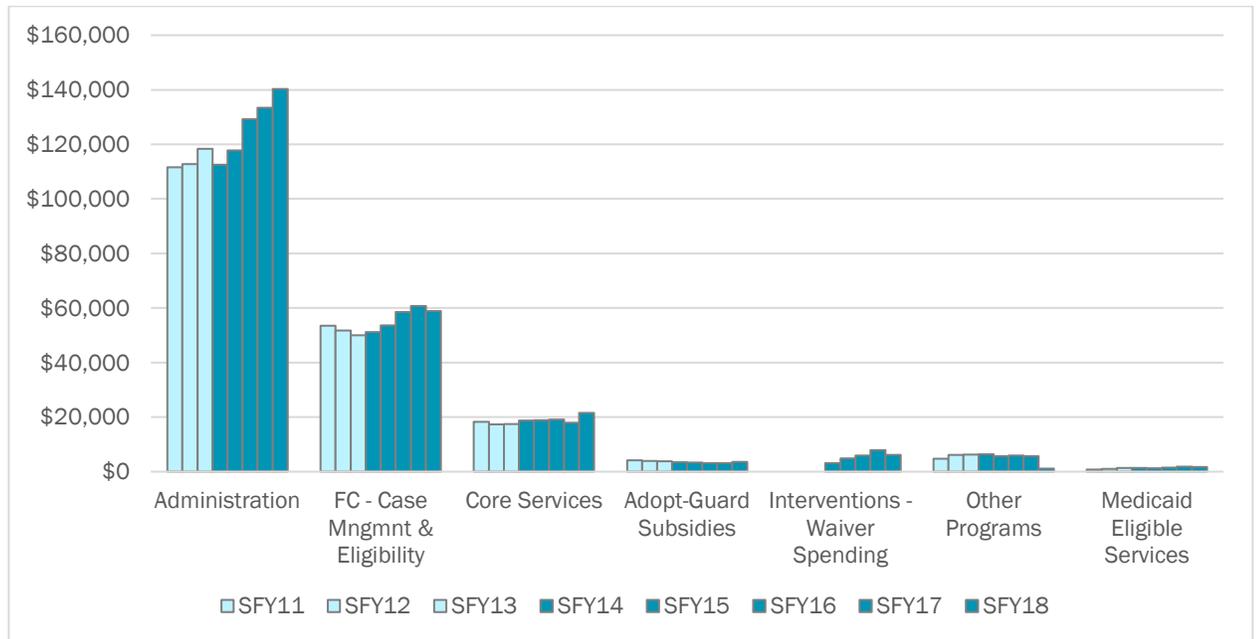
Table 46. Child Welfare Expenditures by Major Category and SFY- Adjusted for Inflation, in Thousands of Dollars

	SFY11	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18
Direct County	\$192,973	\$192,924	\$197,244	\$196,693	\$205,387	\$223,226	\$230,451	\$233,141
OOH Placement	\$104,280	\$95,664	\$87,746	\$79,007	\$72,254	\$75,098	\$78,053	\$82,969
Adopt-Guard	\$49,334	\$47,307	\$46,045	\$44,158	\$42,901	\$42,264	\$41,274	\$40,664
Other Services	\$46,155	\$44,947	\$43,057	\$43,926	\$45,505	\$49,149	\$55,085	\$47,069
Grand Total	\$392,743	\$380,842	\$374,092	\$363,784	\$366,048	\$389,737	\$404,863	\$403,843

Looking at the TLC, each county experienced an increase in Direct County expenditures between SFY 2013 and SFY 2018 (Appendix L). These Waiver changes ranged from a 6% increase to a 27% increase. Counties reported that Direct County expenditures were increasing largely in part due to an increase in county child welfare staff. Increases in FTEs at the county level led to an increase in salaries and associated staffing costs, which make up the majority of Direct County expenditures.

The increase in Direct County expenditures can be seen across almost all expense subtypes. In Figure 77, the expense types which make up 95% of Direct County expenditures (Administration, which includes all staff and caseworker costs for the administration of non-out-of-home services and basic administration of the county's child welfare program, Foster Care Case Management and Eligibility, and Core Services) each experienced about a 20% increase over the course of the Waiver. The new spending on Waiver interventions also contributed a small amount to the increase in Direct County expenditures, with these expenditures adding about an additional 3% of Direct County expenses each Waiver year.

Figure 77. Direct County Expenditures by Type and SFY – Adjusted for Inflation, in Thousands of Dollars



OOH Care Board and Maintenance Expenditures

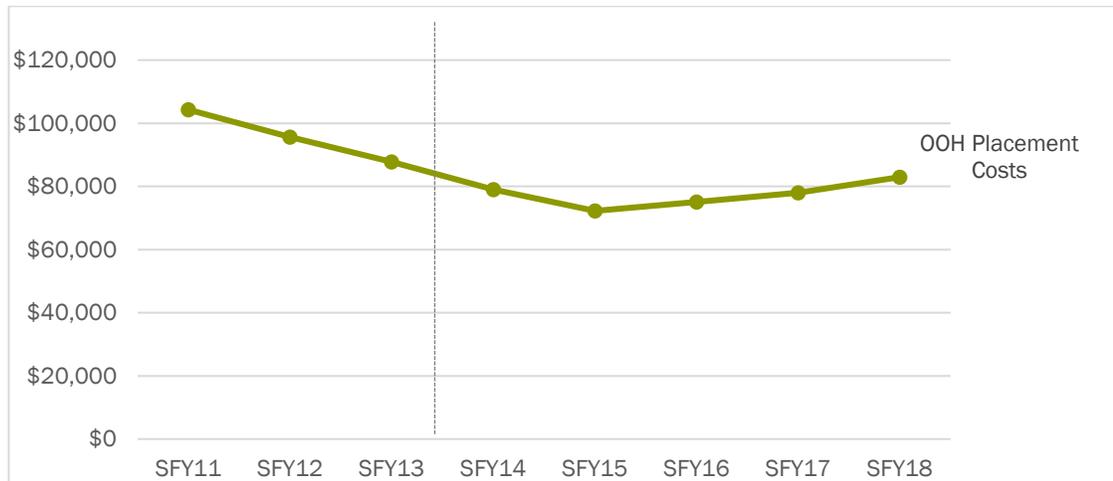
In order to reduce out-of-home placement expenditures, counties would have had to reduce the number of paid placement days, reduce the average daily cost of care, or both. This section presents data on trends in out-of-home expenditures, placement days, and unit costs, as well as the proportion foster care expenditures represented of all child welfare expenditures.

OOH EXPENDITURES AS A PROPORTION OF TOTAL CHILD WELFARE EXPENDITURES

Looking at Figure 78, the out-of-home placement expenditures experienced a decline from the first observed fiscal year, SFY 2011, into the Waiver, reaching a low in SFY 2015. Overall, out-of-home placement costs decreased 5% during the Waiver when comparing SFY 2013 levels to SFY 2018. Although, out-of-home costs have experienced slight annual increases in the past few years, beginning in SFY 2016.

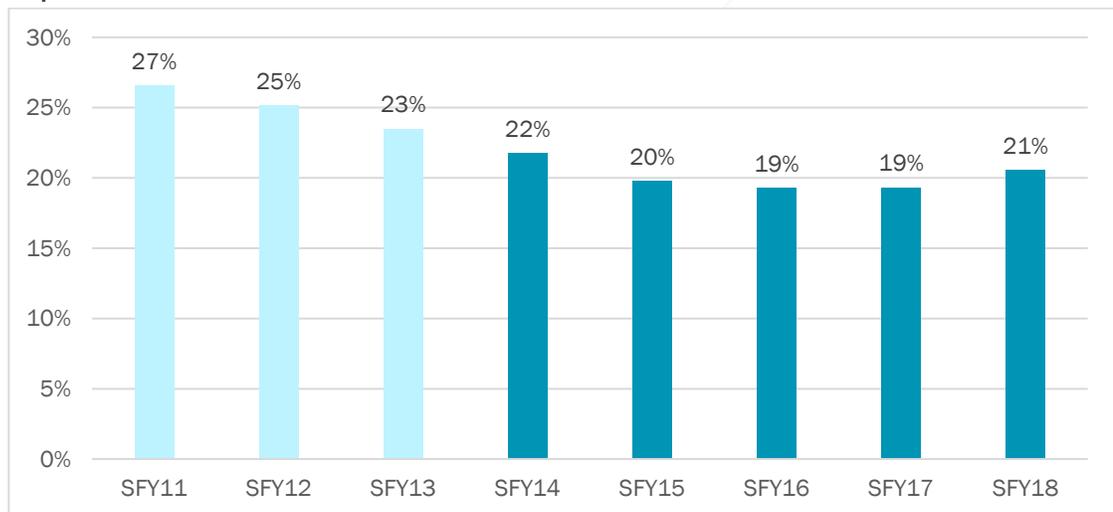
In the TLC, six of the 10 saw an overall decrease in out-of-home expenditures from SFY 2013 to SFY 2018, with a range of 5% to 27% reductions. However, three of the TLC saw increases in total out-of-home costs, with a range of 9% to 15% increases (Appendix L).

Figure 78. OOH Expenditures by SFY – Adjusted for Inflation, in Thousands of Dollars



It can be valuable to view out-of-home expenditures in the context of total child welfare expenditures. Figure 79 presents out-of-home placement expenditures another way – as a proportion of total child welfare expenditures.

Figure 79. OOH Expenditures as a Percentage of Total Child Welfare Expenditures



Although total out-of-home expenditures have been increasing in the past three fiscal years, the proportion of out-of-home expenditures of total child welfare expenditures declined and stayed stable through SFY 2017, only seeing an uptick in SFY 2018.

Tying this proportion back to the general growth of expenditures, Figure 79 demonstrates that although out-of-home expenditures have been increasing, they have been doing so at about the same rate as the total child welfare expenditures, allowing their proportion to stay the same until SFY 2018. The proportion of out-of-home expenditures to total child welfare expenditures does vary by county with a range of 9% to 23% for the TLC in SFY 2018 (Appendix L).

OOH PLACEMENT EXPENDITURE STRUCTURE

To understand shifts in out-of-home placement costs, one must take into account their expenditure structure. Total out-of-home placement expenditures are influenced by two components: price of care and quantity of care days. In other words, how much a child welfare system spends on out-of-home placements (expenditures) is a function of how much that collection of services costs per day (price) and the number of care days for which it is provided (quantity).

$$\text{OOH Expenditures} = \text{Price} * \text{Quantity}$$

In short, a change in the average cost per care day or in the number of care days would affect the total out-of-home expenditures. In the demonstration counties, total placement days have increased each year over the last three fiscal years, although SFY 2018 total days only showed a 1% increase from SFY 2013 levels. So, overall, during the Waiver at a state level, the quantity of placement days did not change significantly. However, placement mix shows a significant shift over the course of the Waiver (Figure 33) from more restrictive to less restrictive placements. The other driver of out-of-home expenditures—price, or average daily unit cost—can be examined.

Average Daily OOH Unit Cost

Average unit costs are calculated by dividing the total annual out-of-home expenditures by total placement days for each fiscal year. At the state level in the demonstration counties, the average daily cost of care showed a consistent downward trend from SFY 2011 through SFY 2017 and an increase in SFY 2018 (Figure 80).

Figure 80. Annual Average Daily Unit Cost and Placement Days - with Costs Adjusted for Inflation

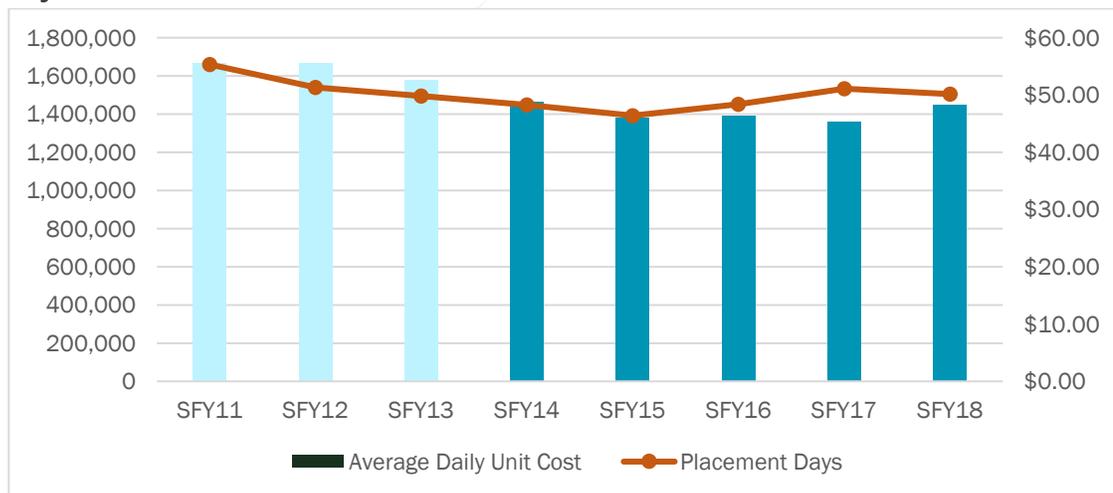


Table 47. Annual Avg. Daily Unit Cost and Placement Days, with Costs Adjusted for Inflation

	SFY11	SFY12	SFY13	SFY14	SFY15	SFY16	SFY17	SFY18
OOH Expenditures	\$92,364	\$85,665	\$78,751	\$70,594	\$64,179	\$67,276	\$69,542	\$72,612
Placement Days	1,659,854	1,540,329	1,495,474	1,448,940	1,392,247	1,451,413	1,533,002	1,505,448
Avg. Daily Unit Cost	\$55.65	\$55.61	\$52.66	\$48.72	\$46.10	\$46.35	\$45.36	\$48.23

This decline in average daily unit cost most likely stems in part from the placement mix shift shown previously (Figure 33) – a shift from more expensive care types (congregate care, foster care) to less costly placement types (kinship care). Importantly, the placement mix shifts appear to have occurred without sacrificing children’s safety (for example, Figure 47). Figure 80 shows that in SFY 2016 and SFY 2017, the average daily unit cost continued to drop while total placement days increased.

Variation in average daily unit cost did differ by county although almost all saw a decrease. Nine of the TLC saw a decrease in average daily unit cost of foster care placement between SFY 2013 and SFY 2018 with four of those counties seeing a 17% or greater decline from SFY 2013 levels. County-by-county details for the TLC on placement mix and average daily unit cost can be found in Appendix L. The state-level aggregate effect for demonstration counties was an 8% decrease in average unit cost between SFY 2013 and SFY 2018.

FISCAL IMPACT OF DECLINING DAILY COSTS

When total child welfare expenditures, including even out-of-home placement costs in SFY 2018, are rising, the fiscal impact of a decline in average daily unit cost for out-of-home placements over the course of the Waiver can be obscured. The impact of a declining average daily unit cost in this environment can be seen more clearly when total out-of-home placement costs are projected from a historical average daily unit cost. To begin, it is assumed that placement mix, and subsequently average daily unit cost, had stayed stable from SFY 2013 onward. When coupling that baseline average daily unit cost with the actual annual placement day count, the projected annual out-of-home expenditures are higher than the actual costs.

Table 48. Baseline OOH Cost Projection, Actual OOH Costs, and Calculated Variance – Adjusted for Inflation, Costs in Thousands¹

Baseline Projection	SFY14	SFY15	SFY16	SFY17	SFY18
Actual Placement Days	1,448,940	1,392,247	1,451,413	1,533,002	1,505,448
Baseline Avg. Daily Unit Cost (from SFY 2013)	\$56.48	\$56.48	\$56.48	\$56.48	\$56.48
Projected Baseline OOH Expenditures	\$81,833	\$78,631	\$81,973	\$86,581	\$85,024

Actual OOH Expenditures	\$70,594	\$64,179	\$67,276	\$69,542	\$72,612
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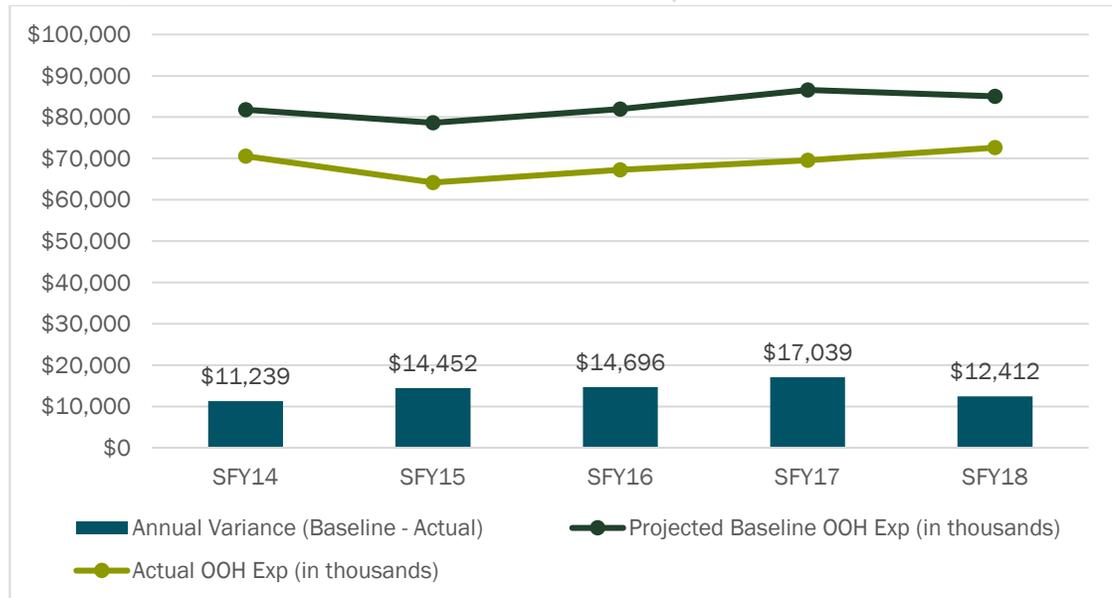
Annual Variance Calculation	SFY14	SFY15	SFY16	SFY17	SFY18
Annual Variance (Baseline - Actual)	\$11,239	\$14,452	\$14,696	\$17,039	\$12,412
Cumulative Variance	\$11,239	\$25,691	\$40,388	\$57,426	\$69,839

Total Variance	\$69,839
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¹ This Table and Figure 80 exclude Adams County due to the kinship placement data inconsistencies mentioned on page 124.

Graphically, this variance can be seen in Figure 81 as the space between the Projected and Actual costs lines.

Figure 81. Projected and Actual OOH Costs with Annual Variance – Adjusted for Inflation, in Thousands of Dollars



During the Waiver, demonstration counties experienced a change in placement mix toward less restrictive, and less expensive, placement types. This change in placement mix had a fiscal impact by lowering the average daily unit cost for placement days, resulting in an estimated \$69.8 million cumulative variance in out-of-home placement costs from SFY 2014 through SFY 2018 in demonstration counties.

Intervention Waiver Spending

As mentioned previously, at the state level, Colorado chose to take advantage of the Waiver’s financial flexibility by distributing a portion of the Waiver funding to counties for Waiver-specified interventions through an annual application process. Counties opted into the Waiver by applying for and receiving intervention funding. Below, Waiver spending on these interventions is reported by intervention type and SFY.

Waiver intervention spending increased through SFY 2017, reaching a high of \$13.4 million, with 70% being spent on the FFE and KS interventions. In SFY 2018, Waiver intervention spending decreased by a quarter down to \$9.9 million with the greatest reduction in the KS intervention (Table 49). As a proportion of total child welfare expenditures, the Waiver intervention spending is small, only 2% in SFY 2018. The increase in spending on Waiver interventions in the first few years of the Waiver is related to the State awarding more funds for the interventions as well as counties being more likely to spend their full allocation of funds as the Waiver years progressed. Several counties expressed an inability to spend down their full annual allocation from the State for at least one of their interventions during SFY 2014 and SFY 2015. These counties cited several reasons for this underspending including: slow implementation, staff retention issues, initial overestimation of intervention costs, and PRT-specific issues. Intervention spending trends did differ by intervention type, and Figure 82 looks at these trends stratified by intervention type.

TOTAL INTERVENTION WAIVER SPENDING

Figure 82. Intervention Waiver Spending – Adjusted for Inflation, in Thousands of Dollars

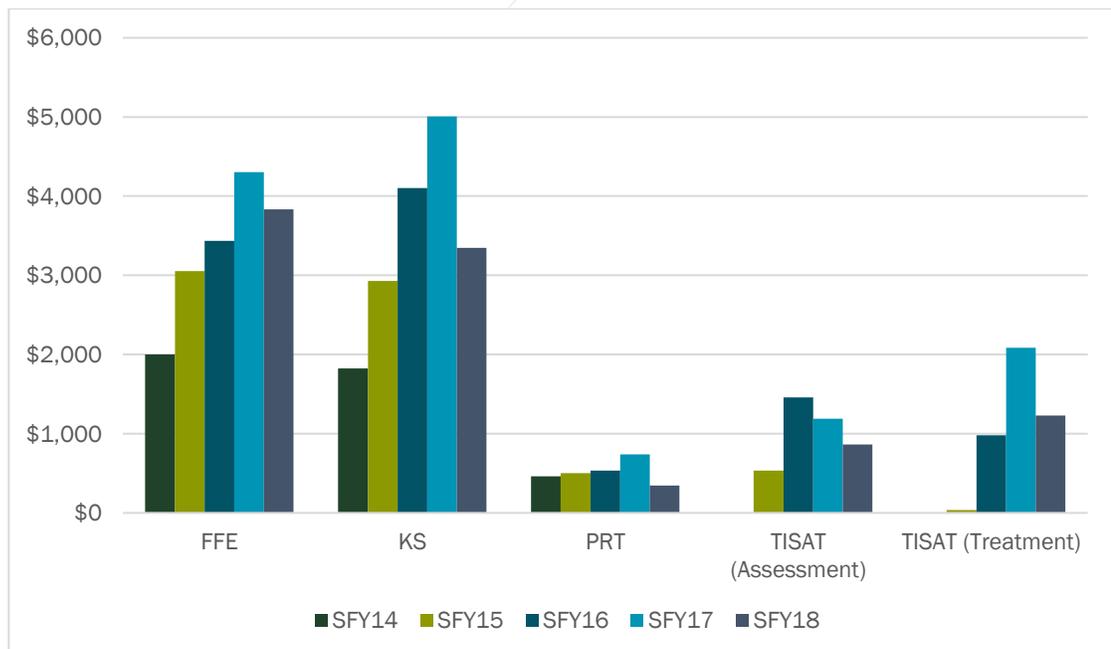


Table 49. Intervention Waiver Spending – Adjusted for Inflation, in Thousands of Dollars

Intervention	SFY14	SFY15	SFY16	SFY17	SFY18
FFE	\$1,999	\$3,053	\$3,435	\$4,305	\$3,834
KS	\$1,825	\$2,931	\$4,103	\$5,006	\$3,346
PRT	\$463	\$501	\$535	\$740	\$347
TSAT (Assessment)	\$0	\$535	\$1,459	\$1,188	\$862
TSAT (Treatment)	\$0	\$38	\$980	\$2,084	\$1,231
Total	\$4,286	\$7,058	\$10,512	\$13,322	\$9,620

An important caveat regarding these spending totals in Figure 82 is that not all expenditures related to these interventions were coded in CFMS in a way that allowed the evaluation team to break them out from other child welfare expenditures. Discussions with counties revealed that for some counties and for some interventions, funding for the intervention was covered partially by set-aside Waiver funding awarded through the annual application process and partially by the county’s general child welfare funding (“the Block”). This was more common in counties where capacity around these interventions existed prior to the beginning of the Waiver (most commonly for FFE). So, the expenditure totals in Figure 82 are those reimbursed by Waiver dollars, not all expenditures on Waiver interventions.

In SFY 2018, Colorado reduced the total Waiver funding available for Waiver interventions, both as a way to encourage sustainability and as an effort to keep spending under its annual Waiver cap. In SFY 2018, FFE made up the largest proportion of Waiver intervention spending (39%) and KS the second largest proportion (34%). This was a change from SFY 2016 and SFY 2017 where KS had the largest investment of Waiver spending. Although both FFE and KS Waiver spending declined in SFY 2018, the steeper decline in KS may have had to do with the larger share of KS dollars that were not for county staff. FFE expenditures tend to be Direct County expenses, with around 84% of FFE Waiver spending going to fund full-time equivalent related expenditures. KS expenditures were more heavily weighted towards purchased services and hard goods (~40%). With this reduction in available Waiver intervention funding, it is possible that counties chose to make smaller reductions to the FFE spending that was supporting county staff. It is also possible that the counties chose to prioritize funding the FFE intervention for programmatic reasons. Findings from the Process Study confirm that counties shifted toward sustaining staff positions, as well as FFE over the other Waiver interventions, as the Waiver progressed.

AVERAGE INTERVENTION WAIVER SPENDING

To analyze the cost of Waiver intervention spending, CFMS fiscal data were integrated with counts of intervention activity units from Trails and our analysis produced the average cost per unit of service for each of the interventions. The Waiver spending in the tables below covers the full Waiver period of July 2013 through June 2018. The intervention counts come from a Trails dataset which spans February 2014 through June 2018. This leaves a seven-month period lacking intervention counts, but given

that period was during the initial implementation ramp up, it is supposed that the effect of excluding that period of intervention counts would be small. Without that period of data, the general observations from these data still apply. These average costs are presented by each of the participating TLC in the tables below.

These tables show the wide variance between the participating TLC in the amount of Waiver spending per unit of service for each intervention. These variances in average cost per service unit for the interventions are likely due to a combination of intervention capacity supported by other funding sources, service intensity, and economies of scale although the impact of each factor varies by intervention type.

Many counties had some capacity to implement FFE prior to the Waiver, so many chose to use the State Waiver funding to expand their program. As previously mentioned, the Waiver Spending in Table 50 contains *only* Waiver spending associated with Waiver interventions, while the count of cases includes *all* cases served by FFE in that county, regardless of how that service was funded. Thus, the actual average cost per case will be less for counties utilizing other funding sources for the cost.

Table 50. FFE – Average Waiver Spending per Case¹

County	Waiver Spending	Case Count	Average Spending per Case
Adams	\$1,088,347	1,576	\$691
Arapahoe	\$640,792	1,783	\$359
Boulder	\$742,322	498	\$1,491
Denver	\$1,920,283	1,967	\$976
El Paso	\$1,463,043	1,646	\$889
Jefferson	\$421,752	1,104	\$382
Larimer	\$1,597,194	1,269	\$1,259
Mesa	\$787,020	480	\$1,640
Pueblo	\$701,871	813	\$863
Weld	\$2,527,656	707	\$3,575
Total	\$11,890,279	11,843	\$1,004

¹Case count includes all cases opened on 2/1/14 or later which opened during years in which a county received set aside Waiver funding for the interventions and which had at least one FFE meeting before 6/30/18.

As a reminder, the vast majority of FFE expenditures are Direct County expenditures (~84%), typically used to cover FFE facilitators and other staff employed by the county. In addition, larger, more urban counties can take advantage of both more full-time staff and a smaller geographic area to cover per FFE staff. Rural counties reported travel expenses as a major cost for the implementation of FFE meetings as FFE facilitators or coordinators had to travel often great distances to attend sometimes a single meeting per day.

Expenditures for the KS intervention were split more evenly between Direct County (~60%) and Purchased Services (~40%), with the proportion of Direct County expenditures growing in the last couple Waiver years to 65%. The Direct County expenditures typically went to funding a Kinship Navigator or kinship worker position

while the purchased services were primarily for hard goods supports for kinship caregivers. These hard goods supports can be seen in the “Types of Services Available for Kin Caregivers” section earlier in the report.

In Table 51, the average spending by provider ranges from \$814 to \$6,958 within the TLC. Since counties were less likely to have had capacity in KS prior to the Waiver, this variance is likely due primarily to a difference in the intensity of services provided – both in the amount of actual services and hard goods provided to kinship providers and the level of Kinship Navigator positions filled in the county.

Table 51. KS – Average Waiver Spending per Provider¹

County	Waiver Spending	Provider Count	Average Spending per Provider
Adams	\$1,092,509	771	\$1,417
Arapahoe	\$603,384	741	\$814
Boulder	\$1,252,481	180	\$6,958
Denver	\$3,618,282	909	\$3,981
El Paso	\$3,968,406	1,040	\$3,816
Jefferson	\$1,711,630	805	\$2,126
Larimer	\$744,723	431	\$1,728
Mesa	\$577,410	221	\$2,613
Pueblo	\$403,312	403	\$1,001
Weld	\$1,584,503	357	\$4,438
Total	\$13,972,137	5,501	\$2,540

¹Provider count includes all providers opened on 2/1/14 or later which opened during years in which a county received set aside Waiver funding for the intervention and which received at least one kinship support or assessment.

PRTs were funded by set-aside State Waiver funding at a lower level than FFE or KS (Figure 82). Also, fewer counties applied for funding for this intervention with only five of the TLC logging Waiver spending in this area. This intervention showed a more consistent average spending per child than per service unit for any of the other interventions, with at most, a \$900 variance between the average per county.

Table 52. PRT – Average Waiver Spending per Child

County	Waiver Spending	Child Count	Average Spending per Child
Adams	\$626,792	360	\$1,741
Denver	\$170,798	150	\$1,139
Jefferson	\$413,070	242	\$1,707
Mesa	\$211,477	249	\$849
Pueblo	\$642,706	421	\$1,527
Total	\$2,064,843	1,422	\$1,452

Although the TSAT intervention encompassed screening, assessment, and treatment, Table 53 focuses only on the average Waiver spending on assessments per child for the TSAT and CWRC interventions. Almost all Waiver spending on trauma assessments is for purchased services, which here likely represent either license

payments to use the assessments or payments to providers to administer the assessments. The counties utilized different assessment types of varying costs, which shows in the average spending. In addition, due to these differences in assessment type, some counties are more successful in getting Medicaid to cover their assessment costs which would account for a lower average Waiver spending per child since the costs covered by Medicaid would not show here.

Table 53. Trauma Informed Assessments – Average Waiver Spending per Child¹

County	Waiver Spending	Child Count	Average Cost per Child
Arapahoe	\$3,509	159	\$22
Boulder	\$90,712	32	\$2,835
El Paso	\$131,693	53	\$2,485
Jefferson	\$156,348	111	\$1,409
Larimer	\$3,439,571	778 ^s	\$4,421
Total	\$3,821,834	1,133	\$3,373

¹Child count includes all children in cases opened on 2/1/14 or later which opened during years in which a county received set aside Waiver funding for the intervention and which had at least one assessment before 6/30/18.

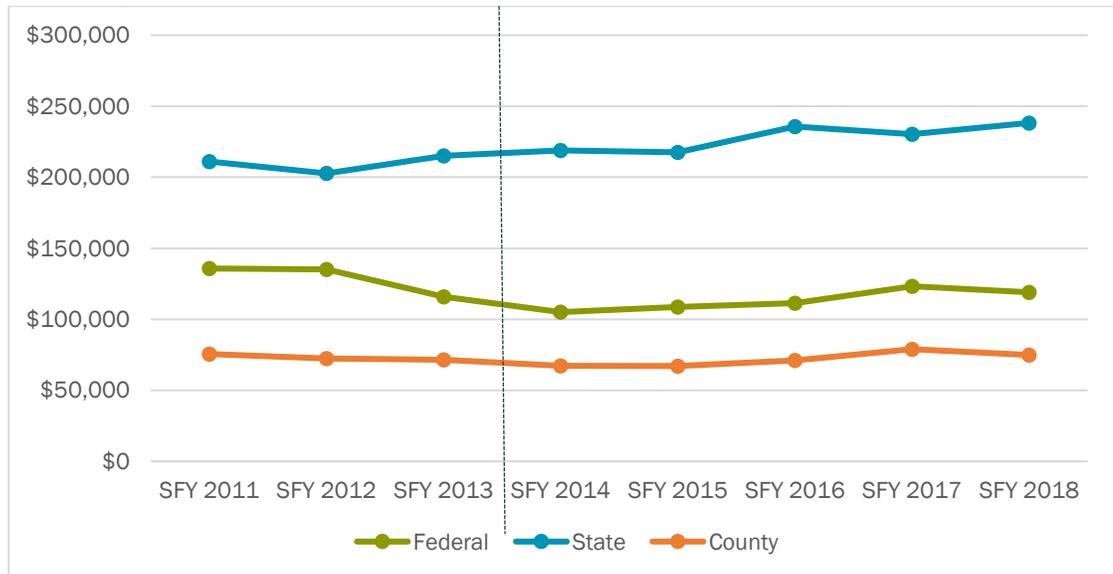
Revenue

REVENUE MIX

Looking across all 64 counties in Colorado, the State saw a slight change in the mix of major revenue sources over the Waiver period. During the Waiver period, child welfare revenue and expenditures grew by 7%. However, each major revenue type (federal, state, and county) grew at a different rate (Figure 83). Federal revenue allocated to child welfare spending stayed the most stable, growing 3% from SFY 2013 to SFY 2018. County revenue allocated to child welfare spending grew by 5% in the same period, and state revenue allocated to child welfare spending filled in the gap, growing 11% over the course of the Waiver. With respect to state revenue, this does not account for overall state investments in social services. Several federal funding sources can be used for a range of social services purposes, such as TANF, Title XX and Title IV-B. It is possible that the state share of those programs went down while it increased its share for child welfare programs.

^s To best match spending with assessment activity, the child count for Larimer County's Trauma Informed Assessment includes the children from all seven counties in the 7-County Child Welfare Resiliency Center (Arapahoe, Boulder, Denver, Douglas Eagle, Jefferson and Larimer). Because it maintained the contract with the company licensing the TOP trauma assessment, Larimer expensed all the assessment spending for those seven counties.

Figure 83. Colorado Child Welfare Revenue by Type and SFY – Adjusted for Inflation, in Thousands of Dollars

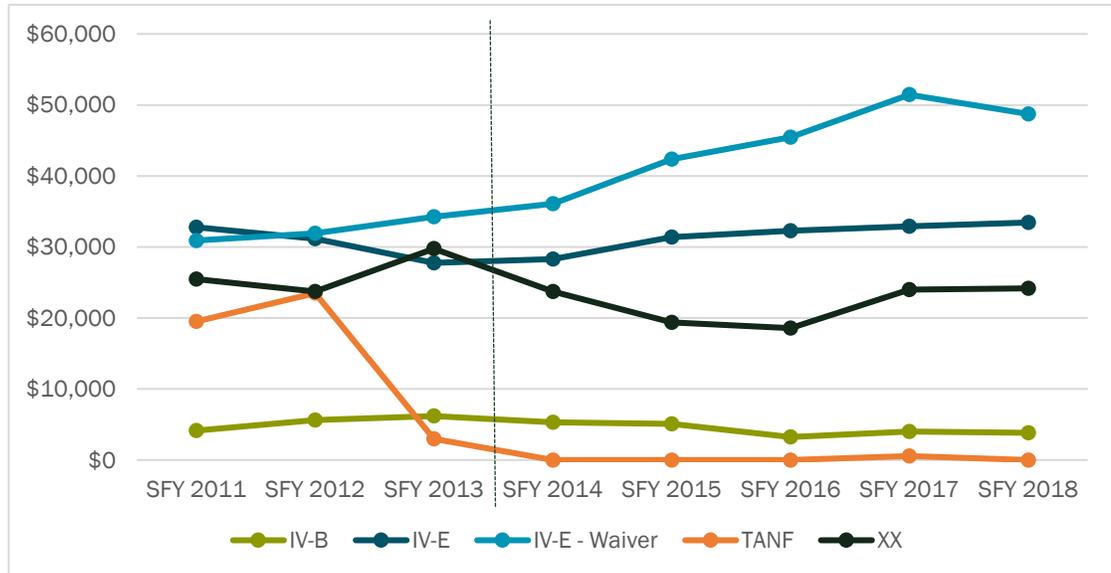


This variance in growth rates led to a slight change in revenue mix with state revenue accounting for 2% more in revenue share in SFY 2018 than in SFY 2013. In SFY 2018, federal revenue accounted for 28% of child welfare revenue, state revenue 55%, and county match at 17%. This differs from the mix in SFY 2013 where federal revenue accounted for 29% of child welfare revenue, state revenue 53%, and county match at 18%.

FEDERAL REVENUE TRENDS

Although federal revenue utilized for child welfare as a whole increased by 3% during the Waiver period, federal revenue trends by major type varied (Figure 84). (Medicaid and Other Federal Revenue have been removed from this figure, each typically making up less than 5% of federal revenue.)

Figure 84. Federal Revenue by Type – Adjusted for Inflation, in Thousands of Dollars



This decline in federal revenue from SFY 2012 through SFY 2014 was primarily due to the replacement of child welfare TANF funding with other state revenue. Title IV-E Waiver-related revenue saw an increase during the Waiver years compared to the three fiscal years prior and grew in proportion of federal revenue from 32% in SFY 2011 to 41% in SFY 2015. One reason for the increase in Title IV-E Waiver-related revenue was due to the State’s ability and choice to flexibly claim approximately \$12-14 million annually in state expenditures that would have been Title IV-B eligible^t under the Waiver at the Title IV-E reimbursement rate in SFY 2015 through SFY 2018. Another reason for the increase in Title IV-E Waiver-related revenue is due to the Waiver intervention-related funding claims.

ESTIMATED WAIVER REVENUE

An important consideration for states and counties that participate in a Title IV-E Waiver is whether they received as much IV-E revenue during the Waiver as they would have without the State operating under the Waiver’s funding model. Any additional revenue received could be spent on services other than foster care board and maintenance.

The table below first looks at the amount of revenue Colorado received under the Title IV-E Waiver. These payment totals were derived from the schedule of fixed payments provided to Colorado by the federal government.

^t Federal funds utilized through Title IV-B to fund child welfare activities are used for a broad variety of child welfare services including, but not limited to, the prevention of maltreatment, family preservation, family reunification, services for foster and adopted children, and training for child welfare professionals.

Table 54. Title IV-E Waiver Revenue Utilization – for All Colorado Counties, in Thousands of Dollars, Not Adjusted for Inflation

Title IV-E Waiver Revenue	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	Total
Fed. Payments Received by State	\$49,686	\$51,820	\$49,948	\$48,059	\$45,767	\$245,279
Reimb. in Absence of Waiver	\$34,042	\$32,316	\$34,384	\$37,406	\$37,988	\$176,135
Total Savings	\$15,644	\$19,504	\$15,563	\$10,653	\$7,779	\$69,143
Intervention Spending	\$4,112	\$6,778	\$10,157	\$13,193	\$9,726	\$43,967
Remaining Revenue Retained by State	\$11,532	\$12,726	\$5,406	(\$2,541)	(\$1,947)	\$25,176

The second row in Table 54 shows the amount of revenue the State would have received in absence of the Waiver. For example, in SFY 2014, the State received \$49.7 million in revenue under the Waiver. Without the Waiver, given the same claiming activity, the State could have expected to see \$34.0 million in Title IV-E revenue. The difference between these two revenue figures, \$15.6 million, is one way to define “savings” under the Waiver. These savings were spent on the four interventions, described in detail above, and on other purposes at the State’s discretion.

The State chose to flexibly spend a portion of its Waiver demonstration revenue by distributing it to counties as a funding source for the Waiver interventions and to increase funding to counties that overspent “The Block”. Intervention funds were allocated to counties via an annual application process. In SFY 2014, the counties spent \$4.1 million of the \$15.6 million in savings on Waiver intervention activity and were reimbursed \$2.0 million in Title IV-E funds.

The remainder of “savings” each year is retained by the State for Waiver administration and reinvestment in child welfare programs.

Discussion

The Fiscal Study provides a way to make a few fundamental statements about the county fiscal experience and decision-making during the Waiver. First, counties increased total child welfare expenditures while in most cases holding steady or decreasing out-of-home care board and maintenance expenditures. Controlling for inflation, total child welfare expenditures increased by 8% over the course of the Waiver for demonstration counties and out-of-home care board and maintenance expenditures decreased by 5%. Netting out the decrease out-of-home care board and maintenance expenditures, all other child welfare expenditures increased by 12%. Second, increases in child welfare spending were funded in part, though not completely, by flexible Title IV-E dollars passed to the counties through intervention-specific funding streams or by increases to “The Block,” the annual allocation from the State that bundled federal and state funding sources. Third, the category of

spending that increased the most (by 18% over the course of the Waiver) was Direct County spending. This increase in Direct County expenditures reflected a state-wide push to explore and encourage services and supports for children and families beyond out-of-home placements and county choices to primarily invest in county staff to deliver these services rather than purchasing those services from contract providers.

Within the category of out-of-home expenditures over the course of the Waiver, the Fiscal Study showed that reduction in average daily unit costs was the most consistent, with reductions in every year of the Waiver except the last year. Even the last year's average daily unit cost was well below pre-Waiver years. During the Waiver, demonstration counties reduced the average daily unit cost by changing placement mix towards less restrictive, and less expensive, placement types, primarily by continuing to decrease foster care and congregate care days and increasing the use of non-certified kinship days. This decrease in average daily unit cost was a likely source of savings, estimated at \$69.8 million over the course of the Waiver assuming that the mix of placement days would not have changed as they increased.

When coupled with the results of both the Outcome Study and Process Study, it can be hypothesized that the Waiver interventions were drivers or contributors to the reduction in average daily unit costs and changing placements mix; the KS intervention supported and sustained both certified and non-certified kinship placements and, under the intervention, children spent more days in kinship care than more restrictive placements. FFE enhanced this impact, serving as a platform for the identification of kin and the assessment of their needs to support them. Further, PRT reduced the number of days youth spent in restrictive placements, like congregate care, while the TSAT interventions enhanced placement stability.

The Fiscal Study also sought to address the question, "What are the costs of Waiver intervention services received by children and families?" While the expenditures on each intervention are in some cases understated, the unit costs per intervention provide a lower bound of how much each of these interventions probably cost. As counties consider investments into the future, it is worth considering the lower bound average costs of these interventions.

Summary, Lessons Learned, Next Steps



Summary

The Colorado Department of Human Services anticipated that its Title IV-E Waiver demonstration project would enhance child safety, permanency and well-being by decreasing out-of-home placement rates and restrictive placements, increasing utilization and sustainability of kin placements, and encouraging collaborative engagement with families as partners. CDHS and county departments of human/social services embraced the opportunity—and fiscal risk—associated with the Waiver, demonstrated through the Waiver’s broad rollout across the state.

Colorado’s Waiver followed a period of decline in restrictive placements across the state, a decrease that aligned with major practice shifts in the state that included the implementation of differential response, the rollout of a statewide child abuse and neglect hotline, and the use of RED teams. To continue these positive shifts and to ensure children and youth were safe, Colorado’s counties implemented five practice innovations—interventions—through the Waiver: facilitated family engagement, kinship supports, Permanency Roundtables, and trauma-informed screening and assessment and trauma-focused treatment. Overall, almost 30,000 children and youth received one of the interventions during the Waiver.

Each of these interventions was associated with positive child safety and/or permanency outcomes. To understand the impact of Colorado’s Waiver, the

evaluation team conducted an evaluation of the five-year demonstration; the evaluation included a Process Study to describe how the demonstration was implemented and the context surrounding implementation, an Outcome Study to assess the state-level impact of the Waiver and the Waiver's impact on case-level safety and permanency outcomes and placement mix, and a Fiscal Study to explore the Waiver's impact on county spending and the State's use of revenue. Combined, the overall evaluation approach included a matched case comparison design and outcomes over time analysis, as well as process and fiscal analyses.

Each study answered specific research questions. Taken together, these seven questions are:

- What is the policy, organizational, and service delivery context that supports or surrounds implementation of the Waiver?
- How are CDHS and counties implementing the Waiver overall and in terms of each intervention?
- What is the case-level fidelity of each Waiver intervention, as defined by CDHS?
- What is the state-level impact of the Waiver on county child welfare outcomes and out-of-home care day use?
- What is the impact of the Waiver interventions on child and youth safety, permanency, and well-being outcomes?
- What effect does the Waiver have on child welfare expenditures in participating counties?
- What are the costs of Waiver intervention services received by children and families?

Multiple data sources were utilized across the three studies, including interviews and focus groups conducted during annual county site visits; State administrator interviews; a survey of kin caregivers; an annual county Implementation Index; Trails; CFMS; the FCDA (based on Trails); and an OBH survey. This final evaluation report includes detailed information for each study related to methods, data sources and data collection, sampling, data analysis, and results.

Major Findings

Below, the major findings from the Waiver are summarized, beginning with the outcomes results, followed by the fiscal findings and intervention-specific findings from all three studies.

Overall, the evaluation found that most counties decreased out-of-home care expenditures when the five years of the Waiver were compared to the previous three years. County staff reported positive practice shifts, and the reach and adherence of the interventions largely increased from the interim point of the Waiver. Counties

invested in additional staff for Waiver interventions (staffing levels increased); some counties reported reducing caseload sizes and enhancing supervision; staff skills and expertise in facilitation and engagement increased; and counties systematized processes for meeting the needs of relative caregivers. With the intervention funding and additional increases to their state allocation, counties did increase expenditures on non-foster care services, mostly in Direct County expenditures on staff and related expenditures. These increases more than offset the reductions in out-of-home expenditures.

However, the findings from the state-level analysis of out-of-home removal trends suggest that only one measured outcome changed during the Waiver period (increased likelihood of placement with kin) in the hypothesized direction and one outcome changed in the opposite direction (increased length of stay as represented by a decrease in the likelihood of discharge within six months). Even so, outcomes findings from the matched case comparison suggest positive intervention effects across all five Waiver interventions.

STATE-LEVEL ANALYSIS OF OUT-OF-HOME REMOVAL TRENDS

Keeping in mind the limitations of the pre/post design, the two strongest findings of the state-level Outcome Study analyses were an increase in the likelihood of being placed with kin and an increase in placement duration. A child coming into care for the first time in the baseline period prior to the Waiver had a 34% chance of initially entering a kinship placement; during the Waiver, this likelihood increased to, on average, 46%. This finding is echoed in the observed increase in kinship placement day usage and the findings in the Fiscal Study showing shifts in out-of-home placement costs. However, when taking into account the increasing use of kinship care prior to the Waiver, this finding does not persist. Duration overall increased during the Waiver period, as well as by placement type for all placement types except congregate care. Two outcomes—placement stability and re-entry—showed weak or no differences from before and during the Waiver.

FISCAL FINDINGS

Under the Waiver, changes in priorities, interventions, and placement mix resulted in a shift in overall expenditure patterns. While total child welfare expenditures increased by 8% (after controlling for inflation) over the course of the Waiver for demonstration counties, out-of-home care board and maintenance expenditures decreased by 5%. Netting out the decrease in out-of-home care board and maintenance expenditures, all other child welfare expenditures increased by 12%. The category of spending that increased the most (by 18% over the course of the Waiver) was Direct County spending. This increase in Direct County expenditures reflected a statewide push to explore and encourage services and supports for children and families beyond out-of-home placements and county choices to primarily invest in county staff to deliver these services rather than purchasing those services from contract providers.

During the Waiver, demonstration counties reduced the average daily unit cost of out-of-home care board and maintenance by 8% between SFY 2013 and SFY 2018. Nine of the state's ten large counties saw a decrease in average daily unit cost of out-of-home placement between SFY 2013 and SFY 2018, with four of those counties seeing a 17% or greater decline from SFY 2013 levels. This was achieved by a significant shift in placement mix from more restrictive to less restrictive placements, primarily by continuing to decrease foster care and congregate care days and increasing the use of non-certified kinship days. This decrease in average daily unit cost was a likely source of savings, estimated at \$69.8 million over the course of the Waiver.^u

INTERVENTION FINDINGS

Facilitated Family Engagement. Children and youth in both out-of-home and in-home cases who received FFE through the Waiver experienced enhanced safety and permanency outcomes. Compared to matched children and youth who did not receive the intervention, children and youth placed out-of-home who received FFE meetings had shorter cases; were more likely to be initially placed with kin; were more likely to spend all or most out-of-home case days in kinship care; were more likely to have no more than one placement disruption; were more likely to have permanency at case close and, specifically, to be reunified with their birth parents; were less likely to experience subsequent child welfare involvement; and were more likely to spend all or most of their subsequent case out-of-home days in kinship care.

And, compared to matched children and youth who did not receive the intervention, in-home children and youth who received FFE meetings had shorter case lengths. Almost all outcomes were better for out-of-home children and youth who received FFE meetings with higher adherence than out-of-home children and youth who received FFE meetings with lower adherence.

FFE was the broadest implemented intervention and counties had the most capacity to implement FFE, demonstrated through the Implementation Index. More so than the other Waiver interventions, some counties were implementing family meetings prior to the Waiver, which was reflected in high initial implementation scores. Further, Colorado's Social Service Rules (Volume 7) included expectation that county departments of human/social services engage with families, and many counties opted into the FFE intervention, at least in part, to meet this rule. Through the Waiver, counties implemented multiple FFE models—from FGDM to TDM—and some counties implemented more than one model to meet differing family or case needs.

County workforces grew through the hiring of FFE facilitators or coordinators, family finding staff, meeting scribes and support staff. The Implementation Index showed strong FFE staffing, though there was a decrease in staffing domain mean scores for medium and small counties during the fourth year of the Waiver, perhaps a reflection of decreased intervention funds allocated by the State.

The reach rate for FFE hovered around 84% for out-of-home cases and 69% for in-home cases, an increase from the interim point of the Waiver. Throughout the

^u Assuming that the mix of placement days would not have changed as they increased.

Waiver, there remained a sense that some families were “difficult to engage” and while almost all counties reported serving the entire target population, those families not served may have been those perceived as challenging to engage with (along with, in some cases, youth who received PRT rather than FFE). Across both in-home and out-of-home cases, holding the initial meeting on time was challenging—adherence was under 40%—confirming county sentiment that seven business days was an exceptionally strict initial meeting benchmark. Participation adherence was higher for out-of-home cases than timeliness and frequency adherence, and counties reported that it was challenging to hold timely meetings with all participants present. Therefore, counties may have chosen to accommodate participants’ schedules to prioritize rich, full meetings over initial meeting timeliness. In-home cases had high meeting timeliness adherence, which aligned with county reports that they were holding meetings much more frequently than the required 180 days for those cases.

Overall, FFE created new and creative avenues for involving families in discussion and decision-making, but it also created new avenues for intra-county collaboration, creating a group process for decision-making rather than leaving decision-making up to caseworkers and supervisors. The five-year demonstration allowed facilitators and supervisors to gain a sense of mastery and pride in their own work. Staff in one county said, “We’re confident. We feel good about what we do. It’s positive. People come here and they like it. People who’ve worked in other counties come here and they like it. People from other states come here and they like it. It’s just part of what we do.”

Kinship Supports. Children and youth whose caregivers received KS through the Waiver experienced enhanced safety and permanency outcomes. Compared to matched children and youth whose caregivers did not receive the intervention, children and youth whose caregivers received KS were more likely to spend all or most out-of-home case days in kinship care; were more likely to have permanency at case close; were more likely to exit their kinship placement to another kinship placement, guardianship, or adoption; and were less likely to experience subsequent child welfare involvement.

The KS intervention was designed to support and meet the needs of kin caregivers in order to prioritize and sustain kinship placements. During the Waiver, staff reported a dramatic increase in kinship placements over congregate care placements and credited this change, in part, to KS. The KSNA was widely used by those counties implementing the intervention to assess the needs of caregivers: 78% of eligible caregivers received an initial assessment, and 56% of those received it within seven business days of their case opening, indicating timely and prompt referral for and assessment of needs. While the Waiver allowed counties to purchase hard goods and tangible items for caregivers, it remained challenging for counties to fully meet the broad needs of caregivers; less than a third of caregivers had at least 75% of their reported needs met with an associated documented service, indicating remaining gaps in the service array. Like the other Waiver interventions, county capacity to implement KS varied by county size, with medium and smaller counties showing lower levels of implementation, especially around policies and procedures, and tools, such as the KSNA.

In addition to meeting the tangible needs of relative caregivers, the KS intervention helped meet the social and emotional needs of caregivers, through trainings, support groups, and through the addition of kinship-specific staff. Kinship staff, including Kinship Navigators, were largely seen as the primary benefit of the intervention; caregivers themselves reported turning to their Kinship Navigators (or other kinship staff) regularly, trusting staff, and receiving help from staff navigating child welfare and the logistical and emotional complexities of kinship caregiving.

Findings from the kinship caregiver survey showed that caregivers did not agree that the support provided by the county department led to more connections with other kin caregivers and/or parents, underscoring requests from kin caregivers during county site visit focus groups for more support groups or opportunities for informal peer support. These support networks should be nurtured by counties and expanded to include community stakeholders.

In many ways, the data related to kinship supports revealed the paradoxes experienced by kin caregivers: needing support but fearing to ask; loving the children in their care but struggling with the implications of kin caregiving, especially for grandparents or those on fixed incomes; grandparents wanting to support their children but protect their grandchildren; requiring county support but resenting the intrusiveness and requirements of the certification and home visit processes; needing to work to make ends meet but struggling with all of the daytime obligations required for caring for children and navigating child welfare. These paradoxes characterized the experience of kin caregivers in Colorado. However, underscoring the paradoxes was a near-universal sentiment from caregivers, captured through both focus groups and the caregiver survey: they would make the same choice all over again to provide care and support for their kin children.

Permanency Roundtables. Children and youth who received PRTs through the Waiver experienced enhanced permanency outcomes. Compared to matched youth who did not receive the intervention, youth 16 and older with an OPPLA goal who received PRTs were more likely to have at least one step-down in placement restrictiveness; were more likely to have more step-downs than step-ups in placement restrictiveness; and were less likely to emancipate. Youth who received PRTs with higher adherence and youth whose removal began during a year in which the county had Waiver funding, rather than prior to a funded year, had even stronger outcomes.

Compared to matched children and youth who did not receive the intervention, children and youth who were in care for 12 months or longer who received PRTs were more likely to spend all or most out-of-home case days in kinship care and were more likely to be living with guardians or adoptive parents at case close.

Permanency Roundtables were not as widely implemented as FFE or KS, though a handful of large counties in the state implemented PRT without Waiver funds and had been implementing the intervention for several years prior to the Waiver. County capacity to implement PRT was generally moderate or high, though medium and small counties had emerging implementation level scores in the policies and procedures and staffing domains.

CDHS identified two target populations for PRT: 1) youth 16 and older with an OPPLA goal and 2) all children in care for longer than 12 months. There was variance in reach, adherence, and county investment in the intervention between these two target populations. The first target population, rolled out during the first year of the Waiver, was widely seen as appropriate and in need of PRTs; these older youth had few permanency options and many were in congregate care. This population was contained both in terms of needs and the number of eligible youth; there were 632 eligible OPPLA youth in those counties implementing the PRT intervention during the Waiver, and those counties reached 75% of those youth with PRTs. During the second year of the Waiver, the intervention expanded to the broader population of all children and youth in care for 12 months or longer. Not only was it challenging for counties to serve this entire population—there were 4,520 eligible youth in care for 12 months or longer in counties receiving PRT Waiver funds—but there was concern about the relevance and appropriateness of the intervention for this population, especially very young children and children with pending adoptions or reunification. This was reflected in the reach rate for this population; counties conducted PRTs for just 30% of the eligible youth in this population. This reach rate may also reflect county capacity, as counties may have been underprepared to serve all children and youth in care for 12 months or longer. And in the absence of broad buy-in to the intervention for that target population, coupled with insufficient capacity, agencies prioritized specific children and youth over others, such as those seen as at risk of eventually having OPPLA goals or those in more restrictive settings.

When PRTs were seen as useful, county staff, community partners and youth themselves were bought into and invested in the intervention. PRTs necessitated collaboration with agency partners and with neighboring counties to fill external consultant roles. While GALs had some concerns about the suitability of PRTs for all eligible youth, counties reported increased buy-in across court and legal representatives as the Waiver progressed. Even so, participation adherence was low for both PRT populations, reflecting challenges for agencies in getting all required attendees to each PRT. Notably, while reach was lower for youth in care 12 months or longer, meetings were more often timely and consistent for those youth than for OPPLA youth.

Trauma Interventions. Compared to matched children and youth who did not receive the interventions, children and youth who received TSAT and CWRC were more likely to have no more than one placement disruption (TSAT only); were more likely to spend all or most out-of-home case days in kinship care (TSAT and CWRC); were more likely to have permanency at case close (TSAT); were more likely to live with non-adoptive kin at case close (TSAT); were less likely to experience subsequent child welfare involvement (TSAT), but if they did experience subsequent child welfare involvement, they were more likely to spend all or most of those out-of-home case days in kinship care (TSAT and CWRC).

The TSAT and CWRC interventions posed considerable challenge and opportunity for counties that chose to or were selected to implement these interventions. Because of the cross-systems nature of the interventions, both county departments of

human/social services and mental health providers had to adapt their practices and processes. Trauma care coordinators, hired by some counties through the Waiver, provided support in encouraging and facilitating cross-systems collaboration, as well as helping families navigate their benefits and available services. As the Waiver progressed, more counties implementing TSAT instituted regular, structured check-ins between child welfare and CMHC staff to touch base about cases and ensure that referrals were followed up on. While both entities prioritized child safety and well-being, the generalist caseworkers and mental health clinicians came from differing backgrounds and paradigms, with the former desiring prompt resolution that could facilitate family reunification and the latter emphasizing longer term, clinical intervention. In addition to growing collaboration, the intervention—through training—resulted in enhanced community capacity to provide trauma assessment and treatment.

While data limitations, which were illuminated earlier in the report, impacted the ability to calculate reach and adherence rates, there was a considerable increase in the number of trauma assessments completed from the interim point of the Waiver through the conclusion of the demonstration for the TSAT intervention—from 103 children receiving documented initial assessments at the interim point to 612 children receiving documented initial assessments by the end of the Waiver. And, underscoring reports during site visits that counties were increasingly focusing on family systems rather than just children, 47% of assessed children’s caregivers received adult PTSD assessments, too. Like the other Waiver interventions, county capacity to implement the TSAT interventions varied. Small counties, especially, reported low training domain scores; however, the Implementation Index scores for trauma are somewhat less meaningful than the other interventions, since fewer counties implemented the interventions and smaller counties implemented in regions.

Notably, the CWRC intervention also enhanced both the capacity of the counties involved to measure and assess child and youth well-being *and* child and youth well-being. Using both the CANS and TOP, well-being improved for all youth assessed in those counties from baseline to post. While well-being did not differ significantly between youth who received a trauma assessment and youth who did not, overall significant improvements were found from baseline to post for youth in both the treatment and control group, suggesting county-level practice and philosophical shifts. Through the intervention, over 883 youth were assessed for well-being. More information can be found in the CWRC Program Evaluation Report, attached as an annex to this report.

TSAT and CWRC resulted in systems-level changes, and counties intend to sustain those changes, though how to do so without flexible funding remains a question. Counties implementing CWRC have leveraged SAMHSA funds for components of the intervention. Moving forward, plans include continuing implementation of the trauma interventions while refining the model to address challenges experienced during the Waiver. Additional future plans relate to redefining or expanding target populations for the interventions. Possible ways in which the targeted population

might change include expanding eligibility to include young people served in other child welfare service program areas, such as prevention or adoptive services. Other considerations for future directions include developing trauma-informed assessments and services for parents as well as identifying other intervention outcomes, such as youth well-being.

Program/Policy Lessons Learned and Recommendations

Below are additional lessons learned and recommendations, including recommendations specific to the Family First Prevention Services Act (FFPSA).

Sustainability and Future Innovations

As Colorado transitions away from the Waiver and to the FFPSA, the State and counties will need to answer three main questions around continuing the services and interventions begun and strengthened under the Waiver within this new context. First, what is the county capacity for identifying children that are not in placement as “candidates” for out-of-home care? Identifying the candidates for preventative services is essential to defining the target population. Secondly, how can the State and counties demonstrate that the county-provided services, including FFE and KS, have the evidence-base needed to qualify under the FFPSA? The answer to this question will speak to how much Waiver funding will be able to be repurposed to the new preventive entitlement. And finally, given the tremendous progress made in shifting more placements to kin, in the absence of the Waiver funds to support the KS intervention, how will the State and counties provide supports and services to kin providers to continue this trend?

SUPPORTING KIN CAREGIVERS AND KINSHIP NAVIGATOR

The answer to the latter question may be, at least partially, in exploring options to certify a larger proportion of kin providers so that they receive assistance under the board and maintenance fee-for-service reimbursement framework—though there are certainly financial and logistical implications for CDHS and county departments of human/social services related to certification. Not only would increased certification rates support the State’s desire to continue the trend toward kin placements, it also reflects the needs identified by caregivers across the state. The kinship caregiver survey results showed that caregivers had concerns about finances, child emotional health, legal issues, and their own emotional support. Caregivers reported a need for additional financial and legal resources and support from the county to reduce the financial burden of raising kin children. Furthermore, there was lack of agreement by caregivers that they had been offered the opportunity to become certified. The increase in kinship care during the Waiver was primarily an increase in non-certified kinship care, which makes sense not only considering the challenges for caregivers related to certification and the requirements of certification but also because the KS intervention was a new, dedicated stream of revenue to address the tangible needs of caregivers. The site visits and kinship survey revealed that some caregivers did not recall being notified about certification as an option—both across counties and within

counties—and still had financial need even with the addition of KS. Given the identified financial burdens, perhaps additional messaging around the certification process should be provided to kin caregivers.

Because of the support available through the KS intervention, counties expressed concern about the conclusion of the Waiver and the implications for the intervention—whereas some counties expected to sustain kinship staff positions, there was less certainty about how counties would continue to meet the tangible needs of caregivers without flexible IV-E dollars. Colorado has been granted Kinship Navigator funds, which will allow for the continued support of caregivers in some counties. The following findings from the KS intervention should inform the emerging Kinship Navigator program in the state.

- The examination of the association between caregiver characteristics and kinship caregiver survey responses revealed a need to focus additional attention on caregivers from the 36-45 age group, male kin caregivers, and caregivers who are not grandparents to ensure that they are being supported appropriately.
- Findings from the kinship caregiver survey also showed that caregivers reported being somewhat surprised by the expectations of them as kin caregivers. During focus groups conducted throughout the Waiver, this was confirmed—caregivers reported confusion about expectations of them and lack of clarity around the resources and services available for kin. This implies that county departments of human/social services could enhance their recruitment materials and training opportunities to better prepare kin for becoming caregivers.
- Responses to the kinship caregiver survey did not show strong agreement from caregivers about the usefulness of the KSNA, and county staff themselves reported inconsistent use of the assessment. Some staff reported completing the assessment with caregivers, while others reported completing it on their own or simply using it as a guide for conversations with kin. Thus, while a strong tool with broad implementation, the KSNA should be reviewed by State, county, and caregiver representatives to potentially make enhancements in the questions and timing of the assessment, if it will be used under Kinship Navigator.
- Those counties that sustain KS, or implement Kinship Navigator, should consider serving those kinship cases with FFE as well. Our analyses indicated that children and youth in closed cases that received both FFE and KS were more likely than those that received KS alone to reunify with parents. Further, since FFE meetings serve as a platform for the identification of kin caregivers and to address the needs of caregivers, the overlap and continued integration of the interventions is warranted.

Given the impressive and continued shift toward kinship care in Colorado, sustaining support for caregivers, through Kinship Navigator or otherwise, is vital. The state-

level outcome analyses showed that compared to the pre-Waiver period, first admissions during the Waiver had a significantly higher likelihood of initially entering a kinship placement. When examined in a year-by-year model, this significant increase was true in each individual Waiver year as well, with the impact growing each year. Further, KS matched case comparison findings showed that a smaller percentage of children and youth (with closed cases) whose caregiver received the intervention experienced a founded or inconclusive re-report of abuse and/or neglect with a subsequent case open than their matched counterparts, demonstrating not only the possibilities of the intervention to provide home-like settings for children but also to keep them safe.

REDUCING USE OF CONGREGATE CARE AND ENHANCING RELATIONAL PERMANENCY

The FFPSA provides new opportunity for CDHS—and the counties—to provide some IV-E reimbursable preventative services to children and families in the absence of the Waiver. The Act also adds new requirements. For example, under the FFPSA, Colorado will likely need to further decrease the use of settings more restrictive than foster care, as federal payments for those placements will be significantly time-limited, and residential settings may need to meet Qualified Residential Treatment Programs criteria. While congregate care rates in Colorado decreased during the Waiver years—and there were positive PRT intervention effects—they remained at almost 18% at the end of SFY18.

Results from the state-level analysis of out-of-home removal trends showed that demonstration counties as a whole saw a significant decrease in the likelihood of youth being placed in congregate care. Among the TLC, four showed a significant decrease in the likelihood of being initially placed in congregate care on a first admission when comparing the pre-Waiver period (SFY2011-SFY2013) to the Waiver period (SFY2014-SFY2018), though all TLC showed a trend in the favorable direction, if not significant. And while the implementation of PRTs was challenging overall, youth 16 and older with an OPPLA goal who received PRTs were more likely than their matched counterparts to have at least one step-down in placement restrictiveness, and more likely to have more step-downs than step-ups, indicating that PRT is an appropriate practice to decrease the use of congregate care for older youth. Therefore, the State, and counties, may consider the continued, targeted use of PRTs to decrease statewide congregate care rates for older youth as the State transitions to the FFPSA. Some counties have cross-trained facilitators to lead both FFEs and PRTs; this practice should be further explored, as it may enhance the capacity of counties that are sustaining FFE to sustain PRT for older youth in the absence of Waiver funds.

It's important to note that while some of the permanency outcomes that were expected to shift for youth who received PRTs did not shift, there were other positive intervention outputs. Permanent connections for both PRT target populations increased. On average, children and youth in both PRT intervention groups increased their number of verified permanent connections by one person. Interestingly, those in the 16 and older with an OPPLA goal population increased more—by about 1.5 people—than the 12 months in care population, even though the 12 months in care

population was less likely to emancipate than the older population; this finding demonstrates that while counties have had success increasing permanent connections for older youth, it has been challenging to translate those connections to legal permanency. Even so, increased permanent connections convey that older youth are, on average, emancipating with stronger support networks through relational permanency.

