

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

September 30, 2017



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Executive Summary

This executive summary describes the evaluation of the Quality Improvement Center for Research-Based Infant-Toddler Court Teams (QIC-ITCT). The summary is divided into six sections. The first presents background information about young children exposed to abuse and neglect, the history of the Safe Babies Court Team (SBCT) approach as a response to the needs of the most vulnerable children reported for abuse or neglect, information about the QIC-ITCT, a description of the QIC-ITCT evaluation design, and information about children and families involved with the infant-toddler courts. The second section describes the training and technical assistance provided by the QIC-ITCT. The third section focuses on program implementation and indicators of success. The fourth section describes common challenges to the implementation of the SBCT approach. The fifth section summarizes sites' work to develop plans, respond to challenges, and lessons learned to help sustain the court teams. The final section of the report presents conclusions, and potential next steps based on the evaluation.

I. Background

Approximately 7.2 million children in the United States were involved in 4.0 million referrals to the child welfare system (CWS) in federal fiscal year 2015 (Administration for Children and Families, 2017a). Data on these child reports to CWS show that victimization is highest for infants (< 1 year of age) compared to all other age groups, at 24.2 victims per 1,000 children. Infants had the largest increase in victimization rate of all age groups in the past 5 years.

Exposure to abuse or neglect during childhood is a toxic stressor that can cause severe disruption throughout a person's life. The loss, absence, or failure to protect and nurture the child by his or her primary caregivers disrupts a critical emotional need during a sensitive period of human development. For children involved with the CWS, the trauma of being separated from the biological caregiver—usually sudden—and placement in foster care with a stranger further jeopardizes the child's well-being. In this way, involvement with CWS aggravates the original insult of the maltreatment. The SBCT focus on healing the experiences of maltreatment and subsequent trauma have the overarching goal of changing negative developmental trajectories and returning to normal development (Calpin, 2017).

The Safe Babies Court Team™ Approach

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” (QIC-ITCT, 2016). The SBCT approach has been recognized by the California Evidence-Based Clearinghouse for Child Welfare as demonstrating promising research evidence.

The first SBCTs were initiated in 2005 and the approach has since been implemented at more than 20 sites across the country, some under the guidance of ZERO TO THREE (a national nonprofit with the mission to ensure that all babies and toddlers have a strong start in life), and others on their independent accord. Each SBCT is a public-private collaboration of ZERO TO THREE, 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 (QIC-ITCT, 2016). The SBCT core components are:

1. Judicial Leadership
2. Local Community Coordinator
3. Active Court Team focused on the Big Picture
4. Targeting Infants and Toddlers in Out-of-Home Care
5. Valuing Birth Parents
6. Placement and Concurrent Planning
7. The Foster Parent Intervention, Mentors and Extended Family
8. Pre-Removal Conferences & Family Team Meetings
9. Parent-Child Contact (Visitation)
10. Continuum of Mental Health Services
11. Training and Technical Assistance
12. Understanding the Impact of Our Work

The QIC-ITCT began in 2014, funded by the United States Department of Health and Human Services; Administration for Children, Youth and Families; Children's Bureau. The QIC-ITCT is operated by ZERO TO THREE and its partners, the Center for the Study of Social Policy (CSSP), the National Council of Juvenile and Family Court Judges (NCJFCJ), and RTI International.

As described in the QIC-ITCT documentation and on its Web page, efforts focus on information-sharing and knowledge-building to help ensure that local jurisdictions and states have the tools they need 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-ITCT project provides training and technical assistance to fully develop and expand infant-toddler court teams based on the SBCT approach at 12 demonstration sites. Its goals are twofold:

- **Site Implementation Goal**—Strengthen and enhance the capacity of demonstration sites to achieve safety, permanency, and well-being for infants and toddlers in foster care
- **Dissemination and Building the Body of Knowledge Goal**—Create momentum for collaborative approaches to meeting the developmental needs of infants and toddlers in foster care.

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

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

By October 2015, demonstration sites in Florida and Mississippi expanded their work into neighboring communities. Florida added four Judicial Circuits: Okaloosa County in Judicial Circuit 1; Bay County in Judicial Circuit 14; Pasco County in Judicial Circuit 6, which also includes the existing site in Pinellas County; and Hillsborough County in Judicial Circuit 13. Rankin County was added in Mississippi. The QIC-ITCT offered to all sites funding for a full-time community coordinator until September 2017. Several sites accepted the funding. All sites received technical assistance (TA) support from the QIC-ITCT on sustainability, including securing local funding for the community coordinator position.

This report presents the journey of 10 demonstration sites under the support and guidance of the QIC-ITCT and documents the associated changes in their community. Due to funding constraints, only one of the two sites in Connecticut—New Haven—was included in the process evaluation. The second site, Milford, was included in the continuous quality improvement (CQI) component and secondary data analysis. The site in Cherokee was evaluated as a case study and a separate report is provided in *Appendix A*.



Evaluation Design

The evaluation component of the QIC-ITCT project was conducted by RTI and guided by the following research 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 (policies, programs, stakeholders) is underway at each program site through implementation of the Safe Babies Court Team approach?

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

3. Which organizational and system conditions have been necessary to support the implementation of the sites' selected evidence-based programs?

Infant-Toddler Court Team Functioning at Sites

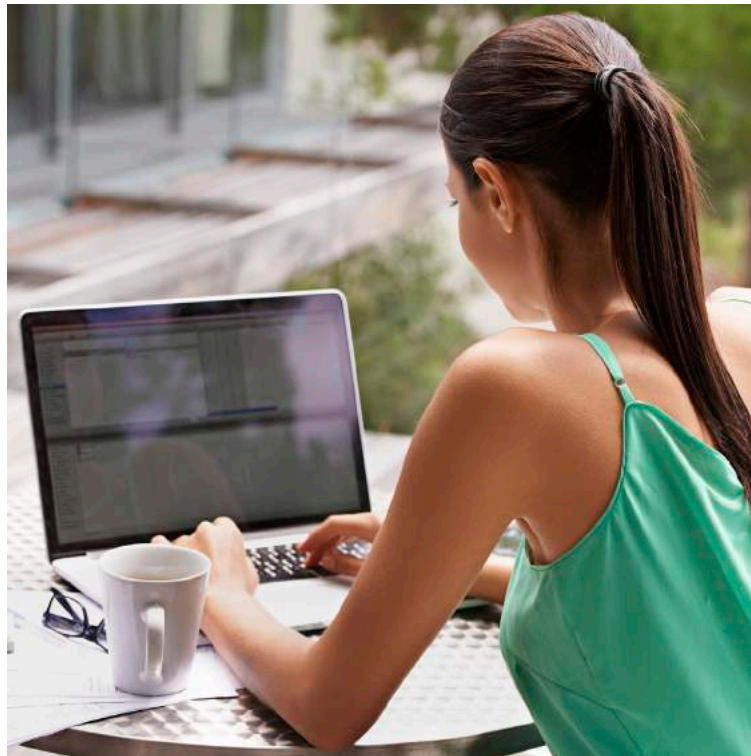
4. To what extent are there observable changes in roles and behaviors of infant-toddler court team members during hearings?

