Baseline Evaluation Report of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams

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RTI INTERNATIONAL

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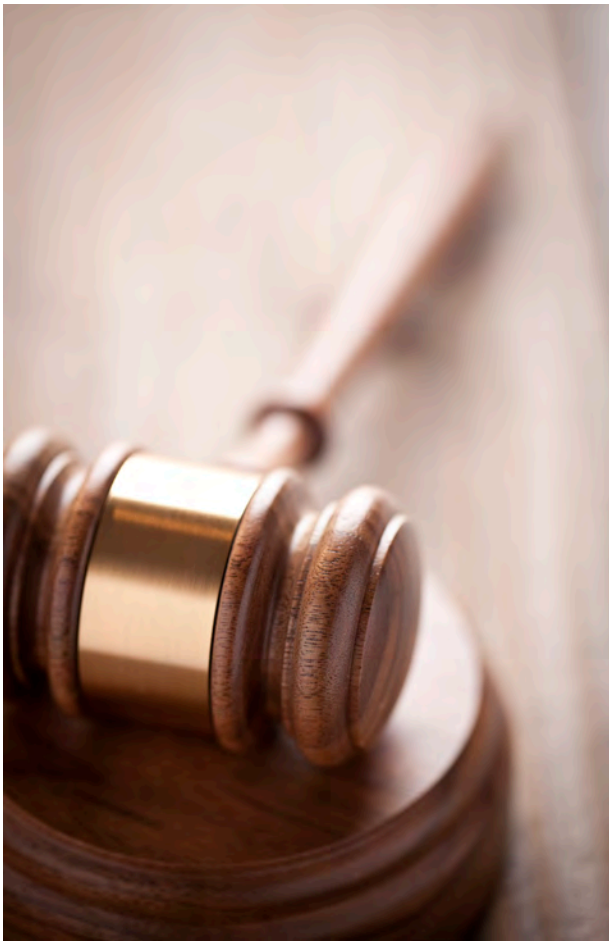
Executive Summary

This executive summary describes the baseline evaluation of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-CT). The summary is divided into four sections. The first presents background information about young children exposed to abuse and neglect, the history and core components of the Safe Babies Court Team (SBCT) approach, and a description of the QIC-CT and the evaluation design. The second section focuses on the results of the QIC-CT baseline evaluation, describing the initial stage of implementation of the SBCT approach at participating sites. The third section describes the findings of an online survey completed by stakeholders at each demonstration site. The fourth and final section summarizes the evaluation team's conclusions after completion of the baseline visits.

I. Background

Based on the most recent estimates of child maltreatment, over 6 million children were involved with the child welfare system (CWS) in 2014, with the highest victimization rate among the youngest children. Exposure to abuse or neglect during childhood is a toxic stressor that can cause severe disruption in the life course. For children involved with the CWS, the trauma of being separated from the biological caregiver—usually suddenly—and placement in foster care with a stranger further jeopardizes the child's well-being. In this way, involvement with the CWS aggravates the original insult of the maltreatment. The resulting sense of profound loss and fear overwhelms the child's capacity to cope.

Motivated by the need to respond actively to the plea of the most vulnerable children reported for abuse or neglect, the Safe Babies Court Team was initiated in 2005 and the approach has since been implemented at 20 sites across the country. The SBCT is "a community engagement and systems-change approach focused on improving how the courts, child welfare agencies, and related child-serving organizations work together, share information, and expedite services for young children in the child welfare system."[1] The SBCT approach has been recognized by the California Evidence-Based Clearinghouse for Child Welfare as demonstrating "Promising Research Evidence," with high relevance to the child welfare system. Each SBCT is a public-private collaboration of ZERO TO THREE (a national nonprofit with the mission to ensure that all babies and toddlers have a strong start in life), local courts, community leaders, child and family advocates, child welfare agencies, early care and education providers, government agencies, private philanthropies, nonprofit and private service providers, and attorneys committed to improving the community's response to child abuse and neglect.