Both youth and county staff reflected on the successes of PRTs, especially those successes not necessarily captured by a legal permanency status—such as increased numbers of positive connections for youth, enhanced relationships with friends and family, youth capacity to plan and prepare for the future, goal setting and goal attainment, and college preparedness and enrollment. However, as conveyed during PRT youth focus groups, some youth felt pressure to connect with individuals they did not wish to connect with; it felt to them as if they lacked agency or choice in determining which family members or other supports they should develop relationships with. Some youth felt that agency staff were upset when the youth didn't have more support people to reach out to; in this way, PRTs were sometimes experienced or internalized as blaming. It's important to note though that the majority of youth felt empowered through the PRT process.

While emancipation rates for youth 16 and older with an OPPLA goal did not shift as much as expected in the matched case comparison—and were still high at 74%—they were slightly lower than their matched counterparts who did not get PRTs, and 10% lower than the treatment group at the interim point of the Waiver. Further, those youth whose removals began during the Waiver were even less likely to emancipate (66%). This difference likely demonstrates not just the impact of receiving PRTs but also the system-impact of the intervention. That is, implementing a targeted permanency practice like PRT might shift philosophy and practice within an agency toward permanency, so that the phenomenon of being in an implementing county was itself impactful. As demonstrated through the Process Study, PRTs shifted the way agencies thought about youth goals, permanent connections, and custody options.

Therefore, in a future evaluation of PRT or other permanency initiative, a systems-level measure is recommended to assess the agency changes under the intervention (such as shifting casework practice), as well as outcomes for all youth served by the implementing agencies rather than just the youth who received the intervention. Further, the addition of a well-being measure is also recommended, such as the CANS or TOP used in the CWRC, to assess the holistic impacts of PRT or other permanency initiative on older youth whose legal permanency outcomes are challenging to budge.

PROVIDING TRAUMA-INFORMED SERVICES FOR FAMILIES

Considering the collaboration between DCW and OBH (at the state level) and child welfare agencies, CMHCs and other mental health providers (at the county level), through the trauma interventions, agencies should explore the continued use of trauma-focused treatments with an evidence base. For example, Trauma Focused

CBT, which is considered well-supported,^v was widely used through the TSAT intervention, and under the FFPSA, IV-E dollars may be used to fund promising, supported, and well-supported mental health services. Not only did the TSAT interventions enhance child, youth, and family access to trauma assessment and treatment, but the matched case comparison found that children and youth who received the intervention were more likely than their matched counterparts to live with birth parents, non-adoptive kin, non-kin guardians, or adoptive parents at case close, suggesting that providing trauma treatment is also impacting permanency outcomes.

In fact, statewide capacity to provide trauma services is expected to increase. Collaboration between child welfare and behavioral health to serve families impacted by trauma will be supported by the creation of formal entities tasked with facilitating easier communication, coordination, and collaboration between the two systems. These formal groups, titled Regional Accountable Entities (RAEs), will work to ensure the mental health needs of young people in foster care are prioritized and to help remove barriers to data collection and sharing between behavioral health and child welfare. Behavioral Health Organizations (BHOs) were replaced with RAEs in 2018. The Director of the Office of Behavioral Health noted that the documented prioritization of child welfare-involved children and youth for mental health and trauma services under the RAEs is an output of the Waiver.

Since all services under FFPSA are expected to be trauma-informed, CDHS and counties across the state might benefit from looking to the child welfare agencies that implemented the TSAT and CWRC interventions for lessons learned on shifting toward trauma-informed practices.

ADHERENCE TO FACILITATED FAMILY ENGAGEMENT

Across the state, counties reported plans to sustain FFE after the Waiver. The State reiterated these plans, with the Title IV-E Waiver Administrator noting, “I think Family Engagement is going to be quite sustainable... we have outcomes, obviously, to show for it. I think with it having standing in rule already, I think with it being so widely practiced universally, I think there really has been this idea that this is now how you do it. And I think we’ve also gotten deep enough into the project for people to realize there’s efficiency associated with Family Engagement, too.”

However, counties expected that the adherence of meetings and types of cases served were expected to shift in some counties. Some counties expected to loosen adherence requirements—to provide meetings less frequently or with fewer participants—in order to operate with fewer facilitators or to shift facilitator responsibilities. While some counties had secured internal funding for facilitator positions, others had not. In some counties, caseworkers solicited family input on if and how meetings should be retained. In those counties that indicated a change to which cases would be served through FFE when the Waiver concluded, court-involved and out-of-home cases were expected to receive priority over FAR or voluntary cases.

^v Through the California Clearinghouse for Evidence-Based Practice

Counties should take caution in reducing FFE model adherence, considering that children and families who received FFE meetings with higher adherence not only had stronger safety and permanency outcomes than the general FFE treatment group but also had stronger outcomes than children and families who received any other Waiver intervention. Those cases that received FFE with higher adherence were more likely to remain in-home during their case, had shorter case lengths, were less likely to have more than one case disruption (were more stable), were more likely to reunify with parents, and had more expedited permanency. Therefore, counties should target their post-Waiver FFE efforts not to reducing alignment with the model but to sustaining timeliness, frequency, and attendee adherence. If counties do not have the capacity to sustain the intervention for all cases, targeting meetings held to adherence for fewer cases rather than infrequent meetings or meetings with fewer participants for more families is recommended. If not, counties may still see some of the positive outputs of FFEs, such as enhanced experiences of inclusion by families, but these outputs may not translate to the safety and permanency outcomes desired.

INTERVENTION SUSTAINABILITY

As the Waiver concluded, the sustainability of the Waiver interventions was of concern to counties. As the five-year demonstration concluded, counties explored possibilities for sustaining Waiver practices by engaging in conversations with county commissioners around budgets and considering how to further collaborate with community providers for services. In the fifth year of the Waiver, some counties reported not yet having workable plans for sustaining practices developed under the Waiver, while other counties were planning to use Core Services funds to sustain the Waiver interventions, viewing them as vital to efficacious, engaging practice.

These are wonderful practices. The outcomes we've had from the Waiver may not be completely demonstrated through the federal outcomes, but the agency's relationship with families is better and it's hard to turn that particular cog in the systemic wheel. This practice is phenomenal.

County administrator

At least one county planned to access reserve funds put aside years ago to continue Waiver services. Other counties reported providing some of the Waiver interventions prior to the Waiver and planned to continue at least a minimal level of those practices after the Waiver ended; FFE was considered the most likely to be sustained, with KS—primarily the hard goods and services component, rather than the staffing component—being the least likely. However, Kinship Navigator funds will allow some counties to continue kinship services.

Other counties also shared plans to expand on their existing Waiver interventions. Examples included developing a “wraparound teen advocacy” model and providing 24/7 access to crisis intervention support for kinship providers or incorporating a trauma-focus into existing work.

In some counties it wasn't just the end of the Waiver that was expected to impact the intervention: budget cuts and cuts in the child welfare block grant allocation were already impacting counties even before the Waiver ended. While some counties were concerned about losing Waiver funds and the flexibility that accompanied them, other counties saw benefits to the conclusion of the Waiver in terms of more flexibility to shift or adapt interventions to work well for their families.

Relationships and collaborations between child welfare agencies and the courts were enhanced under the Waiver, and judges and GALs in particular were integral partners in the implementation and effectiveness of the Waiver interventions. Therefore, no matter which interventions are sustained, Colorado's counties should be in a strong position to meet the FFPSA requirement that judges and court staff are trained on child welfare policies and funding for placements other than foster care.



Colorado Title IV-E Waiver Final Evaluation Report Appendices

Appendix A: County Participation in Colorado's Title IV-E Waiver by Year

County Waiver Participation by Intervention and Year

COUNTY	FFE Meetings					Kinship Supports					Permanency Roundtables					Trauma Interventions			
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018	2015	2016	2017	2018
Adams	X	X	X	X	X	X	X	X	X	X	X	X	X	X					
Alamosa																X	X	X	X
Arapahoe	X	X	X	X	X						X	X	X	X	X	X	X	X	X
Archuleta		X	X	X	X		X	X	X			X	X	X					
Baca	X	X	X	X	X	X	X	X	X	X	X	X			X				X
Bent	X					X	X	X	X	X	X	X	X	X					
Boulder	X	X	X	X	X						X	X	X	X	X		X	X	X
Broomfield	X	X	X	X	X								X	X	X				X
Chaffee	X	X	X	X	X							X	X	X	X				
Cheyenne		X	X	X	X												X	X	X
Clear Creek						X													
Conejos																X	X	X	X
Costilla																X	X	X	X
Crowley	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Custer		X	X	X	X		X	X	X	X		X							
Denver	X	X	X	X	X				X		X	X	X	X	X			X	X
Douglas	X	X	X	X	X	X	X	X	X	X							X	X	X
Eagle				X		X						X							
El Paso	X	X	X	X	X						X	X	X	X	X	X	X	X	X
Elbert	X	X	X	X	X	X	X	X	X	X		X	X	X	X		X		
Fremont		X	X	X	X	X	X	X	X	X	X	X	X	X	X			X	X
Garfield	X	X	X	X	X	X		X				X	X	X	X				
Grand	X					X													
Huerfano	X	X	X	X	X	X	X	X	X	X									
Jefferson	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X
Kiowa	X	X	X	X	X	X	X	X	X	X	X	X			X				X
Kit Carson	X	X	X	X	X	X	X	X	X	X	X	X	X	X			X	X	X
La Plata	X	X	X	X	X		X	X	X		X	X	X	X	X				
Lake												X	X						
Larimer	X	X	X	X	X						X	X	X	X		X	X	X	X
Las Animas	X				X		X	X	X		X	X	X	X	X				
Lincoln	X	X	X	X	X	X	X	X	X	X		X	X	X	X		X	X	
Logan	X	X	X	X	X	X	X	X	X	X		X	X	X	X			X	X
Mesa	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Moffat		X	X	X	X	X						X	X	X	X				
Montrose	X	X	X	X	X	X	X	X	X	X		X	X	X		X			
Morgan														X	X				
Otero	X	X	X	X	X	X	X	X			X	X	X	X	X				
Ouray			X	X	X			X	X	X			X	X					
Park	X	X	X	X	X														
Pitkin	X	X	X	X	X	X		X	X			X	X	X	X				
Prowers	X	X	X	X	X	X	X	X	X	X	X	X		X	X				
Pueblo	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X				
Rio Blanco			X	X	X	X		X	X	X		X	X	X	X				
Rio Grande																X	X	X	X
Routt						X						X							
Saguache																X	X	X	X
San Juan	X	X	X	X	X		X	X	X		X	X	X	X	X				
San Miguel			X	X	X			X	X	X			X	X					
Summit	X	X	X	X	X	X													
Teller	X	X	X	X	X	X	X	X	X	X			X	X	X				
Weld	X	X	X	X	X						X	X	X	X	X	X	X	X	
Yuma	X	X	X	X	X	X	X	X					X	X	X				
Total	35	37	40	41	41	29	25	30	28	22	21	35	34	35	31	10	16	18	19

Appendix B: Intervention Checklists



Permanency Roundtable Checklist
Title IV-E Waiver County

* Complete on each Youth every 6 Months

Client
ID#:

County: _____ Date: _____

Roundtable Make-up

- Caseworker
- Caseworker's Direct Supervisor
- Scribe
- Master Practitioner/Facilitator
- Internal Consultant
- External Consultant
- Administrator

Scheduling

- Transition Roundtable scheduled prior to leaving
- Quarterly Roundtable follow-up scheduled or discussed

Facilitator Observations

- Establishing a non-blaming atmosphere
- Setting a tone for a strength base, solution focused consultation
- Soliciting inclusion from all participants
- Demonstrating respect for all participants
- Balancing support for worker and supervisor while promoting sense of urgency for permanence
- Encouraging multiple brainstorm strategies for consideration
- Encouraging broad participation in the implementation of the Action Plan
- Strategic use of leadership role

Comments regarding any box NOT checked:

Phase 1: Welcome and Overview

- Establish Purpose, process and expectations
- Set stage for appreciative listening

Phase 2: Present the Case

- Case overview without interruption
- Use of allocated time
- Additional information provided by other with knowledge of the case

Phase 3: Clarify and Explore

- Non-blaming inquiry
- Resisting tendency to offer "brainstorming" strategies
- Exploration of worker/supervisor perceptions
- Questions, when answered, support creative thinking and strategy formulation

Phase 4: Brainstorm

- 5 key questions directly or indirectly highlighted
- Creativity, "no bad ideas"
- Willingness to step outside traditional services
- Ideas generated in all 5 areas

Phase 5: Create Permanency Action Plan

- Specificity and concreteness (SMART)
- Impact potential
- Realistic
- Team shares responsibility
- Caseworker willingness and investment

Phase 6: De-Brief

- How can worker best explain the Action Plan to families, youth and key stakeholders?
- Are there any unanswered questions or concerns?
- What did we learn in this Roundtable that could be applied to other cases?



**Family Engagement Checklist
Title IV-E Waiver County**

Family Engagement means joining with the family/kin to establish common goals of safety, well-being, and permanency through the involvement and is inclusive of other systems. This is an overarching theme of practice throughout service assessment, planning and delivery.

County: _____ Household #: _____ Date: _____

Family Preparation

REQUIRED

- Understand purpose, live decision-making
- Role of the Department, who Department can bring to the meeting
- Expectations of the Department, what can the family expect
- Family roles and expectations
- Who can the family bring, why they want to bring these individuals
- Meeting process and agenda, potential safety concerns and solutions
- Provide copy of written appeal process
- Copy of report for the meeting and any plan developed at the meeting

RECOMMENDED

- Levels of confidentiality, who and what can be shared
- Rights and responsibilities
- Consent
- What to bring

Staff Preparation

- Facilitator is impartial
- Facilitator is not connected to the case
- Staff in attendance prepared and trained in Family Engagement Meetings

Time and Location of Meeting

- The family provided input regarding the date, time, and location of the meeting
- The Department was flexible in determining the date, time and location of the meeting

Involvement

- Parent(s) in attendance
- Absent parent involved in meeting
- Youth/child in attendance or involved in meeting should attendance not be appropriate
- Family Identified Support in attendance
- Interpreter services present for non-English and/or deaf participants

Timeliness

Family Engagement meeting conducted at determined decision points:

- Case Open - within 7 business days *
- Within 7 business days of initial placement (If case opened due to removal, only one meeting necessary)
- Every 90 Days during Out-of-Home placement

- Every 6 Months when provided In-Home services to an open case

Family Engagement Meeting Process

FACILITATOR

- Provides a structure meeting, facilitating a process
- Assures safe environment
- Assures use of family-friendly language, including no use of acronyms
- Defines issues, goals, and options to address concerns
- Leads a strength-based, solution-focus process
- Remains impartial throughout the meeting
- Assures everyone has a voice, all voices are heard, and everyone is engaged
- Supports participants in problem solving
- Moves group toward consensus, assisting participants through the process
- Provides summary report

CASEWORKER

- Provides facilitator with specific concerns to include: circumstances, safety, cultural, and/or adaptive (No-Contact orders, large group attendance, interpreter, child care needs, etc.)
- Actively participates
- Provides honest and open dialogue
- Articulates safety, risk, needs for all concerned, sharing the safety and risk tools
- Articulates a clear understanding of Department involvement
- Shares strengths of the family
- Remains open-minded to the family's input
- Prepared to assist in solution development with knowledge of community and multi-systemic resources
- Moves group toward consensus, assisting participants through the process
- Provides summary report

SUPERVISOR

REQUIRED

- Supervisor or other member present to authorize services within the same day of the meeting

RECOMMENDED

- Available for support and consultation
- Clarifies information, provides resources on agency, policy, resources, and/or requirements
- Voice and representative of the Department's perspective

Documentation

- Family Engagement meeting entered into Trails
- Documented Plan provided to the family

Kinship Supports Checklist Title IV-E Waiver County

County: _____ Kinship Family: _____ Date: _____

Category I - Case Management Services

ASSESSMENT

Kinship Needs Assessment completed within 5 business days of initial contact by county

STRENGTH-BASED CONSULTATION AND SUPPORT

Kinship Supports Worker assigned to individual family

Kinship Supports Worker initial contact made face to face

Ongoing contact type based on kinship family discretion and diligent efforts to engaged documented

Contact include:

Discussion of kinship family's concerns

Crisis intervention

Expectations of the Department

Conflict resolution

Problem solving

Other: _____

PLAN DEVELOPMENT

Develop workable plans to address:

Short term needs

Sustainability of placement

Long term needs

Financial needs moving forward

Permanence

Other: _____

SERVICE COORDINATION

Kinship Supports Worker coordinates services to meet the needs of kinship family

Kinship Supports Worker communicates with child/youth Caseworker

Kinship Supports Worker communicates with providers

NAVIGATION

Kinship Supports Worker provides kinship family with information and referral services

Kinship Supports Worker assists kinship family with navigating support services to possibly include: TANF, Medicaid, Child Welfare, legal, and other community services

Kinship Supports Worker assist kinship family with accessing provided orientation and/or training

ONGOING ASSESSMENT

Kinship Supports Worker routinely completes and/or updates the Kinship Supports Needs Assessment

Category II - Kinship Support Services

Kinship Supports Worker ensures Immediate and Ongoing Needs met as assessed on the Kinship Supports Needs Assessment

OPTIONAL

In addition to the needs encompassed in the Kinship Supports Needs Assessment:

Attendance at Family Engagement Meeting

Services to support placement stability

Attendance at Court as kinship family support

Intensive Family Finding efforts

Attendance at IEP/school meeting

Other: _____

Appendix C: Kinship Supports Needs Assessment

Kinship Supports Needs Assessment

Provider Name: _____ Date: _____
 # of Children in Your Care: _____ Ages of Children: _____ Relationship to Children: _____ Date of Placement: _____

This assessment is designed to help identify and prioritize you and your family's needs. We want to assist with meeting these needs to support you providing care. **Please indicate your needs below by circling a number: 1 - no need, 2 - low need, 3 - moderate need, 4 - high need, and 5 - urgent need.**

INITIAL NEEDS						COMMENTS
	NO	LOW	MOD	HIGH	URGENT	
Clothing	1	2	3	4	5	
Baby Items (Car Seat)	1	2	3	4	5	
Bedding (Beds/Cribs)	1	2	3	4	5	
Food	1	2	3	4	5	
Rent/Utility Assistance	1	2	3	4	5	
Child Care	1	2	3	4	5	
Emergency Financial Support	1	2	3	4	5	
Medical Assistance for Child/Self	1	2	3	4	5	
Transportation	1	2	3	4	5	
Hygiene Products	1	2	3	4	5	

ONGOING NEEDS						COMMENTS
	NO	LOW	MOD	HIGH	URGENT	
Training/Support:						
Financial (TANF/Child Support/SSI/Snap/Food Stamps/ Nutrition/WIC)	1	2	3	4	5	
Advocating for Child/Self	1	2	3	4	5	
Budgeting (Credit Counseling)	1	2	3	4	5	
Parenting/Discipline/Rules/Boundaries	1	2	3	4	5	
Child Development	1	2	3	4	5	
Nutrition	1	2	3	4	5	
Home Safety/Childproofing	1	2	3	4	5	
Child Exposure (Domestic Violence/Substance Abuse/Sexual Abuse/Trauma)	1	2	3	4	5	
Family Communication (Bio Parents/Extended Family)	1	2	3	4	5	
Role Definition	1	2	3	4	5	
Education (School Enrollment/Tutoring/ Mentoring/IEP/College)	1	2	3	4	5	

ONGOING NEEDS**COMMENTS****Mental Health Services:**

NO LOW MOD HIGH URGENT

ADHD/ADD

1 2 3 4 5

Children and Trauma

1 2 3 4 5

Stress Relief

1 2 3 4 5

Grief and Loss

1 2 3 4 5

Anger Management

1 2 3 4 5

Conflict Resolution

1 2 3 4 5

Family Counseling

1 2 3 4 5

Individual Counseling

1 2 3 4 5

Other Services:

Respite

1 2 3 4 5

Activities

(Child/Self/Summer Programs)

1 2 3 4 5

Support Group

(Child/Self)

1 2 3 4 5

Employment Resources

1 2 3 4 5

Legal Issues

1 2 3 4 5

Other: _____

1 2 3 4 5

IDENTIFIED SOCIAL SUPPORTS – Who can you count on? How can they help?

Immediate/Extended Family Member: _____

Neighbors/Friends: _____

Church: _____

Community Based Organizations: _____

Others: _____

MOVING FORWARD

What is the greatest strength you bring as a kinship caregiver? _____

What is your greatest worry in being a kinship caregiver? _____

Plan to Address Needs and Next Steps: _____

Appendix D: Waiver Theories of Change

WAIVER THEORIES OF CHANGE

Theory of Change: Underlying the waiver plan is the basic belief that lack of comprehensive family and kin involvement when a referral is made to the county department causes additional harm to the child or youth due to unnecessary out-of-home placements. In addition to changing agency culture, the implementation of the waiver through use of family engagement, Permanency Roundtables, trauma-informed assessment and treatment, and kinship supports will result in better long-term outcomes for children and youth.

Theory of Change for Children and Youth in their own Home

Title IV-E Waiver interventions including family engagement, Permanency Roundtables, kinship supports, trauma-informed assessment, and trauma-informed treatment are provided;

SO THAT

Families, including parents and kin guardians, are actively engaged in identifying needed in-home services and supports;

SO THAT

The county and their community partners can offer the services and supports necessary for families, including trauma-informed treatment and other services;

SO THAT

The behavioral and mental health needs of children/youth can be addressed;

SO THAT

Families can care safely for their children and youth and address their children and youth's well-being needs;

SO THAT

The likelihood that children/youth in contact with the child welfare system are removed from their home is decreased;

SO THAT

Child and youth experience improved safety, permanency, and well-being.

Theory of Change for Children and Youth in Out-of-Home Placement

Title IV-E Waiver interventions including family engagement, Permanency Roundtables, kinship supports, trauma-informed assessment, and trauma-informed treatment are provided;

SO THAT

Families, kin, and other permanency resources are engaged early;

SO THAT

Children and youth's well-being and permanency service needs and supports are assessed at the time of their removal from the home;

SO THAT

Children, youth, families and kin receive services and supports to move children and youth to permanency safely and as quickly as possible;

SO THAT

Children/youth entering out-of-home care are more likely to be placed with kin and less likely to be placed in congregate care;

SO THAT

Children and youth's well-being and safety needs are met through living in home-like permanent settings as quickly as possible.

THEORY OF CHANGE for FAMILY ENGAGEMENT

A neutral, independent, trained facilitator to coordinate, document and run the family engagement meeting leads the family meeting;

SO THAT

Upon determining that services are needed following the assessment phase of casework and in ongoing cases, families are offered routine family engagement meetings (family must have open case);

SO THAT

The family will meet with the facilitator and county staff along with their formal and informal supports;

SO THAT

Families feel valued and supported, and acknowledged as the experts on their children/youth/family;

SO THAT

Caseworkers and staff are provided with more insight into their families, increasing their ability to support children/youth/families;

SO THAT

A collaborative supportive plan might be developed to administer services and assist families in making the sustainable behavioral change necessary to resolve worries about their child/youth's safety;

SO THAT

Families will be more likely to understand and agree with, and act upon the plan and to utilize all identified supports to move forward;

SO THAT

Children and families receive the services and supports they need to meet the needs identified in the assessment

SO THAT

Children and families experience

There will be a decrease in repeat maltreatment after services and an increase in families being able to care for their children and youth safely;

AND

Children and youth, if removed, will be successfully reunified with their families in a timely and safe fashion;

AND

Children and youth, if reunification is not possible, will experience supportive kinship placements and timely permanence; or experience timely permanence if Termination of Parental Rights occurs and kin are not available.

THEORY OF CHANGE for PERMANENCY ROUNDTABLES:

Permanency Roundtables are implemented;

SO THAT

Caseworkers and other key stakeholders have increased knowledge about the details of the youth's case history, their possible connections, and permanency supports in order to understand what has or has not worked for the youth historically;

SO THAT

Youth with an Other Planned Permanent Living Arrangement Goal and their identified family, kin and professionals are engaged in planning for the youth's permanency;

SO THAT

There is a fresh perspective and ideas on appropriate actions for different permanency options and it is known what the youth desires;

SO THAT

All permanency options are explored and a Permanency Action Plan is developed;

SO THAT

Resources and supports can be provided to implement the Plan by identifying permanency resources and barriers (i.e. addressing financial/administrative barriers);

SO THAT

Permanent connections are identified for the youth;

SO THAT

There is an increase in permanency;

AND

A decreased likelihood of placement in congregate care;

AND

A decrease in the length of stay in out-of-home care.

THEORY OF CHANGE for KINSHIP SUPPORTS (Population One):

Kinship support training is provided

SO THAT

Caseworkers are more knowledgeable about family perception, the issues, and development of rapport and trust with the family occurs;

SO THAT

Kinship supports are provided to potential and current kinship placements;

SO THAT

At the onset of the case, the extended family is engaged by the caseworkers to participate and help identify issues and solutions that brought them into the system;

SO THAT

Kin have a clear understanding of the safety concerns and their role in protecting the children and youth by providing care for them;

SO THAT

When the kin become the placement resource, their need for support and resources are identified and provided;

SO THAT

Children and youth can be safely cared and permanently cared for in a manner that preserves their cultural and familial connections, reduces their length of stay in care, and reduces the likelihood that children/youth will be placed in congregate care.

THEORY OF CHANGE for KINSHIP SUPPORTS (Population Two):

Kinship support training is provided

SO THAT

Caseworkers are more knowledgeable about family perception, the issues, and development of rapport and trust with the family;

SO THAT

Kinship supports are provided to kin;

SO THAT

At the onset of the case, the extended family is engaged by the caseworkers to participate and help identify issues and solutions that could otherwise cause entry or re-entry into the child welfare system;

SO THAT

Kin have a clear understanding of the safety concerns and their role in protecting the children and youth;

SO THAT

Families are fully informed about their options and the kin experiences increased satisfaction in their work with the caseworker;

SO THAT

If the kin become the placement resource for a child/youth, their need for support and resources are identified and provided;

SO THAT

Children and youth can be safely cared for in a manner that preserves their cultural and familial connections and there is a decreased likelihood that children/youth will be removed from their home;

SO THAT

Children and youth have permanency and do not enter or re-enter the child welfare system, and the children, youth and kinship family's needs for their well-being are met.

Theory of Change

Children/youth are systematically screened for trauma;

SO THAT

Children/youth who have experienced trauma and the trauma is negatively impacting their functioning are referred for assessment;

SO THAT

Children/youth receive a trauma-informed assessment by their Community Mental Health Center or Behavioral Health Organization in a timely manner;

SO THAT

Children/youth that are assessed as in need of trauma-informed treatment access individualized and appropriate evidenced-based services and practices within their own community;

SO THAT

Children/youth participate in trauma-informed treatment;

SO THAT

Children and youth experience a reduction in trauma symptoms;

AND

Children/youth feel supported by county child welfare Departments, CMHCs, and Behavioral Health Organizations (BHOs) to address the impact of their trauma;

AND

Children/youth have decreased over-reliance on psychotropic medications;

SO THAT, AS APPROPRIATE

Children/youth have decreased likelihood of being removed from home into foster care;

OR

Children/youth have decreased likelihood of congregate care placement;

OR

Children/youth remaining in home, or children/youth in out-of-home care are stable;

OR

Children/youth have an increase in likelihood of permanency through reunification, guardianship, or adoption;

SO THAT

Children/youth have improved well-being demonstrated by their functioning

Appendix E: Waiver Logic Models

FAMILY ENGAGEMENT^a LOGIC MODEL (8/15/13)

INPUTS	PROCESS	OUTPUTS	OUTCOMES
<p>1. Target population: Received report of A/N (PA 5) or youth in conflict (PA 4), and assessed in need of services or placement (need to open case).</p> <p>2. Trained Facilitator, Impartial/ Neutral^b</p> <p>3. Caseworkers^c</p> <p>4. Community Services^d</p>	<p>1. Caseworker notifies facilitator of new case (via referral form)</p> <p>2. Caseworker schedules initial meeting to be held within 7 days of case opening or initial placement (i.e. within 69 days of the report).</p> <p>3. Facilitator or caseworker prepare family^e, child, all participants</p> <p>4. Facilitator/caseworker and family identify who should be at the meeting, with an emphasis on identifying a wider array of natural supports^f</p> <p>5. Meeting scheduled at a time that works for the family; with the option of holding it in a community-based location</p> <p>6. The meeting has an established process/structure. The meeting may discuss: safety concerns; risk statements; the family's understanding of what is happening; what is going well; complicating factors and risks/barriers; identification of extended family members; what services to put in place, timeframes, who is paying for them; plans to prevent removal; transition planning; establishing parenting time.</p> <p>7. Facilitators distribute a summary report outlining decisions to participants. Facilitator follows-up with all parties in between meetings to check on progress.</p> <p>8. Subsequent meetings occur at least every 90 days if the child is living with kin or in OOH placement; at least every 6 months if the child is at home</p>	<p>1. Parents attend^g</p> <p>2. Family feels heard, respected, understands safety concerns and what they need to do^h</p> <p>3. Appropriate services are identified and referrals are authorizedⁱ</p> <p>4. All participants are aware of next steps, responsibilities, timeframe^j</p> <p>5. Participants are held accountable to follow-through on services^k</p> <p>6. Kin are identified who can sustain support, assure safety and/or mitigate risk (e.g. becoming part of a safety plan, providing placement or permanency)^l</p> <p>7. Parents improve their capacity to protect^m</p>	<p>1. Case not opened</p> <p>2. Case doesn't need to be court involved (i.e. voluntary)</p> <p>3. Children remain safely at home (decrease in removals)</p> <p>4. Placement is in least restrictive setting (increase in kinship placements, decrease in use of congregate care)</p> <p>5. Decreased length of stayⁿ</p> <p>6. Decreased re-entry to care^o</p> <p>7. Decreased reoccurrence of maltreatment^p</p> <p>8. Adoption and relative guardianship more timely^q</p>

^a This logic model focuses on family meetings, the activity common to all Waiver counties. In addition, some counties may be doing other activities to promote family engagement.

^b While they should be impartial, the facilitator should have information on the specific family dynamics going into the meeting, if available (i.e. no-contact orders, large group attendance, interpreter, child care needs). Facilitators should be trained on how to engage families; lead a strength-based/solution-focused process; provide summary report outlining decisions to participants; remain impartial throughout the meeting, assure a safe environment, that everyone has a voice, all voices are heard and everyone is engaged; support participants in problem solving; move group toward consent/consensus; define issues, goals, and options/plan for addressing it; and assure shared understanding of common language/hold the group accountable to use family-friendly language.

^c Caseworkers should be prepared to carry out their role: actively participate; communicate honestly and openly; articulate safety, risk, and needs for all concerned (share safety and risk tools); articulate a clear understanding of why department is involved; articulate the family strengths; use family input (be open-minded); brief facilitator about specific safety, cultural, and adaptive concerns/circumstances; be prepared with knowledge of community and multi-systemic resources

^d Services need to have capacity to serve child welfare clients. Service providers need some orientation to or awareness of the family meeting process.

^e Family preparation should include information on the meeting purpose; role/expectations of the department; meeting logistics (including soliciting input on the time the meeting is scheduled, and determining needs for interpreter or child care); family role/expectations/rights and responsibilities; how confidentiality will be handled in the meeting; how consent is determined; what to bring; who to bring, why support should be present; the appeal process; and that they will be provided a copy of the report or plans from the meeting.

^f At a minimum the parents, caseworker, and facilitator must be present in order to have a family meeting. Emphasis is on including family, youth (if developmentally appropriate), extended family, and supports identified by the family. Supervisors should attend when available, possible, and appropriate (e.g. if the supervisor also supervises the facilitator, may become difficult for the facilitator to maintain neutrality). Other participants may include service providers for the child or parent, attorneys, and other staff from the department (e.g. intensive family supports, visitation, scribe).

^g As a result of being adequately prepared, having supports with them, and the meeting being scheduled at a time and location that works for them.

^h As a result of having their culture respected, cultural needs addressed (including but not limited to use of translator, if appropriate), being prepared, having supports with them, having the participation of a prepared caseworker who clearly states the safety concerns, and the structured process facilitated in the meeting.

ⁱ As a result of having a wide range of participants in the discussion, discussion with the family of what services they believe would work for them, and having a supervisor or someone who can authorize service referrals in the meeting or on site.

^j As a result of distributing a plan or meeting notes.

^k As a result of having a having a plan for a follow-up meeting where progress will be checked.

^l Kin could be identified in the preparation phase or through the family meeting process.

^m As a result of discussion in the meeting (which may include the use of risk statements), parents learn their role in the case and what they need to do to protect their children. The department and service providers better recognize parents' capacities so that they can be used as part of a strengths-based plan.

ⁿ Because more appropriate service referrals are made, and participants are held accountable for their part in the plan, safety concerns are addressed more quickly.

^o Because family is more connected to kinship and community supports to meet their needs, and parental capacity to protect is improved.

^p Because family is more connected to kinship and community supports to meet their needs, and parental capacity to protect is improved.

^q Because cases are revisited on a regular basis.

KINSHIP SUPPORTS LOGIC MODEL (10/21/13)

INPUTS	PROCESS	OUTPUTS	OUTCOMES
<ol style="list-style-type: none"> 1. Designated Kinship Supports Worker (KSW)¹ 2. Target populations: <ul style="list-style-type: none"> • In OOH non-kin placement • In Kin placement² • Not in CW system³ 3. Services in community 	<ol style="list-style-type: none"> 1. Training for KSW, Kinship caregivers (KCG), casework staff, and community partners⁴ 2. Do comprehensive assessment of KCG needs⁵ <ul style="list-style-type: none"> • Within 7 days of child placed with kin and ongoing⁶ 3. Assure home safety <ul style="list-style-type: none"> • Immediately for emergency placement • Emergency consultation among staff to stabilize and prevent disruption • Consistent use of safety plan⁷ 4. KCG participate in Family Engagement Meetings⁸ <ul style="list-style-type: none"> • Develop skills of facilitator to deal with interaction of KCG and parents 5. Identify kin (potential caregivers and supports) via family meetings, and word-of-mouth⁹ 6. KSW contacts KCG on an ongoing basis¹⁰ 7. Develop KCG support plan¹¹ 8. Educate community partners¹² regarding kin supports and kin placements 9. KSW develop resources for KCG¹³ 10. Develop network to connect kin to each other 11. Regular contact between KSW and family caseworker 12. Provide specific kinship services (required and optional)¹⁴ 	<ol style="list-style-type: none"> 1. KCG offered consistent and sufficient support from KSW¹⁵ 2. Community has enriched service array to support KCG 3. KSW are more knowledgeable¹⁶ 4. Staff are more educated about dynamics of kin placement and are more supportive with accessing services in the community 5. KCG has increase in skills¹⁷ and greater willingness to continue as KCG 6. KCG has more connections and knows how to get help¹⁸ 7. More Kin come forward to be KCGs¹⁹ 8. Increased percentage of KCG needs assessments completed within 7 days after placement or first contact 	<ol style="list-style-type: none"> 1. Greater number of children in kinship permanency 2. For children in temporary placement: <ul style="list-style-type: none"> • increased proportion living with kin • greater proportion of time in temporary placement spent with KCG 3. Increased number of children who step down from OOH non-kin placement (specifically congregate care) to kinship or kinship foster placement 4. Shorter time from kinship or kinship foster placement to permanency (reunification, adoption, guardianship) 5. Improved placement stability 6. Children better able to maintain connections,²⁰ have greater sense of belonging, and have more connections to family and community 7. Child experiences less stress/trauma 8. More stable well-being outcomes for child (mental health, behavioral health, educational) 9. Less disruption/failed kin adoptions 10. Less financial stress for KCG family 11. Increased percentage of children in kinship foster placements who exit to guardianship²¹

¹ The Kinship Supports Worker (KSW) is preferably a separate person from the family caseworker, but this will vary based on the size and capacity of the county. The family caseworker might do the initial assessment and then turn it over to the KSW, which will require the family caseworker and KSW to work collaboratively. Kinship navigator tasks are included in case management, which is the role of the KSW, in addition to providing other supports.

² Expanded definition of kin (see pick list for relationship to child). Focus on supports for certified and non-certified KCG.

³ For example, KCG seeking information and referral (I&R) and hard goods.

⁴ The training will be county provided. The training will cover topics such as: safety concerns in kinship settings, what it takes to help KCG succeed, especially families who have no experience with the system, and what are safety guidelines for certified and non-certified KCG.

⁵ Needs assessment not entered into Trails, resides in the case file.

-
- ⁶ Required to do a second assessment unless for a KCG seeking I&R or hard goods (e.g., TANF families). There is no defined time to complete the second assessment, based on needs of KCG.
- ⁷ Different requirements for completing safety plan for different kinship arrangements. Existing kinship placements do not have to complete a safety plan. New kinship placements have to complete the safety plan. Safety plans may also vary depending on type of supports being provided.
- ⁸ Relates to optional support of “attending family meetings” if family requests that KCG attends. The KCG should be prepared relative to playing a supportive role in the meeting. The KSW may also be invited to attend family meetings.
- ⁹ Look into enhanced means to identify kin (including absent fathers) through enriched and intensive (i.e., more than usual) means (e.g. getting kin into the family meeting process).
- ¹⁰ Encouraging monthly contact but based on family preference. For non-cases, the contact might be for a one-time need or by family request.
- ¹¹ The support plan is embedded in the needs assessment for all populations.
- ¹² Especially important for the following community partners: court, GAL, and attorneys, although necessary for staff in other agencies as well. The intent is to educate partners about family supports, not to facilitate the recruitment of more KCG. That is a role of intensive family finding and family engagement, not the kinship supports intervention. This is more about word-of-mouth within specific cases to have kin come forward as a KCG.
- ¹³ KSW learn from others in DHS about what resources are available in agency and in community.
- ¹⁴ Respite, child care, basic hard goods, transportation, recreational activities, therapeutic and educational services are required kinship supports (although only if there is a need). Optional supports include other agency supports to maintain kinship placement, going to court with KCG, attending IEP with KCG, and other service referrals as needed.
- ¹⁵ Consistent and sufficient support may also be provided by family caseworker and/or other agency staff. The level of support is based on family need and county capacity, especially around meeting long-term needs.
- ¹⁶ KSW are more knowledgeable (than before providing supports) about community resources, kin family dynamics, family engagement, assessing and meeting KCG needs.
- ¹⁷ Increase in skills for handling relationship with birth parents, handling kinship care role, and in ability to maintain own support network.
- ¹⁸ KCG feeling more supported, increasing their capacity to meet placement needs of child, demonstrating better coping skills, and learning how and when to ask for assistance.
- ¹⁹ More KCG coming into or being recruited into the system is not an overall goal of the kinship supports intervention. This is a case-specific goal that kin step-up to serve as a KCG.
- ²⁰ To peers, siblings, family, and social/spiritual community.
- ²¹ Must go through kinship foster care placement to access guardianship.

LOGIC MODEL for PERMANENCY ROUNDTABLES

INPUTS	PROCESS	OUTPUTS	INTERMEDIATE OUTCOMES	LONG TERM OUTCOMES
<ol style="list-style-type: none"> 1. Target population: a) youth over age 16 in OPPLA, b) youth under age 16 in OPPLA, c) children/youth in care more than 12 months¹ 2. All staff are trained² 3. Partners and stakeholders are trained 4. Coaching model to ensure fidelity to the PRT model and improve staff competence. 5. Community resources 	<ol style="list-style-type: none"> 1. Youth are identified as eligible for PRT when administrator signs off upon designation of OPPLA goal or CWSA review. Scheduling process is determined by the county. 2. Caseworker PRT meeting is held. The meeting includes key staff³ and has an established structure which includes case presentation, brainstorming, action plan creation, and debrief. 3. Action plan may suggest undertaking intensive family finding or diligent search effort. 4. Youth is prepared for Youth Voice meeting, based on action plan developed at the caseworker meeting 5. Youth support(s) (identified by the youth) are prepared for PRT, based on their role (caregiver, birth parent, other) 6. Youth Voice PRT meeting held within 90 days of the initial caseworker PRT to rework the action plan with youth input. 7. Follow-up Youth Voice meetings held quarterly⁴ to monitor the action plan, assure progress towards permanency, review permanency status rating, and develop new goals as needed. 	<ol style="list-style-type: none"> 1. Key staff develop a Permanency Action Plan which includes acknowledgement of the barriers to permanency and how they may be addressed. 2. Youth, stakeholders and relatives/nonrelatives/vested adults participate in reworking the action plan and addressing barriers. 3. Placement providers understand the options for permanency⁵ 4. Community resources that can meet youth needs are identified and improved 5. Resources are provided so that youth needs for the following are addressed⁶: permanent connections, a place to live, financial and emotional support, connections to siblings, post adoption supports, mental health treatment, behavioral health treatment, substance abuse treatment, educational supports, and other needs. 	<ol style="list-style-type: none"> 1. Youth have increased social support; each youth has at least one permanent connection. 2. Youth have increased connections to kin, who can become a permanent connection, and/or provide placement or permanency. 3. Increase in youth in safe family settings believed to be lifelong; permanency issues being addressed/near resolution/resolved (as measured by the child permanency status rating) 	<ol style="list-style-type: none"> 1. For children/ youth needing placement, increase in placement with kin 2. Decrease in length of stay in care; decrease in length of stay in congregate care 3. Increase in exits to permanency⁷

¹ Target population (a) includes youth over age 18. Target population (b) includes children/youth in legal custody of the child welfare agency for more than 12 months, regardless of placement type (non-kin foster care, kinship foster care, non-certified kinship care). Many counties do not intend to reach target populations b and c until their second year of implementation.

² All DHS staff, along with partners and stakeholders attend "Achieving Permanency through Roundtables." IC, EC, MP, caseworkers, supervisors attend "Skills Training" and "Youth Voice." Scribes attend "Skills Training."

³ Caseworker, Supervisor, Internal Consultant, External Consultant, Master Practitioner/Facilitator.

⁴ Until permanency is achieved.

⁵ Due to the preparation they received.

⁶ Because they are identified in the action plan.

⁷ Adoption, legal guardianship, or reunification.

TRAUMA-INFORMED CHILD WELFARE PROCESS LOGIC MODEL

TRAUMA INFORMED CARE INTERVENTION					
TARGET POPULATION: Children and Youth as identified in the approved county IV-E Waiver Demonstration plan - implementation beginning July 1, 2014					
INPUTS	INTERVENTION	OUTPUTS	OUTCOMES		
			Short Term		Long Term
County staff involvement Child/youth/family involvement	→ Trauma Screening	→ Child/youth referred for non-trauma service, or children/youth referred for trauma assessment	→ Families and casework staff have a better understanding of child/youth needs.	 <p>Child/youth experience stability in their living situation, either in home or in out of home placement.</p> <p>Parents are better able to maintain their child/youth in the home safely.</p> <p>Child/youth experience permanency quickly.</p> <p>Child/youth experience less re-entry into foster care.</p> <p>Child/youth increases well-being</p>	
					
Mental health clinician involvement Child/youth/family involvement	→ Trauma assessment	→ Child/youth referred for non-trauma treatment, or children/youth referred for trauma treatment	→ Child/youth receives assessment and referral for appropriate treatment.		
					
Mental health clinician involvement Child/youth/family involvement County staff involvement	→ Trauma treatment	→ Child/youth receive trauma treatment	→ Child/youth decreases trauma symptoms.		

Capacity Building:

INPUTS	PROCESS	OUTPUTS	SHORT-TERM OUTCOMES
<ol style="list-style-type: none"> 1. Child Welfare (CW) Staff (Intake, Ongoing, Youth Services) 2. Behavioral Health Organization (BHO), Community Mental Health Center (CMHC), and/or Community Mental Health Provider Staff 	<ol style="list-style-type: none"> 1. Educate County CW Agencies, BHOs, CHMCs, and community mental health providers on effects of trauma and the partnership between Trauma Informed System of Care (TISOC), Office of Behavioral Health (OBH), Health Care Policy and Finance (HCPF), and Colorado Department of Human Services (CDHS) to share effort and data. 2. Provide training to CW Staff on completing trauma screening tool, assessment referral process, and Trails data entry. 3. Provide training to BHOs, CMHCs, and community mental health providers on age-appropriate, evidence-based trauma-informed assessment tools, and Trails data entry 4. Provide training to BHOs, CHMCs, and community mental health providers on evidence-focused trauma-informed treatment, and Trails data entry 	<ol style="list-style-type: none"> 1. Increased awareness among CW staff, BHOs, CMHCs, and community mental health providers that child behaviors may be due to trauma children in the child welfare system have experienced. 2. CW staff consistently consider trauma by utilizing a systematic process for screening and assessment referral, and are more comfortable and accurate in using screening tools. 3. Increased collaboration among CW, BHOs, CMHCs, and community mental health providers. 4. Decreased system barriers (i.e. funding, data sharing) to children and adults receiving trauma-informed assessments. 5. There are sufficient numbers of clinicians available at BHOs, CHMCs and community mental health providers that are trained and qualified to conduct trauma-informed assessments and provide trauma-focused treatments. 6. There are sufficient numbers of clinicians from BHOs, CHMCs, and community mental health providers that are available and trained to provide evidence-based trauma-informed treatment to CW clients, and are trained in Trails data entry 	<ol style="list-style-type: none"> 1. There is improved system capacity to screen, assess, and treat trauma in children, youth and adults in the child welfare system.

Screening and Referral Phase:

INPUTS	PROCESS	OUTPUTS	SHORT-TERM OUTCOMES
<ol style="list-style-type: none"> 1. Child Welfare (CW) Staff (Intake, Ongoing, Youth Services) 2. Target Population: Any child/youth with open Child Welfare case or receiving services through Family Assessment Response (FAR) (PA 4 & PA 5, In Home and Out of Home Services) 3. Waiver funding and other funding sources 	<ol style="list-style-type: none"> 1. CW agencies determine process to ensure all children in the target population are screened (which staff, at what point in the case, etc.) 2. CW Staff complete age-appropriate screening on any child/youth with open Child Welfare case or receiving services through FAR and enter it into Trails (timeline TBD) 	<ol style="list-style-type: none"> 1. Children/youth are systematically screened for trauma (measured as the % of target population children/youth/adults screened, and within the desired timeframe) 2. If screening determines child/youth is or has experienced trauma and the trauma is negatively impacting their functioning, then the child/youth is referred for a trauma assessment. (timeframe TBD). (can be measured as the % of screened in children/youth who are referred for an assessment, and within the desired timeframe) 3. Primary and secondary caretaker(s) of the child/youth who is screened to be or have experienced trauma and the trauma is negatively impacting their functioning, are also referred for a trauma assessment (timeframe TBD). (can be measured as the % of families of screened in children/youth where an adult caretaker is referred for an assessment, and within the desired timeframe) 	<ol style="list-style-type: none"> 1. Children/youth and adults who are negatively impacted by trauma are identified and referred for an assessment.

Assessment Phase:

INPUTS	PROCESS	OUTPUTS	SHORT-TERM OUTCOMES
<ol style="list-style-type: none"> 1. Child Welfare (CW) Referrals 2. Behavioral Health Organization (BHO), Community Mental Health Center (CMHC), and/or Community Mental Health Provider Staff 3. Target Population: Any child/youth with open Child Welfare case or receiving services through Family Assessment Response (FAR) (PA 4 & PA 5, In Home and Out of Home Services), that has been screened to be experiencing or who has experienced trauma and the trauma is negatively impacting their functioning 4. Waiver funding and other funding sources 	<ol style="list-style-type: none"> 1. Upon receipt of a referral for a trauma assessment, BHOs, CMHCs, and community mental health providers schedule the assessment (timeframe still to be negotiated) 2. Trained clinicians administer the trauma-informed assessment to the child/youth or caretaker 	<ol style="list-style-type: none"> 1. In families where children are screened in, the trauma-informed assessment is scheduled for the child/youth or adult within the desired timeframe. 2. Clinicians consistently enter assessment results into Trails. 	<ol style="list-style-type: none"> 1. Children/youth and adults who are identified in the assessment as needing referral to trauma-informed treatment, are referred for appropriate trauma-informed treatment.

Treatment Phase:

INPUTS	PROCESS	OUTPUTS	ULTIMATE OUTCOMES
<ol style="list-style-type: none"> 1. Child Welfare (CW) Staff (Ongoing, Youth Services) 2. Behavioral Health Organization (BHO), Community Mental Health Center (CHMC), and/or Community Mental Health Provider Staff 3. Target Population: Any child/youth with open Child Welfare case or receiving services through Family Assessment Response (PA 4 & PA 5, In Home and Out of Home Services) who were assessed to be in need of referral to trauma-focused treatment 5. Waiver funding and other funding sources 	<ol style="list-style-type: none"> 1. CW Staff to incorporate trauma-informed treatment into case planning efforts 3. Children/youth and adults who have been assessed to be in need of referral to trauma-informed treatment are referred to evidence-based trauma-informed treatment, with initial appointment scheduled within a certain timeframe (TBD) 4. Children/youth and adults participate in treatment 4. BHOs, CHMCs, and community mental health providers administer a pre-test/post-test tool designed to examine impact of treatment on trauma related symptoms 	<ol style="list-style-type: none"> 1. CW Staff increase incorporation of trauma-informed treatment in case planning 2. Children/youth and adults who are assessed to need a referral for trauma-informed treatment are scheduled for an appointment within the determined timeframe 3. Children/youth and adults who are assessed to need a referral for trauma-informed treatment are participating in trauma-informed treatment 4. Children/youth and adults who are assessed to need a referral for trauma-informed treatment complete treatment. 5. Children/youth and adults feel supported by county CW Agencies, BHOs, CMHCs, and community mental health providers to address the impact of their trauma. 	<ol style="list-style-type: none"> 1. Decrease in over-reliance on psychotropic medications 2. Decrease in likelihood of children/youth placed in congregate care 3. Increase in likelihood children/youth removed from home achieve safe permanency through reunification, guardianship, or adoption 4. Improved child/youth functioning (Changes in trauma-related symptoms measured by the pre-/post-test tool). 5. Improved caretaker functioning 6. Additional outcomes?

Appendix F: Year Five Implementation Index Survey

Colorado Title IV-E Waiver Implementation Index

TEST-2

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Welcome to the Colorado Title IV-E Waiver Implementation Index.

For a full explanation of the Implementation Index, [please click here](#).

Use this home screen to determine which modules need to be completed in your county, access those modules, and monitor the county's completion status. The evaluation team appreciates your time and attention to this evaluation effort.

Survey Code: malamosa

Screening Question	Module (click to edit)	Completion Status	Last Modified
<p>Does the county conduct meetings with families (regardless of how they are funded) that are:</p> <ul style="list-style-type: none"> • facilitated by an impartial person, • include family support people, service providers, and/or other partner • for the purposes of case planning? <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	FAMILY ENGAGEMENT		
<p>Does the county provide supports or services to kin so that they can care for children and youth involved in the child welfare system (regardless of how these supports and services are funded)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	KINSHIP SUPPORTS		
<p>Is the county conducting Permanency Roundtables (regardless of how the practice is funded)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	PERMANENCY ROUNDTABLES		
<p>Does the county currently have any process to consistently screen, assess, or treat children's trauma (regardless of how that process is funded)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	TRAUMA-INFORMED CARE		
<p>Have there been any efforts in the past year to educate child welfare agency staff or other community members about the impact trauma may have on children and families in the community?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	COMMUNITY CAPACITY FOR TRAUMA-INFORMED CARE		

Survey: *malamosa*

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ABOUT THE SURVEY

Thank you for logging into the Colorado Title IV-E Waiver Demonstration Project Implementation Index.

The Implementation Index is an instrument based on research about the process of program implementation. This Index will track the degree and timing of implementation of four child welfare interventions in each of the child welfare departments across Colorado. The evaluation will use the information to look at implementation over time and identify which aspects of the IV-E Waiver have been implemented more or less widely and how the implementation process is related to outcomes.

The Implementation Index is designed in recognition of the following features of Colorado's Title IV-E Waiver Demonstration Project:

1. Counties will vary in which of the interventions they are implementing during the 5-year Demonstration Project.
2. Counties may have implemented some components of an intervention before or after IV-E Waiver funding became available, even if they have not formally indicated an intention to implement the full intervention.
3. Implementation of the identified interventions is a developmental and incremental process that will continue over an extended period of time, perhaps indefinitely.
4. There are no cutoff points at which implementation can be or should be deemed "adequate," "complete," etc.

The Implementation Index is therefore not intended, and will not be used, to assess compliance. Its purpose is to track the nature and extent of intervention activities over time across the state for purposes of the evaluation. For each intervention being implemented in the county, regardless of whether the intervention is funded by the IV-E Waiver, please address the questions in that intervention's module.

For a full explanation of the Implementation Index, [please click here](#). The evaluation team appreciates your involvement in this evaluation effort.

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FAMILY ENGAGEMENT

This section explores the county's implementation of Family Engagement activities. This survey specifically focuses on Family Engagement meetings, that is, meetings that are:

- Facilitated by a neutral, third party (someone who does not have line responsibility for the case)
- Include support people, service providers and/or other partners
- For the purposes of involving the family in their child welfare case planning and decision-making.

In this section, the evaluation would like to know about all of the Family Engagement meetings done in the county, regardless of whether or not they are funded specifically with IV-E dollars.

1. When did family engagement meetings begin in the county?

- Prior to 7/1/2012
- Between 7/1/2012 and 7/1/2013
- After 7/1/2013: Enter month and year began: (MM/YYYY)

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2. Does the county currently utilize any specific model of facilitated family meetings?

- Family Group Decision Making (FGDM)
with county-specific modifications Yes No
- Team Decision Making (TDM)
with county-specific modifications Yes No
- Family Group Conference (FGC)
with county-specific modifications Yes No
- Family Team Meetings (FTM)
with county-specific modifications Yes No
- Partnering for Safety/Safety Organized Practice framework
- Listening to the Needs of Kids (LINKs)
- Family Safety Resource Team (FSRT)
- Family Unity Meeting (FUM)
- Voices
- Other

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3. TARGET POPULATION

a. Which children/families are currently identified for family engagement meetings :

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
i. Newly opening PA4 cases (cases that opened after July 1, 2013, regardless of prior history)	<input type="checkbox"/>				
ii. Newly opening PA5 cases (cases that opened after July 1, 2013, regardless of prior history)	<input type="checkbox"/>				
iii. PA4 cases that opened prior to July 1, 2013	<input type="checkbox"/>				
iv. PA5 cases that opened prior to July 1, 2013	<input type="checkbox"/>				
v. Families served through FAR	<input type="checkbox"/>				
vi. Other, specify <input type="text"/>	<input type="checkbox"/>				

b. Where there is overlap in the target populations of the Family Engagement practice and the Permanency Roundtables practice currently being used by the county, do these children/youth receive just one intervention or both?

- Just FE intervention
- Just PRT intervention
- Receive both interventions—meetings are scheduled back-to-back
- Receive both interventions—meetings not necessarily synchronized
- Not applicable

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4. TIMING

Under your current family engagement practice, how often do the following events in a case trigger any type of family engagement meeting to be held?

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
a. When there is a risk of removal	<input type="checkbox"/>				
b. Once there has been a removal/placement	<input type="checkbox"/>				
c. Placement change being considered	<input type="checkbox"/>				
d. Upon recommendation for reunification	<input type="checkbox"/>				
e. Change in permanency goal or permanency decisions (other than reunification)	<input type="checkbox"/>				
f. Upon case opening	<input type="checkbox"/>				
g. Follow up meetings every 90 days for children in out-of-home care	<input type="checkbox"/>				
h. Follow-up meetings every 6 months for children in home	<input type="checkbox"/>				
i. Other <input type="text"/>	<input type="checkbox"/>				

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5. STAFFING AND ROLES

- a. The evaluation would like some information about the county's current family engagement meeting facilitators. When did they begin facilitating FE meetings? About how many hours per week do they spend in Family Engagement-related tasks? About how much Family Engagement-specific training have they received?

Please note:

1. Family Engagement-related tasks include all tasks related to engaging families and facilitating meetings: preparing for meetings; contact with clients, staff, community members; documentation; etc.
2. Training may have been received prior to the start of the Waiver.
3. Even if facilitators are paid through a contract, please answer the questions as completely as possible. The county may wish to check with their contractor to answer the following questions.

For counties implementing Family Engagement as part of a regional model under the Waiver:

Is the Family Engagement facilitator based in another county? Yes No

If yes, please name the county in which the Family Engagement facilitator is based:

Click here to see staff from last year's Index	Date began facilitating FE meetings? (MM/YYYY)	Average hours per week in Family Engagement-related tasks	How much Family Engagement-related training have they received?	
Add Facilitator				

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5. STAFFING AND ROLES (continued)

b. Is there currently a facilitator job description?

Yes No

If yes,

i. Does it include specific Family Engagement training or qualifications?

Yes No

ii. Does it include specific Family Engagement role/duties?

Yes No

c. For case workers that work with families who are expected to be offered Family Engagement meetings, does the job description for case workers currently include:

i. Specific Family Engagement training or qualifications?

Yes No

ii. Specific Family Engagement role/duties?

Yes No

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6. TRAINING

a. What training regarding the following models have the *current* family engagement facilitators in the county received to date?

	No facilitators received	Few facilitators received (~25%)	Some facilitators received (~50%)	Most facilitators received (~75%)	All facilitators received (~100%)
i. Team Decision Making (TDM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Family Group Decision Making (FGDM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Family Group Conference (FGC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Family Team Meetings (FTM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Partnering for Safety/Safety Organized Practice framework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Listening to the Needs of Kids (LINKs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vii. Family Safety Resource Team (FSRT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
viii. Family Unity Meeting (FUM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ix. Mediation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. General Facilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
xi. Other, specify <input style="width: 150px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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6. TRAINING (continued)

b. What training regarding the following models have the county's *currently employed* caseworkers received to date (beyond what they received in the core training)?

	No workers received	Few workers received (~25%)	Some workers received (~50%)	Most workers received (~75%)	All workers received (~100%)
i. Team Decision Making (TDM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Family Group Decision Making (FGDM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Family Group Conference (FGC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Family Team Meetings (FTM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Partnering for Safety/Safety Organized Practice framework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Listening to the Needs of Kids (LINKs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vii. Family Safety Resource Team (FSRT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
viii. Family Unity Meeting (FUM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ix. Mediation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. General Engagement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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6. TRAINING (continued)

c. What training regarding the following models have the county's *currently employed* supervisors received to date (beyond what they receive in their core training)?

	No supervisors received	Few supervisors received (~25%)	Some supervisors received (~50%)	Most supervisors received (~75%)	All supervisors received (~100%)
i. Team Decision Making (TDM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Family Group Decision Making (FGDM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Family Group Conference (FGC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Family Team Meetings (FTM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Partnering for Safety/Safety Organized Practice framework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Listening to the Needs of Kids (LINKs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vii. Family Safety Resource Team (FSRT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
viii. Family Unity Meeting (FUM)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ix. Mediation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. General Facilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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6. TRAINING (continued)

d. Does the county currently require any family engagement training for caseworkers, supervisors, and supervisors of the facilitators (beyond what they receive in their core training)? If so, how long is the required training?

	No training is required	Less than two hours	Two hours to one day	More than one day
i. Intake/Assessment Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Ongoing/Services Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. Supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Supervisors of the Facilitators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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7. TOOLS

a. Does the county currently use TRAILS to monitor cases or create reports?

Yes No

If yes, how does the county use this data? (check all that apply)

Use this data to provide case level data to line staff to document case activities

Use this data in aggregate for quality improvement purposes

Other, specify:

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7. TOOLS (continued)

b. For families with a case opening after 2/1/2014, would all of the family's Family Engagement meetings be entered into Trails under the Framework with a meeting type of "facilitated family meeting"? (choose only one)

- Yes, all Family Engagement meetings are entered under the Framework with a meeting type of "facilitated family meeting"
- Some Family Engagement meetings are entered in the Framework with a meeting type of "facilitated family meeting" but other Family Engagement meetings are entered with a different meeting type or in other areas of Trails
- No Family Engagement meetings are entered in the Framework with a meeting type of "facilitated family meeting"

c. Does the county currently use any of the following quality assurance activities to assess the success of Family Engagement Meetings?

- Family survey focused on satisfaction
- Family interviews or focus groups
- Other, specify:

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8. POLICIES AND PROCEDURES

a. Does the county have a written policy or procedure to guide Family Engagement activities?

Yes No

If yes, most recently updated:

b. If yes, do they cover: (check all that apply)

- Role and responsibilities of facilitator
- Role and responsibilities of caseworker
- Role and responsibilities of supervisor
- Process for referring families for their first Family Engagement Meeting
- Process for authorizing services in the meeting
- Family rights and responsibilities
- Documentation to be completed in preparation for the meeting
- Documentation to be completed during the meeting

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9. DEBRIEF

a. **Persons completing:** Please note the job title/role(s) of the person(s) completing the Family Engagement module of the Implementation Index:
(check all that apply)

Manager or Administrator

Supervisor

Family Engagement Facilitator

Group Process, specify:

Other, specify:

b. **Please use the following textbox to enter any comments or clarifications related to any of the following questions:**

- Were there any questions where it was difficult to explain the county's implementation, given the options provided?
- Were there any questions that were unclear?
- Is there any important aspect of the county's implementation that was not addressed in this section of the Index?

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This completes the Family Engagement module.

If the county is ready for the evaluation to view its answers, please click here:

Click [here](#) or use the home link above to return to the survey home page.

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ABOUT THE SURVEY

Thank you for logging into the Colorado Title IV-E Waiver Demonstration Project Implementation Index.

The Implementation Index is an instrument based on research about the process of program implementation. This Index will track the degree and timing of implementation of four child welfare interventions in each of the child welfare departments across Colorado. The evaluation will use the information to look at implementation over time and identify which aspects of the IV-E Waiver have been implemented more or less widely and how the implementation process is related to outcomes.

The Implementation Index is designed in recognition of the following features of Colorado's Title IV-E Waiver Demonstration Project:

1. Counties will vary in which of the interventions they are implementing during the 5-year Demonstration Project.
2. Counties may have implemented some components of an intervention before or after IV-E Waiver funding became available, even if they have not formally indicated an intention to implement the full intervention.
3. Implementation of the identified interventions is a developmental and incremental process that will continue over an extended period of time, perhaps indefinitely.
4. There are no cutoff points at which implementation can be or should be deemed "adequate," "complete," etc.

The Implementation Index is therefore not intended, and will not be used, to assess compliance. Its purpose is to track the nature and extent of intervention activities over time across the state for purposes of the evaluation. For each intervention being implemented in the county, regardless of whether the intervention is funded by the IV-E Waiver, please address the questions in that intervention's module.

For a full explanation of the Implementation Index, [please click here](#). The evaluation team appreciates your involvement in this evaluation effort.

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1. KINSHIP SUPPORTS

This section of the survey explores the supports and services that are provided to kin so that they can care for children and youth involved in the child welfare system. Please complete this section regardless of whether these supports and services are funded under the IV-E Waiver.

The intent of this intervention is to ensure kinship caregivers' needs are assessed early and often during their involvement with child welfare. The county is then able to meet the needs of the kinship caregiver through two primary service components: Case management, which includes the kinship support worker's responsibilities for contact, plan development, service coordination, and navigation; and services, which includes child care, respite, transportation, educational or therapeutic services not met by public or private insurance, and access to recreational services.

1. Does the county have a designated kinship supports worker(s) or caseworker(s) to provide case management and supports to kinship caregivers (regardless of how the position is funded)?
 - Yes, the county has designated kinship support worker(s)
 - Yes, the county has caseworker(s) to provide case management and supports to kinship caregivers (Skip to Question 3c)
 - No (Skip to Question 3c)

If the county has designated kinship support worker(s), enter date began (MM/YYYY):

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2. STAFFING AND ROLES

The evaluation team would like some information about the county's Kinship Support Workers. When were they hired for their role? About how many hours per week do they spend in Kinship Support-related tasks?

a. For counties implementing Kinship Supports as part of a regional model under the Waiver:

Is the Kinship Support Worker based in another county? Yes No

If yes, please name the county in which the Kinship Support Worker is based:

b. The evaluation team would like some information about the county's Kinship Support Workers. When were they hired for their role? About how many hours per week do they spend in Kinship Support-related tasks?

Click here to see staff from last year's Index	Hired for their role? (MM/YYYY)	Average hours per week in Kinship-Support-related tasks	
Add Kinship Support Worker			

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3. TRAINING

- a. Have the Kinship Supports Workers currently working in the county received kinship-specific training?
- Yes, prior to 7/1/2012
 - Yes, between 7/1/2012 and 7/1/2013
 - Yes, since 7/1/2013 (enter up to 3 dates in MM/YYYY format)
-
- No (skip to question 3c)
- b. How much Kinship-specific training has been received by the Kinship Support Workers currently working in the county? (Training may have been received prior to the start of the Waiver)
- More than 10 days
 - 6-10 Days
 - 3-5 Days
 - 2 Days or less
- c. Have the currently employed caseworkers (other than designated kinship workers) from any of the following units received kinship-specific training? (check all that apply)
- FAR / Intake
 - Ongoing
 - Permanency
 - Other, specify

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3. TRAINING (continued)

d. **Were the following topics discussed in training?**

(check all that apply)

- i. Safety concerns in kinship settings
- ii. Safety guidelines for certified and non-certified kinship caregivers
- iii. What it takes to help kinship caregivers succeed
- iv. Ways of identifying potential kinship caregivers
- v. Interaction between kinship caregivers and parents
- vi. Core components of the kinship supports intervention
- vii. Process for working with caseworkers
- viii. Kinship needs assessment
- ix. Kinship caregiver support plan
- x. Process of identifying/making referrals to community resources
- xi. Ways to keep kinship caregivers engaged
- xii. Conflict resolution
- xiii. Other, specify

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3. TRAINING (continued)

e. Have any community partners received kinship-specific training in your county?