Child Safety, Placement, and Well-Being

5. What short-term outcomes (referrals made, services received, stability of placement, time to permanency) result for infants and toddlers served by the infant-toddler court team?
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-ITCT evaluation included both quantitative and qualitative data collection, as outlined below:

- Ongoing document review of sites' self-assessment tools and action plans, and documentation generated by QIC-ITCT.
- Output and outcome data gathered via the SBCT online database created by ZERO TO THREE and maintained by the QIC-ITCT for the 12 sites. The database is used by community coordinators to input and track case-level information. The resulting SBCT dataset was provided to RTI after all personal identifiers were deleted for secondary data analysis of all sites involved in the evaluation, and included information from the time of sites' initiation with the QIC-ITCT to April 30, 2017. Two sites, Hillsborough and Cherokee, had fewer than 10 children at the time of receipt of the dataset and were excluded from analysis to avoid any potential identification of children and their families.
- A Web-based survey of stakeholders involved in the SBCT approach and those supporting their effort. At baseline and follow up, the evaluation team worked with each community coordinator to identify a survey champion—a stakeholder who would encourage others to complete the survey, and whose name was attached to the survey invitation e-mail. While most of the court team members responded to the survey, it was decided to extend the invitation to all of those identified by the community coordinators and court team members, including people who were historically involved with the initiative but not necessarily an active stakeholder with the current project. Out of 519 Web survey invitations sent at baseline, 225 (42%) responses were received. Of those, 209 (93%) qualified as usable responses. Out of 361 Web survey invitations sent at follow-up, 174 (48%) responses were received. Of those, 136 (78%) qualified as usable responses. After completion of site visits, the Web survey information was summarized in standard form and a summary report was produced for each site. Due to variations in project initiation time across sites, the time between the baseline and follow-up Web surveys ranged from 6 to 19 months.
- Two 3-day site visits were conducted: one at baseline before the QIC-ITCT program implementation and one at follow up after trainings were completed.



- In-person interviews with key informants. Interviews were conducted with 5 to 15 stakeholders from each of the sites including judges, child welfare caseworkers, attorneys, community coordinators, and service providers (e.g., CPP clinicians or other behavioral health providers).
- Observations of court hearings. To assess the quality of court hearings, RTI adapted existing court observational tools available from the previous JBA Safe Babies Court Team evaluation (Hafford & DeSantis, 2009), Court Improvement Program Instruction (Administration for Children and Families, 2012) and the *Toolkit for Court Performance Measures in Child Abuse and Neglect Cases* (Office of Juvenile Justice and Delinquency Prevention, 2008). These tools contain comprehensive guidance and sample forms for measuring court performance and related outcomes in child maltreatment proceedings. A project-specific form was developed to gather data on the extent to which best practices specific to the SBCT approach were being followed in hearings.
- Observations of stakeholder meetings and family team meetings. Evaluation team members also attended stakeholder meetings and family team meetings. Observation protocols and observer checklists were adapted from similar tools used by RTI on previous court projects, with feedback from QIC-ITCT.

The outcome evaluation was guided by the national standards set for the Child and Family Services Review (CFSR) developed by the Administration for Children and Families for the third CFSR round, and follows the final descriptors provided to the Federal Registry (Administration for Children and Families, 2015), preliminary 2015–2016 results for the CFSR 3 based on 24 states (Children’s Bureau, 2017), and the latest report to Congress on child welfare outcomes (Administration for Children and Families, 2017b).

Information is presented on 251 infants and toddlers and their families whom were served by the court teams from the initiation of the QIC-ITCT project at each site through May 1, 2017. The first QIC-ITCT site was initiated on April 1, 2015 and the last site on August 11, 2016. Across QIC-ITCT sites, slightly more than half of children were males (54.1%). More than half of children were infants 0 to 11 months (55.8%), 24.0% were 12 to 23 months, and 20.3% were 24 to 36 months at the time of entry to the infant-toddler court team. Half of children were White, 22.7% Other (this group includes Native Americans, Native Hawaiians, and children with more than one race), 21.5% Black, and 5.8% Hispanic. Most children’s families were living below the federal poverty line (91.3%). At the time of entering the infant-toddler court, 47.2% of children were placed in foster care (including non-relative placement, foster adopt home, medical foster home, therapeutic foster care, and other foster care), 46.8% were placed with kin living separately from their parents, 5.2% remained at home with their parents, and 0.9% were placed in kin care with the parents residing there as well. About three quarters (76.5%) of children were placed in the same county as their parents, 23.0% out of county, and a few out of state (0.4%). The major reasons for children’s removal from home included neglect (72.3%), parent’s use of alcohol/drugs (69.4%), sibling risk (25.6%), parent’s mental illness (24.4%), and physical abuse (11.6%).

Child health indicators showed many of the children had been exposed to parental substance abuse (57.7%), parental use of drugs (52.4%), parental smoking (25.0%), and parental use of alcohol (14.9%). FASD was suspected but not diagnosed among 11.2% of children. While 0.9% of children had a physical disability, 9.9% had low birth weight, 9.6% were medically fragile, 8.4% had a premature birth, and 7.6% were small for gestational age. All children involved with the infant-toddler courts have one or more adverse childhood experiences (ACEs). The mean and median ACE score was 4, with a range of 1 to 9. More than half of children (57.4%) at QIC-ITCT sites have four or more ACEs.

Slightly less than two thirds of parents involved with the infant-toddler courts were female (62.8%). Fewer than half (40.9%) were employed. Close to half of parents had completed high school or received their GED (48.9%), 34.4% did not complete high school, and 16.7% had education beyond high school. About half of parents owned their home (51.0%), but almost 40% reported doubling up with family/friend (30.4%) or being homeless (9.3%). Among parental risk factors, 82.4% of parents had a history of alcohol or drug abuse, 50.8% had a history of mental health issues, and 48.1% had been incarcerated during adulthood. Parents involved with infant-toddler court teams have also experienced a large number of ACEs. Close to two thirds of parents (59.1%) at QIC-ITCT sites have four or more ACEs. The mean ACEs score was 4.3 and the median was 5.

As most of the sites were either restarting or initiating an infant court, a large number of cases were initiated during the second year of the project and remained within the first 12 months at the project's conclusion. Thus, most of the cases were open at the end of April 2017 (85.5%) and 14.1% of cases were closed during the project period, of which one (0.4%) was reopened (representing 2.4% of closed cases).





2. QIC-ITCT Support

The QIC-ITCT conducted local kick-off meetings with demonstration sites to launch the initiative. Kick-off meetings typically lasted several days and included an overview of the SBCT approach, court team members' roles and responsibilities, and presentations from expert speakers. Sites completed a Child Welfare Assessment Tool to identify and prioritize their areas of needs and developed an executable Action Plan to meet their goals.