In 2014, the United States Department of Health and Human Services; Administration for Children, Youth and Families; Children's Bureau funded the Quality Improvement Center for Research-Based Infant-Toddler Court Teams. The QIC-CT is operated by ZERO TO THREE and its partners, the Center for the Study of Social Policy, and the National Council of Juvenile and Family Court Judges. RTI International is the evaluator. The QIC-CT efforts focus on information sharing and knowledge building to help ensure that local jurisdictions and states have the tools necessary to identify and address the underlying challenges faced by families in the CWS and to ensure that infants, toddlers, and families have access to high-quality, evidence-based services. The QIC-CT project provides training and technical assistance to fully develop and expand infant-toddler court teams based on the SBCT approach at 12 demonstration sites.

[1] www.qicct.org/safe-babies-court-teams

In December 2014, the QIC-CT released a request for applications to sites, offering technical assistance and implementation support to develop and expand infant-toddler court teams. From the 15 applications submitted, 6 sites (including a site with 2 infant-toddler court teams in Connecticut) were selected during the first phase of the QIC-CT and 5 were added with expansion funds in 2015. The original demonstration sites selected were:

- Florida Early Childhood Court, State of Florida (Pinellas County in Judicial Circuit 6)
- Hawaii Zero to Three Court, First Circuit Court, Honolulu, Hawaii
- Eastern Band of Cherokee Indians, Cherokee Safe Babies Program, North Carolina
- Forrest County Safe Babies Court Team, Hattiesburg, Mississippi
- Polk County Safe Babies Court Team, Des Moines, Iowa
- New Haven and Milford Infant-Toddler Court Teams, Connecticut

By October 2015, additional funding allowed the QIC-CT to expand their work to neighboring communities in Florida and Mississippi that had also responded to the original site solicitation. The new sites were:

- Judicial Circuit 1, Okaloosa County, Florida
- Judicial Circuit 14, Bay County, Florida
- Judicial Circuit 6, Pasco County, Florida
- Judicial Circuit 13, Hillsborough County, Florida
- Rankin County, Mississippi

This report presents a status summary of 9 of the 12 sites at project baseline. Two of the sites initiated activities significantly later than other sites so baseline site visits will be completed toward the end of project year 2. The infant-toddler court in Milford, Connecticut is not included in the evaluation.

The evaluation component of the QIC-CT project is guided by the following questions:

Collaboration and Coordination

1. What factors and strategies are associated with successful partnerships and collaborative efforts to implement or sustain an infant-toddler court team using the Safe Babies Court Teams approach?
2. To what extent is there evidence that better practice is under way at each program site through implementation of the Safe Babies Court Teams approach?

Infant Mental Health, Early Intervention, and Service System Capacity and Infrastructure

3. Which organizational and system conditions are necessary to support successful implementation of the sites' selected evidence-based programs (EBPs)?

Infant–Toddler Court Team Functioning at Sites

4. To what extent are there observable changes in roles and behaviors of infant-toddler court team members during hearings?

Child Safety, Placement, and Well–Being

5. What short-term outcomes result for infants and toddlers served by the infant-toddler court teams (stability of placement, referrals made, services received, time to permanency)?
6. What changes in safety, placement, permanency, and well-being for infants and toddlers served by the infant-toddler court team are perceived by stakeholders?

The QIC-CT evaluation includes both quantitative and qualitative data collection, through the following means:

- Ongoing document review of the sites' self-assessment tools and action plans, and documentation generated by QIC-CT.
- A Web-based survey of stakeholders involved in the SBCT approach and those supporting their effort. The Web survey invitations were sent to stakeholders via e-mail approximately 2 weeks prior to the baseline site visit. The Web survey was kept open for about a month after site visits, with reminders sent to stakeholders encouraging them to complete the survey.
- Output and outcome data gathered via a Web portal created by ZERO TO THREE, and maintained by the QIC-CT for the 12 sites. The Web portal is used by community coordinators to input and track case-level information. The resulting SBCT dataset will be provided after all personal identifiers are deleted for secondary data analysis of the 11 sites involved in the evaluation. Analysis will be completed at the beginning of 2017, based on the families involved up to the end of 2016.
- Two 3-day site visits conducted once at baseline before the QIC-CT program implementation and once after training has been completed. Baseline site visits consisted of in-person interviews with key informants, observations of court hearings, and observations of stakeholder meetings and family court team meetings.