- Yes, prior to 7/1/2012
- Yes, between 7/1/2012 and 7/1/2013
- Yes, since 7/1/2013 (enter up to three dates in MM/YYYY format)
- No (skip to question 4)

f. What groups of community partners were involved in the kinship-specific training? (check all that apply)

- Behavioral Health Providers
- CASA
- DYC
- GALs
- Non-profit or faith-based organizations
- Schools
- Other, specify

g. Topics that have been discussed in training: (check all that apply)

- i. Safety concerns in kinship settings
- ii. Safety guidelines for certified and non-certified kinship caregivers
- iii. What it takes to help kinship caregivers succeed
- iv. Ways of identifying potential kinship caregivers
- v. Interaction between kinship caregivers and parents
- vi. Core components of the kinship supports intervention
- vii. Process for working with caseworkers
- viii. Kinship needs assessment
- ix. Kinship caregiver support plan
- x. Process of making referrals to community resources or CDHS resources
- xi. Ways to keep family engaged
- xii. Conflict resolution
- xiii. Other, specify

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4. TARGET POPULATION

Which children/families are currently identified to receive kinship supports in the county?

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
a. Children/youth for whom a kinship placement appears to be imminent	<input type="checkbox"/>				
b. i. Children/youth in non-kinship/relative foster care	<input type="checkbox"/>				
b. ii. Children/youth in congregate care that can be stepped down to kinship foster care	<input type="checkbox"/>				
c. Children/youth in kinship family foster care	<input type="checkbox"/>				
d. Children/youth living with non-certified kin through child welfare involvement	<input type="checkbox"/>				
e. Children/youth living with non-certified kin through an informal family arrangement (no child welfare involvement)	<input type="checkbox"/>				
f. Kinship caregivers seeking information and referral and/or hard goods	<input type="checkbox"/>				
g. Other, specify <input style="width: 150px;" type="text"/>	<input type="checkbox"/>				

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5. REFERRAL PROCESS

How is the Kinship Supports Worker currently notified that a family needs kinship supports in your county?

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
a. Caseworker completes referral form	<input type="checkbox"/>				
b. Kinship Supports worker reviews list of new cases	<input type="checkbox"/>				
c. Other, specify <input type="text"/>	<input type="checkbox"/>				

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6. TOOLS

a. **How does the county currently conduct an assessment of kinship caregiver needs when a child is placed with kin?**

A comprehensive assessment of the needs of kinship caregivers is systematically conducted

Enter date began (MM/YYYY):

Assessment is done informally or on a case-by-case basis

No assessment is conducted at this time

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6. TOOLS (continued)

b. Does the county complete a support plan for kinship caregivers as part of the needs assessment?

Support plans for kinship caregivers are systematically documented

Enter date began (MM/YYYY):

Support plans for kinship caregivers are documented as needed or on a case-by-case basis

Support plans for kinship caregivers are not written at this time

c. Does the county currently have any of the following resources developed specifically for kinship caregivers? (note date began)

County-specific brochure
Enter date (MM/YYYY):

County-specific resource directory
Enter date (MM/YYYY):

Training
Enter date (MM/YYYY):

Support group
Enter date (MM/YYYY):

Special events or conferences
Enter date (MM/YYYY):

Other, specify :
Enter date (MM/YYYY):

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7. POLICIES AND PROCEDURES

a. Does the county have a written policy or procedure to guide Kinship Supports Workers when working with kinship caregivers?

Yes No NA

i. If yes, when was the policy most recently updated? (MM/YYYY)

ii. If yes, does the policy or procedure cover:

- Roles and responsibilities of the designated kinship worker
- Roles and responsibilities of the caseworkers
- Roles and responsibilities of the supervisor
- Timelines for when the Kinship Needs Assessment and/or support plan should be completed
- Services and/or supports provided to certified kinship caregivers
- Services and/or supports provided to non-certified kinship caregivers

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7. POLICIES AND PROCEDURES (continued)

b. Does the county enter non-certified kinship caregivers into Trails as a resource or provider?

- No, non-certified kinship caregivers are not currently entered.
- Yes, whenever a child is living with kin and the county provides a support to the kin, the kin are entered into Trails as a provider with a service type Kinship Care.
- Sometimes the non-certified kinship caregivers are entered as a provider, depends on the extent of the services being provided by the county.

If Yes or Sometimes, when were data first regularly entered in Trails for non-certified kinship caregivers:

- Prior to 7/1/2012
- Between 7/1/2012 and 7/1/2013
- After 7/1/2013: Enter month and year began:

c. Does the county currently use any of the following quality assurance activities to understand if kinship caregivers are receiving the supports they feel they need and/or feel knowledgeable about the options or services available to them?

- Satisfaction survey of kinship caregivers
- Interviews or focus groups with kinship caregivers
- Case-level data on kinship caregivers
- Other, specify

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8. DEBRIEF

a. **Persons completing:** Please note the job title/role(s) of the person(s) completing the Kinship Supports module of the Implementation Index for your county:
(check all that apply)

Manager or Administrator

Supervisor

Kinship Supports Worker

Group Process, specify

Other, specify

b. **Please use the following textbox to enter any comments or clarifications related to any of the following questions:**

- Were there any questions where it was difficult to explain the county's implementation, given the options provided?
- Were there any questions that were unclear?
- Is there any important aspect of the county's implementation that was not addressed in this section of the Index?

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This completes the Kinship Supports module.

If the county is ready for the evaluation to view its answers, please click here:

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ABOUT THE SURVEY

Thank you for logging into the Colorado Title IV-E Waiver Demonstration Project Implementation Index.

The Implementation Index is an instrument based on research about the process of program implementation. This Index will track the degree and timing of implementation of four child welfare interventions in each of the child welfare departments across Colorado. The evaluation will use the information to look at implementation over time and identify which aspects of the IV-E Waiver have been implemented more or less widely and how the implementation process is related to outcomes.

The Implementation Index is designed in recognition of the following features of Colorado's Title IV-E Waiver Demonstration Project:

1. Counties will vary in which of the interventions they are implementing during the 5-year Demonstration Project.
2. Counties may have implemented some components of an intervention before or after IV-E Waiver funding became available, even if they have not formally indicated an intention to implement the full intervention.
3. Implementation of the identified interventions is a developmental and incremental process that will continue over an extended period of time, perhaps indefinitely.
4. There are no cutoff points at which implementation can be or should be deemed "adequate," "complete," etc.

The Implementation Index is therefore not intended, and will not be used, to assess compliance. Its purpose is to track the nature and extent of intervention activities over time across the state for purposes of the evaluation. For each intervention being implemented in the county, regardless of whether the intervention is funded by the IV-E Waiver, please address the questions in that intervention's module.

For a full explanation of the Implementation Index, [please click here](#). The evaluation team appreciates your involvement in this evaluation effort.

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1. PERMANENCY ROUNDTABLES

This section explores the county's implementation of Permanency Roundtables (PRT). Permanency Roundtables have the following features:

- PRTs have a structured, case consultation approach.
- The purpose is to establish a Permanency Action Plan in conjunction with the youth and their supports, which will expedite legal permanency.
- PRTs are generally for youth who have been in care for extended periods and are aimed at identifying and addressing the barriers to permanency.
- Attending the PRT are the child/youth, and their supports, caseworker, supervisor, administrator, external consultant, and a trained facilitator/master practitioner. Participants could also include family or kin, GAL, CASA, or others that the child/youth has invited.
- The child/youth voice is encouraged and heard.

Please describe the county's Permanency Roundtables efforts, regardless of whether or not they have been funded under the IV-E waiver.

1. When did Permanency Roundtables begin in the county?

Prior to 7/1/2012

Between 7/1/2012 and 7/1/2013

After 7/1/2013: Enter month and year began: (MM/YYYY)

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2. TARGET POPULATION

Which children/youth are currently identified for the county's PRT practice:

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
a. Youth over 16 in OPPLA	<input type="checkbox"/>				
b. Youth younger than age 16 in OPPLA	<input type="checkbox"/>				
c. Children/Youth in care > 12 months	<input type="checkbox"/>				
d. Determined on case by case basis	<input type="checkbox"/>				

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3. PRT REFERRAL PROCESS

How does the county currently determine that a case needs a PRT? At what point in the case is the determination made?

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
a. Designated staff person reviews case lists	<input type="checkbox"/>				
b. Caseworker fills out a referral form when youth reaches target population (per county policy)	<input type="checkbox"/>				
c. Caseworker, supervisor or consultation team recommends PRT	<input type="checkbox"/>				

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4. STAFFING AND ROLES

The evaluation team would like some information about the county's *current* Master Practitioners/PRT facilitators. When did they begin facilitating PRTs? About how many hours per week do they spend in PRT-related tasks? About how much PRT-specific training have they received? (PRT-related tasks include all tasks related to holding PRTs: preparing for Roundtables; contact with clients, staff, community members; documentation; etc. Training may have been received prior to the start of the Waiver.)

- a. *For counties implementing PRT as part of a regional model under the Waiver:*
Is the Master Practitioner/facilitator based in another county? Yes No

If yes, please name the county in which the master practitioner/facilitator is based:

b.

Click here to see staff from last year's Index	Date began facilitating PRTs?	Average hours per week in PRT-related tasks?	How much PRT-related training have they received?	If the facilitator has received more than 2 days of training, please specify the nature of the training:	
Add Master Practitioner					

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4. STAFFING AND ROLES (continued)

c. What types of External Consultants are currently trained and available to participate in PRTs in the county?

- Judges
- GALs
- CASAs
- Probation
- Mental health agency staff
- Community volunteers (i.e. board members of community organizations)
- Master Practitioners from nearby counties
- Other, specify

d. In total, how many External Consultants are currently trained and available to participate in PRTs in the county?

- None
- 1 - 2
- 3 - 5
- 6 - 10
- More than 10

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5. TRAINING

a. What training has been received by the caseworkers *currently employed in the county*?

	No caseworkers received	Few caseworkers received (~25%)	Some caseworkers received (~50%)	Most caseworkers received (~75%)	All caseworkers received (~100%)
i. Achieving Permanency Through Roundtables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. PRT Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. PRT Youth Voice Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Intensive Family Finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Cross-over Youth Practice Model	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Other permanency-related training, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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5. TRAINING (continued)

b. What training has been received by the supervisors *currently employed* in the county?

	No supervisors received	Few supervisors received (~25%)	Some supervisors received (~50%)	Most supervisors received (~75%)	All supervisors received (~100%)
i. Achieving Permanency Through Roundtables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. PRT Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. PRT Youth Voice Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Intensive Family Finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Cross-over Youth Practice Model	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Other permanency-related training, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input style="width: 100%; height: 15px;" type="text"/>					

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5. TRAINING (continued)

c. What training has been received by the administrators/managers *currently employed* in the county?

	No administrators / managers received	Few administrators / managers received (~25%)	Some administrators / managers received (~50%)	Most administrators / managers received (~75%)	All administrators / managers received (~100%)
i. Achieving Permanency Through Roundtables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. PRT Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. PRT Youth Voice Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Intensive Family Finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Cross-over Youth Practice Model	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Other permanency-related training, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input style="width: 100%;" type="text"/>				

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5. TRAINING (continued)

d. What training has been received by the (aides, reception, scribes, etc.) *currently employed* in the county?

	No aides received	Few aides received (~25%)	Some aides received (~50%)	Most aides received (~75%)	All aides received (~100%)
i. Achieving Permanency Through Roundtables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. PRT Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. PRT Youth Voice Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Intensive Family Finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Cross-over Youth Practice Model	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Other permanency-related training, specify: <input style="width: 150px; height: 15px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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5. TRAINING (continued)

e. What training has been received by the the program specialists (intervention leads, family engagement facilitators, kinship support workers, etc.) *currently employed* in the county?

	No specialists received	Few specialists received (~25%)	Some specialists received (~50%)	Most specialists received (~75%)	All specialists received (~100%)
i. Achieving Permanency Through Roundtables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. PRT Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. PRT Youth Voice Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. Intensive Family Finding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Cross-over Youth Practice Model	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. Other permanency-related training, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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6. TOOLS

a. For children/youth with their first PRT after 2/1/2014, would all of their PRT meetings be entered into the Trails PRT Module? (choose only one)

- Yes, all PRTs are currently entered into the Trails PRT Module
- Some PRT meetings are currently entered into the Trails PRT Module
- No PRT meetings are currently entered into the Trails PRT Module

b. Does the county currently use Trails to monitor cases or create reports? (check all that apply)

- Use this data to provide case level data to line staff to document case activities
- Use this data in aggregate for quality improvement purposes
- Other, specify:

c. Does the county currently use any of the following methods to assess the perceptions of youth and caretakers involved in PRTs? (check all that apply)

	Youth	Caretakers
i. Survey focused on satisfaction	<input type="checkbox"/>	<input type="checkbox"/>
ii. Interviews or focus groups	<input type="checkbox"/>	<input type="checkbox"/>
iii. Other, specify: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

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7. POLICIES AND PROCEDURES

a. Does the county have a policy or procedure to guide staff as they implement PRT?

Yes No

a.i. If yes, most recently updated:

a.ii. If yes, does it include: (check all that apply)

- Role and responsibilities of facilitator/master practitioner
- Role and responsibilities of caseworker
- Role and responsibilities of supervisor
- Process for referring child/youth for their first PRT
- Process for creating a Permanency Action Plan
- Documentation to be completed in preparation for PRT
- Documentation to be completed during or after a PRT

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8. DEBRIEF

a. **Persons completing:** Please note the job title/role(s) of the person(s) completing the PRT module of the Implementation Index for your county:
(check all that apply)

Manager or Administrator

Supervisor

PRT Facilitator or Master Practitioner

Group Process, specify

Other, specify

b. **Please use the following textbox to enter any comments or clarifications related to any of the following questions:**

- Were there any questions where it was difficult to explain the county's implementation, given the options provided?
- Were there any questions that were unclear?
- Is there any important aspect of the county's implementation that was not addressed in this section of the Index?

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If the county is ready for the evaluation to view its answers, please click here:

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The Implementation Index is an instrument based on research about the process of program implementation. This Index will track the degree and timing of implementation of four child welfare interventions in each of the child welfare departments across Colorado. The evaluation will use the information to look at implementation over time and identify which aspects of the IV-E Waiver have been implemented more or less widely and how the implementation process is related to outcomes.

The Implementation Index is designed in recognition of the following features of Colorado's Title IV-E Waiver Demonstration Project:

1. Counties will vary in which of the interventions they are implementing during the 5-year Demonstration Project.
2. Counties may have implemented some components of an intervention before or after IV-E Waiver funding became available, even if they have not formally indicated an intention to implement the full intervention.
3. Implementation of the identified interventions is a developmental and incremental process that will continue over an extended period of time, perhaps indefinitely.
4. There are no cutoff points at which implementation can be or should be deemed "adequate," "complete," etc.

The Implementation Index is therefore not intended, and will not be used, to assess compliance. Its purpose is to track the nature and extent of intervention activities over time across the state for purposes of the evaluation. For each intervention being implemented in the county, regardless of whether the intervention is funded by the IV-E Waiver, please address the questions in that intervention's module.

For a full explanation of the Implementation Index, [please click here](#). The evaluation team appreciates your involvement in this evaluation effort.

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TRAUMA-INFORMED CARE

The following questions will help the evaluation team understand if the county is currently providing any systematic practices around trauma-informed care to the child welfare population. This set of questions is designed to explore processes to screen, assess and treat child welfare families with trauma-focused practices.

For some questions, the county may be able to provide more complete answers by consulting with its mental health partners. To facilitate discussion between the county child welfare staff and mental health partners, refer to the Trauma-Informed Care section in the [PDF of the Implementation Index](#).

According to the definitions being developed for the IV-E Waiver intervention, the following trauma questions are divided into three sections:

1. Screening: A screen checks for exposure to traumatic events and for trauma-related symptoms.
2. Assessment: A comprehensive assessment documents trauma-related mental health needs for children and caretakers who have been exposed to traumatic events and/or who exhibit trauma-related symptoms.
3. Treatment: In this context, refers to the treatment of mental health needs in a trauma-informed manner.

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I. TRAUMA SCREENING

TRAUMA SCREENING

1. Indicate if the county currently has any process to assure that children are screened for trauma.

- No formal trauma screening process is in place (skip to Trauma Assessment section)
- Child welfare caseworkers consistently screen but do not use a standard instrument
- Child welfare caseworkers screen using a standard tool

Date began using standard tool (MM/YYYY)

If you answer 'No formal trauma screening process is in place', please continue to Trauma Assessment.

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I. TRAUMA SCREENING (continued)

2. TARGET POPULATION

a. When children are determined to need a trauma screening, how often do the following children in the family receive the trauma screening?		Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
i.	Only the child(ren) that is/are the subject of the referral	<input type="checkbox"/>				
ii.	All children named in the referral, assessment or case plan	<input type="checkbox"/>				
iii.	Other, specify: <input type="text"/>	<input type="checkbox"/>				

b. What age are children currently screened for trauma?		Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
i.	Age 0 to 3	<input type="checkbox"/>				
ii.	Age 3 to 8	<input type="checkbox"/>				
iii.	Age 8 to 12	<input type="checkbox"/>				
iv.	Age 12 to 16	<input type="checkbox"/>				
v.	Age 16 and older	<input type="checkbox"/>				

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I. TRAUMA SCREENING (continued)

2. TARGET POPULATION

c.	How often do the following types of child welfare cases currently receive a trauma screening?	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
i.	Founded Assessments	<input type="checkbox"/>				
ii.	Open FAR	<input type="checkbox"/>				
iii.	Open traditional/High Risk Assessment - PA4	<input type="checkbox"/>				
iv.	Open traditional/High Risk Assessment - PA5	<input type="checkbox"/>				
v.	Other, specify: <input type="text"/>	<input type="checkbox"/>				

d. Are caretakers ever screened for trauma? Yes No

If yes, under what circumstances?

- Caretakers of children identified as needing to be screened for trauma
- Caretakers of children who are screened-in (whose screen indicates that the child has been exposed to traumatic events or exhibits trauma-related symptoms)
- Caretakers of children who are being assessed for mental health needs due to exposure to trauma or exhibiting trauma-related symptoms
- Caretakers of children who are being treated for mental health needs
- Other

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I. TRAUMA SCREENING (continued)

3. TIMING

When a trauma screening is identified as needed, is there a timeframe within which the screening must be completed?

- There is no established timeframe
- There is an established timeframe
- Other, specify:

Established timeframe: days after:

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I. TRAUMA SCREENING (continued)

4. STAFFING ROLES AND TRAINING

a. Who in the child welfare agency currently administers the trauma screen to children?

Completed by the assigned child welfare case worker

Other, specify:

b. Have the current staff administering the screening been trained on how to conduct the trauma screening?

Yes No

i. If yes, did the training cover

Information about the effects of trauma on children

Information about the effects of trauma on parents/caretakers

Information about how to administer a specific screening tool

ii. If yes, how long was the training?

less than 2 hours

2 hours to 1 day

more than 1 day

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I. TRAUMA SCREENING (continued)

5. TOOLS

- | | Never | Rarely (~25%) | Sometimes (~50%) | Usually (~75%) | Always (~100%) |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. What tool is currently used to screen children for trauma? | | | | | |
| i. Southwest Michigan Children's Trauma Assessment Center Tool | <input type="checkbox"/> |
| ii. Other (1), specify: <input type="text"/> | <input type="checkbox"/> |
| iii. Other (2), specify: <input type="text"/> | <input type="checkbox"/> |
| iv. Other (3), specify: <input type="text"/> | <input type="checkbox"/> |
| b. How do county child welfare staff use the trauma screening information to determine if comprehensive trauma assessment is needed? | | | | | |
| <input type="checkbox"/> Objective guidelines based on the screening information indicate need for trauma assessment | | | | | |
| i. What are the guidelines? <input type="text"/> | | | | | |
| ii. Can these guidelines be overridden? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| iii. If so, by whom? <input type="text"/> | | | | | |
| <input type="checkbox"/> Subjective decision of staff who completes the screening | | | | | |
| <input type="checkbox"/> Other, specify: <input type="text"/> | | | | | |
| c. Is trauma screening data currently entered into any data system? | | | | | |
| <input type="checkbox"/> Yes (check all that apply) | | | | | |
| <input type="checkbox"/> TRAILS | | | | | |
| <input type="checkbox"/> A local data system | | | | | |
| <input type="checkbox"/> No | | | | | |

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I. TRAUMA SCREENING (continued)

6. POLICIES AND PROCEDURES

Are there written child welfare policies and procedures regarding the practice of completing the trauma screening?

- Policies and procedures regarding eligibility
- Policies and procedures regarding target population
- Policies and procedures regarding how trauma screening is completed
- Other policies and procedures regarding trauma screening - Please describe:

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II. TRAUMA-INFORMED ASSESSMENT

1. Indicate if the county currently has any process to comprehensively assess children for trauma.

- Trauma assessment is currently not done (Skip to Trauma-informed treatment section)
- Nothing systematic; child welfare workers determine if a referral should be made for a trauma assessment
- Nothing systematic; mental health clinicians determine if a child should be assessed for trauma
- Yes, the county has a systematic process to assess children for trauma

If yes, date began (MM/YYYY)

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II. TRAUMA-INFORMED ASSESSMENT (continued)

2. TARGET POPULATION

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
a. How often do the following individuals receive a comprehensive trauma assessment?					
Children with a trauma screening that indicates trauma is negatively impacting their functioning	<input type="checkbox"/>				
Caretakers with a trauma screening that indicates trauma is negatively impacting their functioning	<input type="checkbox"/>				
Other, specify: <input type="text"/>	<input type="checkbox"/>				
b. How often do the following types of child welfare cases receive a trauma assessment?					
Founded assessments	<input type="checkbox"/>				
Open FAR	<input type="checkbox"/>				
Open traditional/High Risk Assessment - PA4	<input type="checkbox"/>				
Open traditional/High Risk Assessment - PA5	<input type="checkbox"/>				
Other, specify: <input type="text"/>	<input type="checkbox"/>				
c. For the non-Medicaid eligible population, how often does a lack of Medicaid funding limit the ability to provide trauma informed assessments to the following individuals?					
Children (i.e. children not in out-of-home care and with income too high for Medicaid)	<input type="checkbox"/>				
Caregivers (i.e. those with income too high for Medicaid)	<input type="checkbox"/>				

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II. TRAUMA-INFORMED ASSESSMENT (continued)

3. REFERRAL PROCESS

a. Is there currently a systematic process by which a referral for a comprehensive trauma assessment is made?

- Yes
- No, informal referral system

If yes,

i. Is there a standardized form? Yes No

ii. Is a trauma screening tool included with the referral for assessment? Yes No

iii. Who makes the referral?

- Assigned Caseworker
- Supervisor
- Automated referral out of TRAILS
- Other, specify:

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II. TRAUMA-INFORMED ASSESSMENT (continued)

3. REFERRAL PROCESS

b. Where are individuals referred to for a comprehensive trauma assessment? (check all that apply)

Community mental health center

Private Practitioner

Other, specify:

c. What if any barriers does the county currently encounter in getting individuals in to have a comprehensive trauma assessment completed? (check all that apply)

No barriers

Waitlist

Eligibility criteria

Funding (e.g. non-Medicaid eligible families)

Lack of qualified providers

Limited availability of providers

Lack of child welfare involvement (child welfare case closes prior to trauma assessment because no safety/risk concerns)

Resistance from families

Other, specify:

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II. TRAUMA-INFORMED ASSESSMENT (continued)

4. TIMING

a. When a comprehensive trauma assessment is identified as needed, is there a timeframe within which the first trauma assessment must be completed?

- There is no established timeframe
- There is an established timeframe
- Other, specify:

Established timeframe: days after referral for trauma assessment

b. What is the frequency of subsequent trauma assessments?

- No standardized subsequent assessments
- Every three months during trauma treatment
- At other regular intervals during trauma treatment
- At the end of trauma treatment

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II. TRAUMA-INFORMED ASSESSMENT (continued)

5. STAFFING ROLES AND TRAINING

a. If the need for a comprehensive trauma assessment is identified, who conducts the trauma assessment?

Staff in child welfare agency

A Mental Health Clinician

Other, specify:

b. Have the current staff administering the comprehensive trauma assessment been trained on how to conduct trauma informed assessments?

All individuals conducting trauma assessment (approximately 100%)

Most individuals conducting trauma assessment (approximately 75%)

Some individuals conducting trauma assessment (approximately 50%)

Few individuals conducting trauma assessment (approximately 25%)

No individuals conducting trauma assessment (approximately 0%)

Unknown

c. Describe training received (e.g. Child Welfare Trauma Toolkit Training):

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II. TRAUMA-INFORMED ASSESSMENT (continued)

6. TOOLS

a. Is a specific tool currently mandated to be used by the staff conducting the trauma assessment?

- Child PTSD Symptom Scale (PCSS)
- Trauma Symptom Checklist for Young Children (TSCYC)
- PTSD checklist for Adults
- Other (1), specify:
- Other (2), specify:

b. Is there a systematic process to share results of the trauma assessment with the assigned child welfare worker?

- No
- Yes

i. If yes, indicate how results are shared

- Sharing is informal
- Sharing is formal discussed in a regularly scheduled meeting
- Sharing is through a written report
- Other, please describe:

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II. TRAUMA-INFORMED ASSESSMENT (continued)

6. TOOLS

c. Is trauma assessment data currently entered into any data system?

No

Yes

i. If yes, what kinds of data systems?

TRAILS

The Office of Behavioral Health survey process (i.e. Survey Monkey)

A local data system

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II. TRAUMA-INFORMED ASSESSMENT (continued)

7. POLICIES AND PROCEDURES

Does the county child welfare agency or mental health provider have written policies and procedures regarding the practice of completing the comprehensive trauma assessment?

- Policies and procedures regarding eligibility
- Policies and procedures regarding target population
- Policies and procedures regarding how trauma assessment is completed
- Other policies and procedures regarding trauma assessment

Please describe:

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III. TRAUMA-INFORMED TREATMENT

1. Indicate if the county currently has any systematic process to assure that children who have received a comprehensive assessment and found to be in need of trauma treatment receive trauma treatment.

- Trauma treatment is currently not available for child welfare population
- Nothing systematic; worker determines if a referral should be made for trauma treatment
- Nothing systematic; mental health clinicians determine if an individual should receive trauma treatment
- Yes, the county has a systematic process to ensure that children receive trauma treatment

If yes, date began (MM/YYYY)

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III. TRAUMA-INFORMED TREATMENT (continued)

2. TARGET POPULATION

a. Which individuals currently receive a trauma treatment?

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
Children with a trauma assessment that indicates trauma is negatively impacting their functioning	<input type="checkbox"/>				
Caretakers with a trauma assessment that indicates trauma is negatively impacting their functioning	<input type="checkbox"/>				
Other, specify: <input type="text"/>	<input type="checkbox"/>				

b. For the non-Medicaid eligible population, how often does a lack of Medicaid funding limit the ability to provide trauma informed treatment to the following individuals?

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
Children (i.e. children not in out-of-home care and with income too high for Medicaid)	<input type="checkbox"/>				
Caregivers (i.e.those with income too high for Medicaid)	<input type="checkbox"/>				

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III. TRAUMA-INFORMED TREATMENT (continued)

3. REFERRAL PROCESS

a. Once a comprehensive trauma assessment has been completed, who makes the recommendation for the trauma treatment?

Assigned child welfare case worker

Child welfare supervisor

Mental health practitioner

Other, specify:

b. Is there a systematic process by which a referral for trauma treatment is made?

Yes

No, informal referral system

If yes,

i. Is there a standardized form? Yes No

ii. Is the trauma assessment included with the referral for treatment? Yes No

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III. TRAUMA-INFORMED TREATMENT (continued)

3. REFERRAL PROCESS

c. How is it determined which provider to refer the client to for trauma treatment?

- The mental health provider who conducted the comprehensive trauma assessment provides the treatment.
- Other, specify:

d. What if any barriers does the county currently encounter in getting individuals into trauma treatment?

- No barriers
- Waitlist
- Eligibility criteria
- Funding (e.g. non-Medicaid eligible families)
- Lack of qualified providers
- Lack of child welfare involvement (child welfare case closes prior to trauma assessment because no safety/risk concerns)
- Resistance from families
- Other, specify:

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III. TRAUMA-INFORMED TREATMENT (continued)

4. TIMING

a. When trauma treatment is identified as needed, is there a timeframe within which the first trauma treatment session must be completed?

There is no established timeframe

There is an established timeframe

Other, specify:

Established timeframe: days after referral for trauma atreatment

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III. TRAUMA-INFORMED TREATMENT (continued)

5. STAFFING ROLES AND TRAINING

a. If the need for trauma treatment is identified, who provides the trauma treatment?

A Mental Health Clinician

Other, specify:

b. Have the staff currently providing trauma treatment been trained on trauma informed treatment?

All individuals conducting trauma treatment (approximately 100%)

Most individuals conducting trauma treatment (approximately 75%)

Some individuals conducting trauma treatment (approximately 50%)

Few individuals conducting trauma treatment (approximately 25%)

No individuals conducting trauma treatment (approximately 0%)

Unknown

c. Describe training received

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III. TRAUMA-INFORMED TREATMENT (continued)

6. AVAILABILITY

How often is trauma-based treatment available for those who need it?

	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
a. Age 0 to 3	<input type="checkbox"/>				
b. Age 4 to 8	<input type="checkbox"/>				
c. Age 9 to 12	<input type="checkbox"/>				
d. Age 13 to 16	<input type="checkbox"/>				
e. Age 17 and older	<input type="checkbox"/>				
f. Adults	<input type="checkbox"/>				

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III. TRAUMA-INFORMED TREATMENT (continued)

7. TOOLS

a. For those clients receiving a trauma treatment, what evidence based treatment methods or promising practices are currently used?	Never	Rarely (~25%)	Sometimes (~50%)	Usually (~75%)	Always (~100%)
i. Individual psychotherapy	<input type="checkbox"/>				
ii. Child parent psychotherapy for 0-5	<input type="checkbox"/>				
iii. Trauma focused Parent Child Interaction Therapy	<input type="checkbox"/>				
iv. TF-CBT	<input type="checkbox"/>				
v. Adolescent Dialectical Behavioral Therapy	<input type="checkbox"/>				
vi. Alternative for Families CBT	<input type="checkbox"/>				
vii. SPARKS	<input type="checkbox"/>				
viii. Complementary or adjunctive supports	<input type="checkbox"/>				
ix. Addressing goals	<input type="checkbox"/>				
x. Alternative therapies	<input type="checkbox"/>				
xi. Bruce Perry work	<input type="checkbox"/>				
xii. Other (1), specify: <input style="width: 150px;" type="text"/>	<input type="checkbox"/>				
xiii. Other (2), specify: <input style="width: 150px;" type="text"/>	<input type="checkbox"/>				

b. Is there a systematic process to determine which trauma treatment is needed ?

Yes No

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III. TRAUMA-INFORMED TREATMENT (continued)

7. TOOLS

c. Is there a systematic process to share progress of the trauma treatment with the assigned child welfare worker?

- No
- Yes

i. If yes, indicate how results are shared

- Sharing is informal
- Sharing is formal discussed in a regularly scheduled meeting
- Sharing is through a written report
- Other, please describe:

d. Is data related to the trauma treatment currently entered into any data system?

- No
- Yes (check all that apply)
 - TRAILS
 - A local data system

Name the system and describe type of data entered into these systems:

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TRAUMA-INFORMED CARE

DEBRIEF

a. **Persons Completing:** Please note the job title/role(s) of the person(s) completing the Trauma module of the Implementation Index:
(check all that apply)

- Manager or Administrator
- Supervisor
- Group Process, specify:
- Other, specify:

b. **Please use the following textbox to enter any comments or clarifications related to any of the following questions:**

- Were there any questions where it was difficult to explain the county's implementation, given the options provided?
- Were there any questions that were unclear?
- Is there any important aspect of the county's implementation that was not addressed in this section of the Index?

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This completes the Trauma-Informed Care module.

If the county is ready for the evaluation to view its answers, please click here:

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ABOUT THE SURVEY

Thank you for logging into the Colorado Title IV-E Waiver Demonstration Project Implementation Index.

The Implementation Index is an instrument based on research about the process of program implementation. This Index will track the degree and timing of implementation of four child welfare interventions in each of the child welfare departments across Colorado. The evaluation will use the information to look at implementation over time and identify which aspects of the IV-E Waiver have been implemented more or less widely and how the implementation process is related to outcomes.

The Implementation Index is designed in recognition of the following features of Colorado's Title IV-E Waiver Demonstration Project:

1. Counties will vary in which of the interventions they are implementing during the 5-year Demonstration Project.
2. Counties may have implemented some components of an intervention before or after IV-E Waiver funding became available, even if they have not formally indicated an intention to implement the full intervention.
3. Implementation of the identified interventions is a developmental and incremental process that will continue over an extended period of time, perhaps indefinitely.
4. There are no cutoff points at which implementation can be or should be deemed "adequate," "complete," etc.

The Implementation Index is therefore not intended, and will not be used, to assess compliance. Its purpose is to track the nature and extent of intervention activities over time across the state for purposes of the evaluation. For each intervention being implemented in the county, regardless of whether the intervention is funded by the IV-E Waiver, please address the questions in that intervention's module.

For a full explanation of the Implementation Index, [please click here](#). The evaluation team appreciates your involvement in this evaluation effort.

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COMMUNITY CAPACITY TO PROVIDE TRAUMA-INFORMED CARE

The following questions will help the evaluation team understand if the county is currently preparing to provide trauma-informed care to the child welfare population. This set of questions is designed to explore training for child welfare agency staff and/or community members about the impact trauma may have on children and families in the community.

1. Please rate the community's current capacity to provide trauma informed care to families:

- Never
- Rarely (~25%)
- Sometimes (~50%)
- Usually (~75%)
- Always (~100%)

Describe:

2. Has the county made any efforts in the past year to educate *child welfare agency staff* about the impact trauma may have on children and families in the community?

- Extensive efforts to educate child welfare staff about impact of trauma
- Moderate efforts to educate child welfare staff about impact of trauma
- Minimal efforts to educate child welfare staff about impact of trauma
- No efforts to educate child welfare staff about impact of trauma

Describe:

3. Has the county made any efforts in the past year to educate the *community* about the impact trauma may have on children and families in the community?

- Extensive efforts to educate community about impact of trauma
- Moderate efforts to educate community about impact of trauma
- Minimal efforts to educate community about impact of trauma
- No efforts to educate community about impact of trauma

Describe:

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4. DEBRIEF

a. **Persons Completing:** Please note the job title/role(s) of the person(s) completing the Community Capacity for Trauma-Informed Care module of the Implementation Index: (check all that apply)

Manager or Administrator

Supervisor

Group Process, specify:

Other, specify:

b. **Please use the following textbox to enter any comments or clarifications related to any of the following questions:**

- Were there any questions where it was difficult to explain the county's implementation, given the options provided?
- Were there any questions that were unclear?
- Is there any important aspect of the county's implementation that was not addressed in this section of the Index?

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This completes the Community Capacity for Trauma-Informed Care module.

If the county is ready for the evaluation to view its answers, please click here:

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Appendix G: Implementation Index Design Details

Colorado Implementation Index Design Details

We developed the Index in collaboration with state and county staff and in adherence with research findings in implementation science, a body of knowledge about the factors that help or hinder the implementation of social programs. A primary source for this knowledge is the comprehensive review of implementation research by Fixsen and colleagues¹. Fixsen et al. identify a set of “core implementation components” that are characteristic of successful efforts to install evidence-based programs with high fidelity. The core implementation components include staff selection, pre-service and in-service training, ongoing coaching and consultation, staff and program evaluation, decision support data systems, facilitative administrative support, and systems interventions. These organizational processes are considered to be both integrated (interacting with one another) and compensatory (weakness in one component can be compensated for by strength in another). Social programs rarely if ever completely achieve full implementation of all of these components, but the compensatory nature of the core implementation components means that programs may be highly effective even with limitations in one area or another.

The Implementation Index is accordingly structured to inquire about a set of domains related to the core implementation components. However, these components have been adapted somewhat to suit the specifics of Colorado’s Waiver - in particular the five interventions as prescribed in CDHS’s Initial Design and Implementation Report (IDIR) and implementation checklists. The Implementation Index is, therefore, designed to serve some of the functions of a fidelity measure but in a more efficient manner and using a standardized format based on the core implementation components that can be applied consistently across interventions and counties.

Five separate modules are included in the Index, including one that addresses general functions and activities of the counties with regard to the IV-E Waiver and one for each of the county-level interventions: family engagement, kinship supports, Permanency Roundtables, trauma-informed screening, and trauma-informed assessment and treatment. The modules are largely organized as a set of domains that are common across the modules: target population, staffing and roles, training, tools, and policies and procedures. The specific content of each domain varies, focusing on the specific activities that are likely to occur as the intervention is implemented.

At the beginning of each module is an introductory explanation that defines the practice it addresses. County departments of human/social services are given the option to skip the questions pertaining to that module if they are not implementing any part of the defined practice. In some cases, these modules may be defined more broadly than the Waiver interventions so that the evaluation may understand practices that are similar to the Waiver intervention - similarities and differences to the Waiver intervention are teased out through subsequent questions in the module. Each module addresses five

¹ Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

domains. Each domain includes one to seven specific activities (items). The survey is designed to collect information about the status of these activities.

Each county is given a unique login username and password that can be shared among staff within the county. Instructions for both the Index and user guide that accompanies it are emailed to each county's department of human or social services director. We requested that this individual either complete the Index or delegate it to those staff who have an understanding of the implementation of each particular intervention and/or the Waiver as a whole and who are authorized to describe the department's activities and plans. It generally takes each county about one hour to complete. The online platform allows staff to exit and re-enter the survey with their responses saved.

Respondents are informed in the instructions that individual counties are never identified in any reporting of the results of the Implementation Index. The job titles/roles of the persons completing the survey are requested in order to understand the expected expertise or authority of the staff completing the survey; however, these are not reported and names are not gathered.

Prior to administering the survey each year, we offer a training webinar on multiple occasions to explain the importance of the survey to the evaluation design, the purpose of the survey, and how the responses will be analyzed and used. The lead Waiver contacts from each county are invited to participate in the webinar of their choosing. The evaluation team also advertises and discusses the survey at the intervention workgroup meetings and with the ESC and answers any questions that stakeholders may have. We provide ongoing technical assistance, as counties request it, for the duration of the survey completion period.

Appendix H: Kin Caregiver Survey

Kinship Caregiver Survey

Q1 How many people are currently in your household? Indicate number of adults and number of children under 18.

Adults (18 or over) (1)

Children (under 18) (2)

Q2 How many kin children are currently in your care?

1 (1)

2 (2)

3 (3)

4 (4)

5 or more, please specify how many: (5)

Q3 How old are the kin children in your care? Indicate by entering the number of kin children in your care in each age range.

0-5 years (1)

6-10 years (2)

11-15 (3)

16-18 (4)

19 years or older (5)

Q4 What is your relationship to the kin children in your care?

- Grandparent (1)
- Aunt / Uncle (2)
- Cousin (3)
- Sibling (4)
- Other relative (5)
- Non-relative (i.e. friend, neighbor, teacher) (6)

Q5 What legal status do you have with the kin children in your care?

- No legal status (1)
 - Power of Attorney (2)
 - Temporary Court Ordered custody (3)
 - Permanent Court Ordered custody (4)
 - Allocation of parental rights (APR) (5)
 - Adopted (6)
 - Unsure (7)
 - Other, please specify: (8)
-

Q6 What are the concerns you have with raising your kin children? Check all that apply.

- Finances (1)
- Legal issues (2)
- Your physical health (3)
- Emotional support for yourself (4)
- Negative impact on your relationship with biological parent(s) (5)
- Kin child(ren)'s physical health (6)
- Kin child(ren)'s emotional health (7)

Q7 What type of support do you have? Check all that apply.

- Family (1)
- Friends (2)
- Formal Kinship Support Group (3)
- Online Support Group (4)
- Community based support (i.e. church, community center) (5)
- None (6)

Q8 Does your support system meet your most important needs?

- Yes (1)
 - No (2)
 - I have no support system (3)
-

Q9 What types of classes would you be interested in attending with other kinship caregivers to support you in caring for your kin child(ren)? Add other topics that you are interested in.

- Parenting a child with difficult behaviors (1)
- Signs and indicators of child sexual abuse (2)
- Caring for children who have experienced to witnessed domestic violence (3)
- Generational differences and its impact on discipline (4)
- Effectively managing connections with other family members (5)
- Self-care (6)
- Add other topics you are interested in: (7)

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)	Not applicable (6)
The purpose of the kinship needs assessment was clearly explained to me. (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The kinship needs assessment helped me identify what I needed for providing care to my kin child(ren). (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was able to identify my needs at the time my worker completed the first kinship needs assessment with me. (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The county department has helped me learn about services and resources available in the community. (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I was able to find the resources I needed in my community once children were in my care. (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The support the county department has provided has led to more connections with other kin caregivers and/or parents. (8)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The support the county department has provided has increased my ability to continue as a kin caregiver. (7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The services and supports the county department has provided helped decrease my financial stress. (3)

I was satisfied with the emotional support provided by my kin worker. (9)

The county department provided items (e.g. crib, bed, car seat) that helped me care for my kin children. (10)

The kin children in my care have less stress because of the resources provided by the county department. (11)

I feel supported by the county department to care for my kin children. (12)

I feel supported by my friends and family to care for my kin children. (13)

My coworkers support my role as a kin caregiver. (14)

The county provided the right amount of contact with my family. (15)

I felt comfortable that I could share my needs with my kin worker without my ability to provide care being questioned. (16)

I was informed about what being a kin caregiver would be like. (17)

I was surprised by what was expected of me as a kin caregiver. (18)

I was offered the opportunity to become a certified kin caregiver. (19)

I was satisfied with the financial support I receive(d) as a kin caregiver. (20)

I was satisfied with the legal support I receive(d) as a kin caregiver. (21)

If I had to do it all over, I would agree to care for my kin children again. (22)

Q11 What is the most beneficial support or service you have received from the county department?

Q12 What would you like to see improved about the supports or services you have received from the county department?

Q13 What has helped you continue to provide for the kin child(ren) in your care?

Q14 Please add any other comments you wish to provide here:

Thank you for your participation. The demographic questions below are very important in understanding how to improve experiences for kinship caregivers. Again, we want to assure you that your responses will be kept confidential.

Q15 How old are you?

- 24 or younger (1)
- 25-35 (2)
- 36-45 (3)
- 46-55 (4)
- 56-65 (5)
- 66-75 (6)
- 76 or older (7)

Q16 What is your gender identity?

- Female (1)
 - Male (2)
 - Gender non-conforming (3)
-

Q17 What is your ethnicity? Check all that apply.

- American Indian or Alaskan Native (1)
 - Asian (2)
 - Black or African American (3)
 - Hispanic/Latino(a) (4)
 - Native Hawaiian or other Pacific Islander (5)
 - White (non-Hispanic/Latino) (6)
 - Other, please specify: (7)
-

Q18 What is your relationship status?

- Single (including divorced or widowed) (1)
- Married or in a domestic partnership (2)

Q19 What is your work status?

- Work full-time (1)
 - Work part-time (2)
 - Not employed (3)
 - Retired (4)
-

Q20 What is your annual household income? (Include income from a job, TANF, SSI and Food Stamps for everyone in the household including children.)

- Less than \$10,000 (1)
 - \$10,000 - \$14,999 (2)
 - \$15,000 - \$24,999 (3)
 - \$25,000 - \$34,999 (4)
 - \$35,000 - \$49,999 (5)
 - \$50,000 - \$74,999 (6)
 - \$75,000 or more (7)
-

If you would like to receive a \$5 gift card to Amazon.com, please enter the email address where you would like the e-gift card to be sent below:

Thank you for participating in this survey. We appreciate your time!

Appendix I: Kin Caregiver Survey Results Infographic

Support for Colorado's Kin Caregivers under the IV-E Waiver

What we learned from the 2017 kin caregiver survey

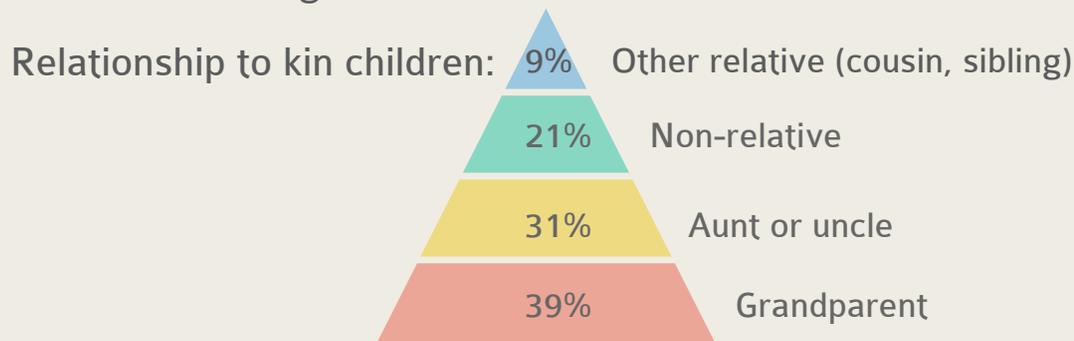
Survey Respondents

232 caregivers who had completed a needs assessment across 16 counties

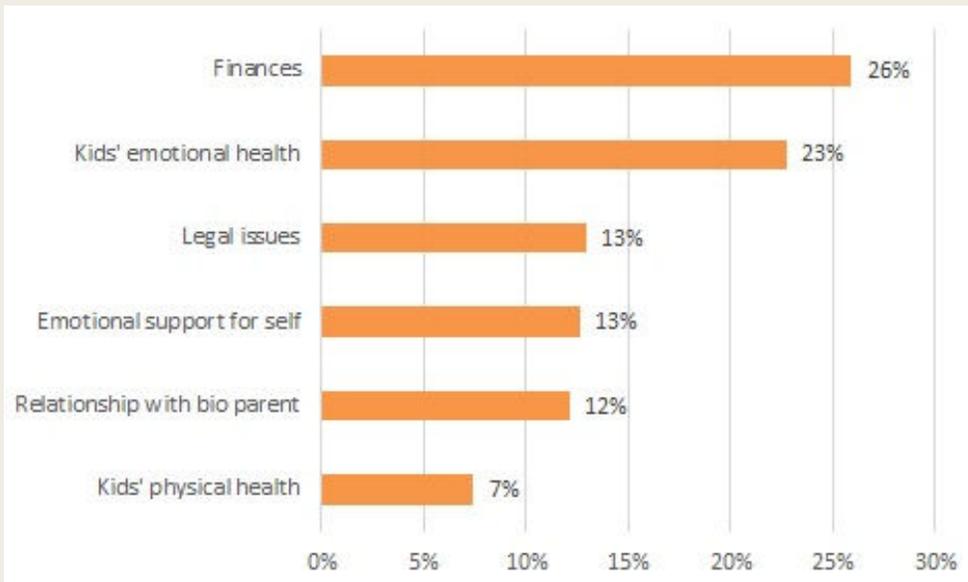
32% of those who received the survey responded

84% had 1-2 kids in their care

89% were women who were working full-time



Kin Caregiver Concerns



Financial stress impacts caregivers:

45% agreed that the services and supports the county department provided helped decrease their financial stress.

38% agreed that they were satisfied with the financial support they received as a kin caregiver.



Support for Colorado's Kin Caregivers under the IV-E Waiver

What we learned from the 2017 kin caregiver survey

Kin Caregivers & Support

 83% felt supported by their friends and family to care for their kin children

 6% had attended an in-person or online support group

 32% felt that their support system did not meet their most important needs or that they didn't have a support system

"I would have liked the opportunity to talk with another kin provider so that I could have had a better handle on a few situations that arose with the child's mother." - Caregiver



69% agreed that the kinship needs assessment was clearly explained to them



64% felt comfortable sharing their needs with their kin worker without their ability to provide care being questioned



Relationships matter. Caregivers identified and praised their caseworkers by name; the emotional support provided by the worker was invaluable. And caregivers agreed to provide care because of their love for and relationship with their kin children: 77% said ***"If I had to do it all over, I would agree to care for my kin children again."***

"I would say the most beneficial thing has been [kin worker's] compassion through the craziness."

- Caregiver

"My kin worker is amazing and has always been a great listening ear."

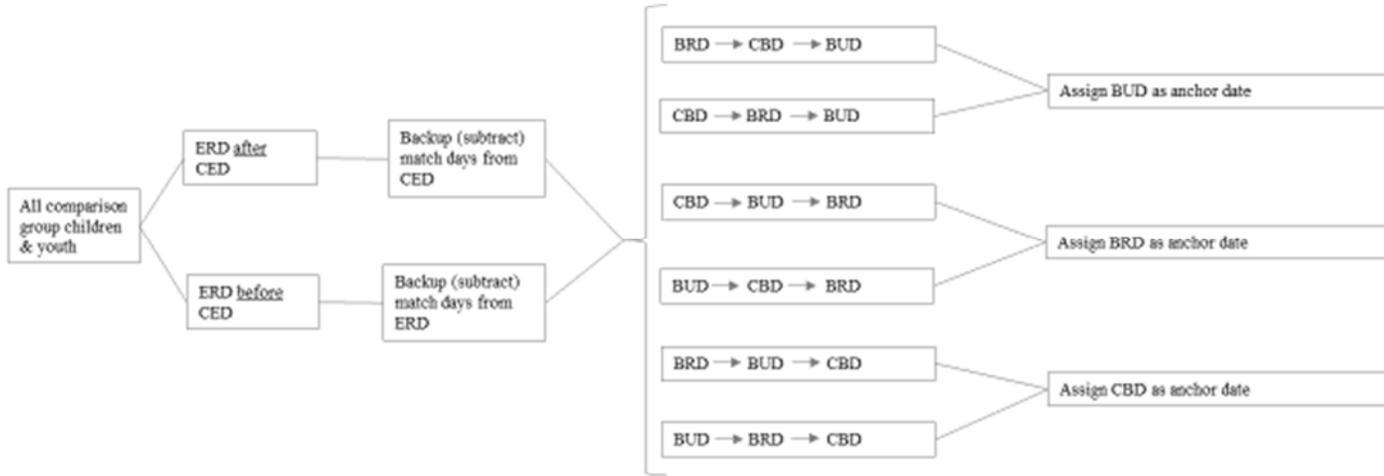
- Caregiver



Appendix J: Anchor Date Assignment Pathway for PRT Comparison Group Children & Youth

Anchor Date Assignment Pathway for PRT Comparison Group Children & Youth

ERD = End Removal Date
 CED = Comparison Group Observation End Date
 BUD = Back up date
 CBD = Comparison Group Observation Begin Date
 BRD = Begin Removal Date



Appendix K: Full Matched Case Comparison Outcome Tables

Full Matched Case Comparison Analysis Tables for each Waiver-Funded Intervention

FFE Meetings – All Children and Youth

Outcome	All Treatment and Comparison Children					
	Treatment Group (n=26,859)	Comparison Group (n=26,857)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Placement Avoidance (never placed out of home during case)</i>						
No Placement	46.2%	50.1%	-3.9%	No	NA	NA

Outcome	Children with at least .50 Overall Adherence and their Comparisons					
	Treatment Group (n=8,535)	Comparison Group (n=8,535)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Placement Avoidance (never placed out of home during case)</i>						
No Placement	67.3%	49.6%	17.7%	Yes	<.01	1.83

Outcome	Children with less than .50 Overall Adherence and their Comparisons
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	Treatment Group (n=18,324)	Comparison Group (n=18,322)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Placement Avoidance (never placed out of home during case)</i>						
No Placement	36.4%	50.3%	-13.9%	No	NA	NA

FFE Meetings – Out-of-Home Children and Youth

Outcome	All Treatment Children					
	Treatment Group (n=14,442)	Comparison Group (n=13,998)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
During Case						
Permanency						
<i>Case Length (of children whose case had closed)</i>						
Mean days (SD)	493.10 (275.22)	518.19 (312.42)	-25.09 (-37.20)	Yes	<.01	0.09
Median days	439	466	-27	Yes	<.01	0.03
<i>Placement Delay (all children)</i>						
No placement at case open	43.3%	42.5%	0.8%	Yes	NS	1.01
No placement within 2 weeks	30.5%	30.9%	-0.4%	No	NA	NA
No placement within 1 month	24.9%	26.4%	-1.5%	No	NA	NA

No placement within 3 months	15.4%	18.2%	-2.8%	No	NA	NA
No placement within 6 months	8.8%	12.0%	-3.2%	No	NA	NA
<i>Least Restrictive Placement (all children)</i>						
First OOH placement in kinship care	42.6%	32.8%	9.8%	Yes	<.01	1.56
All case OOH days in kinship care	40.8%	31.9%	8.9%	Yes	<.01	1.56
Most case OOH days in kinship care	51.5%	42.5%	9.0%	Yes	<.01	1.55
<i>Placement Stability (all children)</i>						
No placement setting changes	40.3%	44.2%	-3.9%	No	NA	NA
1 or fewer placement setting changes	65.6%	69.7%	-4.1%	No	NA	NA
2 or fewer placement setting changes	78.1%	82.3%	-4.2%	No	NA	NA
Case Close						
Permanency						
<i>Permanent Case Close Residence (non-adoption)</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	77.3%	74.9%	2.4%	Yes	NS	1.07
Parent(s)	52.3%	53.7%	-1.4%	No	NA	NA
Non-adoptive kin	23.0%	19.7%	3.3%	Yes	<.01	1.25
Non-kin guardian(s)	2.1%	1.5%	0.6%	Yes	<.05	1.34
<i>Days to Permanency</i>						
Mean days (SD)	436.55 (231.90)	463.05 (284.21)	-26.5 (-52.31)	Yes	<.01	0.07
Median days	397	413	-16	Yes	<.01	0.03
Post Case Close						
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	6.5%	11.0%	-4.5%	Yes	NS	1.05
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						

Mean days (SD)	715.39 (321.17)	598.25 (366.76)	117.14 (-45.59)	Yes	<.01	0.34
Median days	699	606	93	Yes	<.01	0.16
Permanency						
<i>Post Case Close OOH Placement</i>						
Percentage of children with a post-case close OOH placement	13.0%	7.5%	5.5%	No	NA	NA
<i>Least Restrictive Placement Use (of children with a post-case close OOH placement)</i>						
All post-case OOH days in kinship care	12.7%	6.5%	6.2%	Yes	<.01	2.21
Most post-case OOH days in kinship care	15.1%	8.6%	6.5%	Yes	<.01	1.88

Outcome	Children with at least .50 Overall Adherence and their Comparisons					
	Treatment Group (n=2,791)	Comparison Group (n=2,702)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
During Case						
Permanency						
<i>Case Length (of children whose case had closed)</i>						
Mean days (SD)	368.32 (223.44)	523.6 (313.05)	-155.28 (-89.61)	Yes	<.01	0.57
Median days	343	474	-131	Yes	<.01	0.26
<i>Placement Delay (all children)</i>						
No placement at case open	38.4%	41.8%	-3.4%	No	NA	NA
No placement within 2 weeks	24.1%	30.1%	-6.0%	No	NA	NA
No placement within 1 month	19.3%	25.6%	-6.3%	No	NA	NA

No placement within 3 months	12.1%	18.2%	-6.1%	No	NA	NA
No placement within 6 months	7.3%	11.8%	-4.5%	No	NA	NA
<i>Least Restrictive Placement (all children)</i>						
First OOH placement in kinship care	44.0%	32.7%	11.3%	Yes	<.01	1.62
All case OOH days in kinship care	43.5%	31.9%	11.6%	Yes	<.01	1.44
Most case OOH days in kinship care	53.9%	42.6%	11.3%	Yes	<.01	1.41
<i>Placement Stability (all children)</i>						
No placement setting changes	45.9%	43.2%	2.7%	Yes	<.05	1.14
1 or fewer placement setting changes	72.2%	68.8%	3.4%	Yes	<.01	1.21
2 or fewer placement setting changes	83.3%	81.4%	1.9%	Yes	<.01	1.40
Case Close						
Permanency						
<i>Permanent Case Close Residence (non-adoption)</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	90.0%	73.5%	16.5%	Yes	<.01	3.10
Parent(s)	67.2%	53.4%	13.8%	Yes	<.01	1.50
Non-adoptive kin	20.7%	18.4%	2.3%	Yes	NS	1.13
Non-kin guardian(s)	2.0%	1.7%	0.3%	Yes	NS	1.09
<i>Days to Permanency</i>						
Mean days (SD)	363.53 (212.32)	465.71 (287.93)	-102.18 (-75.61)	Yes	<.01	0.13
Median days	343.5	414	-70.5	Yes	<.01	0.21
Post Case Close						
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	5.3%	11.3%	-6.0%	Yes	NS	1.02
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						

Mean days (SD)	605.04 (363.23)	653.49 (382.94)	-48.45 (-19.71)	No	NA	NA
Median days	548.5	653	-104.5	No	NA	NA
Permanency						
<i>Post Case Close OOH Placement</i>						
Percentage of children with a post-case close OOH placement	13.5%	9.0%	4.5%	No	NA	NA
<i>Least Restrictive Placement Use (of children with a post-case close OOH placement)</i>						
All post-case OOH days in kinship care	17.7%	6.4%	11.3%	Yes	<.01	6.25
Most post-case OOH days in kinship care	19.8%	8.3%	11.5%	Yes	<.01	4.86

Outcome	Children with less than .50 Overall Adherence and their Comparisons					
	Treatment Group (n=11,651)	Comparison Group (n=11,296)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
During Case						
Permanency						
<i>Case Length (of children whose case had closed)</i>						
Mean days (SD)	522.08 (278.01)	516.90 (312.28)	5.18 (-34.27)	No	NA	NA
Median days	465	463	2	No	NA	NA
<i>Placement Delay (all children)</i>						
No placement at case open	44.4%	42.7%	1.7%	Yes	NS	1.00
No placement within 2 weeks	32.1%	31.1%	1.0%	Yes	NS	1.03
No placement within 1 month	26.2%	26.6%	-0.4%	No	NA	NA

No placement within 3 months	16.1%	18.3%	-2.2%	No	NA	NA
No placement within 6 months	9.2%	12.0%	-2.8%	No	NA	NA
<i>Least Restrictive Placement (all children)</i>						
First OOH placement in kinship care	42.3%	32.8%	9.5%	Yes	<.01	1.60
All case OOH days in kinship care	40.2%	31.9%	8.3%	Yes	<.01	1.62
Most case OOH days in kinship care	50.9%	42.5%	8.4%	Yes	<.01	1.58
<i>Placement Stability (all children)</i>						
No placement setting changes	39.0%	44.5%	-5.5%	No	NA	NA
1 or fewer placement setting changes	64.1%	69.9%	-5.8%	No	NA	NA
2 or fewer placement setting changes	76.9%	82.5%	-5.6%	No	NA	NA
Case Close						
Permanency						
<i>Permanent Case Close Residence (non-adoption)</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	74.4%	75.3%	-0.9%	No	NA	NA
Parent(s)	48.8%	53.8%	-5.0%	No	NA	NA
Non-adoptive kin	23.5%	20.0%	3.5%	Yes	<.01	1.32
Non-kin guardian(s)	2.1%	1.5%	0.6%	Yes	<.05	1.37
<i>Days to Permanency</i>						
Mean days (SD)	457.22 (233.05)	462.43 (283.36)	-5.21 (-50.31)	Yes	NS	0.02
Median days	414	412	2	No	NA	NA
Post Case Close						
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	6.8%	10.9%	-4.1%	Yes	NS	1.07
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						

Mean days (SD)	735.65 (308.99)	584.56 (361.58)	151.09 (-52.59)	Yes	<.01	0.45
Median days	709	587	122	Yes	<.01	0.21
Permanency						
<i>Post Case Close OOH Placement</i>						
Percentage of children with a post-case close OOH placement	12.9%	7.2%	5.7%	No	NA	NA
<i>Least Restrictive Placement Use (of children with a post-case close OOH placement)</i>						
All post-case OOH days in kinship care	11.5%	6.5%	5.0%	Yes	<.05	1.86
Most post-case OOH days in kinship care	13.9%	8.6%	5.3%	Yes	NS	1.59
Children who Spent One or More Days in Kinship Care and Received Kinship Supports in addition to FFE Meetings						
Outcome	Treatment Group (n=7,776)	Comparison Group (n=7,539)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
During Case						
Permanency						
<i>Case Length (of children whose case had closed)</i>						
Mean days (SD)	502.71 (246.23)	483.20 (280.64)	19.51 (-34.41)	No	NA	NA
Median days	453	442	11	No	NA	NA
<i>Placement Delay (all children)</i>						
No placement at case open	NA	NA	NA	NA	NA	NA
No placement within 2 weeks	NA	NA	NA	NA	NA	NA
No placement within 1 month	NA	NA	NA	NA	NA	NA

No placement within 3 months	NA	NA	NA	NA	NA	NA
No placement within 6 months	NA	NA	NA	NA	NA	NA
<i>Least Restrictive Placement (all children)</i>						
First OOH placement in kinship care	67.3%	32.6%	34.7%	Yes	<.01	3.88
All case OOH days in kinship care	65.8%	31.9%	33.9%	Yes	<.01	4.04
Most case OOH days in kinship care	83.1%	42.4%	40.7%	Yes	<.01	6.62
<i>Placement Stability (all children)</i>						
No placement setting changes	44.2%	44.2%	0.0%	No	NA	NA
1 or fewer placement setting changes	70.4%	69.5%	0.9%	Yes	<.01	1.16
2 or fewer placement setting changes	82.8%	82.2%	0.6%	Yes	<.01	1.34
Case Close						
Permanency						
<i>Permanent Case Close Residence (non-adoption)</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	83.2%	76.3%	6.9%	Yes	<.01	1.49
Parent(s)	45.8%	55.3%	-9.5%	No	NA	NA
Non-adoptive kin	34.9%	19.3%	15.6%	Yes	<.01	2.12
Non-kin guardian(s)	2.5%	1.6%	0.9%	Yes	<.01	1.67
<i>Days to Permanency</i>						
Mean days (SD)	453.90 (211.94)	434.21 (252.64)	19.69 (-40.7)	No	NA	NA
Median days	416	399	17	No	NA	NA
Post Case Close						
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	7.4%	11.4%	-4.0%	Yes	NS	1.04
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						

Mean days (SD)	682.85 (305.00)	579.12 (365.72)	103.73 (-60.72)	Yes	<.01	0.31
Median days	679	559	120	Yes	<.01	0.16
Permanency						
<i>Post Case Close OOH Placement</i>						
Percentage of children with a post-case close OOH placement	7.0%	7.4%	-0.4%	Yes	<.01	1.29
<i>Least Restrictive Placement Use (of children with a post-case close OOH placement)</i>						
All post-case OOH days in kinship care	41.3%	5.6%	35.7%	Yes	<.01	6.88
Most post-case OOH days in kinship care	49.4%	7.6%	41.8%	Yes	<.01	7.61

Outcome	Children who Spent One or More Days in Kinship Care, but did not Receive Kinship Supports in addition to FFE Meetings					
	Treatment Group (n=1,493)	Comparison Group (n=1,451)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
During Case						
Permanency						
<i>Case Length (of children whose case had closed)</i>						
Mean days (SD)	498.74 (282.13)	536.85 (316.36)	-38.11 (-34.23)	Yes	<.01	0.13
Median days	431	476	-45	Yes	<.01	0.06
<i>Placement Delay (all children)</i>						
No placement at case open	NA	NA	NA	NA	NA	NA
No placement within 2 weeks	NA	NA	NA	NA	NA	NA
No placement within 1 month	NA	NA	NA	NA	NA	NA

No placement within 3 months	NA	NA	NA	NA	NA	NA
No placement within 6 months	NA	NA	NA	NA	NA	NA
<i>Least Restrictive Placement (all children)</i>						
First OOH placement in kinship care	59.1%	32.4%	26.7%	Yes	<.01	2.91
All case OOH days in kinship care	49.7%	30.8%	18.9%	Yes	<.01	2.14
Most case OOH days in kinship care	62.6%	42.0%	20.6%	Yes	<.01	2.15
<i>Placement Stability (all children)</i>						
No placement setting changes	37.4%	44.0%	-6.6%	No	NA	NA
1 or fewer placement setting changes	64.7%	67.7%	-3.0%	No	NA	NA
2 or fewer placement setting changes	80.0%	81.8%	-1.8%	No	NA	NA
Case Close						
Permanency						
<i>Permanent Case Close Residence (non-adoption)</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	84.3%	73.7%	10.6%	Yes	<.01	1.89
Parent(s)	58.0%	52.5%	5.5%	Yes	NS	1.18
Non-adoptive kin	24.1%	19.9%	4.2%	Yes	<.05	1.26
Non-kin guardian(s)	2.2%	1.8%	0.4%	Yes	NS	1.68
<i>Days to Permanency</i>						
Mean days (SD)	442.53 (245.95)	483.52 (287.68)	-40.99 (-41.73)	Yes	<.01	
Median days	391	422	-31	Yes	<.01	0.06
Post Case Close						
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	6.5%	10.6%	-4.1%	Yes	NS	1.08
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						

Mean days (SD)	822.29 (269.70)	609.23 (378.87)	213.06 (-109.17)	Yes	<.01	0.65
Median days	804	626	178	Yes	<.01	0.28
Permanency						
<i>Post Case Close OOH Placement</i>						
Percentage of children with a post-case close OOH placement	7.0%	8.5%	-1.5%	Yes	NS	1.01
<i>Least Restrictive Placement Use (of children with a post-case close OOH placement)</i>						
All post-case OOH days in kinship care	11.4%	6.3%	5.1%	Yes	NS	1.32
Most post-case OOH days in kinship care	11.4%	7.5%	3.9%	Yes	NS	1.05

FFE Meetings – In-Home Children and Youth

Outcome	All Treatment and Comparison Children					
	Treatment Group (n=12,417)	Comparison Group (n=12,417)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Mean case length in days (SD)	282.02 (212.41)	272.46 (231.24)	9.56 (-18.83)	No	NA	NA
Median case length in days	227	213	14	No	NA	NA
Permanency						
<i>Permanent Case Close Residence</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	96.6%	96.5%	0.1%	Yes	NS	1.02
Parent(s)	90.2%	90.8%	-0.6%	No	NA	NA
Non-adoptive kin	5.2%	4.9%	0.3%	Yes	NS	1.04
Non-kin guardian(s)	1.3%	0.8%	0.5%	Yes	<.01	1.55