All sites received training from QIC-ITCT expert consultants and other experts brought in at the sites' request. The full list of trainings and technical assistance offered by the QIC-ITCT included:

Site initiation activities:

- Demonstration site kick-off meeting
- Demonstration site community assessment
- Community coordinator training
- Consulting with communities interested in establishing infant-toddler court teams

Regularly scheduled meetings/calls:

- Technical assistance training from QIC-ITCT staff
- Weekly or monthly conference calls between sites and QIC-ITCT staff
- Weekly one-on-one meetings between community coordinators and TA specialists
- Weekly community of practice calls for all community coordinators and QIC-ITCT staff
- Monthly learning networks for court teams and for judges
- Conference calls between states
- Judges' monthly conference calls

Formal trainings (varied by site):

- Judicial leadership (Judge Connie Cohen)
- Judges' training—either NCJFCJ Child Abuse and Neglect Institute or Annual Meeting
- Trauma Informed Practices Consultation (NCJFCJ)
- Clinician training in the delivery of Child-Parent Psychotherapy (Dr. Joy Osofsky)
- Infant mental health
- Child development and infant mental health (Angela Searcy)
- Guided Interaction for Family Time (Darneshia Bell)
- Historical trauma focused on the Native American Experience (Dr. Eduardo Duran)
- Historical trauma focused on the African American Experience (Dr. Marva Lewis)
- Fetal alcohol spectrum disorders (Dr. Larry Burd)
- Sustainability planning (CSSP)
- Training webinar “QIC/SBCT Continuous Quality Improvement Process” (QIC-ITCT and CSSP)
- Training webinar “Advancing Race Equity Outcomes within SBCTs” on the use of the Racial Equity Tool and using data for continuous quality improvement (CSSP and Dr. Marva Lewis)
- Training webinars for community coordinators on court-based system reform (NCJFCJ)
- Training on family team meetings (Darneshia Bell, Tiffany Kell)
- Training for community coordinators on SBCT core components 1–6, common errors in child protection reasoning (Lucy Hudson, Darneshia Bell, Sarah Beilke)

Conferences and events:

- QIC-ITCT/SBCT Cross Sites Meeting 2015, 2016, 2017
- ZERO TO THREE Annual Conference 2015, 2016

The key areas of training conducted by the QIC-ITCT were judicial training, community coordinator training, team training, and evidence-based program training on Child Parent Psychotherapy. Another team training provided by the QIC-ITCT was on CQI. Each site received support and guidance in completing a CQI worksheet, identifying a CQI indicator on which to focus, and assigning court team representatives who would be responsible for carrying out the CQI process. The QIC-ITCT supported team discussions on site-relevant metrics from the SBCT dashboard and helped them examine trends in their data, explore how other supporting data might be found and used, and identify new metrics to work towards once a goal was accomplished. Monthly calls focused on the CQI metric selected by the site (e.g., frequency of parent-child contact), reviewed performance measures and outcomes, identified data problems, supported generating solutions as part of a plan for improvement, discussed use of data to provide feedback to the infant-toddler court team (e.g., low frequency of parent/child visitation, potential barriers and need for plan to improve visitations), and helped sites identify stakeholders who could join the CQI team and support the use of CQI metrics.

Executive Summary

For these meetings, RTI produced analyses with monthly updates of metrics selected by sites, either based on variables available in the SBCT dataset or new data submitted by sites.

The QIC-ITCT supplements its TA and training with the production of resources disseminated through the QIC-ITCT Web site, webinars, and presentations (materials available at <http://www.qicct.org/>). Key resources available from QIC-ITCT include:

[From Standard to Practice: Guiding Principles for Professionals Working with Infants, Toddlers, and Families in Child Welfare](#)

[Web-based resources \(www.qicct.org/evidence-based\)](http://www.qicct.org/evidence-based)

[Annual Cross Sites Meeting Videos and Presentations](#)

[Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System](#)

[Glossary of Key Terms for Infant-Toddler Court Teams: A Judges' Guide](#)

[Supporting Military Families with Infants and Toddlers in the Child Welfare System](#)

[Testifying in Court for Child-Parent Psychotherapy Providers: Helping the Court Understand the Parent, Child, and Relationship](#)

[Evaluating and Assuring the Effective and Safe Use of Psychotropic Medications in Children](#)

[A Guide to Implementing the Safe Babies Court Team Approach](#)





3. Program Implementation Indicators of Success

Between the baseline and follow-up evaluation visits, there was marked overall progress across sites with several of the SBCT core components. This assessment was based on stakeholder interviews, court hearings, observations of family team meetings and stakeholder meetings, and aggregated results from the stakeholder Web survey. The components most consistently in place at both baseline and follow-up were judicial leadership, targeting infants and toddlers in out-of-home care, parent-child contact (visitation), and continuum of mental health services. The components least likely to be in place at follow-up were pre/post removal conferences and monthly family team meetings, and the foster parent intervention, mentors and extended family.

In parallel to the evaluator's assessments of the core components, stakeholders were asked to report on their own perceptions of their court team via the Web survey. To answer the evaluation research questions, evaluators compiled qualitative data from interviews with court team members, court hearings, court team meeting observations, and quantitative data from stakeholder responses to the Web survey. Below is an assessment of each evaluation question based on evaluator observations, quotes from interviewees, aggregated data from the Web survey, and secondary data analysis (if available).

Evaluation Question #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 Team approach?”*

Interviewees reported that partnerships and collaboration have improved across sites as a result of several critical factors, including strong judicial leadership and an active, engaging community coordinator, as well as a court team that is well-informed on the child welfare system, trauma, and child development. Most Web respondents indicated that their agencies provided support for collaboration to schedule and attend meetings. Other influential factors were stakeholders’ passion and buy-in, engaging in frequent communication, having dedicated, stable infant-toddler court team members, and receiving the support of the state court improvement program (CIP).

Evaluation Question #2: *“To what extent is there evidence that better practice (policies, programs, stakeholders) is underway at each program site through implementation of the Safe Babies Court Teams approach?”*

Most demonstration sites saw changes in practice that ranged from modifying policies to adding or expanding programs to improving stakeholder partnerships. The largest gains were in communication and collaboration. Progress is still needed with regards to stakeholders’ awareness of the role racism plays in how families experience the child welfare system.

Positive changes in policies and procedures occurred at each site; this is reflected in interviewee comments as well as Web survey responses. In Florida, efforts to support the infant-toddler courts culminated in a draft for the “State of Florida Early Childhood Court Best Practice Standards” and a bill to be presented in the next session of the state’s legislature to support the current Early Childhood Court (ECC) sites, which will include funding full-time community coordinators. The Florida Guardian ad Litem (GAL) is also submitting a legislative budget request for one new position per site to serve as a dedicated ECC child advocacy manager.

Court Hearings. Infant-toddler court hearings at several sites are taking place more frequently since the initiation of the QIC-ITCT. Most sites hold monthly hearings, with some sites making this hearing frequency a rule for infant-toddler court cases. Between the sites’ initiation in 2015/2016 and May 2017, QIC-ITCT sites had 885 hearings, with almost three quarters of hearings (72.5%) occurring within 1 month or fewer than 2 months after the previous one. Across QIC-ITCT sites, 37.2% of hearings occurred at least monthly, with some sites having hearings every 2 weeks. Another third of hearings (35.8%) occurred between 1 and 2 months, and 11.5% occurred between 2 and 3 months. Only 15.5% of hearings occurred after 3 months or longer

Family Team Meetings. Most demonstration sites now have monthly family team meetings in place. Family team meetings are a core component that require extensive training and TA from the QIC-ITCT, and, for many sites, a transition from traditional case staffings (without parents present) to an approach that includes parents as active participants, where court teams learn to discuss and present all issues in front of the parent, while mastering the use of a strengths-based approach. Thus, for some sites, initiation of family team meetings lagged slightly behind the sites initiated in 2015/2016. But, by May 1, 2017, QIC-ITCT sites have had 765 family team meetings, with over

two-thirds of family team meetings (72.5%) occurring within 1 month or less than 2 months after the previous one. Across QIC-ITCT sites, 42.5% of family team meetings occurred at least monthly, with some sites having family team meetings every 2 weeks. Another third of family team meetings (36.9%) occurred between 1 and 2 months, and 12.2% occurred between 2 and 3 months after the previous one. Only 8.6% of family team meetings occurred after 3 months or longer.