All instruments were tested during a pilot visit to a long-standing SBCT site (Little Rock, AR) independent of the selected QIC-CT sites. The pilot visit was completed between March 30 and April 1, 2015, and included use of the Web survey, interviews with all stakeholders, and observations of a stakeholder meeting, family team meetings, and several court hearings. All RTI staff who were scheduled to conduct the project site visits participated in training on the SBCT approach provided by the QIC-CT in February 2015 and attended the pilot visit.

Site visit notes were analyzed with NVivo software to identify themes and group information. This documentation, along with site-specific data from the Web survey, was compiled to produce baseline site-level reports that were provided to the QIC-CT to guide their training and technical assistance, as well as for distribution to each respective site.

II. Baseline Implementation

Of the nine sites included in this report, five had experience implementing the SBCT approach: Forrest County, Mississippi; Polk County, Iowa; Honolulu, Hawaii; New Haven, Connecticut; and Cherokee, North Carolina; however, four of these five sites had experienced discontinuity, either through a period without the SBCT approach, or through changes in key stakeholders, such as judges and SBCT community coordinators. All of the sites in Florida— Pinellas County, South Okaloosa County, Bay County, and Pasco County—were new to the SBCT approach.

a. Implementation of the Safe Babies Court Team Core Components:

Judicial Leadership. The SBCT approach describes judges as "*the catalysts for change because of their unique position of authority in processing of child welfare cases.*"(ZERO TO THREE, 2011) For six of nine sites, judicial leadership is a strength, while at three sites, leadership is provided by other involved court team members, with some level of judges' support.

Local Community Coordinator. While the role and structure of the community coordinator position can vary across sites, this component is largely in place. The role of the local community coordinator is crucial to the work of an infant-toddler court team (ZERO TO THREE, 2011) and requires someone who is not only highly familiar with the community and its resources and services, but also respected in that community.

Community Court Team Focused on the Big Picture. Every site has an active court team of key community stakeholders working on responding to the needs of maltreated infants and toddlers. Although the level of engagement of stakeholders differs across sites, for most, community court teams meet monthly.

Targeting Infants and Toddlers in Out-of-Home Care. All sites have a court team focused on foster care cases involving children younger than 36 months. The court hearings observed were for

cases involving children aged 0–3 years at the time of removal or early stages of the process. Many cases observed in family team meetings and court hearings revealed a focus on infant and toddler needs for comprehensive developmental, mental, and medical services, and incorporating both needs and services into the case plan document.

Monthly Family Team Meetings. Family team meetings vary somewhat in name, form, and structure by site, but in general meetings were active at most sites and included the community coordinator, service providers, attorneys, and child welfare agency staff along with the family and caregivers.

Placement and Concurrent Planning. As a core SBCT component, securing a permanent home for removed infants and toddlers requires child welfare staff to work diligently and equally with both birth and foster parents at the same time on concurrent planning. For several sites, placement and concurrent planning is difficult to operationalize and implement, with the biggest barriers for implementation being placement options, timing, and deciding how best to approach concurrent planning.

Frequent Parent-Child Contact. All sites, with one exception, reported that they seek opportunities for regular and frequent parent-child contact in convenient, comfortable, and non-intimidating locations.

Continuum of Behavioral Health Services. In all of the baseline visits to the QIC-CT sites, the community was working to provide an array of services for these families. A consistent limitation was the need for more staff availability and training to be able to support the many families in need.

Training and Technical Assistance. ZERO TO THREE staff and consultants provide training and technical assistance to the SBCT community on multiple topics, including infant and toddler development; parenting interventions; services available to foster children in the community; and child and parent trauma. Five of the nine QIC-CT sites were new to the SBCT approach at the time of the baseline site visit; these sites either had not yet had opportunities to participate in professional trainings or receive technical assistance (TA) from the QIC-CT beyond that provided at the kick-off meeting, or had received training for only certain key staff (e.g., community coordinators). TA and training were supported through resources disseminated through the QIC-CT Web site, webinars, and presentations. The Web site was launched in September 2015, providing information about each of the infant-toddler court teams and resources on topics related to infant-toddler court teams. Among the resources used for TA were the completion by sites of a Child Welfare Assessment Tool to prioritize the main areas of action for court teams, and the development of a sustainability plan, as well as initiation of direct training during site visits on sustainability.