Mean days to case close residence with parents, kin, or guardians (SD)	278.21 (204.00)	270.53 (227.06)	7.68 (-23.06)	No	NA	NA
Median days to case close residence with parents, kin, or guardians (SD)	227	212	15	No	NA	NA
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	9.5%	6.6%	2.9%	No	NA	NA
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						
Mean (SD) days to a re-involvement	605.81 (325.10)	480.78 (351.22)	125.03 (-26.12)	Yes	<.01	0.37
Median days to a re-involvement	557	415	142	Yes	<.01	0.20

Outcome	Children with at least .50 Overall Adherence and their Comparisons					
	Treatment Group (n=5,744)	Comparison Group (n=5,744)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Mean case length in days (SD)	269.40 (198.61)	305.57 (250.21)	-36.17 (-51.6)	Yes	<.01	0.16
Median case length in days	230	246	-16	Yes	<.01	0.05
Permanency						
<i>Permanent Case Close Residence</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	96.8%	96.5%	0.3%	Yes	NS	1.14
Parent(s)	90.5%	89.0%	1.5%	Yes	NS	1.05
Non-adoptive kin	5.2%	6.3%	-1.1%	No	NA	NA

Non-kin guardian(s)	1.2%	1.1%	0.1%	Yes	NS	1.27
Mean days to case close residence with parents, kin, or guardians (SD)	267.51 (194.66)	304.01 (248.47)	-46.5 (-53.81)	Yes	<.01	0.16
Median days to case close residence with parents, kin, or guardians (SD)	230	245	-15	Yes	<.01	0.05
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	9.1%	7.7%	1.4%	No	NA	NA
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						
Mean (SD) days to a re-involvement	600.04 (324.51)	518.24 (366.09)	81.8 (-41.58)	Yes	<.01	0.24
Median days to a re-involvement	543	476	67	Yes	<.01	0.31

Outcome	Children with less than .50 Overall Adherence and their Comparisons					
	Treatment Group (n=6,673)	Comparison Group (n=6,673)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Mean case length in days (SD)	293.49 (223.63)	243.93 (209.41)	49.56 (14.22)	No	NA	NA
Median case length in days	225	186	39	No	NA	NA
Permanency						
<i>Permanent Case Close Residence</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	96.5%	96.6%	-0.1%	No	NA	NA
Parent(s)	89.9%	92.3%	-2.4%	No	NA	NA

Non-adoptive kin	5.1%	3.6%	1.5%	Yes	NS	1.18
Non-kin guardian(s)	1.4%	0.6%	0.8%	Yes	<.01	2.08
Mean days to case close residence with parents, kin, or guardians (SD)	287.99 (211.74)	241.72 (202.50)	46.27 (9.24)	No	NA	NA
Median days to case close residence with parents, kin, or guardians (SD)	224	186	38	No	NA	NA
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	9.8%	5.7%	4.1%	No	NA	NA
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						
Mean (SD) days to a re-involvement	610.69 (325.83)	437.36 (328.35)	173.33 (-2.52)	Yes	<.01	0.53
Median days to a re-involvement	574	375	199	Yes	<.01	0.27

Kinship Supports – All Children and Youth

Outcome	All Treatment Children					
	Treatment Group (n=10,114)	Comparison Group (n=8,779)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Case Length (of children with closed cases)</i>						
Mean days (SD)	530.93 (461.35)	543.84 (462.32)	-12.91 (-.97)	Yes	<.01	0.03

Median days	441	443	-2	Yes	NS	0.01
<i>Kinship Placement Length</i>						
Mean days (SD)	196.31 (178.71)	167.88 (168.31)	28.43 (10.4)	Yes	<.01	0.16
Median days	141	112	29	Yes	<.01	0.10
<i>Least Restrictive Placement Use (from kinship placement begin date to observation end)</i>						
All OOH days in kinship care	80.7%	78.3%	2.4%	Yes	<.01	1.19
Most OOH days in kinship care	88.2%	85.4%	2.8%	Yes	<.01	1.30
<i>Placement Stability</i>						
No placement setting changes	57.8%	59.3%	-1.5%	No	NA	NA
Less than two placement setting changes	79.1%	80.1%	-1.0%	No	NA	NA
Less than three placement setting changes	87.8%	89.4%	-1.6%	No	NA	NA
<i>Kinship Placement Exit Reason</i>						
Permanency or least restrictive OOH placement	80.6%	84.4%	-3.8%	No	NA	NA
Return home	31.4%	41.9%	-10.5%	No	NA	NA
Kinship placement	38.6%	33.3%	5.3%	Yes	<.01	1.27
Guardianship	4.3%	3.6%	0.7%	Yes	<.01	1.30
Adoption	6.2%	5.6%	0.6%	Yes	<.05	1.15
Mean days to permanency or least restrictive OOH placement (SD)	206.16 (183.00)	176.54 (171.54)	29.62 (11.46)	No	NA	NA
Median days to permanency or least restrictive OOH placement	150	124	26	No	NA	NA
<i>Permanent Case Close Residence</i>						
Permanency at case close	95.6%	95.3%	0.3%	Yes	NS	1.07
Parent(s)	49.0%	51.9%	-2.9%	No	NA	NA
Non-adoptive kin	30.9%	28.3%	2.6%	Yes	<.01	1.13

Non-kin guardian(s)	2.4%	1.7%	0.7%	Yes	<.01	1.45
Adoptive parents	13.3%	13.4%	-0.1%	No	NA	NA
Mean days to permanency at case close (SD)	511.29 (380.74)	525.45 (408.37)	-14.16 (-27.63)	Yes	<.01	0.04
Median days to permanency at case close (SD)	437	439	-2	Yes	NS	0.00
Safety						
<i>Days to Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	0.8%	6.3%	-5.5%	Yes	<.01	7.79
Mean (SD) days to re-involvement	682.71 (359.5)	684.62 (327.85)	-1.91 (31.65)	No	NA	NA
Median days to re-involvement	708	643	65	Yes	NS	0.00

Outcome	Children in a Kinship Placement with Higher Adherence					
	Treatment Group (n=3,552)	Comparison Group (n=3,107)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Case Length (of children with closed cases)</i>						
Mean days (SD)	514.60 (444.24)	543.62 (472.79)	-29.02 (-28.55)	Yes	<.01	0.06
Median days	427	446	-19	Yes	NS	0.02
<i>Kinship Placement Length</i>						

Mean days (SD)	199.11 (182.22)	168.37 (169.24)	30.74 (12.98)	Yes	<.01	0.18
Median days	144	110	34	Yes	<.01	0.10
<i>Least Restrictive Placement Use (from kinship placement begin date to observation end)</i>						
All OOH days in kinship care	79.8%	78.3%	1.5%	Yes	NS	1.09
Most OOH days in kinship care	87.9%	85.6%	2.3%	Yes	<.01	1.23
<i>Placement Stability</i>						
No placement setting changes	55.5%	58.7%	-3.2%	No	NA	NA
Less than two placement setting changes	78.6%	80.3%	-1.7%	No	NA	NA
Less than three placement setting changes	88.1%	89.6%	-1.5%	No	NA	NA
<i>Kinship Placement Exit Reason</i>						
Permanency or least restrictive OOH placement	80.5%	84.3%	-3.8%	No	NA	NA
Return home	30.5%	41.2%	-10.7%	No	NA	NA
Kinship placement	39.2%	33.6%	5.6%	Yes	<.01	1.28
Guardianship	4.1%	3.8%	0.3%	Yes	NS	1.04
Adoption	6.7%	5.8%	0.9%	Yes	NS	1.25
Mean days to permanency or least restrictive OOH placement (SD)	209.90 (186.19)	179.05 (174.49)	30.85 (11.7)	No	NA	NA
Median days to permanency or least restrictive OOH placement	159	125	34	No	NA	NA
<i>Permanent Case Close Residence</i>						
Permanency at case close	95.7%	95.5%	0.2%	Yes	NS	1.15
Parent(s)	46.2%	50.9%	-4.7%	No	NA	NA
Non-adoptive kin	32.1%	28.8%	3.3%	Yes	NS	1.12
Non-kin guardian(s)	2.5%	1.7%	0.8%	Yes	<.05	1.55
Adoptive parents	14.9%	14.1%	0.8%	Yes	NS	1.08

Mean days to permanency at case close (SD)	497.18 (361.98)	524.00 (405.14)	-26.82 (-43.16)	Yes	<.01	0.07
Median days to permanency at case close (SD)	425	443	-18.00	Yes	NS	0.02
Safety						
<i>Days to Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	0.7%	5.8%	-5.1%	Yes	<.01	8.82
Mean (SD) days to re-involvement	673.20 (316.84)	666.46 (320.52)	6.74 (-3.68)	Yes	<.01	0.02
Median days to re-involvement	629	626	3	Yes	NS	0.01

Outcome	Children in a Kinship Placement with Lower Adherence					
	Treatment Group (n=6,562)	Comparison Group (n=5,672)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Case Length (of children with closed cases)</i>						
Mean days (SD)	540.02 (470.41)	543.95 (456.67)	-3.93 (14.74)	Yes	<.01	0.01
Median days	450	440	10	No	NA	NA
<i>Kinship Placement Length</i>						
Mean days (SD)	194.77 (176.75)	167.60 (167.82)	27.17 (8.93)	Yes	<.01	0.16

Median days	140	113	27	Yes	<.01	0.10
<i>Least Restrictive Placement Use (from kinship placement begin date to observation end)</i>						
All OOH days in kinship care	81.2%	78.3%	2.9%	Yes	<.01	1.25
Most OOH days in kinship care	88.4%	85.3%	3.1%	Yes	<.01	1.35
<i>Placement Stability</i>						
No placement setting changes	59.0%	59.7%	-0.7%	No	NA	NA
Less than two placement setting changes	79.4%	80.0%	-0.6%	No	NA	NA
Less than three placement setting changes	87.7%	89.3%	-1.6%	No	NA	NA
<i>Kinship Placement Exit Reason</i>						
Permanency or least restrictive OOH placement	80.6%	84.4%	-3.8%	No	NA	NA
Return home	31.9%	42.2%	-10.3%	No	NA	NA
Kinship placement	38.3%	33.1%	5.2%	Yes	<.01	1.27
Guardianship	4.5%	3.5%	1.0%	Yes	<.01	1.44
Adoption	6.0%	5.5%	0.5%	Yes	NS	1.1
Mean days to permanency or least restrictive OOH placement (SD)	204.10 (181.21)	175.03 (169.91)	29.07 (11.3)	No	NA	NA
Median days to permanency or least restrictive OOH placement	147	124	23	No	NA	NA
<i>Permanent Case Close Residence</i>						
Permanency at case close	95.6%	95.2%	0.4%	Yes	NS	1.19
Parent(s)	50.5%	52.5%	-2.0%	No	NA	NA
Non-adoptive kin	30.3%	28.1%	2.2%	Yes	<.05	1.13
Non-kin guardian(s)	2.4%	1.7%	0.7%	Yes	<.05	1.43
Adoptive parents	12.4%	12.9%	-0.5%	No	NA	NA
Mean days to permanency at case close (SD)	519.14 (390.61)	526.23 (410.16)	-7.09 (-19.55)	Yes	<.05	0.02

Median days to permanency at case close (SD)	446	435	11	No	NA	NA
Safety						
<i>Days to Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	0.9%	6.6%	-5.7%	Yes	<.01	7.35
Mean (SD) days to re-involvement	727.49 (386.86)	693.28 (331.56)	34.21 (55.3)	Yes	<.01	0.1
Median days to re-involvement	771	673	98	Yes	NS	0.04

PRTs – Youth 16 and Older with an OPPLA Goal

Outcome	All Treatment Youth					
	Treatment Group (n=480)	Comparison Group (n=315)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	4.6%	6.3%	-1.7%	No	NA	NA
Most OOH days in kinship care	6.9%	8.3%	-1.4%	No	NA	NA
At least one step-down in restrictiveness	31.3%	26.7%	4.6%	Yes	NS	1.20
No step-ups in restrictiveness	77.9%	79.0%	-1.1%	No	NA	NA
More step-downs than step-ups	17.9%	14.3%	3.6%	Yes	NS	1.32
<i>Placement Stability</i>						
No placement setting changes	36.3%	45.7%	-9.4%	No	NA	NA
< 2 placement setting changes	58.8%	69.5%	-10.7%	No	NA	NA

< 3 placement setting changes	72.5%	79.7%	-7.2%	No	NA	NA
<i>Permanent Residence at End Removal</i>						
Permanency at case close	13.0%	13.4%	-0.4%	No	NA	NA
Parents	8.0%	8.7%	-0.7%	No	NA	NA
Non-adopt kin	2.8%	2.8%	0.0%	No	NA	NA
Non-kin guardians	0.8%	0.4%	0.4%	Yes	NS	2.22
Adoptive parents	1.4%	1.6%	-0.2%	No	NA	NA
<i>End Removal Reason</i>						
Emancipation	71.7%	74.3%	-2.6%	Yes	NS	1.14

Outcome	Youth with Higher Adherence					
	Treatment Group (n=106)	Comparison Group (n=76)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	2.8%	3.9%	-1.1%	No	NA	NA
Most OOH days in kinship care	4.7%	6.6%	-1.9%	No	NA	NA
At least one step-down in restrictiveness	37.7%	28.9%	8.8%	Yes	NS	1.27
No step-ups in restrictiveness	68.9%	76.3%	-7.4%	No	NA	NA
More step-downs than step-ups	19.8%	13.2%	6.6%	Yes	NS	1.57
<i>Placement Stability</i>						
No placement setting changes	28.3%	44.7%	-16.4%	No	NA	NA
< 2 placement setting changes	49.1%	64.5%	-15.4%	No	NA	NA
< 3 placement setting changes	63.2%	77.6%	-14.4%	No	NA	NA
<i>Permanent Residence at End Removal</i>						

Permanency at case close	14.6%	12.7%	1.9%	Yes	NS	1.02
Parents	13.4%	12.7%	0.7%	Yes	NS	1.11
Non-adopt kin	0.0%	0.0%	0.0%	No	NA	NA
Non-kin guardians	1.2%	0.0%	1.2%	Yes	NS	9.47
Adoptive parents	0.0%	0.0%	0.0%	No	NA	NA
<i>End Removal Reason</i>						
Emancipation	76.8%	61.8%	15.0%	No	NA	NA

Outcome	Youth who Began their Removal During a Year in Which County was Funded					
	Treatment Group (n=134)	Comparison Group (n=111)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	9.0%	6.3%	2.7%	Yes	NS	1.51
Most OOH days in kinship care	11.9%	9.9%	2.0%	Yes	NS	1.01
At least one step-down in restrictiveness	32.8%	25.2%	7.6%	Yes	NS	1.51
No step-ups in restrictiveness	75.4%	78.4%	-3.0%	No	NA	NA
More step-downs than step-ups	20.9%	10.8%	10.1%	Yes	NS	1.37
<i>Placement Stability</i>						
No placement setting changes	19.4%	44.1%	-24.7%	No	NA	NA
< 2 placement setting changes	53.0%	67.6%	-14.6%	No	NA	NA
< 3 placement setting changes	70.1%	80.2%	-10.1%	No	NA	NA
<i>Permanent Residence at End Removal</i>						
Permanency at case close	20.7%	12.6%	8.1%	Yes	NS	1.52
Parents	14.6%	10.3%	4.3%	Yes	NS	1.28

Non-adopt kin	4.9%	1.1%	3.8%	Yes	NS	1718.876
Non-kin guardians	1.2%	0.0%	1.2%	Yes	NS	16.37
Adoptive parents	0.0%	1.1%	-1.1%	No	NA	NA
<i>End Removal Reason</i>						
Emancipation	65.9%	73.6%	-7.7%	Yes	NS	1.57

Outcome	Youth with Lower Adherence					
	Treatment Group (n=374)	Comparison Group (n=239)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	5.1%	7.1%	-2.0%	No	NA	NA
Most OOH days in kinship care	7.5%	8.8%	-1.3%	No	NA	NA
At least one step-down in restrictiveness	29.4%	25.9%	3.5%	Yes	NS	1.19
No step-ups in restrictiveness	80.5%	79.9%	0.6%	Yes	NS	1.10
More step-downs than step-ups	17.4%	14.6%	2.8%	Yes	NS	1.24
<i>Placement Stability</i>						
No placement setting changes	38.5%	46.0%	-7.5%	No	NA	NA
< 2 placement setting changes	61.5%	71.1%	-9.6%	No	NA	NA
< 3 placement setting changes	75.1%	80.3%	-5.2%	No	NA	NA
<i>Permanent Residence at End Removal</i>						
Permanency at case close	12.5%	13.6%	-1.1%	No	NA	NA
Parents	6.5%	7.6%	-1.1%	No	NA	NA
Non-adopt kin	3.6%	3.5%	0.1%	Yes	NS	1.25
Non-kin guardians	0.7%	0.5%	0.2%	Yes	NS	2.01

Adoptive parents	1.8%	2.0%	-0.2%	No	NA	NA
<i>End Removal Reason</i>						
Emancipation	70.3%	77.8%	-7.5%	Yes	NS	1.49

Outcome	Youth who Began their Removal Prior to a Year in Which County was Funded					
	Treatment Group (n=346)	Comparison Group (n=204)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	2.9%	6.4%	-3.5%	No	NA	NA
Most OOH days in kinship care	4.9%	7.4%	-2.5%	No	NA	NA
At least one step-down in restrictiveness	30.6%	27.5%	3.1%	Yes	NS	1.17
No step-ups in restrictiveness	78.9%	79.4%	-0.5%	No	NA	NA
More step-downs than step-ups	16.8%	16.2%	0.6%	Yes	NS	1.16
<i>Placement Stability</i>						
No placement setting changes	42.8%	46.6%	-3.8%	No	NA	NA
< 2 placement setting changes	61.0%	70.6%	-9.6%	No	NA	NA
< 3 placement setting changes	73.4%	79.4%	-6.0%	No	NA	NA
<i>Permanent Residence at End Removal</i>						
Permanency at case close	10.8%	13.9%	-3.1%	No	NA	NA
Parents	6.1%	7.8%	-1.7%	No	NA	NA
Non-adopt kin	2.2%	3.6%	-1.4%	No	NA	NA
Non-kin guardians	0.7%	0.6%	0.1%	Yes	NS	1.41
Adoptive parents	1.8%	1.8%	0.0%	No	NA	NA
<i>End Removal Reason</i>						

Emancipation	73.5%	74.7%	-1.2%	Yes	NS	1.02
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PRTs – Children and Youth in Care 12 Months or Longer

Outcome	All Treatment Youth					
	Treatment Group (n=1,356)	Comparison Group (n=1,015)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	27.1%	17.9%	9.2%	Yes	<.01	1.93
Most OOH days in kinship care	32.9%	23.1%	9.8%	Yes	<.01	1.91
At least one step-down in restrictiveness	73.5%	87.2%	-13.7%	No	NA	NA
No step-ups in restrictiveness	77.1%	82.0%	-4.9%	No	NA	NA
More step-downs than step-ups	61.6%	80.4%	-18.8%	No	NA	NA
<i>Placement Stability</i>						
No placement setting changes	57.4%	59.9%	-2.5%	No	NA	NA
< 2 placement setting changes	76.6%	80.7%	-4.1%	No	NA	NA
< 3 placement setting changes	85.3%	89.2%	-3.9%	No	NA	NA
<i>Permanent Residence at Case Close</i>						
Permanency at case close	88.1%	92.0%	-3.9%	No	NA	NA
Parents	22.4%	30.0%	-7.6%	No	NA	NA
Non-adopt kin	10.0%	13.5%	-3.5%	No	NA	NA
Non-kin guardians	5.5%	2.4%	3.1%	Yes	<.01	2.53
Adoptive parents	50.2%	46.1%	4.1%	Yes	NS	1.13

Outcome	Youth with Higher Adherence					
	Treatment Group (n=448)	Comparison Group (n=334)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	31.0%	20.1%	10.9%	Yes	<.01	1.86
Most OOH days in kinship care	37.5%	26.0%	11.5%	Yes	<.01	1.77
At least one step-down in restrictiveness	79.2%	89.8%	-10.6%	No	NA	NA
No step-ups in restrictiveness	77.7%	82.3%	-4.6%	No	NA	NA
More step-downs than step-ups	66.7%	82.6%	-15.9%	No	NA	NA
<i>Placement Stability</i>						
No placement setting changes	59.6%	61.4%	-1.8%	No	NA	NA
< 2 placement setting changes	78.1%	82.3%	-4.2%	No	NA	NA
< 3 placement setting changes	87.1%	88.9%	-1.8%	No	NA	NA
<i>Permanent Residence at Case Close</i>						
Permanency at case close	93.8%	90.9%	2.9%	Yes	NS	1.15
Parents	26.0%	28.9%	-2.9%	No	NA	NA
Non-adopt kin	12.0%	16.5%	-4.5%	No	NA	NA
Non-kin guardians	6.8%	3.3%	3.5%	Yes	<.05	2.50
Adoptive parents	49.0%	42.1%	6.9%	Yes	NS	1.09

Outcome	Youth who Reached 12 Months in Care During Year in Which County was Funded
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	Treatment Group (n=1,117)	Comparison Group (n=877)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	30.4%	18.9%	11.5%	Yes	<.01	1.92
Most OOH days in kinship care	36.8%	23.7%	13.1%	Yes	<.01	2.00
At least one step-down in restrictiveness	74.1%	87.9%	-13.8%	No	NA	NA
No step-ups in restrictiveness	78.3%	83.4%	-5.1%	No	NA	NA
More step-downs than step-ups	63.0%	81.6%	-18.6%	No	NA	NA
<i>Placement Stability</i>						
No placement setting changes	58.3%	60.2%	-1.9%	No	NA	NA
< 2 placement setting changes	78.2%	81.3%	-3.1%	No	NA	NA
< 3 placement setting changes	87.7%	90.2%	-2.5%	No	NA	NA
<i>Permanent Residence at Case Close</i>						
Permanency at case close	89.8%	91.6%	-1.8%	No	NA	NA
Parents	23.3%	29.9%	-6.6%	No	NA	NA
Non-adopt kin	10.4%	14.3%	-3.9%	No	NA	NA
Non-kin guardians	6.1%	2.1%	4.0%	Yes	<.01	3.01
Adoptive parents	50.0%	45.3%	4.7%	Yes	NS	1.07

Outcome	Youth with Lower Adherence					
	Treatment Group (n=908)	Comparison Group (n=681)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size

Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	25.2%	16.9%	8.3%	Yes	<.01	2.07
Most OOH days in kinship care	30.6%	21.6%	9.0%	Yes	<.01	2.07
At least one step-down in restrictiveness	70.7%	85.9%	-15.2%	No	NA	NA
No step-ups in restrictiveness	76.8%	81.8%	-5.0%	No	NA	NA
More step-downs than step-ups	59.0%	79.3%	-20.3%	No	NA	NA
<i>Placement Stability</i>						
No placement setting changes	56.3%	59.2%	-2.9%	No	NA	NA
< 2 placement setting changes	75.9%	79.9%	-4.0%	No	NA	NA
< 3 placement setting changes	84.4%	89.3%	-4.9%	No	NA	NA
<i>Permanent Residence at Case Close</i>						
Permanency at case close	85.1%	92.5%	-7.4%	No	NA	NA
Parents	20.5%	30.6%	-10.1%	No	NA	NA
Non-adopt kin	8.9%	12.0%	-3.1%	No	NA	NA
Non-kin guardians	4.9%	1.9%	3.0%	Yes	<.05	2.69
Adoptive parents	50.9%	48.1%	2.8%	Yes	NS	1.16

Outcome	Youth who Reached 12 Months in Care Prior to a Year in Which County was Funded					
	Treatment Group (n=239)	Comparison Group (n=138)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
Permanency						
<i>Least Restrictive Placement</i>						
All OOH days in kinship care	11.7%	11.6%	0.1%	Yes	NS	1.77
Most OOH days in kinship care	14.6%	18.8%	-4.2%	No	NA	NA

At least one step-down in restrictiveness	70.7%	82.6%	-11.9%	No	NA	NA
No step-ups in restrictiveness	71.1%	73.2%	-2.1%	No	NA	NA
More step-downs than step-ups	54.8%	72.5%	-17.7%	No	NA	NA
<i>Placement Stability</i>						
No placement setting changes	53.1%	58.0%	-4.9%	No	NA	NA
< 2 placement setting changes	69.0%	76.8%	-7.8%	No	NA	NA
< 3 placement setting changes	73.6%	82.6%	-9.0%	No	NA	NA
<i>Permanent Residence at Case Close</i>						
Permanency at case close	80.6%	94.7%	-14.1%	No	NA	NA
Parents	18.1%	30.9%	-12.8%	No	NA	NA
Non-adopt kin	8.1%	8.5%	-0.4%	No	NA	NA
Non-kin guardians	3.1%	4.3%	-1.2%	No	NA	NA
Adoptive parents	51.2%	51.1%	0.1%	Yes	NS	1.01

Trauma Informed Screening, Assessment, and Treatment and Child Welfare Resiliency Center Children and Youth

Outcome	Children and Youth who Received TISAT treatment <u>and/or</u> a CWRC assessment					
	Treatment Group (n=588)	Comparison Group (n=588)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
During Case						
Permanency						
<i>Case Length (of children whose case had closed)</i>						
Mean days (SD)	365.57 (227.35)	422.80 (297.13)	-57,23 (-69.78)	Yes	NS	0.22
Median days	339	374	-35	Yes	NS	0.08
<i>Least Restrictive Placement (all children)</i>						
All case OOH days in kinship care	34.3%	32.6%	1.7%	Yes	NS	1.21

Most case OOH days in kinship care	42.3%	40.0%	2.3%	Yes	NS	1.33
<i>Placement Stability (all children)</i>						
No placement setting changes	30.3%	35.4%	-5.1%	No	NA	NA
1 or fewer placement setting changes	48.0%	62.9%	-14.9%	No	NA	NA
2 or fewer placement setting changes	57.7%	73.7%	-16.0%	No	NA	NA
Case Close						
Permanency						
<i>Permanent Case Close Residence (non-adoption)</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	88.0%	93.2%	-5.2%	No	NA	NA
Parent(s)	65.2%	69.4%	-4.2%	No	NA	NA
Non-adoptive kin	19.4%	21.0%	-1.6%	No	NA	NA
Non-kin guardian(s)	1.5%	0.6%	0.9%	Yes	NS	2.05
Adoptive parents	1.8%	2.2%	-0.4%	No	NA	NA
<i>Days to Permanency</i>						
Mean days (SD)	364.37 (224.58)	413.78 (293.53)	-49.41 (-68.95)	Yes	NS	0.19
Median days	340	369	-29	Yes	NS	0.06
Post Case Close						
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	20.6%	10.8%	9.8%	No	NA	NA
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						
Mean days (SD)	554.60 (326.36)	641.20 (309.22)	-86.6 (17.14)	No	NA	NA
Median days	546	688	-142	No	NA	NA
Permanency						
<i>Post Case Close OOH Placement</i>						

Percentage of children with a post-case close OOH placement	28.2%	24.3%	3.9%	No	NA	NA
<i>Least Restrictive Placement Use (of children with a post-case close OOH placement)</i>						
All post-case OOH days in kinship care	14.6%	7.3%	7.3%	Yes	NS	2.16
Most post-case OOH days in kinship care	16.7%	12.2%	4.5%	Yes	NS	1.44

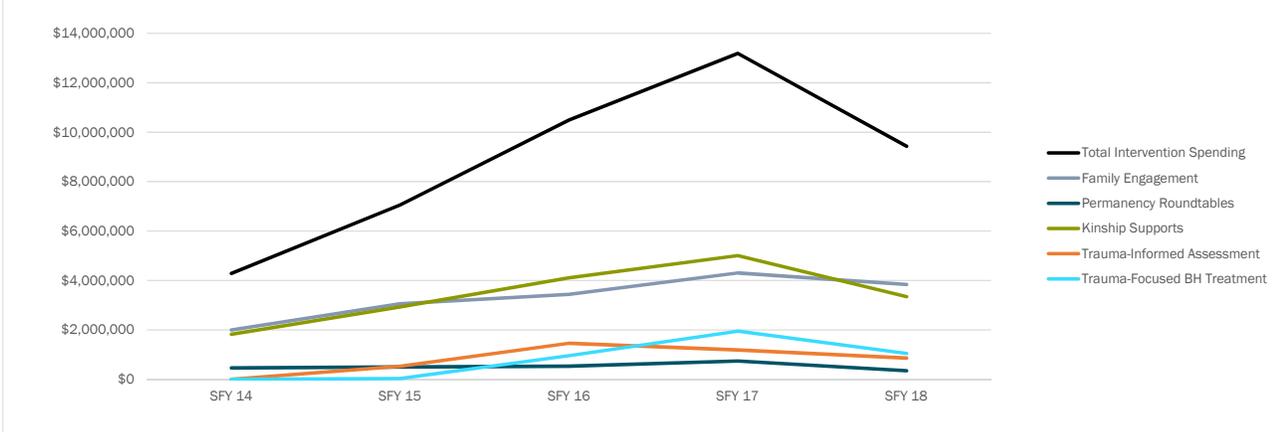
Outcome	Children and Youth who Received TISAT treatment					
	Treatment Group (n=158)	Comparison Group (n=158)	Difference	Difference Indicates Intervention Effect	Significance	Effect Size
During Case						
Permanency						
<i>Case Length (of children whose case had closed)</i>						
Mean days (SD)	432.26 (207.69)	362.59 (267.29)	69.67 (-59.6)	No	NA	NA
Median days	402	332	70	No	NA	NA
<i>Least Restrictive Placement (all children)</i>						
All case OOH days in kinship care	57.7%	34.7%	23.0%	Yes	NS	1.28
Most case OOH days in kinship care	66.2%	41.3%	24.9%	Yes	NS	1.55
<i>Placement Stability (all children)</i>						
No placement setting changes	46.5%	32.0%	14.5%	Yes	NS	1.33
1 or fewer placement setting changes	64.8%	56.0%	8.8%	Yes	NS	1.90
2 or fewer placement setting changes	77.5%	69.3%	8.2%	Yes	NS	2.74
Case Close						
Permanency						
<i>Permanent Case Close Residence (non-adoption)</i>						
Parent(s), non-adoptive kin, or non-kin guardian(s)	96.9%	90.7%	6.2%	Yes	NS	1.81
Parent(s)	55.2%	67.8%	-12.6%	No	NA	NA

Non-adoptive kin	36.5%	19.5%	17.0%	Yes	<.05	2.41
Non-kin guardian(s)	1.0%	0.8%	0.2%	Yes	NS	0.00
Adoptive parents	4.2%	2.5%	1.7%	Yes	NS	2.37
<i>Days to Permanency</i>						
Mean days (SD)	431.69 (202.98)	357.73 (263.71)	73.96 (-60.73)	No	NA	NA
Median days	411	342	69	No	NA	NA
Post Case Close						
Safety						
<i>Re-involvement due to a Re-report (of all children whose case had closed)</i>						
Founded or inconclusive re-report of abuse and/or neglect with case open	20.8%	10.2%	10.6%	No	NA	NA
<i>Days to Re-involvement due to a Re-report (from case open date)</i>						
Mean days (SD)	715.40 (311.28)	590.83 (281.15)	124.57 (30.13)	Yes	NS	0.42
Median days	685	677	8	Yes	NS	0.17
Permanency						
<i>Post Case Close OOH Placement</i>						
Percentage of children with a post-case close OOH placement	12.7%	34.7%	-22.0%	Yes	NS	3.13
<i>Least Restrictive Placement Use (of children with a post-case close OOH placement)</i>						
All post-case OOH days in kinship care	55.6%	8.0%	47.6%	Yes	<.01	14.38
Most post-case OOH days in kinship care	66.7%	12.0%	54.7%	Yes	<.01	14.67

Appendix L: County Level Fiscal Reports

Expenditures adjusted for inflation to SFY18 dollars

All Demonstration Counties - Intervention Waiver Spending by Intervention Type and SFY

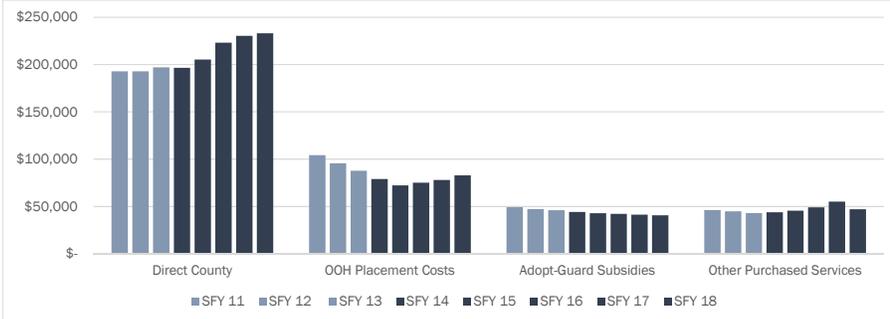


	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$1,999,069	\$3,053,180	\$3,434,742	\$4,304,503	\$3,215,109	\$619,283	\$3,834,391
Kinship Supports	\$1,824,619	\$2,930,780	\$4,102,844	\$5,006,006	\$2,158,556	\$1,187,266	\$3,345,822
Permanency Roundtables	\$462,589	\$501,071	\$535,426	\$739,174	\$302,398	\$44,273	\$346,670
Trauma-Informed Assessment	\$0	\$535,089	\$1,459,180	\$1,187,503	\$96,513	\$765,645	\$862,158
Trauma-Focused BH Treatment	\$0	\$37,836	\$959,436	\$1,948,819	\$146,222	\$898,322	\$1,044,544
Total	\$4,286,278	\$7,057,956	\$10,491,628	\$13,186,005	\$5,918,798	\$3,514,788	\$9,433,586

All Other CW Exp (excludes OOH)	\$284,777,110	\$293,794,016	\$314,639,279	\$326,809,971		\$320,874,143
Intervention Exp Proportion	2%	2%	3%	4%		3%

Expenditures by Major Category and Fiscal Year

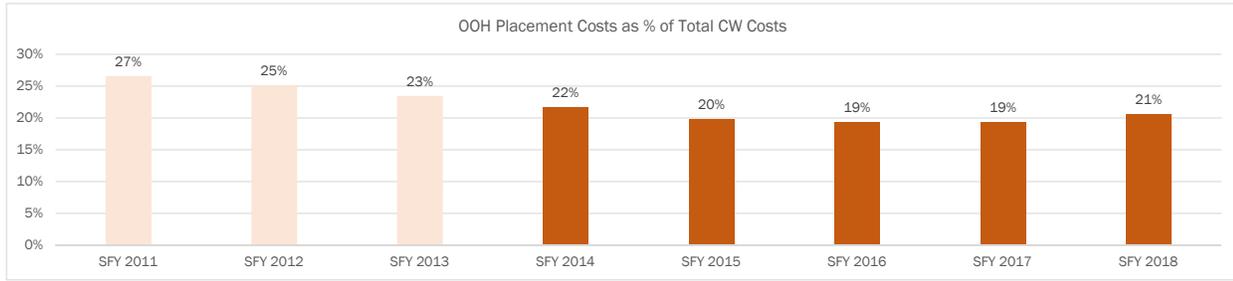
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

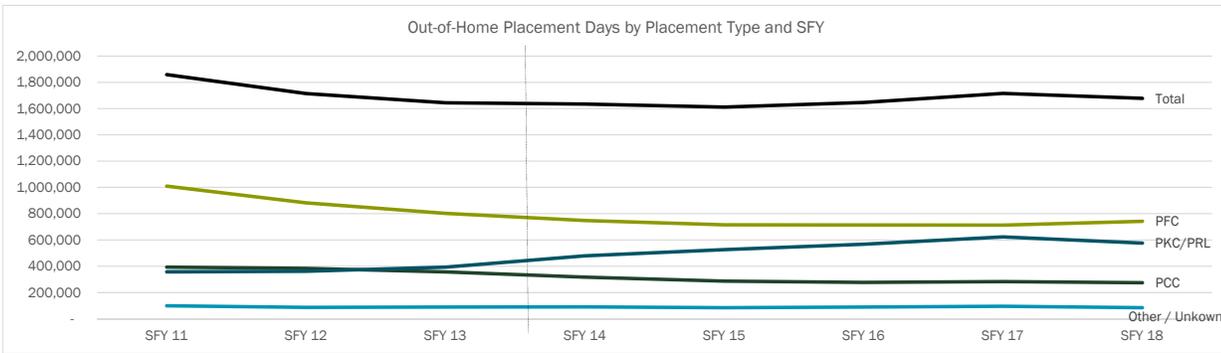
Major Category	Avg Annual Costs	Avg Annual Costs	Average Annual	Average Annual
	- Pre Waiver	- Waiver	Change	% Change
Direct County	\$194,380	\$217,780	\$23,399	12%
OOH Placement Costs	\$95,897	\$77,476	(\$18,420)	(19%)
Adopt-Guard Subsidies	\$47,562	\$42,252	(\$5,310)	(11%)
Other Purchased Services	\$44,720	\$48,147	\$3,427	8%
Grand Total	\$382,559	\$385,655	\$3,096	1%

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$104,280,198	\$95,664,213	\$87,745,559	\$79,007,044	\$72,254,183	\$75,097,703	\$78,052,974	\$82,969,211
Placement Days	1,859,156	1,714,145	1,644,279	1,634,369	1,612,447	1,646,832	1,715,146	1,678,656
Average Daily Unit Cost	\$56.09	\$55.81	\$53.36	\$48.34	\$44.81	\$45.60	\$45.51	\$49.43



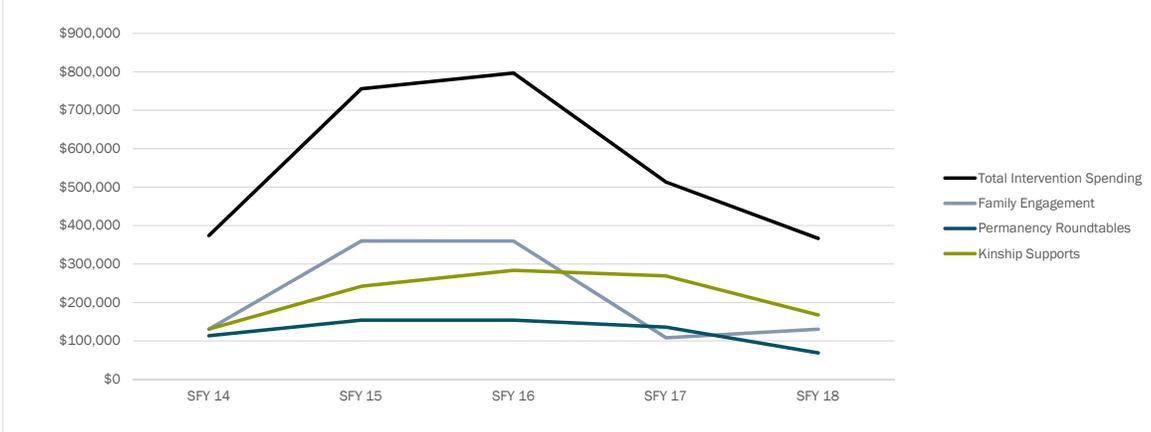
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	392,902	1,010,074	357,343	98,837	1,859,156
2012	383,070	882,463	361,908	86,704	1,714,145
2013	357,454	803,510	393,626	89,689	1,644,279
2014	316,935	748,647	478,872	89,915	1,634,369
2015	286,681	715,580	526,438	83,748	1,612,447
2016	276,416	713,983	567,417	89,016	1,646,832
2017	283,184	713,365	623,353	95,244	1,715,146
2018	274,636	742,891	576,828	84,301	1,678,656

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	377,809	898,682	370,959	91,743	1,739,193
Average Annual Days - Waiver	287,570	726,893	554,582	88,445	1,657,490
Average Annual % Change	(24%)	(19%)	49%	(4%)	(5%)

Expenditures adjusted for inflation to SFY18 dollars

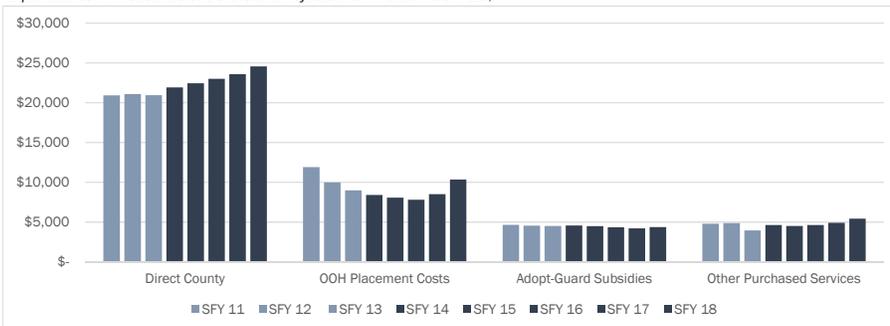
Adams County - Intervention Waiver Spending by Intervention Type and SFY



	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$130,484	\$359,887	\$359,444	\$108,250	\$110,010	\$20,272	\$130,282
Kinship Supports	\$130,520	\$242,144	\$283,343	\$269,085	\$64,666	\$102,750	\$167,416
Permanency Roundtables	\$113,151	\$153,749	\$153,969	\$135,816	\$63,349	\$5,476	\$68,825
Total	\$374,155	\$755,781	\$796,756	\$513,152	\$238,025	\$128,497	\$366,522
All Other CW Exp (excludes OOH)	\$31,148,426	\$31,485,451	\$32,029,208	\$32,730,833			\$34,392,029
Intervention Exp Proportion	1%	2%	2%	2%			1%

Expenditures by Major Category and Fiscal Year

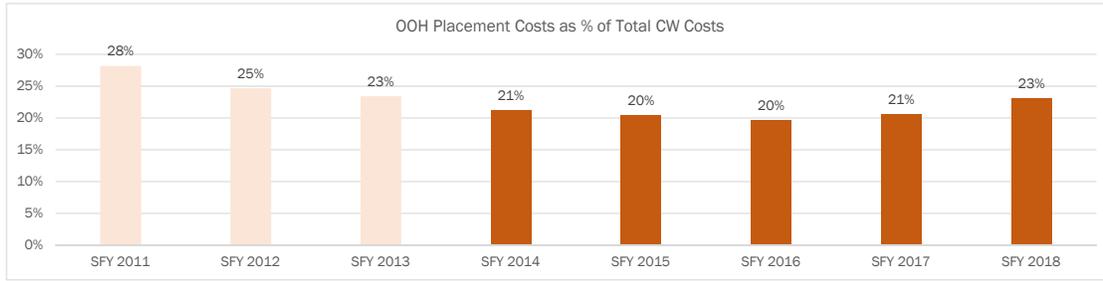
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

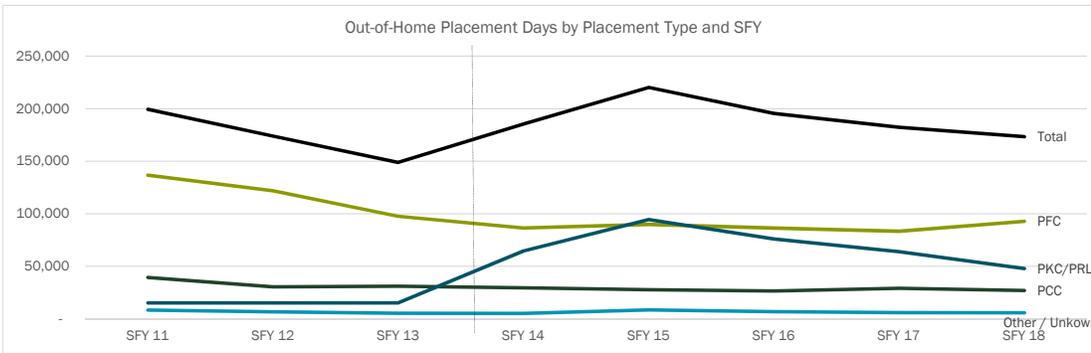
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$20,997	\$23,123	\$2,126	10%
OOH Placement Costs	\$10,303	\$8,636	(\$1,668)	(16%)
Adopt-Guard Subsidies	\$4,572	\$4,403	(\$169)	(4%)
Other Purchased Services	\$4,543	\$4,832	\$289	6%
Grand Total	\$40,415	\$40,993	\$578	1%

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$11,915,922	\$9,999,477	\$8,994,257	\$8,413,441	\$8,075,030	\$7,821,534	\$8,511,068	\$10,357,253
Placement Days	199,302	173,816	148,805	185,429	220,222	195,445	182,144	173,208
Average Daily Unit Cost	\$59.79	\$57.53	\$60.44	\$45.37	\$36.67	\$40.02	\$46.73	\$59.80



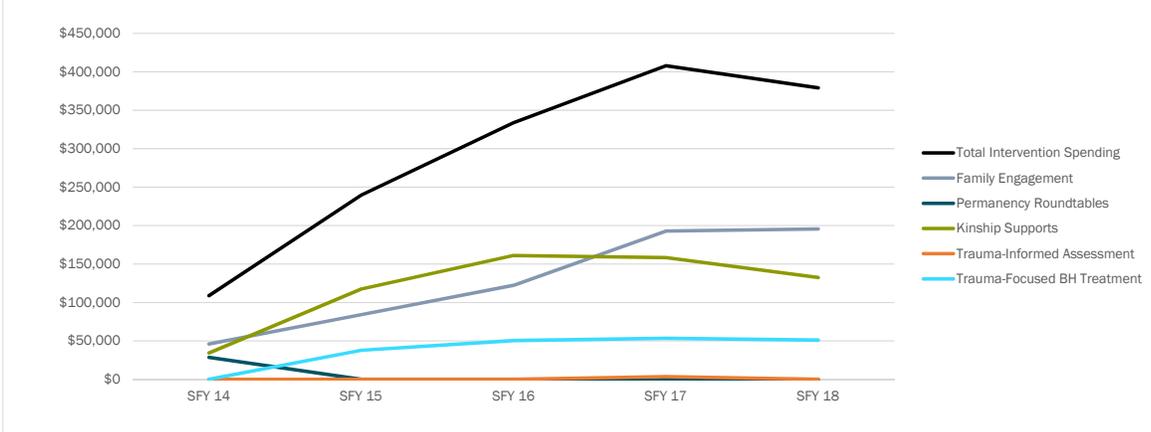
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	39,311	136,704	15,033	8,254	199,302
2012	30,453	121,798	15,017	6,548	173,816
2013	31,019	97,460	15,078	5,248	148,805
2014	29,429	86,402	64,566	5,032	185,429
2015	27,734	89,752	94,390	8,346	220,222
2016	26,366	86,252	76,050	6,777	195,445
2017	29,078	83,283	63,850	5,933	182,144
2018	26,933	92,787	47,818	5,670	173,208

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	33,594	118,654	15,043	6,683	173,974
Average Annual Days - Waiver	27,908	87,695	69,335	6,352	191,290
Average Annual % Change	(17%)	(26%)	361%	(5%)	10%

Expenditures adjusted for inflation to SFY18 dollars

Arapahoe County - Intervention Waiver Spending by Intervention Type and SFY

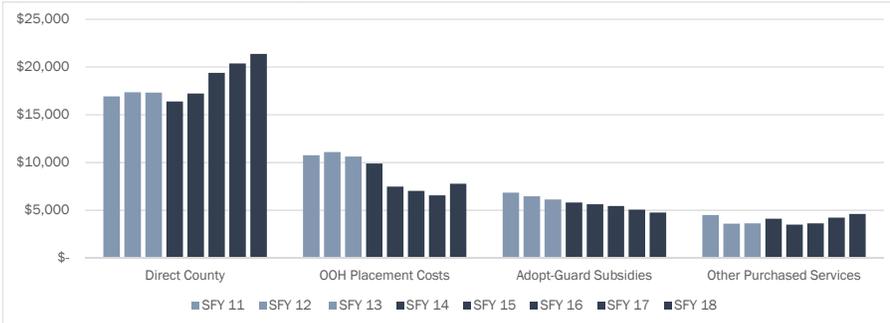


	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$45,998	\$84,162	\$122,263	\$192,736	\$187,277	\$8,356	\$195,633
Kinship Supports	\$34,274	\$117,567	\$161,090	\$158,160	\$95,542	\$36,752	\$132,293
Permanency Roundtables	\$28,539	\$0	\$0	\$0	\$0	\$0	\$0
Trauma-Informed Assessment	\$0	\$0	\$0	\$3,509	\$0	\$0	\$0
Trauma-Focused BH Treatment	\$0	\$37,836	\$50,488	\$53,454	\$15,064	\$36,022	\$51,085
Total	\$108,811	\$239,565	\$333,841	\$407,859	\$297,882	\$81,129	\$379,012

All Other CW Exp (excludes OOH)	\$26,320,353	\$26,362,748	\$28,463,993	\$29,668,667		\$30,759,769
Intervention Exp Proportion	0%	1%	1%	1%		1%

Expenditures by Major Category and Fiscal Year

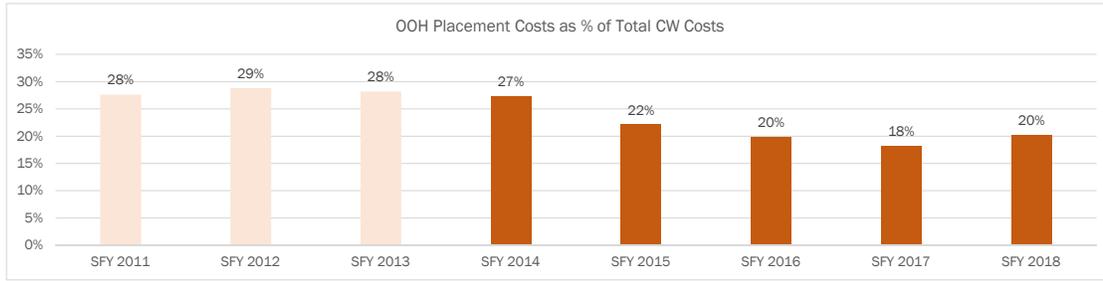
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

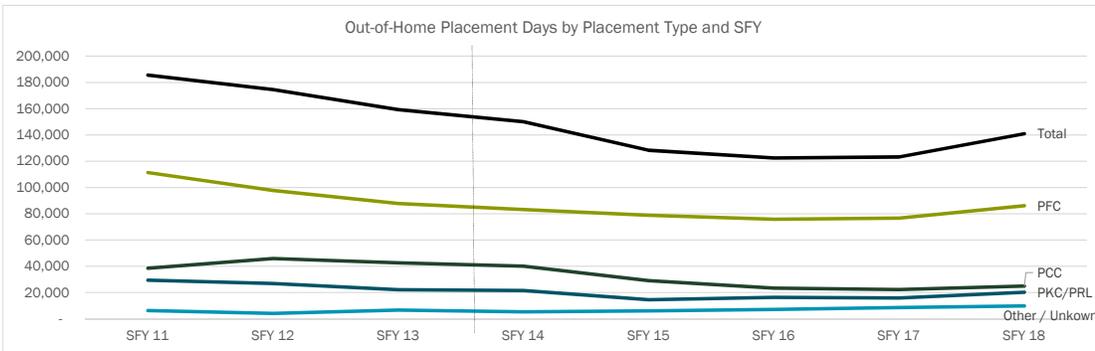
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$17,211	\$18,956	\$1,745	10%
OOH Placement Costs	\$10,830	\$7,750	(\$3,080)	(28%)
Adopt-Guard Subsidies	\$6,476	\$5,346	(\$1,130)	(17%)
Other Purchased Services	\$3,904	\$4,013	\$109	3%
Grand Total	\$38,422	\$36,065	(\$2,357)	(6%)

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$10,772,354	\$11,095,107	\$10,622,947	\$9,891,997	\$7,476,511	\$7,038,314	\$6,555,961	\$7,785,842
Placement Days	185,516	174,448	159,256	150,021	128,253	122,442	123,265	140,893
Average Daily Unit Cost	\$58.07	\$63.60	\$66.70	\$65.94	\$58.30	\$57.48	\$53.19	\$55.26



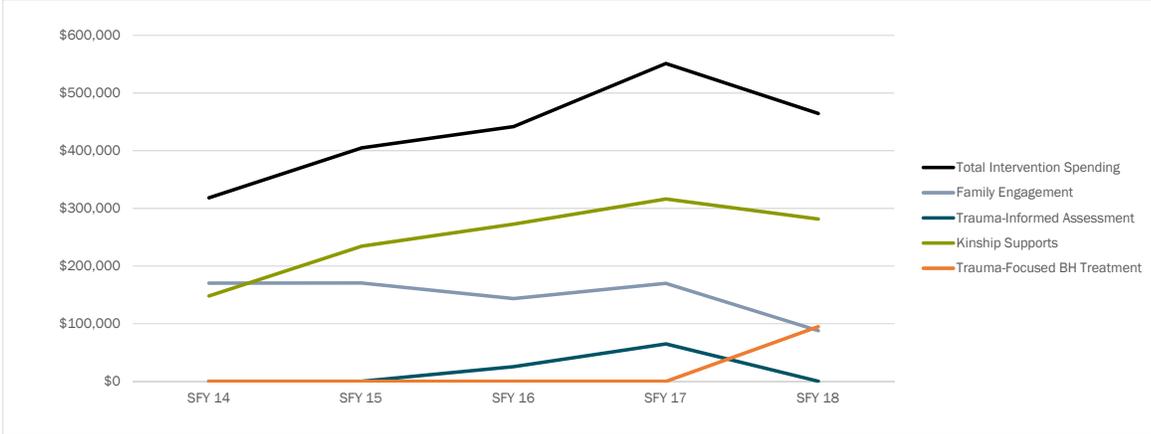
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	38,494	111,338	29,380	6,304	185,516
2012	45,828	97,703	26,882	4,035	174,448
2013	42,651	87,798	22,150	6,657	159,256
2014	40,014	83,175	21,549	5,283	150,021
2015	28,983	78,797	14,515	5,958	128,253
2016	23,292	75,749	16,302	7,099	122,442
2017	22,235	76,662	15,768	8,600	123,265
2018	24,898	86,117	20,158	9,720	140,893

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	42,324	98,946	26,137	5,665	173,073
Average Annual Days - Waiver	27,884	80,100	17,658	7,332	132,975
Average Annual % Change	(34%)	(19%)	(32%)	29%	(23%)

Expenditures adjusted for inflation to SFY18 dollars

Boulder County - Intervention Waiver Spending by Intervention Type and SFY

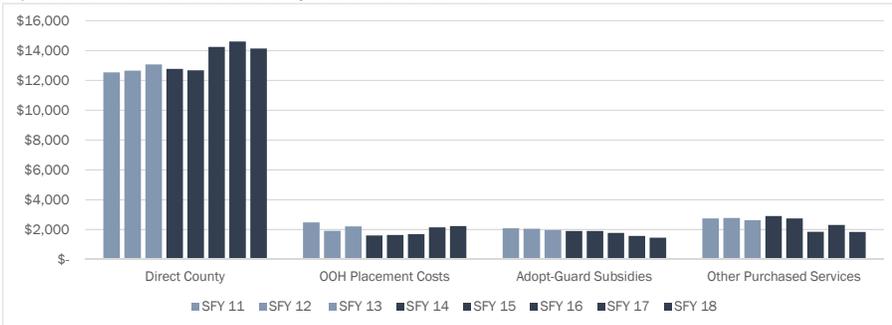


	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$170,190	\$170,659	\$143,539	\$169,996	\$87,937	\$0	\$87,937
Kinship Supports	\$148,139	\$234,109	\$272,559	\$316,292	\$232,408	\$48,975	\$281,383
Trauma-Informed Assessment	\$0	\$0	\$25,675	\$64,892	\$140	\$6	\$146
Trauma-Focused BH Treatment	\$0	\$0	\$0	\$0	\$70,922	\$23,867	\$94,789
Total	\$318,329	\$404,768	\$441,773	\$551,179	\$391,408	\$72,848	\$464,255

All Other CW Exp (excludes OOH)	\$17,591,976	\$17,335,316	\$17,894,767	\$18,506,387		\$17,449,513
Intervention Exp Proportion	2%	2%	2%	3%		3%

Expenditures by Major Category and Fiscal Year

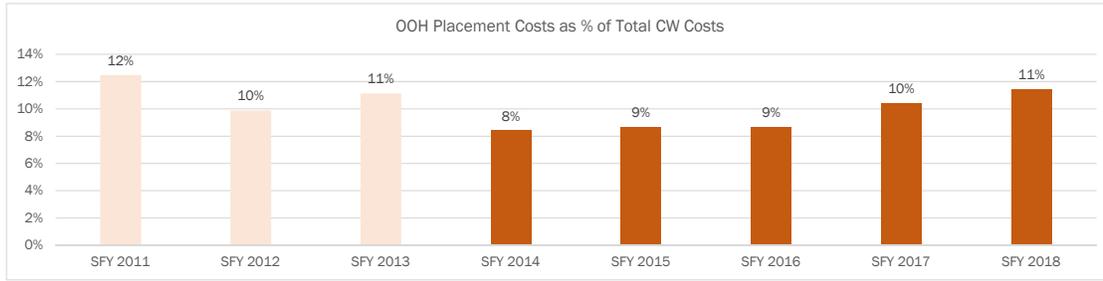
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

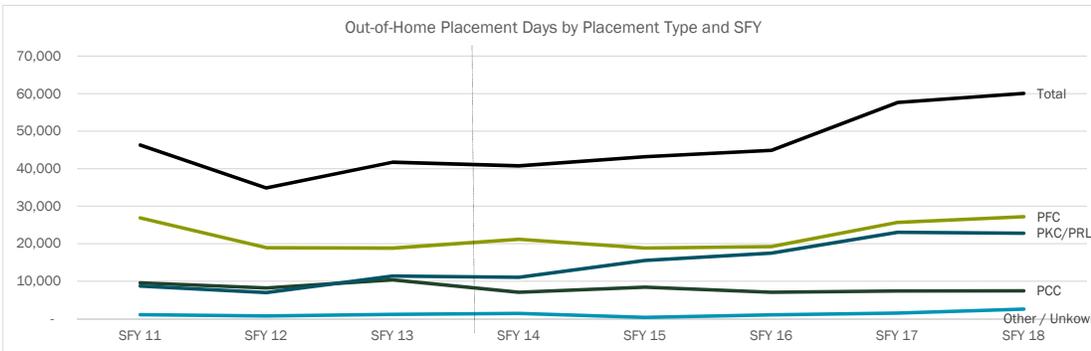
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$12,765	\$13,694	\$930	7%
OOH Placement Costs	\$2,203	\$1,869	(\$335)	(15%)
Adopt-Guard Subsidies	\$2,037	\$1,725	(\$313)	(15%)
Other Purchased Services	\$2,722	\$2,337	(\$386)	(14%)
Grand Total	\$19,728	\$19,624	(\$103)	(1%)

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$2,478,790	\$1,916,802	\$2,214,480	\$1,612,685	\$1,637,409	\$1,697,155	\$2,153,947	\$2,242,853
Placement Days	46,294	34,870	41,729	40,742	43,175	44,881	57,650	60,064
Average Daily Unit Cost	\$53.54	\$54.97	\$53.07	\$39.58	\$37.92	\$37.81	\$37.36	\$37.34



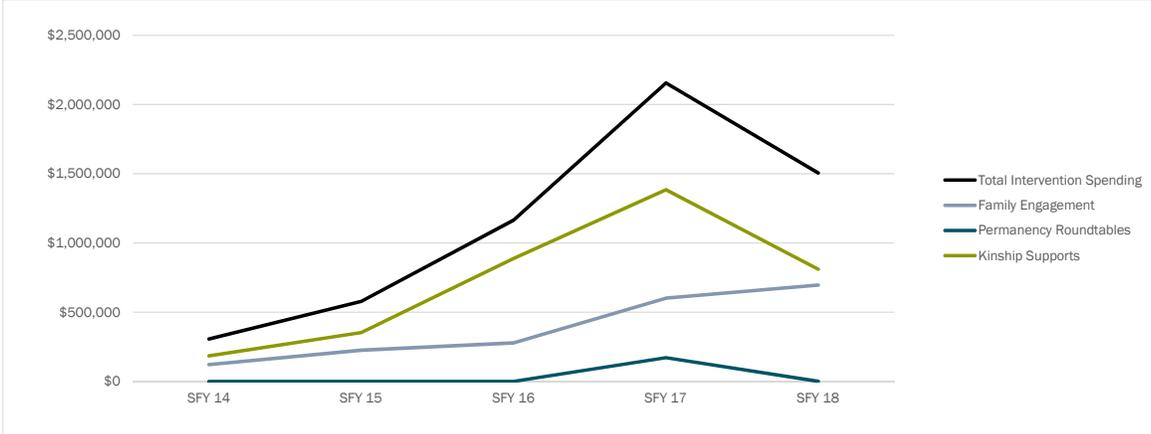
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	9,564	26,892	8,737	1,101	46,294
2012	8,207	18,938	6,981	744	34,870
2013	10,356	18,827	11,391	1,155	41,729
2014	7,074	21,197	11,039	1,432	40,742
2015	8,429	18,850	15,535	361	43,175
2016	7,059	19,257	17,522	1,043	44,881
2017	7,429	25,680	23,035	1,506	57,650
2018	7,461	27,204	22,825	2,574	60,064

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	9,376	21,552	9,036	1,000	40,964
Average Annual Days - Waiver	7,490	22,438	17,991	1,383	49,302
Average Annual % Change	(20%)	4%	99%	38%	20%

Expenditures adjusted for inflation to SFY18 dollars

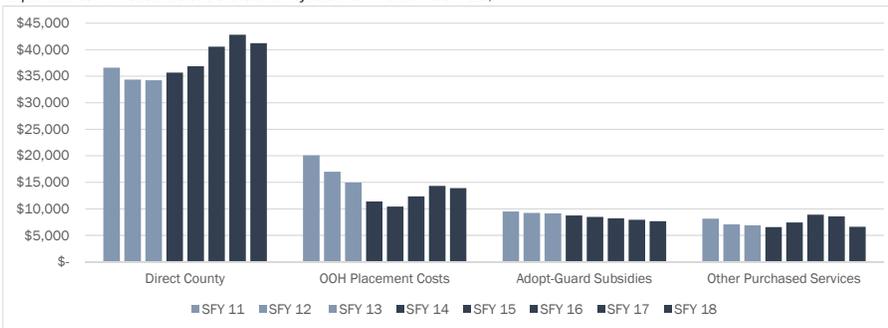
Denver County - Intervention Waiver Spending by Intervention Type and SFY



	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$121,466	\$225,300	\$277,460	\$600,584	\$695,472	\$0	\$695,472
Kinship Supports	\$184,305	\$352,994	\$886,753	\$1,384,139	\$537,828	\$272,264	\$810,092
Permanency Roundtables	\$0	\$0	\$0	\$170,890	-\$93	\$0	-\$93
Total	\$305,770	\$578,294	\$1,164,213	\$2,155,614	\$1,233,207	\$272,264	\$1,505,471
All Other CW Exp (excludes OOH)	\$51,038,135	\$52,815,357	\$57,694,247	\$59,362,673			\$55,513,532
Intervention Exp Proportion	1%	1%	2%	4%			3%

Expenditures by Major Category and Fiscal Year

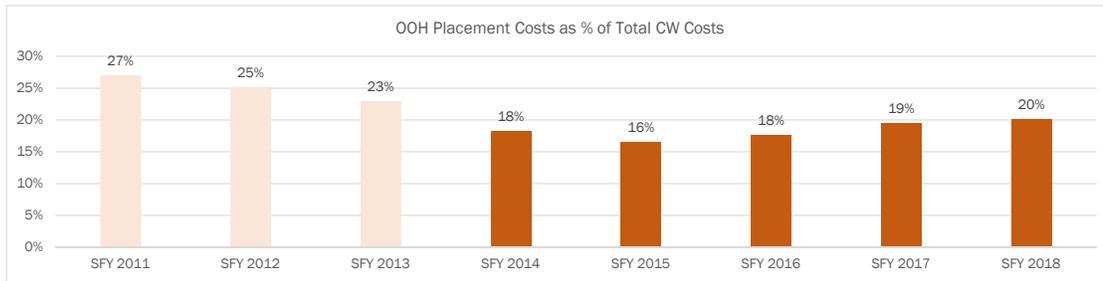
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

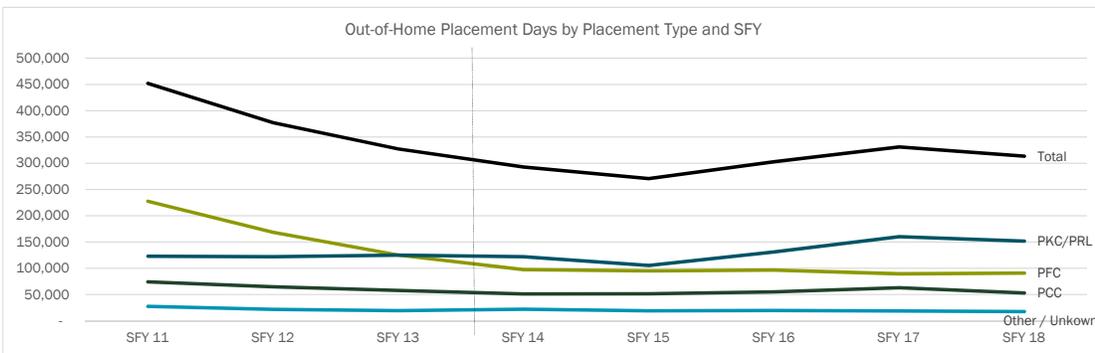
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$35,095	\$39,443	\$4,348	12%
OOH Placement Costs	\$17,361	\$12,486	(\$4,876)	(28%)
Adopt-Guard Subsidies	\$9,297	\$8,221	(\$1,076)	(12%)
Other Purchased Services	\$7,372	\$7,621	\$249	3%
Grand Total	\$69,124	\$67,770	(\$1,354)	(2%)