Pre-Removal Conferences. A newer addition to the infant-toddler court and one not yet implemented at all sites is the pre- or post-removal conference. While at one site, pre-removal conferences have been incorporated as part of standard procedures, other sites are in the process of adapting or developing procedures to offer pre- or post-removal conferences. This conference is held if possible prior to the child being placed in foster care or immediately after and includes the family, their support system, the case investigator, the foster care case worker, and the community coordinator. It sets a welcoming tone for parents, and communicates to parents that the goal is reunification.

Large and Diverse Court Team that Meets Regularly. Large and diverse stakeholder groups have been developed at each site. Stakeholders include judges; attorneys representing the state, parents, and children; GALs; court-appointed special advocates (CASAs); child welfare caseworkers, supervisors and other staff; early childhood specialists; mental health clinicians; early interventionists; college and university staff; domestic violence advocates; substance abuse treatment providers; other service providers; court administrative staff; and others. For most sites, stakeholders meet at least monthly, and the meetings are used for various purposes, such as to review and discuss early childhood court policies and procedures, case and system issues, and community resources, as well as discuss upcoming trainings and research. In addition, many sites have created workgroups that meet regularly and target specific issues.

Thanks to education, training, and technical assistance, stakeholders reported being more informed on the needs of infants and toddlers in foster care; attachment and infant mental health; the impact of child maltreatment, trauma, and placements; parents' individual trauma history; family histories; and the historical trauma influencing the community. This



has led the court teams to respond to the needs of birth parents in the context of traumatic stressors and the history of trauma across parents' lives. Several stakeholders commented on the increased focus on trauma among court team members and the role it plays in being able to adequately support and inform parents.

Parent-Child Contact. Since the implementation of the SBCT approach, not only does parent-child contact occur more frequently at most sites, but interviewees reported that the quality of the contact has improved. The goal of parent-child contact is to promote attachment behaviors and bonding, provide a model for nurturing parenting, and to improve the parent's responsiveness to the child's needs, signs, and cues. Several sites are interested in visit coaching to help assess and increase the quality of parent-child contact. Infant-toddler court teams provided highly individualized parent-child contact plans based on whether the parent could keep the child safe, and their capacity to improve or learn to provide "good enough" parenting, attend to the child's needs, and support the child's social and emotional needs. While court teams could update visitation plans as frequently as needed, there was minimal variation given that from the first visitation the court teams worked toward a high weekly frequency of contact between children and parents. More than 70% of children had a visitation plan that recommended parent-child contact to occur three to five times per week (45.7%) or daily (25.4%). Another quarter had a recommendation of one or two visits per week. Only 5.2% of children received the recommendation not to have any contact with parents. Similarly, close to 90% of children had a visitation plan that recommended contact with siblings. Of the children with information about the most recent actual parent-child contact, close to 60% had a high weekly frequency of contact, with 25.6% daily and 34.5% at three to five times per week; 25.6% had one or two contacts per week; and 7.7% had no visitation.

Parent and Family Engagement. The core component of valuing the birth parents has been operationalized in several ways, including sites implementing several programs and activities to engage and support families. There is also recognition that foster parents and caregivers need additional training and support. Although placement with extended family is the preference for children removed from their homes, typically there is little assistance from the child welfare agency to support them when they take in a child. Foster families are required to receive training in trauma and child development prior to certification and are provided with a family resource book to guide them through the available community resources.

Interviewee reports and family team meeting and court hearing observations demonstrated that parents are critical stakeholders who are valued by court team members, and supported to actively engage in the program. They are encouraged to speak, ask questions, and share their concerns during family team meetings and court hearings. Court team members continually look for ways to improve the program based on feedback from parents.

Reduction of Placement Changes. The court teams are aware of the impact of multiple placements on a child's development and are committed to minimizing the number of times a child is moved to a new home. Procedures are being adapted or changed at most sites as infant-toddler court teams are trying to place children with family before pursuing non-family placements. Judges' awareness of the impact of multiple placements has also helped reduce placements, as it has made placement stability part of the conversation in court hearings, and put pressure on the child welfare

system to be more thoughtful about placement changes. Sites have also been identifying changes in procedures to provide kin and foster caregivers more support to help with placement stability.

Earlier Referral to Services. Many sites have established procedures for frontloading referrals and services. This has resulted in children and families in infant-toddler courts receiving services sooner. At some sites, changes in procedures were implemented to appoint CASAs automatically to infant-toddler court cases. Automatic referrals for child development assessments are common as well. CPP has also become a standard referral at most sites.

Expansion of Mental Health Services. The SBCT approach emphasizes that children traumatized by their parents' care, removal from their home, and placement into foster care may need mental health services. There is also an understanding that parents need some level of intervention to help them overcome the reasons for their neglectful or abusive behavior that is frequently related to their own traumatic experiences and the use of substances as a coping mechanism. Training on the SBCT approach, as well as trauma-informed TA and training, have helped professionals involved in the child welfare system understand the importance of mental health services, and each court team has been working on developing a continuum of mental health services.

Evidence-Based Programs (EBPs) and Child-Parent Psychotherapy (CPP). The SBCT approach has not only helped professionals involved in the child welfare system understand the importance of mental health services, but it also has helped professionals bring important topics to bear when discussing services, including the critical concepts of quality, efficacy, and evidence-based practice. The primary evidence-based intervention used with infant-toddler court cases is Child-Parent Psychotherapy. At most sites, a key change in practice was to make CPP a key referral, working with families to support participation, and communicating consistently that families are expected to engage in CPP services. Most interviewees spoke highly of CPP and its positive impact on parents



and children. Evaluators also observed court hearings and family team meetings during which parents made positive statements about CPP and shared examples of progress made in their CPP work.

Training. Across QIC-ITCT sites, training and TA have been incorporated as a standard practice for court team members and community stakeholders. Some sites have formalized this, such as the Florida ECCs, which have included a section about team training in their Best Practices Standards documentation. Training and education across sites has focused on important topics such as infant and toddler development, trauma, trauma-informed care, parenting interventions, available services for children and families, parental substance abuse, domestic violence, mental illness, and poverty. Education and training have created well-informed court teams, and the perception among interviewees that they are better positioned to understand and help the children and families they serve.

Overall, interviewees at all sites indicated that collaboration and communication has improved. There is also ongoing cross-site collaboration that provides sites the opportunity to share information and learn from each other. Sites have weekly community coordinator phone meetings, monthly judges' phone meetings, monthly learning networks with court teams and judges, and annual cross sites meetings. Several sites have created community partnerships with a mix of local community-based care organizations, corporations, foundations, and universities. This has provided additional support for families' housing, financial, and medical needs as well as child development programs and activities. A supportive CIP was identified as a factor in successful collaboration. In two states, representing seven sites, the CIP state representative actively supports the approach and promotes the expansion of infant-toddler courts across the state.

Evaluation Question #3: *“Which organizational and systems conditions have been necessary to support the implementation of the sites’ selected evidence-based practices?”*

Most sites reported that they used CPP as their EBP of choice for the infant-toddler court team. Some sites also indicated use of Parent-Child Interaction Therapy and Circle of Security. Interviewees identified multiple factors that support the implementation and sustainability of these EBPs. To both implement and sustain EBPs, stakeholders need to be educated on what EBPs are and why they are important. Having this knowledge helps create stakeholder buy-in, the most critical of which is from the judiciary. At several sites, the judges' support of EBPs was also evidenced by the consistency with which progress updates on EBPs is a topic covered in hearings. Judges often ask for information from CPP therapists during hearings, as well as for parents to share what they have learned in therapy. Several sites indicated additional EBP providers (and the training of clinicians to be able to provide CPP), as well as support for those providing CPP were necessary to fully implement and sustain EBPs at their sites. Several sites have built or are in the process of building CPP capacity. The QIC-ITCT has offered trainings on CPP and several clinicians from each site have participated.