Evaluation. Eight of the nine QIC-CT sites were engaged in some form of self-evaluation at the time of the baseline site visits. In most cases, evaluation involved the community coordinators using the SBCT database to enter and track case-level information consistent with the evaluation focus. Because this input and analysis of the data are the responsibility of the community coordinator, most of the QIC-CT sites with newly hired community coordinators were still transitioning to using the SBCT database at the time of the baseline site visit.

b. Strengths and Needs: Direct observation, descriptions from stakeholder interviews, and Web survey responses indicate that key strengths were present across all sites at the initiation of the project. Strengths identified by several sites include strong judicial leadership, highly valued community coordinators, and active involvement, buy-in, support and commitment of several systems, stakeholders, and court team members. Sites also reported on their unique needs and sets of challenges. Several sites identified the need for an increase in the level of commitment and support from key stakeholders, including the judiciary and the child welfare system. Sites also described challenges related to limited time availability for meetings, extended time needed from professionals to dedicate to infant-toddler court team cases, and the need for staff dedicated to the court team. One of the problems widely reported across agencies was the turnover caused by staff being under-resourced and overwhelmed; this was especially true for CWS employees and service providers, who are in need of regular TA and training for new staff. A key challenge at many sites was the limited number of service providers trained in EBPs, with an emphasis on the need for more Child Parent Psychotherapy (CPP)-trained providers.

c. Partnerships and Collaborative Efforts: Strong partnerships and ongoing collaborative efforts were reported by each of the QIC-CT sites. Successful partnerships and collaborative efforts were witnessed in court observations, family team meetings, and stakeholder meetings. They were also reported by interviewees. Two main factors emerged as critical to forming and maintaining healthy partnerships among stakeholders:

(1) Communication. Interviewees and survey respondents across all sites identified communication as a key factor in terms of the success of partnerships, collaboration, and the overall implementation of the SBCT approach.

(2) Agency & System Organizational Support. The active support of the top level of organizations and systems involved with the SBCT approach was also identified as a key factor in successful partnerships and collaboration.

d. Infant-Toddler Court Implementation and Changes in Practices: Although most sites are in the beginning stages of implementing the infant-toddler court team initiative or reinitiating it, interviewees in all but one site identified changes in practice, including improved judicial environment and family focus; increased understanding of several critical topics, such as child development, attachment, and trauma among infant-toddler court team members; increased collaboration, communication, and accountability among court team members; court team members attending hearings with service providers at many sites and encouraged to provide input on progress; and development and implementation of new systems or processes to better serve families.

e. Organizational/System Conditions Supporting EBP Implementation: Over two-thirds of sites reported that organizational/system conditions are in place to support the implementation of EBPs. Eight of the nine infant-toddler court team sites are receiving CPP services as their main EBP. The ninth site had other EBPs and was planning on sending clinicians to CPP training. Although sites are currently providing CPP services, most believe additional CPP providers are needed, with some sites actively engaged in obtaining training for more clinicians. Other interventions identified by interviewees as EBPs available for court team children and families include Parent-Child Interaction Therapy, Triple P: Positive Parenting Program, and Nurse Family Partnerships.

f. Changes in Behavior: Changes in behavior, knowledge, and attitudes of the infant-toddler court team have been identified across settings in most sites. Regarding court hearings, there is a sense of collegiality and cooperation rather than an adversarial climate among team members. Court observations confirm the comments made by interviewees regarding a less adversarial environment at hearings. Another setting in which positive changes in behavior were described by interviewees as well as observed during baseline site visits were family team meetings. Family team meetings were described and observed to be strength-based, organized, productive, and providing the infant-toddler court team with a space to bring all parties together outside of court to focus on the family. Increased communication, knowledge, better trauma-informed practices, and an improved tone were also noted by interviewees in terms of changes in behavior of infant-court team members representing different systems.