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$20,092,047	\$17,022,352	\$14,969,085	\$11,401,383	\$10,422,582	\$12,360,723	\$14,332,604	\$13,910,352
Placement Days	451,859	377,016	327,182	292,576	270,524	302,478	330,845	313,239
Average Daily Unit Cost	\$44.47	\$45.15	\$45.75	\$38.97	\$38.53	\$40.86	\$43.32	\$44.41



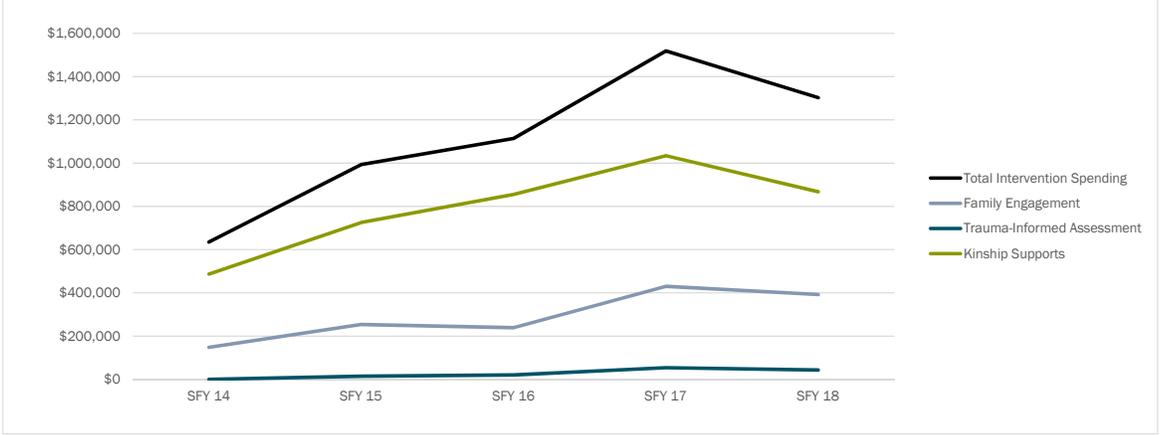
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	74,080	227,461	122,893	27,425	451,859
2012	64,793	168,325	122,114	21,784	377,016
2013	57,732	124,973	125,030	19,447	327,182
2014	51,066	97,394	122,165	21,951	292,576
2015	51,281	94,986	105,205	19,052	270,524
2016	55,158	96,647	131,199	19,474	302,478
2017	62,824	89,333	160,036	18,652	330,845
2018	53,060	90,892	151,837	17,450	313,239

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	65,535	173,586	123,346	22,885	385,352
Average Annual Days - Waiver	54,678	93,850	134,088	19,316	301,932
Average Annual % Change	(17%)	(46%)	9%	(16%)	(22%)

Expenditures adjusted for inflation to SFY18 dollars

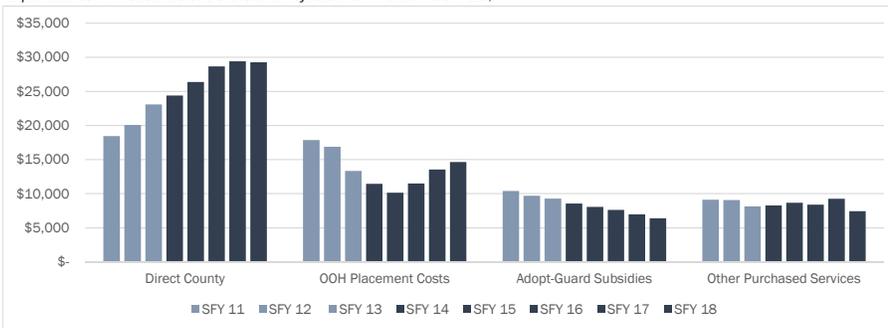
El Paso County - Intervention Waiver Spending by Intervention Type and SFY



	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$148,247	\$253,303	\$239,166	\$430,161	\$388,610	\$3,556	\$392,166
Kinship Supports	\$486,525	\$725,646	\$854,895	\$1,034,202	\$516,064	\$351,074	\$867,138
Trauma-Informed Assessment	\$0	\$14,193	\$20,161	\$54,087	\$0	\$43,253	\$43,253
Total	\$634,772	\$993,142	\$1,114,222	\$1,518,450	\$904,675	\$397,882	\$1,302,557
All Other CW Exp (excludes OOH)	\$41,280,652	\$43,152,703	\$44,705,333	\$45,650,104			\$43,091,489
Intervention Exp Proportion	2%	2%	2%	3%			3%

Expenditures by Major Category and Fiscal Year

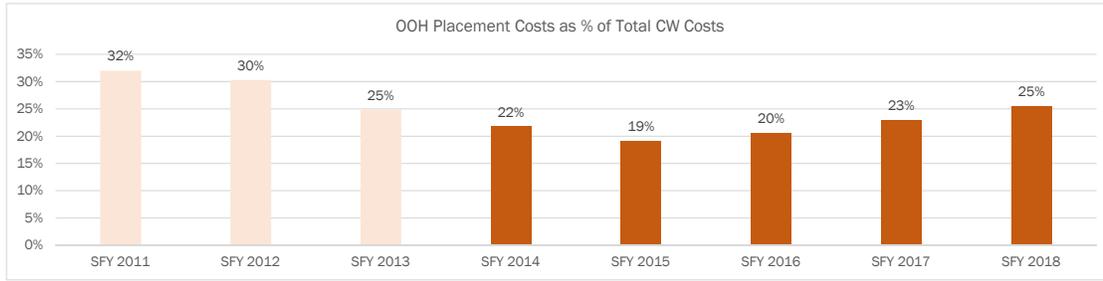
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

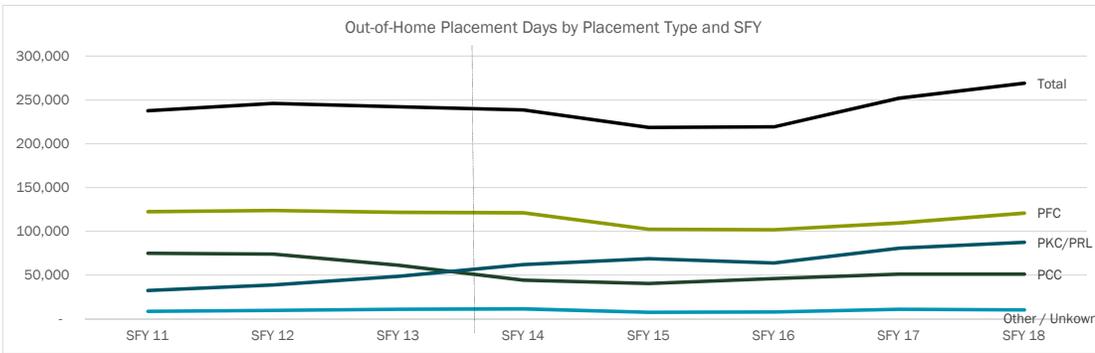
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$20,555	\$27,637	\$7,083	34%
OOH Placement Costs	\$16,037	\$12,264	(\$3,773)	(24%)
Adopt-Guard Subsidies	\$9,799	\$7,526	(\$2,273)	(23%)
Other Purchased Services	\$8,781	\$8,413	(\$368)	(4%)
Grand Total	\$55,172	\$55,840	\$668	1%

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$17,862,729	\$16,893,712	\$13,355,739	\$11,458,512	\$10,143,373	\$11,505,764	\$13,556,137	\$14,655,714
Placement Days	237,641	245,883	242,040	238,467	218,552	219,131	251,978	269,040
Average Daily Unit Cost	\$75.17	\$68.71	\$55.18	\$48.05	\$46.41	\$52.51	\$53.80	\$54.47



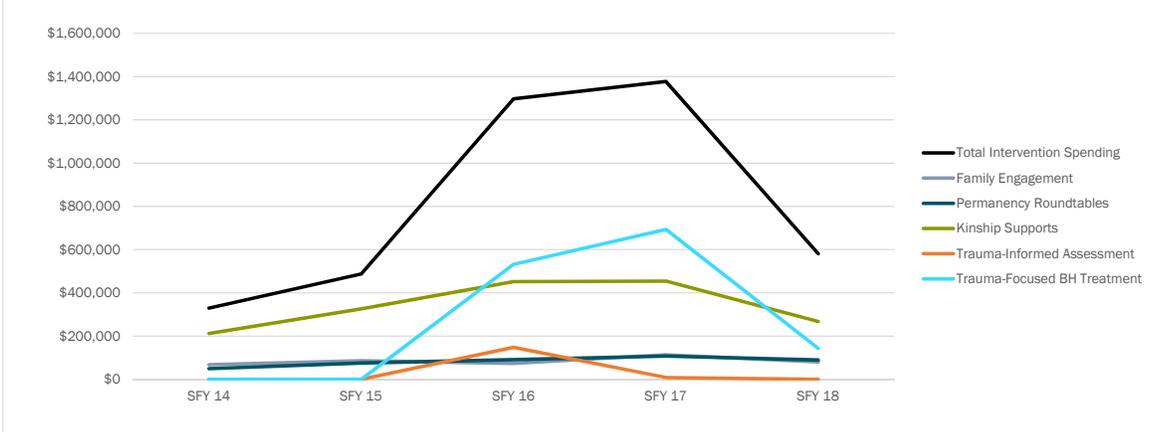
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	74,720	122,247	32,242	8,432	237,641
2012	73,923	123,638	38,723	9,599	245,883
2013	61,156	121,499	48,499	10,886	242,040
2014	44,177	121,041	61,990	11,259	238,467
2015	40,228	102,324	68,648	7,352	218,552
2016	45,944	101,639	63,747	7,801	219,131
2017	51,078	109,439	80,677	10,784	251,978
2018	50,943	120,606	87,356	10,135	269,040

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	69,933	122,461	39,821	9,639	241,855
Average Annual Days - Waiver	46,474	111,010	72,484	9,466	239,434
Average Annual % Change	(34%)	(9%)	82%	(2%)	(1%)

Expenditures adjusted for inflation to SFY18 dollars

Jefferson County - Intervention Waiver Spending by Intervention Type and SFY

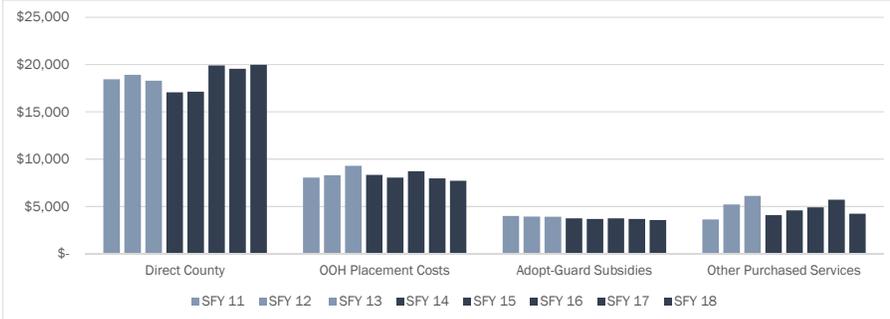


	SFY14 Total	SFY15 Total	SFY16 Total	SFY17 Total	SFY18		Total
					Direct	Purchased	
Family Engagement	\$67,628	\$85,951	\$74,369	\$113,287	\$68,230	\$12,286	\$80,516
Kinship Supports	\$212,254	\$325,779	\$451,749	\$454,331	\$192,427	\$75,090	\$267,517
Permanency Roundtables	\$49,348	\$75,912	\$90,657	\$107,801	\$79,430	\$9,922	\$89,352
Trauma-Informed Assessment	\$0	\$0	\$147,995	\$8,353	\$0	\$0	\$0
Trauma-Focused BH Treatment	\$0	\$0	\$532,101	\$693,194	\$57,755	\$85,631	\$143,386
Total	\$329,230	\$487,642	\$1,296,871	\$1,376,966	\$397,843	\$182,928	\$580,771

All Other CW Exp (excludes OOH)	\$24,908,761	\$25,417,227	\$28,576,247	\$28,950,529		\$27,786,497
Intervention Exp Proportion	1%	2%	5%	5%		2%

Expenditures by Major Category and Fiscal Year

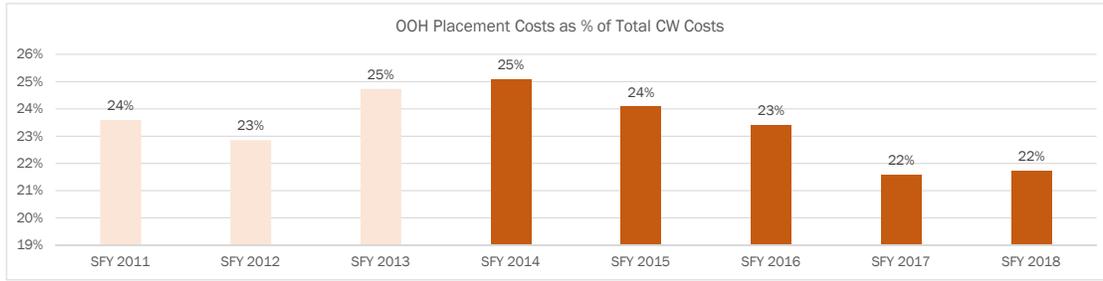
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

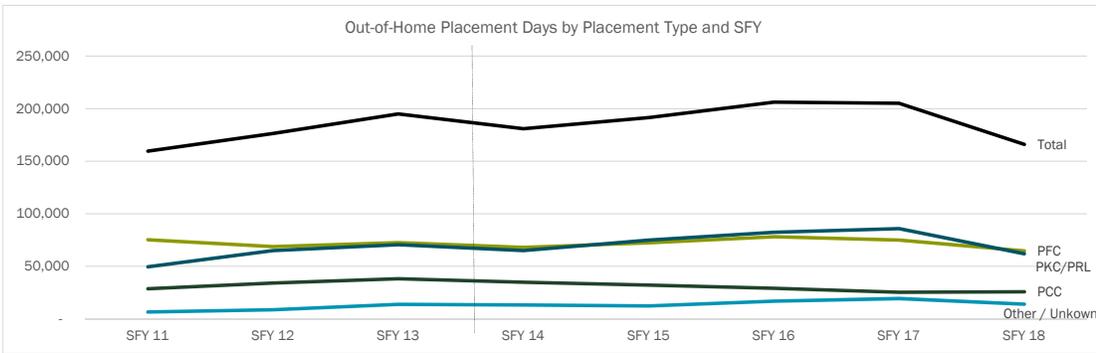
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$18,558	\$18,738	\$179	1%
OOH Placement Costs	\$8,556	\$8,160	(\$395)	(5%)
Adopt-Guard Subsidies	\$3,948	\$3,684	(\$265)	(7%)
Other Purchased Services	\$4,981	\$4,707	(\$275)	(6%)
Grand Total	\$36,044	\$35,288	(\$755)	(2%)

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$8,047,905	\$8,312,973	\$9,305,946	\$8,338,773	\$8,059,188	\$8,723,106	\$7,967,253	\$7,713,953
Placement Days	159,565	176,360	194,954	180,826	191,494	206,156	205,148	165,981
Average Daily Unit Cost	\$50.44	\$47.14	\$47.73	\$46.11	\$42.09	\$42.31	\$38.84	\$46.47



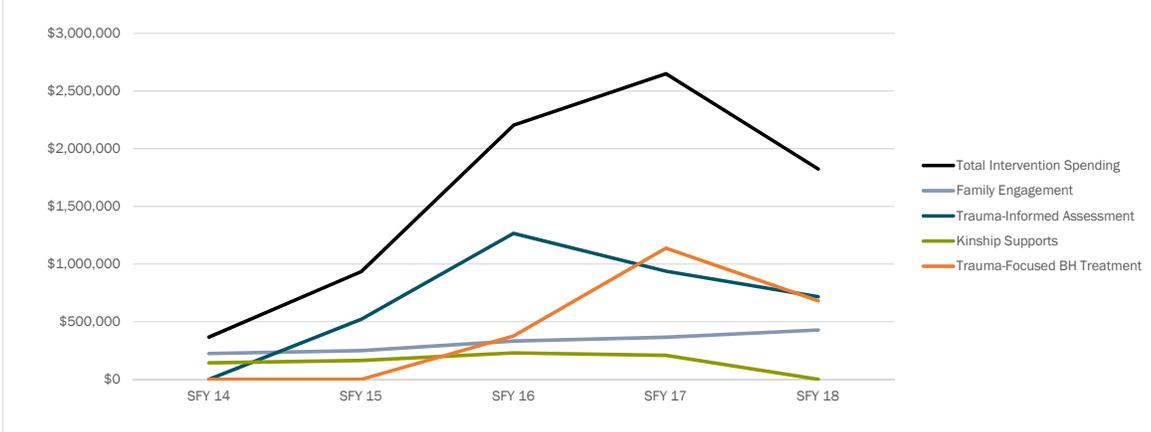
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	28,538	75,233	49,427	6,367	159,565
2012	34,075	68,756	64,953	8,576	176,360
2013	38,114	72,487	70,603	13,750	194,954
2014	34,731	67,982	64,991	13,122	180,826
2015	32,007	72,323	74,949	12,215	191,494
2016	29,010	78,044	82,414	16,688	206,156
2017	25,247	74,942	85,740	19,219	205,148
2018	25,626	64,620	61,930	13,805	165,981

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	33,576	72,159	61,661	9,564	176,960
Average Annual Days - Waiver	29,324	71,582	74,005	15,010	189,921
Average Annual % Change	(13%)	(1%)	20%	57%	7%

Expenditures adjusted for inflation to SFY18 dollars

Larimer County - Intervention Waiver Spending by Intervention Type and SFY

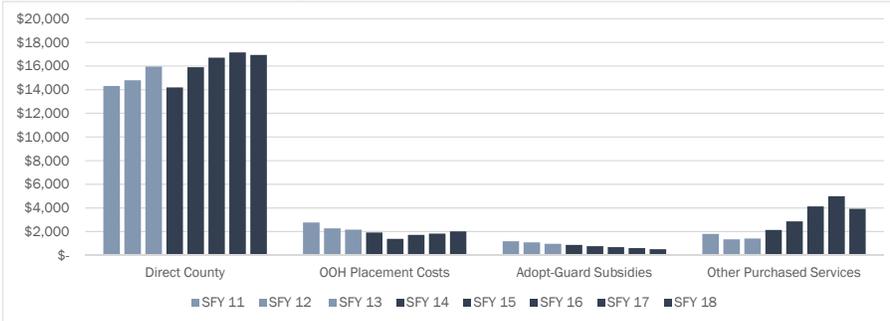


	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$223,265	\$249,372	\$331,418	\$365,762	\$55,663	\$371,713	\$427,376
Kinship Supports	\$143,080	\$163,953	\$229,369	\$208,321	\$0	\$0	\$0
Trauma-Informed Assessment	\$0	\$520,896	\$1,265,350	\$937,136	\$96,373	\$619,817	\$716,189
Trauma-Focused BH Treatment	\$0	\$0	\$376,847	\$1,138,095	\$1	\$680,645	\$680,646
Total	\$366,345	\$934,221	\$2,202,984	\$2,649,313	\$152,037	\$1,672,174	\$1,824,212

All Other CW Exp (excludes OOH)	\$17,204,511	\$19,551,887	\$21,525,512	\$22,759,320		\$21,377,511
Intervention Exp Proportion	2%	5%	10%	12%		9%

Expenditures by Major Category and Fiscal Year

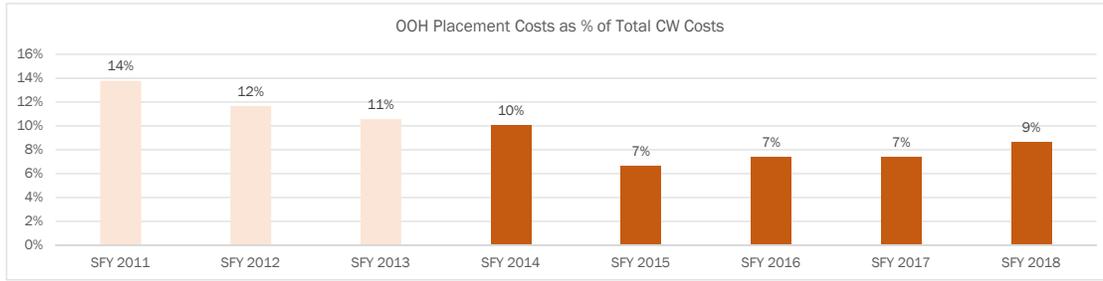
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

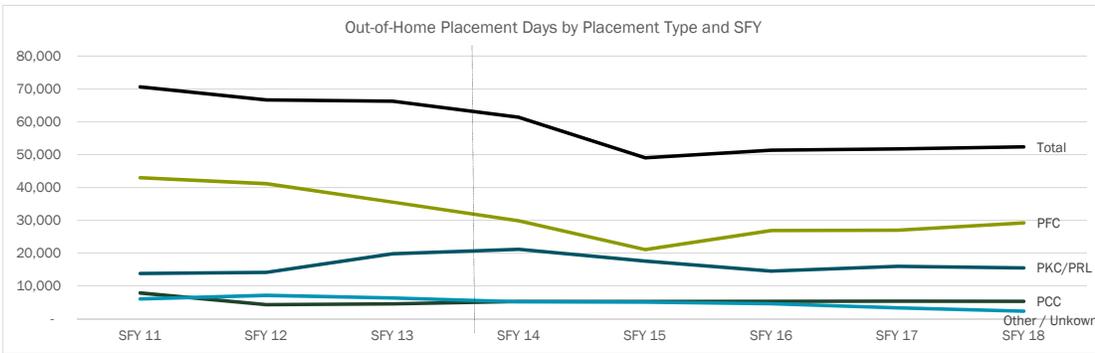
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$15,029	\$16,185	\$1,155	8%
OOH Placement Costs	\$2,403	\$1,774	(\$630)	(26%)
Adopt-Guard Subsidies	\$1,081	\$687	(\$394)	(36%)
Other Purchased Services	\$1,517	\$3,612	\$2,095	138%
Grand Total	\$20,031	\$22,257	\$2,227	11%

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$2,766,000	\$2,277,527	\$2,166,086	\$1,925,414	\$1,383,879	\$1,715,369	\$1,824,678	\$2,018,930
Placement Days	70,650	66,668	66,246	61,380	49,034	51,311	51,724	52,354
Average Daily Unit Cost	\$39.15	\$34.16	\$32.70	\$31.37	\$28.22	\$33.43	\$35.28	\$38.56



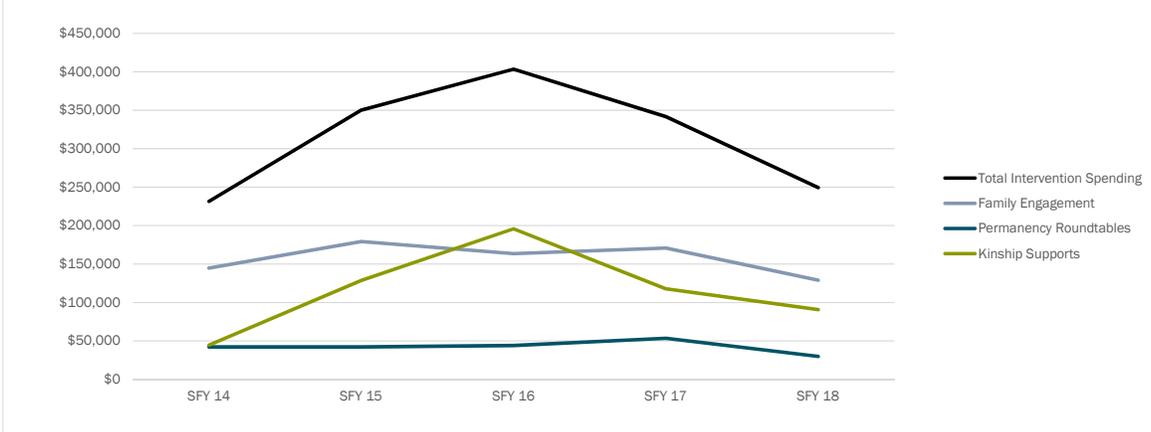
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	7,848	42,955	13,792	6,055	70,650
2012	4,280	41,129	14,138	7,121	66,668
2013	4,561	35,519	19,817	6,349	66,246
2014	5,266	29,833	21,132	5,149	61,380
2015	5,284	21,070	17,588	5,092	49,034
2016	5,294	26,874	14,536	4,607	51,311
2017	5,388	27,001	15,993	3,342	51,724
2018	5,327	29,235	15,492	2,300	52,354

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	5,563	39,868	15,916	6,508	67,855
Average Annual Days - Waiver	5,312	26,803	16,948	4,098	53,161
Average Annual % Change	(5%)	(33%)	6%	(37%)	(22%)

Expenditures adjusted for inflation to SFY18 dollars

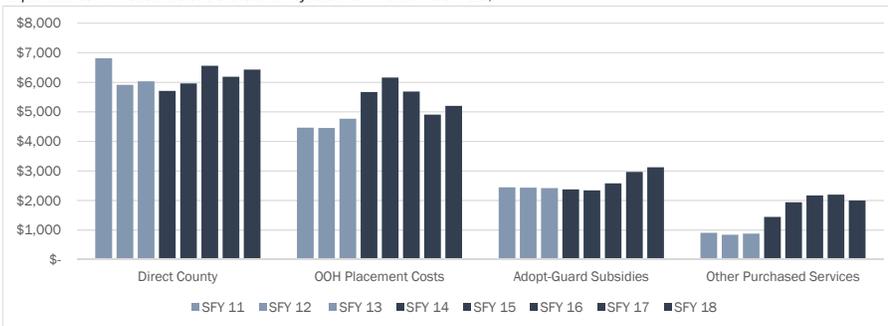
Mesa County - Intervention Waiver Spending by Intervention Type and SFY



	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$144,685	\$179,178	\$163,519	\$170,718	\$30,398	\$98,523	\$128,921
Kinship Supports	\$44,570	\$128,765	\$195,766	\$117,657	\$54,398	\$36,253	\$90,651
Permanency Roundtables	\$42,160	\$42,124	\$44,063	\$53,363	\$2,603	\$27,165	\$29,768
Total	\$231,415	\$350,067	\$403,348	\$341,739	\$87,398	\$161,941	\$249,340
All Other CW Exp (excludes OOH)	\$9,538,483	\$10,257,219	\$11,322,331	\$11,366,065			\$11,563,652
Intervention Exp Proportion	2%	3%	4%	3%			2%

Expenditures by Major Category and Fiscal Year

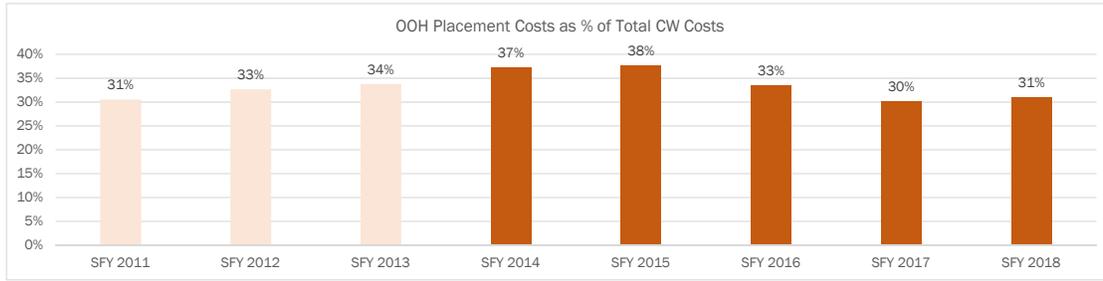
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

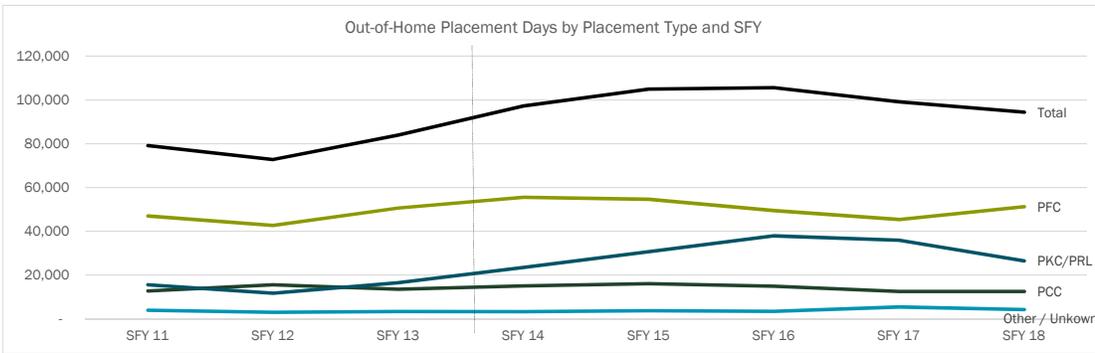
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$6,256	\$6,174	(\$82)	(1%)
OOH Placement Costs	\$4,565	\$5,530	\$964	21%
Adopt-Guard Subsidies	\$2,436	\$2,682	\$246	10%
Other Purchased Services	\$879	\$1,954	\$1,075	122%
Grand Total	\$14,136	\$16,339	\$2,203	16%

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$4,466,708	\$4,459,695	\$4,769,148	\$5,673,544	\$6,166,987	\$5,690,781	\$4,909,820	\$5,206,911
Placement Days	79,111	72,761	83,937	97,232	104,933	105,617	99,115	94,343
Average Daily Unit Cost	\$56.46	\$61.29	\$56.82	\$58.35	\$58.77	\$53.88	\$49.54	\$55.19



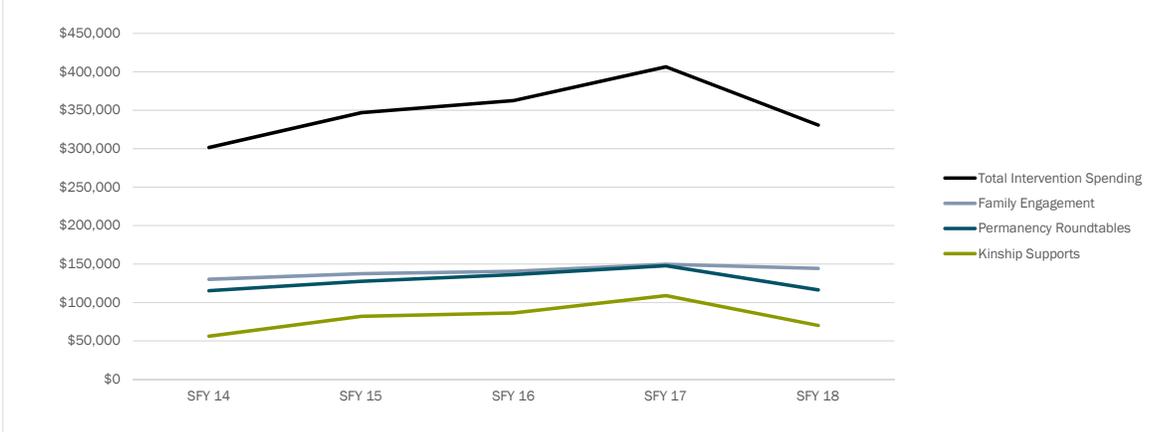
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	12,719	46,963	15,515	3,914	79,111
2012	15,517	42,610	11,690	2,944	72,761
2013	13,527	50,576	16,500	3,334	83,937
2014	15,007	55,501	23,502	3,222	97,232
2015	16,039	54,589	30,643	3,662	104,933
2016	14,910	49,449	37,873	3,385	105,617
2017	12,509	45,343	35,885	5,378	99,115
2018	12,443	51,206	26,464	4,230	94,343

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	13,921	46,716	14,568	3,397	78,603
Average Annual Days - Waiver	14,182	51,218	30,873	3,975	100,248
Average Annual % Change	2%	10%	112%	17%	28%

Expenditures adjusted for inflation to SFY18 dollars

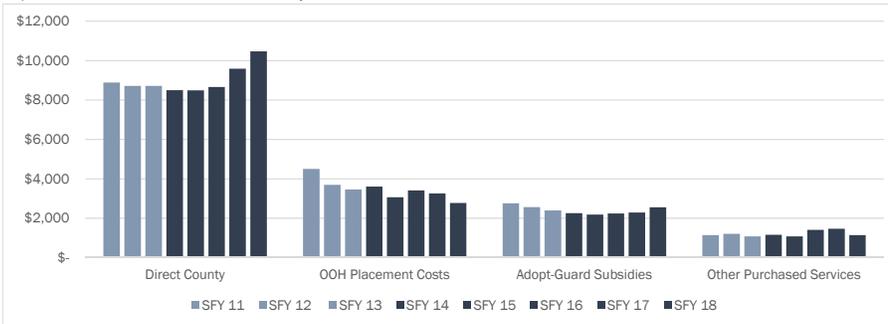
Pueblo County - Intervention Waiver Spending by Intervention Type and SFY



	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$130,078	\$137,412	\$140,374	\$149,718	\$141,977	\$2,312	\$144,289
Kinship Supports	\$56,189	\$81,965	\$86,139	\$108,929	\$0	\$70,089	\$70,089
Permanency Roundtables	\$115,249	\$127,336	\$136,080	\$147,727	\$115,479	\$835	\$116,314
Total	\$301,516	\$346,713	\$362,593	\$406,374	\$257,456	\$73,236	\$330,692
All Other CW Exp (excludes OOH)	\$11,927,082	\$11,768,141	\$12,318,422	\$13,350,389			\$14,169,541
Intervention Exp Proportion	3%	3%	3%	3%			2%

Expenditures by Major Category and Fiscal Year

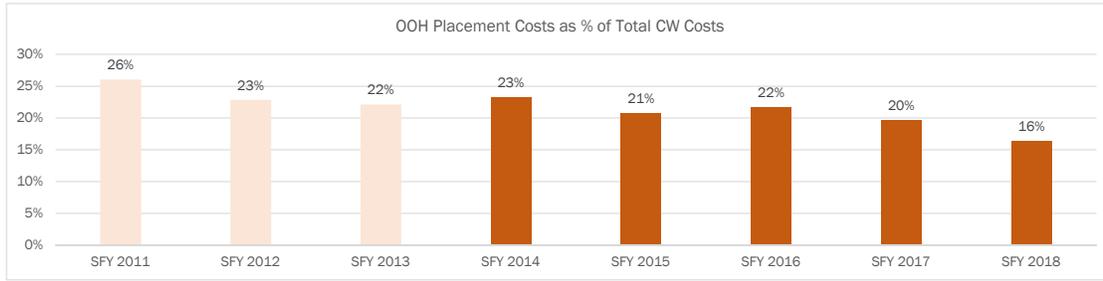
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

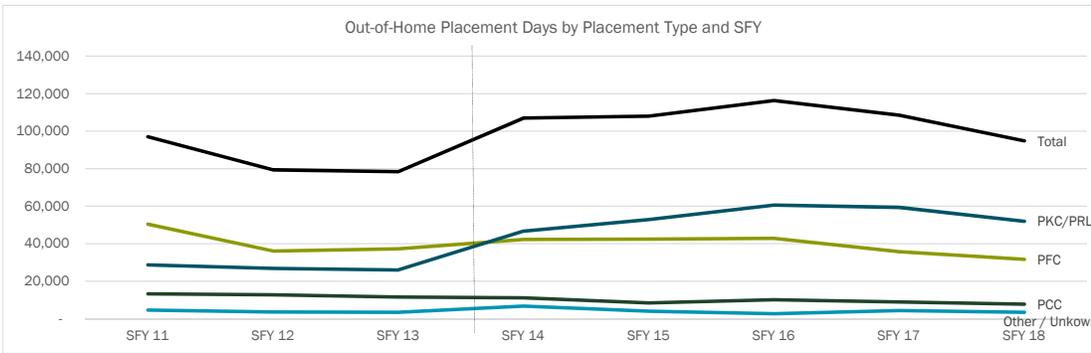
Major Category	Avg Annual Costs - Pre Waiver	Avg Annual Costs - Waiver	Average Annual Change	Average Annual % Change
Direct County	\$8,777	\$9,144	\$367	4%
OOH Placement Costs	\$3,889	\$3,227	(\$663)	(17%)
Adopt-Guard Subsidies	\$2,575	\$2,309	(\$266)	(10%)
Other Purchased Services	\$1,144	\$1,254	\$110	10%
Grand Total	\$16,385	\$15,933	(\$452)	(3%)

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$4,506,464	\$3,699,959	\$3,461,514	\$3,610,429	\$3,064,919	\$3,413,814	\$3,264,109	\$2,779,569
Placement Days	97,055	79,368	78,377	106,954	107,934	116,276	108,469	94,794
Average Daily Unit Cost	\$46.43	\$46.62	\$44.16	\$33.76	\$28.40	\$29.36	\$30.09	\$29.32



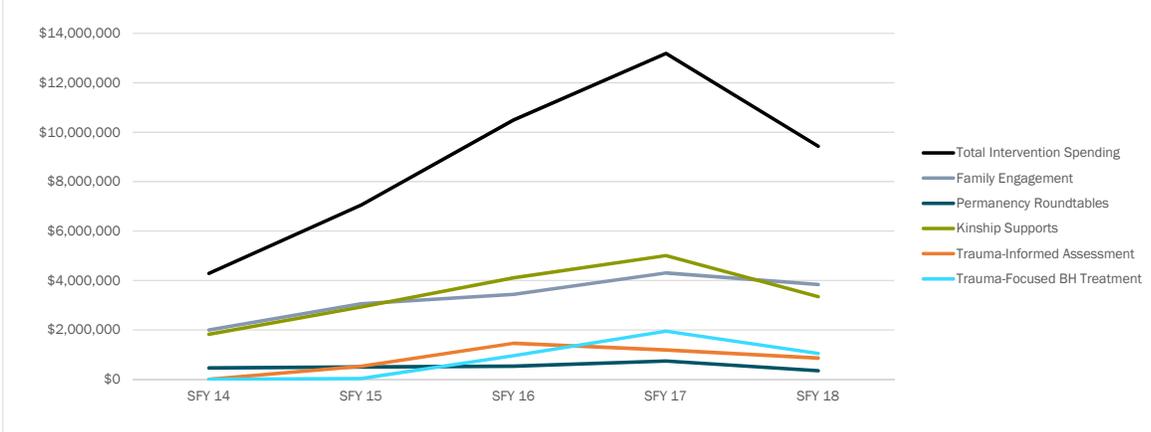
Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	13,279	50,434	28,706	4,636	97,055
2012	12,770	36,084	26,876	3,638	79,368
2013	11,627	37,293	26,024	3,433	78,377
2014	11,207	42,334	46,677	6,736	106,954
2015	8,476	42,448	52,928	4,082	107,934
2016	10,134	42,922	60,559	2,661	116,276
2017	8,982	35,766	59,354	4,367	108,469
2018	7,742	31,654	51,939	3,459	94,794

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	12,559	41,270	27,202	3,902	84,933
Average Annual Days - Waiver	9,308	39,025	54,291	4,261	106,885
Average Annual % Change	(26%)	(5%)	100%	9%	26%

Expenditures adjusted for inflation to SFY18 dollars

Weld County - Intervention Waiver Spending by Intervention Type and SFY

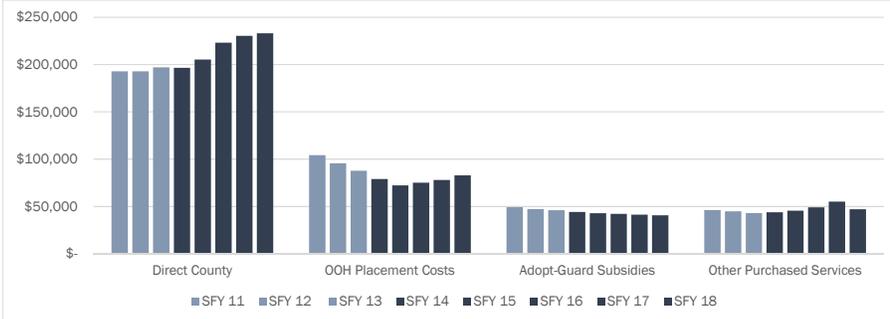


	SFY14	SFY15	SFY16	SFY17	SFY18		Total
	Total	Total	Total	Total	Direct	Purchased	
Family Engagement	\$1,999,069	\$3,053,180	\$3,434,742	\$4,304,503	\$3,215,109	\$619,283	\$3,834,391
Kinship Supports	\$1,824,619	\$2,930,780	\$4,102,844	\$5,006,006	\$2,158,556	\$1,187,266	\$3,345,822
Permanency Roundtables	\$462,589	\$501,071	\$535,426	\$739,174	\$302,398	\$44,273	\$346,670
Trauma-Informed Assessment	\$0	\$535,089	\$1,459,180	\$1,187,503	\$96,513	\$765,645	\$862,158
Trauma-Focused BH Treatment	\$0	\$37,836	\$959,436	\$1,948,819	\$146,222	\$898,322	\$1,044,544
Total	\$4,286,278	\$7,057,956	\$10,491,628	\$13,186,005	\$5,918,798	\$3,514,788	\$9,433,586

All Other CW Exp (excludes OOH)	\$284,777,110	\$293,794,016	\$314,639,279	\$326,809,971			\$320,874,143
Intervention Exp Proportion	2%	2%	3%	4%			3%

Expenditures by Major Category and Fiscal Year

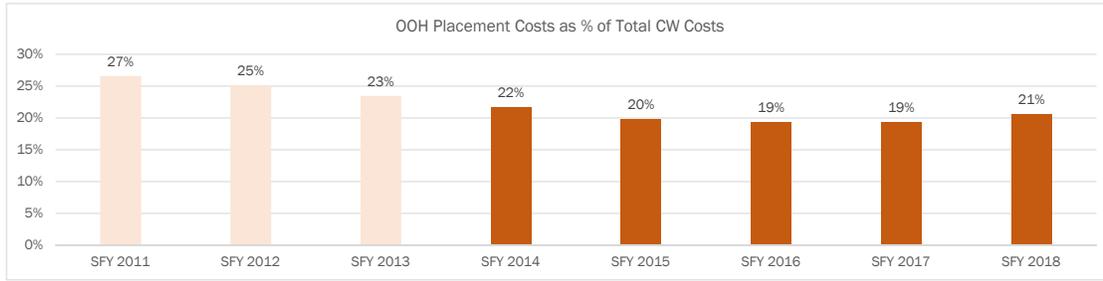
Expenditures in Thousands of Dollars and Adjusted for Inflation to SFY18\$



Average Annual Expenditure Waiver Change - Adjusted for Inflation to SFY18\$

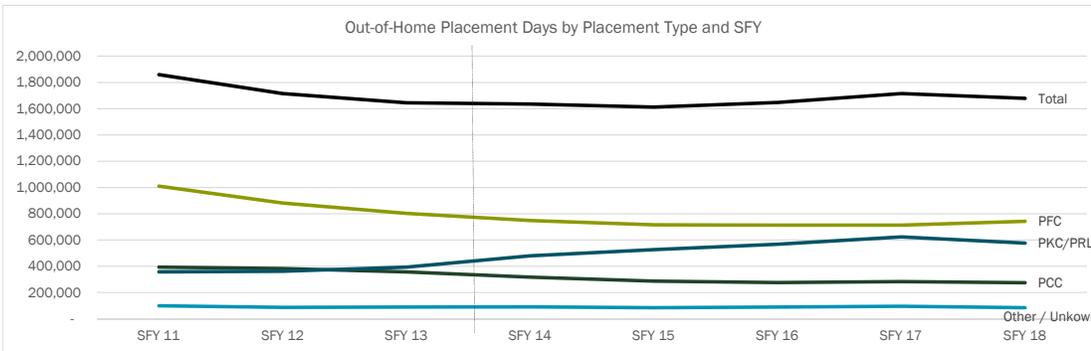
Major Category	Avg Annual Costs	Avg Annual Costs	Average Annual	Average Annual
	- Pre Waiver	- Waiver	Change	% Change
Direct County	\$194,380	\$217,780	\$23,399	12%
OOH Placement Costs	\$95,897	\$77,476	(\$18,420)	(19%)
Adopt-Guard Subsidies	\$47,562	\$42,252	(\$5,310)	(11%)
Other Purchased Services	\$44,720	\$48,147	\$3,427	8%
Grand Total	\$382,559	\$385,655	\$3,096	1%

OOH Expenditures, Average Daily Unit Cost, & Annual Placement Days



Average Daily Unit Cost by SFY

	SFY 11	SFY 12	SFY 13	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18
OOH Expenditures (Adj)	\$104,280,198	\$95,664,213	\$87,745,559	\$79,007,044	\$72,254,183	\$75,097,703	\$78,052,974	\$82,969,211
Placement Days	1,859,156	1,714,145	1,644,279	1,634,369	1,612,447	1,646,832	1,715,146	1,678,656
Average Daily Unit Cost	\$56.09	\$55.81	\$53.36	\$48.34	\$44.81	\$45.60	\$45.51	\$49.43



Placement Days by Placement Type and SFY

SFY	PCC	PFC	PKC/PRL	Other / Unkown	Total Days
2011	392,902	1,010,074	357,343	98,837	1,859,156
2012	383,070	882,463	361,908	86,704	1,714,145
2013	357,454	803,510	393,626	89,689	1,644,279
2014	316,935	748,647	478,872	89,915	1,634,369
2015	286,681	715,580	526,438	83,748	1,612,447
2016	276,416	713,983	567,417	89,016	1,646,832
2017	283,184	713,365	623,353	95,244	1,715,146
2018	274,636	742,891	576,828	84,301	1,678,656

	PCC	PFC	PKC/PRL	Other / Unkown	Total
Average Annual Days - Pre-waiver	377,809	898,682	370,959	91,743	1,739,193
Average Annual Days - Waiver	287,570	726,893	554,582	88,445	1,657,490
Average Annual % Change	(24%)	(19%)	49%	(4%)	(5%)

Appendix M: Matched Case Comparison Balance Tables

INTERVENTION GROUP = ALL OUT-OF-HOME CHILDREN AND YOUTH WHOSE FAMILIES RECEIVED FFE MEETINGS

Matching Variable	Intervention Group (n=14,442)			Comparison Group (n=13,998)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.2	5.8	6.0	7.1	5.8	6.0	0.1	0.0	0.0
Outcome Observation Window (Days)	879.7	425.7	884.0	835.5	428.8	853.0	44.2	-3.1	31.0
			Percentage			Percentage			Percentage
Gender									
Female			45.4%			47.0%			-1.6%
Male			54.6%			53.0%			1.6%
Race/Ethnicity									
American Indian			0.5%			0.7%			-0.2%
Asian			0.5%			0.7%			-0.3%
Black			9.7%			10.5%			-0.8%
Hawaiian			0.2%			0.1%			0.1%
Hispanic			39.4%			39.0%			0.4%
Two or More			5.6%			4.8%			0.7%
White			43.0%			43.4%			-0.5%
Missing			1.2%			0.7%			0.5%
County									
Adams			11.4%			12.2%			-0.8%
Arapahoe			11.4%			10.6%			0.7%
Archuleta			0.2%			0.2%			0.0%
Baca			0.1%			0.1%			0.0%
Boulder			3.3%			2.5%			0.8%
Broomfield			0.7%			0.5%			0.2%
Chaffee			0.4%			0.2%			0.3%
Cheyenne			0.0%			0.0%			0.0%
Crowley			0.1%			0.1%			0.0%
Custer			0.1%			0.0%			0.0%
Denver			16.7%			17.9%			-1.2%
Douglas			2.4%			1.6%			0.8%
El Paso			13.3%			15.5%			-2.2%
Elbert			0.3%			0.4%			-0.1%
Fremont			2.1%			1.7%			0.4%
Garfield			0.8%			0.6%			0.2%
Huerfano			0.2%			0.3%			-0.1%
Jefferson			8.5%			9.5%			-1.0%
Kiowa			0.2%			0.0%			0.1%
Kit Carson			0.1%			0.1%			0.0%
La Plata			0.6%			0.6%			0.1%
Larimer			5.3%			4.6%			0.7%
Lincoln			0.3%			0.2%			0.0%
Logan			0.9%			0.9%			0.0%
Mesa			4.6%			4.0%			0.6%
Moffat			0.2%			0.2%			0.0%
Montrose			1.4%			1.1%			0.2%
Otero			0.3%			0.7%			-0.4%
Park			0.1%			0.2%			-0.1%
Pitkin			0.0%			0.0%			0.0%

Prowers			0.3%			0.1%			0.1%
Pueblo			6.8%			5.7%			1.0%
Rio Blanco			0.1%			0.2%			-0.2%
San Juan			0.0%			0.0%			0.0%
San Miguel			0.0%			0.0%			0.0%
Summit			0.0%			0.1%			-0.1%
Teller			0.5%			0.6%			-0.2%
Weld			6.4%			6.3%			0.0%
Yuma			0.1%			0.2%			-0.1%
Physical Abuse Present									
No			91.2%			89.3%			1.9%
Yes			8.8%			10.7%			-1.9%
Sexual Abuse Present									
No			97.1%			96.1%			1.0%
Yes			2.9%			3.9%			-1.0%
Neglect Present									
No			35.3%			34.2%			1.1%
Yes			64.7%			65.8%			-1.1%
Overall Risk Level									
Low Risk			2.5%			2.6%			-0.1%
Moderate Risk			39.0%			44.5%			-5.5%
High Risk			47.7%			40.5%			7.2%
PA4/No Risk Assess			8.2%			8.3%			-0.1%
Missing			2.6%			4.1%			-1.5%
Report Disposition									
FAR (No Findings)			0.2%			0.2%			0.0%
Report Founded			58.4%			61.3%			-2.9%
Report Inconclusive			17.2%			12.1%			5.1%
No Investigation			12.3%			14.1%			-1.8%
Report Unfounded			6.1%			4.1%			1.9%
Missing			5.9%			8.3%			-2.4%
Case Pathway									
Adoption			1.7%			1.4%			0.3%
FAR			0.2%			0.2%			0.0%
Traditional			98.1%			98.4%			-0.4%
Case Program Area									
PA4			15.3%			14.0%			1.4%
PA5			84.4%			85.2%			-0.8%
PA6			0.3%			0.8%			-0.5%
Case Status									
Closed			62.4%			60.3%			2.1%
Open			37.6%			39.7%			-2.1%

INTERVENTION GROUP = OUT-OF-HOME CHILDREN AND YOUTH WHOSE FAMILIES RECEIVED FFE MEETINGS WITH HIGHER OVERALL ADHERENCE

Matching Variable	Intervention Group (n=2,791)			Comparison Group (n=2,700)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	6.7	5.6	6.0	7.0	5.8	6.0	-0.3	-0.2	0.0
Outcome Observation Window (Days)	768.4	425.1	753.0	837.5	428.6	850.0	-69.1	-3.5	-97.0

			Percentage			Percentage		Percentage
Gender								
Female			46.6%			46.6%		0.1%
Male			53.4%			53.4%		-0.1%
Race/Ethnicity								
American Indian			0.6%			0.6%		0.1%
Asian			0.4%			0.7%		-0.2%
Black			5.1%			12.0%		-6.9%
Hawaiian			0.0%			0.1%		-0.1%
Hispanic			40.4%			38.9%		1.5%
Two or More			4.1%			4.9%		-0.8%
White			48.6%			42.4%		6.2%
Missing			0.7%			0.5%		0.2%
County								
Adams			15.5%			12.4%		3.1%
Arapahoe			3.8%			10.0%		-6.2%
Archuleta			0.3%			0.1%		0.2%
Baca			0.0%			0.0%		0.0%
Boulder			4.4%			2.8%		1.6%
Broomfield			0.4%			0.5%		-0.1%
Chaffee			0.1%			0.1%		0.0%
Crowley			0.0%			0.2%		-0.1%
Custer			0.3%			0.0%		0.3%
Denver			16.6%			17.9%		-1.3%
Douglas			2.5%			1.5%		1.0%
El Paso			4.7%			17.2%		-12.5%
Elbert			0.4%			0.3%		0.0%
Fremont			6.7%			1.5%		5.2%
Garfield			1.5%			0.7%		0.8%
Huerfano			0.1%			0.1%		0.0%
Jefferson			1.9%			8.9%		-7.0%
Kiowa			0.1%			0.0%		0.1%
Kit Carson			0.0%			0.1%		-0.1%
La Plata			0.9%			1.0%		-0.1%
Larimer			9.5%			4.5%		4.9%
Lincoln			0.0%			0.1%		-0.1%
Logan			1.4%			0.8%		0.5%
Mesa			8.7%			4.0%		4.6%
Moffat			0.0%			0.2%		-0.2%
Montrose			2.0%			1.0%		1.0%
Otero			0.2%			0.5%		-0.3%
Park			0.0%			0.0%		0.0%
Pitkin			0.0%			0.1%		0.0%
Prowers			0.1%			0.1%		0.0%
Pueblo			11.4%			5.8%		5.6%
Rio Blanco			0.0%			0.2%		-0.2%
San Miguel			0.1%			0.0%		0.1%
Summit			0.0%			0.1%		-0.1%
Teller			0.2%			0.4%		-0.2%
Weld			6.1%			6.4%		-0.3%
Yuma			0.0%			0.2%		-0.2%
Physical Abuse Present								
No			89.2%			90.5%		-1.3%

Yes			10.8%			9.5%			1.3%
Sexual Abuse Present									
No			97.0%			96.8%			0.2%
Yes			3.0%			3.2%			-0.2%
Neglect Present									
No			32.2%			34.6%			-2.3%
Yes			67.8%			65.4%			2.3%
Overall Risk Level									
Low Risk			2.6%			2.3%			0.3%
Moderate Risk			39.2%			43.1%			-3.9%
High Risk			51.5%			41.4%			10.0%
PA4/No Risk Assess			5.0%			9.1%			-4.1%
Missing			1.7%			4.0%			-2.3%
Report Disposition									
FAR (No Findings)			0.2%			0.1%			0.1%
Report Founded			67.6%			58.9%			8.8%
Report Inconclusive			11.2%			16.6%			-5.4%
No Investigation			11.1%			12.9%			-1.8%
Report Unfounded			3.9%			5.5%			-1.6%
Missing			6.0%			6.1%			-0.1%
Case Pathway									
Adoption			0.5%			1.5%			-1.1%
FAR			0.3%			0.1%			0.1%
Traditional			99.2%			98.3%			0.9%
Case Program Area									
PA4			12.0%			14.8%			-2.8%
PA5			88.0%			84.7%			3.3%
PA6			0.0%			0.6%			-0.5%
Case Status									
Closed			61.3%			60.8%			0.5%
Open			38.7%			39.2%			-0.5%

INTERVENTION GROUP = OUT-OF-HOME CHILDREN AND YOUTH WHOSE FAMILIES RECEIVED FFE MEETINGS WITH LOWER OVERALL ADHERENCE

Matching Variable	Intervention Group (n=11,651)			Comparison Group (n=11,293)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.3	5.8	7.0	7.1	5.8	6.0	0.2	0.0	1.0
Outcome Observation Window (Days)	906.4	421.5	922.0	835.0	428.9	853.0	71.4	-7.4	69.0
			Percentage			Percentage			Percentage
Gender									
Female			45.1%			47.2%			-2.0%
Male			54.9%			52.8%			2.0%
Race/Ethnicity									
American Indian			0.5%			0.7%			-0.2%
Asian			0.5%			0.7%			-0.3%
Black			10.9%			10.2%			0.7%
Hawaiian			0.2%			0.1%			0.1%
Hispanic			39.2%			39.1%			0.1%
Two or More			5.9%			4.8%			1.1%
White			41.6%			43.7%			-2.1%

Missing			1.3%			0.7%			0.6%
County									
Adams			10.4%			12.2%			-1.8%
Arapahoe			13.2%			10.8%			2.4%
Archuleta			0.1%			0.2%			0.0%
Baca			0.1%			0.1%			0.0%
Boulder			3.0%			2.4%			0.7%
Broomfield			0.7%			0.5%			0.2%
Chaffee			0.5%			0.2%			0.3%
Cheyenne			0.0%			0.0%			0.0%
Crowley			0.1%			0.1%			0.0%
Custer			0.0%			0.0%			0.0%
Denver			16.7%			17.9%			-1.2%
Douglas			2.4%			1.6%			0.8%
El Paso			15.3%			15.1%			0.2%
Elbert			0.3%			0.4%			-0.2%
Fremont			1.0%			1.8%			-0.8%
Garfield			0.6%			0.6%			0.0%
Huerfano			0.2%			0.3%			-0.1%
Jefferson			10.1%			9.7%			0.5%
Kiowa			0.2%			0.0%			0.1%
Kit Carson			0.1%			0.1%			0.0%
La Plata			0.6%			0.5%			0.1%
Larimer			4.3%			4.7%			-0.4%
Lincoln			0.3%			0.3%			0.1%
Logan			0.8%			0.9%			-0.1%
Mesa			3.7%			4.0%			-0.4%
Moffat			0.3%			0.2%			0.1%
Montrose			1.2%			1.1%			0.1%
Otero			0.4%			0.7%			-0.4%
Park			0.1%			0.2%			-0.1%
Pitkin			0.0%			0.0%			0.0%
Prowers			0.3%			0.1%			0.2%
Pueblo			5.6%			5.7%			-0.1%
Rio Blanco			0.1%			0.2%			-0.1%
San Juan			0.0%			0.0%			0.0%
San Miguel			0.0%			0.0%			0.0%
Summit			0.1%			0.1%			-0.1%
Teller			0.5%			0.7%			-0.2%
Weld			6.4%			6.3%			0.1%
Yuma			0.1%			0.2%			-0.1%
Physical Abuse Present									
No			91.7%			89.0%			2.6%
Yes			8.3%			11.0%			-2.6%
Sexual Abuse Present									
No			97.1%			95.9%			1.2%
Yes			2.9%			4.1%			-1.2%
Neglect Present									
No			36.0%			34.1%			1.9%
Yes			64.0%			65.9%			-1.9%
Overall Risk Level									
Low Risk			2.5%			2.7%			-0.2%
Moderate Risk			39.0%			44.9%			-5.9%

High Risk			46.8%			40.3%			6.5%
PA4/No Risk Assess			8.9%			8.1%			0.9%
Missing			2.8%			4.1%			-1.3%
Report Disposition									
FAR (No Findings)			0.1%			0.2%			0.0%
Report Founded			59.8%			58.3%			1.5%
Report Inconclusive			12.3%			17.3%			-5.1%
No Investigation			14.8%			12.1%			2.6%
Report Unfounded			4.2%			6.2%			-2.0%
Missing			8.9%			5.9%			3.0%
Case Pathway									
Adoption			1.7%			1.8%			-0.1%
FAR			0.1%			0.2%			-0.1%
Traditional			98.2%			98.0%			0.2%
Case Program Area									
PA4			16.1%			13.8%			2.3%
PA5			83.5%			85.3%			-1.8%
PA6			0.4%			0.9%			-0.5%
Case Status									
Closed			62.7%			60.1%			2.5%
Open			37.3%			39.9%			-2.5%

INTERVENTION GROUP = ALL IN-HOME CHILDREN AND YOUTH									
Matching Variable	Intervention Group (n=12,417)			Comparison Group (n=12,417)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.7	5.1	8.0	7.3	5.0	7.0	0.4	0.1	1.0
Outcome Observation Window (Days)	810.5	453.0	807.0	827.1	315.1	818.0	-16.6	137.9	-11.0
			Percentage			Percentage			Percentage
Gender									
Female			49.2%			48.9%			0.3%
Male			50.8%			51.1%			-0.3%
Race/Ethnicity									
American Indian			0.4%			0.4%			0.0%
Asian			0.7%			0.8%			-0.1%
Black			8.1%			6.8%			1.3%
Hawaiian			0.2%			0.2%			0.0%
Hispanic			35.6%			32.7%			2.9%
Two or More			3.6%			3.2%			0.4%
White			48.0%			50.5%			-2.5%
Missing			3.4%			5.4%			-2.0%
County									
Adams			13.4%			10.6%			2.8%
Arapahoe			15.0%			9.2%			5.8%
Archuleta			0.5%			0.7%			-0.2%
Baca			0.1%			0.1%			0.0%
Boulder			3.4%			3.8%			-0.4%
Broomfield			0.7%			0.4%			0.3%
Chaffee			0.6%			0.2%			0.4%
Cheyenne			0.0%			0.1%			-0.1%
Crowley			0.2%			0.2%			0.0%

Custer			0.0%			0.0%			0.0%
Denver			11.0%			10.4%			0.6%
Douglas			3.3%			1.5%			1.8%
El Paso			11.4%			9.8%			1.6%
Elbert			0.7%			0.7%			0.0%
Fremont			2.3%			2.0%			0.3%
Garfield			1.1%			2.0%			-0.9%
Grand			0.0%			0.0%			0.0%
Huerfano			0.3%			0.5%			-0.2%
Jefferson			6.3%			12.4%			-6.1%
Kiowa			0.1%			0.0%			0.1%
Kit Carson			0.1%			0.4%			-0.3%
La Plata			1.7%			1.5%			0.2%
Larimer			12.8%			16.5%			-3.7%
Lincoln			0.3%			0.2%			0.1%
Logan			0.9%			1.0%			-0.1%
Mesa			2.1%			3.7%			-1.6%
Moffat			0.3%			0.7%			-0.4%
Montrose			1.6%			1.0%			0.6%
Otero			0.2%			0.8%			-0.6%
Ouray			0.0%			0.1%			-0.1%
Park			0.1%			0.5%			-0.4%
Pitkin			0.3%			0.5%			-0.2%
Prowers			0.7%			0.9%			-0.2%
Pueblo			3.7%			2.7%			1.0%
Rio Blanco			0.1%			0.5%			-0.4%
San Juan			0.0%			0.0%			0.0%
San Miguel			0.1%			0.2%			-0.1%
Summit			0.1%			0.5%			-0.4%
Teller			0.6%			0.6%			0.0%
Weld			4.0%			2.6%			1.4%
Yuma			0.1%			0.4%			-0.3%
Physical Abuse Present									
No			90.3%			87.9%			2.4%
Yes			9.7%			12.1%			-2.4%
Sexual Abuse Present									
No			94.3%			93.5%			0.8%
Yes			5.7%			6.5%			-0.8%
Neglect Present									
No			49.1%			49.1%			0.0%
Yes			50.9%			50.9%			0.0%
Overall Risk Level									
Low Risk			3.0%			3.1%			-0.1%
Moderate Risk			43.2%			48.8%			-5.6%
High Risk			41.2%			38.5%			2.7%
PA4/No Risk Assess			3.7%			4.7%			-1.0%
Missing			8.9%			4.8%			4.1%
Report Disposition									
FAR (No Findings)			11.0%			12.5%			-1.5%
Report Founded			47.8%			41.4%			6.4%
Report Inconclusive			15.8%			19.8%			-4.0%
No Investigation			8.0%			7.7%			0.3%
Report Unfounded			7.0%			9.8%			-2.8%

Missing			10.4%			8.8%			1.6%
Case Pathway									
Adoption			0.4%			1.1%			-0.7%
FAR			12.2%			14.8%			-2.6%
Traditional			87.3%			84.0%			3.3%
Case Program Area									
PA4			9.5%			8.6%			0.9%
PA5			90.4%			90.2%			0.2%
PA6			0.0%			0.8%			-0.8%
Missing			0.0%			0.3%			-0.3%
Case Status									
Closed			78.8%			88.8%			-10.0%
Open			21.2%			11.2%			10.0%

INTERVENTION GROUP = IN-HOME CHILDREN AND YOUTH WHOSE FAMILIES RECEIVED FFE MEETINGS WITH HIGHER OVERALL ADHERENCE

Matching Variable	Intervention Group (n=5,744)			Comparison Group (n=5,744)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.5	5.1	7.0	9.3	4.3	9.0	-1.8	0.8	-2.0
Outcome Observation Window (Days)	826.4	451.6	800.5	895.7	324.4	901.0	-69.3	127.2	-100.5
			Percentage			Percentage			Percentage
Gender									
Female			49.4%			49.8%			-0.4%
Male			50.6%			50.2%			0.4%
Race/Ethnicity									
American Indian			0.3%			0.3%			0.0%
Asian			0.8%			0.6%			0.2%
Black			6.9%			7.5%			-0.6%
Hawaiian			0.2%			0.2%			0.0%
Hispanic			36.6%			35.2%			1.4%
Two or More			3.6%			3.7%			-0.1%
White			48.2%			50.6%			-2.4%
Missing			3.4%			1.9%			1.5%
County									
Adams			17.6%			14.2%			3.4%
Arapahoe			16.2%			11.8%			4.4%
Archuleta			0.3%			0.5%			-0.2%
Baca			0.0%			0.1%			-0.1%
Boulder			4.0%			4.4%			-0.4%
Broomfield			0.6%			0.5%			0.1%
Chaffee			0.4%			0.2%			0.2%
Cheyenne			0.0%			0.1%			-0.1%
Crowley			0.1%			0.1%			0.0%
Custer			0.0%			0.0%			0.0%
Denver			8.9%			11.1%			-2.2%
Douglas			3.4%			1.7%			1.7%
El Paso			7.5%			7.9%			-0.4%
Elbert			0.5%			0.7%			-0.2%
Fremont			2.3%			2.3%			0.0%
Garfield			1.4%			1.5%			-0.1%