Sites acknowledged the need to provide better support to CPP clinicians to help them avoid burnout. Large caseloads and vicarious trauma shortens the time that clinicians work with families involved with the child welfare system. Interviewees emphasized the need for regular and institutionalized support for EBP providers to sustain their work with the infant-toddler court across time. Additional supervision, or funding to help reduce clinician caseloads, could have a positive impact. Having

the fiscal capacity to provide training and resources for wrap-around services was also identified as important in implementing and sustaining EBPs. Beyond the cost of psychotherapy treatment sessions (for CPP), the collateral work required from clinicians (including attending family team meetings, hearings, home and day care visits) is estimated to be 10 hours for each hour of clinical work (Osofsky et al., 2007). Typically, the collateral work is not a billable service.

The biggest improvement between the baseline and follow-up Web surveys was in the percentage of respondents who reported that there was evidence for the intervention in the birth to three population (from 69% at baseline and 76% at follow-up). At follow-up, the component most often cited as present was that there was scientific evidence for the selected intervention in the birth to three population (76%).

Evaluation Question #4: *“To what extent are there observable changes in roles and behaviors of infant-toddler court team members during hearings?”*

Positive changes in roles and behaviors of court team members during court hearings were identified during stakeholder interviews and observed during court hearings. For most QIC-ITCT sites, court hearings are an opportunity to collaborate, identify challenges, and resolve issues. Court hearing observations and stakeholder interviews confirmed that judges are asking more questions during hearings, and holding parents and caseworkers accountable for detailed and thorough updates. Infant-toddler court team judges were reported to have a friendly and positive demeanor, which sets a more inviting and encouraging tone in the courtroom. Evaluators observed judges speaking directly to parents, using simple language, and engaging parents throughout the hearing. Judges were observed regularly checking with parents to make sure they understood what was being discussed in court and how it would affect them or their child. Interviewees indicated that judges in infant-toddler court cases are also more informed about a variety of topics, including services, trauma, drug addiction, child development, and the importance of parent-child interaction. Evaluators also observed judges acknowledging the trauma that parents had experienced in their own lives, and the role it played in their current situation. The judges’ knowledge and understanding of trauma was demonstrated in hearings and reported by interviewees.

Court team members’ behaviors were collaborative during court hearings in respectful, attentive, and supportive ways. Several interviewees discussed how the increased frequency of hearings has resulted in greater accountability in terms of team members as well as parents. Others noted that infant-toddler court hearings are also longer and more thorough than hearings in ‘regular’ dependency court. Infant-toddler court hearings include the community coordinators and service providers, and they are often encouraged to provide input. Evaluators observed CPP providers being called upon to provide information about the quality of the parent/child relationship, insight gained by parents, strengths and challenges of the therapeutic process, and the impact of changes on the child’s safety and well-being. Community coordinators were observed providing information on available services during hearings.

Parents are encouraged to bring family members or others in their support system to court hearings. Parents are also active participants in hearings; they speak for themselves instead of through their attorneys. Evaluators observed most judges asking a parent directly for input on their progress,

updates on their children, and whether they had additional needs. The environment in an infant-toddler court hearing is positive, supportive, child and family centered, and family friendly with an increased focus on the needs of the family. Interviewees across sites described infant-toddler court hearings as more supportive of parents. Some sites indicated that a caseworker, therapist, or community coordinator purposely sits next to the parent at hearings to be more supportive of them. Many interviewees noted a conscious effort to recognize parents for progress. Most sites strive to keep the court space family friendly and strengths focused. Several sites have created special areas for children and families.

Evaluation Question #5: “*What short-term outcomes result for infants and toddlers served by the infant-toddler court teams (referrals made, services received, stability of placement, time to permanency)?*”

Service Needs and Receipt: Across sites, at both baseline and follow-up, interviewees highly valued the effort put forth by community coordinators to bring service providers in the community to present at stakeholder meetings and participate in hearings and family team meetings. These improvements across sites were attributed to a variety of things, including the strength of collaboration and communication.

The biggest improvements between baseline and follow-up Web survey responses were an increase in children and parents receiving services like CPP to improve the quality of their relationship (from 65% at baseline to 76% at follow-up), and a higher number of services that take into account a parent’s trauma and substance use history (from 62% at baseline to 73% at follow-up).

Between baseline and follow-up, sites received several trainings and TA related to the developmental needs of young children. Screening for developmental delays during the first quarter of entry to the infant-toddler court team is critical under the SBCT approach. Secondary analysis of the SBCT dataset based on the Ages & Stages Questionnaires (ASQ-3), a set of screening questionnaires for developmental delays completed with parents/caregivers of children aged 1 month to 5.5 years, indicate that about 70% of children have one or more developmental areas that needed to be monitored or were below normal development.

Given the SBCT approach’s guidelines that all children should be screened within the first 3 months of coming into the court team, developmental screening was identified as a service need among more than 95% of children. For newborn children, the recommendation provided to community coordinators is to wait until week 8 to activate a service need for developmental screening.

Analysis of the SBCT dataset indicates that services needed by children included CPP (51.1%), dental care (25.1%), and Early Head Start (12.1%). Among children identified as in need of a service, more than 90% had received their first appointment, from 93.9% for CPP to 98.2% for dental care. The time between the courts ordering the service or time of referral to the date of receiving developmental screening was less than a week for 18.7%, 7 to 30 days for 45.3%, and 31 to 60 days for 22.4%. Overall, about 85% of children received developmental screening within 60 days. Similarly, about 85% of children identified as in need of early intervention had their first appointment within 60 days, with more than half having the appointment within 30 days (12.6% in

less than a week and 41.5% in 7 to 30 days). For CPP, more than 70% of children in need received their first appointment within 30 days (30.7% in less than a week and 41.2% in 7 to 30 days). Close to 90% of children had their first CPP appointment within 60 days. There were no statistically significant differences by race/ethnicity across sites comparing time from order to service receipt for developmental screening, early intervention, and CPP. Overall, more than 80% of children received services within the first 60 days from court order or referral to service.

The finding that 93.9% of children received CPP is higher than the CFSR 3 preliminary results showing that 66% of children across all ages received mental health/behavioral services among those in need (Children's Bureau, 2017). The contrast is even larger when compared to the receipt of specialty behavioral services in the National Survey of Child and Adolescent Well-Being (NSCAW), the only nationally representative study of children investigated for maltreatment. Among children 1.5 to 10 years old at risk for a behavioral or emotional problem, less than a third (28.8%) received any specialty behavioral health service (Ringeisen, Casanueva, Smith, & Dolan, 2011).

Among the array of services needed by parents, the highest need was related to substance abuse. More than 75% of parents need substance abuse screening, 66.9% parent education, 55.6% mental health screening, and 45.6% mental health counseling. Parents also need services for basic needs including housing (19.5%), employment (16.6%), child care (14.8%), and transportation (9.5%).

Among parents across sites, most were receiving needed services. For those in need of substance abuse screening, 90.9% received a screening. Similarly, among those in need, 96.7% received mental health screening, 84.2% psychological evaluation, and 87.5% received psychiatric evaluation. Among those in need of substance abuse treatment, 95.2% received outpatient services without children, and a small number were identified as in need and received inpatient treatment. Close to 95% received mental health counseling, and 93.5% received parent education. Receipt of needed services by parents contrast with the 61% of mothers and 46% of fathers receiving appropriate services reported in the preliminary CFSR 3 results (Children's Bureau, 2017).