g. Perception of Outcomes Associated with Infant-Toddler Court Teams: While at most sites there is a perception of positive outcomes, there are also conflicting perceptions, or the belief that it is too early in the process to see positive outcomes, even among sites that have experience with the approach but went through a period of disruption until the initiation of the QIC-CT projects. This was expected as part of baseline evaluation. For permanency outcomes, interviewees at most sites either did not know if children reached permanency faster or indicated it was too soon to determine as most sites are initiating cases. Thus, there were not enough cases, nor enough time to reach the permanency hearing and compare with regular non-SBCT cases. Interviewees also identified other challenges that would impact the speed of permanency including limited concurrent planning, changes in safety assessments, and state laws. At sites with previous SBCT experience, interviewees did perceive children reaching permanency faster as a result of the SBCT approach. For placement stability, some interviewees reported there are no differences, while others at sites with a history of experience with the SBCT approach reported there is greater stability. Regarding services provision, most sites had a high awareness of positive outcomes associated with the SBCT approach in regard to the services to which families are referred, the timeliness of the referrals and services initiation, the comprehensiveness of needs assessments, and the identification of services with the best fit that are incorporated into the case plan. Interviewees across sites noted an overall positive impact on other outcome areas that the SBCT approach has had on the families, including an increase in parenting capacity with subsequent children, as well as gaining insight on the urgent needs of young children to have stability, with the parent being able to put the needs of the infant or toddler above their own desire to keep their child.

III. Survey Results

In addition to participating in interviews and facilitating the observations of court hearings and meetings, stakeholders were invited to participate in a Web-based survey about their demonstration site. Community coordinators from each site were asked to provide the names of the court team members and stakeholders with whom they work. Lists varied in length from 21 to 103 names. These stakeholders received an e-mail invitation from a preselected champion—unique to each site—on behalf of the evaluation team, inviting them to participate in the QIC-CT Baseline Web Survey. Out of 445 Web survey invitations sent, 187 (42%) responses were received. Of those, 173 (93%) qualified as usable responses. While several sites had previous experience implementing the approach, many court team members were just beginning to learn about SBCT. Most respondents became involved in 2015, with the initiation of the QIC-CT. The respondents represented a wide array of professional positions and organizational systems. Close to a quarter were professionals from the child welfare system, and another quarter were service providers (either from behavioral health services or early childhood/early intervention). The judicial system represented close to one-fifth, including judges, attorneys, guardians ad litem, and court-appointed special advocates. Participating in monthly stakeholder meetings was the most frequent type of involvement, followed by attending trainings sponsored by the infant-toddler court initiative, and working with families involved with the infant-toddler court team.

The following questions were posed to survey respondents:

"To what extent are the SBCT core components in place at your site?"

The components most often reported to be in place at the time of the baseline evaluation visit were regular medical care being provided for children in foster care (90%) and judicial commitment and leadership (90%).

"To what extent has your own agency facilitated your participation in the infant-toddler court team?"

The agency efforts most often reported by the sites were providing support for stakeholders to schedule and attend meetings (84 percent) and approving time needed for infant-toddler court team activities (75 percent). However, "not at all in place" was the response from 14 percent of respondents for providing support for reduced caseloads and 21 percent of respondents for hiring additional staff to serve on the infant-toddler court team.

"To what extent has the infant-toddler court team impacted stakeholders or team members' practice?"

The organizational efforts most frequently cited were the creation of a shared understanding of the impact of child maltreatment, trauma, and multiple placements on a child (91 percent), and the improvement in stakeholders' understanding of the needs of infants and toddlers living in foster care (92 percent). Fifty-three percent of those surveyed reported an increased awareness of how racism affects parents' experience of the child welfare system.

"To what extent are organizational components in place to support the evidence-based intervention selected by your site?"