Huerfano			0.1%			0.7%			-0.6%
Jefferson			6.4%			9.0%			-2.6%
Kiowa			0.0%			0.0%			0.0%
Kit Carson			0.0%			0.1%			-0.1%
La Plata			1.8%			1.8%			0.0%
Larimer			13.3%			14.6%			-1.3%
Lincoln			0.3%			0.3%			0.0%
Logan			1.3%			1.2%			0.1%
Mesa			1.6%			3.2%			-1.6%
Moffat			0.4%			0.6%			-0.2%
Montrose			1.7%			1.3%			0.4%
Otero			0.0%			0.4%			-0.4%
Ouray			0.0%			0.0%			0.0%
Park			0.1%			0.4%			-0.3%
Pitkin			0.3%			0.4%			-0.1%
Prowers			0.3%			0.6%			-0.3%
Pueblo			5.7%			3.7%			2.0%
Rio Blanco			0.0%			0.2%			-0.2%
San Miguel			0.1%			0.1%			0.0%
Summit			0.0%			0.1%			-0.1%
Teller			0.2%			0.5%			-0.3%
Weld			3.1%			3.6%			-0.5%
Yuma			0.0%			0.2%			-0.2%
Physical Abuse Present									
No			89.9%			86.8%			3.1%
Yes			10.1%			13.2%			-3.1%
Sexual Abuse Present									
No			93.9%			93.0%			0.9%
Yes			6.1%			7.0%			-0.9%
Neglect Present									
No			47.9%			50.1%			-2.2%
Yes			52.1%			49.9%			2.2%
Overall Risk Level									
Low Risk			3.5%			3.0%			0.5%
Moderate Risk			42.5%			47.5%			-5.0%
High Risk			42.1%			39.0%			3.1%
PA4/No Risk Assess			2.3%			5.6%			-3.3%
Missing			9.6%			5.0%			4.6%
Report Disposition									
FAR (No Findings)			12.2%			10.4%			1.8%
Report Founded			49.4%			42.8%			6.6%
Report Inconclusive			16.3%			18.7%			-2.4%
No Investigation			6.8%			10.3%			-3.5%
Report Unfounded			7.0%			9.8%			-2.8%
Missing			8.3%			8.0%			0.3%
Case Pathway									
Adoption			0.2%			0.9%			-0.7%
FAR			13.9%			12.5%			1.4%
Traditional			85.9%			86.6%			-0.7%
Case Program Area									
PA4			7.8%			11.2%			-3.4%
PA5			92.2%			88.5%			3.7%
PA6			0.0%			0.1%			-0.1%

Missing			0.0%			0.2%		
Case Status								
Closed			81.3%			88.5%		-7.2%
Open			18.7%			11.5%		7.2%

INTERVENTION GROUP = IN-HOME CHILDREN AND YOUTH WHOSE FAMILIES RECEIVED FFE MEETINGS WITH LOWER OVERALL ADHERENCE

Matching Variable	Intervention Group (n=6,673)			Comparison Group (n=6,673)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.9	5.1	8.0	5.5	4.8	4.0	2.4	0.3	4.0
Outcome Observation Window (Days)	796.8	453.9	814.0	768.0	294.4	752.0	28.8	159.5	62.0
			Percentage			Percentage			Percentage
Gender									
Female			48.9%			48.1%			0.8%
Male			51.1%			51.9%			-0.8%
Race/Ethnicity									
American Indian			0.4%			0.4%			0.0%
Asian			0.6%			0.9%			-0.3%
Black			9.1%			6.1%			3.0%
Hawaiian			0.2%			0.2%			0.0%
Hispanic			34.7%			30.6%			4.1%
Two or More			3.5%			2.8%			0.7%
White			47.7%			50.4%			-2.7%
Missing			3.8%			8.6%			-4.8%
County									
Adams			9.7%			7.6%			2.1%
Arapahoe			13.9%			7.0%			6.9%
Archuleta			0.7%			0.8%			-0.1%
Baca			0.1%			0.2%			-0.1%
Boulder			3.0%			3.2%			-0.2%
Broomfield			0.9%			0.3%			0.6%
Chaffee			0.7%			0.2%			0.5%
Cheyenne			0.0%			0.1%			-0.1%
Crowley			0.2%			0.3%			-0.1%
Custer			0.0%			0.0%			0.0%
Denver			12.8%			9.9%			2.9%
Douglas			3.3%			1.3%			2.0%
El Paso			14.8%			11.5%			3.3%
Elbert			0.8%			0.7%			0.1%
Fremont			2.3%			1.8%			0.5%
Garfield			0.9%			2.5%			-1.6%
Grand			0.0%			0.0%			0.0%
Huerfano			0.5%			0.4%			0.1%
Jefferson			6.3%			15.2%			-8.9%
Kiowa			0.1%			0.0%			0.1%
Kit Carson			0.1%			0.5%			-0.4%
La Plata			1.7%			1.3%			0.4%
Larimer			12.5%			18.3%			-5.8%
Lincoln			0.2%			0.1%			0.1%
Logan			0.5%			0.9%			-0.4%

Mesa		2.5%		4.1%		-1.6%
Moffat		0.3%		0.9%		-0.6%
Montrose		1.5%		0.7%		0.8%
Otero		0.3%		1.2%		-0.9%
Ouray		0.0%		0.1%		-0.1%
Park		0.1%		0.5%		-0.4%
Pitkin		0.2%		0.6%		-0.4%
Prowers		1.0%		1.2%		-0.2%
Pueblo		2.0%		1.9%		0.1%
Rio Blanco		0.2%		0.7%		-0.5%
San Juan		0.0%		0.0%		0.0%
San Miguel		0.1%		0.2%		-0.1%
Summit		0.1%		0.8%		-0.7%
Teller		0.8%		0.8%		0.0%
Weld		4.8%		1.8%		3.0%
Yuma		0.3%		0.6%		-0.3%
Physical Abuse Present						
No		90.7%		88.8%		1.9%
Yes		9.3%		11.2%		-1.9%
Sexual Abuse Present						
No		94.6%		94.0%		0.6%
Yes		5.4%		6.0%		-0.6%
Neglect Present						
No		50.1%		48.2%		1.9%
Yes		49.9%		51.8%		-1.9%
Overall Risk Level						
Low Risk		2.7%		3.3%		-0.6%
Moderate Risk		43.8%		49.9%		-6.1%
High Risk		40.4%		38.1%		2.3%
PA4/No Risk Assess		4.8%		4.0%		0.8%
Missing		8.3%		4.6%		3.7%
Report Disposition						
FAR (No Findings)		10.0%		14.3%		-4.3%
Report Founded		46.5%		40.1%		6.4%
Report Inconclusive		15.3%		20.7%		-5.4%
No Investigation		9.1%		5.5%		3.6%
Report Unfounded		7.0%		9.8%		-2.8%
Missing		12.3%		9.5%		2.8%
Case Pathway						
Adoption		0.7%		1.3%		-0.6%
FAR		10.8%		16.9%		-6.1%
Traditional		88.5%		81.8%		6.7%
Case Program Area						
PA4		11.0%		6.4%		4.6%
PA5		88.9%		91.7%		-2.8%
PA6		0.0%		1.5%		-1.5%
Missing		0.0%		0.4%		-0.4%
Case Status						
Closed		76.7%		89.1%		-12.4%
Open		23.3%		10.9%		12.4%

INTERVENTION GROUP = ALL CHILDREN AND YOUTH WHOSE KINSHIP CAREGIVERS RECEIVED KINSHIP SUPPORTS

Matching Variable	Intervention Group (n=10,114)			Comparison Group (n=8,779)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	5.8	5.0	5.0	5.9	5.0	5.0	-0.1	0.0	0.0
Outcome Observation Window (Days)	823.0	446.0	808.5	780.8	442.5	776.0	42.2	3.5	32.5
			Percentage			Percentage			Percentage
Gender									
Female			48.8%			50.1%			-1.3%
Male			51.2%			49.9%			1.3%
Race/Ethnicity									
American Indian			0.3%			0.6%			-0.3%
Asian			0.4%			0.5%			-0.1%
Black			9.0%			10.5%			-1.5%
Hawaiian			0.2%			0.1%			0.1%
Hispanic			42.0%			43.1%			-1.1%
Two or More			5.8%			4.5%			1.3%
White			41.1%			40.4%			0.7%
Missing			1.2%			0.4%			0.8%
County									
Adams			12.9%			11.5%			1.4%
Arapahoe			11.2%			10.4%			0.8%
Archuleta			0.1%			0.1%			0.0%
Bent			0.2%			0.1%			0.1%
Boulder			2.7%			1.8%			0.9%
Broomfield			0.2%			0.6%			-0.4%
Chaffee			0.3%			0.0%			0.3%
Crowley			0.1%			0.1%			0.0%
Denver			14.5%			23.3%			-8.8%
El Paso			17.3%			13.2%			4.1%
Elbert			0.1%			0.3%			-0.2%
Fremont			2.5%			1.8%			0.7%
Garfield			0.7%			0.3%			0.4%
Jefferson			11.5%			11.3%			0.2%
Kiowa			0.0%			0.0%			0.0%
Kit Carson			0.1%			0.1%			0.0%
La Plata			0.4%			0.4%			0.0%
Larimer			6.4%			5.7%			0.7%
Las Animas			0.1%			0.3%			-0.2%
Lincoln			0.1%			0.2%			-0.1%
Logan			0.6%			0.4%			0.2%
Mesa			3.4%			3.7%			-0.3%
Moffat			0.0%			0.2%			-0.2%
Montrose			0.0%			0.0%			0.0%
Morgan			0.3%			0.9%			-0.6%
Otero			1.1%			1.0%			0.1%
Prowers			0.1%			0.0%			0.1%
Pueblo			6.6%			5.8%			0.8%
Rio Blanco			0.2%			0.2%			0.0%
San Juan			0.0%			0.0%			0.0%
Teller			0.4%			0.1%			0.3%

Female			48.0%			48.7%			-0.7%
Male			52.0%			51.3%			0.7%
Race/Ethnicity									
American Indian			0.3%			0.4%			-0.1%
Asian			0.3%			0.5%			-0.2%
Black			8.5%			9.7%			-1.2%
Hawaiian			0.3%			0.1%			0.2%
Hispanic			42.6%			41.9%			0.7%
Two or More			5.8%			4.6%			1.2%
White			41.5%			42.5%			-1.0%
Missing			0.8%			0.3%			0.5%
County									
Adams			10.8%			11.2%			-0.4%
Arapahoe			11.5%			10.9%			0.6%
Archuleta			0.2%			0.1%			0.1%
Bent			0.2%			0.1%			0.1%
Boulder			4.3%			1.7%			2.6%
Broomfield			0.2%			0.6%			-0.4%
Chaffee			0.3%			0.0%			0.3%
Crowley			0.1%			0.1%			0.0%
Denver			12.4%			22.1%			-9.7%
El Paso			15.2%			13.7%			1.5%
Elbert			0.2%			0.2%			0.0%
Fremont			2.1%			1.5%			0.6%
Garfield			0.4%			0.2%			0.2%
Jefferson			9.7%			11.3%			-1.6%
Kiowa			0.0%			0.0%			0.0%
Kit Carson			0.1%			0.2%			-0.1%
La Plata			0.4%			0.5%			-0.1%
Larimer			4.1%			6.1%			-2.0%
Las Animas			0.1%			0.2%			-0.1%
Lincoln			0.0%			0.2%			-0.2%
Logan			0.8%			0.3%			0.5%
Mesa			3.6%			4.2%			-0.6%
Moffat			0.1%			0.2%			-0.1%
Morgan			0.2%			0.7%			-0.5%
Otero			1.3%			1.1%			0.2%
Prowers			0.1%			0.0%			0.1%
Pueblo			9.9%			5.8%			4.1%
Rio Blanco			0.0%			0.2%			-0.2%
Teller			0.7%			0.2%			0.5%
Weld			11.0%			6.0%			5.0%
Yuma			0.3%			0.1%			0.2%
Physical Abuse Present									
No			91.1%			89.4%			1.7%
Yes			8.9%			10.6%			-1.7%
Sexual Abuse Present									
No			97.0%			95.7%			1.3%
Yes			3.0%			4.3%			-1.3%
Neglect Present									
No			25.2%			27.1%			-1.9%
Yes			74.8%			72.9%			1.9%
Overall Risk Level									

Low Risk		2.1%		2.4%		-0.3%
Moderate Risk		41.0%		45.8%		-4.8%
High Risk		52.6%		45.2%		7.4%
PA4/No Risk Assess		2.1%		2.9%		-0.8%
Missing		2.2%		3.7%		-1.5%
Report Disposition						
FAR (No Findings)		2.6%		1.4%		1.2%
Report Founded		67.3%		65.8%		1.5%
Report Inconclusive		14.7%		18.4%		-3.7%
No Investigation		3.3%		3.9%		-0.6%
Report Unfounded		4.2%		5.2%		-1.0%
Missing		7.9%		5.3%		2.6%
Case Pathway						
Adoption		0.5%		0.5%		0.0%
FAR		3.0%		3.0%		0.0%
Traditional		96.5%		96.5%		0.0%
Case Program Area						
PA4		4.7%		3.7%		1.0%
PA5		93.8%		95.8%		-2.0%
PA6		1.2%		0.5%		0.7%
Missing		0.3%		0.0%		0.3%
Case Status						
Closed		68.6%		67.4%		1.2%
Open		31.4%		32.6%		-1.2%
Kinship Placement Status						
Closed		91.0%		88.2%		2.8%
Open		9.0%		11.8%		-2.8%

INTERVENTION GROUP = CHILDREN AND YOUTH WHOSE KINSHIP CAREGIVERS RECEIVED KINSHIP SUPPORTS WITH LOWER OVERALL ADHERENCE

Matching Variable	Intervention Group (n=6,562)			Comparison Group (n=5,672)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	6.0	5.1	5.0	6.0	5.0	5.0	0.0	0.1	0.0
Outcome Observation Window (Days)	808.3	454.0	785.0	782.1	441.1	782.0	26.2	12.9	3.0
			Percentage			Percentage			Percentage
Gender									
Female			49.2%			50.9%			-1.7%
Male			50.8%			49.1%			1.7%
Race/Ethnicity									
American Indian			0.4%			0.6%			-0.2%
Asian			0.4%			0.5%			-0.1%
Black			9.2%			10.9%			-1.7%
Hawaiian			0.2%			0.1%			0.1%
Hispanic			41.7%			43.7%			-2.0%
Two or More			5.9%			4.5%			1.4%
White			40.9%			39.3%			1.6%
Missing			1.4%			0.5%			0.9%
County									
Adams			14.0%			11.7%			2.3%

Arapahoe			11.0%			10.2%			0.8%
Archuleta			0.1%			0.1%			0.0%
Bent			0.1%			0.1%			0.0%
Boulder			1.9%			1.9%			0.0%
Broomfield			0.2%			0.6%			-0.4%
Chaffee			0.4%			0.0%			0.4%
Crowley			0.1%			0.1%			0.0%
Denver			15.6%			23.9%			-8.3%
El Paso			18.5%			12.9%			5.6%
Elbert			0.0%			0.4%			-0.4%
Fremont			2.6%			2.0%			0.6%
Garfield			0.8%			0.3%			0.5%
Jefferson			12.5%			11.3%			1.2%
Kit Carson			0.1%			0.1%			0.0%
La Plata			0.4%			0.4%			0.0%
Larimer			7.6%			5.5%			2.1%
Las Animas			0.1%			0.4%			-0.3%
Lincoln			0.1%			0.1%			0.0%
Logan			0.5%			0.4%			0.1%
Mesa			3.3%			3.4%			-0.1%
Moffat			0.0%			0.2%			-0.2%
Montrose			0.0%			0.0%			0.0%
Morgan			0.4%			1.0%			-0.6%
Otero			0.9%			0.9%			0.0%
Prowers			0.1%			0.0%			0.1%
Pueblo			4.8%			5.7%			-0.9%
Rio Blanco			0.3%			0.2%			0.1%
San Juan			0.0%			0.0%			0.0%
Teller			0.2%			0.1%			0.1%
Weld			3.0%			6.1%			-3.1%
Yuma			0.2%			0.1%			0.1%
Physical Abuse Present									
No			90.3%			89.8%			0.5%
Yes			9.7%			10.2%			-0.5%
Sexual Abuse Present									
No			96.7%			96.2%			0.5%
Yes			3.3%			3.8%			-0.5%
Neglect Present									
No			27.3%			26.5%			0.8%
Yes			72.7%			73.5%			-0.8%
Overall Risk Level									
Low Risk			2.2%			2.4%			-0.2%
Moderate Risk			42.0%			45.3%			-3.3%
High Risk			49.7%			44.8%			4.9%
PA4/No Risk Assess			2.6%			3.2%			-0.6%
Missing			3.5%			4.3%			-0.8%
Report Disposition									
FAR (No Findings)			2.6%			0.9%			1.7%
Report Founded			67.1%			64.8%			2.3%
Report Inconclusive			14.0%			19.6%			-5.6%
No Investigation			4.5%			4.4%			0.1%
Report Unfounded			4.3%			5.6%			-1.3%
Missing			7.6%			4.7%			2.9%

Case Pathway									
Adoption			1.1%			1.1%			0.0%
FAR			3.0%			1.1%			1.9%
Traditional			95.9%			97.8%			-1.9%
Case Program Area									
PA4			4.8%			5.0%			-0.2%
PA5			94.6%			93.3%			1.3%
PA6			0.5%			1.3%			-0.8%
Missing			0.1%			0.1%			0.0%
Case Status									
Closed			66.7%			68.7%			-2.0%
Open			33.3%			31.3%			2.0%
Kinship Placement Status									
Closed			89.2%			88.4%			0.8%
Open			10.8%			11.6%			-0.8%

INTERVENTION GROUP = PRT 16 & OLDER WITH OPPLA GOAL - ALL YOUTH									
Matching Variable	Intervention Group (n=480)			Comparison Group (n=315)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	17.4	1.5	17.0	17.2	1.2	17.0	0.2	0.3	0.0
Congregate Care Days	621.6	684.0	182.0	319.6	397.0	145.0	302.0	287.0	37.0
Removal Days	1812.1	1273.1	1415.0	1865.9	1461.5	1360.0	-53.8	-188.4	55.0
			Percentage			Percentage			Percentage
Gender									
Female			42.7%			44.4%			-1.7%
Male			57.3%			55.6%			1.7%
Race/Ethnicity									
American Indian			0.6%			0.0%			0.6%
Asian			1.3%			1.0%			0.3%
Black			10.6%			6.0%			4.6%
Hispanic			27.9%			27.3%			0.6%
Two or More			3.8%			1.9%			1.9%
White			55.6%			63.8%			-8.2%
Missing			0.2%			0.0%			0.2%
County									
Adams			23.8%			25.4%			-1.6%
Clear Creek			0.4%			0.0%			0.4%
Custer			0.4%			0.3%			0.1%
Denver			13.5%			0.0%			13.5%
Douglas			5.6%			4.8%			0.8%
Eagle			0.2%			0.3%			-0.1%
Elbert			1.3%			1.9%			-0.6%
Fremont			5.0%			6.7%			-1.7%
Garfield			0.8%			1.6%			-0.8%
Huerfano			0.6%			1.0%			-0.4%
Jefferson			23.3%			25.7%			-2.4%
La Plata			1.0%			1.6%			-0.6%
Las Animas			0.2%			0.6%			-0.4%
Lincoln			1.0%			1.0%			0.0%

Logan			1.7%			2.2%			-0.5%
Mesa			11.0%			14.0%			-3.0%
Montrose			3.3%			2.5%			0.8%
Otero			0.8%			1.6%			-0.8%
Prowers			0.2%			0.3%			-0.1%
Pueblo			3.5%			6.0%			-2.5%
Rio Blanco			0.2%			0.3%			-0.1%
Routt			0.4%			0.3%			0.1%
Teller			1.3%			1.9%			-0.6%
Yuma			0.2%			0.0%			0.2%
Physical Abuse Present									
No			87.3%			88.6%			-1.3%
Yes			12.7%			11.4%			1.3%
Sexual Abuse Present									
No			94.0%			92.7%			1.3%
Yes			6.0%			7.3%			-1.3%
Neglect Present									
No			59.8%			66.7%			-6.9%
Yes			40.2%			33.3%			6.9%
Overall Risk Level									
Low Risk			1.3%			1.0%			0.3%
Moderate Risk			33.5%			27.6%			5.9%
High Risk			38.3%			33.3%			5.0%
PA4/No Risk Assess			13.8%			15.2%			-1.4%
Missing			13.1%			22.9%			-9.8%
Report Disposition									
At Risk/Request Serv			0.6%			0.4%			0.2%
Report Founded			40.0%			41.0%			-1.0%
Report Inconclusive			15.2%			15.8%			-0.6%
No Investigation			19.4%			23.3%			-3.9%
Report Unfounded			4.4%			5.8%			-1.4%
Missing			20.3%			13.5%			6.8%
Case Pathway									
Adoption			10.8%			12.1%			-1.3%
Traditional			89.2%			87.9%			1.3%
Case Program Area									
Other			5.1%			1.5%			3.6%
PA4			23.8%			22.9%			0.9%
PA5			48.6%			61.3%			-12.7%
PA6			22.5%			14.4%			8.1%
Removal Status									
Closed			80.3%			75.2%			5.1%
Open			19.7%			24.8%			-5.1%

INTERVENTION GROUP = PRT 16 & OLDER WITH OPPLA GOAL - HIGHER ADHERENCE YOUTH									
Matching Variable	Intervention Group (n=106)			Comparison Group (n=76)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	17.1	1.4	17.0	16.5	1.9	17.0	0.6	-0.5	0.0
Congregate Care Days	334.7	368.1	233.5	329.2	415.6	155.5	5.5	-47.5	78.0

Adoption			7.9%			14.2%			-6.3%
Traditional			92.1%			85.8%			6.3%
Case Program Area									
Other			6.6%			2.8%			3.8%
PA4			22.4%			26.4%			-4.0%
PA5			42.1%			57.5%			-15.4%
PA6			28.9%			13.2%			15.7%
Removal Status									
Closed			72.4%			77.4%			-5.0%
Open			27.6%			22.6%			5.0%

INTERVENTION GROUP = PRT 16 & OLDER WITH OPPLA GOAL - LOWER ADHERENCE YOUTH									
Matching Variable	Intervention Group (n=374)			Comparison Group (n=239)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	17.6	1.6	17.0	17.7	1.1	17.0	-0.1	0.5	0.0
Congregate Care Days	317.9	388.8	177.5	316.6	391.8	144.0	1.3	-3.0	33.5
Removal Days	1867.4	1269.7	1460.0	1811.8	1371.8	1341.0	55.6	-102.1	119.0
			Percentage			Percentage			Percentage
Gender									
Female			44.4%			44.4%			0.0%
Male			55.6%			55.6%			0.0%
Race/Ethnicity									
American Indian			0.8%			0.0%			0.8%
Asian			1.6%			1.3%			0.3%
Black			12.0%			6.3%			5.7%
Hispanic			26.5%			26.8%			-0.3%
Two or More			3.7%			2.5%			1.2%
White			55.1%			63.2%			-8.1%
Missing			0.3%			0.0%			0.3%
County									
Adams			18.7%			22.2%			-3.5%
Clear Creek			0.5%			0.0%			0.5%
Custer			0.0%			0.0%			0.0%
Denver			16.6%			0.0%			16.6%
Douglas			6.1%			4.6%			1.5%
Eagle			0.3%			0.0%			0.3%
Elbert			1.1%			1.3%			-0.2%
Fremont			2.4%			7.5%			-5.1%
Garfield			0.8%			1.7%			-0.9%
Huerfano			0.8%			0.8%			0.0%
Jefferson			26.7%			28.5%			-1.8%
La Plata			1.3%			1.3%			0.0%
Las Animas			0.3%			0.8%			-0.5%
Lincoln			0.8%			0.8%			0.0%
Logan			2.1%			2.1%			0.0%
Mesa			12.8%			14.2%			-1.4%
Montrose			4.3%			2.1%			2.2%
Otero			1.1%			2.1%			-1.0%
Prowers			0.0%			0.4%			-0.4%
Pueblo			1.9%			6.3%			-4.4%

Rio Blanco			0.0%			0.4%			-0.4%
Rouff			0.3%			0.4%			-0.1%
Teller			0.8%			2.1%			-1.3%
Yuma			0.3%			0.0%			0.3%
Physical Abuse Present									
No			86.1%			87.9%			-1.8%
Yes			13.9%			12.1%			1.8%
Sexual Abuse Present									
No			94.4%			92.5%			1.9%
Yes			5.6%			7.5%			-1.9%
Neglect Present									
No			59.4%			65.3%			-5.9%
Yes			40.6%			34.7%			5.9%
Overall Risk Level									
Low Risk			0.8%			1.3%			-0.5%
Moderate Risk			29.7%			32.6%			-2.9%
High Risk			33.5%			37.7%			-4.2%
PA4/No Risk Assess			14.6%			13.6%			1.0%
Missing			21.3%			14.7%			6.6%
Report Disposition									
At Risk/Request Serv			0.8%			0.5%			0.3%
Report Founded			41.4%			40.1%			1.3%
Report Inconclusive			16.7%			15.2%			1.5%
No Investigation			18.8%			23.0%			-4.2%
Report Unfounded			5.0%			6.4%			-1.4%
Missing			17.2%			14.7%			2.5%
Case Pathway									
Adoption			11.7%			11.5%			0.2%
Traditional			88.3%			88.5%			-0.2%
Case Program Area									
Other			4.6%			1.1%			3.5%
PA4			24.3%			21.9%			2.4%
PA5			50.6%			62.3%			-11.7%
PA6			20.5%			14.7%			5.8%
Removal Status									
Closed			82.8%			74.6%			8.2%
Open			17.2%			25.4%			-8.2%

INTERVENTION GROUP = PRT 16 & OLDER WITH OPPLA GOAL - YOUTH WHO BEGAN OOH REMOVAL DURING A COUNTY WAIVER FUNDED PRT YEAR

Matching Variable	Intervention Group (n=134)			Comparison Group (n=111)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	17.5	1.6	17.0	17.1	1.3	17.0	0.4	0.3	0.0
Congregate Care Days	349.3	328.7	291.0	333.1	439.5	105.0	16.2	-110.8	186.0
Removal Days	788.0	288.8	719.5	2018.3	1636.8	1371.0	1230.3	-1348.0	-651.5
			Percentage			Percentage			Percentage
Gender									
Female			47.0%			45.0%			2.0%
Male			53.0%			55.0%			-2.0%

Other			7.2%			0.0%			7.2%
PA4			31.5%			30.6%			0.9%
PA5			37.8%			67.2%			-29.4%
PA6			23.4%			2.2%			21.2%
Removal Status									
Closed			78.4%			61.2%			17.2%
Open			21.6%			38.8%			-17.2%

INTERVENTION GROUP = PRT 16 & OLDER WITH OPPLA GOAL - YOUTH WHO BEGAN OOH REMOVAL PRIOR TO A COUNTY WAIVER FUNDED PRT YEAR

Matching Variable	Intervention Group (n=346)			Comparison Group (n=204)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	17.4	1.4	17.0	17.3	1.1	17.0	0.1	0.3	0.0
Congregate Care Days	310.9	403.3	124.5	312.3	372.8	152.0	-1.4	30.5	-27.5
Removal Days	2208.7	1285.7	1823.5	1783.0	1353.7	1357.5	425.7	-68.0	466.0
			Percentage			Percentage			Percentage
Gender									
Female			41.0%			44.1%			-3.1%
Male			59.0%			55.9%			3.1%
Race/Ethnicity									
American Indian			0.9%			0.0%			0.9%
Asian			1.7%			1.0%			0.7%
Black			12.4%			5.9%			6.5%
Hispanic			28.0%			28.4%			-0.4%
Two or More			2.6%			2.5%			0.1%
White			54.0%			62.3%			-8.3%
Missing			0.3%			0.0%			0.3%
County									
Adams			23.7%			25.0%			-1.3%
Clear Cree			0.6%			0.0%			0.6%
Denver			17.6%			0.0%			17.6%
Douglas			4.6%			4.9%			-0.3%
Eagle			0.3%			0.5%			-0.2%
Elbert			1.4%			2.5%			-1.1%
Fremont			4.6%			5.4%			-0.8%
Garfield			1.2%			1.5%			-0.3%
Huerfano			0.6%			0.5%			0.1%
Jefferson			20.8%			25.0%			-4.2%
La Plata			1.2%			2.0%			-0.8%
Las Animas			0.3%			0.5%			-0.2%
Lincoln			0.9%			1.5%			-0.6%
Logan			1.7%			2.0%			-0.3%
Mesa			9.8%			15.7%			-5.9%
Montrose			4.0%			2.9%			1.1%
Otero			1.2%			1.5%			-0.3%
Prowers			0.3%			0.0%			0.3%
Pueblo			3.8%			5.9%			-2.1%
Rio Blanco			0.3%			0.5%			-0.2%
Routt			0.6%			0.5%			0.1%
Teller			0.6%			2.0%			-1.4%

Physical Abuse Present									
No			87.6%			88.7%			-1.1%
Yes			12.4%			11.3%			1.1%
Sexual Abuse Present									
No			93.4%			92.6%			0.8%
Yes			6.6%			7.4%			-0.8%
Neglect Present									
No			59.5%			63.7%			-4.2%
Yes			40.5%			36.3%			4.2%
Overall Risk Level									
Low Risk			1.2%			1.5%			-0.3%
Moderate Risk			32.1%			32.4%			-0.3%
High Risk			38.2%			33.8%			4.4%
PA4/No Risk Assess			12.4%			12.3%			0.1%
Missing			16.2%			20.1%			-3.9%
Report Disposition									
At Risk/Request Serv			0.6%			0.5%			0.1%
Report Founded			39.0%			43.1%			-4.1%
Report Inconclusive			18.2%			16.7%			1.5%
No Investigation			22.0%			15.7%			6.3%
Report Unfounded			6.1%			5.4%			0.7%
Missing			14.2%			18.6%			-4.4%
Case Pathway									
Adoption			11.8%			11.8%			0.0%
Traditional			88.2%			88.2%			0.0%
Case Program Area									
Other			2.0%			3.9%			-1.9%
PA4			19.9%			19.6%			0.3%
PA5			59.0%			54.4%			4.6%
PA6			19.1%			22.1%			-3.0%
Removal Status									
Closed			80.6%			81.4%			-0.8%
Open			19.4%			18.6%			0.8%

INTERVENTION GROUP = PRT IN CARE 12 MONTHS OR LONGER - ALL CHILDREN AND YOUTH									
Matching Variable	Intervention Group (n=1,356)			Comparison Group (n=1,015)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.1	4.9	7.0	7.5	4.8	8.0	-0.4	0.1	-1.0
Congregate Care Days	117.0	263.6	0.0	92.2	208.0	0.0	24.8	55.6	0.0
Removal Days	933.6	669.7	787.0	793.4	617.8	612.0	140.2	51.9	175.0
			Percentage			Percentage			Percentage
Gender									
Female			43.7%			46.4%			-2.7%
Male			56.3%			53.5%			2.8%
Missing			0.0%			0.1%			-0.1%
Race/Ethnicity									
American Indian			0.7%			0.4%			0.3%
Asian			0.1%			0.1%			0.0%
Black			5.1%			4.1%			1.0%

Hawaiian			0.1%			0.0%			0.1%
Hispanic			44.4%			39.5%			4.9%
Two or More			3.8%			3.6%			0.2%
White			45.3%			51.7%			-6.4%
Missing			0.4%			0.5%			-0.1%
County									
Adams			18.1%			21.5%			-3.4%
Archuleta			0.0%			0.1%			-0.1%
Baca			0.2%			0.4%			-0.2%
Bent			0.3%			0.1%			0.2%
Crowley			0.3%			0.1%			0.2%
Custer			0.1%			0.0%			0.1%
Denver			6.3%			0.0%			6.3%
Douglas			1.5%			2.0%			-0.5%
Elbert			0.1%			0.2%			-0.1%
Fremont			11.2%			7.6%			3.6%
Garfield			0.1%			0.0%			0.1%
Huerfano			1.0%			0.6%			0.4%
Jefferson			9.6%			16.8%			-7.2%
Kit Carson			0.2%			0.2%			0.0%
La Plata			0.1%			0.8%			-0.7%
Las Animas			0.2%			0.5%			-0.3%
Lincoln			0.1%			0.2%			-0.1%
Logan			2.4%			3.0%			-0.6%
Mesa			14.5%			15.4%			-0.9%
Montrose			0.5%			1.4%			-0.9%
Otero			1.0%			1.7%			-0.7%
Pitkin			0.1%			0.1%			0.0%
Prowers			0.7%			0.7%			0.0%
Pueblo			29.8%			24.6%			5.2%
Rio Blanco			0.0%			0.1%			-0.1%
Teller			1.4%			1.7%			-0.3%
Yuma			0.1%			0.4%			-0.3%
Physical Abuse Present									
No			91.8%			91.2%			0.6%
Yes			8.2%			8.7%			-0.5%
Missing			0.0%			0.1%			-0.1%
Sexual Abuse Present									
No			95.8%			95.2%			0.6%
Yes			4.2%			4.7%			-0.5%
Missing			0.0%			0.1%			-0.1%
Neglect Present									
No			30.9%			32.1%			-1.2%
Yes			69.1%			67.8%			1.3%
Missing			0.0%			0.1%			-0.1%
Overall Risk Level									
Low Risk			2.2%			1.8%			0.4%
Moderate Risk			41.7%			38.9%			2.8%
High Risk			47.6%			46.8%			0.8%
PA4/No Risk Assess			5.4%			7.0%			-1.6%
Missing			3.2%			5.5%			-2.3%
Report Disposition									
At Risk/Request Serv			0.10%			0.10%			0.0%

Court Ordered Services			0.10%			0.20%			-0.1%
Report Founded			65.00%			62.40%			2.6%
Report Inconclusive			16.70%			17.30%			-0.6%
No Investigation			8.00%			10.00%			-2.0%
Report Unfounded			3.70%			5.10%			-1.4%
Missing			6.40%			4.90%			1.5%
Case Pathway									
Adoption			2.7%			3.3%			-0.6%
Traditional			97.3%			96.6%			0.7%
Missing			0.0%			0.1%			-0.1%
Case Program Area									
Other			0.3%			0.6%			-0.3%
PA4			9.2%			11.9%			-2.7%
PA5			87.8%			81.6%			6.2%
PA6			2.7%			5.7%			-3.0%
Missing			0.0%			0.2%			-0.2%
Removal Status									
Closed			65.2%			70.0%			-4.8%
Open			34.8%			30.0%			4.8%

INTERVENTION GROUP = PRT IN CARE 12 MONTHS OR LONGER - HIGHER ADHERENCE CHILDREN AND YOUTH									
Matching Variable	Intervention Group (n=448)			Comparison Group (n=334)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.1	5.1	7.0	7.0	5.2	7.0	0.0	-0.1	0.0
Congregate Care Days	113.2	267.8	0.0	93.7	207.5	0.0	19.4	60.3	0.0
Removal Days	828.6	591.1	667.5	810.7	611.2	604.5	17.9	-20.1	63.0
			Percentage			Percentage			Percentage
Gender									
Female			44.4%			45.2%			-0.8%
Male			55.6%			54.5%			1.1%
Missing			0.0%			0.3%			-0.3%
Race/Ethnicity									
American Indian			0.7%			0.0%			0.7%
Asian			0.0%			0.3%			-0.3%
Black			3.1%			4.2%			-1.1%
Hispanic			49.8%			41.0%			8.8%
Two or More			2.7%			4.8%			-2.1%
White			43.8%			49.4%			-5.6%
Missing			0.0%			0.3%			-0.3%
County									
Adams			16.7%			12.6%			4.1%
Baca			0.4%			0.3%			0.1%
Bent			0.0%			0.3%			-0.3%
Custer			0.2%			0.0%			0.2%
Douglas			0.2%			1.2%			-1.0%
Elbert			0.2%			0.0%			0.2%
Fremont			18.1%			10.8%			7.3%
Huerfano			0.2%			0.6%			-0.4%
Jefferson			3.1%			12.9%			-9.8%

Kit Carson			0.0%			0.3%			-0.3%
La Plata			0.0%			0.3%			-0.3%
Lincoln			0.4%			0.0%			0.4%
Logan			0.4%			3.0%			-2.6%
Mesa			6.7%			15.0%			-8.3%
Montrose			0.2%			1.2%			-1.0%
Otero			0.2%			2.4%			-2.2%
Pitkin			0.2%			0.3%			-0.1%
Prowers			0.2%			1.5%			-1.3%
Pueblo			51.6%			35.9%			15.7%
Teller			0.7%			1.5%			-0.8%
Physical Abuse Present									
No			93.3%			92.2%			1.1%
Yes			6.7%			7.5%			-0.8%
Missing			0.0%			0.3%			-0.3%
Sexual Abuse Present									
No			96.7%			95.2%			1.5%
Yes			3.3%			4.5%			-1.2%
Missing			0.0%			0.3%			-0.3%
Neglect Present									
No			33.3%			35.3%			-2.0%
Yes			66.7%			64.4%			2.3%
Missing			0.0%			0.3%			-0.3%
Overall Risk Level									
Low Risk			1.8%			1.2%			0.6%
Moderate Risk			41.7%			38.6%			3.1%
High Risk			48.0%			47.9%			0.1%
PA4/No Risk Assess			6.3%			7.5%			-1.2%
Missing			2.2%			4.8%			-2.6%
Report Disposition									
At Risk/Request Serv			0.2%			0.0%			0.2%
Court Ordered Services			0.0%			0.3%			-0.3%
Report Founded			62.5%			60.8%			1.7%
Report Inconclusive			17.4%			18.9%			-1.5%
No Investigation			8.9%			10.2%			-1.3%
Report Unfounded			4.7%			4.8%			-0.1%
Missing			6.3%			5.1%			1.2%
Case Pathway									
Adoption			1.6%			3.9%			-2.3%
Traditional			98.4%			95.8%			2.6%
Missing			0.0%			0.3%			-0.3%
Case Program Area									
Other			0.0%			0.3%			-0.3%
PA4			10.9%			12.3%			-1.4%
PA5			86.8%			80.8%			6.0%
PA6			2.2%			6.3%			-4.1%
Missing			0.0%			0.3%			-0.3%
Removal Status									
Closed			68.8%			72.5%			-3.7%
Open			31.3%			27.5%			3.8%

No			95.4%			95.2%			0.2%
Yes			4.6%			4.8%			-0.2%
Neglect Present									
No			29.7%			30.5%			-0.8%
Yes			70.3%			69.5%			0.8%
Overall Risk Level									
Low Risk			2.4%			2.1%			0.3%
Moderate Risk			41.6%			39.1%			2.5%
High Risk			47.4%			46.3%			1.1%
PA4/No Risk Assess			5.0%			6.8%			-1.8%
Missing			3.6%			5.9%			-2.3%
Report Disposition									
At Risk/Request Serv			0.1%			0.1%			0.0%
Court Ordered Services			0.1%			0.1%			0.0%
Report Founded			66.2%			63.1%			3.1%
Report Inconclusive			16.3%			16.6%			-0.3%
No Investigation			7.6%			9.8%			-2.2%
Report Unfounded			3.2%			5.3%			-2.1%
Missing			6.5%			4.8%			1.7%
Case Pathway									
Adoption			3.3%			3.1%			0.2%
Traditional			96.7%			96.9%			-0.2%
Case Program Area									
Other			0.4%			0.7%			-0.3%
PA4			8.4%			11.7%			-3.3%
PA5			88.3%			81.9%			6.4%
PA6			2.9%			5.4%			-2.5%
Missing			0.0%			0.1%			-0.1%
Removal Status									
Closed			63.4%			68.7%			-5.3%
Open			36.6%			31.3%			5.3%

INTERVENTION GROUP = PRT IN CARE 12 MONTHS OR LONGER - CHILDREN AND YOUTH WHO REACHED 12 MONTHS IN AN OUT-OF-HOME REMOVAL DURING A COUNTY WAIVER FUNDED PRT YEAR

Matching Variable	Intervention Group (n=1,117)			Comparison Group (n=877)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	6.9	4.9	6.0	7.5	4.8	8.0	-0.6	0.1	-2.0
Congregate Care Days	96.5	235.3	0.0	88.5	200.9	0.0	8.0	34.4	0.0
Removal Days	767.9	306.0	715.0	773.5	582.6	604.0	-5.6	-276.6	111.0
			Percentage			Percentage			Percentage
Gender									
Female			44.4%			45.4%			-1.0%
Male			55.6%			54.5%			1.1%
Missing			0.0%			0.1%			-0.1%
Race/Ethnicity									
American Indian			0.9%			0.3%			0.6%
Asian			0.1%			0.1%			0.0%
Black			4.2%			4.3%			-0.1%
Hawaiian			0.1%			0.0%			0.1%

Hispanic			45.6%			38.3%			7.3%
Two or More			3.0%			3.2%			-0.2%
White			45.6%			53.2%			-7.6%
Missing			0.5%			0.5%			0.0%
County									
Adams			17.8%			21.7%			-3.9%
Baca			0.3%			0.3%			0.0%
Crowley			0.0%			0.1%			-0.1%
Custer			0.1%			0.0%			0.1%
Denver			4.9%			0.0%			4.9%
Douglas			1.3%			2.1%			-0.8%
Elbert			0.0%			0.1%			-0.1%
Fremont			12.4%			7.8%			4.6%
Garfield			0.1%			0.0%			0.1%
Huerfano			0.8%			0.7%			0.1%
Jefferson			7.8%			16.4%			-8.6%
Kit Carson			0.1%			0.1%			0.0%
La Plata			0.0%			0.7%			-0.7%
Las Animas			0.1%			0.6%			-0.5%
Lincoln			0.2%			0.2%			0.0%
Logan			2.8%			3.3%			-0.5%
Mesa			15.3%			15.1%			0.2%
Montrose			0.4%			1.4%			-1.0%
Otero			0.9%			1.8%			-0.9%
Pitkin			0.1%			0.1%			0.0%
Prowers			0.7%			0.7%			0.0%
Pueblo			32.5%			25.0%			7.5%
Teller			1.5%			1.6%			-0.1%
Yuma			0.0%			0.3%			-0.3%
Physical Abuse Present									
No			93.3%			90.5%			2.8%
Yes			6.7%			9.4%			-2.7%
Missing			0.0%			0.1%			-0.1%
Sexual Abuse Present									
No			96.3%			95.4%			0.9%
Yes			3.7%			4.4%			-0.7%
Missing			0.0%			0.1%			-0.1%
Neglect Present									
No			29.2%			32.5%			-3.3%
Yes			70.8%			67.4%			3.4%
Missing			0.0%			0.1%			-0.1%
Overall Risk Level									
Low Risk			2.1%			2.1%			0.0%
Moderate Risk			42.9%			39.5%			3.4%
High Risk			48.5%			46.2%			2.3%
PA4/No Risk Assess			4.7%			7.1%			-2.4%
Missing			1.8%			5.2%			-3.4%
Report Disposition									
At Risk/Request Serv			0.0%			0.1%			-0.1%
Court Ordered Services			0.0%			0.1%			-0.1%
Report Founded			68.3%			61.7%			6.6%
Report Inconclusive			15.7%			17.9%			-2.2%

No Investigation			7.2%			10.4%			-3.2%
Report Unfounded			3.1%			5.4%			-2.3%
Missing			5.7%			4.4%			1.3%
Case Pathway									
Adoption			2.0%			3.4%			-1.4%
Traditional			98.0%			96.5%			1.5%
Missing			0.0%			0.1%			-0.1%
Case Program Area									
Other			0.1%			0.6%			-0.5%
PA4			8.4%			12.0%			-3.6%
PA5			90.1%			81.4%			8.7%
PA6			1.4%			5.8%			-4.4%
Missing			0.0%			0.2%			-0.2%
Removal Status									
Closed			64.8%			70.2%			-5.4%
Open			35.2%			29.8%			5.4%

INTERVENTION GROUP = PRT IN CARE 12 MONTHS OR LONGER - CHILDREN AND YOUTH WHO REACHED 12 MONTHS IN AN OUT-OF-HOME REMOVAL PRIOR TO A COUNTY WAIVER FUNDED PRT YEAR

Matching Variable	Intervention Group (n=239)			Comparison Group (n=138)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	8.2	4.9	8.0	7.5	4.8	7.0	0.7	0.1	1.0
Congregate Care Days	212.8	353.5	0.0	115.6	247.9	0.0	97.2	105.6	0.0
Removal Days	1708.2	1175.8	1405.0	919.5	797.8	687.0	788.7	378.0	718.0
			Percentage			Percentage			Percentage
Gender									
Female			40.6%			52.9%			-12.3%
Male			59.4%			47.1%			12.3%
Race/Ethnicity									
American Indian			0.0%			0.7%			-0.7%
Asian			0.4%			0.0%			0.4%
Black			9.2%			2.9%			6.3%
Hispanic			38.9%			47.1%			-8.2%
Two or More			7.5%			6.5%			1.0%
White			43.9%			42.0%			1.9%
Missing			0.0%			0.7%			-0.7%
County									
Adams			19.7%			20.3%			-0.6%
Archuleta			0.0%			0.7%			-0.7%
Baca			0.0%			0.7%			-0.7%
Bent			1.7%			0.7%			1.0%
Crowley			1.7%			0.0%			1.7%
Denver			12.6%			0.0%			12.6%
Douglas			2.5%			1.4%			1.1%
Elbert			0.4%			0.7%			-0.3%
Fremont			5.9%			6.5%			-0.6%
Garfield			0.4%			0.0%			0.4%
Huerfano			2.1%			0.0%			2.1%
Jefferson			18.0%			19.6%			-1.6%
Kit Carson			0.8%			0.7%			0.1%

La Plata			0.4%			1.4%			-1.0%
Las Animas			0.8%			0.0%			0.8%
Logan			0.4%			0.7%			-0.3%
Mesa			10.5%			17.4%			-6.9%
Montrose			0.8%			1.4%			-0.6%
Otero			1.7%			0.7%			1.0%
Pitkin			0.4%			0.0%			0.4%
Prowers			0.4%			0.7%			-0.3%
Pueblo			17.2%			22.5%			-5.3%
Rio Blanco			0.0%			0.7%			-0.7%
Teller			0.8%			2.2%			-1.4%
Yuma			0.8%			0.7%			0.1%
Physical Abuse Present									
No			84.9%			95.7%			-10.8%
Yes			15.1%			4.3%			10.8%
Sexual Abuse Present									
No			93.3%			93.5%			-0.2%
Yes			6.7%			6.5%			0.2%
Neglect Present									
No			38.9%			29.7%			9.2%
Yes			61.1%			70.3%			-9.2%
Overall Risk Level									
Low Risk			2.9%			0.0%			2.9%
Moderate Risk			36.0%			35.5%			0.5%
High Risk			43.1%			50.7%			-7.6%
PA4/No Risk Assess			8.4%			6.5%			1.9%
Missing			9.6%			7.2%			2.4%
Report Disposition									
At Risk/Request Serv			0.8%			0.0%			0.8%
Court Ordered Services			0.4%			0.7%			-0.3%
Report Founded			49.4%			66.7%			-17.3%
Report Inconclusive			21.3%			13.8%			7.5%
No Investigation			12.1%			7.2%			4.9%
Report Unfounded			6.3%			3.6%			2.7%
Missing			9.6%			8.0%			1.6%
Case Pathway									
Adoption			6.3%			2.9%			3.4%
Traditional			93.7%			97.1%			-3.4%
Case Program Area									
Other			1.3%			0.7%			0.6%
PA4			13.0%			11.6%			1.4%
PA5			77.4%			82.6%			-5.2%
PA6			8.4%			5.1%			3.3%
Removal Status									
Closed			66.9%			68.1%			-1.2%
Open			33.1%			31.9%			1.2%

INTERVENTION GROUP = CHILDREN AND YOUTH WHO RECEIVED TSAT OR CWRC ASSESSMENT

Matching Variable	Intervention Group (n=588)			Comparison Group (n=588)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median

Age (Years) at Case Open	10.7	4.1	11.0	11.2	3.0	12.0	-0.5	1.1	-1.0
Outcome Observation Window (Days)	727.5	351.0	679.0	776.2	486.5	831.0	-48.7	-135.5	-152.0
			Percentage			Percentage			Percentage
Gender									
Female			47.1%			47.8%			-0.7%
Male			52.9%			52.2%			0.7%
Race/Ethnicity									
American Indian			0.2%			0.3%			-0.1%
Asian			0.2%			0.0%			0.2%
Black			6.0%			10.7%			-4.7%
Hawaiian			0.0%			0.2%			-0.2%
Hispanic			34.4%			37.6%			-3.2%
Two or More			3.2%			4.4%			-1.2%
White			55.6%			45.6%			10.0%
Missing			0.5%			1.2%			-0.7%
County									
ALAMOSA			0.9%			5.1%			-4.2%
ARAPAHOE			7.7%			10.0%			-2.3%
BOULDER			5.1%			8.3%			-3.2%
COSTILLA			0.7%			0.2%			0.5%
DENVER			8.8%			16.2%			-7.4%
DOUGLAS			1.4%			1.4%			0.0%
EL PASO			11.2%			11.1%			0.1%
FREMONT			0.5%			4.4%			-3.9%
JEFFERSON			11.7%			9.7%			2.0%
LARIMER			42.2%			18.9%			23.3%
LOGAN			0.5%			3.6%			-3.1%
RIO GRANDE			0.3%			1.2%			-0.9%
SAGUACHE			0.3%			0.7%			-0.4%
WELD			8.7%			9.4%			-0.7%
Physical Abuse Present									
No			87.1%			90.0%			-2.9%
Yes			12.9%			10.0%			2.9%
Sexual Abuse Present									
No			93.4%			94.6%			-1.2%
Yes			6.6%			5.4%			1.2%
Neglect Present									
No			43.4%			59.0%			-15.6%
Yes			56.6%			41.0%			15.6%
Overall Risk Level									
Low Risk			4.1%			2.6%			1.5%
Moderate Risk			44.0%			40.3%			3.7%
High Risk			37.4%			43.5%			-6.1%
PA4/No Risk Assess			2.2%			3.9%			-1.7%
Missing			12.2%			9.7%			2.5%
Report Disposition									
FAR (No Findings)			11.2%			8.0%			3.2%
Report Founded			43.2%			32.7%			10.5%
Report Inconclusive			9.4%			20.1%			-10.7%
No Investigation			22.3%			23.1%			-0.8%

No			86.1%			90.5%			-4.4%
Yes			13.9%			9.5%			4.4%
Sexual Abuse Present									
No			93.7%			93.7%			0.0%
Yes			6.3%			6.3%			0.0%
Neglect Present									
No			27.2%			53.2%			-26.0%
Yes			72.8%			46.8%			26.0%
Overall Risk Level									
Low Risk			4.4%			2.5%			1.9%
Moderate Risk			44.3%			44.9%			-0.6%
High Risk			31.6%			43.7%			-12.1%
PA4/No Risk Assess			0.0%			1.3%			-1.3%
Missing			19.6%			7.6%			12.0%
Report Disposition									
FAR (No Findings)			2.5%			11.4%			-8.9%
Report Founded			77.8%			40.5%			37.3%
Report Inconclusive			9.5%			15.8%			-6.3%
No Investigation			2.5%			17.7%			-15.2%
Report Unfounded			3.8%			6.3%			-2.5%
Missing			3.8%			8.2%			-4.4%
Case Pathway									
Adoption			0.0%			3.2%			-3.2%
FAR			3.2%			12.0%			-8.8%
Traditional			96.8%			84.8%			12.0%
Case Program Area									
Other			0.0%			0.6%			-0.6%
PA4			2.5%			25.3%			-22.8%
PA5			97.5%			73.4%			24.1%
PA6			0.0%			0.6%			-0.6%
Case Status									
Closed			60.8%			74.7%			-13.9%
Open			39.2%			25.3%			13.9%
Placement Status									
In Home			55.1%			52.5%			2.6%
Out of Home			44.9%			47.5%			-2.6%

INTERVENTION GROUP = CHILDREN AND YOUTH WHOSE KINSHIP CAREGIVERS RECEIVED KINSHIP SUPPORTS, FAMILIES RECEIVED FACILITATED FAMILY ENGAGEMENT MEETINGS, AND CASES CLOSED DURING THE OBSERVATION PERIOD

Matching Variable	Intervention Group (n=5,329)			Comparison Group (n=4,853)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	5.8	5.1	5.0	5.8	5.0	5.0	0.0	0.1	0.0
Outcome Observation Window (Days)	948.3	369.0	955.0	918.0	380.8	955.0	30.3	-11.8	0.0
			Percentage			Percentage			Percentage
Gender									
Female			49.2%			50.6%			-1.4%
Male			50.8%			49.4%			1.4%
Race/Ethnicity									
American Indian			0.4%			0.7%			-0.3%
Asian			0.5%			0.5%			0.0%

Black			8.4%			10.5%			-2.1%
Hawaiian			0.2%			0.0%			0.2%
Hispanic			41.9%			43.1%			-1.2%
Two or More			5.3%			4.8%			0.5%
White			42.2%			40.1%			2.1%
Missing			1.1%			0.3%			0.8%
County									
Adams			11.9%			11.4%			0.5%
Arapahoe			12.4%			9.7%			2.7%
Archuleta			0.2%			0.1%			0.1%
Bent			0.0%			0.1%			-0.1%
Boulder			2.6%			1.7%			0.9%
Broomfield			0.2%			0.7%			-0.5%
Chaffee			0.4%			0.0%			0.4%
Crowley			0.0%			0.1%			-0.1%
Denver			14.1%			24.8%			-10.7%
El Paso			15.8%			11.8%			4.0%
Elbert			0.1%			0.2%			-0.1%
Fremont			2.6%			1.7%			0.9%
Garfield			0.8%			0.4%			0.4%
Jefferson			11.0%			12.0%			-1.0%
Kit Carson			0.2%			0.2%			0.0%
La Plata			0.4%			0.5%			-0.1%
Larimer			8.2%			5.8%			2.4%
Las Animas			0.0%			0.2%			-0.2%
Lincoln			0.0%			0.2%			-0.2%
Logan			0.4%			0.4%			0.0%
Mesa			3.2%			3.4%			-0.2%
Moffat			0.0%			0.2%			-0.2%
Morgan			0.0%			0.8%			-0.8%
Otero			0.6%			0.9%			-0.3%
Prowers			0.1%			0.0%			0.1%
Pueblo			8.0%			6.1%			1.9%
Rio Blanco			0.0%			0.2%			-0.2%
San Juan			0.0%			0.0%			0.0%
Teller			0.4%			0.1%			0.3%
Weld			6.1%			6.2%			-0.1%
Yuma			0.0%			0.2%			-0.2%
Physical Abuse Present									
No			90.8%			89.6%			1.2%
Yes			9.2%			10.4%			-1.2%
Sexual Abuse Present									
No			96.6%			96.1%			0.5%
Yes			3.4%			3.9%			-0.5%
Neglect Present									
No			24.8%			25.7%			-0.9%
Yes			75.2%			74.3%			0.9%
Overall Risk Level									
Low Risk			2.3%			2.3%			0.0%
Moderate Risk			46.6%			45.3%			1.3%
High Risk			46.4%			45.8%			0.6%
PA4/No Risk Assess			1.9%			2.7%			-0.8%
Missing			2.8%			3.8%			-1.0%

Report Disposition									
FAR (No Findings)			4.3%			1.4%			2.9%
Report Founded			65.0%			65.0%			0.0%
Report Inconclusive			14.8%			19.7%			-4.9%
No Investigation			3.5%			3.8%			-0.3%
Report Unfounded			4.3%			5.7%			-1.4%
Missing			8.1%			4.3%			3.8%
Case Pathway									
Adoption			0.2%			0.4%			-0.2%
FAR			4.9%			1.7%			3.2%
Traditional			94.9%			97.9%			-3.0%
Case Program Area									
Other			0.0%			0.1%			-0.1%
PA4			3.8%			4.6%			-0.8%
PA5			96.1%			94.5%			1.6%
PA6			0.0%			0.7%			-0.7%
Missing			0.0%			0.1%			-0.1%
Case Status									
Closed			100.0%			100.0%			0.0%
Open			0.0%			0.0%			0.0%
Kinship Placement Status									
Closed			98.6%			97.7%			0.9%
Open			1.4%			2.3%			-0.9%

INTERVENTION GROUP = CHILDREN AND YOUTH WHOSE KINSHIP CAREGIVERS RECEIVED KINSHIP SUPPORTS, FAMILIES RECEIVED FACILITATED FAMILY ENGAGEMENT MEETINGS WITH HIGHER LEVELS OF ADHERENCE, AND CASES CLOSED DURING THE OBSERVATION PERIOD

Matching Variable	Intervention Group (n=1,120)			Comparison Group (n=1,059)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	5.6	4.9	4.0	5.9	5.0	5.0	-0.3	-0.1	-1.0
Outcome Observation Window (Days)	869.2	376.0	852.0	884.6	382.4	902.0	-15.4	-6.4	-50.0
			Percentage			Percentage			Percentage
Gender									
Female			48.6%			51.9%			-3.3%
Male			51.4%			48.1%			3.3%
Race/Ethnicity									
American Indian			0.4%			0.6%			-0.2%
Asian			0.4%			0.5%			-0.1%
Black			4.6%			9.3%			-4.7%
Hispanic			44.1%			42.1%			2.0%
Two or More			4.5%			5.3%			-0.8%
White			45.4%			42.0%			3.4%
Missing			0.5%			0.2%			0.3%
County									
Adams			18.6%			12.7%			5.9%
Arapahoe			5.7%			9.6%			-3.9%
Archuleta			0.3%			0.0%			0.3%
Bent			0.1%			0.3%			-0.2%
Boulder			2.7%			2.3%			0.4%

Broomfield			0.3%			0.6%			-0.3%
Chaffee			0.2%			0.0%			0.2%
Crowley			0.0%			0.1%			-0.1%
Denver			12.7%			25.2%			-12.5%
El Paso			7.4%			9.0%			-1.6%
Fremont			7.1%			1.5%			5.6%
Garfield			1.0%			0.6%			0.4%
Jefferson			2.9%			11.7%			-8.8%
Kit Carson			0.0%			0.2%			-0.2%
La Plata			0.3%			0.5%			-0.2%
Larimer			16.2%			6.9%			9.3%
Las Animas			0.0%			0.2%			-0.2%
Lincoln			0.0%			0.3%			-0.3%
Logan			0.7%			0.2%			0.5%
Mesa			5.0%			3.6%			1.4%
Moffat			0.0%			0.2%			-0.2%
Morgan			0.0%			0.5%			-0.5%
Otero			0.5%			0.5%			0.0%
Pueblo			13.1%			6.3%			6.8%
Teller			0.4%			0.2%			0.2%
Weld			5.0%			6.8%			-1.8%
Yuma			0.0%			0.3%			-0.3%
Physical Abuse Present									
No			90.0%			90.0%			0.0%
Yes			10.0%			10.0%			0.0%
Sexual Abuse Present									
No			96.5%			96.5%			0.0%
Yes			3.5%			3.5%			0.0%
Neglect Present									
No			23.9%			24.7%			-0.8%
Yes			76.1%			75.3%			0.8%
Overall Risk Level									
Low Risk			2.8%			2.5%			0.3%
Moderate Risk			48.5%			47.9%			0.6%
High Risk			45.7%			43.5%			2.2%
PA4/No Risk Assess			1.3%			2.5%			-1.2%
Missing			1.8%			3.6%			-1.8%
Report Disposition									
FAR (No Findings)			5.7%			2.4%			3.3%
Report Founded			65.9%			63.3%			2.6%
Report Inconclusive			13.8%			20.2%			-6.4%
No Investigation			3.5%			3.7%			-0.2%
Report Unfounded			5.1%			5.8%			-0.7%
Missing			6.0%			4.7%			1.3%
Case Pathway									
Adoption			0.0%			0.7%			-0.7%
FAR			7.0%			2.7%			4.3%
Traditional			93.0%			96.6%			-3.6%
Case Program Area									
PA4			3.8%			4.6%			-0.8%
PA5			96.2%			94.3%			1.9%
PA6			0.0%			0.9%			-0.9%
Missing			0.0%			0.1%			-0.1%

Case Status									
Closed			100.0%			100.0%			0.0%
Open			0.0%			0.0%			0.0%
Kinship Placement Status									
Closed			97.9%			97.5%			0.4%
Open			2.1%			2.5%			-0.4%

INTERVENTION GROUP = CHILDREN AND YOUTH IN CARE 12 MONTHS OR LONGER WHO RECEIVED PERMANENCY ROUNDTABLES, WHOSE FAMILIES RECEIVED FACILITATED FAMILY ENGAGEMENT MEETINGS, AND WHOSE REMOVALS ENDED DURING THE OBSERVATION PERIOD

Matching Variable	Intervention Group (n=543)			Comparison Group (n=495)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	6.0	6.0	6.0	7.3	4.9	7.0	-1.3	1.1	-1.0
Congregate Care Days	62.4	178.6	0.0	85.5	185.2	0.0	-23.1	-6.6	0.0
Removal Days	697.9	245.0	661.0	854.2	590.8	680.0	-156.3	-345.8	-19.0
			Percentage			Percentage			Percentage
Gender									
Female			44.8%			46.5%			-1.7%
Male			55.2%			53.5%			1.7%
Race/Ethnicity									
American Indian			1.1%			0.2%			0.9%
Asian			0.2%			0.0%			0.2%
Black			3.3%			4.4%			-1.1%
Hispanic			45.5%			37.6%			7.9%
Two or More			3.7%			2.8%			0.9%
White			45.1%			54.3%			-9.2%
Missing			1.1%			0.6%			0.5%
County									
Adams			11.2%			22.8%			-11.6%
Archuleta			0.0%			0.2%			-0.2%
Baca			0.2%			0.2%			0.0%
Crowley			0.0%			0.2%			-0.2%
Custer			0.2%			0.0%			0.2%
Denver			5.3%			0.0%			5.3%
Douglas			0.4%			1.0%			-0.6%
Fremont			14.7%			7.1%			7.6%
Huerfano			0.4%			0.6%			-0.2%
Jefferson			6.1%			13.7%			-7.6%
Kit Carson			0.2%			0.4%			-0.2%
La Plata			0.0%			0.6%			-0.6%
Las Animas			0.0%			1.0%			-1.0%
Lincoln			0.2%			0.4%			-0.2%
Logan			2.2%			3.6%			-1.4%
Mesa			15.1%			16.4%			-1.3%
Montrose			0.4%			1.4%			-1.0%
Otero			0.0%			2.0%			-2.0%
Pitkin			0.2%			0.0%			0.2%
Prowers			0.0%			0.2%			-0.2%
Pueblo			40.3%			25.3%			15.0%

Teller			2.9%			2.2%			0.7%
Yuma			0.0%			0.6%			-0.6%
Physical Abuse Present									
No			92.6%			90.9%			1.7%
Yes			7.4%			9.1%			-1.7%
Sexual Abuse Present									
No			96.9%			94.7%			2.2%
Yes			3.1%			5.3%			-2.2%
Neglect Present									
No			26.5%			32.9%			-6.4%
Yes			73.5%			67.1%			6.4%
Overall Risk Level									
Low Risk			2.4%			2.0%			0.4%
Moderate Risk			42.9%			35.6%			7.3%
High Risk			48.1%			50.3%			-2.2%
PA4/No Risk Assess			5.3%			7.3%			-2.0%
Missing			1.3%			4.8%			-3.5%
Report Disposition									
At Risk/Request Serv			0.0%			0.2%			-0.2%
Court Ordered Services			0.0%			0.2%			-0.2%
Report Founded			72.4%			60.8%			11.6%
Report Inconclusive			11.8%			18.8%			-7.0%
No Investigation			6.8%			10.3%			-3.5%
Report Unfounded			4.2%			5.7%			-1.5%
Missing			4.8%			4.0%			0.8%
Case Pathway									
Adoption			0.7%			2.8%			-2.1%
Traditional			99.3%			97.2%			2.1%
Case Program Area									
Other			0.0%			0.8%			-0.8%
PA4			8.7%			12.3%			-3.6%
PA5			90.8%			80.4%			10.4%
PA6			0.6%			6.5%			-5.9%
Removal Status									
Closed			100.0%			100.0%			0.0%
Open			0.0%			0.0%			0.0%

INTERVENTION GROUP = CHILDREN AND YOUTH IN CARE 12 MONTHS OR LONGER WHO RECEIVED PERMANENCY ROUNDTABLES, WHOSE FAMILIES RECEIVED FACILITATED FAMILY ENGAGEMENT MEETINGS WITH HIGHER LEVELS OF ADHERENCE, AND WHOSE REMOVALS ENDED DURING THE OBSERVATION PERIOD

Matching Variable	Intervention Group (n=110)			Comparison Group (n=105)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	7.3	6.3	6.0	7.0	4.9	7.0	0.3	1.4	-1.0
Congregate Care Days	45.3	125.3	0.0	93.2	184.9	0.0	-47.9	-59.6	0.0
Removal Days	528.6	173.3	480.0	875.7	647.2	689.0	-347.1	-473.9	-209.0
			Percentage			Percentage			Percentage
Gender									
Female			44.5%			42.0%			2.5%

Male			55.5%			58.0%			-2.5%
Race/Ethnicity									
American Indian			0.0%			0.8%			-0.8%
Black			0.9%			2.5%			-1.6%
Hispanic			30.9%			39.5%			-8.6%
Two or More			0.9%			2.5%			-1.6%
White			66.4%			53.8%			12.6%
Missing			0.9%			0.8%			0.1%
County									
Adams			10.0%			25.2%			-15.2%
Crowley			0.0%			0.8%			-0.8%
Custer			0.9%			0.0%			0.9%
Denver			1.8%			0.0%			1.8%
Fremont			35.5%			6.7%			28.8%
Jefferson			0.9%			15.1%			-14.2%
La Plata			0.0%			0.8%			-0.8%
Las Animas			0.0%			0.8%			-0.8%
Logan			1.8%			3.4%			-1.6%
Mesa			16.4%			15.1%			1.3%
Montrose			0.0%			1.7%			-1.7%
Otero			0.0%			3.4%			-3.4%
Prowers			0.0%			0.8%			-0.8%
Pueblo			32.7%			25.2%			7.5%
Teller			0.0%			0.8%			-0.8%
Physical Abuse Present									
No			90.0%			88.2%			1.8%
Yes			10.0%			11.8%			-1.8%
Sexual Abuse Present									
No			93.6%			96.6%			-3.0%
Yes			6.4%			3.4%			3.0%
Neglect Present									
No			36.4%			38.7%			-2.3%
Yes			63.6%			61.3%			2.3%
Overall Risk Level									
Low Risk			0.9%			5.0%			-4.1%
Moderate Risk			49.1%			40.3%			8.8%
High Risk			42.7%			46.2%			-3.5%
PA4/No Risk Assess			4.5%			3.4%			1.1%
Missing			2.7%			5.0%			-2.3%
Report Disposition									
Report Founded			69.1%			59.7%			9.4%
Report Inconclusive			11.8%			21.8%			-10.0%
No Investigation			9.1%			5.9%			3.2%
Report Unfounded			0.9%			6.7%			-5.8%
Missing			9.1%			5.9%			3.2%
Case Pathway									
Adoption			0.9%			4.2%			-3.3%
Traditional			99.1%			95.8%			3.3%
Case Program Area									
Other			0.0%			1.7%			-1.7%
PA4			10.9%			10.1%			0.8%
PA5			87.3%			82.4%			4.9%
PA6			1.8%			5.9%			-4.1%

Removal Status									
Closed			100.0%			100.0%			0.0%
Open			0.0%			0.0%			0.0%

INTERVENTION GROUP = YOUTH 16 YEARS AND OLDER WITH AN OPPLA GOAL WHO RECEIVED PRTS, WHOSE FAMILIES RECEIVED FACILITATED FAMILY ENGAGEMENT MEETINGS, AND WHOSE REMOVALS ENDED DURING THE OBSERVATION PERIOD

Matching Variable	Intervention Group (n=80)			Comparison Group (n=74)			Difference Between Groups		
	Mean	SD	Median	Mean	SD	Median	Mean	SD	Median
Age (Years) at Case Open	16.9	1.1	16.0	17.1	1.3	17.0	-0.2	-0.2	-1.0
Congregate Care Days	280.5	309.3	203.5	289.9	376.6	98.5	-9.4	-67.3	105.0
Removal Days	798.1	311.0	717.0	1844.8	1617.3	1171.0	1046.7	-1306.3	-454.0
			Percentage			Percentage			Percentage
Gender									
Female			56.3%			44.6%			11.7%
Male			43.8%			55.4%			-11.6%
Race/Ethnicity									
Asian			1.3%			1.4%			-0.1%
Black			13.8%			6.8%			7.0%
Hispanic			30.0%			20.3%			9.7%
Two or More			3.8%			1.4%			2.4%
White			51.2%			70.3%			-19.1%
County									
Adams			16.3%			28.4%			-12.1%
Custer			0.0%			1.4%			-1.4%
Denver			25.0%			0.0%			25.0%
Douglas			5.0%			2.7%			2.3%
Elbert			0.0%			1.4%			-1.4%
Fremont			7.5%			12.2%			-4.7%
Garfield			1.3%			1.4%			-0.1%
Huerfano			1.3%			1.4%			-0.1%
Jefferson			23.8%			28.4%			-4.6%
La Plata			1.3%			0.0%			1.3%
Lincoln			1.3%			0.0%			1.3%
Logan			1.3%			4.1%			-2.8%
Mesa			8.8%			5.4%			3.4%
Montrose			0.0%			4.1%			-4.1%
Otero			0.0%			1.4%			-1.4%
Prowers			0.0%			1.4%			-1.4%
Pueblo			3.8%			5.4%			-1.6%
Teller			3.8%			1.4%			2.4%
Physical Abuse Present									
No			87.5%			89.2%			-1.7%
Yes			12.5%			10.8%			1.7%
Sexual Abuse Present									
No			95.0%			93.2%			1.8%
Yes			5.0%			6.8%			-1.8%
Neglect Present									
No			63.7%			74.3%			-10.6%
Yes			36.3%			25.7%			10.6%

Overall Risk Level								
Low Risk			1.3%			0.0%		1.3%
Moderate Risk			41.3%			18.9%		22.4%
High Risk			38.8%			35.1%		3.7%
PA4/No Risk Assess			12.5%			21.6%		-9.1%
Missing			6.3%			24.3%		-18.0%
Report Disposition								
At Risk/Request Serv			0.0%			1.4%		-1.4%
Report Founded			40.0%			29.7%		10.3%
Report Inconclusive			7.5%			16.2%		-8.7%
No Investigation			33.8%			24.3%		9.5%
Report Unfounded			2.5%			4.1%		-1.6%
Missing			16.3%			24.3%		-8.0%
Case Pathway								
Adoption			6.3%			10.8%		-4.5%
Traditional			93.8%			89.2%		4.6%
Case Program Area								
Other			0.0%			9.5%		-9.5%
PA4			30.0%			35.1%		-5.1%
PA5			70.0%			33.8%		36.2%
PA6			0.0%			21.6%		-21.6%
Removal Status								
Closed			100.0%			100.0%		0.0%
Open			0.0%			0.0%		0.0%

**Colorado Title IV-E Waiver Final Evaluation Report
Annex: Child Welfare Resiliency Center Program
Evaluation Report**

7-County Consortium

Child Welfare Resiliency Center
Program Evaluation Final Report

September 2018



Social Work Research Center

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Child Welfare Resiliency Center Program Evaluation Report

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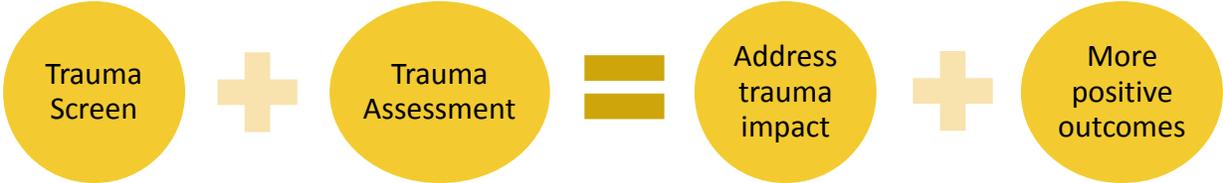
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1. Introduction

This report presents evaluation findings of the 7-County Child Welfare Resiliency Center (CWRC) trauma-informed practice intervention. In mid-2015, the Colorado Department of Human Services (CDHS) invited proposals for an expansion of existing Title IV-E Waiver Demonstration Projects. Seven counties (Arapahoe, Boulder, Denver, Douglas Eagle, Jefferson and Larimer) submitted a proposal as a Consortium to expand their trauma-informed child welfare practice. This proposal was funded and led to the 7-County Child Welfare Resiliency Center.