While community coordinators attributed some delays to limited availability of a service in the area, there were also cases for which it took time for the parent to engage in the service. Overall, analysis of the SBCT dataset indicates that close to 80% of parents received services within 30 days of the court order or referral. For mental health screening, time to service receipt was less than a week for 63.8% and 7 to 30 days for 17.0% of adults. For substance use screening, time to services receipt was less than a week for 71.2% of parents and 7 to 30 days for 17.0%. Time to receipt of the first mental health service (including mental health counseling, mental health medication management, family counseling, or anger management) was less than a week for 53.9% of parents and 7 to 30 days for 26.2%, and for the first substance abuse service (including inpatient with or without children, and outpatient services) was less than a week for 73.8% of parents and 7 to 30 days for 11.3%.

Placement Stability: As court teams learned about the impact of multiple placements on a child's development, stakeholders progressively committed to minimizing the number of times a child is moved to a new home. Judicial leadership was identified as critical for placement stability and concurrent planning, both in terms of clear expectations from the court that this would be a focus of the court team, as well as in terms of setting expectations for parents and caregivers.



Based on the Web surveys, at baseline, one of the most frequently reported effects included an emphasis on kinship guardians being identified and supported as preferred out-of-home placements (66%). At follow-up, this was also cited as the most impacted by the court team (76%).

Secondary data analysis indicates that most cases at QIC-ITCT sites have reunification with the parent as the main permanency goal (90.6%) and for 6.4% of cases the goal is to place the child for adoption. The concurrent plans for close to half of infants and toddlers include adoption (45.3%), legal guardianship (29.7%), or placement with a fit and willing relative (8.0%). Only a small number of cases (7.1%) had a concurrent plan pending.

Across all QIC-ITCT sites, 59.4% of children had one placement, 26.6% had two placements, and 14.0% had three or more placements since removal from home. Overall, 94.2% of cases in care for less than 12 months have no more than two placements, and 79.4% among those in care from 12 to 23 months have no more than two placements. Only three cases were in care for more than 24 months by May 1, 2017. The percentage of cases with no more than two placements was over the upper limit of the national range. Based on the last report to Congress, in 2014 the median was 85.6% and the range from 73.7% to 91.4% for no more than two placements among children in care less than 12 months; and the median was 66.1% and the range from 44.0% to 76.9% among children in care between 12 and 23 months (Administration for Children and Families, 2017b).

Analysis by race/ethnicity of children having no more than two placements was completed across sites for placements regardless of time in out-of-home care, as well as for the subgroups of children in care less than 12 months, and 12 to 23 months. There were no statistically significant differences by race/ethnicity across site for the group overall or by time in foster care. In other words, court teams seem to serve children of all races and ethnicities equally well.

Time to permanency: Interviewees identified factors beyond the control of court teams that are having a direct impact on time to permanency. While most children have had one or two placements, and they were in their final placement for a long time, closing the case was challenging. At one site, children living with their foster-to-adopt parents had their file moved to a different court once termination of parental rights (TPR) was completed and the final decision was adoption.

Evaluation Question #6: “*What changes in safety, placement, permanency, and well-being for infants and toddlers served by the infant-toddler court teams are perceived by stakeholders?*”

Safety: Across sites, interviewees perceived that safety was improved due to QIC-ITCT training, how closely children and families are followed through monthly and sometimes weekly family team meetings, monthly hearings, direct one-on-one TA work with court teams, and the support of community organizations, parent support or mentoring, and services providers. The review process offered by the QIC-ITCT for any re-report, regardless of the outcome of the investigation, was a key part of the TA and learning process of the SBCT approach.

At follow-up visits, interviewees described positive outcomes related to child safety. The factors mentioned in relation to this included improvements in the team’s communication, the services provided to the family, and the frequency of contact with the family. None of the long-standing sites reported maltreatment recurrence during the QIC-ITCT period. Interviewees reported that across time, from the initiation of the SBCT court more than 10 years ago, maltreatment recurrence is a rare event.

Child safety analysis of the SBCT dataset followed the CFSR 3 definition provided in the Federal Registry (Administration for Children and Families, 2015). For Safety Performance Area 2, recurrence of maltreatment should respond to the following question: “Of all children who were victims of substantiated or indicated maltreatment allegation during a 12 month period, what percent were victims of another substantiated or indicated maltreatment allegation within the next 12 months?” (Administration for Children and Families, 2015, p. 5). The national standard by the Children’s Bureau for Safety Performance Area 2 Recurrence of maltreatment is set at 9.1%.

Recurrence among children involved with QIC-ITCT sites was 1.2% during a 12-month period. This finding is in line with the first evaluation of the SBCT approach that reported 0.5% recurrence within the next 6 months among 186 children (Hafford & DeSantis, 2009). This is lower than the current 12 months national standard of 9.1%, and also lower than the child welfare outcomes’ 2014 national median of 4.9% for recurrence of maltreatment that uses a 6-month period instead of 12 months (Administration for Children and Families, 2017b). Of the 11 demonstration sites, 10 had no recurrences of substantiated or indicated maltreatment during the 12-month period and only 1 site experienced a maltreatment recurrence. Three children were affected, two of which were siblings under the same allegation, and all three occurred in the early months of the site’s implementation of the infant-toddler court team. For sites like this one that are in the initial implementation stage, failed reunifications are expected to occur, but they are part of the learning process of a complex approach, giving the opportunity to begin in-depth discussions and gain a better understanding of how to implement the approach successfully.

Permanency: Given the time needed for the legal case of young children placed out-of-home to be completed and closed, only a small number of cases had been closed at each site by the time of the follow up. Interviewees at most sites either did not know if children reached stable permanency or indicated it was too soon to determine. As reported through the Web surveys, only 42% of respondents at baseline and 49% at follow up considered that children reach permanency faster. Even based on a small number of cases, interviewees' perception of this outcome was positive, emphasizing that children were more likely to be reunified with their parents.

Based on analysis of the SBCT dataset, 41 cases (14.1%) were closed across all QIC-ITCT sites. Of those, 92.7% reached permanency within 12 months. Among closed cases, 58.5% were reunified with parents, 29.3% placed with fit and willing relative, 4.9% were placed into adoption, and a few children were referred for legal guardianship. These estimates follow the current CFSR 3 definition for Permanency Performance Area 1: Permanency in 12 months for children entering foster care. As data are still been collected across the nation for this third round of the CFSRs, the national standard established by the Children's Bureau for this indicator is that 40.5% of cases will reach permanency in 12 months for children entering foster care.

Well-being: Interviewees across sites had general positive perceptions of well-being outcomes at follow up. Sites with court teams initiated at the end of 2015 or during 2016 had a span of fewer than 12 months between the two evaluation visits. These sites reported that the timeframe was too short to have data on improvements in child and parent well-being. Some interviewees were unsure if child well-being had improved, some thought there had been no change, and some thought there had been improvements. The lack of quantitative data on well-being from caregiver reports or direct assessments is a limitation in this area.



Many interviewees agreed that there have been marked improvements in child well-being, as there is a focus on the child's needs and provision of services to support the child's development as well as health and mental health. While several interviews reported that "the well-being of the child is good," the need to keep the focus on the healing process and child well-being as the main goal was also stated, as well as the need of children to be raised in a nurturing and loving environment. Parents' well-being was also reported to have improved. Interviewees credited the close monitoring of parents via frequent hearings and family team meetings, regular contact by attorneys, caseworkers, community coordinators, and services providers with the family including home visits, use of EBPs like CPP, caregivers' willingness to coparent, and the court teams' enthusiasm to "think out of the box, as far as therapy is conducted."