Most sites reported on their implementation of Child-Parent Psychotherapy. Seventy-eight percent of survey respondents indicated that there was evidence for the intervention in the birth to three population. Seventy-one percent of respondents said the site provided training, coaching, and supervision for service providers to become proficient in the new intervention.

"To what extent have you observed changes in child and family outcomes associated with the infant-toddler court team?"

The most frequently reported changes include improvements in the number of children and parents receiving services to improve the quality of their relationships (83 percent), and an increase in the frequency of parent-child visitation (81 percent).

IV. Summary and Conclusions

At the time of the baseline evaluation, QIC-CT sites were actively working on either initiating or reinitiating the SBCT approach. Among the five long-standing sites, four had experienced an extended interruption of their infant-toddler court team program or a turnover in key court team members, including judges who had previously provided consistent leadership and community coordinators who had been highly valued by their communities.

It is important to acknowledge that infant-toddler court teams vary across sites due in part to differences in system infrastructure and site-specific situations (e.g., the Cherokee community coordinator leading the court team because the judiciary does not). However, there were many common and positive changes observed across sites related to the implementation of the SBCT approach, including increased communication and collaboration among court team members, community stakeholders, and families; increased knowledge of trauma and child development as well as community resources among court team members, community stakeholders, and families; increased accountability among court team members; and a pervasive strength-based, family-focused environment.

Leadership provided by a judge was in place at six sites, while the others have leadership from the magistrate, Department of Children and Families, and community coordinators. Leaders representing various organizational systems involved in the initiative supported its implementation. These leaders believed in the SBCT vision and highly valued the work of ZERO TO THREE, indirectly providing both explicit and implicit permission for professionals and staff to embark on this process of change. While the SBCT approach identifies leadership as a core component to be provided by the judicial system, the experience at certain QIC-CT sites was that the leadership could be provided by a different system, such as the Department of Children and Families or the community coordinator.

A key element for both initiation and reinitiation of the SBCT approach was the selection and hiring of community coordinators, which was completed to varying degrees at all sites. The selection of community coordinators with deep community ties and strong social and team-building skills was fundamental in bringing key stakeholders to the table and facilitating the initiation of the implementation phase at QIC-CT sites.

Concurrent to the evaluation team's baseline visits, community court teams focused on the big picture were initiating major collaborative efforts to change practices, provide EBPs, and improve outcomes for children and families. Monthly oversight through court hearings, stakeholder meetings, and family team case meetings was active at most sites, helping to focus on the services needs of children and their families. Among the main challenges was the insufficient number of clinicians trained in the delivery of EPBs. Sites involved with QIC-CT have the advantage of access to a nationally recognized trainer with a solid training team, at a time when there is high competition in the field to access training in EBPs. Along with the need for more CPP providers, sites need other mental health and substance abuse services (inpatient) particularly in rural areas. Collaborative efforts to support the implementation of the SBCT approach ranged from working with the community and different organizational systems for support, assessing their own readiness to implement changes in practices (e.g., EBPs), to planning or initiating training across key players and organizations (e.g., new community coordinators, CPP for selected clinicians, community training on trauma informed practice), and regular opportunities for a learning community of judicial leadership from the sites to share and consider issues, challenges, and strengths. The flexibility afforded by the SBCT approach was valued across sites, as each of them had important policy and practice differences.

The QIC-CT leadership team was actively preparing for or already providing TA and training support across communities. QIC-CT support was highly regarded at each site, and there was a great interest for securing training spots. TA and training for community coordinators was perceived as key for the success of the initiative, as stakeholders acknowledged that this is an intensive and demanding role with a steep learning curve.

The QIC-CT project was originally funded for 17 months to end February 28, 2016 and later expanded to September 29, 2017, so sustainability is one of the main challenges. The QIC-CT has a very short timeline to support the implementation of the SBCT approach and prepare sites for sustainability. Sites with previous SBCT experience have struggled with maintaining their infant-toddler court teams across the years. Both the QIC-CT and the demonstration sites will need to work on identifying what is feasible to accomplish by September 2017, and avoid overexpectations among QIC-CT site staff that would risk losing sight of the many accomplishments already in place at baseline that need to be incorporated and solidified across sites during the short timeframe.