The goal of the CWRC was to expand trauma-informed practice to include in-depth assessment of trauma to enable serving more children and youth safely at home, with kin or in foster care, rather than in congregate care settings. In the first quarter of 2015, prior to initial implementation of the CWRC intervention, 28% of children statewide were placed in congregate care, compared to 27% for Consortium counties (CDHS Community Performance Center, 2018). The CWRC adapted a model for trauma-focused screening and assessment of child and youth, in addition to ongoing data collection and assessment of child well-being, a first for public child welfare practice in Colorado. The figure below depicts an overview of the CWRC intervention and a more detailed logic model may be found in Appendix 1.



Grounded in the philosophy that children are best cared for within the family system and their community, the CWRC sought to demonstrate that children and youth can be successfully maintained in their own homes, or kin/foster homes if the impact of trauma is addressed via meeting a young person’s developmental, emotional, and cognitive needs. Although specific to juvenile justice, some evidence suggests that system-involved youth with trauma histories and greater mental health needs are more likely to be placed in more restrictive placement settings. Espinosa, Sorensen, and Lopez (2013) examined a sample of 34,222 youth referred to juvenile probation departments in Texas to investigate the role of gender and mental health service need on out-of-home placement. Trauma indicators were one of the most significant predictors of the severity out-of-home placement. While researchers found that boys were placed deeper in the juvenile justice system than girls, regardless of gender, trauma history was the most influential factor in making placement decisions (Espinosa et al., 2013).

Accordingly, key components of the CWRC intervention involved comprehensive trauma screening and assessment, which aimed to assess a child or youth’s needs, challenges and strengths. Each county identified their own target population for the intervention, for which further details may be found in Appendix 2. Seeking to utilize expertise from both child welfare and behavioral health, the intervention relied heavily on coordination and collaboration between public child welfare agencies, community mental health centers (CMHCs) and independent providers, depicted in the figure below. Child welfare caseworkers conducted trauma screens and collected data on well-being, and referred youth who met screen-in criteria to a mental health service partner who conducted in-depth trauma assessments. After completing an assessment, assessing clinicians provided a summary report to the child, family and child welfare caseworker that included recommendations addressing a comprehensive range of needs and in-home parenting strategies.



Clinicians at the Child Trauma Resilience and Assessment Center (CTRAC) at Colorado State University led the development and implementation of conducting trauma assessments, and also trained and certified other clinicians in Consortium counties to conduct assessments for the intervention. CTRAC adapted methods developed by Dr. Jim Henry at the Southwest Michigan Children’s Trauma Assessment Center at Western Michigan University to formalize the assessment model used for the CWRC intervention.

Implementation fidelity was reviewed monthly via project meetings of representatives from each county, including child welfare and behavioral health services. Two additional meetings were also held each month to focus on aspects of implementation, including a meeting of trauma care coordinators to focus on coordination between system partners, and a meeting of the evaluation sub-committee that focused on data collection and reporting for evaluation

purposes. A greater description of data sources used for the evaluation may be found in Appendix 3.

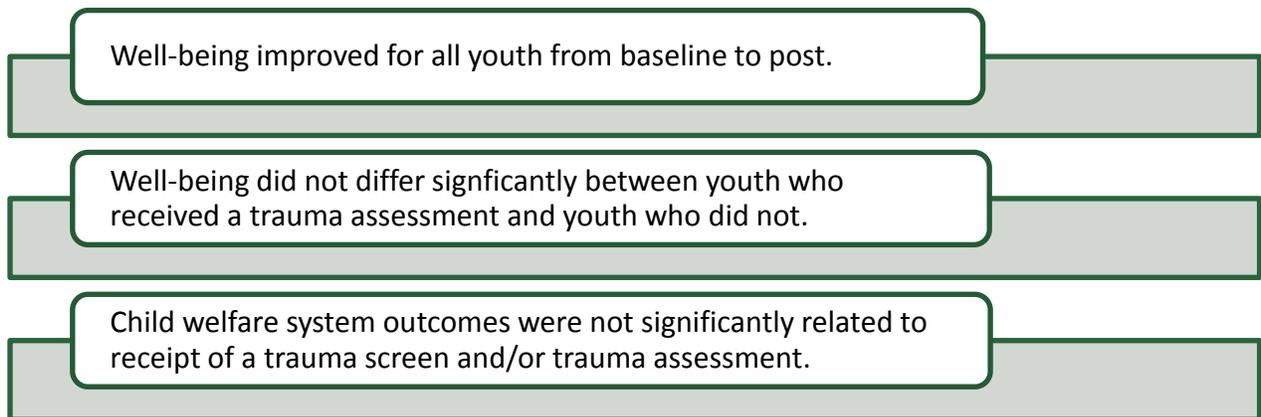
By the end of the two-year timeframe, the CWRC expected fewer youth in out-of-home care, particularly congregate care, and greater utilization of a more comprehensive array of services targeting the effects of complex trauma on children and youth. It was also anticipated that the project would help to enhance partnerships across community and systems partners, including behavioral health, the courts and county human service agencies.

2. Summary of Findings – At a Glance

2.1. Outcomes Evaluation

Overall, significant improvements were found in average scores from baseline to post across TOP domains, suggesting changes in well-being among youth from baseline to post. However, no meaningful differences in well-being were found between youth who received an assessment and youth who did not.

Receipt of a trauma screen and/or trauma assessment was also not found to be predictive of child welfare system outcomes, specifically: subsequent referral, assessment, involvement with Division of Youth Services (DYS), or commitment (following involvement with DHS).



2.2. Process Evaluation

As displayed in Table 1 on the following page, over 1,000 youth were screened for the CWRC intervention during the evaluation period. More than two-thirds of youth ($N = 677$) screened-in and were referred for an in-depth trauma assessment and 450 youth were assessed. An additional 127 assessments were planned and a total of 174 closure surveys were completed at

the time of this report. Trauma-focused parenting, trauma-focused CBT and art therapy were the most common trauma-informed treatments recommended for youth who were assessed. Individual and family therapies were the most common traditional services recommended.

Table 1: Trauma Screens, Trauma Assessments, Closure Surveys, Treatment and Services

Trauma SCREENS	Trauma ASSESSMENTS	Closure Surveys	Treatments and Services
<p>1,029 youth</p> <ul style="list-style-type: none"> • 121 screened in, not referred • 677 screened in, referred • 231 screened out 	<p>577 youth</p> <ul style="list-style-type: none"> • 127 planned • 450 assessed 	<p>174 youth</p> <ul style="list-style-type: none"> • Closure surveys available for 174 youth 	<p>Trauma-Focused</p> <ul style="list-style-type: none"> • Trauma-focused parenting • Trauma-focused CBT • Art therapy <p>Traditional</p> <ul style="list-style-type: none"> • Individual therapy • Family therapy

3. Outcome Evaluation

The following section presents findings from the outcomes evaluation of the CWRC intervention. Two types of outcomes were examined for this evaluation: child and youth well-being and child welfare system outcomes.

3.1. Measuring Well-being

For purposes of the CWRC intervention, data on child and youth well-being were collected using two separate measures: the Treatment Outcome Package (TOP) and the Child and Adolescent Needs and Strengths Tool (CANS). Both of these measures are currently, and previously have been, used elsewhere by community-based providers and child welfare agencies to assess child well-being, identify trauma exposure and mental health needs, and aid in service planning (Rosenbalm et al., 2016). Both also provide a unique advantage by gathering information from multiple sources in order to gain a comprehensive view of a young person’s functioning.

A total of 840 youth were represented in the TOP data and 43 youth in the CANS data. Overall, youth had an average of three “TOP events” during the evaluation period. Caseworkers were the most common type of rater who completed TOPs for the intervention, followed by youth, parents and clinicians.

3.2. Summary of Findings

Overall, significant improvements were found from baseline to post across TOP domains, suggesting changes in well-being among youth from baseline to post. However, no meaningful differences in well-being were found between youth who received an assessment and youth in the control group. Positive changes in well-being found among youth in both groups indicate that while youth in the treatment group did not differ significantly from youth in the control group, the well-being of youth across both groups improved over time.

3.3. Administration of the Treatment Outcome Package (TOP)

The TOP measure was used to assess child and youth well-being by six of the seven counties involved in the CWRC intervention, including: Arapahoe, Denver, Douglas, Eagle, Jefferson and Larimer. TOP data were collected on a total of 840 youth for the current evaluation. While each county differed slightly in timeframes for administering the TOP, each county generally completed a TOP at case opening and every 90 days thereafter. More detailed information regarding each county’s criteria for administering the TOP may be found in Appendix 4.

Each TOP administration involved TOP surveys completed by multiple persons (or “raters”), referred to in this report as a “TOP event.” Typically leading TOP events, caseworkers completed close to one-third of all TOP surveys completed (N=10,886), followed by youth, parents and clinicians, depicted further below.



The figure below presents the average number of TOP events for each youth, overall and by county. Youth in Denver and Eagle had data collected for the fewest TOP events, on average, while youth in Jefferson and Larimer counties had data collected for the most. Overall, youth had data collected for an average of three TOP events.

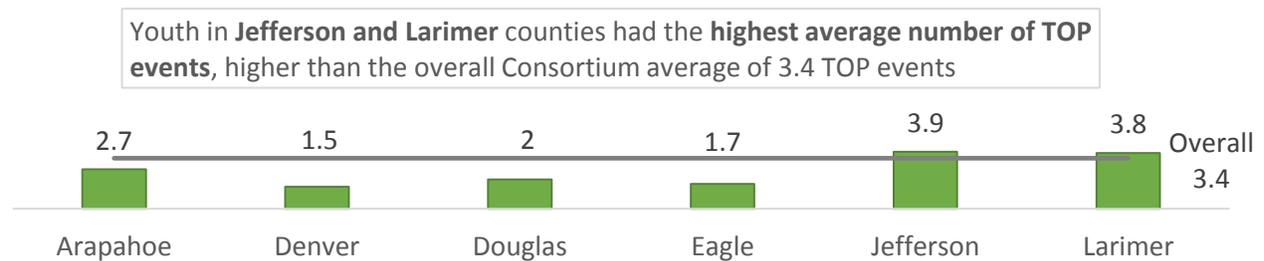


Table 2 presents data on the total number of TOP surveys (as opposed to TOP events) and most common categories of raters who completed surveys in a given county. Not surprisingly, with the exception of Eagle, caseworkers were the most common category of rater represented in the TOP data, likely due to their role in leading the TOP administration process. Other common raters included: youth, parents, non-relative placement providers, clinicians and Guardian ad Litem (GALs).

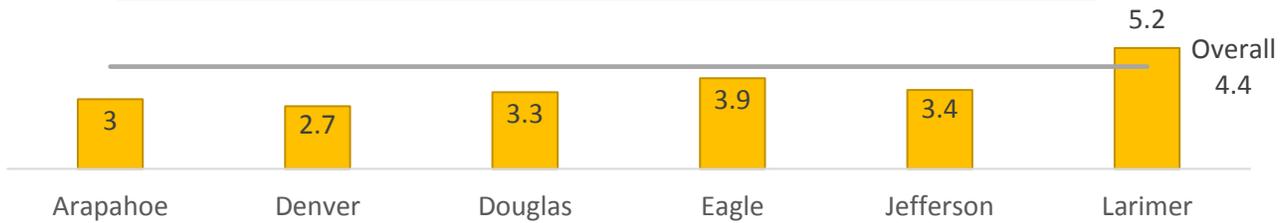
Table 2: Total Youth with TOPs and Top 3 Common Categories of TOP Raters by County

	Arapahoe	<i>n</i> =118	Denver	<i>n</i> =87	Douglas	<i>n</i> =172
1st	Caseworker	100%	Caseworker	100%	Caseworker	100%
2nd	Placement	26.2%	Clinician	41.4%	Clinician	43.0%
3rd	Youth	20.3%	GAL	28.7%	Parent	34.9%

	Eagle	<i>n</i> =23	Jefferson	<i>n</i> =659	Larimer	<i>n</i> =2135
1st	Parent	100%	Caseworker	100%	Caseworker	100%
2nd	Caseworker	82.6%	Youth	29.9%	Youth	60.0%
3rd	Youth	65.2%	Clinician	26.9%	Parent	44.4%

Larimer County completed the greatest number of TOP surveys with youth (*N* = 2,135), and also averaged the highest number of raters per TOP event, depicted in the figure below. Overall, CWRC counties averaged slightly more than four raters per TOP event.

Larimer had the **highest average number of raters** involved in a given TOP event, higher than the overall Consortium average of 4.4 raters



3.4. Administration of Child and Adolescent Needs/Strengths (CANS)

Boulder was the sole county to use the CANS measure. An initial CANS was completed with each youth eligible for services with the CWRC intervention at case opening, and every six months thereafter throughout the duration of the case. Additional information regarding Boulder’s criteria for administering the CANS may be found in Appendix 5. Due to differences in administration, similar data describing raters and events are not available for the CANS.

3.5. Examining Child and Youth Well-being

To examine youth wellbeing, TOP data were analyzed to determine whether changes in well-being occurred between baseline and post for youth who received a trauma assessment (defined as the treatment group) and youth who did not (defined as the control group). The Lime Survey platform was utilized to collect data on referrals and completion of assessments, which were used to identify whether a youth received an assessment. Average changes in well-being among youth were also compared between treatment and control groups. Following is the methodology that was used to identify the number of TOP events for each youth.

- 1) Treatment group
 - a. Youth who received a trauma assessment and had TOP ratings available
 - b. Identification of average baseline and post-assessment TOP ratings for youth
 - i. Baseline – Averaged TOP scores across all domains and given by raters associated with closest caseworker TOP to a youth’s date of referral for trauma assessment
 - ii. Post – Averaged TOP scores across all domains and given by raters associated with latest caseworker TOP available for a youth
- 2) Control group
 - a. Youth who did not receive a trauma assessment and had TOP ratings available
 - b. Identification of average baseline and post TOP ratings for each youth
 - i. Baseline – Averaged all TOP ratings associated with first caseworker TOP

ii. Post – Averaged all TOP ratings associated with last caseworker TOP

A timeframe for a “TOP event” was defined to include 15 days prior/30 days after a caseworker TOP survey. After removing records to only include youth with at least two TOP events to allow for a pre- and post- comparison, the current analysis consisted of 266 youth who received a trauma assessment and 339 youth who were not assessed, for a total of 605 youth.

Table 3: TOP Data Summary Statistics by County

County	# of Youth, by Group		Age			Gender
	Control	Treatment	Min	Average	Max	% Female
Arapahoe	1	23	3	15	21	44
Denver	0	13	7	14	19	46
Douglas	42	3	6	17	20	39
Eagle	0	3	12	14	16	67
Jefferson	60	48	9	17	21	36
Larimer	236	176	1	14	21	42
Overall (N=605)	339	266	1	15	21	42

Data in Table 4 indicate improved functioning at post compared to baseline across all domains. Lower scores represent better functioning and higher scores represent worse functioning.

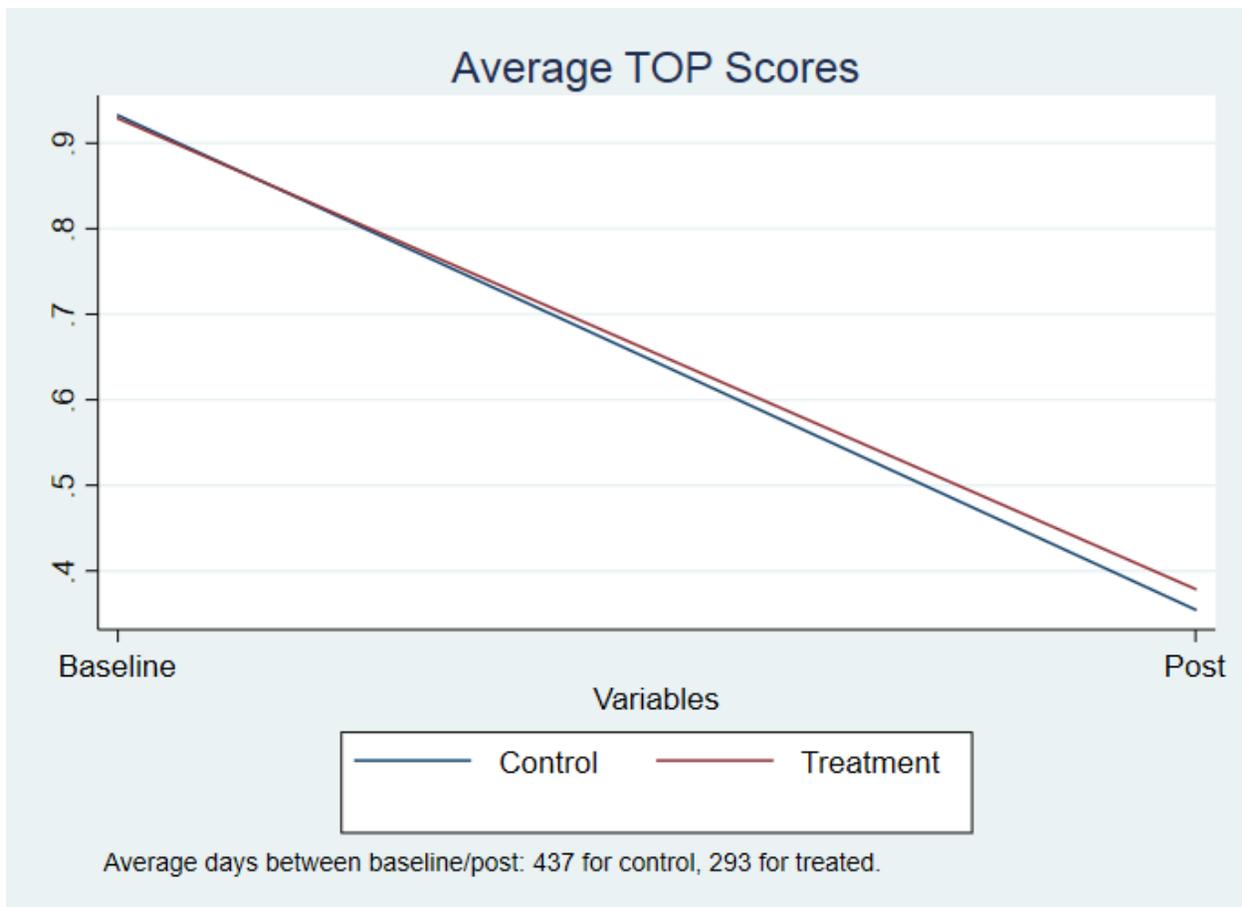
Table 4: Average TOP Scores (Overall)

Domain	Baseline			Post			
	Sample (Control / Treatment)	Average	St. Dev.	Domain	Sample	Average	St. Dev.
ADHD	312 / 248	1.05	1.23	ADHD	327 / 257	.52	.89
ASRTV	113 / 97	-.07	.98	ASRTV	105 / 100	-.43	.78
BOWEL	102 / 98	.49	1.91	BOWEL	106 / 100	.23	1.70
CNDCT	317 / 256	1.79	3.47	CNDCT	333 / 263	.94	2.81
DEPRS	306 / 251	1.00	1.29	DEPRS	325 / 255	.25	1.08
MANIC	196 / 148	-.24	.78	MANIC	219 / 154	-.62	.63
PSYCS	302 / 247	.61	1.58	PSYCS	325 / 257	.05	1.04
SEPAX	96 / 95	.52	1.24	SEPAX	103 / 98	.00	1.03
SLEEP	302 / 245	.53	1.28	SLEEP	325 / 253	-.11	.96
STRNG	113 / 97	1.49	1.42	STRNG	106 / 103	.95	1.28
SUICD	303 / 248	1.10	2.18	SUICD	322 / 255	.36	1.33
SA	205 / 155	1.90	3.61	SA	222 / 157	1.17	2.82
UNEAT	109 / 97	.02	.86	UNEAT	105 / 97	-.27	.75
VIOLN	311 / 250	.85	2.07	VIOLN	328 / 262	.11	1.28
WORKF	207 / 157	.85	1.25	WORKF	224 / 160	.17	1.12
SEXWR	311 / 252	.55	1.00	SEXWR	325 / 258	.39	.74
SCONF	206 / 158	1.73	1.10	SCONF	224 / 159	.96	1.10

3.5.1. TOP Analysis Results

Analysis of variance (ANOVA) was conducted to analyze the TOP data, examining changes in youth well-being from baseline to post and then comparing average change in well-being between youth receiving the trauma assessment and youth in the control group. A full description of the domains measured by the TOP may be found in Appendix 4. A summary of these results is displayed in Figure 1 below. Overall, significant improvements were found in average scores from baseline to post across every TOP domain; however, no meaningful differences were found between youth receiving the assessment and youth in the control group. Some outcomes trended towards showing stronger declines for assessed youth, but these results were likely by chance due to the high number of outcomes tested. Therefore, Figure 1 displays TOP scores averaged across domains to illustrate the overall similarities between treatment and control groups, including improvements in TOP scores over time.

Figure 1: Average Top Scores



3.5.2. CANS Data

Boulder was the only CWRC county to use CANS to measure child well-being. Due to differences in data collection and how each measure is structured, youth in Boulder were not included in the analysis of well-being above. To analyze the CANS data, data were first filtered to only keep records for youth with more than one observation. A youth’s “Initial” record was used as a baseline score, and the last record available (by date) as a post score. Overall, 43 youth had both a baseline and post score for 5 of 14 domains measured by CANS: *Life Domain Functioning, Strengths, Cultural Factors, Behavioral/Emotional Needs* and *Risk Behaviors*. Refer to Appendix 5 for a list of domains and items measured by CANS. More than half of youth represented in the CANS data were male, and the average age was 14 years.

Table 5: CANS Data Summary Statistics

County	Sample Size	Age			% Female
		Min	Average	Max	
Boulder	43 youth	5	14	17	42

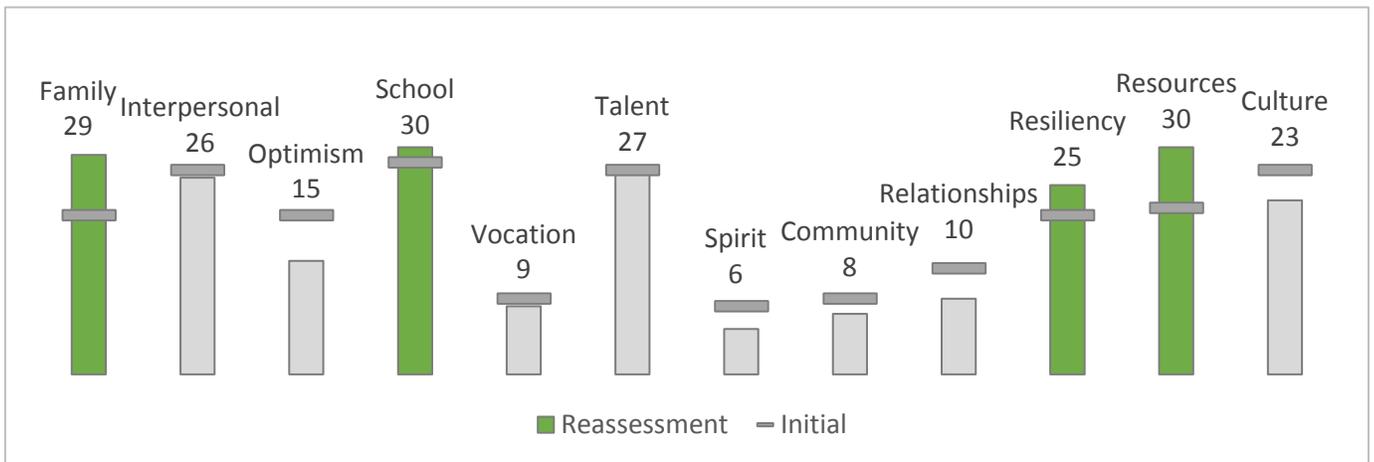
Due to the small number of observations precluding the option for a more rigorous analysis, four domains that had pre- and post-data for all 43 youth were examined to compare the number of youth exhibiting positive functioning at their initial CANS to the number of youth functioning positively at re-assessment. The *Cultural Factors* domain also had data for all 43 youth but was not examined further due to no change in average score between Initial and Reassessment CANS, as shown in Table 6 below. Overall, results were mixed, and provide limited insight into the wellbeing or functioning of youth represented in the CANS data.

Table 6: CANS Data Average Overall Domain Scores at Initial and Reassessment

	Initial					Reassessment				
	N	Mean	St. Dev.	Min	Max	N	Mean	St. Dev.	Min	Max
Life Domain	43	17.7	5.7	3	30	43	18.0	5.8	3	28
Strengths	43	20.6	4.6	9	30	43	21.5	4.2	13	33
Cultural Factors	43	0.6	1.0	0	3	43	0.6	1.1	0	5
Behavioral/Emotional	43	12.2	3.8	3	18	43	13.2	3.9	5	21
Risk	43	5.6	3.2	0	14	43	6.1	3.1	0	13
Trauma	20	6.4	1.4	4	9	41	6.2	1.6	3	9
Traumatic Stress	20	5.5	4.2	0	13	41	5.8	4.1	0	14
Substance Use	14	10.4	1.8	7	14	26	8.3	4.1	0	14
Violence	12	13.8	6.3	0	23	23	13.7	6.7	0	23
Runaway	11	9.8	5.8	0	19	31	7.8	5.4	0	19
Juvenile Justice	17	7.7	3.2	2	13	34	7.1	3.9	0	13

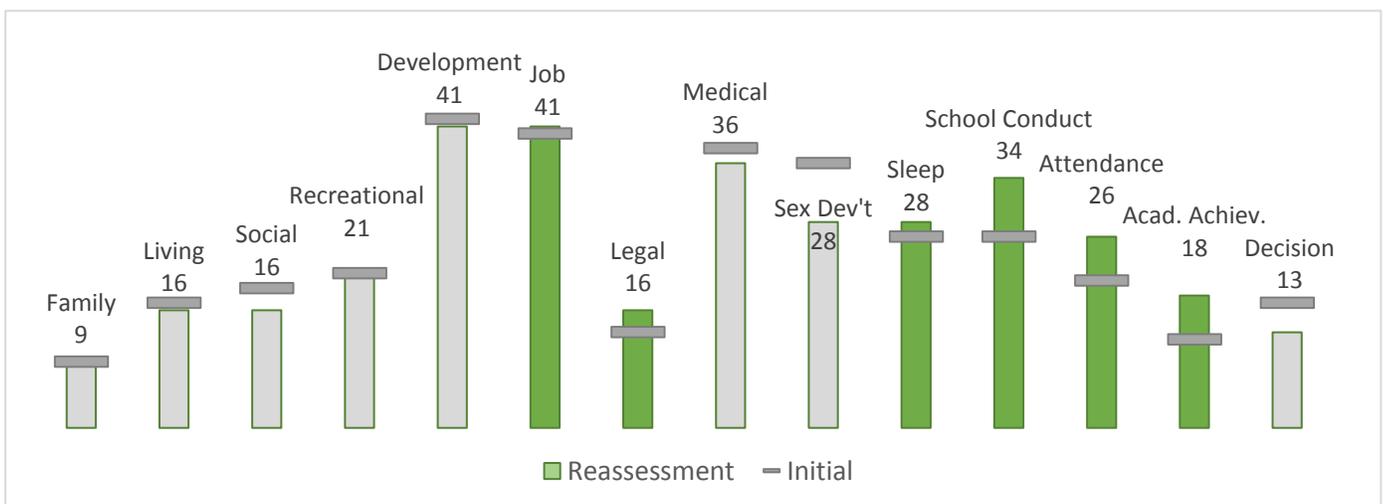
Beginning with the Strengths domain, of the 12 areas measured, four areas saw greater numbers of youth functioning positively at Reassessment compared to Initial, including: *Family, Educational Setting, Resiliency* and *Resourcefulness*. In regards to the Life Functioning domain, more than half (8) of the domain items experienced decline or no change in the number of youth functioning positively, while six items increased in number: *Job Functioning, Legal, Sleep* and *School Behavior, Attendance* and *Achievement*. Specific change between Initial and Reassessment for each domain are presented in the figures below.

Figure 2: Youth Strengths



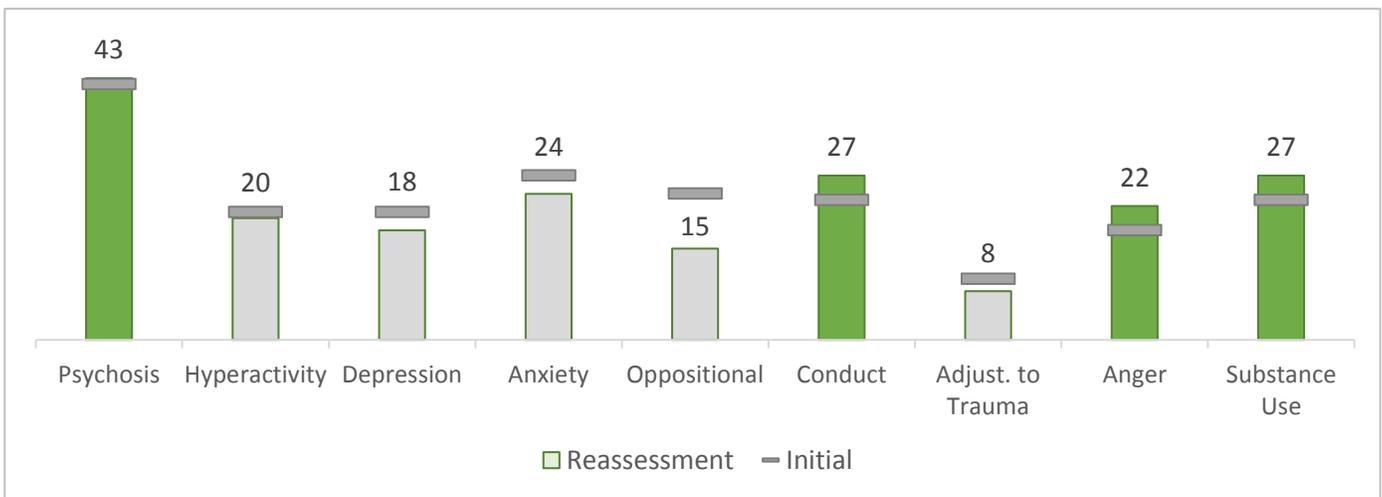
Dashes = youth with positive functioning at Initial CANS.
 Columns = youth with positive functioning at Reassessment (numbers represent Reassessment).
Green columns = # youth functioning well at Reassessment > # youth functioning well at Initial.

Figure 3: Life Domain Functioning



The next domain, related to Behavioral and Emotional needs, increased in the number of youth functioning positively in four of the nine areas measured, including: *Psychosis, Conduct, Anger Control* and *Substance Use*. Almost all youth represented indicated no service need in the area of Psychosis at baseline, and no youth had indicated need in this area at Reassessment. Finally, more than half (5) of the nine items measured in the Risk Behaviors domain saw an increase in the number of youth doing well at Reassessment, including: *Suicide Risk, Non-Suicidal Non-Self Injurious Behavior, Danger to Others, Sexual Aggression* and *Delinquent Behavior*.

Figure 4: Youth Behavioral/Emotional Needs



Dashes = youth with positive functioning at Initial CANS.
 Columns = youth with positive functioning at Reassessment (numbers represent Reassessment).
Green columns = # youth functioning well at Reassessment > # youth functioning well at Initial.

Figure 5: Youth Risk Behaviors



3.6. Child Welfare Outcomes

In addition to youth well-being, the outcomes evaluation also examined child welfare outcomes. Specifically, data were analyzed to evaluate the trauma screen and assessment as an intervention for preventing subsequent involvement with child welfare and youth services among youth already engaged in the system. A somewhat natural experiment occurred during implementation, where some youth did not receive a trauma assessment due to lack of capacity, and allowed for group comparisons. Child welfare outcomes that were examined include: subsequent referral, assessment, involvement with DYS, and commitment to DYS.

Since receipt of a trauma screen and assessment were based on certain criteria and not randomly administered to youth, the likelihood of systematic selection into the treatment group (youth who received a trauma screen and assessment) was potentially dependent on preexisting characteristics, such as prior involvement with child welfare services. To account for the possibility of selection bias, STATA software's *eteffects* package was used to analyze the data, a method that accounts for selection bias by first estimating the probability of receiving treatment as a function of covariates, and then estimating the likelihood of an outcome based on covariates and the treatment variable. Covariates included: prior involvement with child welfare (e.g., number of prior referrals before receiving treatment as a predictor of subsequent referral), ethnicity (Hispanic, African American, other), age, and gender. Prior number of cases was also included when modeling each outcome.

Two sets of analyses were conducted, in which the treatment group was defined to include youth who received both the trauma screen and assessment of the CWRC intervention. The first analysis compared outcomes of youth in the treatment group to youth in a control group consisting of youth eligible for treatment but never received a trauma screen or assessment. The second analysis compared youth in the treatment group to a second control group that included youth who screened in, but never received the CWRC intervention assessment. Across both analyses, we found no evidence for the trauma screen and assessment as a predictor of subsequent child welfare involvement outcomes. We were interested in analyzing the potential effect of treatment on other child welfare involvement outcomes, including remaining home during child welfare involvement, removal from home, and open case, but were unable due to inadequate sample size.

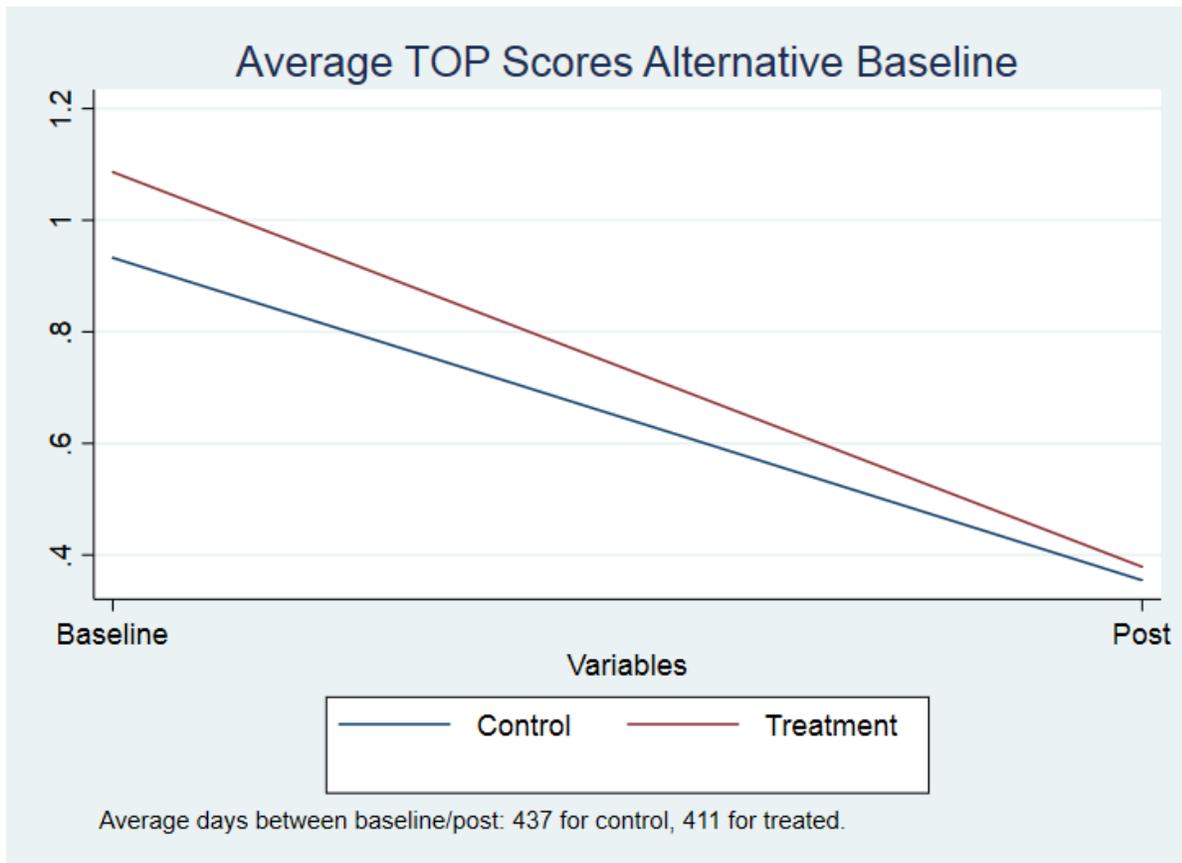
3.7. Discussion

Overall, evaluation results provide limited insight into child welfare outcomes or the well-being of youth involved in the CWRC intervention and should be interpreted with caution. In regards to the CANS, small sample size precluded the ability to analyze the data more rigorously. Regarding the TOP measure, while there clearly was a meaningful decline in TOP scores (where lower TOP scores reflect more positive functioning and higher TOP scores reflect worse functioning), the analysis was limited by the non-experimental design of the evaluation. In an effort to address this concern, youth involved in the CWRC intervention who did not receive an assessment were used to create a control group, primarily represented by Douglas, Jefferson and Larimer counties. However, the number of days between baseline and post TOP scores for the control group was much higher than for youth receiving a trauma assessment, suggesting the potential for marked differences between groups. Due to this discrepancy, a second set of ANOVAs was conducted using the first TOP event for each youth (see Figure 6 on the following page), as opposed to the TOP event closest to the trauma assessment date (as in the first ANOVA analysis). Using the first TOP event, the average number of days between baseline/post scores for the treatment group was 411, comparable to the control group's average of 437.

Regardless of the baseline selection method for treated youth, the analysis found little evidence that youth receiving a trauma assessment fared better than youth not receiving one, *overall*. However, the second set of ANOVA analyses revealed a few marginally significant differences that may be worth exploring further. Specifically, physical violence (p-value: .04), school functioning (.05), sexual acting out (.05), suicidal ideation (.08), assertiveness (.10), depression (.11), separation anxiety (.12) all approached significance. If it is indeed the case that youth exhibiting *greater symptoms of trauma are more likely to receive an assessment*, then the comparable outcomes at follow-up suggest greater declines in symptomology from baseline to follow-up for youth in the treatment group (Figure 6). Such instances may be masked in the outcomes analyses due to low power.

The practical implications of the TOP analysis is that the trauma symptomology of youth served in the seven counties were successfully reduced during implementation of the trauma-informed intervention. The fact that youth who do not receive the trauma assessment are also improving is likely indicative of the overall approach and philosophy being employed by the seven counties and providers in regard to treating trauma throughout the continuum of care. Furthermore, if the trauma assessment does not add value in regard to improving youth well-being, then counties can reallocate the resources needed to complete the assessment toward developing and implementing trauma-informed services, potentially increasing the impact of these interventions.

Figure 6: Average TOP Scores from Baseline to Post



Results of the child welfare outcome analysis also provide limited insight into impact of the trauma-informed intervention on child welfare system outcomes. While the current analysis found no relationship between treatment and subsequent child welfare involvement, the observational design of the evaluation and limited sample sizes challenge the ability to make definitive conclusions. Relatedly, it may be that the impact of trauma-informed practice is with child welfare outcomes not examined in the current analysis.

Future recommendations include taking steps to improve the ability to employ a more rigorous evaluation design that would allow for empirical testing of whether trauma-informed practice can impact youth well-being. First and foremost, a reconsideration of the logic model may be useful to help explain how and why the CWRC intervention, defined as the trauma screen and assessment process, would have an impact on well-being for youth with histories of complex trauma and exhibiting trauma symptoms. For example, it is plausible that a trauma assessment may be particularly helpful for providing services to youth experiencing more serious forms of trauma, such as suicidal ideation or sexual behavior. Trained clinicians may be more likely to

identify these serious forms of trauma, and be able to use this information to provide the best available services to youth standing to benefit the most. Therefore, a more rigorous evaluation, such as one with an experimental design, could be tremendously beneficial for improving services to youth if assessments are in fact leading to better outcomes among these youth.

A more rigorous evaluation design would also allow for further empirical testing of the CWRC intervention's impact on service system outcomes. In addition, future analyses that also include post-assessment services would help to determine whether the intervention is leading to more targeted service provision that subsequently leads to positive service outcomes for families.

4. Process Evaluation

This section presents data describing implementation of the trauma screening, referral and assessment processes. Data describing trauma screens and referrals are presented first, followed by data describing the trauma assessment process and subsequent referral of trauma-informed treatment and services.

4.1. Trauma Screen Overview

Trauma screens were conducted using the Trauma Screening Checklists (TSC) developed by Dr. Jim Henry at the Southwest Michigan Children's Trauma Assessment Center. Two TSCs are available, one for children up to age five, and one for children age six or older. Copies of the TSCs may be found in Appendix 6.

Overall, 1,029 youth were screened for trauma during the evaluation period, of which 677 youth (66%) were referred for a trauma assessment after their Initial Screen, 121 youth screened-in but were not referred, and 231 youth screened out. Initial trauma screens completed with youth most often resulted in a Screened-In Referral (with the exception of Douglas County, which screened out 48% of youth at Initial Screen), suggesting that criteria for the eligible population identified for trauma screening were well-targeted. Similarly, among the two counties for which data were available (Jefferson and Larimer counties), Closure Screens frequently led to Screened-Out results. A number of youth received multiple of the same type of trauma screen, including Initial, Re-Screens and Closure Screens – suggesting a need for further examination around implementation fidelity and/or data entry processes.

4.2. Trauma Assessment Overview

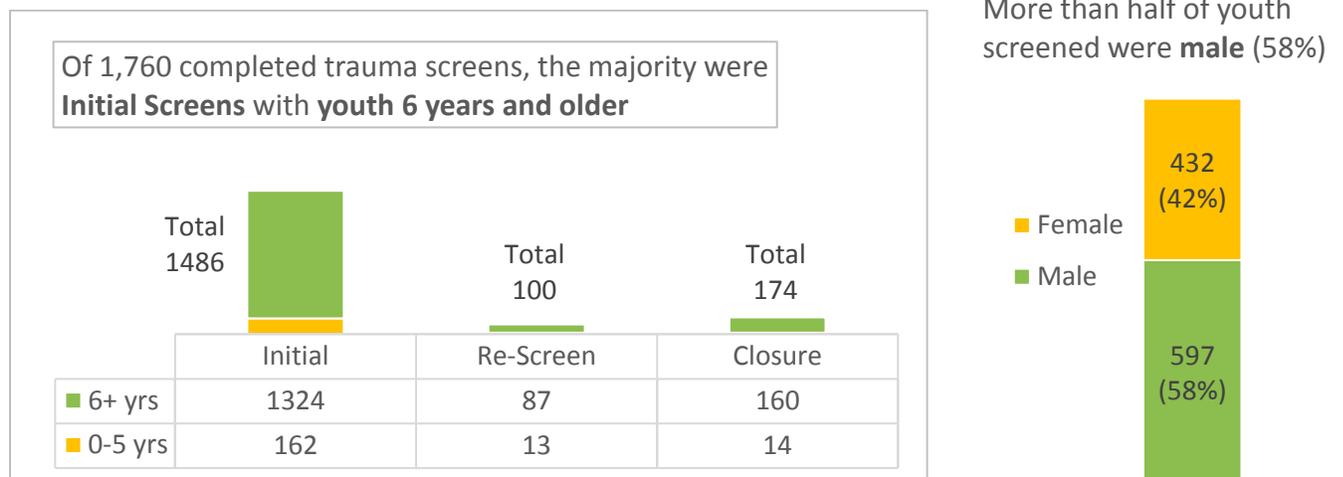
Assessments for the CWRC intervention typically required a full day of time, due to the array of measures and strategies employed to conduct an in-depth assessment of trauma. A list of tools and measures used for the CWRC intervention assessment may be found in Appendix 7.

A total of 450 youth received an assessment during the evaluation period, with assessments planned for an additional 127 youth at the time of this report. The average duration between referral and completion of an assessment was 53 days, and the average time between assessment and debrief report was 47 days. Data from trauma care coordinators indicate that 73% of cases reviewed included assessments completed within the targeted time frame of six weeks from referral.

Closure data were only available for 174 youth, of which 66% ($n=114$) were from Larimer. The most commonly recommended trauma-informed services included trauma-focused parenting, trauma-focused CBT and art therapy. Common traditional services included individual and family therapy.

4.3. Trauma Screen Results

The CWRC intervention completed a total of **1,760** trauma screens with **1,029 youth** between July 2014 and April 2018.



Of the total 1,760 screens administered during the evaluation period, 1,283 were unique (depicted below), indicating some youth received more than one Initial, Re-Screen, or Closure screen. Screens categorized as “Other” represent youth who had trauma screens completed in

non-Consortium counties. Specific numbers of Initial, Re-Screen, and Closure Screens administered by each county are presented in the following pages.

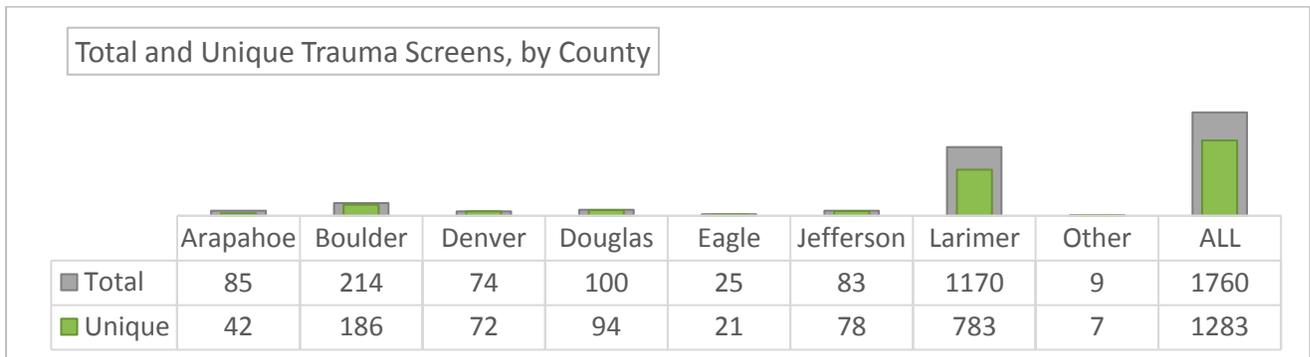


Table 7 presents data for the 1,283 unique Initial, Re-Screens and Closure screens completed during the evaluation period. About two-thirds (66%) of Initial screens were referred, while a large majority (82%) of Closure screens screened out.

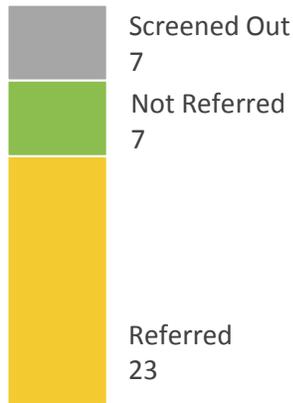
Table 7: Unique Screens and Screening Outcomes

	Referred	Not Referred	Screened Out	Total
Initial	677	121	231	1029
Re-Screen	75	6	9	90
Closure	3	26	135	164
Total	755	153	375	1283

4.3.1. Trauma Screens by County

Arapahoe completed **85 total screens** between September 2014 and July 2017. Unique screens included **37 Initial Screens** and **5 Re-Screens**. As displayed in Table 8 on the following page, **6 female** and **21 male** youth were screened (darker shading reflects greater values).

Almost two-thirds (62%) of Initial screens were Referred



Most Re-Screens also resulted in a Referral

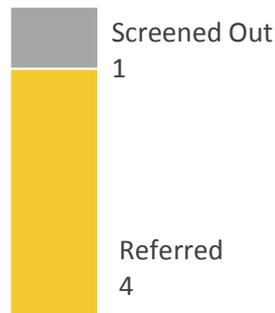
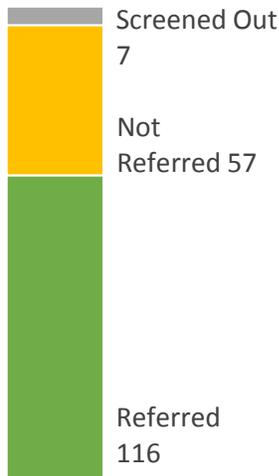


Table 8: Screened Youth

Age	Female	Male
0-5 yrs.	--	1
6 yrs.	--	--
7 yrs.	--	1
8 yrs.	--	1
9 yrs.	3	2
10 yrs.	2	1
11 yrs.	--	4
12 yrs.	--	1
13 yrs.	2	1
14 yrs.	2	3
15 yrs.	6	2
16 yrs.	1	2
17 yrs.	--	2

Boulder completed **214 total screens** with **79 female** and **101 male youth** between November 2015 and November 2017. Unique screens included **180 Initial Screens** and **6 Re-Screens**.

Almost two-thirds (64%) of Initial Screens were Referred



Most Re-Screens also resulted in a Referral

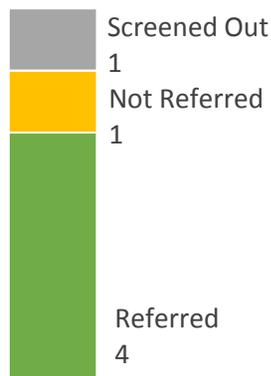


Table 9: Screened Youth

Age	Female	Male
0-5 yrs.	16	16
6 yrs.	4	6
7 yrs.	5	4
8 yrs.	3	8
9 yrs.	5	4
10 yrs.	4	3
11 yrs.	4	8
12 yrs.	4	8
13 yrs.	5	7
14 yrs.	9	12
15 yrs.	10	7
16 yrs.	7	13
17 yrs.	3	5

Denver completed **74 total Initial Screens** (72 unique Initial Screens) between February 2016 and December 2017. As displayed in Table 10, **79 female** and **101 male** youth were screened.

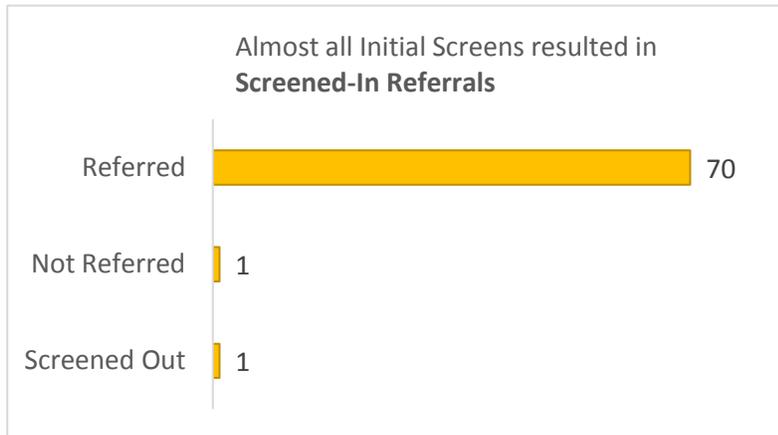


Table 10: Screened Youth

Age	Female	Male
0-5 yrs.	1	2
6 yrs.	--	--
7 yrs.	1	2
8 yrs.	1	1
9 yrs.	--	1
10 yrs.	1	2
11 yrs.	2	3
12 yrs.	2	5
13 yrs.	5	4
14 yrs.	3	4
15 yrs.	4	4
16 yrs.	5	7
17 yrs.	9	3

Douglas completed **100 total screens** between September 2015 and April 2018. Unique screens included **91 Initial Screens** and **3 Re-Screens**. As displayed in Table 12, 30 female and 61 male youth were screened.

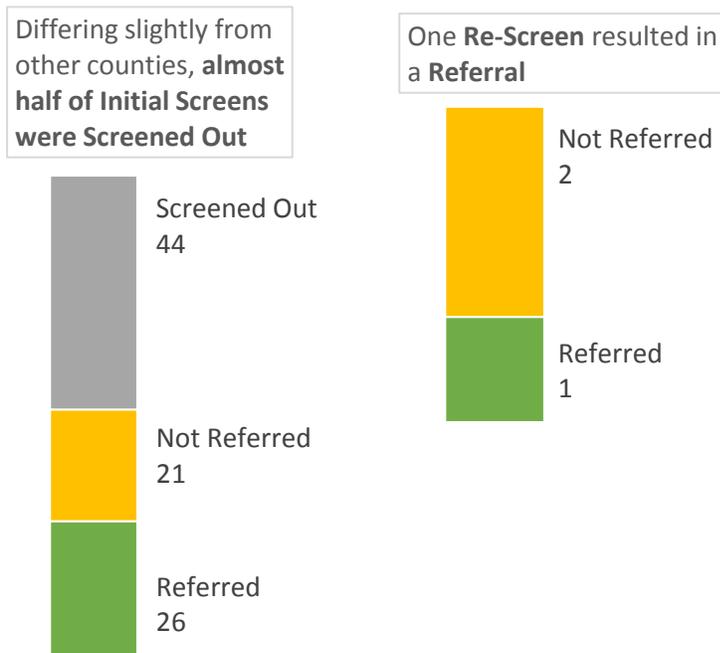


Table 11: Screened Youth

Age	Female	Male
0-5 yrs.	--	--
6 yrs.	--	1
7 yrs.	--	--
8 yrs.	--	1
9 yrs.	--	1
10 yrs.	2	--
11 yrs.	1	--
12 yrs.	3	1
13 yrs.	1	3
14 yrs.	4	4
15 yrs.	4	15
16 yrs.	7	16
17-18 yrs.	8	19

Eagle completed **25 total Initial Screens** (21 unique Initial Screens) and between October 2014 and November 2017. As displayed in Table 12, **10 female** and **11 male** youth were screened.

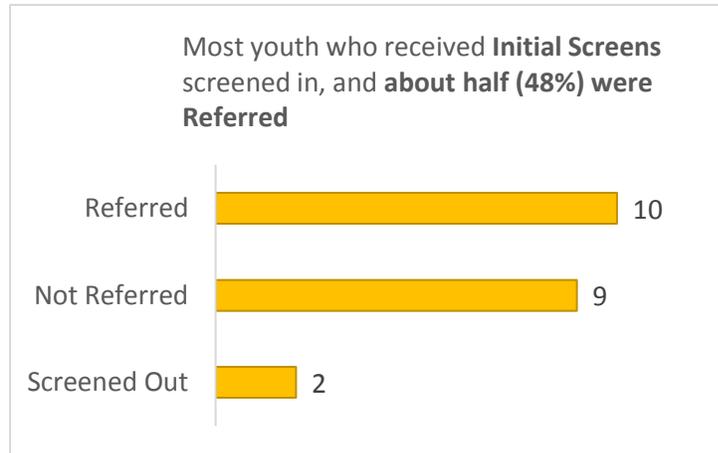
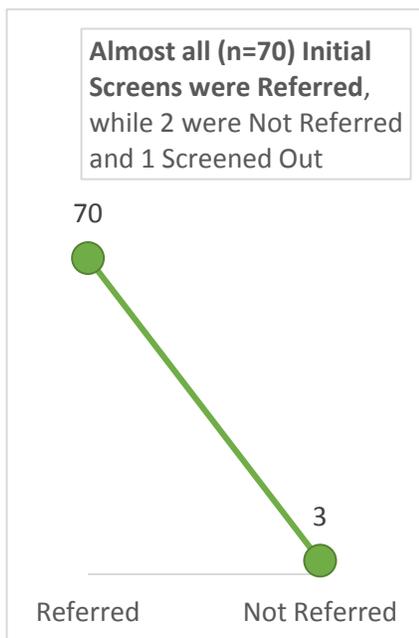


Table 12: Screened Youth

Age	Female	Male
0-5 yrs.	3	1
6 yrs.	--	--
7 yrs.	--	1
8 yrs.	1	--
9 yrs.	--	--
10 yrs.	--	1
11 yrs.	1	--
12 yrs.	2	1
13 yrs.	--	2
14 yrs.	2	--
15 yrs.	--	2
16 yrs.	1	2
17 yrs.	--	1

Jefferson completed **83 total screens** between January 2016 and April 2018. Unique screens included **73 Initial Screens**, **3 Re-Screens** and **2 Closure Screens**. As displayed in Table 13, 27 female and 46 male youth were screened.



2 Re-Screens were Referred and both Closure Screens Screened Out

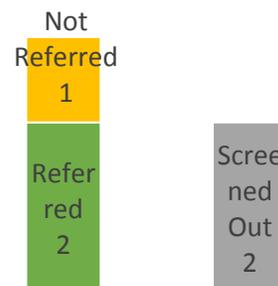


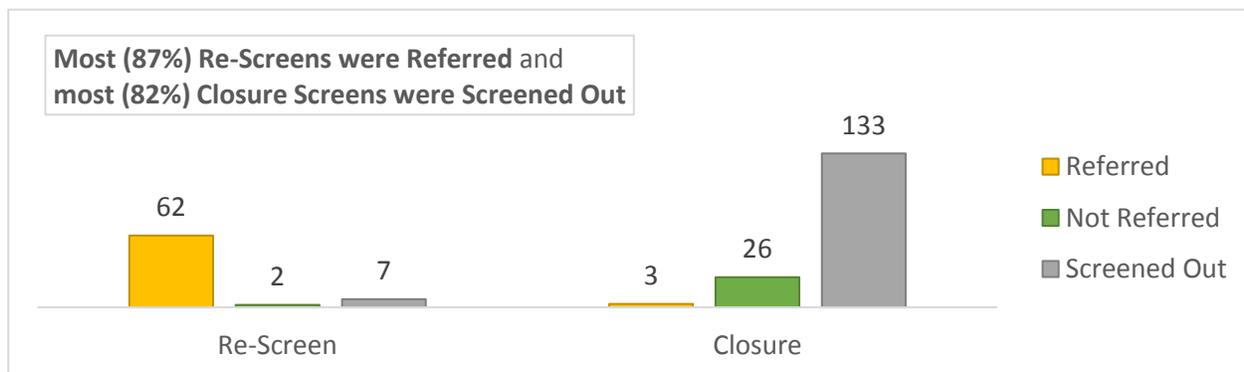
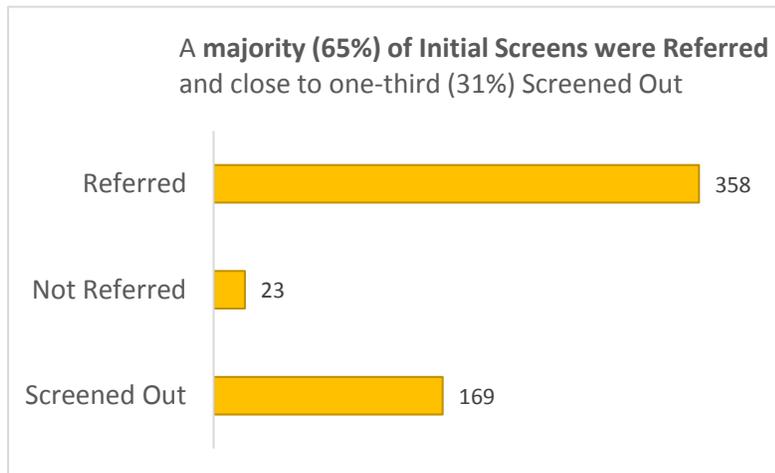
Table 13: Screened Youth

Age	Female	Male
0-5 yrs.	--	--
6 yrs.	--	--
7 yrs.	--	--
8 yrs.	--	--
9 yrs.	--	--
10 yrs.	--	3
11 yrs.	1	1
12 yrs.	2	1
13 yrs.	2	5
14 yrs.	8	4
15 yrs.	6	9
16 yrs.	4	9
17-18 yrs.	4	14

Larimer completed **1170 total screens** between October 2014 and November 2017. Larimer also completed the greatest number of Closure Screens among the seven counties. Unique screens included **550 Initial Screens**, **71 Re-Screens** and **162 Closure Screens**. As displayed in Table 14, 235 female and 315 male youth were screened.