Overall, results related to services receipt and child welfare outcomes are promising as compared to national estimates or standards. Most children were safe, have experienced only one or two placements, and—along with their parents—were receiving needed services, including EBPs like CPP. These positive outcomes were observed without significant differences by child's race/ethnicity. These are highly encouraging results that indicate the readiness of the SBCT approach for the next level of evaluation with a comparison group from regular dependency courts. Nevertheless, some important limitations on the outcomes presented here should be considered. First, many sites were still in the process of learning the SBCT approach. A few sites have not completed a year since initiation. Thus, the number of cases analyzed was small, and sites were still in the process of learning how to improve CWS outcomes following the SBCT approach. Second, families were not randomized to receive the SBCT approach, and at one site all families with children aged 0 to 3 years are part of the court team. It is possible that during the identification of candidate families for the infant-toddler courts, sites could have unintentionally selected the cases with the best prognosis where the parents were perceived by caseworkers to be willing to be engaged. Third, as the evaluation design does not include a comparison group in regular courts not using the SBCT approach, it was not possible to respond to the question of whether children involved with QIC-ITCT sites have different welfare outcomes compared to children in regular court.

4. Challenges to Implementation

Judicial Leadership: Two of the sites have faced significant challenges implementing the core component of judicial leadership. At one site, due to the rotating assignment of judges across all court divisions and the required commitment of time, the judicial system was unable to provide leadership.

Local Community Coordinator: Four of the nine sites are facing challenges in terms of the local community coordinator core component. Three of these four sites do not currently have a full-time community coordinator due to funding constraints. One site lost their community coordinator at the end of September 2017 when support for the position from QIC-ITCT ended. While the community coordinators at these sites are committed and invested in this work, the SBCT approach requires a full-time coordinator to adequately fulfill the responsibilities associated with getting families linked to services, coordinating court team logistics, conducting ongoing community outreach, and leading the system reform work of the stakeholder group.

Active Court Team: Three of the newer expansion sites are facing challenges in terms of this core component. Buy-in to the overall approach, as well as specific components of it, such as implementing concurrent permanency goals, seem to be the key challenge at these sites. Interviewees also reported challenges with collaboration and the need to determine if these challenges represent buy-in problems or the need to better understand the SBCT approach. Other challenges include having some court team members accept the concurrent goal and moving toward TPR when reasonable efforts were made to work with families.

Valuing Biological Parents: Only one site expressed that they face challenges in terms of this core component. Interviewees described progress in the process of engaging, interacting, and supporting birth parents, but they also noted there is still room for improvement and support that court teams can provide to help communities understand trauma and the support needed by children and families.

Placement and Concurrent Planning: Four sites indicated challenges in this area. At one site, the main challenge seems to be with buy-in of some of the court team. Though the team sets concurrent goals, there is little discussion or planning for the secondary goal.

Foster Parent Intervention: This core component was added between the baseline and follow-up visits. Training, education, engagement, buy-in, and support were noted as the biggest challenges.

Pre- or Post-removal Conferences: Pre- or post-removal conferences were added to monthly family team meetings between the baseline and follow-up site visit, so it is not surprising that all but one site is experiencing challenges. For several sites, the challenge lies in the legal constraints that dictate the timing of removals and hearings. For example, at one site, because infant-toddler court team cases undergo a review process before being assigned to the infant-toddler court docket, many cases are not identified until after their shelter hearing.

Monthly Family Team Meetings: For one site, one of the challenges in terms of family team meetings is participation of providers, attorneys, and families. This is likely because family team meetings were scheduled with short notice. Other sites resolved similar challenges by scheduling meetings 1 month in advance and requesting that attorneys share their calendars. For other sites, the main challenge with family team meetings was finding the right balance between a strength-based approach and having what QIC-ITCT refers to as “courageous conversations,” including contentious issues like intimate partners’ conflicts, and lack or limited participation in services.

Parent-Child Contact: Several sites are experiencing challenges in terms of parent-child contact, with the main barrier being transportation resources. Transportation was also a challenge in other areas. Interviewees across sites indicated that transportation issues affect the receipt of services, in-person attendance at family team meetings and court hearings, and parents’ ability to obtain and maintain employment. While public transportation is available at some sites, it is often extremely limited and not a dependable or useful option.

Continuum of Mental Health Services: Three sites are experiencing challenges in terms of the continuum of mental health services. The challenges one site faced were related to working with one management organization that offers an array of services. The convenience of having an array of services housed under the same umbrella was mitigated by the limits it places on the location and extent of the services available. These challenges began to resolve when the judge requested a meeting that included other community providers. One of the challenges that sites continue to face is a demand for CPP providers that exceeds the current clinical capacity. Though the QIC-ITCT offered training on CPP and several clinicians in that county participated, some of the CPP-trained therapists left the area during the project. The problem is compounded by the loss of funding, the increase in drug use over the last decade, and the lack of mechanisms to pay for the collateral work, including attending hearings, preparing reports, and meeting with the infant-toddler court team.

Training and Technical Assistance: Some interviewees indicated that time and financial constraints hinder their ability to be involved in trainings. They also discussed the desire to be notified of trainings and to use the court team to provide additional training.

Understanding the Impact of Our Work: Five sites reported challenges in terms of implementing this core component. Most interviewees know and understand the importance of collecting data and evaluating their work; the challenge lies in the amount of resources needed for data collection, entry, and dissemination. The QIC-ITCT is now including the need to dedicate one day each week for data entry in the community coordinator job description and their training.



5. Sustainability

The QIC-ITCT work on sustainability was initiated at the beginning of the project, simultaneously with the work to launch the sites' operations (QIC-CT, 2016). Local kick-off meetings to commence the QIC-ITCT initiative were held for all the QIC-ITCT sites, incorporating basic training on core SBCT components and sustainability. During the first quarter of the project, the QIC-ITCT and CSSP partners provided TA at a Sustainability Planning conference that included participation of court teams from first-year sites. Across the project, QIC-ITCT and CSSP staff visited sites to support sustainability plans. CSSP staff participated in the monthly calls with each site providing information and recommending initiatives to sustain the infant-toddler court team.

As the QIC-ITCT project was originally funded for 17 months, and later expanded thanks to a second round of funding for an additional year, sustainability is one of the main challenges. The QIC-ITCT had a short timeline to support the implementation of the SBCT approach and prepare sites for its sustainability. The sustainability stage, a long stage that was initiated at baseline, was actively supported by QIC-ITCT and CSSP, and included providing orientation to teams on the sustainability framework and using tools to drive plans for sustainability; providing information at cross sites meetings to increase awareness of potential financial sources for sustaining the infant-toddler court team; and other ongoing sustainability activities.

Because some sites are still so new to the SBCT approach, more time is needed to fully assess the uptake of the program and sustainability needs. The support and training from the QIC-ITCT will end while some sites are still in the initial implementation stage of the program. Sustainability and growth of the program will depend on the teams' ability to continue to put in place and maintain the SBCT core components, recruit families, expand partnerships, support and engage stakeholders, and identify and address barriers and challenges.