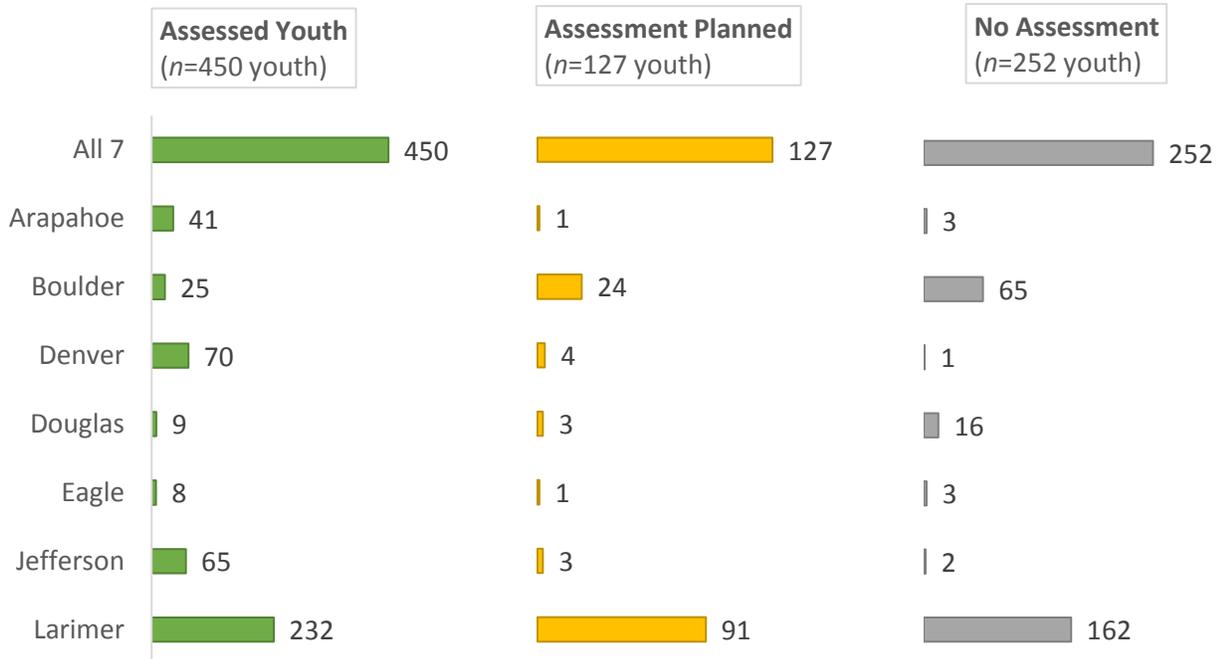
Table 14: Screened Youth

Age	Female	Male
0-5 yrs.	28	47
6 yrs.	13	20
7 yrs.	14	17
8 yrs.	20	19
9 yrs.	16	18
10 yrs.	13	26
11 yrs.	11	19
12 yrs.	16	22
13 yrs.	21	23
14 yrs.	22	36
15 yrs.	30	25
16 yrs.	18	31
17 yrs.	13	12



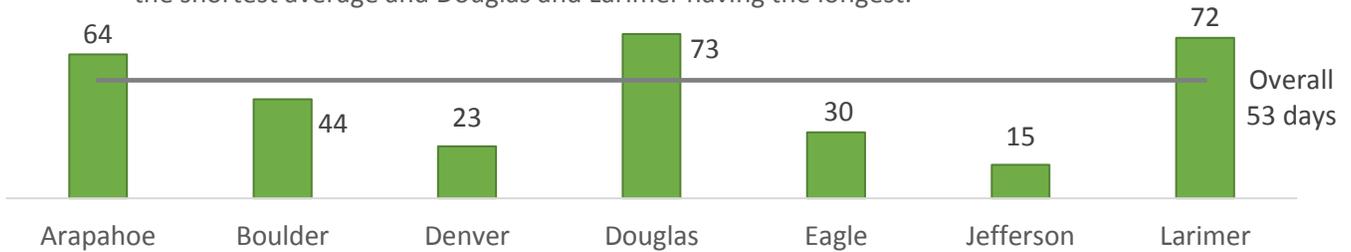
4.4. Trauma Assessments

A total of **829 youth** were referred for and/or assessed for trauma during the evaluation period, with data spanning from May 2015 to April 2018. More than half of the sample, **450 youth**, received a trauma assessment during the evaluation period. Assessments were planned for an additional **127 youth**, and no assessments were planned or completed for the remaining **252 youth** in the sample.

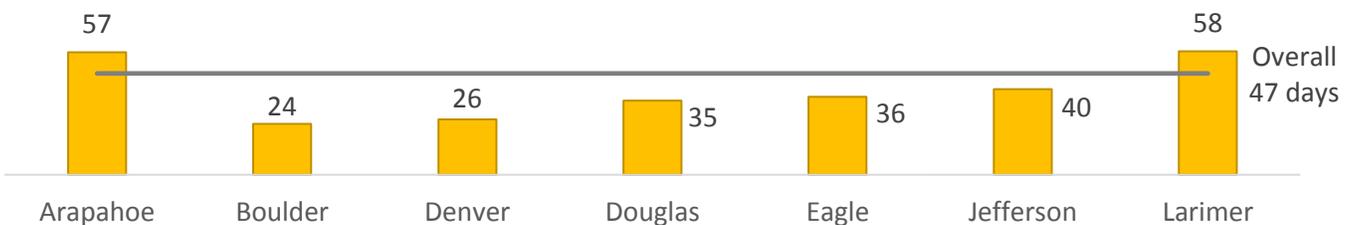


The figures below present average times between referral to assessment, and between assessment to debriefing assessment results with the family. Data indicate considerable variability between these time points across counties, perhaps driven by individual county's business processes and initial implementation while resources were still in development.

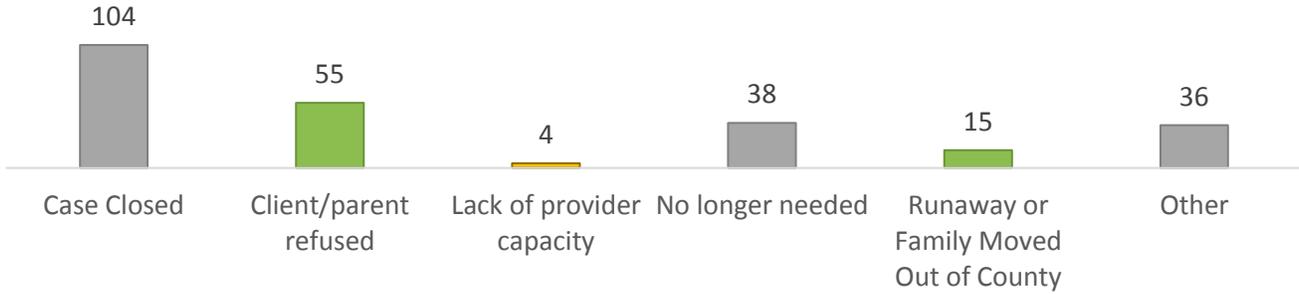
The **overall average time from referral to assessment was 53 days**, with Jefferson having the shortest average and Douglas and Larimer having the longest.



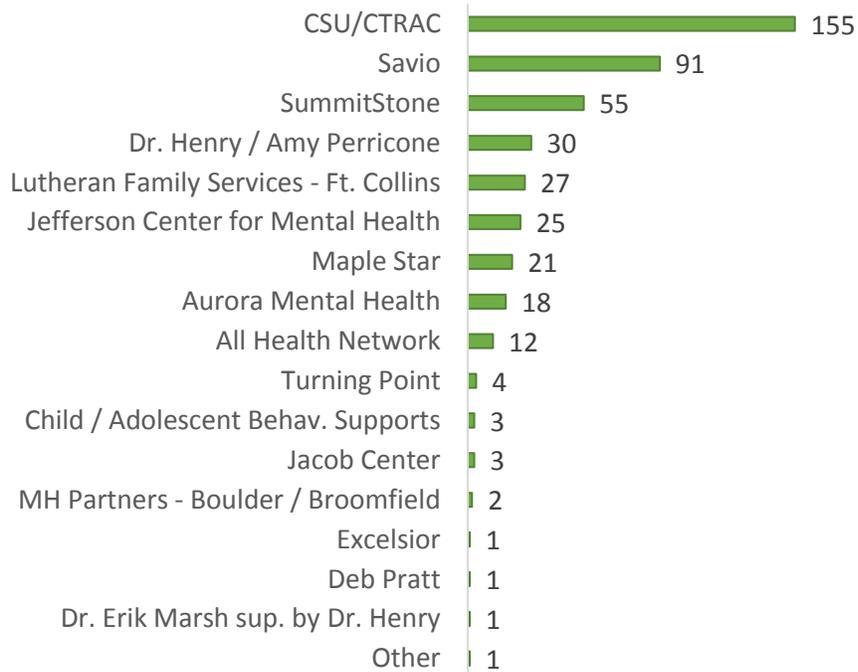
The **overall average time from assessment to debrief report was 47 days**, with Larimer and Arapahoe having the longest times and remaining average times ranging 24-40 days.



Of the 252 youth who were NOT assessed, **more than half (56%)** were due to **practice related reasons**, including case closure, and **28%** were due to **family refusal or absence**.



CTRAC provided the greatest number (34%) of trauma assessments, followed by **Savio** and **SummitStone**



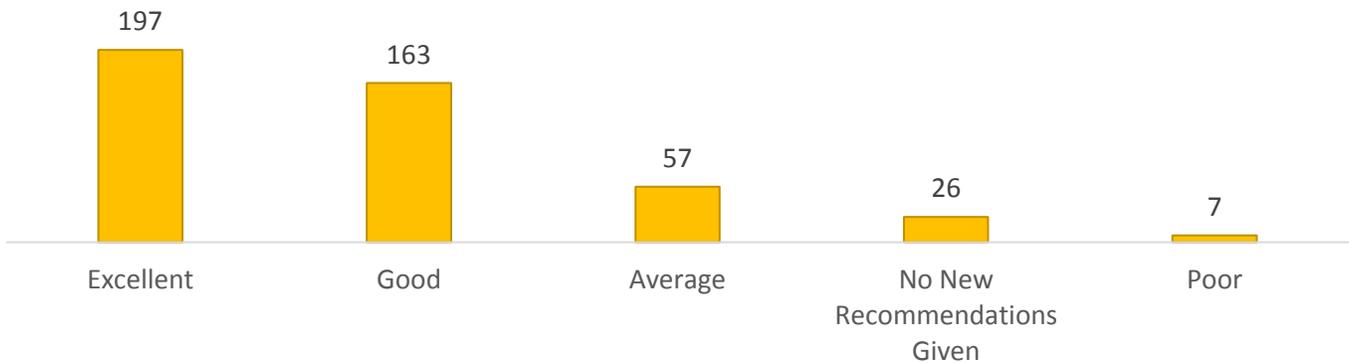
Did the following assessment follow-up activities occur? **Yes (green)** or **No (grey)**?



As depicted in the figure above, follow-up activities after an assessment were implemented more often than not. Debrief and family meetings took place 83% and 76% of the time, respectively. Passing on recommendations immediately to the caseworker and caregiver occurred less often but still consistently, with 72% of caseworkers and 62% of caregivers receiving immediate recommendations. Numbers for each category above do not all total 450 due to data indicating it was sometimes unknown whether an activity took place.

Caseworkers were also asked to rate the recommendations received from an assessment. A large majority (89%) of recommendations were rated as realistic (shown above). A majority of recommendations were also rated as excellent or good in quality, presented below.

A **majority (80%)** of recommendations were rated as **Excellent** or **Good** in quality



This section discusses recommended services and strategies for **174 youth** who received a trauma assessment, with data spanning from December 2016 to April 2018.

A handful of youth (in Denver, Douglas and Larimer counties) had more than one survey completed at case closure, with 181 closure surveys completed for **174 total youth**.

	Arapahoe	Boulder	Denver	Douglas	Eagle	Jefferson	Larimer
■ Total	5	5	19	5	8	22	117
■ Unique	5	5	16	4	8	22	114

In addition to recommending treatments and services, trauma assessment results also provided recommendations for additional assessments as appropriate. Table 15 presents the degree to which five possible assessments were recommended after a trauma assessment, and whether the assessment services were referred, began and/or completed. Medical exams and speech and language assessments were least likely to be recommended, while medication evaluations and educational assessments were the two most commonly begun and completed.

Table 15: Additional Assessments or Exams

	Not Recommended	Referred / Receiving	Complete	Not Referred
Educational Assessment	124	17	22	11
Medication Evaluation	118	25	21	10
Medical Exam	152	4	15	3
Occupational Therapy	133	16	11	14
Speech and Language	150	10	10	4

In regards to trauma-focused treatment and services recommended by a trauma assessment, dialectical behavior therapy and play therapy were the least frequently recommended. Conversely, trauma-focused parenting education was the most commonly recommended and completed service, followed by trauma-focused cognitive behavioral therapy (CBT). Animal-assisted therapy and art therapy were the most common trauma-focused services to be recommended but not referred. Further details regarding recommended trauma-focused services are presented in Table 16 on the following page.

Table 16: Trauma-Focused Therapeutic Services

	Not Recommended	Referred / Receiving	Completed	Not Referred
Animal-assisted	124	12	9	29
Art	109	25	16	24
Parent Child Interaction	141	10	12	11
Phase-Based Trauma	141	17	11	5
Trauma-focused CBT	124	22	20	8
Sensory / Body-Based	134	15	16	9
Dialectical Behavior	160	3	5	6
Sensory Integration	145	9	11	9
Play	160	6	5	3
EMDR	139	10	9	16
Child-Parent Psychotherapy	143	14	7	10
Trauma-focused Parenting	96	28	32	18
Other	142	15	9	8

As displayed in Table 17, among traditional therapeutic treatments and services, individual and family therapy were the most likely to be recommended, began and completed.

Table 17: Traditional Therapeutic Services

	Not Recommended	Referred / Receiving	Completed	Not Referred
Sexual Abuse	150	10	10	4
Substance Abuse	135	22	10	7
Individual Therapy	26	97	38	13
Group Therapy	142	16	12	4
Family Therapy	43	76	36	19
Other	162	2	6	4

Life skills training and services were also included among trauma assessment recommendations, presented in Table 18 on the following page. Mentoring programs and engagement in activities to help promote mastery and development were the two most commonly recommended and completed life skills training or services.

Table 18: Life Skills/Services

	Not Recommended	Referred / Receiving	Completed	Not Referred
Life Skill Development	108	32	17	17
Mentoring	47	61	40	26
Sensory-Based Skill Development	142	10	11	11
OT Support for School	147	11	8	8
Social Skill Coaching	141	11	14	8
Social Skills Group	133	16	12	13
Wraparound Services	137	15	12	10
Trauma-informed Yoga	155	4	4	11
Trauma Treatment Coordinator	125	7	33	9
Mastery Development	79	38	32	25
Visitation	145	11	14	4
Developmental Services	161	6	4	3



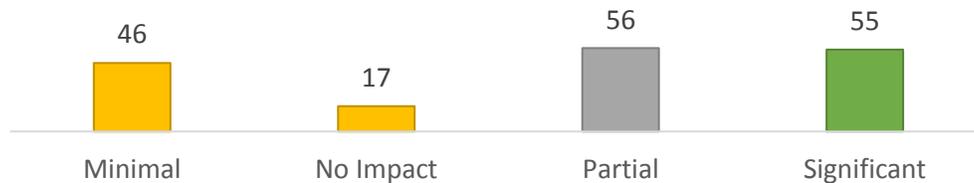
A majority of closure surveys ($n=145$, 83%) indicated that **informal strategies and supports** were included among assessment recommendations. Of these, recommended strategies were implemented close to two-thirds (63%) of the time.

Of the 82 cases that did not have strategies implemented, the most common reasons were **family-driven**, including **refusal**, **lack of engagement** or **youth runaway**.



Caseworkers were asked to rate the impact of the trauma assessment and resulting services on resiliency for youth, choosing from a range of “no impact” to “significant impact.” Presented in the figure below, results indicated a somewhat even spread of ratings. About one-third (32%) rated the impact as Significant, another one-third (32%) as Partial, while the remaining third (36%) indicated ratings of Minimal to No Impact.

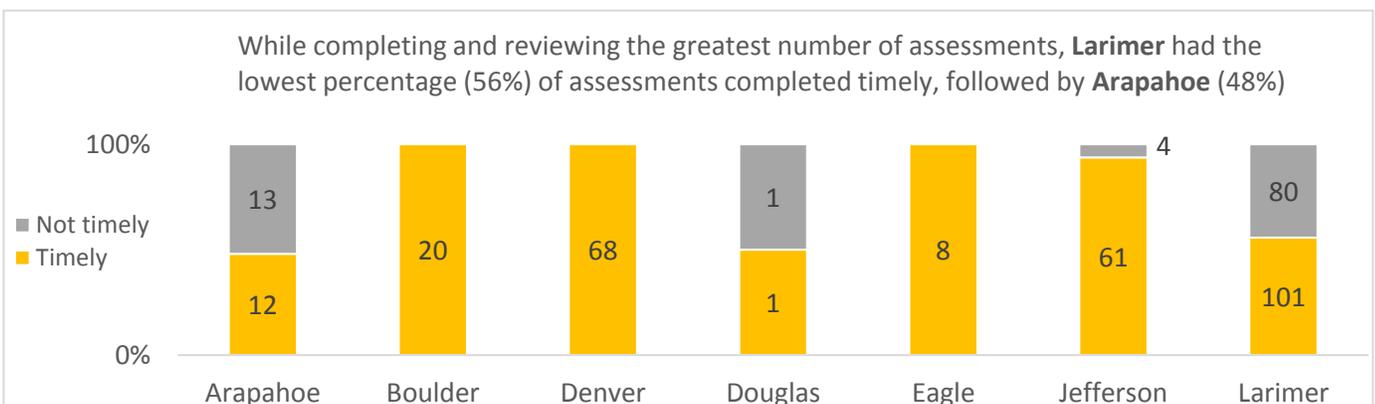
Rate the impact of the trauma assessment and services on resiliency for youth:



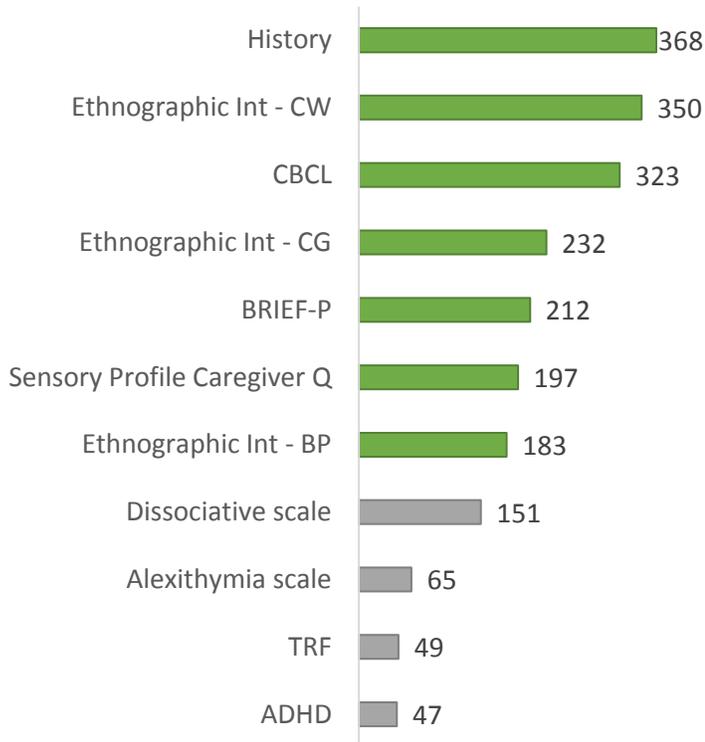
4.5. Trauma Assessment Case Reviews

Of the 450 youth who had assessments completed during the evaluation period, **371** had their cases reviewed by trauma care coordinators to examine whether assessments included all required components. Review results indicated that assessments were completed timely for a majority of cases reviewed ($n=271$; 73%), defined as no later than six weeks after a referral is made. The figure below presents the timeliness status of reviewed cases, by county.

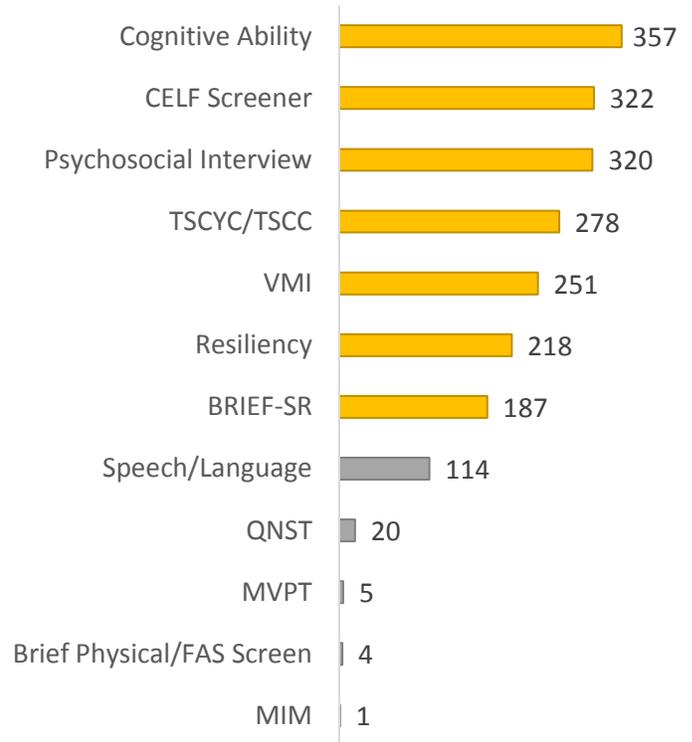
While completing and reviewing the greatest number of assessments, **Larimer** had the lowest percentage (56%) of assessments completed timely, followed by **Arapahoe** (48%)



7 of 11 designated **pre-assessment elements** were included in over 50% of reviewed cases



7 of 12 designated **assessment elements** were included in over 50% of reviewed cases



Trauma care coordinators also examined cases to determine the number of clinicians involved in completing the assessment. More than two-thirds (69%) of reviewed cases had two clinicians involved in assessments, and a large majority (86%) had Master’s level training.

More than two-thirds (69%) of cases reviewed had assessments done with **2-clinician teams**

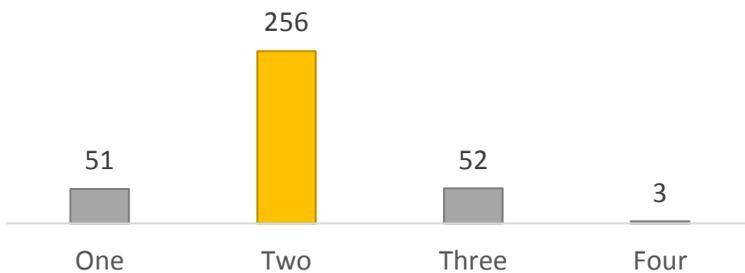
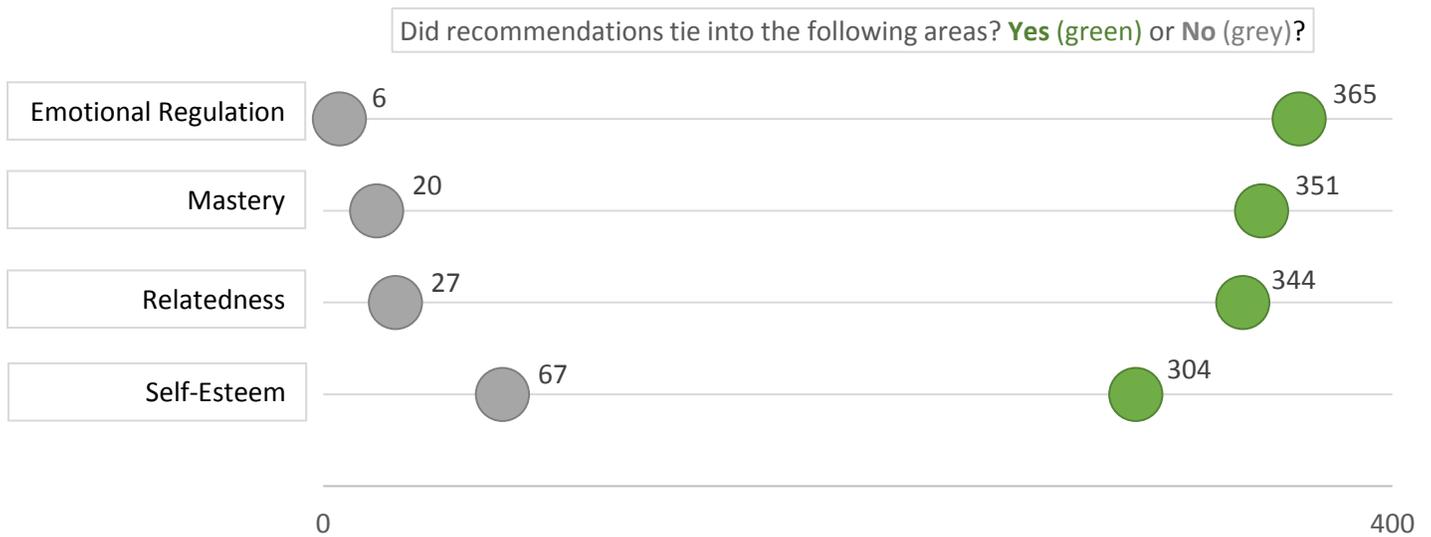
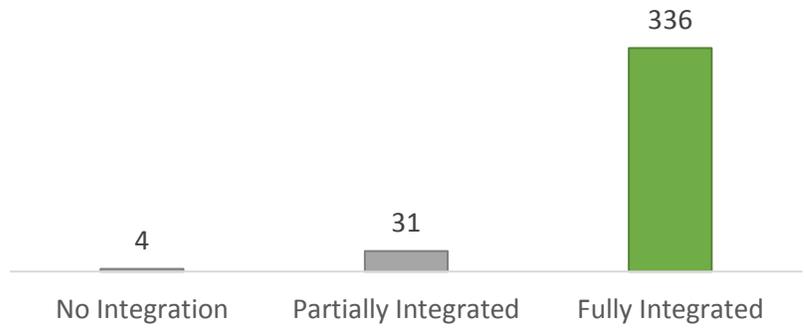


Table 20: Clinical Assessor Backgrounds

	Assessments
Masters	318
PhD	111
Licensed Psychologist	61
Occupational Therapist	13
MD/NP	2
Speech/Language	2
Psychiatrist	2

100% of cases reviewed included a report with summary and recommendations. About one-third ($n=119$, 32%) of reviewed cases also included **recommendations on permanency**.

A large majority (91%) of reports also integrated assessment components into the summary and recommendations, as shown in the figure to the right.



5. Conclusion and Implications

In summary, evaluation findings indicate that well-being improved overall for youth involved with the CWRC intervention, with all youth surveyed with a TOP showing a positive change in well-being from baseline to post. No meaningful difference, however, was found in well-being levels or change between youth who were assessed and youth who were not. Similarly, findings indicated no significant relationship between the CWRC intervention and child welfare outcomes. Regarding implementation, the CWRC intervention successfully screened over 1,000 youth during the evaluation period, assessed 66% of youth referred for an assessment, and had assessment plans in place for over 50% of referred youth waiting for an assessment.

Several factors may help to explain why significant differences were not found between the well-being levels of youth in treatment versus control groups. First and foremost, limitations to the evaluation design preclude the ability to draw definitive conclusions regarding a relationship between the CWRC intervention (defined as the trauma screen and assessment

process) and youth well-being. Specifically, the outcomes analysis employed an observational design due to the inability to actively assign participants randomly to either group. Thus, it is not clear how and when youth were designated into each group, and the degree to which youth and families in each group were kept separate in receiving aspects of the “treatment.” Broad training of staff, service provider communities and system partners around complex trauma and its impact on development and interpersonal relationships was also conducted prior to and throughout the evaluation period, and not specific to only staff involved in the CWRC intervention. Training and increased awareness of complex trauma may have led to all or most youth and families receiving some level of trauma-focused practice and services regardless of their encounter with the CWRC intervention.

Moving forward, the 7-County Consortium is in process of implementing and further developing the CWRC trauma-informed intervention, and current findings may help to inform and refine program and evaluation design. Evidence elsewhere suggests interventions aimed at helping youth reframe their thought patterns and understanding of their experiences of trauma have been linked to promoting recovery and well-being (Kelley, Pransky, & Sedgeman, 2014). For example, an intervention known as the *Three Principles* helps youth develop insight into their traumatic histories and its impact in order to develop resilience and achieve resolution related to their trauma. Studies have found the intervention may be helpful in decreasing psychological symptoms and delinquent behavior particularly in residential and justice settings (Kelley et al., 2014). Another study linked Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to significant decreases in PTSD symptoms among a sample of 132 adolescents receiving treatment from a non-profit residential psychiatric treatment facility in Mississippi. Youth in the sample had histories of trauma exposure, and experienced more acute symptoms than adolescents receiving treatment in other non-residential settings. (Joiner & Buttell, 2018).

Other research has also linked trauma-informed practices to improvement in well-being and achieving permanency. Researchers studied the impact of the Attachment, Self-Regulation and Competency (ARC) intervention on 93 adolescents with complex trauma and child protection involvement receiving services from an outpatient clinic in Alaska. Researchers found that youth who completed the ARC treatment showed a greater level of improvement and high rates of placement permanency. The ARC intervention was also implemented with a highly diverse sample, with varying trauma exposure and histories, involved with child protection (Arvidson et al., 2011). Separately, a longitudinal evaluation was conducted of the Strengthening Family Coping Resources (SFCR) intervention, with a sample of 13 families with children age six or older receiving community-based treatment (Kiser, Backer, Winkles, & Medoff, 2015). The SFCR targets both children and their families, and SFCR was found to

significantly impact both child symptoms and overall family functioning, which did not differ by gender or child age (Kiser et al., 2015).

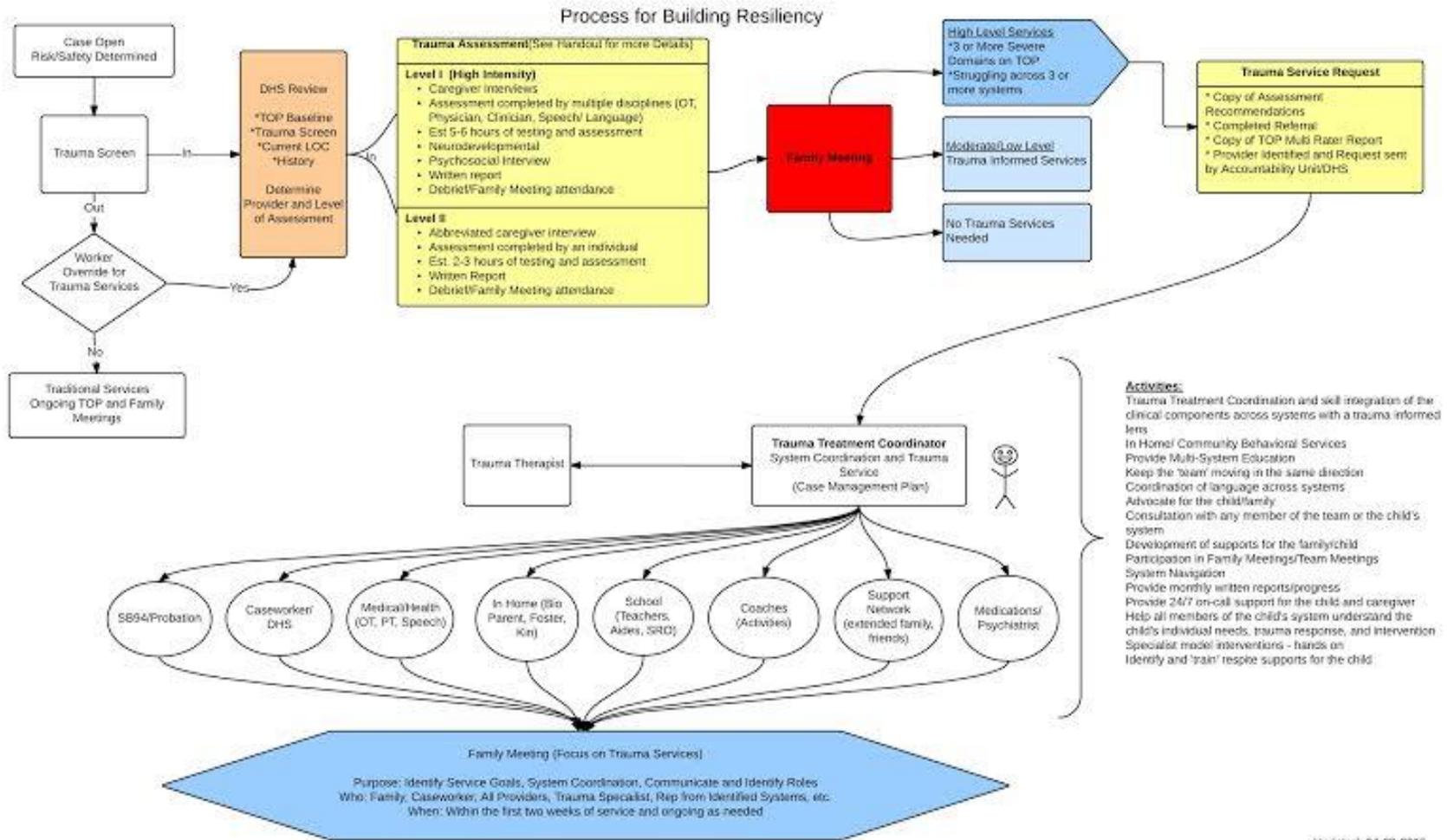
Another intervention, Trauma Systems Therapy (TST) was evaluated with a sample of 1,499 children ages six and older in Kansas who were removed from their caregivers. TST was found to be effective in increasing permanency and children showed improvements in functioning and emotional and behavioral regulation. The evaluation also found that positive effects can be cultivated by any staff member working on the child's service team, and researchers suggest that the influence of TST provided by an entire team, rather than by one staff member, can foster improved outcomes for children. (Murphy, Moore, Redd, & Malm, 2017). In a final example, Weiner, Schneider, and Lyons (2009) examined trauma treatments among a sample of culturally diverse foster care youth. With a sample of 2,434, 3-18 year old youth receiving treatment at various sites in Illinois, the trauma interventions of CPP, TF-CBT, and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) demonstrated equally significant effectiveness across racial groups represented in the sample. All three trauma interventions were administered at the community level, and demonstrated significant improvement in youth functioning and symptom reduction. Researchers noted the important of culturally appropriate tools and cultural competence for practitioners implementing trauma interventions with culturally diverse youth (Weiner et al., 2009).

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Appendix 1 – Child Welfare Resiliency Center Logic Model



Appendix 2 – CWRC Eligible Populations

Eligible Population for Screening & Assessment

Arapahoe	All youth with either an open or FAR case (with services) in Arapahoe County are screened for trauma. The county will specifically target 30 youth identified by area administrators (15 youth who have waited longest for permanency, 15 preventative cases), eventually moving to the next longest waiting youth in out of home placement.
Boulder*	FAR-SP; Ongoing Case; Congregate Care; In Care > 2 yrs.; Disrupting Adoptions
Denver	70 of the highest need ‘legacy youth’ cases in congregate care or out of home placement ‘Legacy youth’ are youth with extensive system involvement and whose cases have been open the longest.
Douglas	Congregate care; In OOH placement > 2 yrs.; Developmentally disabled youth; Disrupting Adoptions; PA4 youth with an open case and in congregate care
Eagle*	All children/youth with an open child welfare case (approx. 40 children)
Jefferson	All children/youth in residential care as of Oct. 1, 2015; plan to eventually include any child/youth placed in a group home or higher level of care. Administrators and supervisors currently identifying youth for assessment and will eventually complete assessments for all youth who screen in once have capacity to do so
Larimer*	All open cases in PA4 or PA5, and selected PA6 cases (e.g., Disrupting Adoptions); FAR; Ongoing Case

* Denotes counties with different target populations for screening and assessment; see below for separate criteria for assessment

Eligible Population for Assessment (if different than target population for trauma screening)

Boulder	Youth with a moderate or high level trauma screen
Eagle	All children/youth with moderate or high level trauma screen
Larimer	All children/youth ages 6 and older, with open case

Utilizing TOPS Assessment

	Criteria for TOP/CANS	Completion Frequency	Raters/Assessors
Arapahoe	Screen-in: 6 or above	<ul style="list-style-type: none"> • Every 90 days 	Required – CWer, caregiver, youth age 10 and > (also by CWer discretion), therapist, GAL, probation/parole officer Optional – CASA, teacher, birth parent (if not directly involved in case), significant adults; siblings; direct care line staff, if applicable
Denver	Screen-in: 6 or above	<ul style="list-style-type: none"> • Every 90 days • Placement change • Case closure 	CWer, youth age 10 and >, caregivers (including foster parents and kin), therapist, probation/parole officer, GAL
Douglas	Screen-in: 6 or above	<ul style="list-style-type: none"> • Every 90 days 	Youth, caregiver, CWer, probation/parole officer, GAL, other providers
Eagle	Screen-in: 6 or above	<ul style="list-style-type: none"> • Every 90 days 	GAL, therapist, caregiver(s), CWer, teacher
Jefferson	Screen-in: 6 or above	<ul style="list-style-type: none"> • Residential – Every 30 days • Other care levels – Every 90 days 	Required – CWer, youth, caregiver Also invited – GAL, parent/guardian, teacher, probation/parole officer, therapist, CASA, mentor
Larimer	Screen-in: 6 or above	<ul style="list-style-type: none"> • Case opening • Every 90 days • Case closure 	CWer, caregiver, birth parent (if different), youth, therapist

Utilizing CANS Assessment**

Boulder	Screen-in: 6 or above	<ul style="list-style-type: none"> • Case opening • Every 6 months • Case closure 	CWer, youth, caregiver, clinician, school staff, court officials (GAL, probation, etc.), mentor (if applicable)
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**Unlike the TOP, the CANS measure is completed only by a trained Assessor who gathers ratings or opinions regarding a young person’s functioning from a range of adults and professionals, such as a teacher or therapist. The assessor then synthesizes the information and completes a CANS measure. Assessors are persons who manage the CANS process, and are separate from any parties involved in a given case. Boulder has identified 2 former caseworkers who will be trained as assessors and manage/coordinate the CANS process.

Appendix 3 – CWRC Data Sources

Description of Data	Data Source
Trauma Screens	Trails
Trauma Assessment Referral and Coordination	Lime Survey
Trauma Assessment Recommendations/Services	Lime Survey
Trauma Care Coordinator – Case Review	Lime Survey
Treatment Outcome Package (TOP)	Kids Insight TOP database
Child and Adolescent Needs and Strengths (CANS)	Boulder County data system

Appendix 4 – Treatment Outcome Package Domains and Scoring

What does TOP measure? TOP Factor Scores

Child TOP

Lack of Assertiveness (ASRTV) This factor taps into potential problems with assertiveness (e.g. had trouble standing up for himself/herself, seemed scared around people, been too shy.)
Strength: Assertiveness

Incontinence (BOWEL)

This factor taps a construct related to a child's bowel and bladder functioning. **Strength: Continence**

Lack of Resiliency (RESIL)

This factor taps a construct related to a child's strengths, or what the child is doing well. Often overlooked in therapy settings, knowing a client's strengths (particularly a child's) can be especially important in providing appropriate care. **Strength: Resiliency**

Separation Anxiety (SEPAX)

This factor taps a construct related to a child's discomfort in being away from his/her caretaker. **Strength: Secure Attachments**

Sexual Acting Out (SEXWR)

This factor relates to worrisome sexualized behavior in children.
Strength: Appropriate Boundaries

Eating Issues (UNEAT)

This factor taps a construct related to a child's reluctance to eat.
Strength: Good Eating Habits

Adolescent TOP

Mania (MANIC)

This factor taps a construct that may be related to manic or hypomanic symptoms. All of this factor's items relate to elevated mood or behaviors associated with elevated mood.

Strength: Balanced Emotions
(at a score of zero; negative scores indicate Depression)

Substance Abuse (SA)

This factor uses the six items from Norm Hoffman's UNCOPE questionnaire and has excellent sensitivity and specificity for substance abuse and dependency issues.

Strength: Good Control of Substance Use

Poor School Functioning (SCHOOLF)

This factor relates to adolescent functioning at school. The items on this factor relate to missing school for any reason and several items about problems at school. **Strength: Good School Functioning**

Social Conflict (SCONF)

This factor taps a construct that relates to how well an adolescent relates to others. **Strength: Positive Relationships**

Both

ADHD Symptoms (ADHDC)

This factor relates to a child or adolescent's pattern of paying attention. Many of the items from this factor directly ask about attention and impulsivity. **Strength: Ability to Focus**

Conduct Disorder (CNDCT)

This factor relates to a child or adolescent's conduct or behavior problems. **Strength: Adherence to Rules**

Depression (DEPRS)

This factor taps a construct that relates to many of the symptoms of clinical depression. The items from this factor on the Child TOP are child-specific; the Adolescent TOP uses items from the Adult clinical scale.

Strength: Happiness

Psychosis (PSYCS)

This factor taps a construct related to psychotic symptoms.

Strength: Ability to Face Reality

Sleep Problems (SLEEP)

This factor relates to difficulty sleeping.

Strength: Healthy Sleep Habits

Suicidality (SUICD)

This factor relates to suicidal ideation.

Strength: Handles Sadness

Violence (VIOLN)

This factor relates to physical violence or anger.

Strength: Deals with Anger Well



Child TOP Factor Scoring

Child ADHD Symptoms (ADHDC) (7 items, theoretical minimum: -1.98, theoretical maximum: 5.78) This factor taps a construct that relates to a child's pattern of paying attention. Many of the items from this factor directly asks about attention (e.g. had trouble paying attention in class, had trouble staying still, had trouble finishing things, lost things), and being impulsive. This factor cannot diagnose or rule out ADHD, but an elevated score can be a sign that further clinical investigation is warranted.

Child Assertiveness (ASRTV) (3 items, theoretical minimum: -1.26, theoretical maximum: 5.53) This factor taps into potential problems with assertiveness (e.g. had trouble standing up for himself/herself, seemed scared around people, been too shy.)

Child Accident (BOWEL) (2 items, theoretical minimum: -0.40, theoretical maximum: 11.17) This factor taps a construct related to a child's bowel and bladder functioning. The two items are (wet clothes, soiled underwear). In the validation paper, this factor is labeled Elimination (ELMAT).

Child Conduct (CNDCT)* (3 items, theoretical minimum: -0.20, theoretical maximum: 27.01) This factor taps a construct that relates to a child's conduct or behavior problems. Items include: had trouble with the police, run away, stolen or shoplifted. Due to low endorsement of the items in this factor among the general population, scores in this factor can be elevated quite quickly, even with only minor endorsement of some items.

Child Depression (DEPRS) (8 items, theoretical minimum: -1.00, theoretical maximum: 9.23)

This factor taps a construct that is most consistent with child depression. The principal questions on the factor are: looked down or depressed, and had little or no interest in things that were enjoyable before. In addition, there are questions that tap into Attachment Theories connection to this construct (e.g. not wanted to be touched, been able to talk, but refused to do so, and shown little emotion when you expected some type of reaction). As we have known for decades, depression in children can take different forms (e.g. Bowlby, Ainsworth, etc.) and be harder to detect than depression in adults and the variety of items on this factor reflects that.

Child Psychosis (PSYCS) (3 items, theoretical minimum: -0.25, theoretical maximum: 9.80)

This factor taps a construct related to child psychosis with two key questions: heard things that were not there, and seen things that were not there. It also contains a minor loading on hurt him/herself.

Child Separation Anxiety (SEPAX) (4 items, theoretical minimum: -0.97, theoretical

maximum: 5.51) This factor taps a construct related to a child's discomfort with being away from his/her caretaker. While this factor should not be used to diagnosis or rule out separation anxiety disorder, it can aid the clinical process by alerting the clinician to symptoms consistent with problems around being away from caretakers. Items include: needed someone nearby in order to fall asleep, been afraid of being alone or did not want to be alone, and had nightmares. This factor has a moderate correlation with the sleep factor (.47).

Child Sexual Worry (SEXWR) (2 items, theoretical minimum: -0.23, theoretical maximum:

7.66) This factor has two items related to worrisome sexualized behavior in children: made sexual comments, and caused you to worry about his/her sexual activity.

Child Sleep (SLEEP) (4 items, theoretical minimum: -0.86, theoretical maximum: 6.29) This

factor taps a construct that relates to difficulties in sleeping: had trouble falling asleep, had nightmares, woke up during the night, and had trouble getting back to sleep in the night.

Child Eating (UNEAT) (3 items, theoretical minimum: -1.30, theoretical maximum: 3.68) This

factor taps a construct related to a child's reluctance to eat. The items on this factor are: eaten a variety of foods (vegetables, fruits, grains, meat) (reverse scored), eaten too little, and been a picky eater.

Child Strengths (STRNG) (6 items, theoretical minimum: -2.19, theoretical maximum: 5.45)

This factor taps a construct that relates to a child's strengths, or what the child is doing well. Often overlooked in therapy settings, knowing a client's strengths (particularly a child's) can be especially important in providing appropriate care. The items on this factor ask about a range of possible strengths and include: done what was asked of him/her, been able to

complete something after complaining that it was boring, gotten along well with others, been easy to live with, looked to share interests and exciting things with others, and followed rules to your satisfaction. Consistent with other factors, a high score on this factor indicates more problems in strengths/assets. In other words, a high score can be interpreted as having relatively few strengths and a lower score can be interpreted as having relatively many strengths compared to the general population. In the validation data, this factor is labeled Resiliency (RSLNT) and it is suspected that this factor taps strongly into a healthy protective factor, helping children cope with stress.

Child Suicidality (SUICD)* (2 items, theoretical minimum: -0.23, theoretical maximum: 22.62)

This factor taps a construct related to suicidal ideation: thought about killing himself/herself or wished to be dead, hurt himself/herself. As with all TOP factors, the score provided is based upon the client's self-report or a parent's report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Due to low endorsement of the items in this factor among the general population, scores on this factor can be elevated quite quickly, even with only minor endorsement of some items. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

Child Violence (VIOLN)* (6 items, theoretical minimum: -0.95, theoretical maximum: 14.86)

This factor taps a construct that relates physical violence or anger. Some of items indicate that the child has actually done something violent (e.g. physically hurt a person or an animal, seriously hurt someone), while other items indicate that the client has had some kind of violent thought (e.g. had thoughts of killing someone else, had desires to seriously hurt someone). Given recent research on bullying and school violence it should be emphasized that two other items load on this factor: been too shy, and hurt himself/herself. As with all TOP factors, the score provided is based upon the client's (or parent's) self-report or a parent's report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

Adolescent TOP Factor Scoring

Adolescent ADHD Symptoms (ADHDC) (8 items, theoretical minimum: -0.47, theoretical maximum: 5.78) This factor taps a construct that relates to a child's pattern of paying attention. Many of the items from this factor directly asks about attention (e.g. had trouble paying attention in class, had trouble staying still, had trouble finishing things, lost things), and being impulsive. This factor cannot diagnose or rule out ADHD, but an elevated score can be a sign that further clinical investigation is warranted.

Adolescent Conduct (CNDCT)* (3 items, theoretical minimum: -0.20, theoretical maximum: 27.01) This factor taps a construct that relates to a child's conduct or behavior problems.

Items include: had trouble with the police, run away, stolen or shoplifted. Due to low endorsement of the items in this factor among the general population, scores in this factor can be elevated quite quickly, even with only minor endorsement of some items.

Adolescent Depression (DEPRS) (10 items, theoretical minimum: -1.04, theoretical maximum: 5.48) This factor taps a construct that relates to many of the symptoms of clinical depression, although an elevated score is not necessarily diagnostic of clinical depression because such diagnosis involves certain time frames (i.e. most of the days – more days than not for at least two weeks), impairment in functioning/high subjective distress, and certain numbers of certain symptoms. The factor correlates very highly with the Beck Depression Inventory (.91). It includes such items as felt down or depressed, felt little or no interest in most things, felt guilty, and felt tired, slowed down, or had little energy. In addition, several of the items represent some of the cognitive components of anxiety (e.g., worried about things, had trouble concentrating or making decisions, noticed your thoughts racing ahead.) This is consistent with recent literature that indicates a high link between anxiety and depression.

Adolescent Mania (MANIC) (5 items, theoretical minimum: -1.19, theoretical maximum: 5.35) This factor taps a construct that may be related to manic or hypomanic symptoms. All of this factor's items relate to elevated mood or behavior associated with elevated mood: noticed your thoughts racing ahead, felt rested after only a few hours of sleep, felt you were better than other people, felt on top of the world. Very high scores on this factor are more likely to represent mania or hypomania. It is possible that extremely high scores on this factor as well as extremely low scores are associated with some form of psychological problem (mania or depression), while moderate scores are associated with psychological health.

Adolescent Psychosis (PSYCS)* (6 items, theoretical minimum: -0.65, theoretical maximum: 12.26) This factor taps a construct relating to psychotic symptoms. Items include: seen or heard something that was not really there, felt someone or something was controlling your mind, and worried that someone might hurt you. Items relating to this factor, but carrying less weight, include: felt rested after only a few hours' sleep, and had nightmares.

Adolescent Social Conflict (SCONF) (4 items, theoretical minimum: -0.70, theoretical maximum: 5.41) This factor taps a construct that relates to how well someone relates to other people. Endorsement of most of the items on the factor indicates some kind of social conflict (been emotionally hurt by someone, felt someone else had too much control over your life, felt too much conflict with someone, worried someone might hurt you, and felt sexually incompatible with your partner).

Adolescent Sleep (SLEEP) (4 items, theoretical minimum: -1.06, theoretical maximum: 4.63) The factor taps a construct that relates to difficulties in sleeping. While the items do not

specify the cause of any sleep disturbance, they do specify the symptoms. The sleep problems asked about include: having difficulty falling, staying, or returning to sleep, and having nightmares.

Adolescent Suicidality (SUICD)* (5 items, theoretical minimum: -0.20 theoretical maximum: 16.31) This factor taps a construct related to suicidal ideation, recent suicide attempts, or recent suicidal gestures: thought about killing yourself or wished you were dead, planned or tried to kill yourself, inflicted pain on yourself, felt worthless, and felt you were going to act on your violent thoughts. As with all TOP factors, the score provided is based upon the client's self-report or a parent's report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Due to low endorsement of the items in this factor among the general population, scores on this factor can be elevated quite quickly, even with only minor endorsement of some items. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

Adolescent Substance Abuse (SA)* (6 items, theoretical minimum: -0.34, theoretical maximum: 18.91) This factor uses the six items from Norm Hoffmann's UNCOPE questionnaire and has excellent sensitivity and specificity for substance abuse and dependency issues. According to Dr. Hoffman's research a patient who positively answers two or more questions is likely to have a substance abuse issue. With three or more questions there is greater than 90% chance of a substance dependency.

Adolescent Violence (VIOLN)* (4 items, theoretical minimum: -0.28, theoretical maximum: 20.47) This factor taps a construct that relates physical temper and violence. More serious and focused than previous TOP violence factor scores, this factor now clearly focuses on serious actions and plans, not just angry feelings. Items include: physically hurt someone else or an animal, had desires to seriously hurt someone, had thoughts of killing someone else, and felt that you were going to act on violent thoughts). As with all TOP factors, the score we provide you is based on the client's self-report. We cannot guarantee that the reporter is accurate, nor can we predict future behavior. Due to low endorsement of the items in this factor among the general population, scores on this factor can be elevated quite quickly, even with only minor endorsement of some items. Any elevation in this score should be assumed to be serious and immediate, appropriate clinical action is recommended.

Adolescent Work/School Functioning (WORKF) (6 items, theoretical minimum: -1.12, theoretical maximum: 6.33). This factor taps a construct that relates to functioning at work or school. The items on this factor include one item about missing work or school for any reason and several items about problems at work (e.g. had conflicts with others at work or school regardless of fault, had not been acknowledged for your accomplishments, had your performance criticized); and an item on fulfillment (not been excited about your work or school work).

TOP Score Ranges

The healthy range for any domain is any score under 1.5. A mild problem is defined as a domain score between 1.5 and 2.0, while a score between 2.0 and 3.0 is considered a moderate case. Any domain over 3.0 standard deviations is considered to be severe.

Using Theoretical Minimum and Maximum Scores

If a domain was normally distributed, you might expect to see theoretical minimum and maximum scores in the negative five to positive five range. When one of these scores is a lot higher, you can conclude that the distribution of scores within the general population does not look like a normal bell curve. Knowing these theoretical minimums and maximums is important for several reasons:

- When the theoretical maximum score for a particular factor is in the high teens or twenties, it indicates that almost everyone in the general population clusters around the mean of zero, with a few, rare cases out near the extreme. People who score very high on these scales may be acutely aware of how different they feel, and may be desperately seeking relief, but reluctant to discuss it fully.
- You can be confident that TOP was developed to measure change beyond the range of traditional bell curves. However, in the rare event that a client scores at the theoretical maximum, you should wonder if their distress is even greater than reported, or whether they are greatly exaggerating their symptoms.
- TOP scores are not designed to go very far into the healthy range (usually just 1-2 standard deviations below the general population average). A client at the theoretical minimum could indicate that this domain may be a strength for them and you could explore how to use this strength during the course of treatment. The only factor that does not follow this rule is Mania, where very low scores might be a sign of depression.

Appendix 5 – Child and Adolescent Needs and Strengths Domains and Scoring

THE CANS

The CANS is a multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the CANS Comprehensive is to accurately represent the shared vision of the youth/youth serving system—children, youth, and families. As such, completion of the CANS Comprehensive is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the CANS Comprehensive is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the CANS Comprehensive.

SIX KEY PRINCIPLES OF THE CANS

1. Items were selected because they are each relevant to service/treatment planning. An item exists because it might lead you down a different pathway in terms of planning actions.
2. Each item uses a 4-level rating system. Those levels are designed to translate immediately into action levels. Different action levels exist for needs and strengths. For a description of these action levels please see below.
3. Rating should describe the youth, not the youth in services. If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an “actionable” need (i.e. ‘2’ or ‘3’).
4. Culture and development should be considered prior to establishing the action levels. Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the youth’s developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young youth but would be for an older youth or youth regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the youth/youth’s developmental age.
5. The ratings are generally “agnostic as to etiology”. In other words this is a descriptive tool; it is about the “what” not the “why”. Only one item, Adjustment to Trauma, has any cause-effect judgments.
6. A 30-day window is used for ratings in order to make sure assessments stay “fresh” and relevant to the youth/youth’s present circumstances. However, the action levels can be used to over-ride the 30-day rating period.

MEASUREMENT PROPERTIES

Reliability

Strong evidence from multiple reliability studies indicates that the CANS can be completed reliably by individuals working with youth and families. A number of individuals from different backgrounds have been trained and certified to use the CANS assessment reliably including health and mental health providers, youth welfare case workers, probation officers, and family advocates. With approved training, anyone with a bachelor's degree can learn to complete the tool reliably, although some applications or more complex versions of the CANS require a higher educational degree or relevant experience. The average reliability of the CANS is 0.78 with vignettes across a sample of more than 80,000 trainees. The reliability is higher (0.84) with case records, and can be above 0.90 with live cases (Lyons, 2009). The CANS[®] is auditable and audit reliabilities demonstrate that the CANS[®] is reliable at the item level (Anderson et al., 2001). Training and certification with a reliability of at least 0.70 on a test case vignette is required for ethical use. In most jurisdictions, re-certification is annual. A full discussion on the reliability of the CANS assessment is found in Lyons (2009) *Communimetrics: A Communication Theory of Measurement in Human Service Settings*.

Validity

Studies have demonstrated the CANS' validity, or it's the ability to measure and their caregiver's needs and strengths. In a sample of more than 1,700 cases in 15 different program types across New York State, the total scores on the relevant dimensions of the CANS-Mental Health retrospectively distinguished level of care (Lyons, 2004). The CANS[®] assessment has also been used to distinguish needs of children in urban and rural settings (Anderson & Estle, 2001). In numerous jurisdictions, the CANS has been used to predict service utilization and costs, and to evaluate outcomes of clinical interventions and programs (Lyons, 2004; Lyons & Weiner, 2009; Lyons, 2009). Five independent research groups in four states have demonstrated the reliability and validity of decision support algorithms using the CANS (Chor, et al, 2012, 2013, 2014; Cardall, et al, 2016; Epstein, et al, 2015; Israel, et al, 2015, Lardner, 2015).

RATING NEEDS & STRENGTHS

The CANS Comprehensive is easy to learn and is well liked by children, youth and families, providers and other partners in the services system because it is easy to understand and does not necessarily require scoring in order to be meaningful to the youth and family.

- ★ Basic core items – grouped by domain - are rated for all individuals.
- ★ A rating of 1, 2 or 3 on key core questions triggers extension modules.
- ★ Individual assessment module questions provide additional information in a specific area

Each CANS Comprehensive rating suggests different pathways for service planning. There are four levels of rating for each item with specific anchored definitions. These item level definitions, however, are designed to translate into the following action levels (separate for needs and strengths):

Basic Design for Rating Needs

Rating	Level of Need	Appropriate Action
0	No evidence of need	No action needed
1	Significant history or possible need that is not interfering with functioning	Watchful waiting/prevention/additional assessment
2	Need interferes with functioning	Action/intervention required
3	Need is dangerous or disabling	Immediate action/Intensive action required

Basic Design for Rating Strengths

Rating	Level of Strength	Appropriate Action
0	Centerpiece strength	Central to planning
1	Strength preset	Useful in planning
2	Identified strength	Build or develop strength
3	No strength identified	Strength creation or identification may be indicated

CORE ITEMS

Life Domain Functioning

Family Functioning
Living Situation
Social Functioning
Recreational

Developmental/Intellectual*
Job Functioning
Legal
Medical/Physical
Sexual Development
Sleep
School Behavior

School Attendance
School Achievement
Decision Making

Strengths

Family Strengths
Interpersonal
Optimism
Educational Setting
Vocational
Talents and Interests
Spiritual/Religious
Community life
Relationship Permanence
Resiliency
Resourcefulness
Cultural Identity
Natural Supports

Cultural Factors/Acculturation

Language
Traditions and Rituals
Cultural Stress

Caregiver Needs and Resources

Supervision
Involvement with Care
Knowledge
Organization
Social resources
Residential stability

Medical/Physical
Mental Health
Substance Use
Developmental
Safety

Behavioral/Emotional Needs

Psychosis
Impulsivity/Hyperactivity
Depression
Anxiety
Oppositional
Conduct
Adjustment to Trauma*
Anger Control
Substance Use*

Risk Behaviors

Suicide Risk
Non-Suicidal Self-Injurious Behavior
Other Self-Harm (Recklessness)
Danger to Others*

Sexual Aggression*
Runaway*
Delinquent Behavior*
Judgment*
Fire Setting*
Intentional Misbehavior

Appendix 6 – Trauma Screening Checklists



Ages 0–5

CTAC Trauma Screening Checklist: Identifying Children at Risk

1. Are you aware of or do you suspect the child has experienced any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy |
| <input type="checkbox"/> Neglectful home environment | <input type="checkbox"/> Lengthy or multiple separations from parent |
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Placement outside of the home (foster care, kinship care, residential) |
| <input type="checkbox"/> Exposure to domestic violence | <input type="checkbox"/> Loss of significant people, places, etc. |
| <input type="checkbox"/> Exposure to other chronic violence | <input type="checkbox"/> Frequent/multiple moves; homelessness |
| <input type="checkbox"/> Sexual abuse or exposure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Parental substance abuse | |
| <input type="checkbox"/> Impaired parenting (mental illness) | |
| <input type="checkbox"/> Exposure to drug activity <i>aside from parental use</i> | |

Even if no areas are checked above, but multiple concerns are present below, further assessment may still be indicated, as there is a strong relationship between the following areas and trauma exposure.

2. Does the child show any of these behaviors:

- | | |
|--|---|
| <input type="checkbox"/> Aggression towards self; self-harm | <input type="checkbox"/> Social/developmental delays in comparison to peers |
| <input type="checkbox"/> Excessive aggression or violence towards others | <input type="checkbox"/> Repetitive violent and/or sexual play (or maltreatment themes) |
| <input type="checkbox"/> Explosive behavior (going from 0-100 instantly) | <input type="checkbox"/> Unpredictable/sudden changes in behavior (i.e., attention, play) |
| <input type="checkbox"/> Hyperactivity, distractibility, inattention | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Excessively shy | |
| <input type="checkbox"/> Oppositional and/or defiant behavior | |
| <input type="checkbox"/> Sexual behaviors not typical for age | |
| <input type="checkbox"/> Difficulty with sleeping, eating, or toileting | |

3. Does the child exhibit any of the following emotions or moods:

- | | |
|--|---|
| <input type="checkbox"/> Excessive mood swings | <input type="checkbox"/> Flat affect, very withdrawn, seems emotionally numb or 'zoned out' |
| <input type="checkbox"/> Frequent, intense anger | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic sadness, doesn't seem to enjoy any activities, depressed mood | |

4. Does the child have any of the following relational/attachment difficulties:

- | | |
|--|--|
| <input type="checkbox"/> Lack of eye contact, or avoids eye contact | <input type="checkbox"/> Doesn't reciprocate when hugged, smiled at, or spoken to |
| <input type="checkbox"/> Sad or empty-eyed appearance | <input type="checkbox"/> Doesn't seek comfort when hurt or frightened; shakes it off, or doesn't seem to feel it |
| <input type="checkbox"/> Overly friendly with strangers (lack of appropriate stranger anxiety) | <input type="checkbox"/> Has difficulty in preschool or daycare |
| <input type="checkbox"/> Vacillation between clinginess and disengagement and/or aggression | <input type="checkbox"/> Other _____ |

Ages 6–18

CTAC Trauma Screening Checklist: Identifying Children at Risk

1. Are you aware of or do you suspect the child has experienced any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Pre-natal exposure to alcohol/drugs or maternal stress during pregnancy |
| <input type="checkbox"/> Neglectful home environment | <input type="checkbox"/> Lengthy or multiple separations from parent |
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Placement outside of the home (foster care, kinship care, residential) |
| <input type="checkbox"/> Exposure to domestic violence | <input type="checkbox"/> Loss of significant people, places, etc. |
| <input type="checkbox"/> Exposure to other chronic violence | <input type="checkbox"/> Frequent/multiple moves; homelessness |
| <input type="checkbox"/> Sexual abuse or exposure | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Parental substance abuse | |
| <input type="checkbox"/> Impaired parenting (mental illness) | |
| <input type="checkbox"/> Exposure to drug activity <i>aside from parental use</i> | |

2. Does the child show any of these behaviors:

- | | |
|--|---|
| <input type="checkbox"/> Aggression towards self; self-harm | <input type="checkbox"/> Social/developmental delays in comparison to peers |
| <input type="checkbox"/> Excessive aggression or violence towards others | <input type="checkbox"/> Repetitive violent and/or sexual play (or maltreatment themes) |
| <input type="checkbox"/> Explosive behavior (going from 0-100 instantly) | <input type="checkbox"/> Unpredictable/sudden changes in behavior (i.e., attention, play) |
| <input type="checkbox"/> Hyperactivity, distractibility, inattention | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Excessively shy | |
| <input type="checkbox"/> Oppositional and/or defiant behavior | |
| <input type="checkbox"/> Sexual behaviors not typical for age | |
| <input type="checkbox"/> Difficulty with sleeping, eating, or toileting | |

3. Does the child exhibit any of the following emotions or moods:

- | | |
|--|---|
| <input type="checkbox"/> Excessive mood swings | <input type="checkbox"/> Flat affect, very withdrawn, seems emotionally numb or 'zoned out' |
| <input type="checkbox"/> Frequent, intense anger | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic sadness, doesn't seem to enjoy any activities, depressed mood | |

4. Does the child have any of the following problems in school:

- | | |
|---|--|
| <input type="checkbox"/> Low or failing grades | <input type="checkbox"/> Difficulty with authority/frequent behavior referrals |
| <input type="checkbox"/> Attention and/or memory problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Sudden change in performance | |

5. Does the child have any relational/attachment difficulties?

- Lack of eye contact, or avoids eye contact
- Lack of appropriate boundaries in relationships
- Does not seek adult help when hurt or frightened

Appendix 7 – Trauma Assessment Measures and Elements

Level I (High Intensity) Trauma Assessments
Assessment Preparation
<ul style="list-style-type: none"> • Review of abuse/neglect history, Educational Records/IEP, prior assessments, medical/health • Ethnographic interview with current caregiver and birth parent • Caregiver Forms – Trauma Symptom Checklist for Young Children (TSCYC), Child Behavior Checklist (CBCL), Teacher Report Form (TRF), Sensory Profile Caregiver Questionnaire, Dissociative Scale, Alexithymia Scale, BRIEF-P • Pre Assessment Meeting with child’s team
Assessment (5-6 hours with the child)
<ul style="list-style-type: none"> • Assessment completed by multiple disciplines (OT, Speech/Language, Physician/Nurse, Clinician) • Neurodevelopmental testing – VMI (Visual-Motor Integration), consider also CELF, QNST, MVPT • Psychosocial Interview • Assess Verbal and Nonverbal Cognitive ability with the K-Bit (Kaufman Brief Intelligence Test), quick estimate of intelligence • Pragmatics Protocol (Speech/Language) • CELF language screener • MIM (Marschak Interaction Method) parent/child observation to assess parent/child relationship and guide treatment planning (Training available by Theraplay Institute) • Child Forms/Tools – TSCC, Resiliency Scales, BRIEF-SR • Brief Physical and FAS screen
Post Assessment
<ul style="list-style-type: none"> • Post Assessment meeting with the child’s team address immediate recommendations • Develop written report • Debrief recommendations using a Family Meeting with the caregivers and child, if appropriate
Level II (Lower Intensity) Trauma Assessment
Pre Assessment
<ul style="list-style-type: none"> • Review of abuse/neglect history, Educational Records/IEP, prior assessments, medical/health • Abbreviated Ethnographic interview with current caregiver • Caregiver Forms – TSCYC, CBCL, TRF, Sensory Profile Caregiver Questionnaire
Assessment (2-3 hours with the child)
<ul style="list-style-type: none"> • Assessment completed by an individual • Assess Verbal and Nonverbal Cognitive ability with the K-Bit (Kaufman Brief Intelligence Test), quick estimate of intelligence • CELF language screener • Psychosocial Interview
Post Assessment
<ul style="list-style-type: none"> • Develop written report • Debrief of recommendations using a Family Meeting with the caregivers and child, if appropriate