6. Conclusions and Recommendations

The Safe Babies Court Team approach is flexible and adaptable to be used in different contexts. The core components can be tailored to different types of courts and systems, as demonstrated by the sites participating in the QIC-ITCT. The flexibility of the approach is critical for implementing the SBCT because sites have large differences in resources, sources and stability of funding, agencies involved, and types/stability of champions and stakeholders involved. Resources are very limited so court teams must work to remain focused on providing community support for young children and their families, and proactively frontloading services. Of the core components of the SBCT approach, three are critical to initiate and sustain an infant-toddler court:

- Strong judicial leadership
- A community coordinator with experience working with vulnerable families
- An active court team that values the SBCT approach.

When one of these critical components is absent, infant-toddler courts can survive, but progress is slowed and other core components that are in place begin to falter.

The strengths-based work of the SBCT approach, along with the perception of community coordinators as genuinely neutral and dedicated to the child and the family, are fundamental for parents' engagement. Stakeholders described years of experience with parents feeling excluded, judged, talked about without being acknowledged during court procedures, and unsupported. The SBCT approach is valued by stakeholders, and especially parents' attorneys, as their clients report feeling understood, respected, and supported by their infant-toddler court team. Moreover, parents highly suspicious and with no trust in the courts and the child welfare system, learn to trust first their community coordinator, and in time their court team.

Here, we present recommendations to better support the TA and training needed for implementing and sustaining the SBCT approach. These suggestions to the QIC-ITCT are based on the evaluation findings, site visits, observations of monthly meetings with sites, TA and training materials, and observations of training at cross sites meetings:

- *Court Processes:* Establish Trauma-Informed Practice Consultations as a standard part of initiating and implementing the SBCT approach. Integrate recommendations from the trauma consultations as new action plans are developed. Schedule the infant-court docket on the same days each month to promote attorneys' regular attendance. Scheduling that considers attorneys' calendars will help to ensure their presence, reduce continuances, and provide an opportunity to introduce them to the new practices.
- *Community Coordinator Role:* Review the list of responsibilities assigned to the community coordinator. The work with families and the community is a full-time job and requires a high level of commitment and dedication. Data entry responsibilities may need to be supported by other staff, volunteers, or graduate students. Every site highly valued and praised their community coordinator. Both the selection process and the community coordinator training that are in place should be used by sites interested in implementing an infant-toddler court team.
- *Court Teams:* Active participation of child welfare agency head staff (e.g., county or regional directors) in the monthly stakeholder meeting is necessary. When agency leaders believe in the SBCT vision, they provide both explicit and implicit permission for professionals and staff to embark on this process of change. Support from child welfare commissioners is fundamental. There are specific stakeholder groups whose buy-in of the approach and participation on the court team would have significant positive effects. As such, engaging and collaborating with these groups should be made standard practice:
 - Departments/groups/divisions that are responsible for the removal and placement of children. Bringing these groups on board will help use the SBCT approach from the beginning of the child welfare process, which can improve the relationship with parents and relatives, and the suitability and stability of placements
 - Departments/groups/divisions that oversee the adoption of children. Speeding up the legal process after TPR or relinquishment is critical for caregivers and children. The long process for adoption and closing of the case extends the period of uncertainty and is an added layer of stress for caregivers.
 - Foster parent associations and related organizations are key to strengthening the foster parent intervention. Their buy-in and participation is necessary to fully implement the SBCT approach.

Consider providing court teams with *A Guide to Implementing the Safe Babies Court Team Approach* when initiating implementation. Early in this process, stakeholders need to identify the roles and responsibilities of court team members. Interviewees repeatedly indicated this was an area that needed clarification.

- *Monthly Family Team Meetings:* Extend training on conducting family team meetings to the first 12 to 18 months of work for community coordinators. Extended training time is necessary for community coordinators and meeting facilitators to develop the skills needed to have “difficult conversations” and develop the strength-based approach while navigating conflicts and setbacks. This training should include a minimum number (e.g., 10 of each) of mock family team meetings and mentoring/TA during family team meetings. Consider asking TA specialists to complete a checklist after each mock and actual family team meeting to track progress and needs. Some training on family team meetings should be available for all court team members, including mock family team meetings and mentoring for frontline team members. The family team meeting summary form developed by QIC-ITCT is a tool that may also help strengthen these meetings.
- *Targeting Infants and Toddlers:* Expand the target population to infants and toddlers who are not removed from their homes. The support provided by QIC-ITCT to one site that requested work with in-home cases and the lessons learned from this site are of interest to others. As stated by CWS stakeholders, the ultimate goal is to prevent the removal of children and provide services before families are even involved with the child welfare system.
- *Support for Parents:* Transportation is a barrier across sites. For the benefits of the SBCT approach to be fully realized, parents and children need to be able to access the services to which they are referred, have their frequent court-ordered child-parent contact, and participate in family team meetings and court hearings. Strategies to address the lack of transportation need to be developed and implemented. Additional support for parents should include visit coaching to improve the quality of parent-child contact and help rebuild that relationship.
- *EBPs and Community Capacity Building:* An annual needs assessment for each site will help identify gaps in existing services and training. To help reduce burnout and increase provider availability, community clinicians should have access to annual training on CPP and other EBPs targeted for young children and their parents. It is also important to identify funding sources for training in CPP/EBP and to provide continuous guidance for identifying and requesting funding for clinical sessions and collateral work.
- *TA and Training:* Offering annual cycles of training will help introduce new court team members to the approach and provide boosting sessions for longer-term members. TA and training are constantly necessary to respond to turnover of frontline court team members, to strengthen champions of the SBCT approach and site fidelity to core components, and to incorporate new research that further enhances the work of the infant-toddler court teams. Training on trauma, ACEs, brain development, and other key topics covered by the QIC-ITCT creates a common language and understanding of children and parents that support changes in attitudes and behaviors across stakeholders. Developing and providing training tailored for attorneys may help improve attorney buy-in and increase the number of attorneys dedicated to infant-toddler court.

- *Understanding the Impact of Our Work:* As mentioned with the community coordinator's role, consider providing a position on the court team for a data entry person. In addition, dedicated evaluation staff will need training on the need for updated and regular feedback to court teams on CQI metrics, and the key role of data for sustainability. The rate for submitting monthly data updates for each active case may also be improved by suggesting sites identify information needs related to the team goals or to provide to funders. Also, aligning derived variables in the SBCT dataset and dashboard with the current federal outcome indicators will facilitate court teams' regular checks on outcome status. Having these materials ready will help with presentations to supporters and potential funders. Creating indicators to be updated every 3 to 6 months will support court team decisions on reunification based on QIC-ITCT safety reviews that include, "1) whether the parent can keep the child safe; 2) whether the parent exhibits stable mental health and does not abuse substances; 3) whether the parent has stable, safe housing; 4) whether the parent can provide sensitive or "good enough" parenting; 5) whether the parent can attend to the child's daily needs and support her social and emotional development; 6) whether she can implement a consistent routine despite the other pressures in her life" (Osofsky, 2016, p. 2).
- *Evaluation Design:* Change the evaluation design. While a randomized control trial would be ideal for evaluating the SBCT approach, this would require extensive funding and upfront work with courts and judges to be able to assign families randomly to regular or infant-toddlers courts. A more reachable next step would be to use a quasi-experimental design with a comparison group generated from an available dataset. We recommend considering the creation of a comparison group using propensity score matching from the NSCAW (McCombs-Thornton & Foster, 2012), or the ECC dataset in Florida. The Propensity Score Matching method can reduce the effects of selection bias by finding groups of children who are sufficiently similar based on their propensity to be treated such that intervention effects can be attributed to the intervention—in this case, participation in the court team program—rather than to selection bias.

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